

Summary of important points from Pregnancy Webinar presented by Vienna
Barger 9-12-11

- There are currently no CMIS measures for PMH patients at this time
- OBCMs should not delay patient engagement; if a referral is received and it is obvious that patient requires intervention, do not wait for screening to be completed and entered into system.
- Spell out Pregnancy Care Manager; OBCM is just for use and clarity in CMIS.
- As of 9/01/11 all Pregnancy Care Management documentation should be occurring in CMIS; any cases where this is not happening are to be reported to Regional Social Work Consultant for remedial action.
- As of 9/01/11 all Pregnancy Care Management documentation should be occurring in CMIS within 72 hours or sooner. This is critical as we deal with patients across county lines, with inpatient issues and with PCM involvement. It is critical that all care managers in the state are able to access the current care being provided to a patient (completed and pending tasks).
- Do not document on paper and in CMIS on same patient simultaneously.
- All active patients should be up to date in CMIS as of 10/01/11. It is not necessary to document retrospectively. Use a task note to indicate all prior documentation location; example: “ All documentation prior to 10/01/11 can be found in paper chart at WCHS”
- Every Risk Screening must be entered into CMIS regardless if they have a risk factor or not, with appropriate completed and pending tasks documented.

- Key factors to ensure that you document in CMIS include: Due date, Prenatal Care Provider, Patient Program (Pregnancy Care Management- this is found in demographics, far right hand column, below CC4C), Pregnancy Care Manager, patient care status.
- Process for entry of Risk Screening Forms into CMIS:

Pregnancy Care Manager Assignment is required even if patient has no priority risk factors and/or is deferred. Patient should be assigned to an OBCM so if issues arise for this patient in the future, the OBCM listed in CMIS can then be contacted for help in following up with the patient. If a patient is deferred originally, the OBCM should take the opportunity to contact the patient and engage them in care when/if they receive notification of a new issue. This includes patients that have previously refused or declined services.

- If clerical staff are entering risk screening forms, they should assign all patients to an OBCM, per agency protocol, and that person (supervisor or care manager) should defer those patients who do not meet screening criteria.
- 17P documentation reminders:
Pregnancy Care Managers are responsible for weekly documentation for any patient who is receiving 17P. The patient will therefore be on “heavy” status. Weekly contact with the patient is not required, but it is essential to confirm that she has received her injection and to work with the practice if she misses a dose. Practice may want Pregnancy Care Manager’s assistance in reminding patient of upcoming injection appointment. If anyone in your county is unclear about how to track patients on 17P in CMIS or how to work with these patients, contact your Regional Social Work Consultant ASAP. This documentation is key and is the only way to monitor/track our success ; it is the OBCM’s responsibility to do this.

- Unanticipated hospital utilization as a risk factor (responsibilities per LHD Contract) :
 1. Any hospital utilization during the antepartum period (ED visit, L&D triage visit, hospital admission) is unanticipated because it is not normal to need to visit the hospital during pregnancy, but can result from access to care issues; medical complications of pregnancy; injury or other illness while pregnant.
Each agency needs to identify/ create mechanisms to allow their OBCM staff to recognize ways to receive referrals from hospital encounters.
 2. For Hospitalized Pregnant Patients outreach should be conducted to hospitalized patient within 72 hours of her discharge .Connecting with patient while she is still in the hospital, when OBCM is aware the patient is in the hospital, is an appropriate encounter.
 3. Important assessment of the patient to include the following should occur: Determine if she has a prenatal care provider, if no provider, help her engage in prenatal care ASAP .If already in PNC, ensure that she has an appointment within 1-2 weeks of discharge and is able to get to the appointment. Hospital staff do not always make f/u appointment.
 4. It is often difficult to determine specific discharge instructions / post hospital care required when you cannot view the discharge summary. Therefore, it is important to ask the patient to show you their copy of the discharge instructions.
 5. Assess for care management needs including assisting with obtaining medications and/or other discharge instructions / follow-up.
Determine if patient is able to access a pharmacy or does she need help arranging for other services.

6. Coordination with Primary Care Managers :

When initiating Pregnancy Care Management with a new patient locate her in CMIS and check to see if she is currently being care managed by a Primary Care Manager (PCM). if she is, check to see if Primary Case Status is Heavy, Medium or Light and if Primary Care Manager has pending or recently completed tasks. Contact the Primary Care Manager before engaging the patient and discuss the case and plan for coordination of care management services. The Primary Care Manager may be an excellent source of assessment information. Coordination is essential to avoid duplication of services/ effort. Meet and Greet opportunities between PCMs and OBCMs is important to help with these hospital transitions

- Network and Local Health Department Agreement :

Network and Local Health Department Agreement Includes a budget for Pregnancy Care Management services.

Budget is based on the most recent September payment projection x 12.

Use pink Justification boxes to indicate how expenditures link directly to contract Services to be Provided and/or Performance Measures. Language is similar to DPH contract that staff worked under previously and is very detailed. Monies should go to staff salaries hired to support the PMH Program.

- Patients that are in a local jail for a brief time should retain their Medicaid and should still be engaged in Pregnancy Care Management. However, those incarcerated in a prison will lose their Medicaid and will receive prenatal care through the prison system and its contracts with providers.
- Regional training seminar dates for Fall/ Winter is pending DHS budget approval.
- Plans are under way for Motivational Interviewing seminar in the Spring.
- Starting in 2012 they hope to begin an annual conference like the Baby Love Program sponsored in the past.