

Pregnancy Home Initiative

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

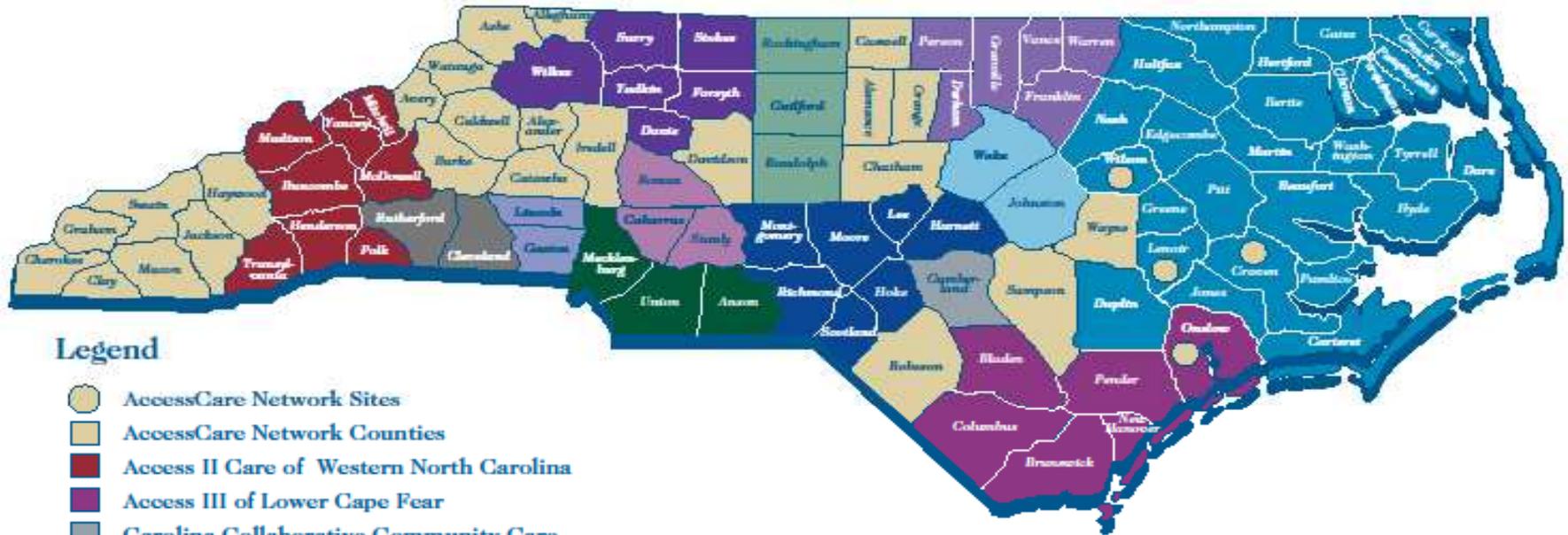


Community Care
of North Carolina



Community Care of North Carolina

Access II and III Networks



Legend

- AccessCare Network Sites
- AccessCare Network Counties
- Access II Care of Western North Carolina
- Access III of Lower Cape Fear
- Carolina Collaborative Community Care
- Carolina Community Health Partnership
- Community Care of Wake / Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care Network
- Partnership for Health Management
- Sandhills Community Care Network
- Southern Piedmont Community Care Plan



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**
 - 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



Provider Portal

- **Secure web access to the Medicaid patient record**
 - Visit history
 - Medication list and pharmacy claims history
 - Laboratory results when available
- **Access a compendium of low-literacy patient education materials, screening and assessment tools, health coaching, disease management**
- **Retrieve medication information patients in multiple languages in print and video formats**
- **Must have an agreement in place with your Community Care Network**



CCNC & Pregnancy Home

- **CCNC approach**---Focus on best practices for providers and care management of high risk patients
- **Network OB team** (physician champion and nurse coordinator) to support this model
- **Public Health Pregnancy Care Managers**—will work with high risk patients to help them manage their care



Why Pregnancy Homes?

- Improve birth outcomes in North Carolina by providing evidence-based, high-quality maternity care to Medicaid patients
- Improve stewardship of limited perinatal health resources

Pregnancy Home initiative global goals



- Improve the rate of low birth weight by 5% in year 1 and in year 2
 - 10.25% in 2009
 - Year 1 goal (July 2012): 9.74%
 - Year 2 goal (July 2013): 9.25%
- Primary c-section rate at or below 20%
 - C/S rate in North Carolina has increased annually for the past 15 years; 31.7% in 2009
 - Risk of surgical complications, newborn complications, risks in future pregnancies
 - Medicaid patients have a lower c-section rate than privately insured patients (27.9% in 2010)

Role of local CCNC Network



- **Network is accountable to DMA for outcomes of this initiative (pregnancy medical homes and pregnancy care management)**
- **Each network to have an OB team:**
 - OB coordinator (nurse) and
 - OB clinical champion (physician)
- **OB team will:**
 - educate and recruit practices
 - work with providers and other local agencies to make the system changes necessary for program
 - provide technical and clinical support to participating pregnancy homes and to OB case management



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



Pregnancy Home Responsibilities

- Provide comprehensive, coordinated maternity care to pregnant Medicaid patients and allow chart audits 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 case management**



Benefits of Becoming a Pregnancy Home

- **Data-driven approach to improving care and outcomes**
- **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)



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



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



- 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
 - Physician referral, hospital utilization are also “triggers”
- 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



- 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)
- Tobacco use
- Substance abuse
- Unsafe living environment (housing, violence, abuse)
- Unanticipated hospital utilization
- Missing 2 or more prenatal appointments without rescheduling
- Provider request for care management assessment



More risk screening info

- **Demographics**

- Height and weight
- Age
- Due date
- Gravidity/parity
- Insurance status

- **Additional risk factors:**

- Diabetes
- Hypertension
- Short interpregnancy interval
- History of pregnancy loss
- Communication barriers
- Pregnancy intendedness
- Cervical insufficiency
- History of postpartum depression



Risk screening

- Provider can check “requests assessment” box to trigger PCM assessment
- Complete form at first OB visit and submit to PCM within seven days
- PCM enters information into Case Management Information System (CMIS) within seven days and completes assessment of all “priority” patients within 30 days



Transition to Pregnancy Care Management

- **Population management model**
- **Risk-based eligibility**
- **Care management services**
 - Needs driven
 - 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 will work with local health department to ensure that each new PMH has a pregnancy care manager assigned
- CCNC can help facilitate communication between PMH and PCM
- PCM should be considered an integral part of care team
- Two-way communication



Hand-offs in maternity care

- **Pregnancy Medical Homes that do not provide intrapartum care must:**

“develop agreements, within one year of becoming a pregnancy home, with the entities that provide this care to recipients receiving maternity care from the Participant, to ensure optimal coordination of care, availability of medical records at the time of delivery, and appropriate transition to and from the intrapartum care provider. When becoming a pregnancy home, these practices will need to describe their current arrangements for coordinating care with the intrapartum care provider.”



Early entry/access to care

Challenges

- Providers unwilling to see patients until they can demonstrate Medicaid coverage
- Riskiest patients least likely to enter prenatal care early, complete Medicaid application early

Recommendations

- Work locally to educate and strategize about presumptive eligibility
- Expedite DSS processing of Medicaid applications for pregnant patients (33-day statewide average processing time for all Medicaid applications, 45 days allowed)
- Explore strategies for PMHs to assist women with Medicaid application



Transitions among maternity care providers

Challenges

- Low-income patients more likely to have multiple care providers (LHDs, FQHCS, family medicine)
- Approx. 1/3 of Medicaid patients get prenatal care in a LHD; postpartum care in family planning clinic
- Variable arrangements with local OB providers for intrapartum care

Recommendations

- Formalize relationships between prenatal and intrapartum care providers; establish postpartum follow-up process
- Increase capacity of OB practices serving Medicaid patients throughout the maternity period (and beyond?!)

Postpartum care

Challenges

- Postpartum care billed as part of global package; claims do not verify the patient had a postpartum visit
- Inappropriate billing practices related to billing for in-patient postpartum care
- Adequate follow-up of medical complications and/or chronic disease

Recommendations

- Educate providers about billing standards for postpartum care
- Allow for billing of E&M codes for in-patient postpartum care
- Develop/adopt evidence-based standards for postpartum care
- Interconception care waiver for women meeting specific criteria (poor pregnancy outcome, presence of certain chronic diseases)



Reproductive Life Plan

Challenges

- Variable access to some family planning methods
- Provider concerns about some long-acting contraceptives due to impending loss of Medicaid coverage

Recommendations

- Ensure all PMH patients have access to a standard set of contraceptive options
- Facilitate transition to Family Planning Waiver
- Increase provider awareness of FPW options (e.g., Essure/HSG)



The two elephants in the room...

- Women need health insurance across the life span, not just during 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.

Perinatal Quality Collaborative of NC (PQCNC)



- **Based at UNC, grant-funded voluntary organization focused on in-patient quality improvement**
- **Maternal and neonatal initiatives**
 - 2009-2010:
 - The “39 Weeks Project” and CABSI (catheter-associated blood stream infections)
 - 2010-2011:
 - Supporting Intended Vaginal Birth and Exclusive Breastfeeding during the hospital stay



Perinatal Quality Collaborative of NC (PQCNC)



Challenges

- How to fund hospital collaboratives at the state level
- Financial disincentives from the hospital perspective due to potential revenue loss
- Lack of consensus among provider community about appropriate quality measures, focus areas

Recommendations

- Pay for performance/quality
- Investment by public and private payors
- Adherence to Joint Commission perinatal care measure set
- Identify other valid, relevant quality measures for in-patient perinatal care



Thank you!



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