Pregnancy Home Initiative

A partnership with Community Care of North Carolina, Division of Medical Assistance and Division of Public Health

Community Care of North Carolina

Why Pregnancy Homes?

- Improve birth outcomes in North Carolina by providing evidence-based, high-quality maternity care to Medicaid patients
  - **Initial focus: preterm birth prevention**
- Improve stewardship of limited perinatal health resources
- Outcome-driven model
- Statewide standardization

Pregnancy Home initiative global goals

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- Improve the rate of low birth weight by 5% in year 1 and in year 2
  - 11.03% in FY2010 excluding Emergency Medicaid deliveries
  - 9.94% in FY2010 including Emergency Medicaid deliveries
- Primary c-section rate at or below 20%
  - Primary c-section rate among Medicaid deliveries in FY2011: 19.32%
  - Primary c-section rate among Medicaid deliveries excluding Emergency Medicaid coverage: 18.19%
  - Variation across networks, hospitals

Who can become a PMH provider?

Providers must be enrolled with N.C. Medicaid as one of the following:

- General/Family Practice, OB/GYN, or Multi Specialty Group
- Federally Qualified Health Clinic /Rural Health Clinic
- Local Health Department
- Nurse Practitioner
- Nurse Midwife

Practice must sign an agreement with a local CCNC network to participate.

Benefits of Becoming a Pregnancy Home

- **Data-driven approach to improving care and outcomes**
- **Support of local CCNC network**
- **Incentives:**
  - Increased rate of reimbursement for global fee for vaginal deliveries to equal that of c-section global fee (similar increase for providers who do not bill global fee)
  - $50 incentive payment for initial risk screening
  - $150 incentive payment for postpartum visit
  - No prior authorization required for OB ultrasounds (but still must register with MedSolutions within 5 days)

Pregnancy Home Responsibilities

- Provide comprehensive, coordinated maternity care to pregnant Medicaid patients and allow chart review for evaluation purposes for quality improvement measures
- Four performance measures:
  - No elective deliveries <39 weeks
  - Offer and provide 17P to eligible patients
  - Reduction in primary c-section rate
  - Standardized initial risk screening of all OB patients,
- Provide information on how to obtain MPW, WIC, Family Planning Waiver
- **Collaborate with public health Pregnancy Care Management programs to ensure high-risk patients receive care management**

Postpartum visit

- **Depression screening using validated screening instrument**
  - ACOG Committee Option 453, February 2010 as reference
- **Address the patient's reproductive life plan**
- **Referral for ongoing care**
  - Ongoing Medicaid eligibility (Family Planning Waiver)
  - Other options within the community

Role of local CCNC Network

- **Network is accountable to DMA for outcomes of this initiative (pregnancy medical homes and pregnancy care management)**
- **Each network has an OB team:**
  - OB coordinator (nurse)
  - OB clinical champion (physician)
- **OB team:**
  - educates and recruits practices
  - works with providers and other local agencies to make the system changes necessary for program success
  - provides technical and clinical support to participating pregnancy homes and to pregnancy care management
    - Focus on best practices and quality improvement

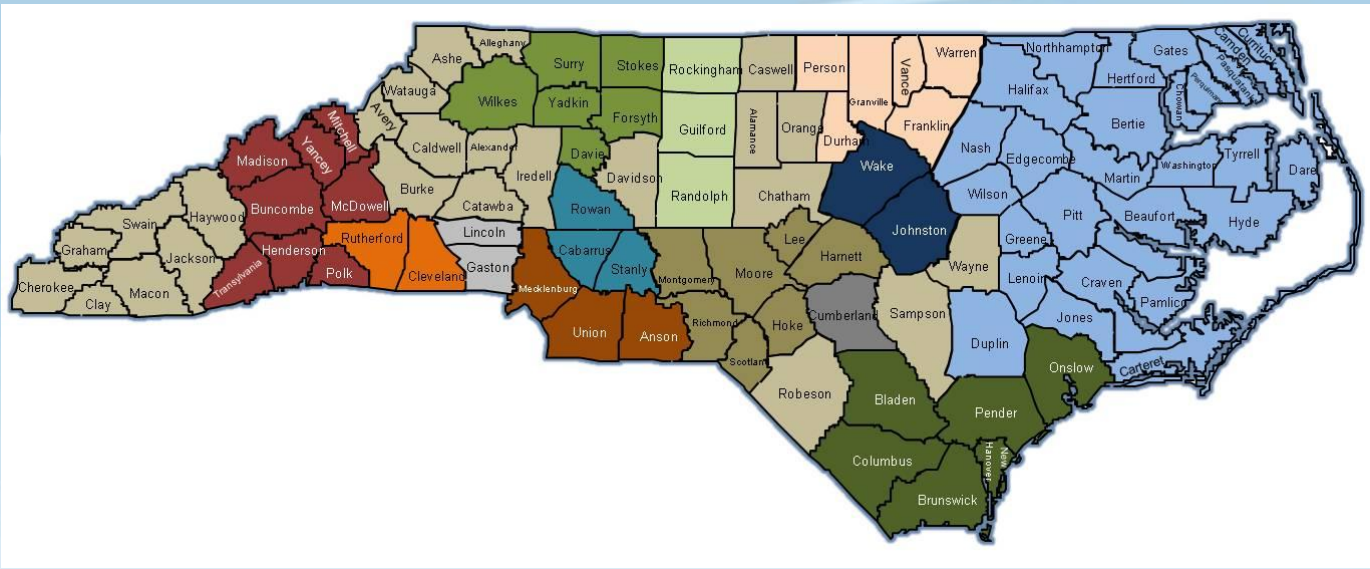
Each CCNC Network Has:

- Clinical Director(s)
- Network Psychiatrist(s)
- Network Director
- Nurse and Social Worker Care Managers
- Network Pharmacist (s)
- Quality Improvement Coordinator
- Informatics System Managers

Key program Asset- Data

- **Informatics Center - Medicaid claims data, birth certificate data**
  - Utilization (ED, Hospitalizations)
  - Providers (Primary Care, Mental Health, Specialists)
  - Diagnoses
  - Medications
  - Labs
  - Costs
  - Individual and Population Level Care Alerts
- **Real-time Data**
  - Hospitalizations, ED visits, Provider referrals

Pregnancy Medical Home Program: OB Nurse Coordinators



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How does the PMH model work?

- Practice (private OB, LHD with Maternal Health Services, FQHC with prenatal clinic, midwifery group) signs a contract with a CCNC network to become a PMH
- Local health department signs a contract with a CCNC network to provide Pregnancy Care Management
- Patient chooses an OB provider, which may or may not be a PMH
  - Optional program
  - Patient does not enroll but will get PMH info from DSS
- Practice has a designated pregnancy care manager who will work with the patient if she is at risk for poor pregnancy outcome; integral member of the care team

Risk Screening of the Pregnant Medicaid Population

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- Risk screening is the responsibility of the Pregnancy Medical Home at the first OB visit
- PMH submits a claim for the risk screening incentive payment, thereby establishing that practice as the "home" for the pregnancy
- Positive risk screen triggers pregnancy assessment with care manager
- Follow-up screen at end of 2nd trimester or any time a new risk factor is identified

Priority Risk Factors – focus on prematurity/low birth weight prevention

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- History of preterm birth (<37 weeks)
- History of low birth weight (<2500g)
- Chronic disease that might complicate the pregnancy
- Multifetal gestation
- Fetal complications (anomaly, IUGR)
- Substance abuse
- Tobacco use
- Unsafe living environment (housing, violence, abuse)
- Unanticipated hospital utilization
- Late entry to prenatal care/missing 2 or more prenatal appointments without rescheduling
- Provider request for care management assessment

Transition to Pregnancy Care Management

- **Population management model**
- **Risk-based eligibility**
- **Care management services**
  - Needs driven, flexible
  - Risk stratification model
- **Integrated collaboration with prenatal care provider**
  - Pregnancy care managers assigned to specific practices
- **Provided by Local Health Department, working by contract with CCNC network**

Working together

- CCNC works with local health department to ensure that each new PMH has a pregnancy care manager assigned
- CCNC can help facilitate communication between PMH and pregnancy care manager
- Pregnancy care manager should be considered an integral part of care team
- Two-way communication
- State-level coordination among DMA, DPH, CCNC

The two elephants in the room…

- Women need health insurance across the life span, not just during pregnancy.
  - **Approximately 2/3 of patients covered by Medicaid during pregnancy are not Medicaid-eligible outside of pregnancy.**
- North Carolina has a sizeable population of undocumented immigrant women of reproductive age who are not eligible for Medicaid but whose children go on to become both U.S. citizens and Medicaid patients.

Thank you!

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