

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
- Improve stewardship of limited perinatal health resources
- Reduce preterm birth rate, rate of low birth weight, cesarean section rate

Who Is Involved in Pregnancy Homes?



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- **DMA/DPH/CCNC steering committee**
 - **DMA project team**
 - **CCNC OB workgroup**
 - Perinatologists, obstetricians, midwife, family medicine
 - Local health departments
 - DPH Women's Health Branch
 - Division of MH/DD/SA
 - Division of Medical Assistance
 - Local CCNC network leadership
 - **DPH Women's Health Branch team**

Local Health Department Role in the Pregnancy Home Initiative



- Potential roles for LHDs in the Pregnancy Home model:
 1. **Pregnancy Medical Home (PMH) – LHDs with maternal health services**
 2. **Pregnancy Care Management (PCM) – All LHDs**
- These are two separate components of the Pregnancy Home initiative.
- No changes to other “Baby Love” services (childbirth education, postpartum home visiting)
- Networks are planning to partner with LHDs for the provision of PCM services

Pregnancy Home Responsibilities



- Provide comprehensive, coordinated maternity care to pregnant Medicaid patients and to allow chart audits for the 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



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- **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)
 - **Support from CCNC network**
 - Example: pharmacy working group re: 17P and long-acting contraceptives

Role of CCNC Local 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

Role of NCCCN, Inc.



- North Carolina Community Care Networks (N3CN) will provide the informatics support for both the pregnancy medical home and pregnancy care management components
- N3CN will coordinate the CCNC pregnancy medical home program at the state level, in collaboration with the 14 local CCNC networks
- N3CN Pregnancy Home team:
 - Nurse coordinator – Kate Berrien
 - Physician champion – Kate Menard, MD, MPH

Risk Screening of Pregnant Population



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- Risk criteria include a combination of medical risk, psychosocial factors, and utilization (or lack thereof)
 - Positive risk screen will trigger case management assessment (as will physician request, visits to L&D triage or ED, hospitalizations during pregnancy)
 - Risk screening data to be entered into CMIS by case managers
 - Risk screening to be performed at first OB visit; follow-up screen at end of 2nd trimester to identify risks emerging during pregnancy
 - Follow-up screen may be performed any time a new risk factor is identified

Transition From MCCP to Pregnancy Care Management



- **Risk-Based eligibility**
- **Case Management Services**
 - Needs Driven
 - Risk Stratification Model
- **Integrated collaboration with prenatal care provider**
 - Pregnancy care managers assigned to specific practices

Case Management Information System (CMIS)



- Centralized, statewide database with access to Medicaid patient data from the CCNC Informatics Center (IC)
- Electronic documentation of all case management services
- Web-based access for case managers, supervisors, and monitoring

Thank you!



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