According to the 2017 Healthy Texas Babies Initiative through the Department of State Health Services (DSHS), the counties Aetna Better Health of Texas TX serves are among the 23 counties in the state with the highest preterm birth rate, highest concentration of African Americans and highest Medicaid population. These are all risk factors for maternal and infant morbidity and mortality.

We want women to have healthy pregnancies, for newborns to stay with their mothers, and for infants to stay healthy

Aetna Better Health® of Texas

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At Aetna Better Health of Texas, we brought together our clinical team and leadership team to outline a comprehensive prenatal to infant health program that aims to:

- Prevent preterm birth
- Prevent avoidable NICU admissions
- Improve NICU efficiency
- Improve Well Child Visit and Immunization rates for first year of life

We already do this through intensive rounding, 17-P access, postpartum depression screening, substance use intervention, and birth spacing. But there are new opportunities to improve the health of mothers and infants.

We need a system of care approach

NICU cost drivers are multifactorial:

- Opioid use disorder in women of child bearing age and risk of infant with neonatal abstinence syndrome.
- Infant and maternal death rates are high
- Families live in conditions that promote adverse childhood experiences - leading to negative chronic health effects.
- The March of Dimes rates Texas a "D" for Preterm Birth Rate.
- In Texas, maternal child health is a health equity issue
- Mothers have chronic conditions that lead to babies that end up in the NICU

When a child is admitted to the NICU it is already too late

We start with preventive methods to improve the health of women of child bearing age

- Health screening for cancer and preventable diseases
- Disease management to minimize risk
- Routine immunizations
- Access to primary care and preventive services

What Aetna Better Health of Texas is doing right now

System of Care - Clinical and non-clinical interventions working together to improve health outcomes and achieve health equity in a coordinated manner.

- **Women's Health**
  HPV vaccine
  Promoting routine health screening
  SUD prevention, treatment and recovery
  Chronic disease management
  Connecting with primary care and women's health services
  Trauma Informed Care approach to ICM
- **Prenatal**
  Incentives for prenatal visits
  New member calls
  Care management outreach
  Text4Baby and community outreach
- **Postpartum**
  Incentives for PP visit
  Depression screening
  Continuity of care and access to care
- **Infant Health**
  NICU Intensive Rounding
  Discharge Planning and community connections
  Connecting with pediatric primary care and specialty services
  ECI referrals

Moving Forward

- Dedicated NICU team led by board certified neonatologist
- Continuous quality improvement to refine interventions and identify new opportunities
- Continue to identify and launch opportunities to improve maternal child health through wellness and preventive health campaigns
- Alternative Payment Models with providers that augment the health of mothers and babies
- Ongoing strategic collaboration with and support of community health initiatives that impact our population

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