# Attachment 4 - EQRO Review Guidelines

## REVIEW CRITERIA

Reviewers use the following guidelines to abstract data from the medical record(s) submitted by the clinics and/or the MCOs. The elements align with contract requirements for the MCOs, and include other data elements DHS wanted to collect for program planning and evaluation.

| Demographics |
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| Member Medicaid Identification Number (MCI) |
| Member Last name |
| Member First name |
| Members Middle initial |
| Member date of birth |
| MCO Name |
| Medical Home Clinic Name |
| Name and credentials of primary care physician, if documented |
| Name and credentials of OB physician / provider, if documented |
| Name and credentials of Care Coordinator, if documented |
| Name and credentials of Certified Nurse Midwife, if documented |
| Name and credentials of other providers, if documented |
| **Enrollment Requirements** |
| The member must be enrolled in the medical home after 1/1/2014 and within the first 16 weeks of pregnancy. The reviewer will calculate the date at 16 weeks by entering the EDC via ultrasound date in the calculator, subtract 24 weeks and enter the result on the review tool. Use the first ultrasound date (usually around 20 weeks) for the calculation. <br><br> http://www.timeanddate.com/date/dateadded.html?m1=11&d1=21&y1=2012&type=sub&ay=&am=&aw=24&ad <br><br> If the EDC is unknown, the staff person who enters the data into the DXC portal will calculate the 16/18 week date using the calculator and the EDC auto-populated in the portal following entry of the last menstrual period date (LMP). |
| Record the date of the member's last menstrual period (LMP), if found in the record. |
| Record the actual delivery date.  If the date of delivery in the medical record does not match the documented in the DHS dataset, staff will conduct additional research in ForwardHealth interChange to determine which date has been verified through data exchanges used in the eligibility systems. |
| Document the date of the first OB provider visit or the first visit with a care coordinator.  This date will serve as the Medical Home enrollment date – The DXC system will automatically determine whether the enrollment by 16/18 weeks requirement is met, using this date and the date at 16/18 weeks referenced above. |

## Prenatal Visits

Members must attend a minimum of 10 appointments with the OB care provider.

Count and record the number of pre-natal visits with an OB health care provider that the member attended after enrolling in medical home prior to delivery. Count pregnancy support group visits, like Centering Pregnancy if specifically documented, toward the 10 prenatal visits.

## Postpartum Visit

Members must remain enrolled and receiving services through the 60 days associated with the postpartum period.

Document the date of the postpartum visit with an OB care provider. Document the reason for any delay or the reason that the visit did not take place at all from information in the medical record. The DXC system will automatically determine whether the postpartum visit date meets the 60 day requirement.

## Verification of Care Plan Requirement

**A care management plan was developed as a result of an initial intake process where all needs are identified.**
The reviewer will read the medical record submissions to identify the needs identified at intake and determine if the care plan addresses those identified needs. Needs may be medical or nonmedical. Care plans are dynamic but evidence should include that the plan was initiated within the first 3 visits in order to record a positive result for this element. Enter a negative result if not all needs appear on the plan and/or if the plan was not initiated within the first three visits. Document a note on the worksheet, if plan is initiated after first 3 visits.

**The OB care provider developed the care management plan in conjunction with the care coordinator, the primary care physician (PCP), and the member.**
Enter a positive result if the care plan is signed by the OB care provider or if it lists the OB care provider as a team member. Evidence that others were involved in the development of the care plan may be by signature or by reference (it may be a listing of participants). It is more likely that someone other than the OB provider, probably the care coordinator, would take the lead on developing the care plan.

**The care management plan includes a self-management/self-care component.**
Self-care/self-management is a core aspect of Centering Pregnancy. Enter a positive result if the medical record contains evidence of this model or other pregnancy support group. Other examples of self-care/self-management include: medical management, role management, and emotional management—and/or any of these six self-management skills--problem solving, decision making, resource utilization, the formation of a patient-provider partnership, action planning, and self-tailoring.

## Verification of Care Coordination Requirements

The care management plan includes information regarding monthly home visits by nurse, social worker or care coordinator.

The required monthly home visit is designed to help the care coordinator establish a personal relationship with the medical home member in a non-medical setting. It is also designed to help ensure a comprehensive assessment of the member's needs, including identification of any psycho-social issues. Home visits should be presented as an opportunity to help the member become an active partner in their care team and should be scheduled at the convenience of the member.

Determine if home visits have been presented to the member by the care coordinator and if the member declines, that the care coordinator offered to meet at a more convenient neutral site, e.g., a library, a local restaurant, or a community center. Pregnancy support groups may be another alternative if the member agrees and has the opportunity to consult personally with the care coordinator. If the member agrees to home visits or visits at an alternate community location, document a positive result. In the event a member refuses to allow the home visit, the refusal and alternatives offered must be documented in the medical record in order for the reviewer to document a positive result for this element.

The care management plan should include an indication of frequency of home visits. Count and record the number of actual home visits. The plan may reference home visits by the medical home care coordinator, the HMO, or by a PNCC provider. Count visits associated with agreements for alternate locations. Do not count postpartum home visits.

**Regular Care Coordination communications between the OB-care provider, the PCP and the member must be documented in medical record.**

Document a positive result if evidence of communication with the PCP as part of the care plan development and as part of the discharge planning, at a minimum is present in the medical record. This communication may happen directly with the OB care provider or through the care coordinator.

Ideally, communication between the OB care provider and the care coordinator should roughly coincide with the prenatal visits.

Care plan updates showing results of prenatal or primary care visits and member contacts may also show evidence of communication.

## Verification of Postpartum Care Coordination and Discharge Planning

**At least one postpartum visit within 60 days post-delivery if the member had a healthy birth outcome.**

In addition to recording the date of the actual postpartum visit as described above, the reviewer will document any information related to the reasons for no postpartum visit, delayed or rescheduled postpartum visits (including the number of these events) and the types of outreach strategies that are used to encourage the member in securing postpartum care.

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| **Poor Birth Outcome**<br>From the available medical records determine if the birth outcomes fit the DHS definitions of a poor birth outcome as follows:<br>Pre term (<37 weeks), low birth weight (< 2500 grams), or infant demise within 28 days. The reviewer should not use postpartum visit information that is "general," i.e. "the baby is healthy and doing well" for determining the outcome OTHER than for infant demise within 28 days. |
| **Communication with the PCP post-delivery if the PCP is other than the OB provider**<br>The reviewer should document a positive result for any evidence of post-delivery communication with the member's PCP, if identified, or if the OB provider is documented as the member's primary care provider. A letter or phone call informing the PCP of delivery meets the requirement. If the member does not have a PCP or if the OB provider is not serving as the PCP, document a negative result for this element. |
| **Member education on inter-conception care specific to the member's needs, family planning preferences, and depression screening.**<br>The reviewer should document a positive result if evidence is present in the medical record for any one or more of the focus areas noted in the requirement above. |
| **Member education regarding breastfeeding and newborn care**<br>The reviewer should document a positive result if evidence is present in the medical record for one or both of the focus areas noted in the requirement above. Pre-birth classes only count if the curriculum is documented for the member and shows evidence that these topics were covered. |
| **Follow-up care for any member with a chronic condition**<br>The reviewer will document the member's chronic conditions on the worksheet using the following definition:  A chronic condition is one that is of ongoing duration, but is actively treated, assessed or monitored.  Do not include conditions that were part of the member's past history unless it an active issue. These chronic conditions are specifically identified in the DHS HMO contract: pulmonary disease, asthma, cardiac disease, hypertension, diabetes. The reviewer will document a positive result if the record includes the chronic conditions were followed-up on. This can include evidence of referrals to specialists, when needed, and if so, whether the woman went to the referral, including any needed changes in the care plan as a result.  The reviewer will document details related to these circumstances on the worksheet. |