



**Name of Intervention:** Case Management/Care Coordination for highest risk Members

**Description:** Individualized Member and family-centered case management programs with on-site case managers and fully engaged providers have demonstrated a net reduction in total cost of care. We will provide Integrated Case Management/Care Coordination for Members with complex and persistent physical and behavioral issues requiring dedicated support from a dedicated resource. Care coordinators reevaluate clients on a regular basis and also “check-in” with Members with chronic conditions to assess status and determine current needs. Case identification will be based on Business Intelligence and Data Management stratification, real-time/near real-time data such as utilization management (UM), predictive analytics, electronic referrals to adjust risk profile, and other referrals (no wrong door). Our primary goal is for the Member to achieve their greatest functional and health status and improve their ability to live a full and productive life in the community.

- Electronic communication will be provided to care coordinators and providers to identify Members and provide information on health status, related agency involvement through the integrated information system
- Program will be staffed by multidisciplinary care team, which comprises RNs, social workers, health coaches, the Member and family members, and to include all providers working with the individual Member. Staffing, co-location, and interoperability facilitates the flow of information to providers that will enable them to address the multidimensional needs of these complex Members
- Case management will caseloads vary by intensity of caseload but approximate 50:1. These are the highest risk Members and we will have increased contacts and frequency of outreach to the Member, family and other agencies to provide support, linkages, and access to health care
- Over time, as the Member becomes more stable and, frequency will be reduced depending on individual needs. Along a continuum, there will be a small cohort with intense, immediate needs; a group of Members who are engaged in education, life training and linkages to community resources and a more stable group in which the focus is on monitoring and reassessment
- We will address the needs of Members at highest risk and will use all the Regional resources we have—linking to our extensive provider and community supports including 1915b(3) waiver services
- We will work with providers and care coordinators to identify Members most appropriate for this level of care coordination and fully engaging the Member and their families in the process
- Our model is multi-model incorporating multiple avenues to improve health literacy, resiliency, engage health neighborhoods, and coordinate care across providers and geographic areas

**Please check one of the following three options:**

- Evidence-Based: (1) Druss BG (2007) Improving medical care for persons with serious mental illness: challenges and solutions. *J Clin Psychiat*68 (Suppl. 4): 40-44. (2) Druss BG, Rorhbaugh RM, Levinson CM and Rosenheck RA (2001b) Integrated medical care for patients with serious psychiatric illness: a randomized trial. *Archs Gen Psychiat*58: 861-868.
- Promising Practices:
- Other:

**How the frequency of intervention will be determined:** This is a person- and family-centered approach building on the recommended model for complex case care coordination (evidence-based reference above). We develop a care plan collaboratively with the full team including the Member, family members, all providers, the care coordinator, and any other members of the team. Interventions are developed that are consistent with the care plan to support the Member meet individualized goals. Our model includes explicit goal interventions to stabilize the Member’s health, coordinate their care, better understand their medical requirements (e.g., medications), assist them in obtaining necessary services such as education or housing and nutrition to reach their goals and transition to self-management.

**How the method of delivering the intervention will be determined:** We develop a care plan collaboratively with the full team including the Member, family members, all providers, the care coordinator, and any other members of the team. Interventions are developed that are consistent with the care plan to support the Member to meet individualized goals.

**Potential outcomes:**

- Reduction in inpatient admissions for those with chronic conditions
- Reduction in Emergency Department (ED) utilization
- Increase in medication compliance/adherence
- Increase in health-related quality of life

**Name of Intervention:** Care Coordination for Members at moderate risk due to transitions of care or recent change in stratification level

**Description:** Care coordination targeted to emerging trends (based on changes in stratification level or clinical assessment by the Primary Care Medical Provider or care coordinator) in the wrong direction due to newly identified condition, transitions of care (hospital discharge, post-acute care transition, release from criminal justice system) or recent pattern of utilization (multiple ED visits, super utilizer/Client Over-Utilization Program). Because our established integrated community-based care coordination program, we are able to provide services to Members wherever they may be located and meeting their individual needs.

We will use all the various tools available to us to identify Members in need—Member stratification scores, HRA assessments, behavioral and physical health claims data, and on-the-ground assessments by Primary Care Medical Providers (PCMP) and care coordinators. We will target at-risk Members and provide on-site care coordination located within PCMP settings or as close to the site of care as possible.

We will incent PCMPs to provide care coordination within their practices. Other PCMPs will have care coordination provided onsite at the practices or as close to the practice as possible (for smaller practices). Health Colorado will provide the management and administrative tools necessary to assure successful care coordination through:

- Management reports

- Stratification tracking
- Predictive tools, medication, and visit alerts to PCMPs and other providers to support:
  - Prevention and disease management
  - Proactive communication to address medication gaps, well visit gaps, transitions of care
  - Early intervention and visits for Members after discharge from hospital/skilled nursing facility
  - Communities of practice and best practice sharing among providers
  - Linking Members to specialists especially where there is no local specialist
  - Actively coordinating care with local dentists to increase access to oral health
  - Identifying Members at risk and linking them to community food, wellness, transportation services
  - Supporting Members through transitions of care

**Please check one of the following three options:**

- Evidence-Based: (1) Druss BG, von Esenwein SA, Compton MT, Rask KJ, Zhao L and Parker RM (2010a) A randomized trial of medical care management for community mental health settings: the primary care access, referral and evaluation (PCARE) study. *Am J Psychiat* 167: 151-159. (2) Daumit GL, Crum RM, Guallar E. and Ford DE (2002) Receipt of preventive medical services at psychiatric visits by patients with severe mental illness. *Psychiatr Serv* 53: 884-887.
- Promising Practices:
- Other:

**How the frequency of intervention will be determined:** We offer a well-tested person- and family-centered approach building on the recommended model for complex case care coordination (evidence-based reference above). Working with a Member, their family and their full local care team, we will develop an objective care plan. The frequency and intensity of the intervention will be personalized to meet the individual's physical and social needs.

**How the method of delivering the intervention will be determined:** A care plan will be developed collaboratively in a team model that includes the Member, family members, all providers serving the Member, the care coordinator, and other members of the team. Based on the individualized care plan, a range of interventions will be developed to help that Member meet their goals.

**Potential outcomes:**

- Reduction in inpatient admissions for those with chronic conditions
- Reduction in ED utilization
- Lower total cost of care
- Increase in medication compliance/adherence
- Increase in health-related quality of life

**Name of Intervention:** Leverage Technology for wellness and prevention

**Description:** We will offer and use text-based population health campaigns and tools to support wellness and prevention campaigns for all Members across the region. We propose using the Text4Health solution to effectively communicate with and educate Members, as well as reach a broader audience. Using technology will supplement our existing efforts in the community, with PCMPs, care coordination, public health, and across the spectrum of our close relationships in Region 4.

- Cellular phone adoption and the use of texting is very high with Medicaid Members, especially those in rural and frontier counties
- Text messaging is a cost effective and widely accepted method of communicating with Members
- Over 90 percent of text messages are viewed within 3 seconds of receipt
- Text messaging for health has been widely researched and is a well-established population health solution that has proven effective
- Because of the flexibility of Text4Health, we will be able to add additional wellness and prevention campaigns that reach all Members with minimal cost or planning time. PCMPs and care coordinators will be engaged in these campaigns so that they can share consistent messages and reinforce the texting information that Members will receive

**Please check one of the following three options:**

- Evidence-Based: Evidence: (1) Healthcare via Cell Phones: A Systematic Review - Telemedicine and eHealth 2009. (2) Krishna,S., Boren,S.A., & Balas, E.A. (2009). (3) Mobile Text Messaging for Health: A Systematic Review of Reviews. Amanda K. Hall,1 Heather Cole-Lewis,2,3 and Jay M. Bernhardt4 Annu Rev Public Health. 2015 Mar 18; 36: 393–415. (4) Text Message Reminders of Appointments: A Pilot Intervention at Four Community Mental Health Clinics in London. Psychiatric Services 63:161–168, 2012.
- Promising Practices:
- Other:

**How the frequency of intervention will be determined:** Through Text4Health, we will be able to communicate with all Members in the region on a regular basis, communicating with them as frequently as daily, depending on the campaign. We will begin by engaging all Members concerning general wellness, especially need for well visits for adults. Because of the flexibility of this technology approach, we will expand wellness and prevention messaging to address timely issues such as flu shots in the winter, how to access a PCMP, safe driving, binge drinking, healthy exercise, etc.

**How the method of delivering the intervention will be determined:** This is a text-based solution. The Clinical Director and the PIAC will develop an implementation schedule as part of finalizing the Population Health Management Plan with input from the Member Advisory Council, care coordinators, PCMPs and the Department.

**Potential outcomes:** The goal of this initial campaign will be to improve the number of Members of all ages in populations with at least 90 days of continuous program enrollment that have a well visit within a rolling 12-month period.

**Name of Intervention:** Reduce incidence of smoking through a text solution and QuitLine

**Description:** We will provide the necessary supports and interventions for members to quit smoking so that we may reduce the high incidence of smoking in Region 4 (see Social Determinants of Health):

- QuitLine and Medicaid prescription benefits are already available for Members and will be encouraged
- Outcome data demonstrate a need for additional Member support to reduce the incidence of smoking in Region 4
- Evidence demonstrates that integrating technology support with the commitment of the PCMP improves success rates. PCMPs and care teams are integral members of this solution
- Support of statewide initiative: Colorado Opportunity Project and Colorado Winnable Battles
- By purchasing at a multi-region level we will be an aggregator of this common technology. Members moving from one region to another will be able to keep the tools that are working for them
- Text2quit is a program to help people quit smoking and stay quit. It includes text messages, emails, and access to a personal web portal. Members have to enroll and then the text messages can be used on their own
- Message frequency varies by account settings. Messages are sent according to quit date. For the 4 weeks before and 4 weeks after the Member's quit date, they receive about 2-5 messages per day. For the remainder of the program, they are sent 1-5 messages per week. The messages are personalized to the quit date and other items in the Member's smoking profile (e.g., smoking triggers, medications used).

**Please check one of the following three options:**

- Evidence-Based: Evidence: (1) In a randomized controlled trial 11 percent of Text2quit users were abstinent compared to 5 percent of the control group ( $p < 0.05$ ). At 6 months, 32 percent of the Text2quit group reported not smoking in the past 7 days compared to 21 percent of the control group ( $p, 0.01$ ). Non-respondents were assumed to have smoked. (2) <https://www.cdc.gov/tobacco/stateandcommunity/best-practices-health-equity/pdfs/bp-health-equity.pdf>. (3) Am J Prev Med. 2014 Sep;47(3):242-50. A randomized trial of Text2quit: a text messaging program for smoking cessation. Abrams LC1, Boal AL2, Simmens SJ2, Mendel JA2, Windsor RA2.
- Promising Practices:
- Other:

**How the frequency of intervention will be determined:** Frequency varies by user participation. Minimum 1 message/week.

**How the method of delivering the intervention will be determined:** This is a text-based solution. The Clinical Director and the PIAC will develop an implementation schedule as part of finalizing the PHMP.

**Potential outcomes:** The goal of this initial campaign will be to reduce the incidence of smoking in the population as measured over time.

**Name of Intervention:** Reduce suicide through the use of Zero Suicide Teams

**Description:** Zero Suicide teams will use the seven core tenets of zero suicide to lead, train, identify, engage, treat, transition and improve outcomes for Members who are suicidal. Zero Suicide teams will provide education on the Zero Suicide Model to PCMPs and providers.

- Provider Relations will highlight the Zero Suicide Model to all Region 4 providers e model
- Our intervention will target PCMPs and Provider groups in areas of the region with the greatest levels of suicide among their panel of patients
- Accountable and Collaborative PCMP practices will receive education annually
- We will develop and deploy practice support tools for suicidal patients including Member/family/provider resource sheets, screening tools, and assistance with billing for depression screening
- We will connect PCMPs to Psychiatric Consultation upon request. We will work with PCMPs to ensure patients are transitioned to appropriate referrals with providers who can treat suicidal thoughts directly. We will ensure that there was a successful transition to the right provider.
- We will conduct annual quality review of programs to ensure fidelity to Zero Suicide model.
- The Zero Suicide Team will be led by a multi-disciplinary of quality, social work, and medical staff to mobilize all staff to believe that suicide can be prevented

**Please check one of the following three options:**

- Evidence-Based: Evidence: (1) <http://zerosuicide.sprc.org/about>. Zero Suicide is an evidence based program endorsed by the Colorado Legislature through legislation and embedded in statewide programs through Colorado Department of Public Health and Environment
- Promising Practices:
- Other:

**How the frequency of intervention will be determined:** The frequency of intervention will be determined by the data that identifies areas with high rates of suicide.

**How the method of delivering the intervention will be determined:** The method of delivering the intervention will be determined by identifying PCMPs and Providers in these high risk areas who are willing to participate in training. We will provide a PCMP toolkit that will be enhanced or improved on an annual basis. The Toolkit may consist of the following:

- Informational Resource sheets to identify suicidal behavior
- Screening Tools
- Billing assistance
- Posters
- Referral resources and support
- Education on how to treat a suicidal patient

**Potential outcomes:** Potential outcomes include increased identification of suicidal members, reduced suicide, and increased education to treat suicidal thoughts and behaviors directly.

**Name of Intervention:** Reduce ED Visits for Ambulatory Sensitive Conditions

**Description:** We will actively promote the Department’s Nurseline and after-hours call services at all local providers through Member education, Member Portal access and wellness materials, Text4Health, and PCMP engagement to educate Members on alternatives to using EDs. Region 4 has already reduced ED utilization significantly. This is an area we believe can continue to be enhanced. Members who have a history of over-utilizing EDs or who have multiple ED visits will be identified for care coordination assessment and appropriate follow-up.

**Please check one of the following three options:**

- Evidence-Based: (1) Association between primary care practice characteristics and ED use in a Medicaid managed care organization. Lowe RA, Localio AR, Schwarz DF, Williams S, Tuton LW, Maroney S, Nicklin D, Goldfarb N, Vojta DD, Feldman HI. *Med Care*. 2005;43(8):792–800. (2) Bogdan GM, Green JL, Swanson D, Gabow P, Dart RC. Evaluating patient compliance with nurse advice line recommendations and the impact on healthcare costs. *Am J Manag Care*. 2004;10(8):534–542. (3) Margolius D, Bodenheimer T. Redesigning after-hours care. *Ann Intern Med*. 2011;155:131–132.
- Promising Practices:
- Other:

**How the frequency of intervention will be determined:** Education on using after-hours call centers, accessing the Member Portal and communicating proactively with PCMPs and care coordinators is an ongoing effort that needs continuous messaging. Targeted messaging and communications will be made available on the Health Colorado website, available for providers to include on their websites, along with materials and messages for PCMP offices, care coordinators, case managers and peer specialist as well as on the Member Portal. There will be regular text messages from Text4Health that are distributed to targeted populations. These materials will be developed and the frequency of their distribution

will be managed by the Clinical Director and his/her staff. Care Coordination is one component of this solution for Members with chronic conditions and/or who have a history of over-utilization of EDs.

**How the method of delivering the intervention will be determined:** Messaging on appropriate use of EDs for ambulatory sensitive conditions and use of alternatives such as the Department’s Nurseline is an ongoing, multifaceted intervention. We will regularly assess changes in ED utilization by reason, community, age of the population, etc., and revise the intervention to target areas of need. We will engage PCMPs in this process, sharing data on utilization by their Members as well as community-wide data. Through the PIAC, Health Colorado will also explore other options to further improving appropriate use of EDs for ambulatory sensitive conditions.

Overuse or multiple use of EDs our criteria for care coordination case identification. These cases will be referred to care coordinators for assessment and appropriate follow up. This is a second group of Members that will be targeted by this intervention.

**Potential outcomes:** Reduced ED visits for ambulatory sensitive conditions.

**Name of Intervention:** Improve Well Visits Rate (Number of Members that have had a well visit within a rolling 12-month period).

**Description:** Health Colorado will use three primary methods to further engage Members in their health care to improve the number of Members who obtain well visits:

- PCMPs and care coordinators will receive regular alerts identifying attributed Members that have not had a well visit six months into their membership. This is in addition to any Members who, through stratification or other risk categories, have been identified for care coordination including access to more immediate health services
- Text4Health will include regular messages to all Members stressing the benefits of a well visit
- Member services representatives will include a brief statement on the availability of well visits in their contacts with Members
- Information on the importance of well visits, how to access a PCMP, and how to get assistance in making appointments will be included on the Health Colorado website and will be provided to all PCMPs, Federally Qualified Health Centers, and Community Mental Health Centers to add to their Member Portals and websites.

**Please check one of the following three options:**

- Evidence-Based: (1) Colorado Opportunity Project – addressing full life cycle of population. Also, building Health Neighborhood. (2) Text message-based program boosts adherence to appointments, Montifiore Medical Center Randomized Control Trial.
- Promising Practices:

Other:

**How the frequency of intervention will be determined:** Education on the need for a well visit, the benefit of well visits and how to access a PCMP or receive assistance is an ongoing effort that needs continuous messaging both for reinforcement and as new Members are enrolled in Medicaid. Targeted messaging and communications will be made available on the Health Colorado website, available for providers to include on their websites, along with materials and messages for PCMP offices, care coordinators, case managers and peer counselors, as well as on the Member Portal. There will be regular text messages from Text4Health that are distributed to targeted populations. These materials will be developed and the frequency of their distribution will be managed by the Clinical Director and his/her staff.

**How the method of delivering the intervention will be determined:** Our staffs have already developed effective strategies for educating Members on the importance of having a PCMP and obtaining necessary medical care.

We will focus efforts to stress the importance of well visits for adults, how easy it is to access care in our area and potential benefits through this intervention. We will seek input from Members through the Member Advisory Council to develop message that resonate with our audiences, e.g. various ages, cultural backgrounds, and communities that make up Medicaid Members. We will regularly assess gaps and revise the intervention to target areas of need.

**Potential outcomes:** Increase percentage of Members who have a PCMP visit in rolling 12-month period.

**Name of Intervention:** Reduce the Risk of Cardiovascular Disease, Stroke and Diabetes

**Description:** The population to be served consists of Members at risk of cardiovascular disease, stroke, and/or diabetes including Members at risk and/or diagnosed with any of these conditions. Coronary heart disease and cerebrovascular disease are leading causes of death in the United States. As of April, 2016, the U.S. Preventive Services Task Force (USPSTF) strongly recommended that clinicians discuss aspirin with adults who are at increased risk for coronary heart disease based on an assessment of the Member's risk.

We propose a multifaceted effort that includes the Health Colorado, care teams, community partners, care coordinators, engaged Members, and technology in addressing cardiovascular disease, stroke, and diabetes.

Our partners and other medical homes in our community as well as community partners already support multiple efforts to produce the risk of cardiovascular disease, stroke, and/or diabetes as shown in **Attachment 13**. We will maintain our engagement with our partners, other clinical team efforts such as communitywide campaigns to promote physical activity, worksite programs for obesity, prevention, diet and physical activity programs and school-based settings, and nutrition programs at our clinical sites.

This specific intervention will include:

- Providing educational materials on the Member Portal and at provider sites such as the Agency for Healthcare Research and Quality materials: [https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/heart-health/talk-with-your-doctor-about-taking-aspirin-every-day#the-basics\\_1](https://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/heart-health/talk-with-your-doctor-about-taking-aspirin-every-day#the-basics_1)
- Engaging physicians in the dialogue by sharing national standards and research from national organizations on the provider portal, directly to care teams, and through provider newsletters and other communications
- Through incorporating health neighborhoods, reduce gaps in health literacy, and activate Members to more responsibility for healthy behaviors
- Adding text-based messaging for all Members focusing on health risks and also targeting specific Members at high risk of cardiovascular disease, stroke, and diabetes

**Please check one of the following three options:**

- Evidence-Based: (1) <https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/aspirin-to-prevent-cardiovascular-disease-and-cancer>. (2) Example: West Virginia Walks (Reger-Nash et al. 2008). (3) Example: The Rockford Coronary Health Improvement Project (CHIP) (Englert et al. 2007). (4) Example: A community-oriented, coronary heart disease prevention program (Hoffmeister et al. 1996).
- Promising Practices:
- Other:

**How the frequency of intervention will be determined:**

- Leverages the extensive programs and supports in place at provider sites, community locations in Region 4
- Member-level interventions will be individualized based on Member needs and the level of risk
- Health Colorado will implement region-wide provider and Member education on multiple aspects of this intervention including the use of aspirin therapy for at risk Members, the importance of nutrition and physical activity in overall wellness and prevention and encouraging Members to participate with other aspects of the health neighborhood
- Health Colorado will emphasize cardiovascular disease, stroke, and diabetes prevention in our overall wellness and prevention programs and Community based activities. We will actively promote and participate with County Departments of Public Health, religious institutions, schools, and the various members of the Health Neighborhoods to meet this goal. Furthermore, we will actively support, publicize, and encourage Members to participate in the multiple related programs and activities sponsored by our local provider partners

**How the method of delivering the intervention will be determined:**

- Leverage CONNECTS platform to identify at-risk Members and refer them to care coordination for evaluation, referral to community programs, etc.
- Use point-of-decision prompts to increase exercise while linking at-risk Members to community based programs, work with departments of public health and other related community agencies to educate.
- Expand use of aspirin therapy across the region including use of the Aspirin Guide App to determine Member's risk and indication for aspirin therapy.
- Care4life. Diabetes: Comprehensive education support program to improve self-care behaviors.
- Leverage existing community specific efforts to promote physical activity by creating a virtual community with WebX or similar phone-based communication system to build community-wide campaigns to promote physical activity.

**Potential outcomes:** Reduce the risk of cardiovascular disease, stroke, and diabetes.

**Name of Intervention:** Improve medication adherence for Diabetes and Depression

**Description:** The population served will consist of Members with Diabetes and/or Depression and on guideline medications . Provider alerts concerning medication adherence will be sent when factors such as Medication Possession Ratio or Proportion of Days Covered indicate an adherence or compliance issues.

Members may also manage their medications and other self-management of Diabetes through a text-based solution. This text based solution, Care4life is a nationally-recognized, widely disseminated personalized diabetes management solution. Developed in collaboration with leading diabetes educators at American Diabetes Association and Voxiva (now Wellpass), Care4life has been used by over 150,000 participants. The American Diabetes Association encourages participants to enroll in Care4life as an ongoing personalized resource for diabetes management.

Care4life provides diabetes education, motivation, and self-management tools. Participants receive tailored content based on their diabetes type, medication, and experience with diabetes. Messages include practical advice on healthy snacks and recipes, exercise suggestions, and stress management. Care4life prompts users to monitor their blood glucose before and after meals, and helps them set goals for weight and exercise. The program also emphasizes the importance of preventive measures and disease management, including regular exams, medication adherence, and diabetes-specific eye and foot exams.

**Please check one of the following three options:**

- Evidence-Based: (1) Mobile Telephone Text Messaging for Medication Adherence in Chronic Disease A. Meta-analysis. Jay Thakkar, FRACP1,2,3; Rahul Kurup, MBBS1; Tracey-Lea Laba, PhD2,3; et alKarla Santo, MD2,3; Aravinda Thiagalingam, PhD1,3; Anthony

Rodgers, PhD<sup>2,3</sup>; Mark Woodward, PhD<sup>2,3,4,5</sup>; Julie Redfern, PhD<sup>2,3</sup>; Clara K. Chow, PhD<sup>1,2,3</sup> JAMA Intern Med. 2016;176(3):340-349. (2) Interventions to Improve Medication Adherence in Schizophrenia-Psychiatry. Volume 159, Issue 10, October 2002, pp. 1653-1664. Annette Zygmunt, Ph.D., Mark Olfson, M.D., Carol A. Boyer, Ph.D., and David Mechanic, Ph.D. (3) Community Health Workers, Mobile Health, or Both for Management of Medicaid Patients with Diabetes. Richard J. Katz, Gail Nunlee-Bland, et al. American Diabetes Association 77th Scientific Sessions. June 12, 2017.

- Promising Practices:
- Other:

**How the frequency of intervention will be determined:** Daily electronic notices to PCMPs and their care teams that identify gaps in medication adherence.

**How the method of delivering the intervention will be determined:**

- We will leverage the use of interoperable technology available in the region through alerts and CONNECTS to provide early identification of medication adherence issues.
- Implement Care4life on an individualized basis.
- Review and enhance formulary management by the providers to insure that the Member receives the necessary medication in a timely and cost effective manner.
- Push notices to care coordinators and providers to identify Members not filling scripts for specific chronic conditions.

**Potential outcomes:**

- Improves health
- Reduces ED use
- Reduces complications and other negative outcomes

**Name of Intervention:** Improve prenatal care rates for pregnant women.

**Description:** Text4baby is a well-established technology solution to improve pregnant care rates for pregnant women. Text4baby is a collaborative program that is implemented with the PCMP or obstetrician. The provider and the Member will voluntary enroll and work together to improve prenatal care for pregnant women. This approach was designed with major national organizations dedicated to improving care for pregnant women and newborns.

Text4baby sends personalized messages directly to the Member with information developed by experts from all over the country. There is also an app that provides additional information about baby's development, pregnancy, childcare tips, and more.

Text4baby topics include:

- Nutrition for mother and baby
- Baby’s milestones
- Doctor visit and personalized appointment reminders for mother and baby
- Car seat safety
- Urgent health alerts
- Safe sleep tips
- Signs and symptoms of labor
- Breastfeeding advice
- Information on health insurance
- Resource hotlines and websites

Text4baby is a free service provided in partnership by the nonprofit organization, ZERO TO THREE, and Voxiva, Inc. The text messages are sent for free. Beacon will be purchasing access to Text4baby on behalf of Health Colorado.

**Please check one of the following three options:**

- Evidence-Based: (1) <https://www.text4baby.org/about/data-and-evaluation>. (2) Improving Adolescent Preventive Care in Community Health Centers. Jonathan D. Klein, Marjorie J. Allan, Arthur B. Elster, David Stevens, Christopher Cox, Viking A. Hedberg, Rita A. Goodman. Pediatrics, February 2001, VOLUME 107 / ISSUE 2.
- Promising Practices:
- Other:

**How the frequency of intervention will be determined:** Daily/weekly during pregnancy and intermittently for female Members based on age to educate people on the need for prenatal care early in the pregnancy. We will also implement personalized messages and doctor appointment reminders.

**How the method of delivering the intervention will be determined:** Multimodal approach that emphasizes Member-centric, team-based care. We will work collaboratively with community partners, providers, care coordinators, and all components of the Member’s team to improve prenatal care. This includes:

- Care coordination for women identified as high risk
- Interface with Public Health Departments, WIC programs, etc.
- Technology solutions:
  - CONNECTS
  - Electronic medical records systems
  - Text4baby

- Social media campaigns

**Potential outcomes:** Increase number of women who are identified during the first term of pregnancy, increase number of women who seek care throughout their pregnancy.