

Medicaid/VCCI High Risk Pregnancy Case Management Program

The High Risk Pregnancy (HRP) Program is a new program through the Vermont Chronic Care Initiative (VCCI) at the Department of Vermont Health Access. The goal of this program is to improve pregnancy outcomes for Medicaid covered pregnant women and their babies. Research has demonstrated that prenatal care that includes non-medical and medical support services improves birth outcomes, especially among at-risk populations. Enhanced prenatal care that includes a comprehensive psychosocial assessment, care coordination, an individualized maternity care plan, and improved access to services may result in improved pregnancy outcomes.

The HRP case management team will collaborate with Agency of Human Services (AHS) partners including IFS (Integrated Family services), DCF/CIS (Department of Children and Families, Children’s Integrated Services program) and the VDH/MCH (Vermont Department of Health, Maternal Child Health unit), as well as other community partners to improve pregnancy outcomes, including decreasing pre-term births and low birth weight infants and associated complications. The HRP case managers will facilitate access to prenatal services and help prevent gaps in care and redundancy of services.

The service will be launched in Franklin County in October 2013, with progressive statewide expansion.

Eligibility Criteria:

- Enrolled in Medicaid as sole insurance
- Vermont resident
- Currently pregnant *and*
- Considered high-risk, including and of the following:
 - Previous or current substance abuse
 - Previous medical or mental health condition affecting pregnancy
 - Prior pre-term birth
 - New pregnancy complication
 - Fetal complication
 - Any other condition requiring complex care coordination

Case Manager Role:

- Facilitate access to an obstetrical provider, primary care medical home, and any needed specialists. Coordinate communication and care among service providers, including mental health and substance abuse providers. Facilitate access to pediatric medical home for the infant.
- Develop a plan of care for case management of chronic and complex health conditions affecting pregnancy, based on priorities of both the provider and beneficiary.
- Support development of skills for effective self-management of high risk pregnancy as well as transition to parenting via coaching, education, and/or referral to programs and/or services (eg. nutrition, smoking cessation, childbirth, parenting, and breastfeeding education).
- Refer to appropriate resources to reduce the socioeconomic barriers to a healthy pregnancy, including access to safe and affordable housing, employment, food, fuel assistance and transportation to health care appointments.
- Comprehensive transitional care at birth by coordinating the obstetrical postpartum visit as well as any needed visits with specialists, ensuring transition of care back to beneficiary’s own medical home, and a pediatric medical home for the infant.