The Pregnancy Care Management Standardized Plan outlines methods and standards for pregnancy care managers to follow, working together with Pregnancy Medical Home (PMH) providers, in order to achieve the goal of improving the quality of maternity care, improving birth outcomes, and providing continuity of care for high risk pregnant women.

What is Pregnancy Care Management?

Pregnancy care management is a collaborative set of interventions and activities, including assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services that address the health care and preventive service needs of pregnant and postpartum women through communication and available resources to promote quality, cost effective outcomes.

Pregnancy care management is outcome-focused, with an emphasis on improving birth outcomes through reducing the rate of preterm birth, and monitors the pregnant Medicaid population and prenatal service delivery system using data. Pregnancy care management applies systems and information to improve care and assist patients in becoming engaged in a collaborative process designed to manage medical, social, and behavioral health conditions more effectively.

When a pregnant woman reaches the optimum level of prenatal health, everyone benefits: the mother and her baby, her support system, the health care delivery system and the various reimbursement sources. Pregnancy care management serves as a means for achieving prenatal and postpartum wellness through advocacy, communication, education, identification of service resources, and service facilitation. Pregnancy care management services are best offered in a climate that allows direct communication between the pregnancy care manager, the patient, and all service providers, in order to optimize the outcome for all concerned.

(Adapted from Case Management Society of America, 2010. *Standards of Practice for Case Management*. Little Rock, Arkansas.)

Why is standardization important and how are Pregnancy Care Management activities measured?

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 improve quality of care while containing costs.

CCNC and Division of Public Health (DPH) staff use the CCNC Case Management Information System (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.

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Reporting on Performance Metrics:
Pregnant and postpartum Medicaid patients who receive risk screening for pregnancy care management eligibility and/or active pregnancy care management services 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, utilization, care management activity, and outcome measures (e.g., adherence to best practice guidelines; achievement of goals for performance measures).

Guiding Principles for Care Management

Pregnancy Care Managers:
- Use a patient-centric, collaborative partnership approach.
- Whenever possible, facilitate self-determination and self-care through the tenets of advocacy, shared decision-making, and education.
- Use a comprehensive, holistic approach.
- Practice cultural competence, with awareness and respect for diversity.
- Promote the use of evidence-based care, as available.
- Promote optimal patient safety.
- Promote the integration of behavioral change science and principles.
- Link with community resources.
- Assist with navigating the health care system to achieve successful care, for example during transitions.
- Pursue professional excellence and maintain competence in practice.
- Promote quality outcomes and measurement of those outcomes.
- Support and maintain compliance with federal, state, local, organizational, and certification rules and regulations.

Pregnancy care management guiding principles, interventions, and strategies are targeted at the achievement of patient stability, wellness, and autonomy through advocacy, assessment, planning, communication, education, resource management, care coordination, collaboration, and service facilitation. They are based on the needs and values of the patient and are accomplished in collaboration with all service providers, including the pregnancy medical home. This accomplishes prenatal and postpartum care that is appropriate, effective, patient-centered, timely, efficient, and equitable.

(Adapted from Case Management Society of America, 2010. *Standards of Practice for Case Management*. Little Rock, Arkansas.)

Who is the priority population for Pregnancy Care Management?

Referrals for pregnancy care management can occur through multiple mechanisms. The primary source for patient identification is the Pregnancy Risk Screening form completed by a Pregnancy Medical Home practice. 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, including maximizing use of the CCNC OB ADT report or other local hospital reports. Additional sources of potential referrals include non-PMH prenatal care providers, other community agencies, and self-referral.

Pregnancy Care Management Priority Risk Criteria:
Patients meeting one or more priority risk criteria (listed below) 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, are the eligible target population for pregnancy care management.
- Multifetal gestation
- Fetal complications
- Chronic condition which may complicate the pregnancy
- Current use of drugs or alcohol/recent drug use or heavy alcohol use (month prior to learning of pregnancy)
- History of preterm birth (<37 weeks)
- History of low birth weight (<2500g)
- Unsafe living environment (physical/sexual abuse, domestic violence, homelessness)
- Tobacco use (current smoker or quit after learning of pregnancy)
- Late entry into prenatal care (>14 weeks/missing 2+ prenatal appointments)
- Hospital utilization during pregnancy (Emergency Department, antepartum admission; Labor and Delivery triage and/or observation)
- Provider request for care management, for any reason

Patients meeting other non-priority risk criteria on a PMH Pregnancy Risk Screening form, by referral of any agency or provider or self-referral, may be served with pregnancy care management, if all of the needs of the priority patient population have been met, and additional resources are still available.

Pregnancy Risk Screening Forms
Every Pregnancy Risk Screening Form received must be entered into CMIS within 7 calendar days of receipt, even if no risk factors are indicated or if no information has changed since a prior risk screening was entered for the same pregnancy.

Population 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 this urgency and need. Hospitalized patients need to have a documented attempt to engage within 72 clock hours of receipt of referral.

- Utilize targeted data and referrals, including urgency of identified risk factors, to inform the process of identifying and prioritizing 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. Ensure that the auto-generated pending task ("Other") that will appear on the pending tasks list of the individual who entered the Risk Screening Form is appropriately affiliated with the assigned Pregnancy Care Manager, as a reminder that this patient needs to be assessed. For subsequent referrals during the same pregnancy of a previously deferred patient, reassign the patient to Pending and conduct outreach attempts to engage.

- Contact Priority Patients to engage them in care management using Motivational Interviewing techniques and document patient engagement activities as tasks in CMIS. Present care management as support to work with her and her prenatal care provider, to address her needs and goals, to ensure she receives the best possible care while she is pregnant and after she delivers her baby.

- During a brief, initial evaluation 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.

    o 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 brief, initial evaluation process can include a review of: a prior Comprehensive Health Assessment (CHA), prior Pregnancy Assessment, and/or other information in CMIS (if applicable); data from Provider Portal; the patient's medical record; and information from the referral source. Any assessment findings should be documented on the pregnancy assessment and include the source of the information. A task describing how the assessment findings were obtained must also be documented.

- Once the patient is engaged, continue to document information gathered through ongoing comprehensive assessment on the pregnancy assessment, and document the care management activities as patient tasks in CMIS.

- 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 all new assessment findings as they are learned, and at least every 90 days and during the postpartum period, for all patients with OB Heavy, OB Medium or OB Light case status. The pregnancy assessment is a working document that shows the patient's past and current medical, behavioral, and social history and current needs. Any pregnancy care manager or CCNC staff member should be able to review a pregnancy assessment and feel secure that they are aware of all pertinent medical and psychosocial information that will assist them in working with the patient.

What is expected of the Pregnancy Care Manager?

Pregnancy care managers, working with each CCNC network, provide a variety of services in the form of population management and direct pregnancy care management, as integral members of the prenatal care team. 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 clock hours.

Pregnancy Care Management Core Functions

- Conduct initial and ongoing **assessment** of patient risk factors and comprehensive medical and psychosocial needs.

- Facilitate **communication and coordination** between members of the prenatal care team, and involve the patient in the decision-making process, to coordinate needed care and services.

- **Educate** the patient and members of her prenatal health care delivery team about options, community resources, and psychosocial concerns related to her clinical and social needs, so that timely and informed decisions can be made.

- **Empower** the patient to problem-solve by exploring options of care, when available, and alternate plans, when necessary, to achieve desired outcomes. **Encourage** the appropriate use of health care services and strive to improve the quality of care and maintain cost effectiveness on a case-by-case basis.

- The care management functions of assessing, identifying conditions/needs, establishing goals, and documenting interventions/tasks are essential to **developing a care plan** with the patient, family, prenatal care provider, other health care and service providers, to meet the patient's identified needs.

  - 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 descriptive statements about what the patient and the pregnancy care manager agree to work toward, and should be supported by documentation in the "as evidenced by" section that describes specifically how and when a determination will be made that the goal has been met. Goals should be patient-centric and specifically relate to the patient's risk factors and needs as identified at Pregnancy Risk Screening and during ongoing pregnancy assessment.

  - Perform regular periodic **status and goal reviews** with the patient and document in CMIS at least every 90 days at a minimum.

- Document attempted, completed, and pending **Interventions/Tasks** that reflect activity to respond to the identified needs and achieve the patient's goals.

- Determine follow up/monitoring frequency and assign **OB Case Status** based on patient needs. OB Case Status will change over time, as patient needs change. OB Case Status should reflect the current need for care manager follow up, either with or on behalf of the patient. **Provide care management services in response to the urgency of patient needs.**

- **Document** all ongoing care management activities: Interventions, Tasks, progress toward Goals, etc. in CMIS.

- **Assist** the patient in any care transitions. Strive to **promote** patient self-advocacy and self-determination. **Advocate** for both the patient and the payer to facilitate positive outcomes for the patient, the health care team, and the payer. The primary focus of care management is always addressing patient needs and goals.

(Adapted from Case Management Society of America, 2010. *Standards of Practice for Case Management*. Little Rock, Arkansas.)

Collaboration with Prenatal Care Provider

Pregnancy care management services must be delivered in close collaboration with the patient's prenatal care provider and when reinforcing and supporting the clinical care plan. Pregnancy care managers must communicate regularly with the prenatal care provider about patient progress toward goals, as well as current needs and issues that may impact clinical care. Pregnancy Care Managers are a part of the patient's prenatal care team, should regularly visit the Pregnancy Medical Home practices to which they are assigned, and must develop effective 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. Conduct appropriate follow up activities to ensure that the referral was received and document the activities.

- 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, Pregnancy Assessment, and Goals, as needed.

- The transition from one pregnancy care manager to another should reflect a coordinated, "warm" hand-off and should not result in interruption of care management services.

Collaboration with other Pregnancy Care Managers (Patient Sharing)

In situations where patients are receiving prenatal care in an out-of-county Pregnancy Medical Home, the home-county pregnancy care manager may find it more efficient and effective to work

collaboratively with the pregnancy care manager assigned to the PMH, who has an established relationship with the PMH provider and more direct access to the patient's medical record and prenatal care team, as well as access to the patient when she is attending her medical appointments at the practice. If two pregnancy care managers are working collaboratively to efficiently provide care management to address the patient's needs, they will both document in the patient's CMIS record. The home-county pregnancy care manager typically remains the assigned pregnancy care manager in CMIS.

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 CCNC primary care manager. For those pregnant Medicaid patients who are linked to CCNC primary care practices and receiving care management from a CCNC primary care manager, 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 receiving active care management (Heavy/Medium status) from a CCNC primary care manager (PCM).
- If the patient is receiving CCNC primary care management, 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, provider portal, and the CCNC 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.
- When transferring a patient to a CCNC primary care manager at the end of the postpartum period, call the assigned CCNC 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 (Carolina Access II) beyond the postpartum period are eligible to receive CCNC primary care management. A pregnancy care management patient should be referred to a CCNC primary care manager if she was in Heavy/Medium CCNC primary care status when pregnancy care management began and/or if she has an ongoing need and an assigned CCNC primary care manager through her primary care provider.

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.

Common Pathway for Pregnancy Care Management for patients with any Priority Risk Factor

Prenatal Period:

Prenatal Care Access
1. Ensure that the patient is established with a prenatal care provider.
2. Assess and address any barriers to keeping prenatal visits.
3. Assist with the application process for Medicaid, if this has not already been completed.
4. Establish with the patient that you are a resource for helping to enable her to attend all of her prenatal appointments and consultations, complete all of her labs, ultrasounds and any other procedures that are included in her clinical care plan.
5. Ensure that the patient is able to obtain all prescribed medications and understands how to take them.

Referrals and Education
6. Refer for WIC, if not already done.
7. Educate patient that her prenatal visits are a priority for the monitoring of her health status and that of her baby.
8. Educate the patient about the importance of avoiding tobacco, alcohol and drug use, eating a healthy diet, taking a prenatal vitamin, and getting regular prenatal checks.
9. Discuss family planning options.
10. Provide educational materials and/or referrals as appropriate.
11. During your encounters with the patient, encourage her to verbalize any concerns or issues that she may be having. Address those that are within your scope of practice and seek assistance for those that are not.

Collaboration with Prenatal Care Provider
12. Communicate with the prenatal care provider to ensure patient understanding of the clinical care plan, in order to provide needed support for the clinical care plan and to share relevant assessment findings and other activities with the clinical care team.
13. Share relevant information learned through the care management assessment process with the prenatal care provider, and assist provider with incorporating care management findings into the clinical care plan, as appropriate.
14. Notify the obstetrician if the patient is being followed by any other specialists, including mental health professionals.
15. Keep the lines of communication open between the patient, her provider and yourself. If at any time you have concerns, contact the patient's prenatal care provider. This type of teamwork is essential for a successful outcome.

Monitoring and Follow-Up
16. Ensure patient has kept all her medical appointments (prenatal care and other specialists).
17. Ensure patient has kept all her scheduled ultrasound appointments.
18. Evaluate the status of any referral made for the patient earlier in the pregnancy.

19. Review the warning signs and symptoms of preterm labor with the patient each time you speak with her. Make sure she understands what steps to take if experiencing any of these symptoms. Check with her provider to determine what protocol they follow; however, typical standard warning symptoms of preterm labor are as follows:
    - Six or more contractions in an hour
    - Cramping in the abdomen that comes and goes and may or may not be associated with diarrhea
    - Any change in vaginal discharge
    - Pressure that feels like the baby is "pushing down"
    - Low, dull backache that comes and goes, or does not go away
20. Assess for any new problems, concerns or needs.

Postpartum period:

Postpartum Care Access
1. Discuss the importance of scheduling and attending the postpartum clinical visit, and ensure that the patient is seen for a postpartum visit with her provider.
2. Assist with transportation for postpartum clinic visit, if indicated.
3. Discuss family planning options and assist the patient in obtaining the contraceptive method of her choice.

Referrals and Education
4. Discuss the importance of newborn care, including well child care and immunization schedules, and ensure the patient is connected to a well child care provider.
5. Refer the patient to the local Department of Social Services for Medicaid eligibility determination, and assist patient in applying for ongoing Medicaid coverage, including the Family Planning Waiver, if applicable.
6. Refer the patient to WIC.
7. Assess for any new needs in the postpartum period and assist as necessary with referrals, education, and support.
8. Assess newborn for referrals into any needed services, such as Care Coordination for Children (CC4C) or Early Intervention.

Collaboration with Prenatal/Postpartum Care Provider
9. Ensure that the prenatal care provider is aware of any issues that arise during the postpartum period.
10. Assist with referrals for any needed ongoing primary care after the postpartum period, including the transition to a primary care medical home, if applicable.

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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 should not be counted toward OB case status requirements. Direct patient contact and patient engagement are required to move a patient from pending status to an active case status. For patients in active case status (OB Heavy, OB Medium, OB Light) OB case status, goals, and pregnancy assessment must be updated at a minimum of every 90 days.

Pregnancy Care Managers are required to schedule a pending task for all patients who have an active case status of OB Heavy, OB Medium, OB Light or OB Pending. The pending task(s) should reflect planned activity to address the patient's identified risk factors and needs. Documentation should clearly explain why the patient is receiving care management and how the planned activities will help to achieve the patient's goal(s).

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).
- One or more documented patient-centric goals in place.
- One or more documented and completed tasks at least every 7 days or more often depending on patient need.

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).
- One or more documented patient-centric goals in place.
- One or more documented and completed tasks at least every 30 days or more often depending on patient need, but less than every 7 days. (Patients needing care management activity every 7 days or more often should have their case status updated to OB Heavy.)

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.
- One or more documented patient-centric goals in place.
- One documented and completed task at least every 90 days and postpartum, or more often depending on patient need, but less than every 30 days. (Patients needing care management activity every 30 days or more often should have their case status updated to OB Medium or OB Heavy.)

Pregnancy Care Management - Pending
- Period when pregnancy care manager is attempting to engage the patient.
- Period when newly identified patients are being screened and evaluated to determine level of care management required.
- Pending Status should generally not be used for more than 30 days, unless outreach efforts are close to securing contact and engagement, and documentation reflects ongoing attempted contacts.

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Pregnancy Care Management - Deferred

Patients can be deferred for the following reasons: [*Note: A patient should be moved back out of Deferred status and into a Pending or Active OB case status during the same pregnancy and/or postpartum period, if her circumstances change (e.g., priority risk factor identified on a subsequent Pregnancy Risk Screening, antenatal hospitalization, etc.).*]

DEFERRAL REASON	DEFINITION
Deceased	Deceased
Does Not Meet Screening Criteria	Patient does not have a pregnancy priority risk factor.
Identified Needs/Goals Have Been Met - *This reason may not be selected for patients with priority risk factors.*	Identified needs/goals for patient have been resolved as a result of pregnancy care management activity. Pregnancy Care Manager is no longer providing services. Select this reason only if pregnancy care management services have been provided. This reason can be used for patients without priority risk factors who have received pregnancy care management services.
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 60th postpartum day falls, or earlier in the postpartum period, if all patient postpartum needs and goals have been met. Can be used for live births, pregnancy losses, and fetal deaths.
Prenatal Care Provider Recommends Deferral	Patient is deferred at Pregnancy Medical Home/prenatal care provider's request and/or recommendation.
Refused Services	Patient verbalizes she does not want pregnancy care management services at this time or refuses referral for linkage.
Rolled Off	Patient is currently not enrolled with Medicaid. Patients lose Medicaid enrollment when they move out of North Carolina. This reason can also be used for a patient who has concluded a period of "presumptive eligibility" for Medicaid, without receiving ongoing Medicaid coverage.
Unable to Contact	Pregnancy Care Manager has a minimum of 3-5 documented, unsuccessful, timely attempted contacts at different times, on different days, and in different ways. 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.
Unable to Participate in Case Management at this Time	Patient is unable to participate in care management 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.
Well-linked - *This reason may not be selected for patients with priority risk factors.*	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 deferral reason is only for patients without priority risk factors, who do not receive pregnancy care management because they are already well-linked to appropriate services that are meeting their needs.

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 that the CCNC primary care manager is aware that pregnancy care manager is deferring the patient.

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