

Pregnancy Medical Home Update: October 2012



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 Physician Champions

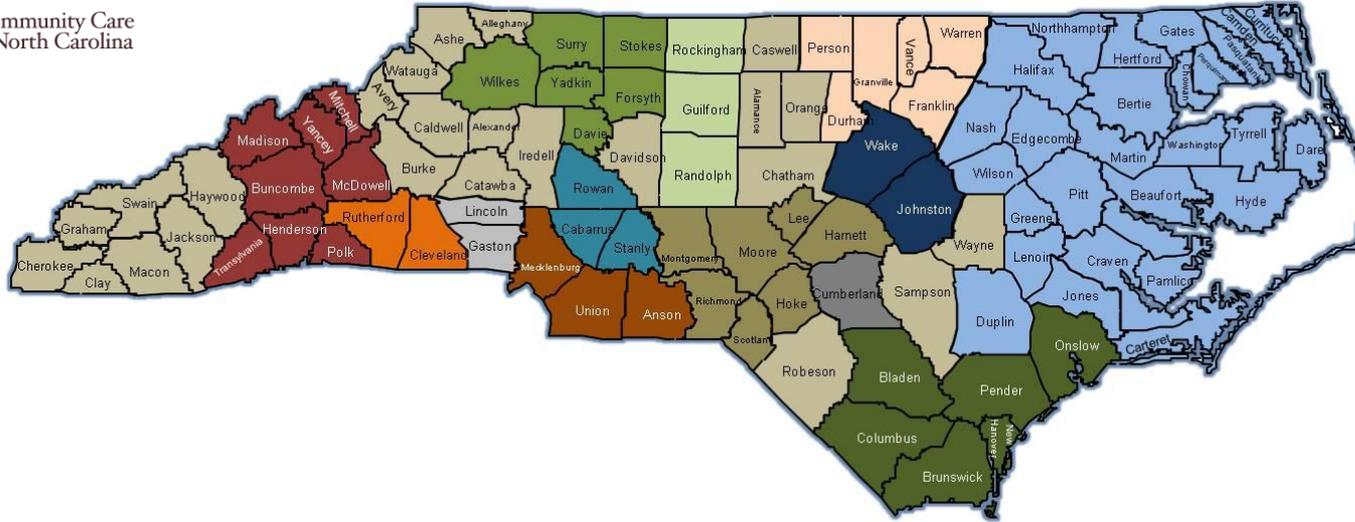


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|--|---|--|
| <ul style="list-style-type: none"> AccessCare
Kate Menard, MD, MPH
UNC Maternal-Fetal Medicine Community Care of Western North Carolina
Richard Hudspeth, MD, Pardee Hendersonville
Arthur Ollendorff, MD, MAHEC Women's Community Care of the Lower Cape Fear
Lydia Wright, MD
Wilmington Maternal-Fetal Medicine Carolina Collaborative Community Care
Stuart Shelton, MD
Cape Fear Valley Perinatology Community Care of Wake/Johnston Counties
Cathi Weatherly-Jones, MD
Wake County Human Services Community Care Partners of Greater Mecklenburg
Steve Goldman, MD
Carmel OB/GYN | <ul style="list-style-type: none"> Carolina Community Health Partnership Community Care Plan of Eastern Carolina
Jeff Livingston, MD, ECU
James DeVente, MD, ECU Community Health Partners
Velma Taormina, MD
Gaston County Health Department Northern Piedmont Community Care
Philip Heine, MD
Duke Perinatal Northwest Community Care Network
Harold Pollard, MD, Lyndhurst OB/GYN
Bradley Jacobs, MD, Lyndhurst OB/GYN Partnership for Health Management | <ul style="list-style-type: none"> Community Care of the Sandhills
John Byron, MD
Southern Pines Women's Health Center Community Care of Southern Piedmont
Russell Suda, MD
Cabarrus Health Alliance |
|--|---|--|





Pregnancy Medical Home Program: OB Nurse Coordinators



- | | | |
|--|---|---|
| <p> AccessCare
Priscilla Bell pbell@ncaccesscare.org
C: 910-214-0777</p> | <p> Carolina Community Health Partnership
Dana Franklin dana.franklin@clevelandcounty.com
O: 828-287-3351</p> | <p> Community Care of the Sandhills
Ashley Johnson ajohnson@cc-sandhills.org
O: 910-246-9806, x366, C: 910-585-8202</p> |
| <p> Community Care of Western North Carolina
Angel Huneycutt ahuneycutt@ccwnc.org
O: 828-348-2832 C: 828-772-1316</p> | <p> Community Care Plan of Eastern Carolina
Christy Welborn cwelborn@vidanthhealth.com
C: 252-847-5031</p> | <p> Community Care of Southern Piedmont
Starla Hatley starlahatley@CCofSP.com
O: 704-754-4470</p> |
| <p> Community Care of the Lower Cape Fear
Doris Robinson doris.robinson@carelcf.org
O: 910-332-1632 C: 910-521-3435</p> | <p> Community Health Partners
Sharon Utiss-Thomas stthomas@gfhs.info
O: 704-874-7008</p> | <p>North Carolina Community Care Networks
(CCNC Central Office)
Kate Berrien kberrien@n3cn.org
O: 919-745-2384</p> |
| <p> Carolina Collaborative Community Care
Cacilie Glasgow-LeBatard clebatard@carolinacc.com
O: 910-485-1250, x8417</p> | <p> Northern Piedmont Community Care
Judy Blalock judy.blalock@duke.edu
C: 919-384-6428</p> | |
| <p> Community Care of Wake/Johnston Counties
Betty Mazzeo emazzeo@wakedocs.org
O: 919-365-9961, C: 919-333-5234</p> | <p> Northwest Community Care Network
Allison Wood allwood@nwcommunitycare.org
O: 336-713-6226</p> | |
| <p> Community Care Partners of Greater Mecklenburg
Lisa Tucker lisa.tucker@carolinashalthcare.org
C: 704-582-2185</p> | <p> Partnership for Health Management
Tia Broadnax tbroadnax@p4hm.org
C: 336-944-1585</p> | |

PMH recruitment



- **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)**

PMH/Pregnancy Care Management Collaboration



- **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

Pregnancy Medical Home Program Care Pathway: Management of women with hypertensive disorders of pregnancy August 2012

A. Background

Preeclampsia is a leading cause of iatrogenic preterm birth. In the past, severe preeclampsia was treated by timely delivery. Current data suggest improved perinatal outcomes with expectant management of severe preeclampsia (1). The average gestational age gained with expectant management of severe preeclampsia ranges from 7-14 days (2). Patients with superimposed preeclampsia are treated in a similar fashion as those with severe preeclampsia (3). Patients with mild preeclampsia should be managed expectantly until ≥ 37 weeks (4).

B. Definitions

Definitions apply to women at a gestational age > 20 weeks (5)

- I. Gestational hypertension: A systolic BP ≥ 140 mmHg or diastolic BP ≥ 90 mmHg taken on 2 occasions >6 hours apart but < 7 days apart in the absence of proteinuria that occurs after 20 weeks of gestation in a woman with previously normal blood pressure.
- II. Preeclampsia: A systolic BP ≥ 140 mmHg or diastolic BP ≥ 90 mmHg taken on 2 occasions > 6 hours apart but < 7 days apart in the presence of new onset proteinuria after 20 weeks of gestation. Preeclampsia is not defined as an increase in BP of 30/15 mmHg over baseline.
- III. Severe gestational hypertension: Unexplained elevation in systolic BP ≥ 160 mmHg or diastolic BP ≥ 110 mmHg after 20 weeks of gestation in the absence of proteinuria.
- IV. Chronic hypertension with superimposed preeclampsia: Onset of proteinuria in a woman with preexisting hypertension, sudden increase in proteinuria if already present in early gestation, sudden increase in hypertension or development of HELLP syndrome, beyond 20 weeks of gestation.

John Byron, MD

James DeVente, MD, PhD

Steven Goldman, MD

Phillip Heine, MD

Richard Hudspeth, MD

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Kate Menard, MD, MPH

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Harold Pollard, MD

Stuart Shelton, MD

Russell Suda, MD

Velma Taormina, MD

Cathi Weatherly-Jones, MD

Lydia Wright, MD

- 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

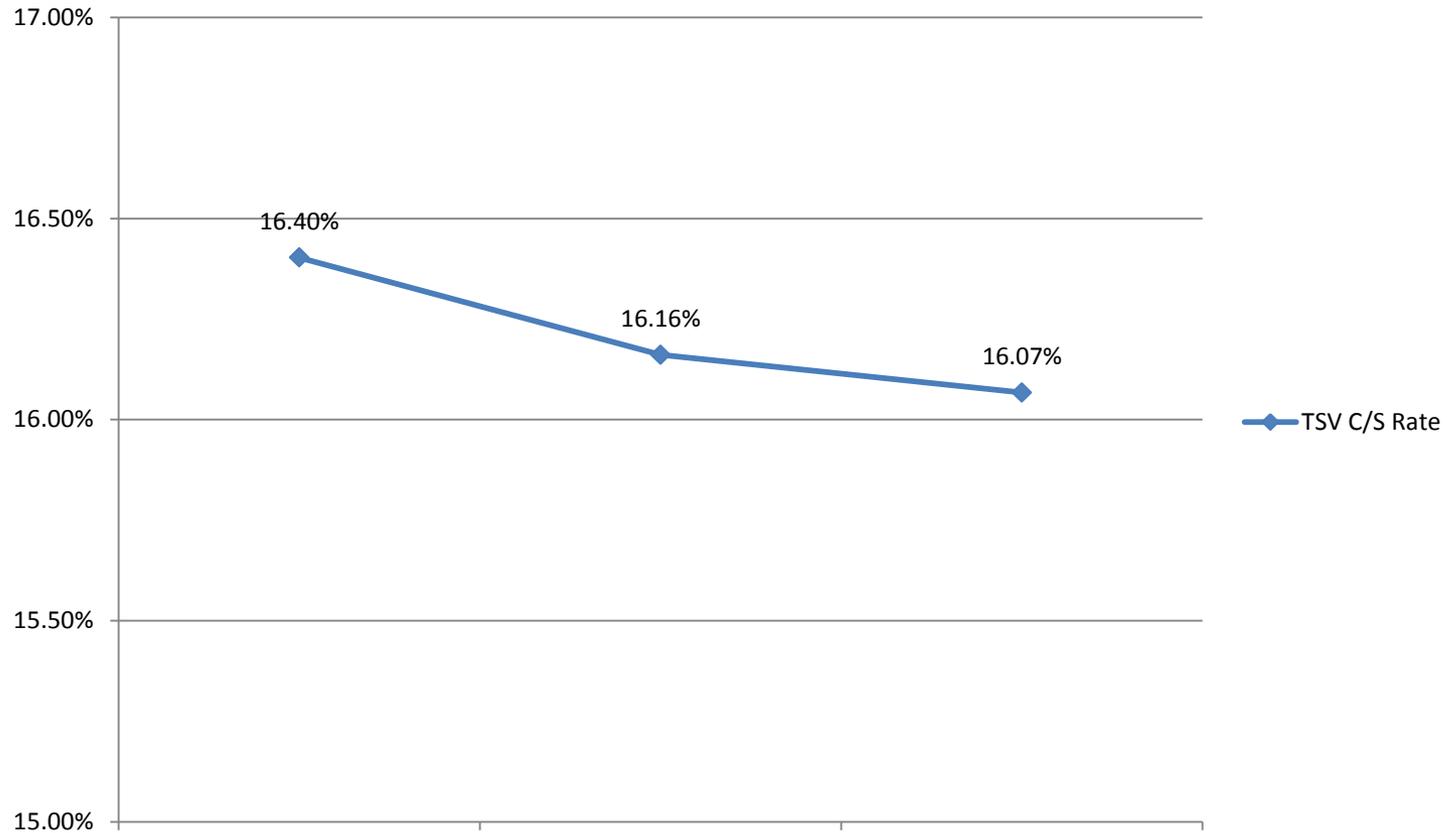


- **Use of Medicaid claims matched to birth certificates and CMIS data**
 - Key metrics include rate of preterm birth, rate of low birth weight, primary c-section among term, singleton, vertex
- **Practice-level data for PMHs to be released by end of 2012**
- **OB ADT (admission/discharge/transfer) data**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

PMH program goals

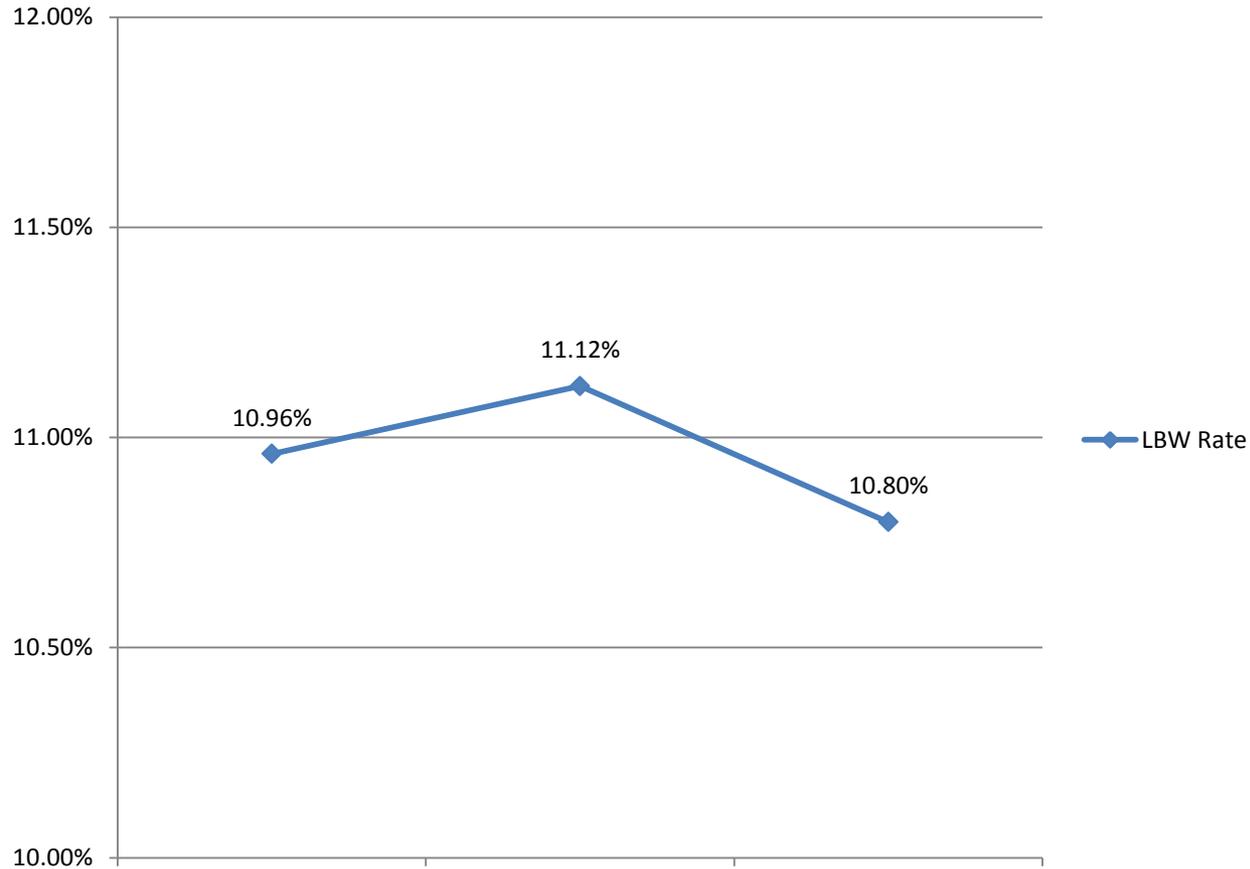
- **Reduction in rate of low birth weight (infants born weight less than 2500g/5.5 pounds):**
 - FY11 rate (baseline year) – 11.12%, FY12 rate – 10.80%
 - 2.8% decrease from baseline year in first program year
- **Reduction in rate of very low birth weight:**
 - Infants born weighing less than 1500g (3.3 pounds)
 - 6.4% decrease from baseline year in first program year
- **Primary cesarean delivery rate among term, singleton infants at term \leq 16%**
 - FY11 rate – 16.16%, FY12 rate – 16.07%

Primary Term, Singleton, Vertex C/S Rate among NON-emergency Medicaid – STATE LEVEL (NC)



Year	Primary TSV Cesarean Rate (non-emergency Medicaid)
FY2010	16.40%
FY2011	16.16%
FY2012	16.07%

Low Birth Weight Rate among NON-emergency Medicaid – STATE LEVEL (NC)



Year	LBW rate (without emergency Medicaid)
FY2010	10.96%
FY2011	11.12%
FY2012	10.80%

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!

Kate Berrien, RN, BSN, MS

Pregnancy Home Project Manager

North Carolina Community Care Networks, Inc.

Phone: 919-745-2384

Email: kberrien@n3cn.org