Pregnancy Dashboard - Current & Retrospective

The Current Pregnancies Dashboard contains statewide data and is available within One Login using the following path:

One Login > Care Impact > Care Impact for OBCM and CC4C > Pregnancy Dashboard – Current and Retrospective > Current Pregnancies – Dashboard

The Dashboard Header consist of seven pages:

- Current Pregnancies - Dashboard
- Current Pregnancies - Patient List
- Current Pregnancies - Report Details
- Retrospective Pregnancy Measures - Care During Pregnancy
- Retrospective Pregnancy Measures - Care After Delivery
- Retrospective Pregnancy Measures - Patient List
- Retrospective Pregnancy Measures - Report Details

The Current Pregnancies Reports Details page and the Retrospective Pregnancy Measures Reports Details page include report details that should be reviewed and studied prior to using the dashboard to ensure understanding of the data.

To create a graph, select the appropriate filters from these options: Date and County

1. To filter the graph by date, click the down-arrow within the date field. Once you click the arrow, dates will appear in the drop-down box. Select the date for review by clicking on the date.

2. To filter the graph by county, click on the down-arrow and click the “All” box to deselect “All”. Next, begin typing the county name in the drop-down box or scroll down to locate the county for which you are searching.
3. Once the desired county is within view, click the box for the selected county, then click “Apply” and the data will load into the graph.

The graph provides a filter that allows the desired data lines for State and County to be displayed.
1. Once the drop-down box appears, unclick “All”.

2. Next, check the box for the desired county and click “Apply” to generate the graph. If you choose to view the County trend lines, the State trend lines will remain on the graph.
3. To filter the graph to display the County lines, click the down-arrow to open the drop-down box.

4. To choose a different date, find the date that is desired for review on the County trend line and hover over the dot for the date value. An information box will appear.
I. Current Pregnancies-Dashboard

The map displays counties highlighted in red, yellow or green. Below the map, a legend provides the range of percentages each color represents. The dashboard measure that each county should work towards is “green”, which is the benchmark for satisfactory performance.

Select the date for the time-period that is desired for review.

Note: The Salt Shaker marker indicates counties with small denominators of $< 30$ priority patients in managed episode status.

The Current Pregnancies Dashboard includes data on the following measures:

1. Priority Patients in a Non-Active OB Episode Status
2. Priority Patients in a Managed OB Episode Status (and in High, Medium or Low Engagement)
3. Priority Patients in a Managed OB Episode Status without a face-to-face contact (and in a High, Medium, or Low engagement level).

The first measure represents patients with a Maternal Infant Impactability Score of $\geq 200$, with a valid Medicaid ID. These patients were less than 30 weeks gestation when first flagged as being a priority. Also, these patients were identified as priority for at least 30 days and have been in a non-active OB episode status.

The second measure represents patients with a Maternal Infant Impactability Score of $\geq 200$, with a valid Medicaid ID. These patients were less than 30 weeks gestation when first flagged as being a priority.
priority and have been identified as priority for at least 30 days, in a managed OB Episode Status at High, Medium, or Low engagement levels.

The third measure represents patients with a Maternal Infant Impactability Score of \( \geq 200 \), with a valid Medicaid ID. These patients were less than 30 weeks gestation when first flagged as being a priority and have been identified as priority for at least 30 days. They are also currently in a managed OB Episode Status with a High, Medium, or Low engagement level, but have not had a face-to-face contact completed within the last 30 days.

A face-to-face contact is defined as a visit at one of the following locations: (1) the home of the member (or at the home of others), (2) a hospital, (3) a care facility, (4) a medical office or at (5) another facility such as a community site. **The face-to-face contact must have been completed with the member and only the member.**

Hovering over a specific county on the state map will generate an information box that provides the county’s data.

When clicking on an individual county the option to “keep only” or “exclude” the county will be made available. When clicking “keep only” the rest of the counties will fade away and the selected county’s information will be highlighted for review in all three maps. When clicking “exclude”, the selected county will be excluded from all three maps. To return to the entire state map, select “All” from the drop-down box above the graphs and click “Apply”.
Note: If you wish to create a spreadsheet with the patient-level data for a specific county, it is best to use the Current Pregnancies Dashboard - Priority Patient List.

Note: The data in the Current Pregnancies Dashboard is based on the Current Pregnancies Report. The Current Pregnancies - Dashboard relies on Virtual Health Data and there is a lag in availability!

II. Current Pregnancies-Patient List

The Current Pregnancies-Patient List page provides a list of patients with filters that are available by the following: Date, County, Network, District Primary Care Manager, Pregnancy Care Manager, Episode status, and OB Engagement level. By filtering, a list of patients for a specific item can be reviewed. The steps are below:

1. Select the desired date. The page automatically defaults to the most recent date the data was uploaded.
2. Select the desired county, by clicking the down arrow and typing the county name or by scrolling down the drop-down list until the desired county is identified.
3. Select the county and click “Apply”.

A filter by Primary Care Manager can be applied, however, the Pregnancy Care Manager may be providing services but may not be taking the lead as Primary. The best practice is to filter by Pregnancy Care Manager, as this ensures the list includes all cases assigned to that specific Pregnancy Care Manager.

The Episode filter can be used to confirm that a patient’s status is appropriate and that the patient is moving through the episode status flow appropriately. Using the OB engagement level filter is a way...
to confirm appropriate engagement levels. All managed OB patients should have an OB engagement level assigned for the data to populate the measures correctly.

Once the appropriate filter(s) has been chosen a list of names is displayed. This list can be downloaded to Excel (Crosstab) to view all the available columns that are built within the report. Click within the body of names and then click on “Download”; a box will appear that has several options. Click Crosstab and the patient list will be placed in an Excel document. See the example of an Episode filter below.

Note: To obtain a patient list without using the filter, click within the body of names, click the Download button, and then click the Crosstab icon. This method provides all the patient names on the Crosstab sheet which can be filtered to locate multiple views from the Crosstab sheet without having to return to the filters.
III. Current Pregnancies-Report Details

The Current Pregnancies Dashboard-Report Details page provides the definitions for the numerator and denominator for each measure (see Section I). Two dates are provided for each measure. The numerator data includes patients that met the numerator definition by or before the “maximum date” provided. The Denominator date is the “maximum date minus 30” due to the denominator definition that requests that patients have been a priority for at least 30 days.

IV. Retrospective Pregnancy Measures-Care During Pregnancy

The Retrospective Pregnancy Measures-Care During Pregnancy page report looks at deliveries in a six-month time frame. December signifies July-December and June Signifies January-June. The report date filter allows the desired 6-month period to be displayed on the State Map. The report can be filtered by Date, County, Network or District, using the drop-down boxes.

The heat map scale provides a visual to view the performance of the measure. An information box appears by hovering over a county. The information box provides the percentage of patients engaged during pregnancy, the number of patients engaged during pregnancy, and the total number of patients that delivered during that six-month period.
Each measure has a trend line that can be filtered by County, Network or District. Above those filters is a filter that allows you to choose how to display the data lines (State, County, Network, or District). Click the down arrow to open the drop-down box, then select State/Network/District or County trend line. The State trend line will remain on the graph, even when other filters are applied.

There are 5 measures that are reported on this page:

- Measure 1: Patients Engaged During Their Pregnancy
- Measure 2: Patients with a Risk Screen Completed During Their Pregnancy
- Measure 3: Patient with a Priority MIIS During Their Pregnancy
- Measure 4: Priority Patients Engaged During Their Pregnancy
- Measure 5: Priority Patients in Heavy or Medium, with 5+ face-to-face contact During Their Pregnancy
V. Retrospective Pregnancy Measures-Care After Delivery

The Retrospective Pregnancy Measures - Care After Delivery page reports in a six-month time frame. December signifies July-December and June signifies January-June. The report date filter allows the desired 6-month period to be displayed on the State Map. The heat map scale allows for visual identification of the performance of the measure.

An information box appears by hovering over a county and provides the percentage of patients engaged during pregnancy, number of patients engaged during pregnancy, and the total number of patients that delivered during that six-month period.
Each measure has a trend line that can be filtered by County, Network or District. Above those filters is another filter that specifies how the data lines are displayed (State, County, Network, or District). Click the down-arrow to open the drop-down box, then select the State, Network, District or County trend line. The State trend line will remain on the graph, even when other trend lines are selected.

There are 3 measures that are reported on this page:

- Measure 6: Patients Managed in an Active Case Status with an Interaction Completed within 30 Days Postpartum
- Measure 7: Patients Managed in an Active Case Status with an Interaction Completed within Postpartum
- Measure 8: Patients Managed in Case Status with a Postpartum Visit within 60 Days of Delivering

VI. Retrospective Pregnancy Measures-Patient List

The Retrospective Pregnancy Measures - Patient List includes filters for Report date, Care Manager, County, Network and District.

1. Select the desired date for review. The page automatically defaults to the most recent date the data was uploaded.
2. Select the county that is desired for review by clicking the down arrow and typing the county name, or by scrolling down the drop-down list until the desired county is identified.
3. Select the county and click “Apply”. The list can be filtered by “Care Manager” or by “NULL”.

VII. Retrospective Pregnancy Measures-Report Details

The Retrospective Pregnancy Measures-report Details page provides explanations for inclusion into the denominator and numerator. For Measures 1-3, the denominator includes all deliveries where the birth occurred within the 6-month reporting window. There must be a Medicaid delivery claim linked to that birth record and all duplicate records. Patients with emergency Medicaid are removed.

The numerator on Measures 1-3 are slightly different. To be attributed to Measure 1, the patient must have been in a High, Medium or Low OB Case status, have had a patient-centered interaction completed with the patient (including a phone call, home visit, hospital visit, practice encounter, or community encounter) and had a goal started or evaluated at some point during their pregnancy.
For Measure 2, the patient must have had a risk screen completed to be captured in the numerator. To be included in the numerator for Measure 3, the patient should have had a priority MIIS of >= 200 at any point during her pregnancy.

For Measure 4, the denominator includes all deliveries where the birth occurred within the 6-month reporting period. There must be a Medicaid delivery claim linked to that birth record. All duplicate records and patients with emergency Medicaid are removed and patient must have had a priority MIIS >= 200 at any point during the pregnancy. To be included in the numerator, the patient had to have been in HML (Heavy, Medium or Light) OB Case status, have had a completed patient-centered interaction and a started or evaluated goal at any point during the pregnancy.

To be included in the denominator for Measure 5, the delivery must have occurred within the 6-month reporting window. There must be a Medicaid delivery claim linked to that birth record. All duplicate records and patients with emergency Medicaid are removed. Patient must have had a priority MIIS >= 200 and the patient must have been in a H/M (Heavy or Medium) status at some point during the pregnancy. For Measure 5, the numerator requires five or more face-to-face encounters completed during their pregnancy.

The denominator for Measures 6-8 includes patients that delivered within the 6-month reporting period, had a Medicaid delivery claim, and were in an active HML (Heavy, Medium or Light) OB case status when delivering. All duplicate records and patients with emergency Medicaid are removed. The numerator on measures 6-8 are slightly different. Measure 6 requires a completed patient-centered interaction within 30 days after delivery. Measure 7 includes a completed patient-centered interaction within 90 days after delivery and Measure 8 requires that the postpartum visit be documented in Virtual Health within 60 days postpartum and/or a postpartum visit claim billed within 60 days postpartum.