Delivering Patient-Centered Pregnancy Care Management

S. Vienna Barger, MSW, MSPH, CPH

Pregnancy Care Management Program Manager

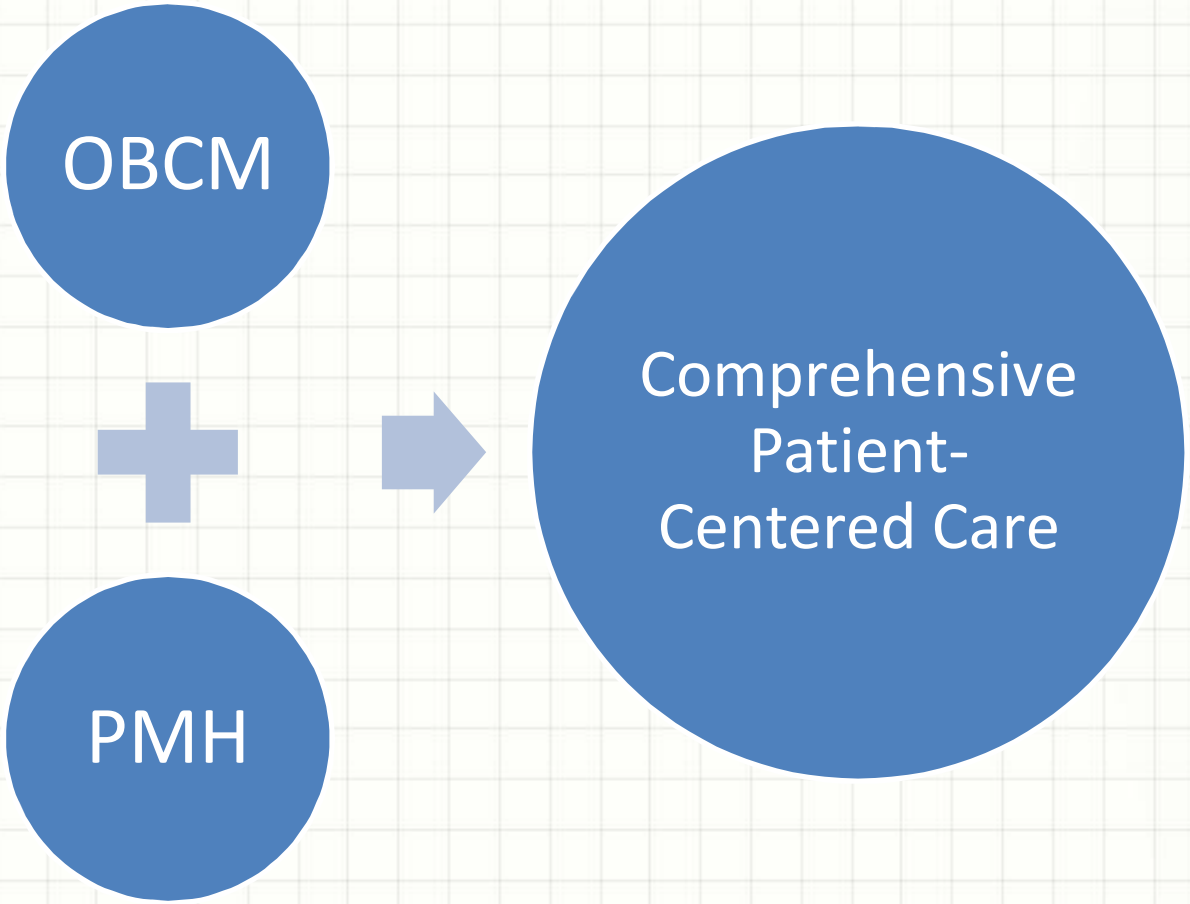
NC Division of Public Health

Working Together

Pregnancy Care Management is the **main** intervention of the Pregnancy Medical Home model

Care management must be tailored to meet each patient's unique needs

WORKING TOGETHER


OBCM
PMH
Comprehensive Patient-Centered Care

Cross-County Collaboration

- County of patient's Medicaid (county of residence) has responsibility for assuring the delivery of OBCM to the residents of their county.
- All counties are working together to achieve statewide program goals.
- Local OBCM supervisors need to coordinate cross-county OBCM activities.

Co-managing patients

- When more than one OBCM is working with a patient:
  - Patient CMIS documentation needs to stay current
    - Case status, goals, assessment, tasks
- Standardized Plan provides additional guidance
- “Home” county OBCM generally remains the primary OBCM, but may not provide the bulk of the care.

Pregnancy Care Management

Patient Identification

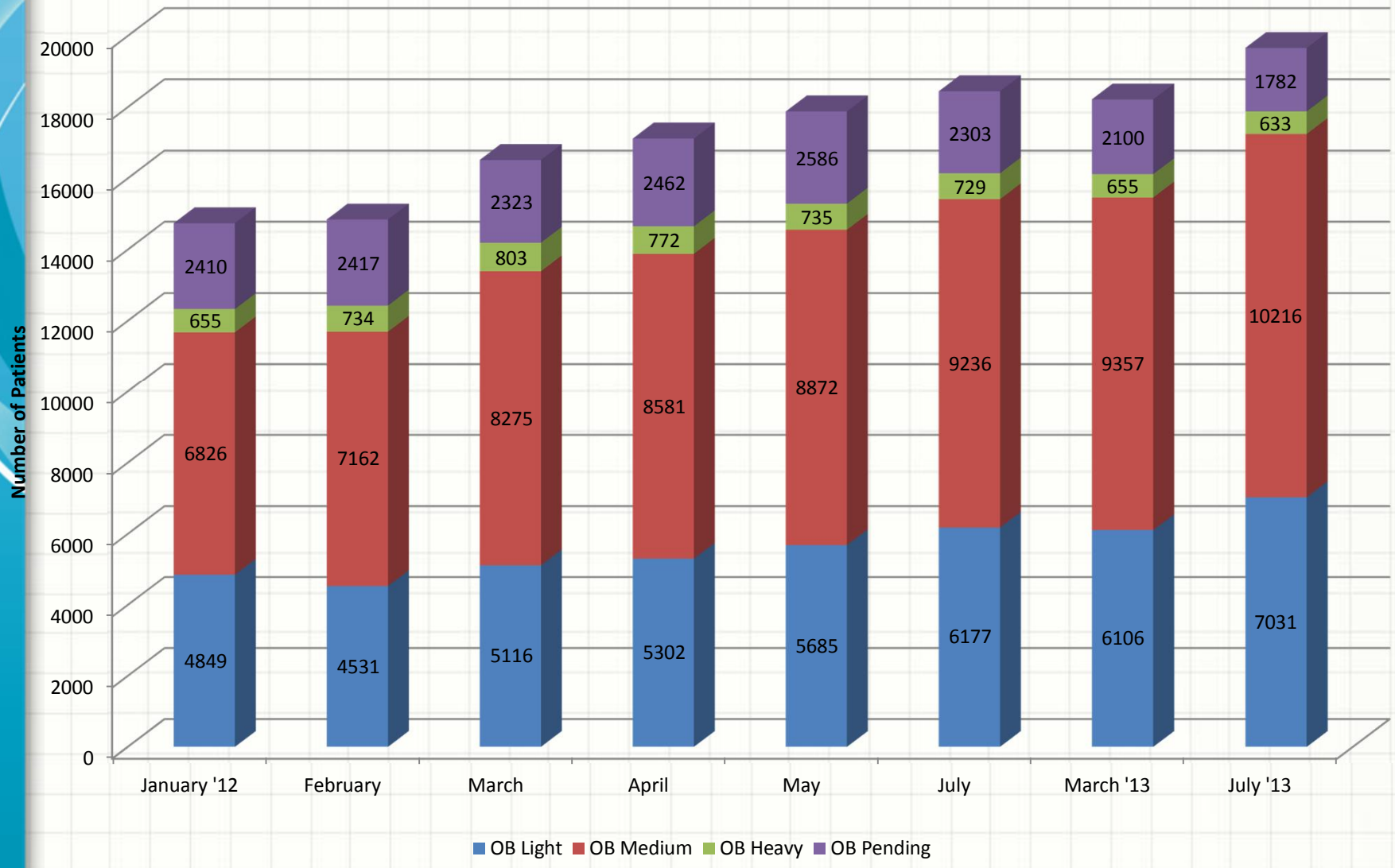
No wrong door

- Both Identification and Engagement are paramount in a population management model.
- While Risk Screening forms are primary source, all other referral sources are equally valid.
- If the referral source is not a Risk Screening form, the OBCM is responsible for determining if the patient meets priority criteria by assessing for those components using the Pregnancy Assessment.

Engagement

- For OBCM to be successful, you want the priority patients on your caseload.
- Use of Motivational Interviewing techniques for effective engagement approaches
- Reduce Deferrals

Pregnancy Care Management Statewide Caseload Trend - 2012-13



Care Management Interventions

- Interventions that improve birth outcomes
  - **Current pregnancy**
  - Subsequent pregnancies
    - Completion of postpartum visit
    - Received desired family planning
    - Linked to needed care services

Data Indicators

- OBCM Data Dashboard measures are not there to show you where you “failed”. They are there to point you in a direction, for you to then take a closer look, and determine what possible changes could be considered, which may result in an improvement.

PATIENT-CENTERED OBCM

Assessment

- Timely and “complete” assessment
- As needs are identified, whether at the initial contact and/or at a subsequent contact, the specifics of the need should be assessed and documented in the comment box.
- Updated regularly
- Remains a dynamic, current, “snapshot” of the patient’s history and current situation

Goals & Care Planning

- Goals need to be the patient's goals
  - **S**pecific – Who? Under what condition? How well?
  - **M**easurable – What?
  - **A**ttainable – Is it a reasonable goal?
  - **R**elevant – Does the patient think it is important? Is it releavant to the patient's pregnancy assessment?
  - **T**ime-Based – When?
- All her goals need to be listed.
- Updated as she makes her desired progress. Goals should be evaluated at each contact.

Tasks

- Care Management is an active process that requires planned interventions from the OBCM.
- Timely future tasks planned, beyond autogenerated tasks.

A word about “following”

Someone who is literally “following” you really isn’t doing anything to directly help you or support you in reaching your goals.

Who are you?

- What are some words for what you **are** or what you **do** for your patients?
- What role(s) do you fill in their lives?
- What action verbs describe the work you do?

CMIS Documentation

- CMIS serves a dual purpose.
  - A patient record.
  - A data source.

  It is very important that CMIS documentation is as accurate as possible, to effectively achieve both of these purposes.

OBCM Performance Measures

FY13-14 Pregnancy Care Management Service Agreement

OBCM Performance Measures – Exhibit B

- The following measures reflect fundamental Pregnancy Care Management performance expectations.
- Baseline data will be provided by CCNC during the first quarter of this Agreement.

OBCM Performance Measures

- CCNC will share data for these performances measures with Networks and Contractors quarterly using a “rolling year” methodology, contingent upon timely receipt of required administrative datasets, including Medicaid claims and birth certificate files.
- Additional quality improvement measures will be implemented on an ongoing basis over the course of this Agreement to support achievement of program goals.

1. Increase the proportion of pregnant Medicaid beneficiaries with pregnancy risk screening form entered into CMIS.

   Baseline year is SFY2013.

Target:

Å 5% improvement from baseline by end of SFY2014, or 95%, whichever is lower.

2. Increase the proportion of pregnant Medicaid beneficiaries meeting CCNC priority criteria based on risk screening data who are contacted by a Pregnancy Care Manager.

   Baseline year is SFY2013.

Target:

- 5% improvement from baseline rate by end of SFY2014, or 95%, whichever is lower.

3. Increase the proportion of pregnant Medicaid beneficiaries meeting CCNC priority criteria based on risk screening data who receive pregnancy care management assessment.

   Baseline year is SFY2013.

Target:

Å 5% improvement from baseline rate by end of SFY2014, or 95%, whichever is lower.

4. Increase the postpartum visit rate for Medicaid beneficiaries who were receiving pregnancy care management services at the time of their delivery.

   Baseline year is SFY2013.

Target:

Å 5% improvement in baseline rate by end of SFY2014, or 95%, whichever is lower.

OBCM Performance Measures

While these measures will serve as indicators of Contractor performance, Contractors are expected to focus efforts on realizing the aims of improved care, improved birth outcomes and reduced costs for the Target Population.

OBCM Service Contract – Exhibit A

"Local Care Management Entity (LCME) is responsible for providing the following services to achieve the goals and serve the Target Population for **Pregnancy Care Management (OBCM)**."

OBCM Service Contract – Exhibit A

- Outreach
- Population Identification and Engagement
- Assessment and Risk Stratification
- Interventions
- Integration with health care provider
- Collaboration with Network
- Training
- Staffing (includes Supervision)

QUESTIONS?

Thank you!

NCPH
North Carolina Public Health