The Care Management for High Risk Pregnancies (CMHRP) Standardized Plan outlines methods and standards for care managers to follow, working together with Pregnancy Management Program (PMP) providers, with the goal of improving the quality of maternity care, improving birth outcomes and providing continuity of care for the pregnant Medicaid population.

What is Care Management for High Risk Pregnancies?

Care Management for High Risk Pregnancies (CMHRP) is outcome-focused, with an emphasis on improving birth outcomes through reducing the rate of preterm and low birthweight births and monitors the pregnant Medicaid population and prenatal service delivery system using data. CMHRP applies systems and information to improve care and assist members in becoming engaged in a collaborative process designed to manage medical, social and behavioral health conditions more effectively.

Meeting the diverse and complex needs of members requires a holistic, person-centered approach that addresses both physical and behavioral health. A holistic approach must consider the social determinants of health—"conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (Office of Disease Prevention and Health Promotion, 2016). The more complex the needs, the more comprehensive the approach should be for assisting the member with a care plan that addresses the whole person and collaborates with other systems that impact the member’s well-being.

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

Why is standardization important and how are Care Management for High Risk Pregnancies’ activities measured?

The Division of Health Benefits (DHB), four pre-paid health plans (PHP) and one provider-led entity (PLE), in partnership with the Division of Public Health (DPH) and local health departments, are responsible for the delivery of Care Management for High Risk Pregnancies services. These services aim to improve birth outcomes in the North Carolina Medicaid population and to improve quality of care while containing costs.

Local health department staff use VirtualHealth to assess the impact of CMHRP; therefore, it is imperative that care managers utilize the standardized processes defined in this plan and document their involvement and all activities with individuals receiving CMHRP services in a consistent manner across the state.
Reporting on Performance Metrics:

Pregnant and postpartum Medicaid members will be followed for PHP, PLE and DPH program evaluation and reporting purposes. PHP, PLE and DPH program staff analyze Medicaid claims, birth certificate and care management data 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). Data sources include care management documentation, Medicaid claims, Pregnancy Risk Screening Forms, birth certificate data and other sources.

Guiding Principles for Care Management:

Care Managers:

- Use a member-centered, collaborative partnership approach.
- Whenever possible, facilitate self-determination and self-care through the tenets of advocacy, shared decision-making and education.
- Practice cultural competence, with awareness of and respect for diversity.
- Promote the use of evidence-based care, as available.
- Promote optimal member 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.
- Ensure coordination with and avoid duplication of available community services beyond Pregnancy Care Management.
- Identify and assess for Social Determinants of Health (SDoH).

Care Management for High Risk Pregnancies guiding principles, interventions and strategies are targeted at the achievement of member stability, wellness and autonomy through advocacy, assessment, prioritization, planning, communication, education, resource management, care coordination, collaboration, service facilitation, follow up and evaluation. They are based on the needs and values of the member and they are accomplished in collaboration with all service providers, including the pregnancy medical program. This accomplishes prenatal and postpartum care that is appropriate, effective, member-centered, timely, efficient and equitable.

(Adapted from Case Management Society of America, 2010. Standards of Practice for Case Management. Little Rock, Arkansas.)
How is the pregnant Medicaid population identified?

The primary source for identification of the pregnant Medicaid population is the Pregnancy Risk Screening Form, which is completed by a PMP practice. Hospital admission/discharge/transfer (ADT) data feeds are also used to identify pregnant women with Medicaid coverage, as are direct referrals from prenatal care providers or other community agencies and programs. In addition, CMHRP programs should use local strategies to identify as many Medicaid-eligible pregnant women in their communities as possible.

Who is the priority population for Care Management for High Risk Pregnancies?

As of June 1, 2017, the Maternal Infant Impactability Score (MIIS) is used to prioritize members for Care Management for High Risk Pregnancies. The MIIS was developed by analyzing several years of Pregnancy Care Management service delivery data, data from Pregnancy Medical Home Risk Screening Forms and birth outcome data from vital records. This analysis indicated that members with certain risk factors or combinations of risk factors are “impactable,” meaning they experience a reduced risk of delivering a low birth weight infant if they receive care management services. Members without an elevated priority status were shown to be less impactable, meaning that care management services have limited effect on the birth outcome.

Priority members are women with a MIIS of 200 and greater; members with a MIIS of 500 and greater are considered highly impactable. Priority members should receive intensive care management services throughout the pregnancy, including a minimum of 8-10 care management interventions prior to delivery, at least half of which should be face-to-face. Members with a MIIS of 500 and greater should receive at least 8-10 face-to-face interventions during pregnancy. If the member is not identified until after 30 weeks of gestation, care management services are less likely to have an impact on the risk of low birth weight. Therefore, every effort should be made to engage priority members in care management as early in pregnancy as possible.

- Consistent, sustained engagement throughout the pregnancy is a programmatic expectation. This expectation is reflective of face-to-face contact every 30 calendar days.
- If a priority member is identified after 30 weeks of gestation, including during the postpartum period, her current care management needs should be assessed, and services should be provided accordingly.
- If the Risk Screening Form is not available or not provided, then the care manager should conduct a Brief Pregnancy Assessment to determine if the member is in the priority population. A brief assessment consists of the fields in the Comprehensive Needs Assessment-OB (CNA-OB) that are also on the Pregnancy Risk Screening Form (see MIIS Cheat Sheet). This allows for the calculation of a MIIS for that member. This would also apply to members who are referred by ADT data or are identified through local community outreach strategies.
• Members who appear to be in the priority population should be contacted and receive an assessment of their comprehensive medical and psychosocial needs within 3 business days of receipt of the referral.

• When members are identified during the postpartum period or at the time of a pregnancy loss, such as a first trimester miscarriage, the care manager should conduct a brief assessment of current needs and provide support and referrals accordingly.

Any member who is directly referred to Care Management for High Risk Pregnanecies by her prenatal care provider or any other agency should be contacted and receive a full assessment, regardless of MIIS, within 3 business days of receipt of the referral.

The care manager should use professional judgment to determine if a member needs care management services, even if she is not in the MIIS priority population. Members who should receive care management services at an intensity level based on assessment of current need include those:

• With a MIIS less than 200 who, in the judgement of the care manager, would benefit from care management intervention
  o This includes members with medical/obstetrical complications that are too rare to be included in the MIIS (i.e. HIV, cancer)
• Who have psychosocial needs, regardless of their score
• Who are referred directly by the prenatal care or other medical or behavioral health provider
• Who are referred by a community agency
• Who self-refer
• With hospital utilization during pregnancy, as identified on the ADT Report or other local hospital reports

Members with a MIIS of less than 200 who are identified or referred through any of these mechanisms (provider, community agency, hospital utilization, self-referral or case review by care manager) should be assessed by the care manager for current level of need and served accordingly, regardless of the MIIS. These members may benefit from short-term care management services. If the decision is made to discontinue providing CMHRP services to a member with a MIIS of less than 200, who is referred from a provider or other agency, the care manager must communicate that decision with the referral source.

**Pregnancy Risk Screening Forms:**

Every Pregnancy Risk Screening Form received must be entered into VirtualHealth as quickly as possible and no later than within 7 calendar days of receipt, even if no information has changed since a prior risk screening was entered for the same pregnancy. For a current MIIS to be calculated efficiently, Pregnancy Risk Screening Forms should be entered without delay.
A new OB Episode must be created when entering the Risk Screening Form. Any additional Risk Screening Forms, inclusive of the 28-week screening forms, must be entered into VirtualHealth as quickly as possible and no later than within 7 calendar days of receipt, even if no information has changed since a prior screening was entered for the same pregnancy. If the member’s episode was previously closed for “Ineligible,” then a new OB Episode should be created, the 28-week screening form entered, and the OB Episode status updated accordingly.

**Population Prioritization:**

New referrals need to be triaged to provide services based on members’ urgency and need. Hospitalized members need to have a documented attempt to engage as quickly as possible and no later than within 3 business days of receipt of referral.

- Utilize targeted data and referrals, including the MIIS, to guide the process of prioritizing members who will most benefit from Care Management for High Risk Pregnancies.
- Assign a Pregnancy and Primary Care Manager for:
  - All referrals for members with a MIIS score of 200 and greater
  - All members referred by their prenatal care provider or another agency
  - All members with a MIIS of less than 200 who, in the judgment of the care manager, would benefit from care management intervention
    - Examples include members with medical/obstetrical complications that are too rare to be included in the MIIS calculation; members with psychosocial needs regardless of their score, or members who were identified through one of the referral mechanisms listed above
- Assign all referrals, including any member with a Risk Screening Form, to a Pregnancy Care Manager, for the member information to be assessed (see Care Management Process: OB Workflow document and MIIS Flowchart for New Referrals).
- For any member who has been identified in need of care management services, ensure that a pending task is assigned to the Pregnancy Care Manager, as a reminder that this member needs to be assessed.
- Contact priority members to engage them in care management, using Motivational Interviewing techniques and document member engagement activities in the Interaction Tracker.
  - Offer care management as a support for the member during pregnancy, and coordinate with 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 gives birth.
  - If the member verbalizes that she does not want to engage with the care manager and/or refuses referrals for linkage, complete the Interaction Tracker documenting the member outreach, check, “Member opts out of Case Management,” and review the “CMHRP Step-by-Step Guide for Documentation” to complete the appropriate process for OB Episode closure.
The initial evaluation process should include a review of: prior Comprehensive Needs Assessments-OB and/or other care management documentation; information from claims data; the member’s medical record; and information from the referral source. Any assessment findings should be documented on the Comprehensive Needs Assessment-OB (CNA-OB) and include the source of the information (i.e. Per EMR, member hospitalized for hyperemesis.).

- A case note describing how the assessment findings were obtained should also be documented (see CMHRP Step-by-Step Guide for Documentation).

Once the member is engaged in an open OB Episode, continue to document information gathered through ongoing assessment on the CNA-OB, and document the care management activities in the Interaction Tracker.

- Each time the assessment is updated there should be a corresponding interaction documented, which reflects how the information was obtained (e.g., telephone call, home visit, etc.)

A CNA-OB must be completed for all members who are engaged in care management services. The CNA-OB should be continuously updated with all new assessment findings as they are learned, and at least every 30 calendar days and during the postpartum period, for all members. The CNA-OB is a working document that shows the member’s past and current medical, behavioral and social history and her current needs. Any care team member should be able to review a CNA-OB and feel secure that they are aware of all pertinent medical and psychosocial information that will assist them in working with the member.

For subsequent referrals during the same pregnancy of a previously deferred member, create a new OB Episode and follow the “CMHRP Step-by-Step Guide for Documentation.” Conduct outreach attempts to engage, as appropriate.

**What is expected of the Pregnancy Care Manager?**

It is expected that Pregnancy Care Managers will use professional judgement, in collaboration with programmatic guidelines, to provide quality, comprehensive care management services to identified members.

Pregnancy Care Managers provide a variety of services in the form of population management and direct care management, as integral members of the prenatal care team. Once identified and engaged, members must have clear documentation of a Comprehensive Needs Assessment-OB, interactions, care plan and goal(s) and other Care Management for High Risk Pregnancies activities. Specifically, CMHRP activities done with or on behalf of members are recorded as interactions, including outreach to members to engage them in care management. All care management activity must be documented as quickly as possible but no later than 3 business days.
Care Management for High Risk Pregnancies

Care Management for High Risk Pregnancies Core Functions:

- Conduct initial and ongoing assessment of member’s comprehensive medical and psychosocial needs.
- Facilitate communication and coordination between members of the prenatal care team, and involve the member in the decision-making process, to coordinate needed care and services.
  - This process is best achieved by the Pregnancy Care Manager being embedded or integrated into the prenatal care team including being present in the office on a minimum of weekly basis, and by attending practice care conference meetings.
- Educate the member and members of her prenatal care team about options, community resources and psychosocial concerns related to her clinical and social needs, so that timely and informed decisions can be made.
  - Provide referrals to community resources, as needed, and ensure that appropriate follow up with each referral takes place. This may involve acting as a liaison between the member and a community agency in the initial stages of referral, and additional follow up with the member and the community agency to ensure the member is effectively linked into care. A case note should be documented to indicate the initial referral was made and again to indicate the status of all referrals made on behalf of the member.
- Empower the member to participate in the decision-making process related to her health care.
- 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 needs, establishing goals and documenting interactions are essential to developing a care plan with the member, family, prenatal care provider, other health care and/or service providers, to meet the member’s identified needs.
  - The Comprehensive Needs Assessment-OB will auto-generate some care plan needs based on the member’s assessment; additional identified needs may be manually entered onto the care plan. It is recommended to utilize the auto-generated care plans. If the member does not want to work towards the auto-generated goal, then the “Problem Status” within the care plan should be moved to “declined.” Assign Goals within the care plan - Goals reflect those areas in which the member agrees to work with the Pregnancy Care Manager; they are the member’s goals, not what the Pregnancy Care Manager thinks the member’s goals should be. Perform regular goal reviews with the member and document progress toward the goal, or lack thereof, at a minimum of every 30 days, for members with High, Medium and Low Engagement Levels. Members assigned an Intermittent Engagement Level should have goal reviews at a minimum of every 90 days.
- Document attempted and completed interactions that reflect activity to respond to the identified needs and achieve the member’s goals within the Interaction Tracker. Care Plans should be updated to indicate member’s progress towards the goal within the goals tab.
- Assist the member in any care transitions. Strive to promote member self-advocacy and self-determination. Advocate for both the member and the payer to facilitate positive outcomes for
the member, the health care team and the payer. The primary focus of care management is always addressing member needs and goals.

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

**Coordination of Care:**

A core expectation of the Pregnancy Care Manager is to ensure that the member’s health care and other services are well coordinated. The Pregnancy Care Manager should identify all other providers currently or recently involved in the care of the member. These include prenatal care provider(s), primary care provider(s), other medical or behavioral health care providers, substance use disorder treatment, social service providers, including Child Protective Services, other Pregnancy Care Managers, Care Management for At-Risk Children Care Managers, and other community programs. Many of these providers can be added to the member’s care team within VirtualHealth (Care Team ➔ Select “Other” ➔ Select Parent, Caregiver, Partner, etc.).

The Pregnancy Care Manager should review what services the member is receiving from each of these providers at the time of initial assessment. It is the responsibility of the Pregnancy Care Manager to establish communication with any other services that are already connected to the member. This should be done as part of the process of developing a care plan that reflects alignment of the care and services the member is receiving and avoids duplication of services.

**Collaboration with Prenatal Care Provider:**

Care Management for High Risk Pregnancies services must be delivered in close collaboration with the member’s prenatal care provider. Pregnancy Care Managers must communicate regularly with the prenatal care provider about the member’s progress toward goals, as well as current needs and issues that may impact clinical care. Pregnancy Care Managers are a part of the member’s prenatal care team and must develop effective practice-specific communication strategies to ensure coordination of care.

All Pregnancy Medical Program (PMP) practices, including those with low volume, should have regular, consistent Pregnancy Care Manager presence. The degree of embedding in a PMP practice will vary by location based on member volume and impactability. PMPs with high member volumes and with higher proportions of impactable members may require multiple embedded Pregnancy Care Managers. Regional high-risk centers that serve members from multiple counties may need regular presence of Pregnancy Care Managers from additional counties. For members who receive prenatal care in another county, one Pregnancy Care Manager in the home county should work with members who go to the same “out-of-county” practices.
Coordination with other medical providers:

The Pregnancy Care Manager should ensure the prenatal care team is aware of all medical services the member is receiving at the time of entry to prenatal care. This can be determined through member interview, review of the medical record and review of available claims data. The Pregnancy Care Manager can inform the prenatal care team of any medical services the member has received of which they may not already be aware.

If the member is referred during pregnancy for medical services outside of the prenatal care setting, the Pregnancy Care Manager should help coordinate this care, including ensuring needed appointments are scheduled, that the member is able to attend the appointments and that updates to the medical care plan are shared across the care team. For example, if the member is referred to a specialist, such as a psychiatrist or cardiologist, who orders specific tests or prescribes a new medication, the Pregnancy Care Manager should ensure that the member understands and is able to adhere to these recommendations and that the prenatal care team is aware of any changes.

Coordination with community programs:

Pregnancy Care Managers should maintain current knowledge of the programs serving pregnant women in their communities, including referral procedures and policies related to release of information. Pregnancy Care Managers should proactively obtain consent from a member to discuss her care plan with other agencies serving the member, preferably by having the appropriate consent form on hand at the time of the member assessment. This includes programs offering substance use disorder treatment and other behavioral health services.

Collaboration with home visiting or other care coordination programs for pregnant women:

Members who do not meet priority criteria for Care Management for High Risk Pregnancies should be connected to other programs in the community that serve pregnant women, as appropriate, based on eligibility criteria for those programs. Members with a MIIS of less than 200 can be linked with these programs and their episode closed rather than being served by Pregnancy Care Management, if there are no additional CMHRP service needs.

Pregnancy Care Managers working with members with a MIIS of 200 or greater who are receiving home visitation and/or case management services from local programs for pregnant women (e.g., Nurse Family Partnership, Adolescent Parenting Program, Healthy Beginnings, Healthy Families, Parents as Teachers, etc.) should maintain these members on their caseload and coordinate their services with these programs to avoid duplication. This includes direct communication with the professional from the program who is working with the member. These members may be maintained in a “Monitored” OB Episode Status and an “Intermittent” Engagement Level, if the Pregnancy Care Manager determines that the member is receiving intensive direct services from another program. The Pregnancy Care Manager should have contact with the member, at a minimum of every 90 days, to
Care Management for High Risk Pregnancies
Standardized Plan

reasses her needs and ensure they are being met appropriately by the community program. The Pregnancy Care Manager should have contact with the community program care manager, at a minimum of every 90 days to discuss the member’s progress towards the care plan and verify the program is still able to meet the member’s current level of need (See OB Engagement Status section of the CMHRP Standardized Plan)

Collaboration with other Pregnancy Care Managers (Member Sharing):

In situations where members are receiving prenatal care in an out-of-county Pregnancy Medical Program, it may be efficient and effective for the home-county Pregnancy Care Manager to work collaboratively with the Pregnancy Care Manager embedded at the member’s PMP. The embedded Pregnancy Care Manager may have an established relationship with the PMP provider, access to the member’s medical record and the prenatal care team. The embedded Pregnancy Care Manager can also work with the member when she attends medical appointments, as available. The home-county Pregnancy Care Manager is typically the assigned Pregnancy Care Manager, but the assignment can be adjusted based on whatever the two Pregnancy Care Managers agree is the most effective arrangement for the member. Any Pregnancy Care Manager working with the member must document all activity in the member’s record. This includes documenting interactions, updating care plans and goals and the CNA-OB. When more than one Pregnancy Care Manager is involved, the two Pregnancy Care Managers should ensure regular communication, especially after each interaction with the member.

Transfer between Pregnancy Care Managers:

* If a new address is not known, then the member CANNOT be transferred

When a member moves to another county during pregnancy or the postpartum period:

- Call the lead Pregnancy Care Manager in the member’s new county of residence. An updated list is available in VirtualHealth (OneLogin→ServiceNow→Knowledge Base);
- After talking with the lead Pregnancy Care Manager, change the Primary Care Manager and Pregnancy Care Manager to the new Pregnancy Care Manager’s name;
- Change the member’s address to reflect her new county;
- Set yourself a pending task for 7 calendar days to ensure member has had appropriate outreach by the new Pregnancy Care Manager;
- The new Pregnancy Care Manager is responsible for adjusting tasks, updating the CNA-OB and care plans, Episode Status, Engagement Status, etc.;
- 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 between Pregnancy Care Management and CCNC services:**

If a pregnant Medicaid member is receiving Care Management for High Risk Pregnancies services and a Community Care of North Carolina (CCNC) program or service, then it is important that services are coordinated and organized to best meet the needs of the member.

- When receiving a new referral, first review the Complex Episode Status and recent interactions to see if the member has been receiving active care management from a CCNC Complex Care Manager or other member support staff.
- If the member is receiving CCNC care management, contact the care manager by phone or email, prior to initiating services, in order to coordinate care. The Pregnancy Care Managers should discuss who is most appropriate to act as the Primary Care Manager and set themselves as the Primary within the member’s care team. REMINDER: The care manager listed as the Primary will receive ALL notifications for the member.
- Review the Comprehensive Needs Assessment-Complex (CNA-Complex). Use the CNA-Complex, Provider Portal and the CCNC Care Manager as information sources for conducting the member's CNA-OB.
- Review the member’s care plan to see current and previous needs/problems, as well as active and graduated goals.
- A Pregnancy Care Management member should be referred to a CCNC Complex Care Manager if she has an ongoing need and/or is assigned to a CCNC Complex Care Manager through her primary care provider. Only members who will continue to be covered by Medicaid beyond the postpartum period are eligible to receive CCNC Complex Care Management. When transferring a member to a CCNC Complex Care Manager at the end of the postpartum period, call the assigned CCNC Complex Care Manager (or the CCNC OB Coordinator, if the Complex Care Manager is unknown) to review the case and current member needs/problems and document the call.

If a pregnant member is admitted to the hospital during pregnancy for any reason other than delivery, a CCNC care manager may become involved in the case based on the member’s needs and risk for readmission. If the CCNC care manager determines the member would benefit from Complex Care Management upon hospital discharge, then this should be coordinated with the Pregnancy Care Manager to avoid duplication of services and to ensure all member needs are being met.
OB Engagement Status:

Within VirtualHealth, High, Medium and Low Engagement Levels all correspond to intensive care management, meaning there is at least one intervention with the member every 30 days. All members with a priority MIIS who are receiving Care Management for High Risk Pregnancies services should have an Engagement Level of High, Medium or Low, unless the OB episode is in “Monitored” status (see below for indications to use “Monitored” status with a priority member). These members should also have a minimum of one face-to-face intervention every 30 days.

It is the Pregnancy Care Manager’s responsibility to determine the appropriate follow up/monitoring frequency and assign the corresponding Engagement Status based on planned care management activity. The Engagement Status will change over time, as member needs change. The Engagement Status should reflect the current level of need for Pregnancy Care Manager follow up, either with or on behalf of the member. Provide care management services in response to the urgency of member needs.

<table>
<thead>
<tr>
<th>Engagement Status</th>
<th>Frequency of Contact with Member/Caregiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Daily to weekly engagement with the member/caregiver (more than 4x/month)</td>
</tr>
<tr>
<td>Medium</td>
<td>Weekly to bi-weekly engagement with the member/caregiver (3-4x/month)</td>
</tr>
<tr>
<td>Low</td>
<td>Bi-weekly to monthly engagement with member/caregiver (1-2x/month)</td>
</tr>
<tr>
<td>Intermittent</td>
<td>Monthly to quarterly (90 day) engagement with member/caregiver (less than 3x/90 days)</td>
</tr>
</tbody>
</table>
**OB Episode Status:**

Within VirtualHealth, Episode Status represents the member’s current stage within the care management process. Most episode statuses are automatically assigned by the system based on what is documented in the member’s record, including in the Interaction Tracker, on the member profile and on the care plan. The only episode statuses that the Pregnancy Care Manager assigns manually are “Pending” and “Ineligible.” If an OB Episode is moved to a closed status, such as “Unable to Reach” or “Lost Contact,” during pregnancy and then the member reconnects with Care Management for High Risk Pregnancies, then open a new episode in “Pending” status and restart the process with the new episode.

<table>
<thead>
<tr>
<th>Episode Status</th>
<th>Definition</th>
<th>Open/ Closed Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pending</td>
<td>Referral received; not yet assigned to a Primary Case Manager</td>
<td>Open</td>
<td>When opening an OB Episode after receiving a new referral, such as a Pregnancy Risk Screening Form or direct provider referral, use “Pending” Episode Status while working to engage the member.</td>
</tr>
<tr>
<td>Referred</td>
<td>Assigned to a Primary Case Manager; member has not yet been engaged or declined services</td>
<td>Open</td>
<td>VirtualHealth will assign a “Referred” OB Episode Status to a newly opened OB Episode as a result of an ADT or other system-generated referral.</td>
</tr>
<tr>
<td>Engaged</td>
<td>Member accepted care management</td>
<td>Open</td>
<td>Member accepted services as indicated on the Interaction Tracker.</td>
</tr>
<tr>
<td>Managed</td>
<td>Necessary assessments are complete; member signed care plan and at least one problem is set to “Managed” on the care plan</td>
<td>Open</td>
<td>Member is actively receiving care management interventions; Care Plan must be signed by the care manager and the member (or the Care Manager signs to indicate the member’s acceptance of Care Plan). At least one problem on the Care Plan must be in “Managed” status for the OB Episode Status to update to “Managed.” The goal is to move members into a “Managed” OB Episode Status as quickly as possible after referral.</td>
</tr>
</tbody>
</table>
| Monitored      | Member has an open care plan but is not receiving interventions from the care manager; Problems are set to “Monitored” on the care plan | Open | Member is not actively receiving care management interventions but should remain on the caseload for monitoring or future interventions later in the pregnancy or postpartum period. For CMHRP, use for members:  
  - In county jail for a short sentence, where the care manager is not able to provide direct services but anticipates being able to work with the member later during the pregnancy or postpartum period.  
  - In a residential substance use treatment or other facility where the care manager is unable to work directly with the member.  
  - Receiving services from an intensive home visiting/care coordination program, such that the member’s direct service care management needs are met by that program.  
The care manager continues to document care coordination interactions during the period when s/he is not directly providing interventions to the member. |
| Graduated      | At least one problem on the care plan is set to “Graduated”; all others can be set to “Graduated” or “Declined” for an OB Episode that was previously in a status of “Managed” or “Monitored” | Closed | When updating a problem on the Care Plan to “Graduated,” make sure there is at least one additional problem in “Managed” status, if the member continues to actively receive care management services. |
| Declined       | Member declined services upon initial outreach or at any point after an OB Episode was set to “Engaged,” “Managed” or “Monitored” | Closed | Set all problems on the Care Plan to “Declined” to update the OB Episode Status to “Declined” and use the box at the top of the Care Plan to indicate the “Member opted out of care management.” |
# Care Management for High Risk Pregnancies

## Standardized Plan

**Unable to Reach (UTR)**

<table>
<thead>
<tr>
<th><strong>Unable to Reach (UTR)</strong></th>
<th><strong>Member could not be reached in order to engage in or decline care management</strong></th>
<th><strong>Closed</strong></th>
<th><strong>Use the “Unable to Reach” box on the Member Profile to indicate the OB Episode Status should be closed for “UTR”</strong></th>
</tr>
</thead>
</table>

*Do NOT use if another program Episode is open*

**Lost Contact**

<table>
<thead>
<tr>
<th><strong>Lost Contact</strong></th>
<th><strong>Member could not be reached after already being engaged in care management (lost to follow up)</strong></th>
<th><strong>Closed</strong></th>
<th><strong>Set all problems on the Care Plan to “Lost Contact” to update the OB Episode Status to “Lost Contact”</strong></th>
</tr>
</thead>
</table>

*Do NOT use if another program Episode is open*

**Terminated**

<table>
<thead>
<tr>
<th><strong>Terminated</strong></th>
<th><strong>Member lost coverage and is no longer able to receive care management services</strong></th>
<th><strong>Closed</strong></th>
<th><strong>An OB Episode will not terminate automatically based on Medicaid eligibility; if an episode needs to be closed because member no longer has Medicaid or has moved out of state, then set status to “Ineligible”</strong></th>
</tr>
</thead>
</table>

*This will not be used for CMHRP members*

**Deceased**

<table>
<thead>
<tr>
<th><strong>Deceased</strong></th>
<th><strong>Episode closed due to member’s death</strong></th>
<th><strong>Closed</strong></th>
<th><strong>Documented on Member Profile</strong></th>
</tr>
</thead>
</table>

**Ineligible**

<table>
<thead>
<tr>
<th><strong>Ineligible</strong></th>
<th><strong>Member does not qualify for services or episode created in error</strong></th>
<th><strong>Closed</strong></th>
<th><strong>Use “Ineligible” status for:</strong></th>
</tr>
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- Referrals who do not meet priority criteria for CMHRP and for whom the care manager has not identified a need for care management intervention
- Members who have lost Medicaid coverage or have moved out of state

**Prior to closing an OB Episode for “Unable to Reach,” the Pregnancy Care Manager must attempt 3-5 different ways and different days of outreach. Outreach to the member’s Pregnancy Medical Program must also be completed prior to closing an OB Episode for “Unable to Reach.”**

Prior to closing an OB Episode for a priority member, the case must be reviewed with the care management supervisor.

When a member who has been receiving Care Management for High Risk Pregnancies services are closed:

- Inform the member and her prenatal care provider that she will no longer be receiving CMHRP services, as appropriate.
- For members who receive both CMHRP and other care management services during the pregnancy, ensure the other care managers have been notified of the CMHRP closure.
CMHRP Common Pathway

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.