Pregnancy Home

A Partnership Between
DMA,CCNC, Local Health Departments, DPH, and NC Obstetricians

Using the Power of the Medicaid Program to Improve the Standard of Care Across the State of North Carolina

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The Key Visions

Using the power of the Medicaid program to improve the standard of care across the State of North Carolina

- **Managing care via population management strategies**
  - turning care/case management right side up
- **Community Care is a clinical program not a financing mechanism—Medicaid is financing mechanism**
- **Public-private partnership – DMA/CCNC/LHDs/Local Doctors**
- **The medical home is key for success**
  - focusing care and leadership locally
- **Community-based, local physician led**
- **Quality and outcome-driven metric oriented**

Basic Operating Premise

- **Medicaid provided the focused idea, but North Carolina's physicians, hospitals, health departments, and other safety net providers will be serving the patients**
- **Real ownership of the improvement process must be vested in those who have to make it work**
- **Providers who care for patients will work together as never before**
- **The State will partner with and support our community providers who are willing to build the care systems that are needed to produce quality**
- **Focus on quality improvement – outcome-driven metrics**
- **Information, communication, and feedback are key at the local level**
- **PMH is a value-based program developed to improve outcomes**
- **A Value-added program**

The Partners: Community Care of North Carolina

- **Is a community of providers (hospitals, health departments, and departments of social services) joined with primary care physicians**
- **Designated primary care medical home**
- **Creates community networks that assume responsibility for managing recipient care**
- **Obstetricians in the Pregnancy Home are affiliate members of CCNC**

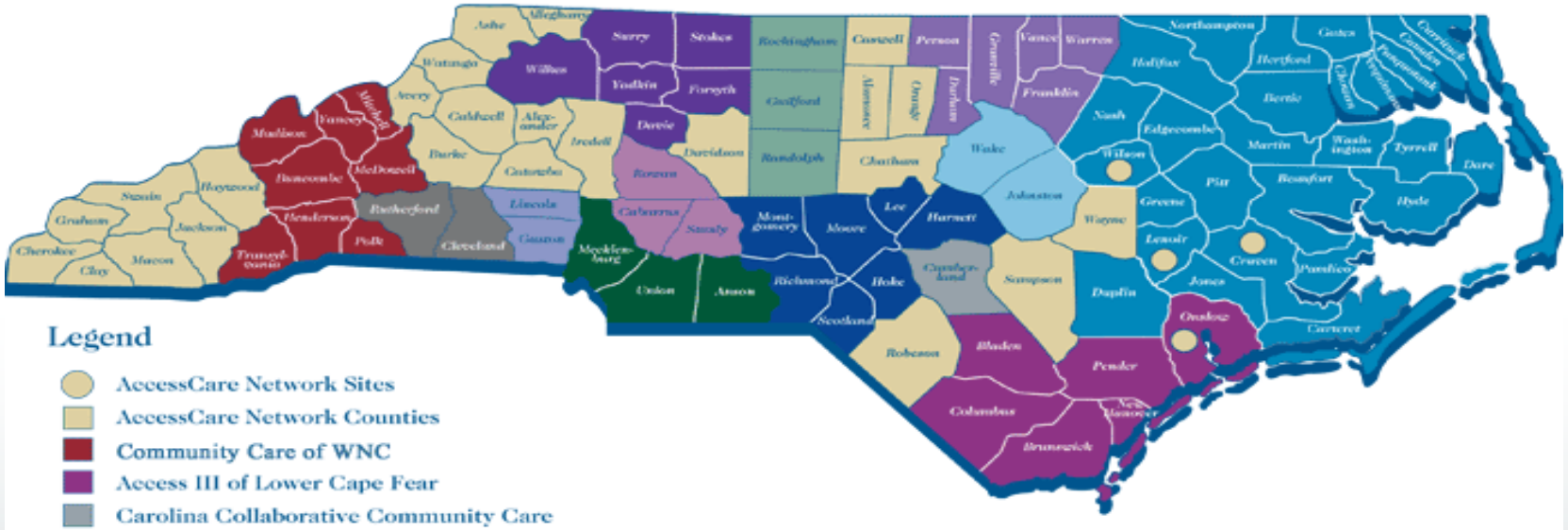
Community Care of North Carolina – 2011

- **CCNC is focused on improved quality, utilization and cost effectiveness of chronic illness care**
- **14 Networks with more than 4500 Primary Care Physicians (1360 medical homes)**
- **Over one million Medicaid enrollees**
- **The objective is outcome-driven metrics, which adds value by measuring effectiveness of care**

Community Care of North Carolina

14 Networks in All 100 NC Counties

Community Care of Western North Carolina



Using the power of the Medicaid program to improve the standard of care across the State of North Carolina

Current Community Care Resources

- 4,200 primary care physicians
- 400 local care managers
- 30 local medical directors
- 18 clinical pharmacists
- 10 local psychiatrists
- Informatics Center providing quality and care management data to networks and practices
- 28 central staff members supporting clinical program implementation

Pregnancy Home Joins a Family of Care Management Initiatives

- Rapid Cycle Quality Improvement

- Asthma
- Diabetes
- Pharmacy Management (PAL, Nursing Home Polypharmacy)
- Dental Screening and Fluoride Varnish
- Emergency Department Utilization Management
- Case Management of High Cost-High Risk
- Congestive Heart Failure
- Chronic Care Program – including Aged, Blind and Disabled

Pregnancy Home Components

- **Enrollment/Outreach**
- **Screening/Assessment/Care Plan**
- **Risk Stratification/Identify Target Population**
- **Patient-Centered Pregnancy Medical Home**
- **Transitional Support**
- **Pharmacy Home – Medication Reconciliation, Polypharmacy & PolyPrescribing**
- **Care Management**
- **Mental Health Integration**
- **Informatics Center**
- **Self-Management, Teaching/Education**

Opportunities to Improve Care

FYI 2011 (2010 – 2011)

- **Pregnancy Home to improve birth outcomes**
- **Better integration mental health and medical services for Pregnant women**
- **Turns care/case management right side up**
  - No longer everything for everybody
  - Targeted toward patients with the greatest needs based on medical and social necessity

Pregnancy Home Initiative

A partnership between Division of Medical Assistance (Medicaid), Community Care of North Carolina, Division of Public Health Local Health Departments.

and

Local Obstetricians

Why Pregnancy Homes?

- **Improve birth outcomes in North Carolina by providing evidence-based, high-quality, outcome-driven maternity care to Medicaid patients**
- **Improve stewardship of limited perinatal health resources – financially a zero-sum game**
- **Reduce preterm birth rate, rate of very low birth weight infants, alter NICU length of stay, rationalize cesarean section rate**
- **The Pregnancy Home program only works financially if we improve care clinically—financially neutral to NC**

Perinatal Health in North Carolina

- **Getting better but North Carolina still got an "F" from the March of Dimes in 2009[1]**
- **#17 for preterm birth rate of 13.3% in 2009[1]**
- **#12 for preterm birth with a rate of 13.7% in 2008[1]**
- **North Carolina just announced the lowest rate of infant mortality ever recorded for 2009 at 7.9 per 1000 births[2] – but still 44th in the nation**
- **The ethnic minority infant mortality rate is 2.6 times the white infant mortality rate (14.1 vs. 5.4) and increased in 2009[2]**

[1] March of Dimes Peristats

[2] North Carolina State Center for Health Statistics

Who is involved in Pregnancy Homes?

- **DMA/DPH/CCNC steering committee**
- **DMA project team—led by Debbie Pittard, project manager**
- **CCNC OB workgroup**
  - Perinatologists, obstetricians, midwife, family medicine
  - Local health departments
  - DPH Women's Health Branch
  - Division of MH/DD/SA
  - Division of Medical Assistance

Who will be a Pregnancy Home?

- **Any current licensed, qualified provider of maternity care will be able to sign an agreement with a CCNC network to become a Pregnancy Home:**
  - OB/GYN practices
  - Family medicine (qualified)
  - Certified nurse midwives
  - Nurse practitioners
  - Local health departments
  - Federally qualified health centers

- **May or may not also be a CCNC Primary Care Provider**

Pregnancy Home Responsibilities:

- **Agree to provide comprehensive, coordinated maternity care to pregnant Medicaid patients and to allow chart audits**
  - Locally organized and locally supervised—Local AHEC
- **Four performance measures or outcome-driven metrics:**
  - No elective deliveries <39 weeks
  - 17P (weekly injections to prevent preterm birth)
  - Reduction in c-section rate among nulliparous women (no previous deliveries >20 weeks) goal at or below 20%
  - Universal risk screening of all new OB patients, follow-up screening, postpartum assessment and close coordination with local care/case management
- **Actively provide information on how to obtain MPW, WIC, Family Planning Waiver**
- **Close professional collaborations with local public health department's care/case management to ensure high-risk patients receive case management: medically necessary-driven**

Benefits of becoming a Pregnancy Home

- **Support from CCNC network**
- **Data-driven approach to improving care and outcomes**
- **Incentives:**
  - Increased rate of reimbursement for global fee for vaginal deliveries equal that of c-section global fee (prorated for providers who do not bill global fee)
  - Incentive payment for risk screening tool with local implementation with care/case management
  - Incentive payment for postpartum visit
    - Stressing importance of family planning and pregnancy spacing
    - Emphasizing the value of global care/continuity of care
  - No prior authorization required for OB ultrasounds (but still must register with MedSolutions in weekly batches so practices can be paid

Role of CCNC local network

- **Each network to have OB coordinator (nurse) and OB clinical champion (physician)**
- **PMPM based on MPW population (by county of residence)**
- **Network is accountable to DMA for outcomes**
- **CCNC OB team will:**
  - Recruit, train and guide practices
  - Work with providers and other local agencies to make the system changes necessary for program
  - Provide technical and clinical support to participating pregnancy homes and to OB case management
    - Advice—get to know your local CCNC network leadership and use them to solve problems or suggest improvements!

Risk screening of pregnant population

- **Risk screening criteria include a combination of medical risk, psychosocial factors, and utilization (or lack thereof)**
- **Positive risk screen will trigger case management assessment (as will physician request, visits to patient's home, ED utilization review and follow up, hospitalizations during pregnancy)**
- **Risk screening data to be entered into CMIS by case managers – for intensive tracking**
- **Follow-up screen at end of 2nd trimester to identify risks emerging during pregnancy**
- **Level of service based on medical/social necessity**

Pregnancy Case Management

- **Partnership with local public health departments**
- **OB case management to be paid by PMPM, no longer will be part of consolidated case management**
  - Eliminates concerns about "any willing provider" serving as case managers for this program—amplifies local health department competence
- **Change from current MCC Program paradigm of all Medicaid-eligible patients to focusing on those with risk factors – turning case management right side up**
- **This is not a "desk jockey" job: case management means active, aggressive, on-the-street, in-the-house, patient care. It means vigorous advocacy, assistance, and medical management**

Pregnancy Case Management Provider Agencies

- **Providers – Local Health Departments (or other agencies if LHD unwilling)**
- **Population – Medicaid-Eligible Pregnant Women who are County Residents – ages 14 - 44**
- **Care Management vs. Case Management**
- **Referrals for Case Management:**
  - Risk Screenings from Pregnancy Homes
  - Provider Referral
  - Specific Medicaid Claims Triggers

Transition from MCCP to Pregnancy Case Management

- **Risk-Based eligibility**
- **Case Management Services**
  - Needs Driven
  - Risk Stratification Model
- **Integrated collaboration with prenatal care provider**
  - Our expectation is that case managers will be familiar faces in the local offices.
  - They should help remove much of the "hassle factor" from the Medicaid patient.
  - The case managers are an extension of the OB office for clinical care

Case Management Information System (CMIS)

- **Centralized, statewide database with access to Medicaid patient data from the CCNC Informatics Center (IC)**
- **Electronic documentation of all case management services**
- **Web-based access for case managers, supervisors, to provide uniform monitoring of patient outcomes**

Case Management Training and Support

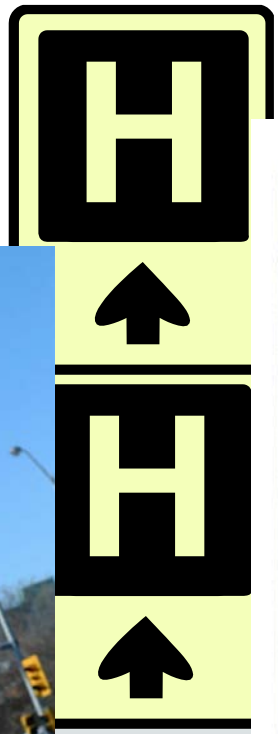
- **DPH Women's Health Branch Regional Social Work Consultants and Program Manager**
- **Connection to local CCNC Network and Network OB Coordinator**

- **Training**
  - Transition and Implementation
  - Ongoing
- **Monitoring**
  - Overall Project Goals
  - Case Management Outcome Measures

Pregnancy Medical Home is a Dynamic Project

- **Program started with focused outcome metrics**
- **A cooperative clinical program between obstetrical providers and local care/case management**
  - Managed by the local CCNC network
  - Financed by NC Medicaid
  - SOMETHING IS MISSING IN THIS EQUATION

WHERE ARE THE HOSPITALS ?



What is the Hospital role in the Pregnancy Home?

- **Health policy to support good care**
  - Monitor and manage elective induction before 39 weeks
  - Monitor and manage C-section rate for department and individual doctor
    - Primary C-section rate at or < 20%

Maternity

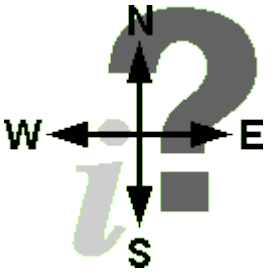
Good Care often Costs Less

- **Would money be a motivator toward better outcomes?**
  - Obstetricians paid the same for a vaginal birth and a C-section
  - Fee for non-pregnancy home providers is at old rate

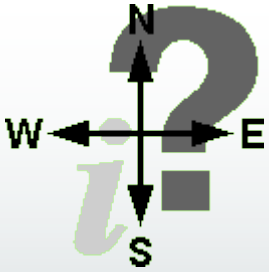
Hospital Pregnancy Care Financing

- **Is it time for Hospitals to change from a volume-driven payment to a value-driven payment model?**
  - Obstetrical care paid at a flat rate?
  - Outcome-driven metrics the basis for part of the payment?
    - Payment based on quality outcome-driven metrics
    - C-section rate
    - Birth weights
    - Obstetrical complications in hospital
    - What will good care do to the NICU census?
  - Bundle payments?
    - Who get the payment—the hospital or the doctor?

The Customer →



Questions?



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