BALTIMORE CITY HEALTH DEPARTMENT

HealthChoice
Maryland's Medicaid Managed Care Program

Electronic Prenatal Risk Assessment (ePRA) Toolkit:

Linkages to Care

Toolkit created for clinicians, health departments, and administrative care coordination units

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Hyphen Health, LLC (2022)
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Executive Summary

Pregnancy is an opportune time to connect individuals and their children to community and clinical resources to improve health outcomes.

Created as a component of electronic **Prenatal Risk Assessment** pilot project, this toolkit is funded by the "Increase Linkages to Substance Use Disorder Treatment Programs for the Baltimore Regional Area Mothers" initiative out of the Maryland Department of Health and operationalized through the Baltimore City Health Department. This document offers insights and recommendations to providers and health departments interested in integrating the Maryland Prenatal Risk Assessment (MPRA) from a paper-form into an electronic medical record.

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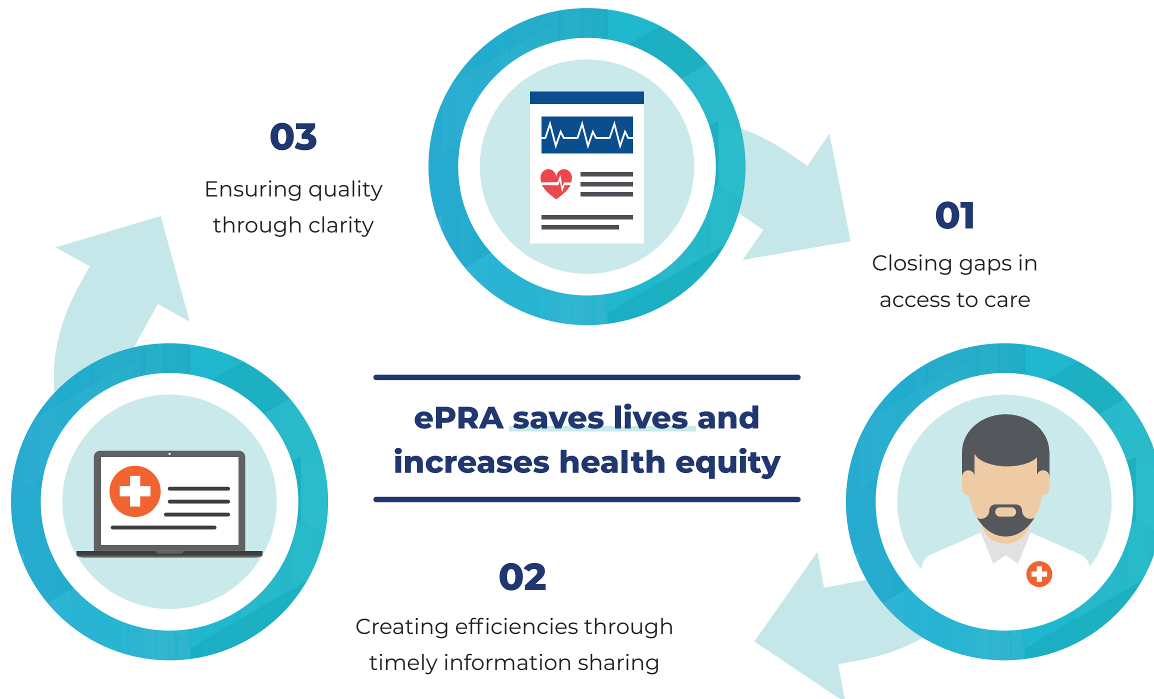
The electronic Prenatal Risk Assessment (ePRA) project tested a novel pathway to improve maternal and fetal health outcomes in Maryland by integrating the MPRA into electronic medical records in clinical settings for effective and efficient connection to care.

The purpose of the MPRA, a paper form required by the Code of Maryland Regulations, is to identify and refer all **pregnant people** on Medicaid or who are Medicaid eligible from local health department and Administrative Care Coordination Unit (ACCU) services.

ACCU services complement medical care and may be provided by nurses, social workers, interpreters, care coordinators, community health workers, and other outreach workers. Services include:

- Education of covered Medicaid benefits,
- Navigation of the complex health and safety net system,
- Short term care coordination, and
- Connection to other medical, safety net, and community resources (e.g., substance use treatment services, transportation to appointments, community programs available in the mother's county).



The ePRA saves lives and increases health equity by:

- Closing gaps in access to care
- Creating efficiencies through timely information sharing
- Ensuring quality of care coordination through clear information sharing

How can providers transition to an ePRA:

- Seek organizational approval from leadership
- Define scope and workflows
- Engage the information technology team
- Request form build from information technology team
- Do a test run and troubleshoot any issues
- Engage the county local health department ACCU program for feedback/suggestions on ePRA form before implementing the final format into the EMR
- Clarify the new workflow internally through trainings, tutorials, designation of staff roles in completing and submitting the ePRA
- Define and implement your plan for sustainability; begin submissions

It was more than helping me out with the baby. ***She was helping me too. I was kinda going through a lot. She [the care coordinator] also had a connection with me. I felt I had the call center to keep on going. If it was not for her I probably wouldn't have had my baby. Because she knows what I've been through. People told me I shouldn't have the baby and I would have been better off. But she helped me.***

-M.M.

Client connected to care coordination program through the PRA process

Introduction

Pregnancy is an opportune time for health systems to intervene and support people with needed services for healthier outcomes. Pregnancy is a vulnerable time for both the pregnant person and the fetus. Yet, there are often **missed opportunities** to close gaps in care. Health systems and social service programs should be linked together to efficiently provide direct healthcare and social needs services such as substance use treatment services, transportation to and from doctors' visits, supplemental food support, and more.

Absolutely recommend it to other practices. It's made everything so much easier. Saves so much time and space. It helps me feel and stay more organized in connecting a person to additional services.

-H.A., Clinical staff at Pilot Site A

The electronic Prenatal Risk Assessment (ePRA) is a novel pathway to improve maternal and fetal health outcomes more efficiently in Maryland.

This ePRA Toolkit aims to **increase awareness among providers** about the MPRA and its benefits for pregnant people. The toolkit brings together best practices to integrate the MPRA into electronic medical records systems and to support health departments and ACCUs in providing technical assistance to providers, practices, and health systems. The use of the ePRA saves lives and increase health equity by:

- Closing gaps in access to care
- Creating efficiencies through timely information sharing
- Ensuring quality of care coordination through clear information sharing

If your medical practice is not already completing and submitting the MPRA, we recommend you provide training to your staff to comply with state regulations. Ask your local health department ACCUs to provide additional support and to facilitate training.

What is the MPRA and what is the ePRA

The MPRA is an assessment to link pregnant people with Medicaid or who are Medicaid-eligible to care coordination services. The MPRA, a paper form updated in May 2022, is a mandated brief assessment that captures demographic data, social needs information, and patient history of the pregnant person.

The assessment identifies medical, nutritional, psychosocial, and socioeconomic risk factors of poor maternal health and birth outcomes ***(Appendix A: Updated MPRA)***. Providers assess the patient and send the form to ACCUs at local health departments who screen patients and refer them to additional safety net services. Safety net services include transportation services, maternal peer coaching programs, home visiting services, and more. Some services may be specific to the jurisdiction in which the patient resides. Providers are reimbursed for completing the assessment by the patient's managed care organization ***(Figure 1)***.

01. Provider completes an assessment using the MPRA form provided my Maryland Department of Health.

02. Within 10 days of completing the MPRA, provider team forwards the MPRA to the local health department ACCU in the jurisdiction in which the pregnant patient resides. ACCU fax numbers are listed on the third page of the MPRA or integrated directly into the electronic medical with the ePRA.

03. ACCU coordinates care of pregnant patient. For example, they offer linkages to the patient's behavioral health and substance use disorder benefits coverage.

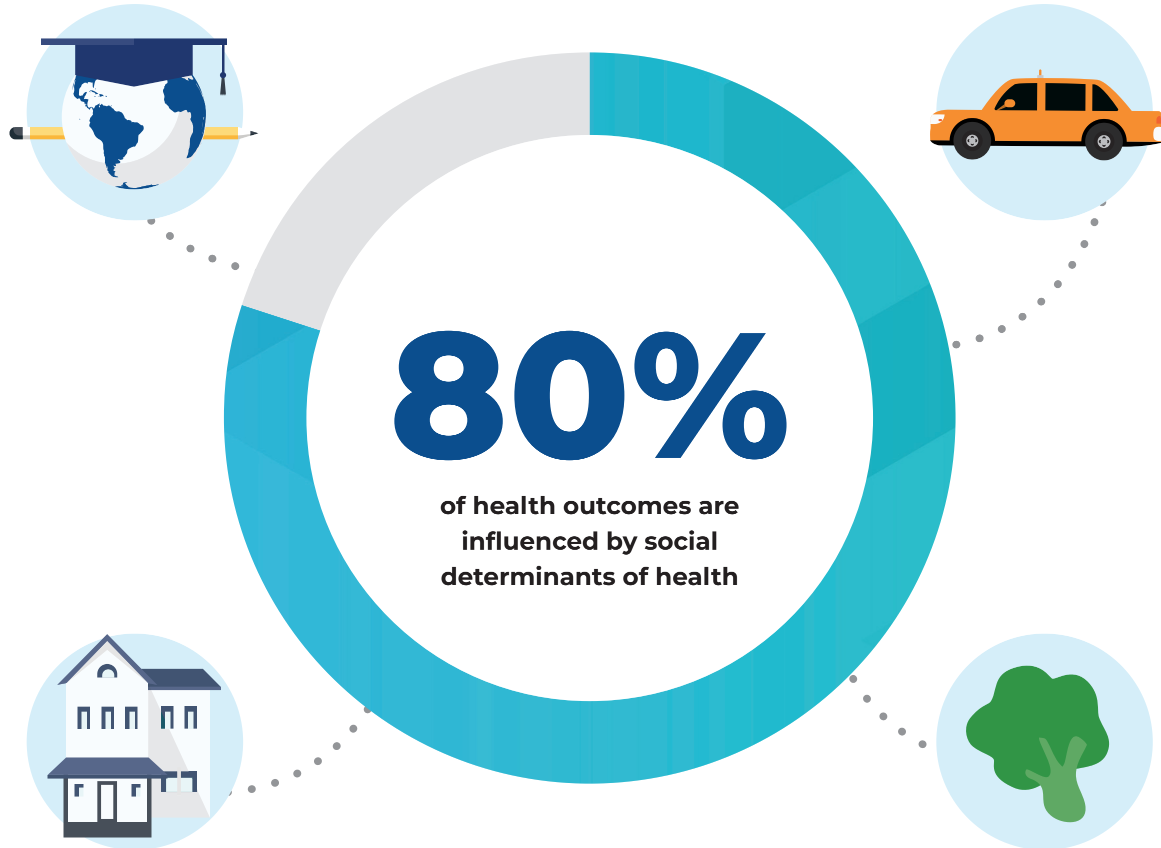
04. Provider team bills for the completion of the MPRA and development of the plan of care, is H1000.

FIGURE 1: *General process to submit the MPRA*

The "ePRA Linkages to Care for Pregnant People" initiative is a pilot project to facilitate timely and effective completion of the MPRA.

Funded by the Maryland Department of Health and managed by the Baltimore City Health Department to integrate the MPRA into at least five clinical sites across the Baltimore metro area. Efforts are focused on providers in three jurisdictions: Baltimore City, Baltimore County, and Anne Arundel County.

The project's theory of change posited that if clinical sites transitioned from the paper MPRA form to the ePRA, clinical sites would a) increase completion and submission rates, b) improve quality of submissions, and c) increase efficiency of connection to care, all factors that improve outcomes for pregnant people and infants.



Why should providers connect patients to safety net services quickly?

Nearly 80% of health outcomes are influenced by social determinants of health, the conditions in which we live, learn, work, and play that inform risk behaviors and health outcomes. Pregnancy presents health systems with a unique opportunity to reach a person during a vulnerable time for the pregnant person in order to provide linkages to needed services.

Becoming acutely aware of their own health and their baby's health, a pregnant person is likely to **engage deeply with the health system** and see providers more often. These circumstances amplify chances to support individuals with community and/or wraparound services that can **decrease high-risk behaviors** (i.e., tobacco use, substance use, poor nutrition) and improve their health outcomes.

Voices from the Field ePRA webinar: This webinar provides an overview of the work being done to complete the PRA.

Why should providers connect patients? *(continued)*

To enable this, providers should consider the MPRA because:

1. Maryland regulations REQUIRE OB PROVIDERS complete the form.
The Code of Maryland Regulations (COMAR) 10.67.04.08 requires that the MPRA be completed at the first prenatal visit with their medical provider for all Medicaid/Medicaid eligible patients.[1] The form must be submitted to the local health department within 10 days.

The Code of Maryland Regulations requires that the MPRA be completed at the first prenatal visit with a medical provider for all Medicaid/Medicaid eligible patients.

2. Submitting the MPRA by first or second visit helps decrease "no show" rates.
When the MPRA form is submitted, patients are connected to many safety net services such as Medical Assistance Transportation for patients with transportation barriers. In addition to transportation services, patients are linked to parenting support programs. These programs also encourage and enforce patients to attend all OB appointments.

1. Refer to: **http://www.dsd.state.md.us/comar/comarhtml/10/10.67.04.08.htm**

3. Providers are reimbursed for the MPRA submissions.
As an incentive to increase submissions, providers are reimbursed for submitting the MPRA to the ACCU. The ACCU forward to the managed care organizations (MCOs) to reimburse providers at $40. This reimbursement is not applicable to Federally Qualified Health Centers (FQHCs).

4. Integrated care is the future of healthcare.
Siloed and fragmented healthcare systems cannot effectively and efficiently serve patients and community members. To integrate systems, particularly those that are reaching people during times of higher vulnerability, public health, healthcare, and social service systems must make a concerted effort to connect and sustain care.

Did you know? The MPRA form connects patients to safety net services. Submitting the MPRA by the first or second visit decrease "no show" rates.

The MPRA connects people to care and the ePRA ensures that health systems can operationally optimize connecting pregnant people to services. (***Appendix B*** provides an overview of health system stakeholders involved in the MPRA.)

Complementary to this initiative, is the larger Maryland Statewide Integrated Health Improvement Strategy (SIHIS) effort. SIHIS aligns statewide efforts to create critical collaboration and streamline health systems across domains. Domains include total population health on diabetes, opioid use disorder, and maternal and child health. The aim is to better serve communities, improve healthcare quality, and manage cost of care.

The MPRA aligns with the goals of SIHS to streamline services between health departments and health systems, improve maternal and child health outcomes, and connect people to necessary services-including substance use disorder treatment. Targeted to high-risk populations, linkages to essential support services create a pathway towards equitable outcomes during pregnancy.

Targeted to high-risk populations, complementary community services create a pathway towards increasing equitable outcomes.

Risk factors include:

- Substance use
- Diabetes
- Tobacco use
- Poor nutrition

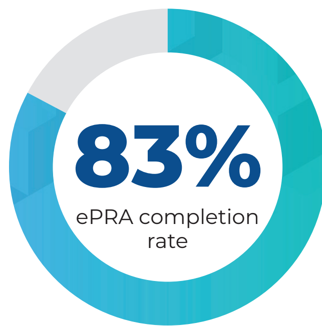
2. Refer to Maryland Total Cost of Care Model: **https://hscrc.maryland.gov/Pages/Statewide-Integrated-Health-Improvement-Strategy-.aspx**

Why try an (ePRA): Operational effectiveness increases healthy outcomes

In an assessment completed by the Baltimore City Health Department using internal data, individuals without completed MPRAs are **5.1 times more likely** to have a fetal or infant death than individuals who did have a MPRA. Yet, paper MPRAs are completed for only a fraction of eligible candidates within and across jurisdictions.

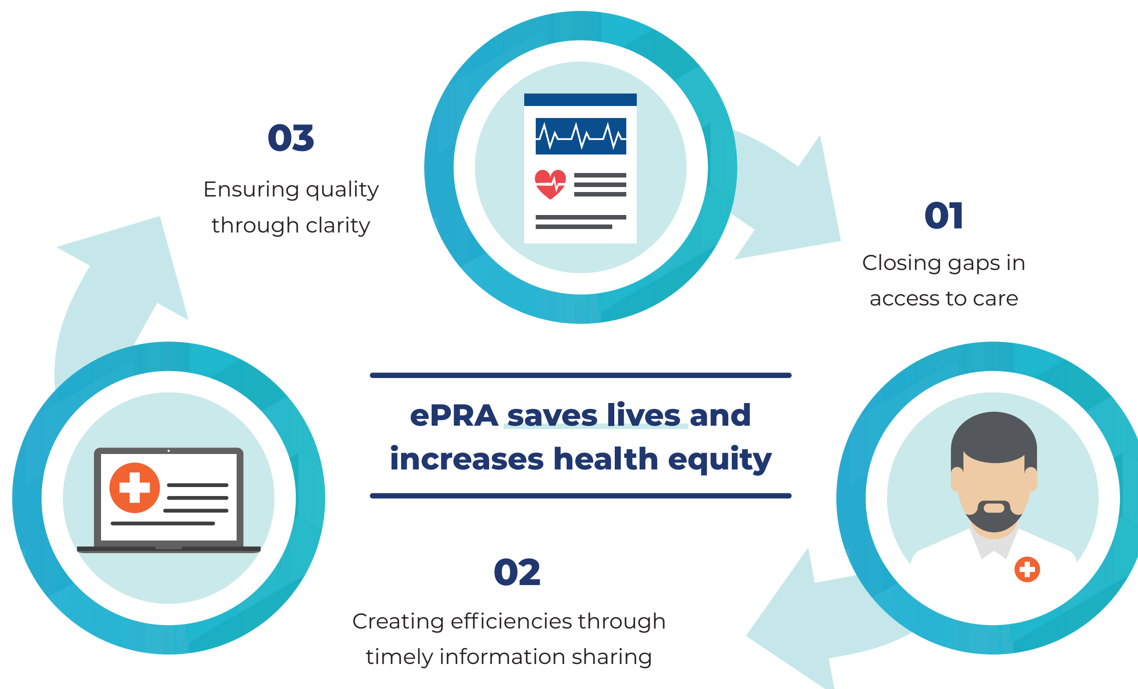
> ***Absolutely recommend it to other practices. It's made everything so much easier. Saves so much time and space. It helps me feel and stay more organized in connecting a person to additional services.***
>
> *-H.A., Clinical staff at Pilot Site A*

Operational challenges presented by varying workflows, paper-based form management in an era of predominantly electronic medical record systems, and lack of awareness of the MPRA and its benefits have led to barriers to completion and submission.



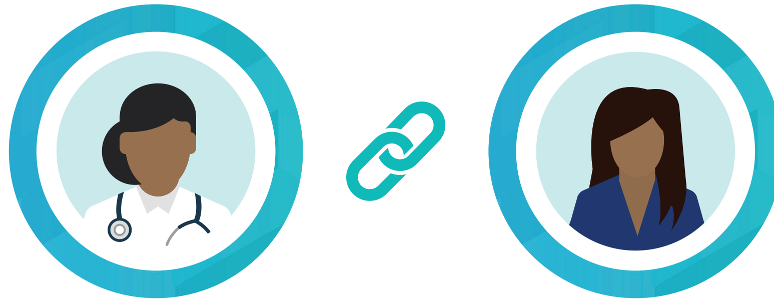
Prior to this pilot, one site in Baltimore City had an 83% ePRA completion rate during a timeframe with significant staff turnover.[3] This is compared to an average annual paper MPRA completion rate of 65% in the jurisdiction.[4]

3 Calculated by comparing number of ePRAs with number of new OB appointment (8/1/19-2/1/20) 4. Calculated over 3 years (2013-2017) linking PRA to Vital Stat records



Moving to the ePRA can decrease these barriers, save lives, and increase health equity. ePRA integration can:

- **Close gaps in care** because the electronic process increases rate of completion as medical providers complete form fields in real time.
- **Create efficiencies** and ensure timely delivery of the MPRA to local health department ACCUs. Many fields required by the paper-based MPRA are captured in other standard questions during OB visits. Thus, integrating the ePRA can reduce redundancies in completing a paper MPRA separately from the electronic medical record systems.
- **Improve the quality of information provided.** Paper-based documentation can be difficult to read due to illegible handwriting. With electronic documentation sent through eFax, providers report no further call backs from the ACCUs with legibility issues.



How to transition to the ePRA

Integrating the MPRA into your clinic's electronic medical record is impactful for staff and patients. The preliminary learning from the pilot project suggests that successful integration requires a cross collaborative team and a clear champion who serves as the project manager moving the project forward. While the process can vary based on institution, a stepwise list of actions for providers is below:

1. Seek organizational approval from leadership. If your clinical site currently completes the MPRA, identify who needs to approve integrating the ePRA into your medical record.

   a. Consider, is your organization ready to complete this?

   b. Who needs to be involved in the decision?

   c. How does leadership sign off on this process?

2. Define scope and workflows. Consider:

   a. Who is currently responsible for and involved in completing the MPRA?

   b. What are their roles and responsibilities?

   c. What does their current workflow take into account?

   d. What is your current process for submission (i.e., in batches; when completed etc.)

3. Engage the technology team. Identify the information technology (IT) colleagues who you will partner with and submit a request for integration.

   a. This process may require multiple meetings to share the current workflow.

   b. Provide the IT colleagues with a copy of the paper form (Appendix A)

   c. Of note, if your clinic is currently using EPIC, check the EPIC Community Portal, which contains at least two models of the ePRA from previous hospital integrations.

4. Request form build by IT. Consider:

   a. Where are data fields already being collected in your electronic medical record?

   b. What should the user experience look like for providers?

   c. How will this information be eFaxed to the respective health departments? Fax numbers can be found on the last page of the MPRA.

   d. Make sure to connect eFaxing to the ACCU jurisdiction where the patient lives, not necessarily where the practice serves the patient.

How to transition to an ePRA *(continued)*

5. Do a test run and troubleshoot any issues. Consider:

a. Contact your local ACCU with a test form or a real patient's form

b. Confirm they received it and ask if the form meets quality requirements for the ACCU.

c. If your clinical site is part of a larger network of providers, encourage other providers in the network to use the ePRA.

Voices from the Field: "How to complete an ePRA" video by Amy Radion: This is an example of training materials completed at one location.

6. Clarify the new workflow internally. Identify:

a. Who completes the form (i.e., office manager, medical assistant, OB/GYN, nurse practitioner)?

b. Who back fills the role if the person who completes the form is not available?

c. How consistently will the clinical site submit forms to the ACCU?

7. Define and implement your plan for sustainability. Consider:

a. Train staff to ensure everyone is clear on the new workflow.

b. Create materials for support. Training staff and back up staff is critical for consistent connection to care. Other clinics have used tip sheets, workflows, and videos .

c. Staff will turn over or go on vacation. Ensure there is proper training with additional staff as back ups.

d. Integrate these efforts into consistent onboarding practices. This is a key step in building awareness about the form and ensuring it is completed.

Conclusion and Key Takeaways

The ePRA pilot initiative provides a critical pathway to improve maternal and infant outcomes by connecting people to services effectively, efficiently, and with simplicity. The objectives of this pilot were to increase submissions and ensure practices can directly connect pregnant people to community and health services.

This toolkit provides an overview of the MPRA, its benefits, and guidance and recommendations for integrating it into an electronic medical record, as well as insights and reflections from the field. We encourage providers and clinical sites to consider integration of the MPRA into their electronic medical records and hope the insights provided here support their efforts. As always, please consider reaching out to your local health departments to increase integration of service and to stay informed on any updates on MPRA or ePRA.

Maryland Prenatal Risk Assessment- MDH 4850

(***Refer to the Instructions at the bottom of this document before completing this form***)

Provider Demographic Information:
Date of Initial Prenatal Visit/ Form Completed: ______/______/______
Provider NPI#: ______________________ Site NPI#______________________
Provider Name: ______________________ Provider Phone Number: _______-_______-________

Patient Demographic Information:
Patient Last Name:______________________ First Name:______________________ Middle I:__________
DOB: _____/_____/_______ Preferred Pronouns: ______________________
Social Security Number: ________-________-__________ Medical Assistance Number (MA): ______________________
Current Address: Street ______________________City________________County ______________State_____Zip Code __________
Best Contact Phone Number: _________-_________-_________ Email: ______________________
Emergency Contact Name: ______________________ Contact Phone Number:_______-_______-_______
Communication Barrier: Yes ____(Requires an Interpreter Y/N) No _______ Primary Language ______________________

Insurance Status (at time of prenatal visit):

Uninsured: Y_____N_______	FFS: Y ____N ______	Applied for Maryland MA: Y____N____ Date: _____/_____/_____
Maryland Medicaid: Y _____N____		MCO: ______________________

Demographics:

Biologic Sex	Male _____Female______	Other: ________________	
Gender Identity	Cisgender: Male ______Female_______	Other: (Patient's own definition) ____________________	
Race (check all that apply)	Black or African American _____	Asian _____	American Native _____
	Hispanic _____	Native Hawaiian/Pacific Islander _____	Alaska Native _____
	Non Hispanic White_____	Multiracial_____	Unknown_____
Educational Level:	Highest Grade Completed _______	Currently in School: Yes _____ No______	GED: Yes ____No____
Marital Status:	Married _____	Unmarried _____	Unknown _____
	Separated _____	Divorced _____	

Obstetric History Gravida______Para _________________:

#Full Term Births		#Preterm Births		#Ectopic Pregnancies	
#Spontanous Abortions		#Theraputic Abortions		#Living Children	

Entry to Prenatal Care:

OB Date of Initial Visit	_____/_/_________	Trimester of 1st Prenatal visit	_____1st ______2nd ______3rd
Previous OB Care	_____/___/_________	LMP ___/___/______	EDC ___/___/______

1

APPENDIX A: *Original Prenatal Risk Assessment | Prenatal Risk Assessment updated Summer 2022 https://health.maryland.gov/mmcp/Documents/Maryland_Prenatal_Risk_Assesment_Revised_5_2022_v_3.1.pdf*

Risk Factor Assessment:

Psychosocial Risks (Check all that apply)

Mental/Behavioral Health[1]	Overwhelming Anxiety/Stress: Y____N_____ Poor Coping Skills: Y ___N____ Depression: (Active Diagnosis : Y ___N___, Past Hx: Y ____N____) Partner Dissatisfaction: Y___N____ Intimate Partner/Family Violence/Abuse: Y____N_____ Developmental Disability: Y_____N_____
Behavioral Health Admissions[2]	Recent Psychiatric Inpatient Admission within <1 year: Y____N____ Admission Diagnosis: _______________
Substance Misuse[2]	Drugs and/or Opioid Misuse/Addiction: Y ____N____ Drug: ____________ Currently in SUD treatment: Methadone________Subutex ___________ Recent SUD related Inpatient Admission. within <1 year: Y______N____ Exchanging sex for drugs: Y_____N______ Nicotine/Tobacco/Vaping use: Y_____N_____ Amount:____________ Alcohol: Y _____N______Amount ____/day
Financial Insecurity[3]	Currently Unemployed:. Y_N _________ Temporary Assistance for Needy Families (TANF) eligibility: Y___N _______
Social Support/Network[4]	Identified lack of Friends/Family Social Support Network: Y____N_____ Housing Insecurity/Homelessness: Y_____N_____ Lack of Transportation: Y_____N______ Child Care Issues: Y______N _______ Recent incarceration/Partner currently incarcerated: Y_____N ______
Nutrition	Food Insecurity/Poor Nutrition: Y_____N_____
Exercise//Self Care	Lack of regular exercise (30min/day for at least 3x/wk): Y______N______

Medical Risks (Check all that apply)

Maternal Age	Age< or = 16 _____ Age> or = 35 _____
Maternal BMI	BMI<18.5 _____ or BMI>30 ______
Sexually Transmitted Infection - STI. (GC/Chlamydia/HIV/Hep B/C or Syphilis)	Current/Recently Treated STI: STI Name: _________________ STI screening (including Syphilis) completed for current Pregnancy: Y ___N__ Past STI Hx: (Syphilis) _____(Herpes)______
Chronic Disease	Asthma: Y_____N_____ Inhaler Rx: Y___N Diabetes Y__ N___: If yes then Treatment Medication: ______________ Chronic HTN/Heart Disease: Y__N__ Sickle Cell Disease: Y___N______ Sickle Cell Trait: Y______N______ Anemia - HCT<33 or HGB <11: Y___ N ___ Lab Result _______ AutoImmune Disorder: Y_____N_____ If yes please name: __________________ H/O - Thrombophilias/DVT: If yes please describe: _____________________________

Dental Care	Last Dental visit >1 year. Y____N_____

Pregnancy Risk Factors (Check all that apply)

Identified obstetric risks	Patient's First Pregnancy: Yes____No____ Covid Vaccinated: Yes ____No______ Covid Booster Current: Yes ____No _____ Short Interval Pregnancy <9 Months from last birth: Yes_____No______ Late Entry into Care >14 week: Y___N____ Previous H/O Preterm Labor/Birth: Y____N_____ H/O Previous Gestational Diabetes: Y___N____ Current multiple gestation pregnancy: Y____N_____ H/O previous LBW Baby: Y_____N_____ H/O previous Fetal Death In Utero >20 weeks: Y ____N_____ Previous Pregnancy affected with Preeclampsia/Eclampsia/HELLP Syndrome: Y ___N_____ H/O Cervical Incompetence: Y ____N____ H/O Previous infant affected with congenital defect: Y ___ N____Define: ___________

DEFINITIONS (To help complete Risk Assessment)

[1]Mental/Behavioral Health	Concern for the need of BH Services.
[1]Intimate Partner/Family Violence/Abuse	Physical, psychological abuse or violence within the patient's environment.
[1]Exposure to long-term stress	Partner-related, financial, personal, emotional.
[2]Substance Misuse	• Concern for use of illegal substances within the past 6 months. • At "risk-drinker" as determined by a screening tool such as T-ACE, CAGE, or AUDIT.
[3]Financial Insecurity	Example: Unemployed > 3months. Involved in exchanging sex for drugs.
[4]Lack of social/emotional support	Absence of support system I.e. family/friends. Feeling isolated.
Family History/Genetic risk.	At risk for a genetic or hereditary disorder. Known genetic carrier. H/O congenital anomalies.
Communication barrier	In need of an interpreter.
Dental Care	Last Dental Visit > 1year.
Prior Preterm birth	H/O of preterm birth (prior to the 37th gestational age).
Prior LBW birth	Low birth weight birth (under 2,500 grams).

2

APPENDIX A: *Original Prenatal Risk Assessment | Prenatal Risk Assessment updated Summer 2022 https://health.maryland.gov/mmcp/Documents/Maryland_Prenatal_Risk_Assesment_Revised_5_2022_v_3.1.pdf*

Maryland Prenatal Risk Assessment Form (Instructions for use)

Purpose of Form: Identifies pregnant women who may benefit from local health department Administrative Care Coordination (ACCU) services and serves as the referral mechanism. ACCU services complement medical care and may be provided by nurses, community health and outreach workers and may include education about Medicaid benefits, reinforcement of the medical plan of care, resource linkage and other related services.

Instructions: On the initial visit the provider/staff will complete the demographic and assessment sections for pregnant women enrolled in Medicaid at registration and those applying for Medicaid.

- Enter both the provider and site/facility NPI numbers.
- Print clearly; use black pen for all sections.
- If the client does not have a social security number, indicate zeroes.
- Indicate the person completing the form.
- Review for completeness and accuracy.

Faxing and Handling Instructions: **Fax the MPRA to the local health department in the client's county of residence**. To reorder forms call the local ACCU.

Mailing Address (client resides)	Phone Number
Allegany County ACCU 12501 Willowbrook Rd S.E. Cumberland, MD 21502	301-759-5094 Fax: 301-777-2401
Anne Arundel County ACCU 3 Harry S. Truman Parkway, HD8 Annapolis, MD 21401	410-222-7541 Fax: 410-222-4150
Baltimore City ACCU Healthcare Access Maryland 1 N. Charles St., #900 Baltimore, MD 21201	410-949-2357 Fax: 1-888-657-8712
Baltimore County ACCU 6401 York Rd., 3rd Floor Baltimore, MD 21212	410-887-8741 Fax: 410-828-8346
Calvert County ACCU 975 N. Solomon's Island Rd. Prince Frederick, MD 20678	410-535-5400 Fax: 1-833-662-7942
Caroline County ACCU 403 S. 7th St. Denton, MD 21629	410-479-8189 Fax: 410-479-4871
Carroll County ACCU 290 S. Center St. Westminster, MD 21158-0845	410-876-4941 Fax: 410-876-4949
Cecil County ACCU 401 Bow Street Elkton, MD 21921	410-996-5130 Fax: 410-996-0072
Charles County ACCU 4545 Crain Highway White Plains, MD 20695	301-609-6760 Fax: 301-934-7048
Dorchester County ACCU 3 Cedar Street Cambridge, MD 21613	410-901-8167 Fax: 410-228-8976
Frederick County ACCU 350 Montevue Lane Frederick, MD 21702	301-600-3124 Fax: 301-334-7770
Garrett County ACCU 1025 Memorial Drive Oakland, MD 21550	301-334-7695 Fax: 301-334-7771

Harford County ACCU 2015 Pulaski Highway, Suite E Havre De Grace, MD 21708	410-942-7999 Fax: 443-502-8975
Howard County ACCU 8930 Stanford Blvd. Columbia, MD 21045	410-313-7567 Fax: 410-313-5838
Kent County ACCU 125 S. Lynchburg Street Chestertown, MD 21620	410-778-7035 Fax: 1-844-222-7105
Montgomery County ACCU 1401 Rockville Pike, Suite 2400 Rockville, MD 20852	240-777-1635 Fax: 240-777-4645
Prince George's County ACCU 9314 Piscataway Rd. Clinton, MD 20735	301-856-9550 Fax: 301-856-9607
Queen Anne's County ACCU 206 N. Commerce Street Centreville, MD 21617	443-262-4456 Fax: 443-262-9357
St Mary's County ACCU 21580 Peabody St. Leonardtown, MD 20650	301-475-4330 Fax: 301-309-4117
Somerset County ACCU 8928 Sign Post Road Westover, MD 21871	443-523-1758 Fax: 410-651-2572
Talbot County ACCU 100 S. Hanson Street Easton, MD 21601	410-819-5600 Fax: 410-819-5683
Washington County ACCU 1302 Pennsylvania Avenue Hagerstown, MD 21742	240-313-3229 Fax: 240-313-3222
Wicomico County ACCU 108 E. Main Street Salisbury, MD 21801	410-543-6942 Fax: 410-543-6987
Worcester County ACCU 9730 Healthway Drive Berlin, MD 21811	410-629-0164 Fax: 410-629-0185

3

APPENDIX A: *Original Prenatal Risk Assessment | Prenatal Risk Assessment updated Summer 2022 https://health.maryland.gov/mmcp/Documents/Maryland_Prenatal_Risk_Assesment_Revised_5_2022_v_3.1.pdf*

The Health System and the MPRA

Multiple sectors of the health system use the PRA in different ways.

Patient: The same patients who receive the MPRA should receive an ePRA. They are either pregnant people with Medicaid or pregnant people eligible for Medicaid. They are connected to health and safety net care services when the MPRA or ePRA form is completed by the provider.

Medical providers: Medical providers (i.e., nurse practitioners, OB/GYNs, midwives) use the MPRA or ePRA to screen pregnant people with Medicaid or eligible for Medicaid. Providers complete the MPRA or ePRA during the first prenatal visit. Within 10 days of completing the assessment, providers forward the PRA to the local health department ACCU in the county where the person resides. Providers receive $40 per form for submission (not applicable to FQHCs).

Local health department ACCUs: ACCUs provide assistance navigating the healthcare system and address social determinants of health by connecting people to necessary community-based services. ACCUs support MCOs to help patients understand their benefits and clarify how to access services through the MCO. ACCUs help link people to dental care and Medicaid transportation services, renew benefits, and explain rights. Linkages are made via direct referrals to Special Needs Coordinators or Newborn Coordinators at the MCO. All MCOs receive a copy of the outreach summary generated by the ACCU of the MPRA for all of their referred members.

MCOs: MCOs use the MPRA or the ePRA and other information to identify pregnant people and link them to care coordination and case management services. This can include identifying services to address risk factors, assigning a case manager who communicates regularly with a member about their health needs, and documenting a plan of care to support members on an ongoing basis.

Local health department community health resources: Local health departments provide other services in addition to care coordination through the ACCU. These services vary by jurisdiction. These services may include but are not limited to home visiting programs, Special Supplemental Nutrition Program for Women, Infants & Children (WIC), substance use disorder treatment, home visits, peer support, other preventative services, and community resources.

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To: Prenatal Risk Assessment

Pages: 3

Date/Time: 8/29/2022 11:06:30 AM

Report Listing:

Report Title	Pages
EPRA Document	2

APPENDIX C: *Test-Case Example ePRA*

Maryland Prenatal Risk Assessment

Provider Demographic Information

Data of Initial Prenatal Visit/Form Completed: AUG-29-2022

Provider NPI: | Site NPI: Testing Faxing to AA Co

Provider Name: Bitar, MD, Wael | Provider Phone: 1234567890

Patient Demographic Information

Patient Last Name: ZZZTEST | First Name: IDXGUHFOUR | Middle I:

DOB: 06-30-1990 | Preferred Pronoun: - HE/HIM/HIS-He/Him/His

Social Security: XXX-XX-0000 | Medical Assistance Number: TESTING4578908764

Current Address: Street 6595 LUNCHBOX LANE | City: NOTTINGHAM | State: MD | Zip 21236

County of Residence: xePRA-AA

Best Contact Phone Number: 410-933-5763 | Email: rimmie.a.james@medstar.net

Emergency Contact Name: IMPORTANT, SOMEONE | Contact Phone Number: 301-252-5656

Communication No | Requires an Interpreter: No | Primary Language: English

Insurance Status(at the time of prenatal visit)

Uninsured: No	FFS: No	Applied for Maryland MA: Yes	Date:
Maryland Medicaid: Yes		MCO: AMERIGROUP MD	

Demographics

Biological Sex:	Female		
Gender Identity:	Male		
Race:	African American		
Educational	Highest Grade Completed: High school diploma/GED	Currently in School: No	GED: No
Marital Status:	Single		

Obstetric History Gravida: 2 Para: 1

#Full Term Births: 1	#Pre Term Births: 0	#Ectopic Pregnancies: 0
#Spontaneous Abortions: 0	#Therapeutic Abortions: 1	#Living Children: 0

Entry to Prenatal Care

OB Date of Init Visit:	08-29-2022	Trimester of 1st Prenatal Visit:	1st
Previous OB Care:		LMP: 06-22-22	EDC: 03-29-23

Pregnancy Risk Factors

Patient's First Pregnancy:		No
COVID Vaccinated:	Yes	
COVID Booster Current:	Yes	
Short Interval Preg <9 mo from lst birth:		No
Late Entry in Care >14 week:		No
Previous Hx of Preterm Birth:		No
H/O Gestational Diabetes:		No
Current Multiple Gestation:		No
H/O LBW Baby:		No
H/O Fetal Death in Utero >20 weeks:		No
Prev Preeclamp/Eclampsia/HELLP synd:		No
H/O Cervical Incompetence:		No
H/O Prev Infant w/congenital defect:		No

Fax sent to: +1(410)222-4150|| County of Residence:xePRA-AA || Page 1 of 2

APPENDIX C: *Test-Case Example ePRA*

Maryland Prenatal Risk Assessment

Psychological Risks

Overwhelming Anxiety/Stress:		No
Poor Coping Skills:		No
Depression (Active Diagnosis):		No
Past Hx of Depression:		No
Partner Dissatisfaction:		No
Partner/Family Violence/Abuse:		No
Developmental Disability:		No
Recent Psych Inpt Admit w/in < 1 yr:		No
Drugs/Opioid Misuse/Addiction:		No
Currently in SUD Treatment:	Yes	
Methadone:		No
Subutex:		No
Recent SUD Inpt Admit w/< 1 year:		No
Exchanging Sex for Drugs:		No
Nicotine/Tobacco/Vaping use:	Yes	
Alcohol:		No
Currently Unemployed:	Yes	
Temp Asst Needy Families eligible:		No
Lack of Friends/Fam/Soc Support Network:		No
Housing Insecurity/Homelessness:		No
Lack of Transportation:		No
Child Care Issues:		No
Recent Incarceration/Partner Incar.:		No
Food Insecurity/Poor Nutrition:		No
Lack Reg Exercise (30min/day 3x/wk):		No

Medical Risks

Maternal Age < or = 18:		No
Maternal Age > or = 35:		No
BMI < 18.5:		No
BMI > 30:	Yes	
Chronic Hypertension/Heart Disease:		No
Anemia (Hgb <11):		
Anemia (HCT <33):		
Asthma:		No
Has Inhaler Rx:		No
Sickle Cell Disease:		No
Sickle Cell Trait:		No
Autoimmune Disorder:		No
H/O Thrombophilias/DVT:	Yes	
Last Dental Visit >1 year:		No
Currently/Recently Treated STI:		No
STI Scrn(incl. Syphilis) curr. Preg:		No
Past Hx Syphilis:		No
Past Hx Herpes:		No

BMI: 34.54 | 08-26-22 08:33

Anaemia (HGB):

Anaemia (HCT):

Section Reference: Psychological Risks

Behavioural Health Admission Dx (Recent Psych Inpt Admit):

Drug Name (Drug/Opioid Misuse/Addiction):
Heroine, Percocet

Amount (Nicotine/Tobacco/Vaping Use):
Smokes 1/2 PPD

Amount per Day (Alcohol):
Drank 6 beers daily until positive pregnancy

Section Reference: Medical Risks

Auto Immune Disorder Name:

Describe H/O Thrombophilias/DVT:
Had DVT R leg 2019

STI Name (Currently/Recently Treated STI):

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APPENDIX C: *Test-Case Example ePRA*

BALTIMORE CITY HEALTH DEPARTMENT

HealthChoice
Maryland's Medicaid Managed Care Program