

Pregnancy Care Management Training
Working Lunch Activity – 45 minutes

Sharing Successful Strategies

1. If you were orienting a new staff person to Pregnancy Care Management, what strategies would you share that you have found to be effective in engaging patients in Pregnancy Care Management services, both at first contact and with subsequent contacts?

Initial

- Depends on the patient
- Meet with the provider/care team/WIC
- “It’s part of Medicaid,” “It’s a special program”
- Re-read the pamphlet on the phone
- Meet face-to-face or “sneak” attack
- Inform patient that I work with Medicaid and Medicaid wants us to contact all patients receiving Medicaid to assist with health care concerns. Patient is more responsive if I tell them Medicaid wants us to contact them.

Subsequent

- Give the patient the heads up you will be calling
- Unannounced home visits
- Remember something important about the patient
- Hospital/home visits after delivery

2. What have you found to be effective for communicating and collaborating with Pregnancy Medical Homes and their providers to provide successful care management services?
 - Build relationship with front desk staff. They are most helpful/accessible to find out 17P compliance, date/time of next appointment.
 - Most problems occurred with turnover of staff. With new RN at practice or new PCM and building the relationship/collaboration all over again.
 - By knowing your practice routines, i.e. U/S days – new pt. days
 - Be aggressive and establish a rapport with the practice.
 - Access with EMR and having provider log-in and have secure CMIS access for emails.
 - Space to be embedded in office
 - That all OB providers would meet every 6 months with CCNC OB Champions to know goal and changes.
 - Having a specific “lead” worker at each PMH that the OBCM can contact by phone/face to face (works best) on daily or weekly basis.
 - Having a “space” at each PMH where the OBCM can see patients that are there for appointments.
 - Collaborating with ER at local hospital – ER notifying OBCM of any patients seen with positive pregnancy test.

- The PMH faxing screenings over to OBCM and OBCM faxing back that screening was received plus F/U re: patient's status.
- Weekly/monthly clinical staff meetings to discuss priority patients. OBCM(s) sitting in on meetings.
- Asking OB provider what works best for them.
- Informing practices that OBCM does home visit as needed.
- Organizing medical management meetings: HD + PMH

3. What strategies have you found to be effective in assessing patient needs? What methods have you used to assess patient needs? What do you find to be the most successful approaches to assessing patient needs? What are your most common assessment findings?

Approaches

- Face to face interviewing which allows motivational interviewing.
- Review risk screen questions which allows client to elaborate.
- Ask reflective questions.
- Do not be judgmental.
- Keep the conversation to the point of the question.
- Access to medical records at PMH.
- Collaborate with community agencies (WIC, etc.)
- Provider portal to access diagnoses and services
- Face-to-face is most successful—patients are more open to talk.
- Having assigned PCM's for a PMH
- Assign the PCM (Nurse) to do routine follow-up with patients at visits. Ex: BP check, GD, AFP's, etc. and update findings in CMIS
- Most successful=Flexible=have someone available to see the patient at all times.

Common Assessment Findings:

- Hx smoking but quit d/t pregnancy and not smoking now.
- Late entry \geq 14 weeks – c/t report d/t MCD process
- Behavioral health issues
- Lack of social and emotional support
- Smoking
- Mental Illness
- Substance Abuse
- Single Parents
- STD's
- Late Prenatal Care
- Late PNC
- Substance use
- GD
- Tobacco use
- Obesity (under chronic condition)

4. What are the most common risk factors in the pregnant Medicaid population in your community? What strategies have you found to be effective in addressing these risk factors?
- Late Entry
 - Relationships with provider and DSS to get sooner appointments and faster turnover for MPW applications.
 - Screen out through family practice when positive test and signup for MPW
 - Mental Health
 - Poor resources for mental health
 - MPW pays for mental health mobile crisis van
 - (Grant Funded) substance abuse counseling in house through Mental Health/New Horizon/Port
 - Smoking – providing specific materials, quit line
 - Chronic Conditions – provide pocket materials about preterm birth.
 - Late Entry Prenatal Care
 - Transportation – DSS transportation; gas vouchers (if prenatal care is with the health dept.)
5. Describe your experiences working with pregnant Medicaid patients with substance abuse disorders. What strategies have been effective? What have been your experiences working with patients in methadone treatment programs or who are on suboxone? What about patients receiving treatment from pain clinics or other pain management providers? What recommendations can you make about providing effective care management to this population?
- Make referrals to treatment facilities
 - Establish a relationship with the social workers in the treatment facilities to work together with patients
 - When talking with patients, be careful how you frame conversations/questions. Remain non-judgmental.
 - Until they realize they have a problem, efforts are in vain.
 - Some patients say that smoking THC is not as bad as cocaine or meth—smoking THC eases nausea.
 - Medical providers don't address substance abuse issues.
 - DSS referral
 - In-patient monitoring for prenatal substance abusing women.
6. Describe your experiences working with pregnant Medicaid patients with mental illness (of all forms, including depression, anxiety, eating disorders, bipolar disorder, schizophrenia, etc.). What strategies have been effective? What community services do you find helpful for these patients? What recommendations can you make about providing effective care management to this population?

Barriers:

- Lack of providers for mental health services.
- OB providers not adequately addressing mental health.
- Long wait for initial mental health evaluation.
- OB providers not willing to prescribe medications.

What has been effective?

- Staffing with OB to ensure patient receives mental health referral, services, etc.

Recommendations:

- Educate OB providers on resources.
- Encourage OB to contact OBCM for assistance to help a patient access mental health services.
- Integrated Behavioral Health, contracting with a mental health provider.
- Crisis intervention—connect with a provider and do a “warm hand off”
- CDC Website—“Choices”
- Network Mental Health to work with care managers to educate on resources.
- Review provider portal for a thorough review and possible meds.
- Providers-Narcotic Registry
- OB to NICU workgroup to prepare moms for outcomes and treatment involved.

7. Describe your experiences working with pregnant Medicaid patients who are experiencing domestic violence/sexual assault and/or related trauma. What strategies have been effective? What community services do you find helpful for these patients? What recommendations can you make about providing effective care management to this population?

Experiences:

- Vary from success to death

Strategies:

- Shelters, education, referrals to EastPointe Mental Health, DV Centers, Law Enforcement, DSS
- Effective listening between patient/providers
- Gaining trust, building rapport, be persistent
- Access patient alone, McKinney-Vento Law, providing resources in ladies rest room on back of business cards or other literature.
- Safety Plan – having interpreters with good rapport
- Communication with the health care team
- Identify resources within the community
- Work on empowerment
- Build self-esteem, make safety plan, give resources, shelter info

Barriers: Patient acknowledgement of D.V.

- Getting patient to resources/counseling services

8. What are some of the reasons that pregnant Medicaid patients in your community do not enter prenatal care in the first trimester? What are some strategies that could be implemented to improve the proportion of Medicaid patients receiving first trimester prenatal care?

Barriers:

- Waiting for Medicaid care/approval
- Private providers will not take presumptive/non-Medicaid patients.

- Presumptive Medicaid issues:
 - Only LHD's, FQHC's, Hospital-based clinics can initiate
 - Some presumptive applications are not initiated till 3rd trimester.
 - Some LHD's only initiating presumptive on illegal aliens.
- LHD volume in large counties
- Private providers refuse to participate
- Private providers limit number of patients they take per month.
- Patients cannot pay for "official pregnancy test" and do not know where to get free test.
- Ignorance/not educated in importance of early prenatal care.
- Patients waiting till they get Medicaid so they can see private MD
- Certain cultures do not value
- Medicaid – Delay in getting
- Delay in applying for Medicaid
- Providers will not accept patients until they are enrolled
- Irregular menstrual cycles or didn't know they were pregnant
- Drug abuse
- Lack of transportation

Recommendations:

- Faster Medicaid processing.
- DSS educating patients in MPW/refer to providers at time of application.
- National campaign with TV/radio/newspaper regarding importance of early prenatal care
- Awareness that patients can be seen at LHD without Medicaid
- Changes in Presumptive processes.
- Get providers to accept presumptive and not limit Medicaid.
- Have facilities doing pregnancy test refer/schedule prenatal appointments
- Initiate nurse prenatal visits.
- OBCM should collaborate with DSS Medicaid CM

Strategies:

- More education to all women and the importance of PNC
- PMH's more flexible hours/schedules
- Other sources besides Medicaid transportation if available
- Consult with DSS

9. What are some of the reasons that pregnant Medicaid patients in your community utilize the emergency department frequently and/or miss multiple prenatal appointments? What are some strategies that could be implemented to improve appropriate and desired utilization of prenatal care resources?

ED Utilization:

- Urgent medical concerns that require immediate attention
- Lack of transportation
- Told to go by OB, practice too busy to see
- After hours and weekends
- Complain of pain in order to receive pregnancy test and ultrasound

- Convenience
- Don't feel need for prenatal care due to several previous pregnancies
- Missed PN Appointments:
 - No transportation
 - Visit ER rather than waiting for next PN appointment

Strategies to Improve:

- Improve public transportation
- After hours clinic
- Mobile units
- More incentives offered by OB provider to attend appointments

10. What strategies have you found to be effective in working with patients who receive prenatal care outside of your county or in collaborating with other OBCMs outside of your county?

- Home visits with patients
- Practice encounters
- Contact at each office to speak with
- CMIS messaging with OBCM or telephone call
- Meet with providers to introduce self
- Develop working relationships by communicating with the practices, telephone, faxes, and meetings with the practice to discuss expectations.
- Quarterly Meeting
- CMIS, Fax Phone and letters
- Have a contact person in neighboring counties.
- Lead contact form.
- Embedded Hospital; you may receive clients from other counties, you then have opportunity to contact OBCM's or RN's to refer the client to the appropriate county.
- Fax all hospital assessments to the county of residence.