Perinatal Care Program

The Perinatal Care Program is designed to improve pregnancy outcomes, reduce neonatal hospitalizations, and reduce all costs associated with preterm birth and other complications of pregnancy. This is accomplished by providing perinatal education, promoting safe health behaviors, and enhancing the management of maternity care for women identified at high-risk for premature labor and delivery. Program goals include:

- Reduction in the incidence of preterm births
- Reduction in the incidence of low birth weight babies
- Reduction in the number of neonatal intensive care unit days
- Provision of improved perinatal education, promotion of safe health behaviors, and enhanced management of maternity care for women identified as high-risk for premature labor and delivery

Program Content

Member identification and enrollment is initiated once a pregnant member is identified or a referral is received. Referrals may come from the physician, The Health Plan Outreach Program, self-referral, and claims data. Physicians are provided a perinatal risk screening tool to forward to The Health Plan. Postcards are also provided to the physician office for use in member self-enrollment.

Outcome monitoring is continuous and reported regularly. These reports include:

- Rate of preterm deliveries
- Rate of low birth weight deliveries
- Rate of cesarean section deliveries
- NICU days/1,000 births
- NICU length of stay
- Rate of smoking at enrollment and at delivery
- Rate of perinatal care in the first trimester
- Rate of check-up after delivery

The targeted time for enrollment of all members is between 12 to 15 weeks gestation. A telephonic assessment of the clinical and psychosocial status of the member is completed by outreach staff at enrollment and again at week 24. Consideration is given to other health conditions. The assessment tool, along with the perinatal risk screen completed by the physician, is reviewed by the program nurse navigator. The mother-to-be is placed in the appropriate low-risk pregnancy group or the high-risk pregnancy group to be case managed.

A late referral education component is available for those women enrolled after 34 weeks gestation. A partial program is offered for those individuals who decline to enroll in the complete program but who want to receive educational materials.
The identification of low-risk pregnant women early in pregnancy is designed with the intent of improving the outcome of the pregnancy. Educating the pregnant woman on healthy lifestyle measures reduces risk factors throughout the pregnancy. The low-risk pregnant woman receives an initial assessment, a second trimester assessment, a third trimester assessment, and post-partum assessment conducted by the Outreach Department. The final call ensures the well-being of mother and child.

High-risk pregnancies are monitored and managed aggressively as early as possible and continuously throughout the pregnancy. This group receives general educational mailings as well as specific education materials based on assessment findings. All participants receive proactive calls from the perinatal care nurse navigator. The perinatal nurse navigator promotes positive outcomes for the pregnancy through individualized interventions. A specific plan of care is developed based on the risk status. Ongoing monitoring by the perinatal care navigators ensures timely intervention in the event of a change in risk status. The frequency of outbound calls to participants by the perinatal nurse navigator is determined by the severity of pregnancy risks and complications. This may result in daily contact in times of high-risk or concern. When home care is needed in high-risk cases, the perinatal nurse navigator works with the physician and home care agency to coordinate the necessary care and services.

A major component of the program is to educate the pregnant woman on proactive and healthy lifestyle measures that reduce risk factors throughout the pregnancy. This is achieved by providing mailings of education materials addressing perinatal care, birth alternatives, and newborn care as well as verbal education during assessments focusing on pregnancy wellness and patient-specific risk factors. Lifestyle issues are addressed such as illegal drug use and smoking. Smoking cessation interventions are a major focus for those members who are identified as smokers or recent smokers. Standard education materials are available for all members and risk-specific written education materials are provided for specific pregnancy issues. ACOG and March of Dimes are the resources for risk specific educational materials.

All identified pregnant members receive an initial mailing in the first trimester and the third trimester. Smoking cessation is offered telephonically as a major component of the program.

A successful perinatal care program is dependent on the coordination of health care services. The role of the physician is vital and this program is intended to compliment the medical care the member is receiving from her physician. The goal of The Health Plan is to foster a collegial relationship between the physician and the perinatal nurse navigator to coordinate the necessary health care to promote a healthy mother and a healthy baby.