North Carolina's Pregnancy Medical Home Program

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

Program Overview – March 8, 2012

Community Care of North Carolina

What is the PMH program?

- **The Pregnancy Medical Home program is a partnership among Division of Medical Assistance, Division of Public Health, Community Care of NC and providers across the state**
  - DMA provides program coordination and health policy support
  - CCNC networks (14 across the state) recruit and support maternity care providers
  - Local health departments contract with CCNC to provide Pregnancy Care Management
- **Population management approach to improving birth outcomes**
  - Provider-driven
  - Voluntary
  - Quality improvement framework - outcome-driven metrics

What are we trying to accomplish?

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- Improve birth outcomes in the North Carolina Medicaid population
  - **Provide evidence-based, high-quality maternity care to Medicaid patients**
  - **Focus care management resources on those women at highest risk for poor birth outcome**
- Improve stewardship of limited perinatal health resources
  - **In this program, quality improvement goals are aligned with cost savings goals – keeping more babies out of the NICU and avoiding associated expenses**

North Carolina Background

- In NC Medicaid population, rate of low birth weight:
  - **FY2010: 11.0%**
  - **FY 2011: 11.1%**
  - **1st quarter FY2012: 11.0%**
- Roughly 2/3 of women covered by Medicaid while pregnant are not Medicaid-eligible outside of pregnancy
  - Medicaid for Pregnant Women (MPW) coverage ends on the last day of the month in which the 60th postpartum day occurs
  - Presumptive Eligibility provides temporary coverage while waiting for the Medicaid application to be processed

Pregnancy Home initiative global goals

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- **Improve the rate of low birth weight by 5% in year 1 and in year 2** (11.1% to 10.5%)
- **Primary c-section rate at or below 20%**
  - Risk-adjusted rate (term, singleton, vertex) at or below 16%
- **Initial focus of this initiative is on preterm birth prevention**
  - Interventions for the multiple clinical and psychosocial risk factors that contribute to preterm birth

How are we going to accomplish our goals?

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- **Quality improvement focus for PMH practices**
  - Identify outliers, work with them to improve performance
- **Four physician performance measures**:
  - No elective deliveries <39 weeks
  - Offer and provide 17P to eligible patients
  - Maintain primary c-section rate at or below 20%
  - Standardized initial risk screening of all OB patients coordinated with LHD care managers
- **Pregnancy Care Management is the key intervention to improve the rate of low birth weight and preterm birth**
  - Identify the population most at risk of poor birth outcome and focus resources on these women

PMH Responsibilities

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- Provide comprehensive, coordinated maternity care to pregnant Medicaid patients and allow chart audits for evaluation purposes for quality improvement measures
- **Collaborate with public health Pregnancy Care Management programs to ensure high-risk patients receive care management**
- Postpartum visit must include, at a minimum:
  - Depression screening using a validated screening tool
  - Addressing the patient's reproductive life plan
  - Connecting the patient to ongoing care if it will not be provided in the PMH practice
- Provide information on how to obtain Medicaid during pregnancy, WIC, and Medicaid Family Planning Waiver postpartum

PMH Responsibilities

- **Eliminate elective deliveries (induction of labor and scheduled cesareans) before 39 weeks**
- **Maintain primary c-section rate at or below threshold level**
  - Risk-adjusted (term, singleton, vertex) primary C/S rate of 16% or lower
- **Offer and provide 17p to eligible patients**
- **Conduct standardized risk screening on all Medicaid patients to determine eligibility for referral for Pregnancy Care Management services**

PMH incentives

- **Incentive payments for:**
  - Completion of initial risk screening
  - Completion of the postpartum visit
    - No forms required, just documentation of key 3 elements
- **Increased rate of reimbursement for vaginal deliveries**
  - Roughly equal to c-section rate, depending on which code is used; 13.2% increase
- **Bypass of pre-authorization requirement for OB ultrasounds**
  - Must register all OB ultrasounds with MedSolutions within 5 days

PMH incentives

- **Practices are supported by CCNC OB team (OB physician champion and nurse coordinator)**
  - Education, technical assistance, best practices
  - Opportunities to share issues affecting maternity care in the Medicaid population, Medicaid clinical policy questions, billing concerns
  - OB champions meet regularly across the state to address issues and develop strategies to improve program processes and outcomes
- **Data-driven approach to perinatal quality improvement**
  - Access to multiple data sources through CCNC Informatics Center:
    - Medicaid claims
    - Birth Certificate data
    - Real-time hospital utilization data

How does the PMH model work?

- Practice (private OB, Local Health Department with Maternal Health Services, FQHC with prenatal clinic, midwifery group) signs a contract with a CCNC network to become a PMH
- Local health department signs a separate contract with a CCNC network to provide Pregnancy Care Management
- Patient chooses an OB provider, which may or may not be a PMH
  - Optional program
  - Patient does not enroll but will get PMH info from DSS
- Health department designates a pregnancy care manager to work collaboratively with each PMH practice
- **Care manager works with "priority" patients (those who meet risk criteria) as an integral member of the care team**

Identification of the "priority" pregnant Medicaid population

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- **Risk Screening Form**
  - Completed by a PMH provider
- **Hospital admission/discharge/transfer data**
  - ANY hospital utilization during the antepartum period makes the patient "priority" (Emergency Department, Labor & Delivery triage, antepartum admission)
- **Referral from community provider**
  - WIC, school system, domestic violence agency, faith community, DSS, family planning clinics, home visiting programs, etc.
- **Self-referral**

Priority Risk Factors

Focus on preterm birth prevention

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- History of preterm birth (<37 weeks)
- History of low birth weight (<2500g)
- Chronic disease that might complicate the pregnancy
- Multifetal gestation
- Fetal complications (anomaly, IUGR)
- Tobacco use
- Substance abuse
- Unsafe living environment (housing, violence, abuse)
- Unanticipated hospital utilization (ED, L&D triage, hospital admission)
- Late entry to prenatal care/missing 2 or more prenatal appointments without rescheduling
- Provider request for care management assessment

Prevalence of PMH priority risk factors

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- **In first 9 months (4/1/11-12/31/11), ~60% of pregnant Medicaid patients received risk screening**
- **70% of patients have at least one priority risk factor**
  - Tobacco use
    - 34% of patients report tobacco use at the time they learned of pregnancy
    - 19% of patient report continuing to smoke at the time of the screening
  - Late entry to prenatal care
    - 22% of patients entered prenatal care >14 weeks' gestation
  - Chronic condition which may complicate pregnancy:
    - 4.5% of patients have mental illness
    - 4.4% of patients have asthma
    - 2.67% of patients have hypertension
    - 1.76% of patients have diabetes (pregestational)

Pregnancy Care Management Responsibilities

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- **Engage priority patients in an active care management relationship, at a level appropriate for the patient's needs**
- **Assess the patient's clinical and psychosocial needs on an ongoing basis and assist the patient with setting goals**
- **Provide education, referrals, and direct interventions to address identified needs**
  - Guide and monitor community-based referrals
  - Monitor prenatal care and related appointments (e.g., ultrasounds, specialists) and proactively address barriers to care
  - Utilize evidenced-based care management interventions

Pregnancy Care Management Responsibilities

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- **Communicate with the prenatal care providers**
  - Share care management findings and interventions
  - Recommend needed provider-level interventions
  - Coordinate care between multiple providers/settings
- **Address postpartum needs**
  - Postpartum clinical visit attendance, including obtaining desired family planning method
  - Needed referrals for newborn
  - Medicaid eligibility determination
  - Transition to needed ongoing primary care services

PMH Program Status at end of 2011

- **Approximately 300 Pregnancy Medical Home groups as of 12/31/11**
  - Private practices (OB/GYN, family medicine, multi-specialty, nurse midwifery), hospital-based clinics, FQHCs, local health departments, rural health clinics
  - There are 350-400 groups providing maternity care to Medicaid patients – Efforts continue to recruit all Medicaid OB Providers to become PMHs
  - >1,000 clinicians (obstetricians, family physicians, nurse midwives, nurse practitioners, physician assistants) involved in PMH program currently

PMH Program Status at end of 2011

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- **Risk Screening of pregnant Medicaid patients**
  - Since program launch on April 1, 2011, more than 23,000 Medicaid patients had initial risk screening by 12/31/11
    - 31,000 patients total had initial risk screening, some of whom subsequently became Medicaid patients
  - In the three months September 1, 2011- November 30, 2011:
    - 11,000 patients received initial risk screening statewide (both Medicaid and uninsured, some of whom later enroll with Medicaid)
    - 7,690 patients had at least one priority risk factor (70%)
    - 5,778 “priority” patients were Medicaid patients (75%)

Next Steps

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- **Continued efforts to improve processes to identify the priority population, including new data on hospitalized patients**
- **Enhanced techniques to improve patient engagement in care management services**
  - New marketing materials: patient brochure, patient contact letters, telephone contact scripts for care managers
  - Motivational Interviewing training for care managers, to promote patient engagement, behavioral change, and health promotion
- **Dissemination of effective best practices for successful communication mechanisms between OB providers and pregnancy care managers**

Next Steps

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- **Exploring opportunities to address system gaps and enhance care coordination for:**
  - Patients needing behavioral health and substance abuse services
  - Patients receiving care at tertiary center high-risk OB clinics outside of their home communities and those with antenatal hospitalizations
- **Further development of program evaluation, examining factors associated with:**
  - Gestational age at entry to prenatal care
  - Utilization of hospital services in the antenatal period
  - Identification of priority risk factors
  - Engagement in care management services
  - Gestational age at delivery
  - Completion of the postpartum clinical visit
  - Effectiveness of interface between clinical care and care management

Thank you!

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