Developing targeted interventions to advance maternal health in a geographic Medicaid Accountable Care Organization: Lessons from the Implementation of *Camden Delivers*

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Executive Summary

Maternal mortality in the U.S. more than doubled in the last decade, and half the deaths were preventable.[1] [2] Complications in pregnancy due to chronic disease are a major cause of these deaths, and the rate of unhealthy pregnancies due to chronic comorbidities in women of maternal age is increasing.[3] Many population-level maternal health initiatives focus health goals on the perinatal, prenatal and postpartum care. But, the Centers for Disease Control (CDC) and Health Resources and Services Administration (HRSA) recommend that effective strategies to manage chronic disease impacting pregnancy should also engage women at interconception—the period between pregnancies.[4] In Camden, New Jersey the state of maternal health is bleak with women of maternal age in the city substantially worse off compared to women in New Jersey and the US. Camden has one of the highest maternal mortality rates in the country: for every 100,000 women, a little over 30 women die in childbirth.

The Camden Coalition is a 501c3 non-profit focused on delivering better care at a lower cost to Camden residents. The Coalition began in 2002 when a small group of primary care providers in the city began meeting over breakfast to discuss issues they faced while practicing in the city. More than 10 years later, the Coalition has evolved into one of the first community-based Medicaid Accountable Care Organization's (ACOs) in New Jersey comprised of Camden-area hospitals, primary care and specialty providers, behavioral health providers, community organizations and City residents. Grants from The Nicholson Foundation, which supported infrastructure development played a pivotal role in expediting the organizations evolution into a viable Accountable Care Organization, that is now collectively responsible for over 38,000 covered-lives, including 8,500 women of maternal age. [5] Recognizing that the ACO could provide essential tools to address chronic illness among women of reproductive age in Camden, the Coalition launched *Camden Delivers,* a novel approach to advance women's health using a geographic Medicaid ACO to find and address chronic illness in a vulnerable population in Camden, New Jersey.

Using the process of planning and designing *Camden Delivers* as a case study, this paper highlights early lessons learned in developing targeted interventions within an ACO to improve maternal health in a Medicaid-covered population, including:

- Using data to understand community need and design interventions around that need;
- Establishing a population health surveillance mechanism to produce actionable data to intervene on behalf of a complex population;
- Instituting a tiered intervention system targeted to identified need; and
- Leveraging and coordinating across existing resources in the community to reduce duplication.

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[1] Agrawal (2015), Maternal mortality and morbidity in the United States of America http://www.who.int/bulletin/volumes/93/3/14-148627/en/

[2] Wallace (2015). Why is the maternal mortality rate going up in the United States? http://www.cnn.com/2015/12/01/health/maternal-mortality-rate-u-s-increasing-why/

[3] Centers for Disease Control and Prevention (2015). Severe Maternal Morbidity in the United States http://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html

[4] Kotelchuck (2013). Improving the Health of Women following Pregnancy: Inter-conception Care http://www.hrsa.gov/advisorycommittees/mchbadvisory/InfantMortality/Meetings/20130424/kotelchuck.pdf

[5] http://www.state.nj.us/humanservices/dmahs/info/Camden_Coalition_of_Healthcare_Providers.pdf

Background

NATIONAL AND LOCAL MATERNAL HEALTH TRENDS

The U.S. is one of eight countries, and the only industrialized nation, where the maternal mortality rate increased in the last decade[6]. Chronic disease is seen as a leading cause of this increase in U.S. maternal mortality, as rates of obesity, other metabolic risk-factors and cardiovascular disease among pregnant women are rising.[7] Nationally, over 30% of maternal deaths are caused by chronic disease.[8]

In response to this disturbing trend, the U.S. healthcare community is re-conceptualizing maternal health care delivery from short, pregnancy-based interventions to longitudinal solutions that can address chronic disease between pregnancies by providing chronic disease management and access to affordable, quality healthcare. The CDC and HRSA support adoption of the Life Course Model, a framework that addresses maternal health challenges throughout a woman's life, versus only during early prenatal care and the six-week postpartum period. Additionally, health care delivery experts increasingly recognize there may be too many other physical and emotional demands on a women during pregnancy to adequately address medical, behavioral health, and social challenges and these may be more effectively managed between pregnancies. [9]

In Camden, New Jersey, economic and health disparities are stark. In 2013, the average annual household income was $22,000 compared to $70,000 in New Jersey and unemployment was nearly 13%, almost double the rest of the state.[10] Compared with surrounding areas, Camden City has higher rates of diseases like asthma, higher rates of smoking, lower rates of exercise and lower rates of health insurance coverage.[11] Maternal health in Camden reflects these disparities with women of maternal age substantially worse off when compared to New Jersey and national statistics. Camden has one of the highest maternal mortality rates in the country with over 30 women per 100,000 dying in childbirth.

CAMDEN ACCOUNTABLE CARE ORGANIZATION AND MATERNAL HEALTH

The Camden Coalition of Healthcare Providers (the Coalition) is a 501c3 non-profit focused on delivering better care at a lower cost to Camden residents, through improved care delivery. The Coalition provides community-based care management to patients and works at the city, state and regional levels to convene multi-stakeholder groups able to improve health care delivery through technical assistance, policy, and advocacy.

The Coalition began in 2002, when a small group of primary care providers in Camden, New Jersey started meeting over breakfast to discuss issues they faced while practicing in the city. More than 10 years later, the Coalition has evolved into one of the first community-based Medicaid Accountable Care Organization's (ACOs) in New Jersey, comprised of Camden-area hospitals, primary care and specialty providers, behavioral health providers, community organizations and City residents. Grants from The Nicholson Foundation which supported infrastructure development played a pivotal role in expediting the organization's evolution into a viable ACO

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[6] Kassebaum, Nicholas J et al. (2014), Global, regional, and national levels and causes of maternal mortality during 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013, The Lancet , Volume 384 , Issue 9947 , 980 - 1004

[7] Centers for Disease Control and Prevention (2015). Safe Motherhood. http://www.cdc.gov/chronicdisease/resources/publications/aag/maternal.htm

[8] Centers for Disease Control and Prevention (2016). Pregnancy Mortality Surveillance System http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html

[9] Ibid

[10] http://www.camdencountyoeo.com/employment-training.html

[11] http://www.nj.com/gloucester-county/index.ssf/2013/07/tri-county_community_health_needs_assessment_points_to_chronic_disease_obesity_mental_health_issues.html

now collectively responsible for over 38,000 covered-lives, including 8,500 women of maternal age. [12] By establishing new financial incentive mechanisms, the ACO provides the potential to steer healthcare delivery towards better meeting the needs of the population while simultaneously supporting cost containment. Additionally while, providers continue to receive their usual Medicaid reimbursement for the patient visit if they meet quality benchmarks and establish cost containment, the ACO is eligible to receive shared savings payments, which can be distributed to participants based on a proposed gainsharing plan.

Using the technical infrastructure of the Coalition ACO, the Camden Coalition successfully implemented a citywide post-hospitalization reconnection effort for patients to see their PCP within seven days of hospital-use. Through this effort, the Coalition recognized that with the right data and outreach capacity, the ACO has the potential to address barriers to maternal health care delivery in the city. The Camden Coalition secured funding from the Merck for Mothers Initiative and launched *Camden Delivers,* a novel approach to advance women's health using a geographic Medicaid ACO to find and address chronic illness in a vulnerable population in Camden, New Jersey.

Using the process of planning and designing *Camden Delivers* as a case study, this paper highlights early lessons learned, described below, in developing targeted interventions within an ACO infrastructure to improve maternal health in a Medicaid-covered population, including:

- Utilizing data to understand community need and design interventions around that need
- Establishing population health surveillance systems that produce actionable data to intervene with a complex population
- Instituting a tiered intervention system targeted to identified need, and
- Leveraging and coordinating across existing resources in the community to reduce duplication.

This paper can be used by other organizations looking to develop targeted interventions for sub-groups within an ACO model.

Building the Initiative and Lessons Learned

USING DATA TO UNDERSTAND COMMUNITY NEED

Prior to establishing Camden Delivers, the Camden Coalition engaged in a 9-month planning period during late 2013 and early 2014, funded by Merck for Mothers. The planning grant supported a mixed method (quantitative and qualitative) assessment to understand the need related to maternal health in Camden. Analysis identified a pool of maternal aged women with complex medical, behavioral health, and social conditions that could potentially benefit from a person-centered care management intervention addressing medical complexity during pregnancy and continuing through interconception periods.

The Coalition performed quantitative analysis on birth certificate data and 2007-2012 claims data from the three main hospitals in Camden. This analysis revealed that approximately 1,600 women who lived in Camden give birth at one of Camden's hospital each year. Chronic health conditions lead nearly 35% of these women (approximately 560) to be admitted to the hospital or visit the emergency department within a year of giving birth. Further, chronic conditions drove 22% (approximately 350) of these women to visit the hospital more

[12] http://www.state.nj.us/humanservices/dmahs/info/Camden_Coalition_of_Healthcare_Providers.pdf

than ten times in the four-year period surrounding the birth of their child with receipts for care exceeding $3.5 million over the four-year period.[13]

During the planning year, the Coalition conducted an assessment of existing resources and maternal health programs in Camden. This assessment found that it was not for lack of maternal and infant health programs that moms in Camden have increasingly poor health outcomes. There are over 20 maternal health programs available to women in Camden. The programs range from the nationally renowned and evidence-based Nurse Family Partnership (NFP) to local peer support groups for parents and hospital-based group prenatal care offerings. It also was not for lack of coordination between programs. The Southern New Jersey Perinatal Cooperative (SNJPC), a regional coordinating body in operation for over 30 years, oversees many of Camden's programs and coordinates referrals between each through a central intake for patient referrals from providers and community outreach workers. Most recently, the federal Healthy Start program in Camden increased its capacity in order to engage 1,000 women per year with the mission to reduce infant mortality, increase access to prenatal care and reduce the incidence of low birth weight (LBW) babies.[14] The central intake team reviews referrals and makes appropriate assignments to community programs, based on patient need, desire, and program inclusion criteria. The programs are rarely at capacity and report regular outreach to expand panel-size. Anecdotally, staff reported that patient engagement and retention is a major challenge requiring frequent revisions to outreach approaches and to staff training. Some programs engage women for two years. None of the programs, however, find and address medical complexity between pregnancies, which the CDC and HRSA recommends to ameliorate the effects of chronic disease on maternal mortality. Rather, the programs target specific risk factors such as smoking, parenting education, immunizations, breastfeeding, child development, and lead poisoning or disease states related directly to the proximate pregnancy such as postpartum depression.[15] While many or all of these programs have components designed to ensure access to healthcare, they are generally social rather than clinical in nature, leaving the medical and behavioral health complexity to be absorbed by the clients' medical providers. Care management to facilitate health care delivery for women of reproductive age with medical and behavioral health complexity was identified as a gap.

In late 2013 and early 2014, the Coalition conducted several focus groups to learn about the experience of maternal-aged women in Camden with regard to health care and community services. Women reported that they feel connected to their OB provider and to their child's pediatrician, but many do not have a meaningful connection to a PCP. Women are offered numerous opportunities to engage with local programs for mothers, often at various points during pregnancy and during the postpartum period. Some women reported they decline services due to competing priorities. Some reported they decline for a lack of trust in the service being offered. While women report declining many services, Camden mothers in our focus groups also reported that they want information about how to maintain their own health and they want the information to be clear and consistent across providers and community partners. An emergent theme from the focus groups was that women receive conflicting information about various pregnancy-related topics such as breastfeeding, medications safe in pregnancy and nutrition from their providers and local programs. When a new mom does not have a close relationship to her OB and receives conflicting information from various health care providers and social services organizations, she turns to community mentors or family members for information. If she does not believe community or family information to be accurate she turns to Internet resources, including

[13] Internal data of the Camden Coalition of Healthcare Providers (2012-2014).

[14] http://www.snjpc.org/programs/parenting/camdenhealthystart/chs_about.html

[15] http://www.snjpc.org/programs/

social media, for guidance. Women strongly preferred to be able to call their OB for information about their health.

Finally, part of the planning period involved assessing a pilot program of a group prenatal care, Pregnancy and Parenting Partners (P3), run by the University of Colorado and implemented by the Coalition in partnership with the Cooper Women's Care Center. The pilot program began 2012 and was funded by the Campbell Healthy Communities program, a collective impact initiative aimed at reducing childhood hunger and obesity in the city of Camden.

The major finding of P3 was that patients who elected to engage in the program were neither medically complex nor lacking other maternal health and social resources. In fact, the patients were well-connected to other programs and resources, and had low rates of chronic comorbidity. A majority of patients who joined the program were women interested in general health education versus care management or development of a relationship to a provider for health maintenance. The Coalition worked with the women throughout their pregnancy and into the postpartum period. Most women in the groups declined to attend the program after their delivery unless the visits aligned with appointments for their children. Many women stopped attending the program about one month after delivery because they chose to return to school or work and could no longer keep the daytime meeting schedule required of group prenatal care.

In 2014, the Coalition decided to end its engagement in the study early as it failed to engage the most medically complex patients. Group prenatal care, at its core, is well-designed to address the needs of low-risk pregnancy and the Coalition's mission is to target the most complex patients in the city. As we exited the study, we channeled this learning into the design of our population-health initiative which would use the strategy of assessing all women with a pregnancy in the city in order to engage women who are less likely to seek out and find supportive services on their own.

Overall our assessment of community need and existing programs to address need suggested that women are bombarded with services during and just after pregnancy, which is a time of significant overwhelm. Additionally, programs have incomplete access to information about chronic disease among their patients and do not directly offer care management to ameliorate the impact of conditions on future pregnancies or help integrate conflicting health information into a patient-centered health narrative catered to the individual's personal health goals. We also found that women are generally connected to reproductive health services (e.g. OB/GYN, Planned Parenthood), but may not be as well connected to primary care services able to identify and facilitate management of chronic illness leading to maternal morbidity and maintaining Camden as among the most statistically dangerous places in the US to give birth.

ESTABLISHING A POPULATION HEALTH SURVEILLANCE SYSTEM TO PRODUCE ACTIONABLE DATA

Based on findings during the planning period, in late 2014 the Coalition ACO established a population health surveillance system to identify, assess and engage maternal-aged women with chronic diseases at all stages of pregnancy and interconception.

Establishing a Population Health Surveillance System

While becoming an ACO is not a prerequisite to population-health management, we found that access to system-level data is necessary to find women unlikely to self-select health maintenance programs due to lack of trust, overwhelm or other reasons not identified during our planning period. The Camden Coalition ACO, prior to its official designation as an ACO acquired hospital utilization data from Camden's three hospitals and two

contracts with Medicaid payers (Horizon NJ Health and UnitedHealthcare). These relationships with payers were the result of an early engagement with UnitedHealthcare, through which the Coalition was given the opportunity to coordinate care for a cohort of 50 medically complex, high-cost patients. Through the pilot engagement, the Coalition used its flagship model of community-based care management including home visits, medical accompaniment and support in accessing social services, to create cost-savings and a decrease in emergency room utilization. With these encouraging results, UnitedHealthcare entered into a 2-year ACO contract with the Coalition in December 2013. After securing this contract, the Coalition was able to initiate a similar arrangement with Horizon NJ Health, the other major Medicaid MCO in the area. The Coalition's contract with Horizon NJ Health launched in January of 2015.

Additionally, the Coalition had developed relationships with the three main Camden hospitals and a majority of primary care providers in Camden city to which most Medicaid patients in Camden are assigned for health care. These relationships were cultivated over almost a decade, starting from the period in which Jeffrey Brenner, the founder of the Coalition, was himself practicing as a primary care provider in Camden. Dr. Brenner established a breakfast group with the primary care providers in the city to build relationships and start to discuss common barriers facing providers in the city. When the time came to formalize these relationships through a Medicaid ACO model, these dedicated hospitals and practices signed on to participate. With the payers, hospitals and practices on board, we were able to receive daily admission, discharge and transfer data from the Camden area hospitals and monthly capitation lists from the MCOs for each of the 12 primary care practices in the ACO. We integrated these data with our city-wide Camden health information exchange (CHIE) established in 2010, to provide us a daily feed of all patients in the ACO who were visiting Camden-area Emergency Departments and inpatient wards.

Another critical partnership that we established through the planning grant from Merck for Mothers was with SNJPC and its subsidiary, the Family Health Initiative (FHI). These organizations work in tandem to manage statewide data on perinatal risk in pregnancies among Medicaid-covered patients. In New Jersey, completion of the Perinatal Risk Assessment (PRA) is required by any obstetrics practice billing Medicaid when a woman initiates care at its practice. The OB providers and the Coalition each have relationships with the payers, so the new partnership completed a link between providers, patients and community resources for the assessment and care management of chronic disease. During the planning period, the Coalition established that these two data-driven organizations (the Coalition and SNJPC) with robust information systems and the infrastructure to integrate multi-system data, could work together to build a real-time population health management system. At the end of 2014, SNJPC became a participating entity of the CHIE contributing PRA data.

The result of these key partnerships established the Camden Coalition's ability to set up two, distinct tracks to monitor women of reproductive age in Camden in order to assess and address medical complexity in the population; the first through the PRA for all known pregnancies in the ACO, and the second through hospital utilization data for pregnancies found on hospitalization prior to initiation of prenatal care or between pregnancies for women with chronic illness. This data integrated through the CHIE allowed the Coalition to develop a daily population-health surveillance system to monitor women of reproductive age in Camden and to trigger outreach and implement care management workflows to adequately address complex medical and social needs. In the first year-and-a-half of Camden Delivers, the Camden Coalition reviewed PRAs documenting 2,073 pregnancies among ACO patients and triaged 2,565 hospital readmissions of women of reproductive age (15-49 years).

Producing Actionable Data to Activate Real-time Workflows

Based on the data infrastructure described above, the Coalition receives real time feeds of several data sets. Every morning the Coalition receives a flow of the following data sets from the CHIE into its internally-housed HIPAA-compliant relational database:

1. Hospital Inpatient Admit-Discharge-Transfer (ADT) feeds providing alerts on all women who were admitted to a Camden hospital the day before (this includes all women who are admitted to the Labor & Delivery floors)
2. Emergency Department Admit-Discharge-Transfer (ADT) feeds providing alerts on all women who visit the emergency department the day before along with chief complaint and diagnosis
3. New Perinatal Risk Assessments of women in Camden initiating OB care, indicating where the woman is receiving OB care as well as her expected due date and any biopsychosocial risk factors identified in her pregnancy

These data inputs are linked to our patients based on the capitation lists from the two payers in our ACO. As a result, we can reference in real-time whether a patient is pregnant and has initiated OB care through their perinatal risk assessment and if the woman is using the hospital and whether the utilizations indicate chronic illness better managed in outpatient settings. On a daily basis, triage specialists at the Coalition monitor these data and triage patients, based on their medical complexity, into workflows designed to eliminate barriers to accessing services to improve patient health.

INSTITUTING A TIERED INTERVENTION SYSTEM TARGETED TO IDENTIFIED NEED

Over the course of 2015, Coalition established a set of five different tiered intervention workflows, designed to respond to varying levels of complexity: enrollment in community-based care management of the Camden Coalition; engagement by Camden Coalition ACO Community Health Worker (CHW); reconnection to OB during pregnancy and at postpartum; reconnection to PCP at interconception; and referrals to existing maternal health programs in the region. On a daily basis we review PRA and hospital utilization data in order to ensure all pregnancies in the ACO are monitored and that the most medically complex patients have access to community-based care management.

Community-based Care Management

During our daily triage, women of maternal age who have been admitted to the hospital are assessed for eligibility for the Coalition's community-based care management intervention (CMI). Criteria for this intervention involves substantial medical complexity, documented mental illness or substance use disorder, as well as documented social barriers including unstable housing, lack of social support, language barriers, mobility barriers, past trauma, or being labeled as "non-compliant" in her medical record. Women who are eligible for this initiative are met at the bedside and offered the opportunity to enroll in the program which involves high-touch community-based support including home visits, navigation of and accompaniment to medical services and connection to social services in the community. Patients enrolled in this intervention stay on the panel for an average of 90 days and work with an interdisciplinary care team made up of RN, LPNs, community health workers, health coaches, social workers and behavioral health specialists as needed. We maintain a small number of currently pregnant women on CMI because most women with significant chronic illness in pregnancy are already enrolled in a well-developed high-risk clinic at a local hospital during pregnancy. CMI more frequently works with women with chronic illness at interconception to focus on setting health goals, Reproductive Life Planning and accessing consistent care to maintain health in the context of present chronic

illness. Of 2,565 hospitalizations triaged, 251 women of reproductive age were eligible for the CMI intervention and 51 were enrolled.

Light-touch engagement by CHW

Women who do not qualify for CMI but who have either been admitted inpatient or who are high-utilizers of the emergency department (meaning they have visited an ED five or more times in the past six months) are assigned to be engaged by the Coalition's community health worker. This engagement could occur at bedside, over the phone, or through accompaniment to a medical appointment. Once the CHW makes contact with a woman, she engages in a light-touch intervention to address any needs that that the patient identifies. In particular, during this engagement, the CHW focuses on ensuring that the woman is connected to primary or OB care (dependent on stage of pregnancy), as well as addressing insurance barriers and other social needs.

The Camden Delivers CHW maintains an active daily panel of approximately 12 patients. Patient engagement occurs almost entirely as a result of our access to PRA data. Our CHW, with team support, monitors pregnancies and makes follow-up phone calls at the onset of prenatal care, at postpartum and during pregnancy anytime a hospital utilization occurs. On the call, the CHW offers medical accompaniment, a home visit with a medical fellow, support linking to other community programs and linkage to social services, including maintenance of health insurance. The patients most likely to accept ACO care coordination services of all kinds are women with medically uncomplicated pregnancies who are already mothers and who request support accessing financial assistance and housing. Of 2,073 PRAs reviewed, 1,275 received at least one outreach attempt for engagement. As the light-touch intervention became refined, only pregnancies with documented medical and social complexity were contacted. Through this intervention, 1,700 individual patient-level interactions, including medical accompaniments, appointment scheduling, public benefits access meetings and housing access assistance communications were completed in the first year-and-a-half of the initiative's implementation.

Reconnection to OB

When women who are currently pregnant are seen through the ADT feed – either because they were admitted inpatient or visit the emergency department the day before – our team attempts to connect with them back to OB either at bedside or over the phone. The purpose of this engagement attempt is to confirm that the woman is in fact connected to OB care and that she is attending her regular prenatal appointments. During these engagements, our team seeks to identify if there are any other social needs or barriers that we can help her to address, and we offer to accompany her to OB or other appointments to access services. Many women do not require assistance, but many do ask for help with insurance or other barriers. Some of the women are already receiving case management services but still request help. In these cases, we connect with the existing program to prevent duplication of services and confusion for the patient.

The second OB reconnection workflow occurs for all women in the ACO who have a completed pregnancy. Because we have PRA data with an estimated date of delivery, we are able to attempt to connect with all women around the time of their estimated delivery date to help ensure that they schedule and attend their postpartum visit should they have kept the baby to term. The postpartum visit is important to our payers because it is a HEDIS measure, an indicator of quality in health care delivery related to ensuring women are screened for risk-factors after delivery or other pregnancy outcome. Many women do not attend the visit because they are busy with a new baby, including attending numerous pediatric appointments. To mitigate competing interests and responsibilities and to assist in removing some barriers for woman accessing the postpartum OB visit, the Coalition provides two patient access incentives: a taxi to and from the postpartum appointment, and a $20 gift card for the woman upon completion of the visit.

The Coalition has attempted implementing this systematic reconnection to postpartum care through its own Camden Delivers care management team (comprised of a clinical manager, CHW and two health coaches) as well as handing off this workflow to the OB provider office. Instating a new workflow in a busy medical practice is difficult and slow-going, but the most effective patient outreach to-date is initiated by the OB practice, which already has a relationship with the patient. Coalition staff support OB practices by making appointment reminder calls, scheduling appointments, and offering medical accompaniment to patients unlikely to make the appointment. There are three OB practices in Camden and we have had success in getting one practice workflow fully off the ground and operationalized. We believe this success has been driven by beginning the work with a high-level champion trained as a social worker. That person tailored the Coalition recommended workflows to the practice and refined her outreach before task-shifting the work to front-desk and patient services staff. We are attempting to replicate this success at our other two practices in Camden but face administrative challenges due to staff changes and general inertia related to new workflows. In the meantime, we flex our own staff onto this work as needed until these practices are self-sufficient with the workflows. In the first year-and-a-half of Camden Delivers, the Camden Coalition and the three OB practices citywide made at least three attempts per patient to reconnect 1,184 women to their OB provider within six-weeks of a pregnancy outcome. Outcome data is not yet verified for this reconnection effort.

Reconnection to PCP

Similar to our postpartum OB reconnection workflow, reconnection workflows for women back to primary care are activated for every woman with a completed pregnancy in the ACO. Our Camden Delivers team provides, via a list shared through our HIPPA compliant web-based database, a cohort of women who delivered in a particular month to the assigned primary care practices for those women. We then ask that primary care scheduling champions reach out to these women to schedule a well-woman visit within three months of their expected delivery date.

The visit is to address conditions emerging in one pregnancy prior to onset of a subsequent pregnancy. Many interventions designed to connect with women during pregnancy occur too late to mitigate risk for that particular pregnancy. A primary care provider can prepare the woman for a healthy pregnancy by reviewing changes to biopsychosocial risk and comparing health before a pregnancy and after one. The Coalition facilitates the development of a sustained primary care relationship between ACO patients and their providers by linking patients back to primary care after pregnancy outcome.

The workflow for the interconception care visit is rolled-out across the ACO. But our reconnection rate to this visit remains low. We suggest practices schedule a well-woman visit within three months of a pregnancy outcome, but this is not a standard of care and many busy providers find it challenging to find room in the schedule for it. In order to incentivize this work, we are not only providing the same patient access benefits (taxi to and from the appointment and $20 gift card upon appointment completion), but are also offering the practice an additional $100 payment on top of the reimbursement they receive from Medicaid. This has helped to initiate the work and generate the buy-in necessary to speak more with providers about the reason for and content of this visit. Next steps include focusing providers on using the visit to achieve CDC and HRSA recommendations for management of chronic illness between pregnancies.

By taking a systematic, population-level approach, the Coalition ensures every patient is evaluated during and after pregnancy for chronic conditions, including mental illness, as well as changes to social supports so these may be addressed before a potential, subsequent pregnancy. Through this approach we begin to change the attitudes of providers about how to conceptualize the end of a pregnancy as an important moment of re-

engagement as a women transitions from receiving care from her OB back into primary care for her own health maintenance. It encourages ACO providers to acknowledge and address the current reality that many patients are lost to health care altogether once the OB relationship ends. In the first year-and-a-half of Camden Delivers, the Camden Coalition and the citywide primary care practice members of the Camden Coalition ACO attempted to reconnect 1,275 women back to primary care within three months of a pregnancy outcome. Outcome data is not yet verified for this reconnection effort.

LEVERAGING AND COORDINATING ACROSS EXISTING RESOURCES TO REDUCE DUPLICATION

A theme, which weaves across all four of the reconnection efforts outlined above and which is fundamental to the Coalition's strategy is that we make a sincere effort not to duplicate services in the community. At any point that a Coalition or practice team touches a woman through Camden Delivers, there is always an effort to identify current programs engaging the same patient, or to connect the patient to a program that might be particularly helpful to her at the time of engagement. If the woman is already connected to a service, our team makes every effort to connect with the case manager from that program and to coordinate and avoid duplication of services. More than a workflow, this is a consistent philosophy in our approach to care management in Camden where many services exist that are often under-utilized because it can be difficult to remain engaged with clients when so many biopsychosocial barriers exist in their lives.

Conclusion

Through the design and launch of *Camden* Delivers the Coalition developed targeted interventions within an ACO infrastructure to advance maternal health in a Medicaid-covered population. Key insights from this process include the need to:

- Utilize data to understand community need and design interventions around that need
- Establish a population health surveillance system to produce actionable data to intervene with a complex population
- Institute a tiered intervention system targeted to identified need, and
- Leverage and coordinate across existing resources in the community to reduce duplication.

Going forward, with the infrastructure developed by the Coalition to collect and review health data, along with the intricate web of community partners and resources, the next step in this program is to enhance feedback loops between partners and to help navigate patients seamlessly between partners during the highly fragmented experience of managing a pregnancy and healthcare during the interconception period. A formal network of communication between patients, case workers, care managers, providers and community resources through more sophisticated use of data and convening will allow us to support vulnerable patients in an even more effective manner. The Coalition looks forward to playing this convener role and working across groups to the end of better care management services and improved health for women of maternal age in Camden.