ATTACHMENT E: CARE MANAGEMENT FOR HIGH-RISK PREGNANCY POLICY FOR MEDICAID AND NC HEALTH CHOICE MEMBERS

1. BACKGROUND.

A. "Care Management for High-Risk Pregnancy" refers to care management services provided to a subset of high-risk pregnant women by Local Health Departments (LHDs).

B. For Contract Year 1, LHDs shall have "right of first refusal" as contracted providers of Care Management for High-Risk Pregnant Women. Women participating in Care Management for High-Risk Pregnant Women with an LHD are also eligible for Tailored Care Management (i.e., a second care manager) to address other needs that are not included in the LHD model.

C. After Contract Year 1, Care Management for High-Risk Pregnancy shall be fully subsumed into the Tailored Care Management model.

2. SCOPE.

A. The scope of this Policy covers the Contract between the BH I/DD Tailored Plan and LHDs offering Care Management for High-Risk Pregnancy, as outlined below and in the Contract.

3. GENERAL CONTRACTING REQUIREMENT.

A. LHD shall accept referrals from the BH I/DD Tailored Plan for Care Management for High-Risk Pregnancy services.

4. CARE MANAGEMENT FOR HIGH-RISK PREGNANCY: OUTREACH.

A. LHD shall refer potentially Medicaid-eligible pregnant women for prenatal care and Medicaid eligibility determination, including promoting the use of presumptive eligibility determination and other strategies to facilitate early access to Medicaid coverage during pregnancy.

B. LHD shall contact patients identified as having a priority risk factor through claims data (emergency department utilization, antepartum hospitalization, utilization of Labor and Delivery triage unit) for referral to prenatal care and to engage in care management.

5. CARE MANAGEMENT FOR HIGH-RISK PREGNANCY: POPULATION IDENTIFICATION AND ENGAGEMENT.

A. LHD shall review and enter all pregnancy risk screenings received from Pregnancy Management Program providers covered by the pregnancy care managers into the designated care management documentation system within five (5) Calendar Days of receipt of risk screening forms.

B. LHD shall utilize risk screening data, patient self-report information and provider referrals to develop strategies to meet the needs of those patients at highest risk for poor pregnancy outcomes.

C. LHD shall accept pregnancy care management referrals from non-Pregnancy Management Program prenatal care providers, community referral sources (such as Department of Social Services or WIC programs) and patient self-referral and provide appropriate assessment and follow-up to those patients based on the level of need.

D. LHD shall review available BH I/DD Tailored Plan data reports identifying additional pregnancy risk status data, including regular, routine use of the Obstetric Admission, Discharge and Transfer (OB ADT) report, to the extent the OB ADT report remains available to LHD.

E. LHD shall collaborate with out-of-county Pregnancy Management Program providers and Care Management for High-Risk Pregnancy teams to facilitate cross-county partnerships to ensure coordination of care and appropriate care management assessment and services for all patients in the target population.

6. CARE MANAGEMENT FOR HIGH-RISK PREGNANCY: ASSESSMENT AND RISK STRATIFICATION.

A. LHD shall conduct a prompt, thorough assessment by review of claims history and medical record, patient interview, case review with prenatal care provider, and other methods on all patients with one or more priority risk factors on pregnancy risk screenings and all patients directly referred for care management for level of need for care management support.

B. LHD shall utilize assessment findings, including those conducted by the BH I/DD Tailored Plan, to determine level of need for care management support.
C. LHD shall document assessment findings in the care management documentation system.
D. LHD shall ensure that assessment documentation is current throughout the period of time the care manager is working with the patient and continually update that documentation as new information is obtained.
E. LHD shall assign case status based on level of patient need.

7. CARE MANAGEMENT FOR HIGH-RISK PREGNANCY: INTERVENTIONS.

A. LHD shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients and meeting their needs. This includes face-to-face encounters (practice visits, home visits, hospital visits, community encounters), telephone outreach, professional encounters and/or other interventions needed to achieve Care Plan goals.
B. LHD shall provide care management services based upon level of patient need as determined through ongoing assessment.
C. LHD shall develop person-centered Care Plans, including appropriate goals, interventions and tasks.
D. LHD shall utilize NCCARE360 to identify and connect members with additional community resources.
E. LHD shall refer the identified population to childbirth education, oral health, BH or other needed services included in the member's BH I/DD Tailored Plan Network.
F. LHD shall document all care management activity in the care management documentation system.

8. CARE MANAGEMENT FOR HIGH-RISK PREGNANCY: INTEGRATION WITH THE BH I/DD TAILORED PLAN AND HEALTH CARE PROVIDERS.

A. LHD shall assign a specific care manager to cover each Pregnancy Management Program provider within the county or serving residents of the county. LHD shall ensure that an embedded or otherwise designated care manager has an assigned schedule indicating their presence within the Pregnancy Management Program.
B. LHD shall establish a cooperative working relationship and mutually agreeable methods of patient-specific and other ongoing communication with the Pregnancy Management Program providers.
C. LHD shall establish and maintain effective communication strategies with Pregnancy Management Program providers and other key contacts within the practice in the county or serving residents of the county.
D. LHD shall ensure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of patients in the target population.
E. LHD shall ensure awareness of BH I/DD Tailored Plan members' "in network" status with providers when organizing referrals.
F. LHD shall ensure understanding of the BH I/DD Tailored Plan's prior authorization processes relevant to referrals.

9. CARE MANAGEMENT FOR HIGH-RISK PREGNANCY: COLLABORATION WITH BH I/DD TAILORED PLAN.

A. LHD shall work with the BH I/DD Tailored Plan to ensure program goals are met.
B. LHD shall review and monitor BH I/DD Tailored Plan reports created for the Pregnancy Management Program and Care Management for High-Risk Pregnancy services to identify individuals at greatest risk.
C. LHD shall communicate with the BH I/DD Tailored Plan regarding challenges with cooperation and collaboration with Pregnancy Management Program and non-Pregnancy Management Program prenatal care providers.
D. LHD shall participate in pregnancy care management and other relevant meetings hosted by the BH I/DD Tailored Plan.

10. CARE MANAGEMENT FOR HIGH-RISK PREGNANCY: TRAINING.

A. LHD shall ensure that pregnancy care managers and their supervisors attend pregnancy care management training offered by the BH I/DD Tailored Plan and/or the Department, including webinars, new hire orientation or other programmatic training.
B. LHD shall ensure that pregnancy care managers and their supervisors attend continuing education sessions coordinated by the BH I/DD Tailored Plan and/or the Department.
C. LHD shall ensure that pregnancy care managers and their supervisors pursue ongoing continuing education opportunities to stay current in evidence-based care management of pregnancy and postpartum women at risk for poor birth outcomes.
D. LHD shall ensure that pregnancy care managers and their supervisors utilize motivational interviewing and trauma-informed care techniques on an ongoing basis.

11. CARE MANAGEMENT FOR HIGH-RISK PREGNANCY: STAFFING.

A. LHD shall employ care managers meeting pregnancy care management competencies, defined as having at least one of the following qualifications:
    i. Registered nurses
    ii. Social workers with a Bachelor's degree in social work (BSW, BA in SW, or BS in SW) or Master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education-accredited social work degree program.
    iii. Care managers for High-Risk Pregnancy hired prior to September 1, 2011, without a Bachelor's or Master's degree in social work may retain their existing position; however, this grandfathered status does not transfer to any other position.
B. LHD shall ensure that Community Health workers for Care Management for High-Risk Pregnancy services work under the supervision and direction of a trained care manager.
C. LHD shall include both registered nurses and social workers on their team in order to best meet the needs of the target population with medical and psychosocial risk factors.
D. If the LHD has only a single care manager for High-Risk Pregnancy, the LHD shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline.
E. LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with a pregnant population at high risk for poor birth outcomes. This skill mix should reflect the capacity to address the needs of patients with both medically and socially complex conditions.
F. LHD shall ensure that pregnancy care managers demonstrate:
    i. Proficiency with the technologies required to perform care management functions
    ii. Motivational interviewing skills and knowledge of adult teaching and learning principles
    iii. Ability to effectively communicate with families and providers
    iv. Critical thinking skills, clinical judgment and problem-solving abilities
G. LHD shall provide qualified supervision and support for pregnancy care managers to ensure that all activities are designed to meet performance measures, with supervision to include:
    i. Provision of program updates to care managers
    ii. Daily availability for case consultation and caseload oversight
    iii. Regular meetings with direct service care management staff
    iv. Utilization of reports to actively assess individual care manager performance
    v. Compliance with all supervisory expectations delineated in the Care Management for High-Risk Pregnancy Program Manual
H. LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following BH I/DD Tailored Plan/Department guidance about communication with the BH I/DD Tailored Plan about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery.
    i. Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by the BH I/DD Tailored Plan.

Contractor: Legally Authorized Representative