



Pregnancy Care Management

Working together to improve birth outcomes in the North Carolina Medicaid population

Brief Description:

The North Carolina Division of Public Health, in partnership with the North Carolina Division of Medical Assistance and Community Care of North Carolina (CCNC), has implemented a Pregnancy Medical Home initiative, which is inclusive of Pregnancy Care Management (OBCM) services. The goal of the Pregnancy Medical Home (PMH) model is to improve the quality of maternity care, improve birth outcomes, and provide continuity of care. The model involves engaging obstetrical providers as Pregnancy Medical Homes and local health departments as providers of Pregnancy Care Management services.

Priority Risk Factors:

Pregnancy Care Management services are provided for pregnant Medicaid recipients who are determined to be at risk for poor birth outcome. All PMH providers are required to complete a pregnancy risk screening, at the initial prenatal visit, to identify these and other risk factors. Non-PMH prenatal care providers can also refer their patients for Pregnancy Care Management services. Additionally, referrals can be made by partner entities that provide services to pregnant Medicaid recipients. Some local health departments also allocate specific funding to provide Pregnancy Care Management services to women who are ineligible for Medicaid.

Priority risk factors include:

- A history of preterm birth
- A history of low birth weight
- Multiple gestation
- Fetal complications
- Chronic conditions which may complicate pregnancy
- Unsafe living environment (homelessness, inadequate housing, violence or abuse)
- Substance use
- Tobacco use
- Missing two or more prenatal appointments without rescheduling
- Antenatal hospital utilization

Pregnancy Care Management Services:

Pregnancy Care Management services are provided by nurses and social workers, and are based on patient need and risk status. Contacts are determined by the patient's individual needs and plan of care, in order to effectively meet desired outcomes. Contacts may occur in multiple settings including the health care provider office, community, or patient's home, as well as by phone. All documentation for OBCM services is completed online in the CCNC Case Management Information System (CMIS).

Pregnancy Medical Home Relationships:

Each Pregnancy Medical Home serving Medicaid eligible pregnant women has a specific Pregnancy Care Manager(s) assigned to work with their patients. Effective and ongoing communication and collaboration between the Pregnancy Care Manager and the patient's Pregnancy Medical Home is a key component of the program model.

CCNC Network Relationship:

Each OBCM agency works in collaboration with their local CCNC network. The network will use reports based on data from CMIS, Medicaid claims, vital records and other administrative sources for quality improvement purposes and to identify the extent to which the program is achieving its goals.

Goal and Outcome Measures:

The overall model seeks to improve birth outcomes, which is measured by NICU length of stay, infant medical care costs in the first year of life, gestational age at delivery, rates of low birth weight and very low birth weight, and the primary cesarean section rate.

Pregnancy Care Management services specifically, are evaluated on the following outcome measures:

- Increase the risk screenings entered into CMIS.
- Increase the number of pregnant women meeting CCNC priority risk criteria who receive a pregnancy assessment.
- Increase the postpartum visit rate for PMH patients who receive pregnancy care management services or whose infant was admitted to the NICU.
- Increase percent of women who receive 100% of the 17P injections they are eligible to receive.
- Increase the percent of PMH patients, who receive pregnancy care management services, referred for Family Planning Waiver or full Medicaid coverage until achieving 95%.