

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

Prenatal Period:

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. Refer for WIC, if not already done.
5. 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.
6. Ensure that the patient is able to obtain all prescribed medications and understands how to take them.
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. 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.
10. 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.
11. Notify the obstetrician if the patient is being followed by any other specialists, including mental health professionals.
12. 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.
13. 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.
14. Discuss family planning options.
15. Provide educational materials and/or referrals as appropriate.

Care Manager Monitoring & Follow-up:

1. Ensure patient has kept all her medical appointments (prenatal care and other specialists).
2. Ensure patient has kept all her scheduled ultrasound appointments.
3. Evaluate the status of any referral made for the patient earlier in the pregnancy.
4. 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
5. Assess for any new problems, concerns or needs.

Postpartum period:

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 the importance of newborn care, including well child care and immunization schedules, and ensure the patient is connected to a well child care provider.
4. Discuss family planning options and assist the patient in obtaining the contraceptive method of her choice.
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.
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.