Local Public Health Agencies (LPHA)
and Home State Health (HSH) Care Coordination for Pregnant Mothers

Home State offers local public health agencies the following workflow process for the care coordination of pregnant mothers.

Program Overview: Care Coordination for pregnant mothers

Home State to perform following tasks:

- HSH will reimburse through claims

- Designated staff for a point of contact will be provided

- HSH to set up remote access for remote documentation in provider portal. Refer to Workflow for education on assessment, notes, and referrals.

- HSH can utilize LPHA to help ensure the member receives wrap around services including but not limited to home nurse visits, community resources, referrals, transportation, and health education. Support will be directed by the HSH CM to meet the needs of the member, if member agrees to both services. (see line item 5 in workflow process) If member agrees for both services, frequency of contact between HSH and LPHA CMs should be at a minimum of monthly to quarterly, however, can be increased based on clinical judgment by HSH CM.

Local Public Health Agency (LPHA) to perform the following tasks:

- For HSH members while in the care of the LPHA, LPHA may assign a nurse to pregnant mother for CM. Each contact with the member should be designed around these goals: healthy pregnancy and delivery for mother and healthy outcome for newborn.

- Suggested Care Coordination protocol should include the following, but not limited to:
  - Closure of Care Gaps
  - Development of an individualized plan of care in concert with the member and/or member's family, Primary Care Provider (PCP), and managing providers.
  - Application of appropriate interventions to remove barriers to meeting goals included in the plan of care.
  - Referrals and assistance to ensure timely access to providers.
  - Active coordination of care linking members to providers, medical services, residential, social and other support services where needed.
  - Ongoing monitoring and revision of the plan of care as required by the member's changing condition and the rationale for implementing services.
  - Continuity and coordination of care, the nature of the relationship.
  - Ongoing monitoring, follow up, and documentation of all care coordination activities.

- Addressing the member's right to decline participation in the program or dis-enroll at any time.
- Accommodating the specific cultural and linguistic needs of all members.
- Conducting all member contact in compliance with HIPAA and state law.
- Improved member care, and health outcomes.
- Reduction of inappropriate inpatient hospitalizations or utilization of emergent services and lower total costs through better educated providers and members.
- Discharging/dis-enrolling a member from program – LPHA nurse to contact the HSH designated Care Manager to determine if HSH can provide assistance:
  - ❖ Possible dis-enrollment criteria would include the following:
    - Unable to reach member prior to enrollment, 3 attempts have been made (for 3 attempt definition, see line item 6 in workflow process)
    - Member cannot be reached after program enrollment, 3 attempts have been made. (for 3 attempt definition, see line item 6 in workflow process)
    - Member declined or opts out of program services
    - Loss of HSH coverage/benefits
    - Miscarriage or intrauterine death/not currently pregnant
    - Member expires
    - Care coordination no longer needed - Reached the maximum medical improvement or established goals regarding improvement or medical stability.

- Access HSH's Client Portal to complete the following :
  - Notes: General Note
  - Assessments: Notification of Pregnancy
  - Referrals

- Local Public Health Agency is to submit claims using specified codes
  - Diagnosis Code starting with either letters O or Z
  (Example: Diagnosis Code of: 009.899 for Supervision of High risk pregnancy, unspecified trimester.)

* Fees to be paid are 100% of the then current Medicaid Fee Schedule.

*Service Category		Identifier Code	Modifier		TOS	Definition
			1	2		
Prenatal Case Management (Pregnant Women)	Risk Appraisal	H1000			1	Home State Health Notification of Pregnancy Form complete on Provider Portal
	Initial Visit	H1001			1	Full Assessment completed at the home and a general note to be completed on the Provider Portal
	Home Visit (POS 12)	H1004			1	Follow up visit completed **at the home** and a general

						note to be completed on the Provider Portal
	Subsequent Face to Face	H1001	TS		1	Follow up visit **completed at the office** and a general note to be completed on the Provider Portal
	Phone / Letter Contact - Telephonic Contact – contact made with member and conversation was related to but not limited to: program enrollment, education, appointment set up, follow up, and/or resources, etc.	H1001	TS	52	1	Telephonic contact and a general note to be completed on the Provider portal No payment for: reaching a voicemail, reaching persons other than member, incorrect number, no member contact

Documentation Workflow:

1. When a pregnant member is identified as being enrolled with HSH, launch the HSH Provider Portal.

2. Verify member has coverage and address care gaps listed on portal.

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	CARE GAPS
👍	05/10/2017	▮▮▮▮▮	05/10/2017	No PAP in past 36 months. Non-compliant for annual well visit. Risk Category Alerts: COPD/Asthma

3. Offer program services –
   a. If member agrees to program, on provider portal:
      1. Complete the Notification of Pregnancy (NOP) assessment, if one has not already been completed for current pregnancy.

Example: Today's date is 8/1/17. Member has had a recent NOP submitted so it does not need to be completed.
If NOP was submitted a year ago for her last pregnancy, complete a current NOP.

Previous Assessments

Assessment Name	Submit Date
SSFB WEB ONLY Provider NOP	06/12/2017

2. Document in Client Portal for each contact with member using the Notes, general notes and complete a referral (see line item 9) (see line item 5 for follow up frequency with HSH CM)

b. If member declines program, on provider portal:
1. Complete the Notification of Pregnancy (NOP) assessment, if one has not already been completed for current pregnancy.
2. Document in Client Portal for each contact with member using the Notes, general notes. Discharge member from program and complete a referral (see line item 9)

If it is a face to face visit – select Outbound call and successful for outcome

General Note

Select an Option
Admin Note
Inbound Call Note
Outbound Call Note

Outcome:
○ Left Voicemail
○ Successful
○ Unsuccessful

Overview
Authorizations
Care Plan
Assessments
Health Record
Document Upload
Notes
Referrals

Encounter Date:
mm/dd/yy

Contact Name:

Contact Reason:
Select an Option. ▼

Select appropriate reason – see below

Note:

Note:
- Start notes off with "LPHA", then document type of contact "(enrolled in CM program with LPHA, Initial home visit, Follow up home visit, Office visit, phone contact) completed, Member declined program with LPHA"

Submit

Select an Option.
Discharge Planning
POM Call
Verify Appointment
Other (Use Note Text Area)
Post Partum Outreach
Change of Address
Continuation of Care
Nurtur
Visit
Post Discharge Outreach
UTR Letter
17P
LifeShare ED
Member Connections
Case Management
Member Returned Call
Benefit Advice
ED Letter
Care Coordination

Select an Option. ▼

Post Partum Outreach
Change of Address
Continuation of Care
Nurtur
Visit
Post Discharge Outreach
UTR Letter
17P
LifeShare ED
Member Connections
Case Management
Member Returned Call
Benefit Advice
ED Letter
Care Coordination
Disease Management
Change of Phone Number
Pharmacy Staff
Obtain NOP
Other

Select an Option. ▼

Contact reason options most likely to be used:
Verify appointment
Post Partum Outreach
Change of Address
Visit
Case Management (Medium acuity)
Member returned call
Benefit Advice
Care Coordination (Low acuity)
Change of phone number
Obtain NOP (when member not referred)
Other

Contact Reason:
Other ▼

Contact Reason Other

EXAMPLE:

General Note

Note Category:
Outbound Call Note ▼

Outcome:
○ Left Voicemail
◉ Successful
○ Unsuccessful

Encounter Date:
22/02/2222

Contact Name:
Jane Doe

Contact Reason:
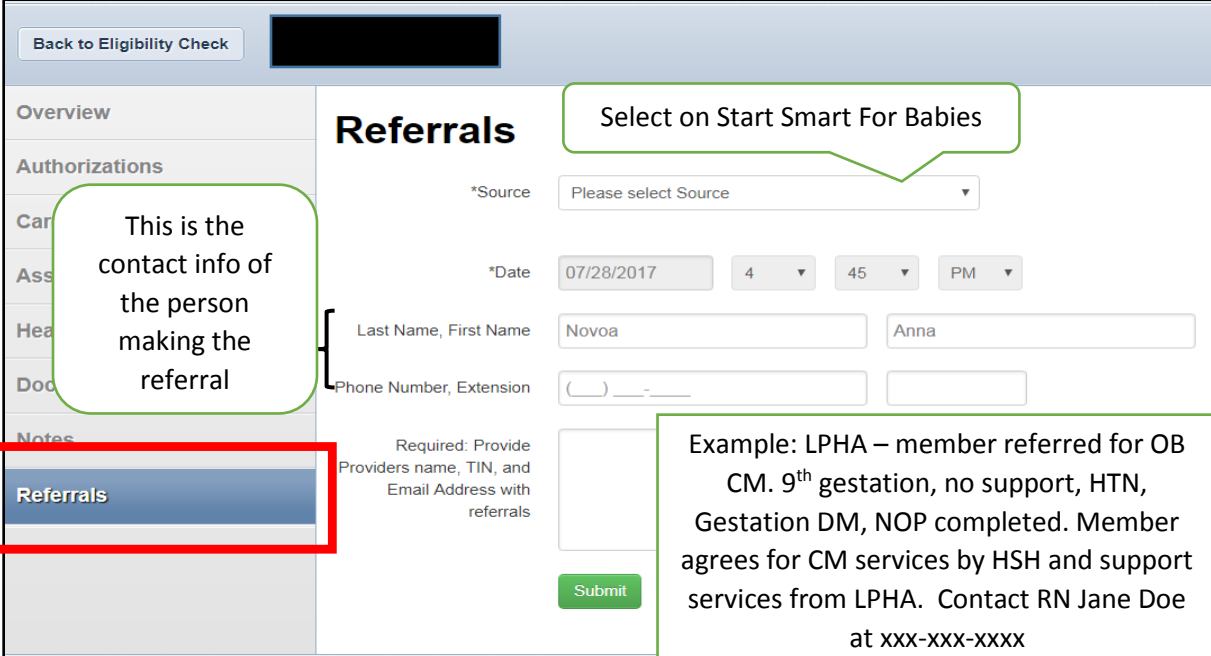Case Management ▼

Note:
LPHA – Enrolled in LPHA CM program, initial home visit completed. RN John Smith, 000-000-0000

NOTE: All notes need to include CM name and phone number.

4. Follow up with member at specified frequency and acuity that both the nurse and member agree with and verify demographics. **Document in Client Portal for each contact with member using the Notes, general notes.**

5. Follow up with HSH CM at specified frequency: a minimum of monthly to quarterly however can be increased base on clinical judgment by HSH CM.

6. 3 attempt outreaches to be done when reaching out for program enrollment and when member is enrolled into program. An outreach is defined as: a phone, a Face to Face, or a letter. Attempts also must be made at various times (before, during, and after regular working hours)
   ○ An attempted also must be made out to the Provider/WIC/Specialist/HSH for any updated demographics

7. If there have been changes with the medical status of Member's pregnancy or newborn, the nurse should:
   • Repeat the health/pregnancy assessment
   • Re-stratify the member to a higher or lower level of care coordination services
   • Update problem, goals, and interventions as indicated
   • Update care plan if applicable
   • Request the medical treatment plan from the Provider as indicated.

8. Once member delivers, nurse is to contact member after delivery for first attempt to reach for PP assessment. If unsuccessful, follow the 3 attempt outreach guideline on line item 6.
    a. Newborns are covered for 1 year. Member is covered up until 60 days post-delivery for full coverage with HSH, afterwards Medicaid will cover for 1 year of contraception and well Women's visits. LPHA to educate member about coverages for both member and newborn.

9. If referring member to HSH for Care Management services, open the client portal on the member. Click on the "Referrals tab"

Back to Eligibility Check

Overview

Authorizations

Referrals

Select on Start Smart For Babies

This is the contact info of the person making the referral

*Source   Please select Source ▾

*Date   07/28/2017   4 ▾   45 ▾   PM ▾

Last Name, First Name   Novoa   Anna

Phone Number, Extension   (__) ___-____

Required: Provide Providers name, TIN, and Email Address with referrals

Example: LPHA – member referred for OB CM. 9th gestation, no support, HTN, Gestation DM, NOP completed. Member agrees for CM services by HSH and support services from LPHA. Contact RN Jane Doe at xxx-xxx-xxxx

Submit

10. Discharging/dis-enrolling a member from program –
    a. Possible Dis-enrollment criteria would include the following:
        o Unable to reach member prior to enrollment, 3 attempts have been made (see line item 6 for definition)
        o Member cannot be reached after program enrollment, 3 attempts have been made. (see line item 6 for definition)
        o Member declined or opts out of program services
        o Loss of HSH coverage/benefits
        o Miscarriage or intrauterine death/not currently pregnant
        o Member expires
        o Services no longer needed - Reached the maximum medical improvement or established goals regarding improvement or medical stability.

As always, Home State appreciates your partnership in transforming the health of the community. If you have any questions contact care manager, Anna Novoa, R.N. at 636-534-4705 or email at anovoa@HomeStateHealth.com .