Maternity Care Management

Program Description

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Table of contents

Introduction

The Maternity Care Management Program, also known as MCM, supports women at greater risk of complications during pregnancy, delivery and/or the postpartum period. The overall objective of this program is to maximize the chances of delivery of a healthy, full-term baby by reducing and/or managing the member's risk. The program makes every effort to move the member to a more moderate risk level. The program goals will be accomplished through early identification of pregnant members, immediate connection to an obstetrical provider for prenatal care, coordination and integration with appropriate community resources, coaching and care navigation support to ensure the member receives all prenatal care and has needs met throughout her pregnancy. The program facilitates quick identification of the high-risk maternity members' needs and fosters its commitment to healthy families and assists in continuous improvement.

The overall goals of the program are:

- Delivery of a healthy, full-term baby.
- Reduced/managed risk to the mother.
- Successful transition of mother and infant to home with ongoing postpartum and neonatal follow up.

The MCM Program team tracks, trends, monitors and measures members throughout their pregnancy. Using analysis of program data and metrics, the team also evaluates and modifies the MCM program's performance for continuous improvement.

Care management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes.

Members are assessed for risk levels and referred to appropriate programs and services, including the High-risk Maternity Program. In addition to covered services, pregnant members may also receive other health-related services to address needs and gaps. Health-related services are non-covered services that are offered as a supplement to covered benefits under Oregon's Medicaid Plan. These services improve care delivery and overall member and community health and well-being. Health-related services include:

- InterCommunity Health Network Coordinated Care Organization, also known as IHN-CCO, members can be linked with flexible services which are cost-effective services offered to an individual Medicaid member to supplement covered benefits.
- Community benefit initiatives are community-level interventions focused on improving population health and health care quality. These initiatives apply to members in all product lines. Examples may be community agencies and organizations for education and support, digital applications and assistance with social determinants of health.

Program design and implementation considerations

The following are key implementation considerations for the Samaritan Health Plans Maternity Care Management Program:

- Availability and integration with local provider-based and health plan-based programs for high-risk mothers.
- Care management platform capabilities.
- Available data sources, reporting and analytics capabilities.
- Network access to obstetric, perinatal and pediatric specialties, inpatient and facility-based care and other ancillary services.
- Level of resources available to determine scope and extent of interventions.
- Regulatory requirements related to program content and/or client-driven program customization.

There are industry-leading best practices that were taken into consideration when developing the MCM Program. Samaritan Health Plans' MCM Program includes aspects of the following resources:

- National Institute of Health — **nichd.nih.gov/health/topics/high-risk/more_information/resources**.
- American College of Obstetricians and Gynecologists.
- Centers for Disease Control and Prevention — **cdc.gov/pregnancy**.
- U.S Department of Health & Human Services - Office on Women's Health — **womenshealth.gov/pregnancy**.
- March of Dimes — **marchofdimes.org**.

Pregnant members are identified for the appropriate level of care management:

Maternity care management (low risk):

- High-risk pregnancy screening.
- Customer service support to assist with linkages to providers.
- Community health worker to provide care coordination with social determinant of health needs, community agencies and resources, educational materials (written and digital).
- Data analytics to monitor for changes in risk factors elevating member to high risk.
- Referral to Intensive Care Coordination for change in status to high-risk maternity.
- Monitor hospitalizations for rising risk factors.

High-risk maternity care management:

- Assist member in identifying practitioners.
- Dedicated Care Transitions Program and team consisting of registered nurses, licensed clinical social worker, clinical social work associate, licensed professional counselor, licensed marriage and family therapist, licensed psychologist, qualified mental health professional and community health workers.
- Face-to-face visits, in home, hospital or both.
- Facilitate Interdisciplinary Care Team meetings and consistent flow of communication.
- Facilitate provider-to-provider communication.
- Facilitate sharing of treatment plan.
- Assist member in obtaining medical records as needed.
- Attend practitioner appointments with member as indicated.
- Track frequency of member's provider transitions as indicated.

- Facilitate communication between Interdisciplinary Care Team members.
- Participation in discharge planning meetings.
- Member contacted within 24 to 72 hours of hospital discharge.

Target population

The target population for the Samaritan Health Plans' Maternity Care Management Program are those members identified as pregnant. Services are provided to pregnant members according to their risk level.

Pregnant members who are at a lower risk are provided care coordination through SHP's Customer Service and Care Coordination teams. These services may include, but are not limited to:

- Health risk screening.
- Linkages with obstetrical providers.
- Educational materials (e.g., Healthwise, pregnancy applications).
- Assistance with social determinants of health, (e.g., housing, food pantries, financial aid).
- Referrals to Health Department programs (e.g., CoCoon, Babies First).

Members deemed at higher-than-average risk for complications during pregnancy, delivery or postpartum receive Intensive Care Coordination services.

A list of potential criteria that may indicate higher risk includes but is not limited to:

- Less than age 19 (less than age 16 has higher risk).
- Greater than age 34 (greater than 40 has higher risk).
- Late entry into prenatal care (>14 weeks gestation).
- Multifetal gestation.
- Presence or history of fetal complications (e.g., fetal anomaly, intrauterine growth restriction, polyhydramnios).
- Presence or history of domestic abuse or violence.
- Unsafe living situation.
- Interval between previous delivery and onset of pregnancy 12 months or less.
- History of premature delivery (<37 weeks), low or very low birth weight in previous delivery, or other complication pre or post-delivery for mother or neonate in prior pregnancy.
- History of pregnancy loss in the second or third trimester.
- Current tobacco or nicotine use or recently quit in the last three months.
- Missed two or more prenatal appointments.
- Known physical or mental health condition that may compromise a normal pregnancy and delivery. Examples include:
    - Diabetes (Type I or II).
    - Hypertension and hypertensive disorders (e.g., eclampsia, pre-eclampsia and hemolysis, elevated liver enzymes and low platelets syndrome, also known as HELLP).
    - Cardiovascular disease causing functional impairment.
    - Infectious diseases (HIV, hepatitis, pyelonephritis).
    - Neurological disorders (e.g., active seizure disorder, myasthenia gravis, previous cerebrovascular accident).
    - Serious mental illness, depression.
    - Substance/alcohol abuse.
    - Seizure disorder.
    - Asthma.
    - Renal disease.

    - Hematologic condition such as blood clots, bleeding disorder, anemia.
    - Autoimmune disease.
    - Sickle cell.
    - Organ transplant.
    - Rheumatological disorders.
    - Cancer in pregnancy.
    - Obesity.
- Hospital utilization in the antepartum period.
- No identified and available family/community support system, especially significant for young mothers.

Identification

The program aims to identify high-risk pregnancies as early as possible. The primary method of identifying candidates for the High-Risk Maternity Program are individual member referrals and reactivation events. However, multiple sources are used, such as:

- Enrollment file.
- Health risk screening.
- Reimbursement request for childbirth classes.
- Providers who diagnose and treat pregnancy.
- Self-referral by members who are pregnant.
- Referrals from other care management programs or plan departments that have communication with the member, (i.e., Customer Service, Behavioral Health, Utilization Management, discharge planners, Nurse Advice Line).
- Other members of the care team, including facility-based programs.
- Utilization Management.
- Data analytics.
- External agencies (e.g., Babies First, CoCoon, Nurture Oregon, Department of Health, community agencies).

General awareness efforts are important to ensure that all providers in the network caring for women who may become pregnant (particular focus on primary care practitioners — primary care providers, also known as PCPs and obstetrical/gynecological providers or OB/GYN — are educated about the program and encouraged to refer members as soon as pregnancy is identified. Communications are sent to members emphasizing convenient routes to joining the program. Member rewards and incentives for participation may be considered and offered.

Measures to ensure early identification of women that can benefit from the program and ensure that all pregnancies are screened for gestational risk, may include provider value-based programs to ensure pregnant members are completing pre and post-natal appointments.

The program utilizes the following data sources for identification such as:

- IHN-CCO enrollment indicator of Priority Population and Pregnant.
- Claims/encounter data with a diagnosis of pregnancy or pregnancy-related condition or service.
- Pharmacy claims for medications specific to pregnancy.
- Screening and assessment tools.
- Admission, discharge and transfer data (inpatient and Emergency Department).
- Laboratory data.
- Health risk screening.
- Data through predictive tools to identify members as greater risk for admissions/complications.
- Notifications through Collective Medical Technology system.

Member engagement

Employer Group Plans members who are are identified with high-risk pregnancies through referrals and data analytics, receive outreach from the Care Coordination team to offer care management.

All new Medicare and Medicaid health plan members receive an initial outreach welcome call.

- A health risk screening is conducted and members are asked about pregnancy status.
- If pregnancy is identified at the time of the call, a referral is made to Care Coordination. Further screening is completed to determine risk status or scheduled with the member for later completion at the earliest convenience for the member.
- Community health workers assist members with lower needs, while intensive care coordinators assist members with more complex needs.
- If member is deemed high risk through screening, the maternity care manager completes an initial high-risk maternity assessment and confirms or arranges an OB visit.

Members may also be contacted after data-driven identification or referral indicates the need for outreach.

- A list of members for outreach is created weekly.
- On a daily basis, Emergency Department and hospital reports through Collective Medical Technology indicating members with positive pregnancy test or indicators of pregnancy at the visit are reviewed.
- High-risk maternity outreach staff contact the member to inform them of the option to enroll in the High-risk Maternity Program, describing the support and benefits available to program participants.
- If member agrees to enroll, the member is flagged in the care management system and assigned a personal high-risk maternity care manager.

Program interventions

The key roles the Maternity Care Management care coordinator undertakes are described below and include completing a comprehensive assessment of needs and developing, implementing, coordinating, monitoring and evaluating the person-centered culturally appropriate care plan.

Assessment

- Initial assessment of the member's health status, including condition-specific issues.
- Documentation of clinical history, including current and past medications and refill status, medication reconciliation, ED admissions, inpatient stays, past pregnancies, estimated date of delivery.
- An initial maternity assessment is completed followed by the appropriate follow-up trimester maternity assessment.
- Assessment of maternal attachment and readiness for parenting.
- Assessment of behavioral health status including alcohol/substance abuse.
- Assessment of social determinants of health issues (e.g., economic and social conditions that affect a wide range of health, functioning and quality of life outcomes and risks that affect the member's ability to meet the care management goals including food, housing/utilities, transportation and interpersonal safety).
- Assessment of safety and suitability of living situation including the potential presence of domestic abuse or violence.
- Identification of current gaps in care.

- Utilizilization of screening tools, for example, for depression (including NIH and PHQ 2 tool).
- Assessment of member's level of risk, based on identified issues/barriers and clinical conditions.
- A home assessment is conducted including the appropriateness and what additional supports are required, if needed.
- Member's level of risk to self or others is determined, based on identified issues/ barriers and clinical conditions.

From the assessment the care coordinator develops a care plan with member and caregiver to include but not limited to:

- In collaboration with the member and their caregivers, develops an individualized care management plan that sets short and long-term personal, measurable goals for their needs (including resource to be utilized, time frame for reevaluation, prioritization of goals).
- Develops individualized and personalized goals with the member and caregiver, keeping in mind preferences and involvement.
- Establishes members of the care team and contacts them as needed to clarify treatment plan.
- Identifies barriers to a member meeting goals or complying with the plan (literacy, transportation, motivation, economics, culture and impairments).
    - Facilitates member referrals to resources and a follow-up process to determine whether members act on referrals.
- Assesses progress to the plan and revises the plan as appropriate.
    - Schedules follow-up and communication with the member.
    - Develops and communicates with the member the self-management plan as appropriate.
- Establishes a schedule for follow-up contact.
- Updates in a timely manner documentation in member's case file.

Interventions

The high-risk maternity program uses a care management model with special focus on pregnancy and readiness for parenting. These members will receive active outreach, a full assessment and a designated high-risk maternity care manager.

Outreach:

- Member engagement through initial membership screening, annual screenings and reactivation events.
- Outreach completed to members that are pregnant after initial membership (based on identification sources) or referred to the high-risk maternity program.
- Program enrollees for high-risk maternity care management are notified and engaged.

Implement:

- Distribute pregnancy and postpartum education materials (e.g., written materials through HealthWise, digital pregnancy applications).
- Arrange/schedule an initial appointment with OB provider.
- Use motivational interviewing skills to establish personal goals with member.
- Educate member about use of primary care physician vs. OB vs. emergency department.
- Educate member on impact of tobacco/ nicotine/e-cigarettes, alcohol and other toxins on fetus.
- Coach/educate member on importance of regular contact with treating providers.
- Arrange attendance at childbirth education classes.

- Teach, coach, mentor member re: stages of pregnancy, infant development, labor and delivery, premature delivery, post-delivery, family planning.
- Monitor changes needed in the level of care through data (ultrasounds, lab data, ED visits) and interaction with OB.
- Access flexible spending resources for needed supplies/equipment such as car seats, diapers.
- Refer to other care available through support programs such as lifestyle behavior change, tobacco cessation.
- Refer to economic support programs (e.g., housing, utility assistance).
- Identify and link member with primary care physician if needed.
- After discussing with physician, refer member to pharmacist for consultation and explanation of medications.
- Arrange for counseling with behavioral health counselors for alcohol/substance abuse.
- Initiate Substance Use Disorder Program.
- Collaborate with behavioral health care manager for substance use disorder.
- For members with substance use disorder, conduct handoff to the behavioral health care manager following completion of postpartum.
- Connect member to tobacco/nicotine cessation program, as appropriate.
- Arrange home health assessment/services.
- Arrange access to pharmacies for obtaining medications.
- Arrange transportation.
- Assist member with navigating health care system.
- Refer to appropriate community resources (Babies First, CoCoon, Nurture Oregon).
- Educate member regarding postpartum symptoms (e.g., what to expect, when to call the doctor, postpartum and newborn visits, complications, depression, newborn care).
- Screen for postpartum depression.
- Assist in arranging newborn provider visit.
- Evaluate newborn for referral to care management or other programs.
- Tobacco/nicotine prevention for at-risk members.

Coordinate:

- Coordinate effort to address identified SDOH-related issues.
- Coordinate care and needs with treating physician(s) or other treating provider.
- Coordinate care and needs with other care management programs and/or community resources.
- Coordinate with hospital navigators and existing hospital resources.
- Collaborate with provider care team to determine need for perinatologist and arrange appointment if needed.
- Coordinate post-delivery follow up with home visit/outreach to assess for complications, parenting, educational needs, when to call the provider, postpartum depression screening.
- Ensure appointments with provider(s) are arranged including postpartum and newborn.

Monitor:

- Monitor member's nutritional, living and financial status.
- Monitor member's pregnancy and condition, referring to additional resources as needed.
- Refer to physician if there are concerns with the member's pregnancy.
- Monitor for attendance to provider appointments, prenatal and/or parenting classes.

Evaluate:

- Evaluate the effectiveness of the care plan in achieving the individual member's goals.

Member goals/ outcomes measured

Each member in Maternity Care Management is assessed as to whether their personal goal(s) for the care management program have been met, partially met or not met. In addition, the results of the program on a population basis are tracked and reported to determine the efficacy of the program. Graduation from the program is achieved once a member meets their goals or elects to withdraw from the program.

The following are member-specific goals that may be tracked:

- Maintain comprehensive prenatal care.
- Deliver a healthy child.
- Minimize complications of pregnancy.
- Participate in postpartum programs as needed.
- Improvement in lifestyle behaviors, such as daily exercise or cessation of tobacco/nicotine cessation/substance use.
- Percentage of members in which social determinants of health screening was conducted.

Program performance measurement and reporting

Program-wide outcome metrics for members in Maternity Care Management that may be tracked include:

- Percentage of deliveries that received recommended prenatal and postpartum visits.
- Frequency of ongoing prenatal care.
- Cesarean sections (C-section) rate.
- Average number of weeks members receive prenatal care prior to delivery.
- Emergency department visits during pregnancy and postpartum period.
- Number of premature deliveries (≤35 weeks gestation) with and without complications.
- Overview of birth weights (including number/percent of infants with low or very low birth weight).
- Overview of APGAR scores.
- Number/percent of women hospitalized prior to delivery for preterm labor.
- Average length of stay per hospitalization.
- Number/percent of infants discharged home with mother.
- Number/percent of women and infants discharged in 24 to 48 hours post-normal vaginal delivery.
- Number/percent of women and infants discharged in 72 to 96 hours post C-section delivery.
- Number/percent of successful follow-up calls within two business days of discharge.
- Percentage of pregnant mothers with dentist visits during or prior to 26th week gestation.
- Percentage of pregnant tobacco, nicotine or e-cigarette users who participate in a cessation program during pregnancy.
- Percentage of newborns with first pediatric visit scheduled.
- Percentage of mothers with completed postpartum depression screening.
- Percentage of mothers with completed postpartum visit between 7 to 84 days.
- Percentage of mothers with prenatal care visit in the first trimester or within 42 days of enrollment in the health plan.

The following are examples of management reports that may be used to monitor the Maternity Case Management Program:

- Reach rates and engagement rates.
- Program enrollment and completion/ disenrollment volume.
- Program active caseload and annual caseload.
- Program average case duration.

Process and outcome metrics for the Maternity Care Management Program will be monitored on a monthly, quarterly and annual basis at a program and plan level.

Addressing social determinants of health

Social determinants of health are the non-medical factors that influence health outcomes. By addressing a member's social determinants of health needs, health, functioning, cost and quality of life outcomes can be improved. As part of the SHP Maternity Care Management Program, through partnerships with treating providers and community-based organizations, SHP screens and addresses member's SDOH needs using race, ethnicity, language and disability, also known as REALD data. Questions related to housing, food insecurity, transportation and personal safety are embedded within provider interactions, health risk screenings and maternity assessments to identify needs, which can then be addressed through care plans and interventions.

Key social determinants of health, which will be screened for and addressed by the Care Transitions Program, include the following:

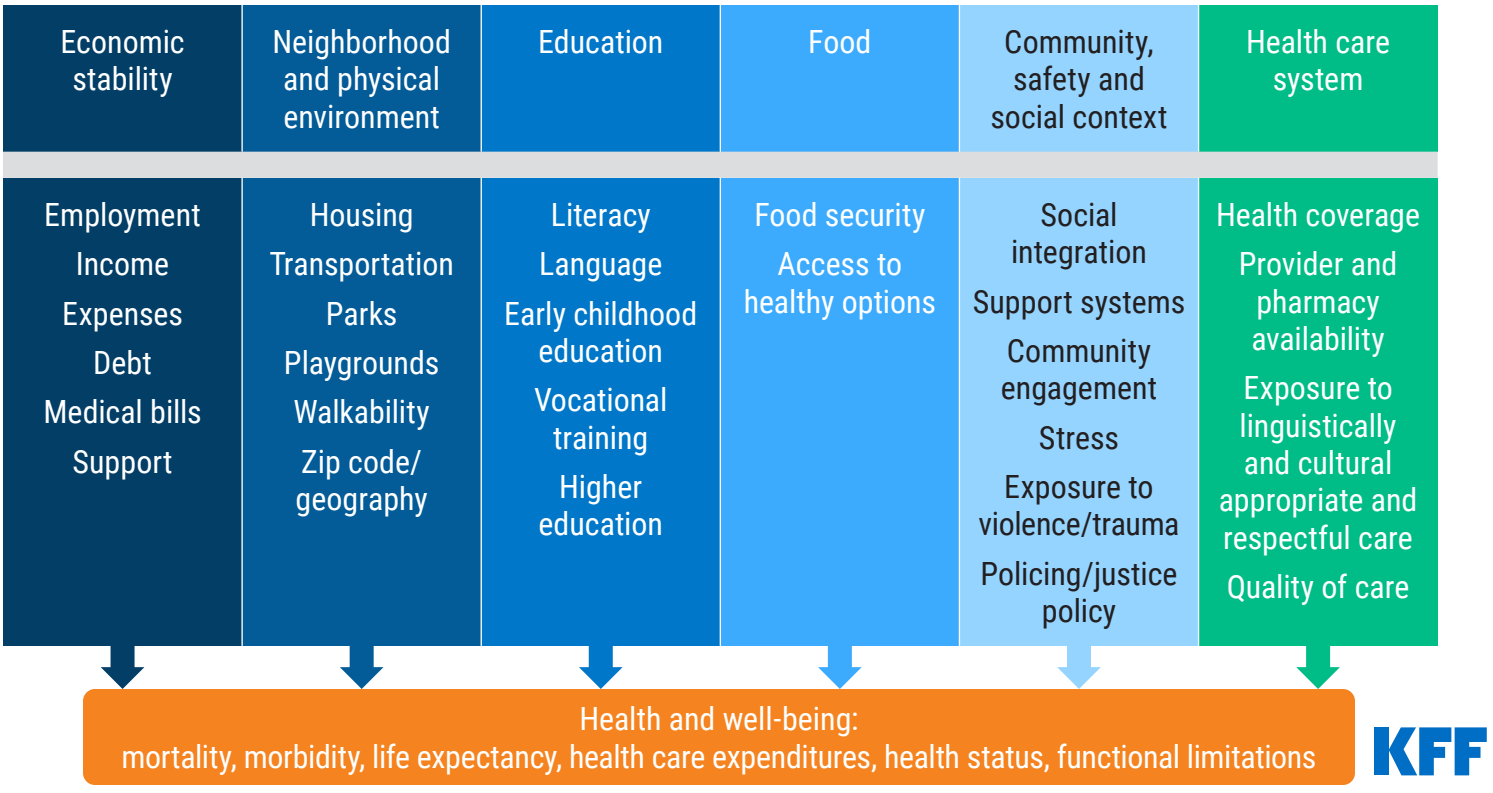
Figure 1: Social determinants of health outlined by the Kaiser Family Foundation, 2021.

Image source: **kff.org/coronavirus-covid-19/issue-brief/implications-of-covid-19-for-social-determinants-of-health/**

Individuals with identified SDOH needs are referred to a community health worker or care manager who assists with linking individuals with appropriate resources. Interventions are identified and incorporated into care plans.

Figure 1

Social determinants of health



Program staffing

The Maternity Care Management team is composed of both clinical and non-clinical staff. Non-clinical staff assist in outbound and inbound communication and documentation. Clinical staff are typically RN's or qualified behavioral health professionals and may be certified case managers or licensed practitioners.

Average staffing ranges:

- Caseload of active care coordination/ community health worker assigned members — 100 enrolled members depending on line of business and acuity.
- Case load of active care management members — 50 to 80 enrolled members depending on the line of business and acuity.
- Expected case duration of approximately six months, including pre and postpartum.

Program success dependencies

The following assist in the success of the Maternity Care Management Program:

- Structured program of training and ongoing skill development for both clinicians/ non-clinicians.
- Knowledge review of pathophysiology and newly developed treatments for pregnancy.
- Review Milliman Chronic Care Guidelines or other source adopted by health plan.
- Updated listings and referral channels to provider-based programs for pregnancy and specialty diagnostic and treatment services.
- Motivational interviewing skill development.
- Care manager and community health worker skill development in Teach Back method to assess understanding.
- Strong network of community services such as faith-based organizations, Meals on Wheels, caregiver respite programs, with knowledge of scope of services and how to leverage.
- Established contracts with valuable ancillary and home services and local high-quality providers for pregnancy in the program.
- Physician and physician staff understanding the role care managers can play.
- Comparative provider performance information and transparency tools available to care manager and members to support decisions about providers and sites of care.

References

- CSD-CC-CM-52 IHN-CCO – Coordination of Care Transitions Policy.
- CSD-CC-CM-53 IHN-CCO – Transition of Care Policy.
- CSD-CC-CM-56 IHN-CCO – Acuity and Caseload Policy.
- Chapter 410 of Health Systems Division – Medical Assistance Programs:
  - Rule 410-141-3865 – Care Coordination Requirements.
  - Rule 410-141-3870 - Intensive Care Coordination.
  - Rule 410-141-3525 – Outcome and Quality Management.
  - Rule 410-141-3860 - Integration and Coordination of Care.
- 2022 Care Coordination Program.
- 2022 Quality Improvement Program.
- 42 C.F.R § 438.208(b)(2)(ii) – Coordination and Continuity of Care.
- Oregon Health Authority – Oregon Health Plan, Health Plan Services Contract; Coordinated Care Organization.
- National Institute of Health — **nichd.nih.gov/health/topics/high-risk/more_information/resources**.
- American College of Obstetricians and Gynecologists.
- Centers for Disease Control and Prevention — **cdc.gov/pregnancy**.
- U.S Department of Health & Human Services - Office on Women's Health — **womenshealth.gov/pregnancy**.
- March of Dimes — **marchofdimes.org**.

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