Purpose: The purpose of this best practice document is to provide joint guidance to enhance collaboration between Nurse-Family Partnership (NFP) and Pregnancy Care Management (OBCM) programs across North Carolina as many clients are currently served by both programs. Collaboration and team work can greatly enhance client outcomes for the families served.

Population Identification: Below you will find the enrollment criteria for NFP and OBCM. While both programs serve pregnant women and their families, the criteria for enrollment and programmatic expectations differ between the two programs.

NFP:

- Voluntary program enrolling first time mothers only; an exception is given to 1 tribal site in North Carolina (Eastern Band of Cherokee Indians) and 2 other sites who are participating in a multiparous research pilot (Care Ring in Mecklenburg County and Buncombe County).
- Patients must enroll in pregnancy (as early as possible AND before 28 weeks gestation), and they are served until the child turns 24 months old.
- NFP serves low-income clients; however, they do not have to be enrolled in Medicaid. Individual sites must verify income eligibility upon enrollment per their local policy to ensure the client meets their low-income criteria.
- NFP can enroll clients who are documented or undocumented.
- Programmatic expectations for frequency of nurse home visits and contact in NFP is guided by the Strengths and Risks (STAR) framework and NFP guidelines. Visits typically occur every other week with weekly in the first month and again in the first 6 weeks postpartum. Moms in NFP may also receive telehealth per NFP telehealth parameters.

OBCM:

- The Pregnancy Care Management program provides services to all pregnant women who have Medicaid and meet program criteria. Criteria is determined by utilization of the Maternal Infant Impactability Score (MIIS), in addition to the OBCM’s professional judgement. Professional judgment is essential in situations in which there is not a large enough data sample of pregnant women with certain conditions such as HIV or cancer to determine impactability. Women with these conditions may present with a low MIIS, but they would still meet screening criteria due to utilization of the OBCM’s professional judgment.
- The Impactability Score, in addition to patient’s needs, dictate the frequency of contact and number of visits required. For example, the higher the score, the more contact a client will receive.
- The programmatic expectations for the frequency of contact between the OBCM and the member (client) engaged in Pregnancy Care Management is:
Referrals:

- OBCMs will be provided with brief talking points on NFP and brochures that can be given to prospective clients. The OBCM indicates that she/he let the client know about NFP by checking the box on the referral form from the OBCM to NFP.
- NFP referral forms will include a check box to signify the client is aware of the referral (examples provided).
- OBCMs may send names and/or a full referral for all first-time pregnant women with the proper agreement in place (See bullet 6). NFP agencies will evaluate referrals to identify those of the highest risk that can most benefit from NFP services. Please collaborate at your individual sites to determine the best referral practices and communication plans.
- NFP is responsible for letting OBCM know the status of the referral (disposition, waiting list and time frame for possible enrollment).
- Local NFP and OBCM programs should agree on a process for NFP to refer to OBCM. This process is necessary for new clients and previously deferred clients whose conditions have changed; they may need to be reevaluated for eligibility for Pregnancy Care Management services.
- Memorandum of Understanding (MOU) /Memorandum of Agreement (MOA): if OBCM and NFP are not in the same agency, then they must have an MOU/MOA in place. The referral process must be outlined in your MOU/MOA.

Collaboration and Communication:

- A member/leader with OBCM should be a participant on the NFP Community Advisory Board (CAB).
- Each local OBCM/NFP team should develop a communication plan to include the following:
  - MOUs/MOAs for those not in the same agency;
  - Referral process and communication;
  - Identify a way in which OBCM is notified of all new enrollments in NFP (even if not referred by OBCM)
  - Possible picture directory for NFP and OBCM staff (example from Buncombe);
  - Regularly scheduled meetings with OBCM and NFP (Ex: NFP participates quarterly at the OBCM meeting) to promote ongoing collaboration.
- Joint case conferences (Ex: the OBCM can join the NFP case conference when discussing a client who is participating in both programs)
- Family meetings and/or joint visits, as needed, for families participating in both programs
- NFP is responsible for informing the OBCM when the client is enrolled, unable to be contacted, discharged or if any other issues or significant changes arise.
- OBCMs working with members that have a MIIS of 200 or greater AND who are receiving intensive home visitation and/or case management services from Nurse Family Partnership, should maintain these members on their caseload and coordinate their services with NFP 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 “Monitored” OB Episode Status and an “Intermittent” Engagement Level, if the OBCM determines that the member is receiving intensive direct services from NFP. The OBCM should have contact with the member at a minimum of every 90 days, to reassess her needs and ensure they are being met appropriately. OBCM should have contact with the NFP Nurse Home Visitor at a minimum of every 30 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.
- Orientation of new staff: An overview of NFP and OBCM should be included in new staff orientation to increase familiarity with available community services. When possible, OBCM and NFP shadowing or spending time together to familiarize themselves with the other program is preferred.

Next Steps:

- Medicaid Transformation: Collaboration between OBCM and NFP state-level leadership will continue, and guidance will be updated, as appropriate.
- Read-only access to each program’s patient records (DMCN (NFP) and VirtualHealth (OBCM)) is being explored statewide. NFP currently has read-only access to VirtualHealth only in the western counties.
- Monitoring Collaboration: State-level Pregnancy Care Management and NFP leadership will continue to monitor the collaboration between OBCM and NFP at the local level and continue facilitation, as needed. Please be ready to discuss collaboration processes, the written communication plan and policies during site visits.