D. Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Women

Improving birth outcomes has been a high priority for the Department for several years for HMO members in Dane and Rock counties as well as Southeast Wisconsin. Continuing and expanding the OB Medical Home initiative for high-risk pregnant women is an important part of this effort.

The OB Medical Home for high-risk pregnant women is a care delivery model that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality. The obstetric provider serves as the team leader and works in partnership with patients, other care providers, staff within the clinic and a care coordinator. The care team is responsible for meeting the patient's physical, behavioral health and psychosocial needs.

The HMO, in partnership with the medical home sites, must be guided by four core principles:

- Having a designated obstetric (OB) care provider who serves as the team leader and a point of entry for new problems. The OB care provider is defined as a physician, nurse midwife, nurse practitioner or physician assistant with specialty in obstetrics, who provides prenatal care and performs deliveries;
- Providing ongoing care over the duration of the pregnancy and postpartum period;
- Providing comprehensive care (e.g., care that meets the member's range of health and psychosocial needs); and
- Coordination of care across a person's conditions, providers and settings.

Additional information regarding the OB Medical Home Initiative may be found on the ForwardHealth Portal (click the link to be directed to the website):

OB Medical Home Initiative

Requirements

1. Target Population

   The target population for this medical home initiative is pregnant BadgerCare Plus and Medicaid SSI members who are at high-risk for a poor birth outcome.

   a. Poor Birth Outcome

      For this initiative, the Department has defined a poor birth outcome as:

      - Preterm birth – gestational age less than 37 weeks
      - Low birth weight – birth weight less than 2,500 grams (5.5 pounds)
      - Neonatal/early neonatal death – death of a live-born infant within the first 28 days of life
      - Stillbirth – fetal demise after 20 weeks gestation

   b. Eligible Members

Documentation must indicate that the member is within the first 16 weeks of pregnancy to be enrolled in the medical home and must meet one or more of the following criteria:

- Listed on the Department's Birth Outcome Registry Network (BORN) of high-risk women
- Less than 18 years of age
- African American
- Homeless
- Have a chronic medical or behavioral health condition which the obstetric care provider determines would negatively impact the outcome of the pregnancy

The reason(s) for the member's medical home eligibility must be documented in the medical record.

2. Medical Home Sites

The Medical Home must be a single clinic or network of clinics that is accountable for the total care of the member and must:

a. Include an OB care provider that serves as the care team leader and a point of entry for new problems during the member's pregnancy. The OB care provider, the care coordinator, and the member's primary care physician (who may or may not be the OB care provider) will work together to identify the prenatal, postpartum and psychosocial needs of the member to ensure that she will have a healthy birth outcome.

b. Adopt written standards for patient access and communication to the member as determined by the HMO and approved by the Department. These written standards must, at a minimum, meet appointment and waiting times according to Art. V of the contract. In addition, treatment and/or medical advice must be available 24 hours a day, seven days a week.

c. Use an electronic health record system to manage patient data in order to:

- Document medical home enrollment date,
- Organize clinical information,
- Identify diagnoses and conditions among the provider's patients that have a chronic condition that will impact the pregnancy,
- Track patient test results,
- Identify abnormal patient test results,
- Systematically track referrals and follow up, and
- Document birth outcomes.

d. Adopt and implement evidence-based guidelines that are based on, but not limited to, treatment and management of the following chronic medical conditions:

- Asthma
- HIV/AIDS
- Cardiac disease
- Diabetes mellitus
- Hypertension
- Pulmonary disease
- Behavioral health/mental health
- Morbid Obesity

The HMO and medical home sites must have clear procedures for addressing the complex needs of women with these conditions, including, but not limited to, referrals to appropriate specialists.

e. Actively support and promote patient self-management.

f. Demonstrate cultural competency among provider and office staff.

3. Care Coordination

A key component of the OB Medical Home initiative is the coordination of care for the member. Each medical home site must have a designated care coordinator on-site (located where the member's OB care provider is located) that performs the following tasks:

a. Communicates with the member and other care providers to identify needs and assist in developing a care plan and keeping the plan up-to-date;

b. Makes referrals to appropriate services (e.g., physical, dental, behavioral health and psychosocial) and provides follow up. Referrals are not complete without timely follow up with the member and/or with the provider to track the results of the referral. For example, to ensure the member received the service or to obtain laboratory results.

c. Provides member education and assists the member in managing her own care, and

d. Assists in removing barriers to care.

The care coordinator may be an employee of the medical home site or of the HMO, under contract, or under a Memorandum of Understanding/Agreement. All care

coordinators must be easily accessible on a regularly established schedule for members participating in the medical home.

To ensure continuity of care, the care coordinator shall work with the member to obtain the appropriate release forms, and contact the office(s) of any PCP that the participating member had/has an ongoing relationship with, to gather information about the member's medical history, current health conditions and any concerns that the PCP may have regarding the member.

HMOs and medical home sites must utilize the OB Medical Home Registry, provided by the Department and hosted by the Department's External Quality Review Organization, to track enrollment in the OB Medical Home Initiative.

4. Care Plan

   The OB care provider must develop a care management plan for the member in conjunction with the care coordinator and the PCP (if not the OB care provider). To the extent possible, the member must be included in the development of the care management plan.

   The care management plan must be based on an initial assessment, including the initial prenatal clinic visit, where all needs of the member are identified to ensure that the medical home will provide comprehensive care.

   The care management plan must include a patient self-care component and should include home visiting services. Best practice suggests that the home visit occur within 30 days of enrollment in the medical home. Members should be offered on-going home visiting services. The offer attempts and any refusals must be documented in the medical record.

   The care coordinator must establish regular communication with the member, OB care provider and PCP, if any, and home visiting agency/provider to track progress on the care management plan.

   The care plan must be signed by the OB care provider and dated. The plan must be reviewed and updated as the member's health and circumstances change.

5. Discharge Plan

   All members shall remain enrolled and receiving services as needed within the medical home for 60 days postpartum.

   a. Healthy Birth Outcome

      If the member had a healthy birth outcome, the following activities shall take place within the member's 60 day postpartum period:

- The member shall have at least one postpartum follow-up appointment with the OB care provider that meets all American Congress of Obstetricians and Gynecologists (ACOG) and other postpartum guidelines that apply.

- Ensure that the member is connected to/has an appointment with a PCP and/or pediatrician.

- The care coordinator shall contact the member's PCP to inform of the birth outcome and any concerns that the OB care provider has regarding the member's and/or child's health postpartum.

- The care coordinator shall educate the member on interconception care specific to her needs.

b. Poor Birth Outcome

In addition to items listed in Art. IV, D.5.a, for members who have a poor birth outcome, as defined by the Department, the HMO is responsible for the following:

- Working with the medical home site to develop a care management plan for the infant and the mother that incorporates input from the mother, the OB care provider, and the PCP and/or pediatrician. The plan shall include the coordination of care with other providers (which may be within the medical home) who are appropriate to provide ongoing services for the mother's and infant's specific needs.

- Maintaining contact with the mother to ensure that the initial referral appointments with other providers are kept and providing follow up, as needed.

- To the extent feasible, maintain contact with the mother at least twice a year for two years following the birth to ensure the mother and child are receiving appropriate care. HMO responsibility for follow up ends when the member is no longer enrolled in the HMO.

6. Reporting

The HMO must submit a report to the Department semi-annually evaluating its OB Medical Home initiative – one due the first business Monday of August (reporting for January through June) and one due the first business Monday of February (reporting for July through December). The report shall include:

a. A list of participating clinics and primary contact information;
b. A narrative describing how the medical home satisfies all OB MH requirements;
c. A narrative that includes specific examples of processes and outcomes detailing how the medical home site, in conjunction with the care coordinator, provides comprehensive and patient-centered care, and correctly identifies the needs of the member;
d. Status report on patient access standards defined in the OB MH requirements; and
e. Any corrective action that is being taken to meet the requirements of the medical home initiative.

7. External Quality Review

The Department has established a process for verifying that members enrolled in the OB Medical Home initiative meet the requirements.

The Department's External Quality Review Organization (EQRO) will conduct medical chart reviews that:

a. Verify members enrolled in the OB Medical Home initiative meet the defined contract requirements;
b. Collect data to support potential future program refinements; and
c. Collect data to support program evaluation.

The HMO is responsible for working with the medical home sites, PNCC providers, hospitals and any other care provider that may or should have documentation of OB Medical Home services to ensure required documentation is submitted to the Department in a timely manner.

The Department does not provide additional reimbursement to HMOs or clinics for submission of medical records. HMOs are encouraged to define responsibilities of each party, which may include reimbursement policies and reporting requirements, in their subcontracts or agreements with medical home providers.

8. Payment Structure

Enhanced payments are available for pregnant women that meet the defined eligibility criteria, which will be verified through EQRO chart reviews. The Department issues payment to the HMOs and the HMOs pass the enhanced payments on to the medical home site.

If the EQRO is unable to verify, through chart review, any of the criteria as required by the OB Medical Home initiative, the clinic is ineligible for the enhanced payment for those women. At minimum, the clinic must clearly document that the following criteria are met.

The member:

a. Has had a pregnancy-related appointment with a health care provider within the first 16 weeks of her pregnancy. She must be enrolled in the OB Medical Home within 20 weeks of her pregnancy (the clinic is responsible for obtaining all medical records for documentation),

b. Has attended a minimum of 10 medical prenatal care appointments with the OB care provider,

c. Has a member centric, comprehensive care plan that has been reviewed by the member and, at minimum, the OB provider,

d. Has received continuous care coordination services,

e. Has received or been offered home visiting services throughout her pregnancy, including documentation of each home visit offer and, if necessary, refusal,

f. Has been continuously enrolled during her pregnancy, and

g. Has continued enrollment through 60 days postpartum, including the date of the scheduled 60 day postpartum visit, and any documentation of no shows or appointment refusals.

For each pregnant member meeting these criteria, the Department will pay $1,000 in addition to the kick payment to the HMO for every birth to an eligible member enrolled in the medical home initiative. The amount will increase to $2,000 if the birth has a good outcome as defined by the Department.

9. Evaluation

The HMO must assure that appropriate members of the organizations participating in the OB Medical Home initiative will work with the Department and authorized representatives of the Department to evaluate the initiative. This may include, but is not limited to, the following:

a. Assuring the clinic staff will complete pre-intervention and post-intervention surveys to identify process changes within the clinic;
b. Assuring that staff will be available to participate in meetings related to the evaluation;
c. Collecting and reporting needed data, as identified by the evaluator;
d. Reviewing findings and offering comments/suggestions; and
e. Sharing information with relevant stakeholders and distributing reports following approval by the Department.

10. HMO representative

The HMO must designate a staff person to oversee the execution of the medical home initiative. The HMO representative will be responsible for representing the HMO regarding inquiries pertaining to the medical home initiative and will be available during normal business hours. The HMO representative will be responsible for ensuring the medical home is implemented in accordance with the contract.