## Priority risk factors include:

- History of preterm birth
- History of low birth weight
- Multiple gestation
- Fetal complications
- Chronic conditions which may complicate pregnancy
- Unsafe living environment
  *e.g., homelessness, inadequate housing, family violence*
- Substance or tobacco use
- Late entry into prenatal care
- Missing two or more prenatal appointments without rescheduling
- Unanticipated hospital utilization
  *Emergency Department or Labor & Delivery triage visits, ante partum hospitalization*
- Physician request for care management assessment

Medicaid recipients with any of these priority risk factors will receive an assessment from a pregnancy care manager. These are not the only reasons why a patient may need pregnancy care management, and a provider can request an assessment at any time.

**For more information about joining the initiative, contact:**


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Community Care
OF NORTH CAROLINA

north carolina medicaid

# Pregnancy Medical Home Program

Working together to improve the health of mothers and babies in the NC Medicaid population

# What is the Pregnancy Medical Home program?

Community Care of North Carolina (CCNC), the Division of Medical Assistance (DMA) and the Division of Public Health (DPH) invite OB practices to become Pregnancy Medical Homes. We are working together to improve birth outcomes in the Medicaid population through coordinated, evidence-based maternity care management for women at risk for poor birth outcomes, with a focus on quality improvement.

## Benefits of OB participation

Providers will contribute to the health and well-being of pregnant mothers and their babies while receiving the following benefits:

- A $50 incentive for completing a standardized risk screening at the initial OB visit
- A $150 incentive for performing the post partum office visit
- Exemption from prior approval for OB ultrasounds (OB ultrasounds must be registered)
- An enhanced rate for vaginal deliveries equal to the cesarean section rate
- Coordination and support from the OB team (physician champion and nurse coordinator) from one of CCNC's 14 local networks
- A pregnancy care manager assigned to your practice to help you meet the needs of patients identified as being at-risk for poor birth outcomes
- Care management services provided based on the patient's level of need to facilitate access to resources
- Regular care management contact with the patient and prenatal care provider to improve coordination of care
- Access to practice-specific process and outcome data

## What is required to join?

The Pregnancy Medical Home program is an outcome-driven initiative monitored for specific performance standards. Practices join by signing an agreement with their local CCNC network to do the following:

- Complete a standardized risk screening on each pregnant Medicaid recipient in the practice
- Coordinate the plan of care with the pregnancy care manager
- Participate in medical records review related to quality improvement efforts
- Participate in the local CCNC network
- Eliminate elective deliveries performed before 39 weeks of gestation
- Offer and provide 17P to eligible patients (weekly injections to prevent preterm birth)
- Achieve and maintain a primary cesarean section rate at or below 20 percent