Prenatal Period:

Prenatal Care Access

1. Ensure that the member 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, including facilitating Presumptive Eligibility (PE) determination, if needed.
4. Establish with the member that you are a resource for helping to enable her to attend all her prenatal appointments and consultations, complete all her labs, ultrasounds and any other procedures that are included in her clinical care plan.
5. Ensure that the member can obtain all prescribed medications and understands how to take them. (NOTE: Pregnant women who receive Medicaid have a $0 copay for prescription medications).

Referrals and Education

*Note: Pregnancy Care Managers should refer to the CMHRP Pathway: Patient Education for guidance on the timing of member education and the use of approved materials.*

6. Refer for WIC, if not already completed.
7. Educate member that her prenatal visits are a priority for the monitoring of her health status and that of her baby.
8. Educate the member about the importance of avoiding, discontinuing or reducing tobacco and alcohol use and substance misuse, including the value of medication-assisted therapy for opioid use disorder, eating a healthy diet including proper hydration, taking a prenatal vitamin and getting regular prenatal checks.
9. Discuss the member's (and her partner’s) reproductive life plan and review family planning options. Ensure the prenatal care provider is aware of the member’s desired method of contraception for the postpartum period.
10. Provide educational materials and/or referrals as appropriate based on member need.
11. During your encounters with the member, encourage her to verbalize any concerns or issues that she is 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 member understanding of the clinical care plan, in order to provide needed support for the plan.
13. Share relevant information learned through the care management assessment process with the prenatal care provider and assist the provider with incorporating care management findings into the clinical care plan, as appropriate.
14. Notify the prenatal care provider if the member is being followed by any other specialists, including mental health professionals, or is receiving prescriptions from other providers.
15. Keep the lines of communication open between the member, her provider and yourself. If at any time you have concerns, contact the member’s prenatal care provider. This type of teamwork is essential for a successful outcome.

Monitoring and Follow-Up

16. Ensure member has kept all her medical appointments (prenatal care and other specialists).
17. Ensure member has kept all her scheduled ultrasound appointments.
18. Evaluate the status and “close the loop” of any referral made for the member. Follow up as appropriate to ensure referrals are completed.
19. Review the signs and symptoms of preterm labor with the member 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. 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 member is seen for a postpartum visit with her provider.
2. Assist with transportation referrals for postpartum clinic visit, if indicated.
3. Review family planning options and assist the member in obtaining the contraceptive method of her choice.

Referrals and Education

Note: Pregnancy Care Managers should refer to the CMHRP Pathway: Patient Education for guidance on the timing of member education and the use of approved materials.

4. Discuss the importance of newborn care, including well child care and immunization schedules, and ensure the member is connected to a well child care provider.
5. Refer the member to the local Department of Social Services for Medicaid eligibility determination, and assist member in applying for ongoing Medicaid coverage, including Be Smart (family planning coverage), if applicable.
6. Refer the member 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 Management for At-Risk Children (CMARC) 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.