

# Pregnancy Care Management Standardized Plan

*The intent of the Pregnancy Care Management Standardized Plan is to outline methods and standards for the pregnancy care manager to follow in an effort to achieve the goals of improved quality of care and outcome measures. These standards are not intended to preclude alternative needs for evaluation, referral and management of the patient based on clinical judgment.*

## **Standardization & Reporting:**

### **Why is standardization important?**

Community Care of North Carolina (CCNC) networks, in partnership with local health departments, are responsible for the delivery of pregnancy care management services that will improve birth outcomes in the NC Medicaid population and thereby reduce costs. This plan outlines the methods and standards by which pregnancy care management is provided and evaluated.

### **Who uses this tool?**

Pregnancy care managers and other staff who work with pregnant and postpartum women who might benefit from pregnancy care management interventions.

### **What is expected of the Pregnancy Care Manager and how is it measured?**

The pregnancy care managers, working with each CCNC network, provide a variety of services in the form of population management and direct pregnancy care management. CCNC has established priority risk criteria that identify pregnant and postpartum women who are most likely to benefit from pregnancy care management interventions. Once identified and engaged, patients must have clear documentation of a pregnancy assessment, conditions/needs, interventions, goals and other pregnancy care management activities recorded in the CCNC Case Management Information System (CMIS). Specifically, pregnancy care management activities done with or on behalf of patients are recorded as tasks, including outreach to patients to engage them in care management. All care manager activity must be documented in CMIS within 72 hours.

CCNC and Division of Public Health (DPH) staff use CMIS to assess the impact of pregnancy care management; therefore, it is *imperative* that care managers utilize the standardized processes defined in this plan to document in CMIS their involvement with the individuals receiving pregnancy care management services; and that the documentation be consistent across CCNC networks.

### **For Reporting Outcomes:**

Pregnant and postpartum Medicaid patients who receive pregnancy care management will be followed for CCNC/DPH program evaluation/reporting. CCNC and DPH program staff will retrieve medical and utilization outcome data from CMIS, the Medicaid claims database, birth certificate data, and other sources. These data will then be analyzed for meaningful trends in quality and outcome measures (e.g., adherence to best practice guidelines; achievement of goals for performance measures).

## **Implementation:**

### ***Population Identification***

Referrals for pregnancy care management can occur through multiple mechanisms. The primary source for patient identification is the completion of Initial Risk Screening forms and Follow Up Risk Screening forms by Pregnancy Medical Home practices. Hospital utilization (emergency department, labor & delivery triage, hospital admission) during pregnancy is also a priority risk factor. As such, identification of hospitalized patients through any available means is appropriate. Additional sources of potential referrals include non-PMH prenatal care providers, other community agencies, and self-referral.

#### **Pregnancy Care Management Priorities (in order of priority):**

- Patients meeting priority risk criteria\*, identified on a PMH Pregnancy Risk Screening form, by referral of any agency or provider or self-referral, or through claims and/or utilization data, including hospital admission/discharge/transfer reports.
- Patients meeting non-priority risk criteria on a PMH Pregnancy Risk Screening form, by referral of any agency or provider or self-referral.

\* "CCNC Pregnancy Medical Home Program - Priority Risk Factors" document

#### **Risk Screening forms:**

- Every Initial and Follow Up Risk Screening Form received must be entered into CMIS, within 7 days of receipt, even if no risk factors are indicated.

### ***Prioritization***

Within the population of patients with priority risk factors are varying degrees of urgency and need. New referrals need to be triaged, to provide services based on urgency and need. Hospitalized patients need to have a documented attempt to engage within 72 hours of receipt of referral.

- Utilize targeted data and referrals, as defined in "Pregnancy Care Management Priorities" above, to inform the process of identifying patients who may benefit from pregnancy care management.
- Assign Pending status for all referrals meeting one or more priority risk criteria. Concurrently assign to a Pregnancy Care Manager.
- Contact Priority Patients to engage them in care management; document patient engagement activities as tasks in CMIS.
- During a brief/initial assessment period, determine if the patient is a candidate for pregnancy care management based on the presence of priority risk factors and patient's willingness to engage with the care manager.
  - If the patient verbalizes that she does not want to engage with the care manager and/or refuses referrals for linkage, assign OB Case Status as "Deferred- Refused Services" in CMIS.

- The patient assessment process can include a review of: a prior Comprehensive Health Assessment (CHA) and other information in CMIS (if applicable); claims data from Provider Portal; the patient’s medical record; and information from the referral source.
- A pregnancy assessment must be completed for patients who engage in care management services at a case status level of OB Heavy, OB Medium, or OB Light (See “OB Case Status” below.). The pregnancy assessment should be continuously updated with new assessment findings and at a minimum of once every 90 days and during the postpartum period for all patients with OB Heavy, OB Medium or OB Light case status.

## ***Intervention***

### **Pregnancy Care Management Process**

- **Assess** patient risk factors and needs, clinical and social stability, potential for care management interventions, and patient willingness to engage with care manager.
- Identify and open **Conditions**.
- Assign **Goals** - Goals reflect those areas in which the patient agrees to work with the care manager; they are the patient’s goals, not what the care manager thinks the patient’s goals should be. Goals are broad statements about what the patient and the care manager agree to work toward, and should be supported by documentation in the “as evidenced by” section that describes specifically how a determination will be made that the goal has been met.
- Document attempted, completed, and pending **Interventions/Tasks**.
- Determine follow up/monitoring frequency and assign **OB Case Status** based on patient needs. OB Case Status may change over time, as patient needs change.
- **Document** all ongoing care management activities: Interventions, Tasks, progress toward Goals, etc. in CMIS. All patients with a case status of OB Heavy, OB Medium, or OB light must have a minimum of one pending task at all times.
- Perform regular periodic status and goal reviews with the patient and document in CMIS at a minimum of 90 day intervals.
- Provide care management services in response to the urgency of patient needs.

### **Collaboration with Prenatal Care Provider**

Pregnancy care management services should be delivered in close collaboration with the patient's prenatal care provider and should reinforce and support the clinical care plan. Pregnancy care managers should communicate regularly with the prenatal care provider about patient progress toward goals, current needs and issues that may impact clinical care. Pregnancy Care Managers should function as part of the patient's prenatal care team, should regularly visit the Pregnancy Medical Home practices to which they are assigned, and should develop practice-specific communication strategies to ensure coordination of care.

## **Transfer**

*When a patient moves to another county during pregnancy or the postpartum period:*

- Contact the new pregnancy care manager (or lead Pregnancy Care Management contact) to communicate about the patient transfer and document the contact, and conduct appropriate follow up activities to ensure that the referral was picked up.
- The receiving pregnancy care manager is responsible for assigning him- or herself as the new OB Care Manager, conducting an assessment of the patient to determine current needs, and updating the OB Case Status and Pregnancy Assessment, as needed.
- When transferring a patient to a primary care manager at the end of the postpartum period, call the assigned primary care manager listed in CMIS to review the case and current patient needs and document the call. Only patients who will continue to be covered by Medicaid beyond the postpartum period will be eligible to receive primary care management.

## **Collaboration between Primary and Pregnancy Care Management**

The pregnant Medicaid population is composed of approximately one-third patients who are Medicaid-eligible, outside of pregnancy, and two-thirds patients who are in the Medicaid for Pregnant Women (MPW) category. Existing Medicaid patients may be linked to a CCNC practice and care manager before becoming pregnant. Some MPW patients are linked to a primary care medical home but are unlikely to have an existing relationship with a primary care manager. For those pregnant Medicaid patients who are linked to CCNC primary care practices and care managers, AND who qualify for pregnancy care management, it is important that services are coordinated and organized to best meet the needs of the patient.

- When receiving a new referral, first check CMIS (look at primary case status and task list) to see if the patient is being actively care-managed by a primary care manager (PCM).
- If YES - contact the primary care manager by phone and/or CMIS messaging, prior to initiating services in order to coordinate care.
- Review the comprehensive health assessment (CHA) in CMIS. Use the CHA and the primary care manager as information sources for conducting the patient's pregnancy assessment.
- Review the patient's care plan to see current and previous conditions, as well as active and deferred goals.

If a pregnant patient is admitted to the hospital for any reason other than delivery, a CCNC care manager may become involved in the case based on the patient's needs and risk for readmission. If the CCNC care manager determines the patient would benefit from Transitional Care upon hospital discharge, this should be coordinated with the pregnancy care manager in order to avoid duplication of services and to ensure all patient needs are being met.

## **OB CASE STATUS**

*Case status defines the level of pregnancy care management needs for THE PATIENT and must reflect direct service with or on behalf of the patient. Activities not directly related to a patient-centered intervention, i.e., tasks related to engaging the patient, should not be counted toward case status determination.*

### **Intense Pregnancy Care Management – OB Heavy**

- Potential to impact quality, utilization, and/or outcomes with patient's engagement/willingness to participate.
- A current Pregnancy Assessment (within the last 90 days).
- A minimum of 1 documented goal in place.
- One or more documented and completed tasks per week.
- A minimum of 1 pending task.

### **Moderate Pregnancy Care Management – OB Medium**

- Potential to impact quality, utilization, and /or outcomes with patient's engagement/willingness to participate.
- A current Pregnancy Assessment (within the last 90 days).
- A minimum of 1 documented goal in place.
- One or more documented and completed tasks per month, but less than 1 per week.
- A minimum of 1 pending task.

### **Pregnancy Care Management – OB Light**

- A current Pregnancy Assessment (within the last 90 days).
- Maintenance of stable conditions/problems and/or monitoring of priority risk factors.
- A minimum of 1 documented goal in place.
- At least 1 documented and completed task per trimester and postpartum period, but less than 1 per month.
- A minimum of 1 pending task.

### **Pregnancy Care Management - Pending**

- Period when newly identified patients are being screened and assessed to determine level of care management required.
- Pending Status should not be used for more than 30 days.

## Pregnancy Care Management - Deferred

*Note: A patient can move back out of Deferred status and into an active OB Case Status during the same pregnancy and/or postpartum period, if her circumstances change (e.g., priority risk factor identified on a Follow Up Risk Screening, antenatal hospitalization, etc.).*

Patients can be deferred for the following reasons:

- **Does Not Meet Screening Criteria** - Patient does not have a pregnancy priority risk factor.
- **Well-linked** - Patient assessment reveals no care management needs at this time because patient is stable, well-linked to prenatal care and/or other services, and has no priority risk factors. This reason should not be selected for pregnant patients with priority risk factors. This deferral reason is only for patients who do not receive CM because they are already well-linked to appropriate services that are meeting their needs.
- **Refused Services** - Patient verbalizes she does not want CM services at this time or refuses referral for linkage.
- **Unable to Contact** (at least 3 documented attempts) - CM has attempted contact at different times, on different days, and in different ways and has not been successful. An important opportunity to contact and engage patients is through their prenatal care provider when the patient is scheduled for a prenatal care visit. If a patient is engaged in prenatal care, she should not be deferred for “unable to contact” until outreach has been conducted through the prenatal care practice site.
- **Identified Needs/Goals Have Been Met** - Identified needs/goals for patient have been resolved as a result of CCNC OB CM activity. OB CM is no longer providing services. Select this reason only if OB CM services have been provided. This reason should not be selected for pregnant patients with priority risk factors.
- **Is Not Adherent to Care Plan or Goals** - CM has made multiple attempts to help patient set and work towards meeting goals without success due to patient being unwilling or unable to adhere to care plan. (User should select this after she/he has attempted to work with the patient. This is not based upon prenatal care provider request to defer.)
- **Postpartum Period Ended** - Pregnancy Care Management services conclude at the end of the month during which the 60<sup>th</sup> postpartum day falls. Can be used for live births, pregnancy losses, and fetal deaths.
- **Rolled Off** - Patient is currently not enrolled with Medicaid.
- **Prenatal Care Provider Recommends Deferral** - Patient is deferred at PMH’s request/recommendation.
- **Unable to Participate in Case Management at this Time** - Patient is unable to participate in CM services at this time due to living in a facility (e.g., institutionalized or incarcerated) or other circumstances that prohibit patient from setting goals, such as significant mental impairment.
- **Deceased**

*When a patient who has been receiving pregnancy care management services is deferred:*

- Inform the patient that she will no longer be receiving pregnancy care management services, as appropriate.
- For patients who receive both primary and pregnancy care management during the pregnancy, ensure the primary care manager is aware that pregnancy care manager is deferring the patient.