Community Care of North Carolina
BRINGING VALUE HOME

Pregnancy Medical Home

Maternal & Infant Outcomes in the Medicaid Population

Community Care of North Carolina (CCNC) launched the Pregnancy Medical Home (PMH) program in 2011 until 2021 to enhance access to comprehensive care for pregnant Medicaid beneficiaries and to improve birth outcomes. The PMH program promoted evidence-based, high-quality maternity care in more than 400 practices across the state. PMH practices represented 95% percent of prenatal care providers who serve the Medicaid population. The PMH model included six core components:

Statewide Provider Network

There were more than 450 practices and 2,500 individual providers, with PMH practices in 95 of 100 counties. This represented 95% of practices that serve pregnant women with Medicaid.

Standardized Risk Screening

Patients at risk of poor birth outcomes are identified through a standardized risk screen administered at the first prenatal visit. Nearly 80% of patients who received care in a PMH are assessed using a standardized pregnancy risk screening tool. The screening tool captured medical, obstetric and psychosocial risk factors associated with preterm birth. In 2017, CCNC operationalized the Maternal-Infant Impactability Score™ (MIIS) stratification model. Every pregnant woman received a score based on her own characteristics and risk factors, which reflected the relative ability of a care manager to reduce the risk of low birth weight when the woman receives intensive care management. Greater weight was given to those factors shown to improve with consistent and frequent care management.

Community-Based Care Management

Care Management for High Risk Pregnancies (CMHRP*) was a care coordination model for pregnant Medicaid patients at risk of preterm birth who were identified using the PMH risk screening form and other patient identification strategies. CMHRP services were provided by county health department nurses and social workers. These care managers partnered with prenatal care providers; many were embedded in the prenatal care setting, enabling effective integration with the care team and face-to-face interaction with patients.

**CMHRP was previously called Pregnancy Care Management*

Local Clinical Leadership

CCNC supported the PMH provider community through clinical leadership, provider education, technical assistance and by providing practice-level analytics. Statewide PMH clinical leadership teams ("OB teams") supported high quality care to the pregnant Medicaid population by disseminating statewide care pathways which establish best practices based on current evidence. OB teams also shared meaningful data about key quality and performance metrics and support PMH practices to implement quality improvement strategies.

Care Pathways

The PMH program promoted **clinical best practices that reflect the most current evidence base** in terms of strategies to prevent preterm birth. PMH Care Pathways, available on CCNC's website, were used to standardize care, promote best practices, and set performance expectations across all PMH settings. PMH Care Pathways were developed by CCNC physician champions with input from local OB providers. Pathway topics focused on the management of pregnancy-related conditions, including hypertension, obesity, tobacco use, substance use, and multiple gestation, and specific components of care, such as induction of labor, progesterone treatment, postpartum care, and family planning. PMH Care Pathways can be found at: http://ccnc.care/pathways.

Informatics

CCNC used **Medicaid claims, birth certificates, and risk screening data** to produce quarterly metrics. **Measurement of clinical quality** reflected program priorities, such as low birth weight, timeliness of entry to prenatal care, postpartum care, and risk screening rate.

For more information, contact:

Kimberly DeBerry, RN, BSN, CCM
Maternal Child Health Director at CCNC
kdeberry@communitycarenc.org

About Community Care of North Carolina

CCNC is a national leader in transforming health care, joining community-based care managers with local primary care physicians and diverse teams of health professionals to develop whole person plans of care. Informed by statewide data and predictive analytics, the CCNC program builds patient-centered practice models, connects people to the right local resources, and leads collaborations with health systems and public health. This proven population health management approach delivers better health outcomes at lower costs. For more information, visit https://www.communitycarenc.org.

Community Care OF NORTH CAROLINA