Pregnancy Medical Home Program

- Population approach to improving quality of care and birth outcomes for pregnant Medicaid patients while reducing costs – launched in April 2011

- Pregnancy Medical Home providers (prenatal care providers) agree to meet performance standards, making them eligible for incentives from Medicaid
  - Standardized risk screening, 17p, no electives <39 weeks, primary c-sections, postpartum visit, collaboration with care manager

- Pregnancy Care Managers working in partnership with prenatal care providers serve the “priority” population
  - Based in local health departments, some embedded in PMH practices
PMH update – October 2012

What have we been doing for the past year?

- Establishing CCNC “OB teams”
- Recruiting PMH practices and building relationships
- Screening pregnant Medicaid recipients and connecting those in the priority population to pregnancy care management
- Improving quality of maternity care
- Collaborating with NC stakeholders around key issues
- Applying for federal Strong Start funds from CMS Innovations Center
CCNC OB Teams

- OB nurse coordinators and OB physician champions in each of the 14 CCNC networks provide local support to PMH practices
  - Importance of physician engagement at the practice level to promote program goals and obtain feedback
  - OB RNs meet at least twice monthly by phone and every 6 to 8 weeks in person with DPH Women’s Health Branch consultants who support pregnancy care managers in local health departments
  - OB champions meet monthly by phone and in person every third month
Pregnancy Medical Home Program: OB Nurse Coordinators

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Current enrollment in PMH program:
- 350 PMH practices (private practices, hospital clinics, health departments, FQHCs)
- 1,500+ individual providers (obstetricians, family physicians, certified nurse midwives, nurse practitioners, physician assistants)

Approximately 85% of all prenatal care providers serving Medicaid patients are enrolled in PMH program
- Number of prenatal care practices/providers is a moving target

Some practices now willing to accept more Medicaid patients than in the past
Identification of and outreach to priority pregnant population

- From January – June 2012, PMHs submitted risk screening forms on 20,288 pregnant Medicaid patients
  - >75% of pregnant Medicaid patients received risk screening (based on estimate using FY2011 Medicaid deliveries)
  - 70% of these patients had a positive risk screen (“priority” population) and were referred to a pregnancy care manager
  - 80% of priority population had contact with a pregnancy care manager
- Rates of screening and of pregnancy care manager contact were significantly improved over previous measurement (September – December 2011)
Essential partnership to address patient’s risk factors for preterm birth, both in the clinical and in the community settings

Focus on increasing communication between clinicians and pregnancy care managers

- Embedding/regular presence at PMHs
- EMR access
- Increased understanding of issues affecting patient’s health, pregnancy and ability to adhere to clinical care plan
Quality improvement

- Improved use of 17p in local settings
  - Education for PMH providers about Medicaid coverage of 17p resulting in fewer women inappropriately paying out-of-pocket

- PMH Care Pathway development to standardize care across the state
  - Management of hypertensive disorders of pregnancy
  - Use of cervical length measurement/progesterone for preterm birth prevention

- Care Pathways for pregnancy care managers
  - Common Pathway establishes standard expectations statewide
  - Tobacco use
First PMH Care Pathway, released August 2012: Management of Hypertensive Disorders of Pregnancy

Next PMH Care Pathway scheduled for October 2012 release: Use of progesterone and cervical length measurement to prevent preterm birth
PMH Use of Informatics for QI

- Use of Medicaid claims matched to birth certificates and CMIS data
  - Key metrics include rate of preterm birth, rate of low birth weight, primary c-section among term, singleton, vertex
- Practice-level data for PMHs to be released by end of 2012
- OB ADT (admission/discharge/transfer) data
- Exploration of potential enhancements to Provider Portal to meet needs of obstetric providers
PMH program goals

- Reduction in rate of low birth weight (infants born weight less than 2500g/5.5 pounds):
  - FY11 rate (baseline year) – 11.12%, FY12 rate – 10.80%
  - 2.8% decrease from baseline year in first program year

- Reduction in rate of very low birth weight:
  - Infants born weighing less than 1500g (3.3 pounds)
  - 6.4% decrease from baseline year in first program year

- Primary cesarean delivery rate among term, singleton infants at term ≤ 16%
  - FY11 rate – 16.16%, FY12 rate – 16.07%
<table>
<thead>
<tr>
<th>Year</th>
<th>Primary TSV Cesarean Rate (non-emergency Medicaid)</th>
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<tbody>
<tr>
<td>FY2010</td>
<td>16.40%</td>
</tr>
<tr>
<td>FY2011</td>
<td>16.16%</td>
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<tr>
<td>FY2012</td>
<td>16.07%</td>
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</tbody>
</table>
### Low Birth Weight Rate among NON-emergency Medicaid – STATE LEVEL (NC)

<table>
<thead>
<tr>
<th>Year</th>
<th>LBW rate (without emergency Medicaid)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2010</td>
<td>10.96%</td>
</tr>
<tr>
<td>FY2011</td>
<td>11.12%</td>
</tr>
<tr>
<td>FY2012</td>
<td>10.80%</td>
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</tbody>
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PMH Collaboration around Key Issues

- Medicaid coverage of progesterone gel/suppositories for pregnant women with short cervix
- Access to specialty care for pregnant Medicaid recipients, especially behavioral health services
- Opiate dependence in pregnancy
- CenteringPregnancy model of prenatal care
- Elective deliveries <39 weeks (“NC39Weeks” initiative with NC Hospital Association, NC Quality Center)
- Improved access to long-acting contraceptives for Medicaid recipients
- Oral health
Thank you!

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