

## **Coordination between CCNC and Pregnancy Care Management**

### **Background:**

The pregnant Medicaid population is composed of approximately one-third patients who are Medicaid-eligible outside of pregnancy and two-thirds patients who are in the Medicaid for Pregnant Women (MPW) category. Existing Medicaid patients may be linked to a CCNC practice and care manager before becoming pregnant. Some MPW patients (ranges from 10-50% depending on network and county) get linked to a primary care medical home but are unlikely to have an existing relationship with a CCNC care manager. For those pregnant Medicaid patients who are linked to CCNC primary care practices and care managers, and who qualify for pregnancy care management, it is important that services are coordinated and organized to best meet the needs of the patient.

### **Message for Pregnancy Care Managers (OBCMs):**

When receiving a new referral, first check CMIS to see if she is being actively care-managed by a primary care manager (PCM), which can be determined by looking at her primary case status and her tasks list. Be sure to contact the PCM (using CMIS messaging or using the phone number listed for that person in CMIS) prior to initiating services in order to coordinate care. The current primary care manager will also be an important source of information in terms of completing the patient's pregnancy assessment. These patients should all have current comprehensive health assessments (CHA) completed in CMIS; the CHA should be reviewed by the OBCM before initiating the pregnancy assessment. The OBCM can also review the patient's care plan to see current and previous conditions, as well as active and deferred goals.

If a pregnant patient is admitted to the hospital for any reason other than delivery of her infant, a CCNC care manager may become involved in the case if she meets certain criteria (ABD, chronic disease) that make her a "transitional care" patient. CCNC care managers have specific requirements for the follow-up of these patients. This follow-up should be coordinated with the OBCM in order to avoid duplication of services and to ensure all of the patients needs are being met.

### **Message for CCNC Care Managers (PCMs/TCMs):**

In terms of CCNC care management, the addition of Pregnancy Care Management has not changed the current status of any existing network initiatives. Patients who are already in CCNC "buckets" (such as a chronically diabetic patient) will not leave those buckets just because they are pregnant, but they may now also be in the Pregnancy Care Management "bucket" (presence of a chronic disease that may complicate pregnancy qualifies the patient as "priority" for OBCM). CCNC and OB care managers need to coordinate their services when working with these patients. Some patients will need to be followed by both care managers during the pregnancy; good coordination is essential to ensure that patient needs are met and services are not duplicated.

If a pregnant patient who meets Transitional Care (TC) criteria is discharged from the hospital, she requires the same follow-up as all other TC patients. However, this follow-up should be done in close coordination with the Pregnancy Care Manager in order to avoid duplication of services and ensure the patient's needs are being met. Pregnancy Care Managers are not currently expected to perform nor are they trained in medication reconciliation. Hospital utilization during the antepartum period is a "priority risk factor" for pregnancy care management. This means that she should be referred to a Pregnancy Care Manager for assessment and follow-up of identified needs. Therefore, in a subset of pregnant patients with hospital admissions, both CCNC and Pregnancy care managers will be trying to accomplish required follow-up and need to coordinate their efforts. This should be beneficial to both care managers, who can serve as resources for each other. CCNC care managers are not expected to serve pregnant Medicaid patients who do not meet CCNC criteria.

Pregnancy Care Managers end their relationship with the patient at the end of the postpartum period (roughly 60 days after delivery). For patients who will remain on Medicaid, the Pregnancy Care Manager may refer the patient to her assigned Primary Care Manager for ongoing follow-up.