External Quality Review

Fiscal Year 2017 – 2018

Healthy Birth Outcomes – Medical Home Enrollees

Calendar Year 2016
Final Report

Prepared for

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Division of Medicaid Services

Prepared by

METASTAR

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External Quality Review Organization

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Introduction and Overview

Purpose of This Report

This report summarizes the results of the evaluation of medical records for pregnant women enrolled in a Medical Home through a managed care organization (MCO) participating in the Wisconsin Department of Health Services (DHS) Obstetric Medical Home (OBMH) initiative. MetaStar, Inc. conducted the review during fiscal year 2016-2017 for births occurring during calendar year 2016 (CY16). This is an optional external quality review activity requested and directed by the DHS.

MetaStar is the external quality review organization (EQRO) contracted and authorized by DHS to conduct independent evaluations of Medicaid MCOs that provide health care services to pregnant women eligible for BadgerCare Plus (BC+) or Supplemental Security Income (SSI) Medicaid in the State of Wisconsin. See the Appendix for more information about external quality review, the EQRO team, and a description of the methodology used to conduct the review activity.

Review Methodology

MetaStar's review is conducted using criteria and reviewer guidelines agreed upon with DHS, and based on the "Contract for BadgerCare Plus and/or Medicaid SSI HMO Services." Requirements for MCOs and clinics are found in the DHS-MCO contracts dated January 1, 2014 – December 31, 2015 and January 1, 2016 – December 31, 2017. The MCOs and clinics were subject to the requirements in each contract depending on the time of the member's enrollment in the OBMH initiative and timeframe associated with her prenatal and postpartum care. Some minor changes to the review methodology were implemented during this reporting period and are specified in the results sections of the report, if applicable. Information from the data abstraction process is documented in a system implemented and maintained by DHS Medicaid Information System vendor DXC Technology (DXC), formerly Hewlett Packard Enterprise Services. MetaStar reviewed 1,135 enrollee records for this Health Home. The purpose of the review was:

- To assess the MCO's and clinics' levels of compliance with requirements contained in the MCO's contract with DHS;
- To verify enrollment into the OBMH within the required timeframe; and
- To evaluate the compliance with enrollment eligibility, coordination of care, comprehensiveness of care and designation of an obstetric (OB) team lead.

Medical Home Profile

The Medical Home model is part of DHS' Healthy Birth Outcomes (HBO) initiative, focused on eliminating racial and ethnic disparities in birth outcomes and infant mortality for pregnant women eligible for BC+ or SSI Medicaid. Information about the initiative can be found on these DHS websites:

- http://www.dhs.wisconsin.gov/healthybirths/
- https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Managed_Care_Medical_Homes/Home.htm.spage

During the time period associated with prenatal care for members who delivered infants in CY16, 12 MCOs contracted with clinics and established memoranda of agreements to implement OBMH in Dane, Rock, Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties. Not all MCOs established agreements with all clinics in their networks that provide prenatal care to its enrollees.

The MCOs and their respective service areas are documented in Table 1 below.

Table 1: MCOs and Service Areas

Service Area	Managed Care Organization
Dane County	Dean Health Plan (DHP)
	Group Health Cooperative of South Central Wisconsin (GHC-SCW)
	Physicians Plus Insurance Corporation (PPIC)
	Unity Health Plan (Unity)
Rock County	DHP
	MercyCare Health Plan (MCHP)
	MHS Health Wisconsin (MHS)
	United Healthcare of Wisconsin (UHC)
Southwestern WI – Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties	Anthem Blue Cross and Blue Shield (Anthem)
	Children's Community Health Plan (CCHP)
	Independent Care Health Plan (iCare)
	MHS
	Molina Healthcare of Wisconsin (MHWI)
	Trilogy Health Insurance (Trilogy)
	UHC

The most recent MCO enrollment data available at the time of the review and ongoing is posted to the following DHS website:

https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Enrollment_Information/Reports.htm.spage

CONTRACT REQUIREMENTS

DHS states in its contract with MCOs that the OBMH for high-risk pregnant women is a care delivery model that is patient-centered, comprehensive, team-based, coordinated, accessible and focused on quality. The OB 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 health, behavioral health, and psychosocial needs.

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

- Having a designated 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
- Coordinating care across a person's conditions, providers, and settings.

The specific contractual requirements for each element are outlined in the following results section.

RESULTS

This section describes the dataset for this report, the requirements verified, and the results of key review elements included for data abstraction as directed by DHS. In some instances, results are reported in two sections, one section of aggregated data for each MCO and in the second section, aggregated data for each clinic.

DATASET AND RECORD SUBMISSION SUMMARY

DHS delegated responsibility for dataset creation and MCO communications for medical record submissions to MetaStar. Following confirmation of the members in each dataset, DHS and/or MetaStar requested medical records for each member. The total number of women in the dataset for the report period was 1,135. The number of members served by each MCO and their service areas are depicted in Table 2 below

Table 2: Medical Home and MCO Enrollment – Records Reviewed

MCO	Service Area	Number of Members in Dataset
Anthem	SE WI	154
CCHP	SE WI	377
DHP	Dane/Rock Counties	263
GHC-SCW	Dane County	12
*i*Care	SE WI	13
MCHP	Rock County	40
MHS	Rock County/SE WI	18
MHWI	SE WI	155
PPIC	Dane County	16
Trilogy	SE WI	13
UHC	Rock County/SE WI	48
Unity	Dane County	26
Total Records		**1,135**

The following table identifies the number of records reviewed for each OBMH clinic and the clinic's MCO affiliations for the records reviewed.

Table 3: OBMH Clinics, Service Area, and MCO Affiliation – Records Reviewed

Clinic	MCO	Total Records
Access Community Health Centers Dane County	PPIC	16
	Unity	26
All Saints and All Saints Family Care Center* SE WI	Anthem	11
	CCHP	14
	MHS	2
	MHWI	18
	UHC	8
Aurora Midwifery & Wellness Center SE WI	Anthem	9
	CCHP	40
	MHWI	17
Beloit Clinic Rock County	MHS	1
	UHC	1
Columbia St. Mary's Family Health Center SE WI	Anthem	22
	CCHP	42
	*i*Care	6
	MHS	6
	MHWI	25
Dean Clinics Dane and Rock Counties	DHP	263
Froedtert East OB/GYN Residency Clinic SE WI	Anthem	31
	CCHP	87
GHC-SCW Clinics Dane County	GHC-SCW	12
Life Time OB/GYN* SE WI	Anthem	17
	CCHP	46
	MHWI	5
	Trilogy	2
	UHC	23

Lisbon Avenue Health Center SE WI	Anthem	14
	CCHP	34
	iCare	6
	MHWI	23
	Trilogy	1
	UHC	3
Mercy Health Systems Clinics Rock County	MHCP	40
Milwaukee Health Systems SE WI	Anthem	1
	CCHP	3
	iCare	1
	MHWI	3
Sixteenth Street Community Health Center SE WI	Anthem	8
	CCHP	30
	MHWI	16
	Trilogy	1
	UHC	4
St. Joseph's Hospital Women's Health Center SE WI	Anthem	15
	CCHP	32
	MHS	7
	MHWI	21
	Trilogy	7
	UHC	9
Waukesha Family Medicine Center SE WI	Anthem	14
	CCHP	15
	MHWI	9
Wheaton Franciscan Glendale Family Care Center SE WI	Anthem	12
	CCHP	34
	MHS	2
	MHWI	18
	Trilogy	2
Total Records		**1,135**

***Notes:** The LifeTime OB/GYN Medical Home has two clinic sites; however, insufficient information was present in the medical records to accurately identify the location, so the results for these members are combined. All Saints also operates two clinic sites (All Saints and All Saints Family Care Center); however, insufficient information was present in the medical records to accurately identify the location, so the results for these members are also combined.

The DHS information system used to house data for OBMH, maintained by DXC, includes documentation of whether a full or partial medical record was submitted for review. The medical record is considered complete when clinic, care coordination, and hospital or other records documenting the infant delivery are submitted to MetaStar, or are accessible to reviewers through an electronic medical record (EMR).

Table 4 documents the number of complete and incomplete medical record submissions by clinic, and notes the overall rate of complete submissions.

Table 4: Complete Medical Records Submissions

Medical Home Clinic	Total Number of Records	Complete	Incomplete	Rate Complete
Access Community Health Centers	42	38	4	**90.5%**
All Saints	53	48	5	**90.6%**
Aurora Midwifery & Wellness Center	66	58	8	**87.9%**
Beloit Clinic	2	2	0	**100.0%**
Columbia St. Mary's Family Health Center*	101	69	32	**68.3%**
Dean Clinics*	263	247	16	**93.9%**
Froedtert East OB/GYN Residency Clinic	118	111	7	**94.1%**
GHC-SCW Clinics	12	11	1	**91.7%**
Life Time OB/GYN *	93	50	43	**53.8%**
Lisbon Avenue Health Center	81	15	66	**18.5%**
Mercy Health Systems Clinics	40	23	17	**57.5%**
Milwaukee Health Systems	8	4	4	**50.0%**
Sixteenth Street Community Health Center	59	45	14	**76.3%**
St. Joseph's Hospital Women's Health Center	91	64	27	**70.3%**
Waukesha Family Medicine Center	38	15	23	**39.5%**
Wheaton Franciscan Glendale Family Care Center*	68	8	60	**11.8%**
Total	**1,135**	**808**	**327**	**71.2%**

* Indicates EMR

After confirmation of the dataset, the MCOs worked with the clinics to submit or provide access to the complete medical records. Overall, 28.8 percent of records were incomplete during CY16.

Table 5 documents the rates of complete medical record submissions for clinics that appeared in both the 2015 and 2016 datasets. Some clinics have improved the rate of submissions of complete records, while others have declined.

Table 5: Comparison of Complete Medical Record Submissions 2015 and 2016

Medical Home Clinic	Rate of Complete Records 2015	Rate of Complete Records 2016
Access Community Health Centers	71.4%	90.5%
All Saints	20.9%	90.6%
Aurora Midwifery & Wellness Center	50.0%	87.9%
Beloit Clinic	41.7%	100.0%
Columbia St. Mary's Family Health Center*	54.7%	68.3%
Dean Clinics*	94.8%	93.9%
Froedtert East OB/GYN Residency Clinic	77.2%	94.1%
GHC-SCW Clinics	33.3%	91.7%
Life Time OB/GYN *	69.0%	53.8%
Lisbon Avenue Health Center	27.1%	18.5%
Mercy Health Systems Clinics	66.7%	57.5%
Milwaukee Health Systems	0.0%	50.0%
Sixteenth Street Community Health Center	66.7%	76.3%
St. Joseph's Hospital Women's Health Center	40.3%	70.3%
Waukesha Family Medicine Center	57.1%	39.5%
Wheaton Franciscan Glendale Family Care Center*	13.8%	11.8%
Total	**61.7%**	**71.2%**

* Indicates EMR.

SECTION 1 - REVIEW FINDINGS BY MCO

VERIFICATION OF ENROLLMENT REQUIREMENTS

The DHS-MCO contract outlines that:

- Women enrolled on or after January 1, 2014, must make the first medical home visit within the first 16 weeks of pregnancy;
- Members must attend a minimum of 10 appointments with the OB care provider; and
- Members must remain enrolled and receiving services through the 60 days associated with the postpartum period.

The review findings for the above requirements are documented in Tables 6A, 6B, and 6C.

Table 6A reports by MCO, the number of records reviewed, and the number of records that met the criteria that enrollees make an initial OBMH visit within the first 16 weeks of pregnancy. The rate at which all MCOs met the criteria is also shown. In addition, the table notes the number and percent of records where MetaStar was unable to verify the criteria due to missing information, or incomplete record submissions.

Table 6A: First Medical Home Visit and Enrollment within First 16 Weeks

MCO/Number of Records	Met	Not Met	Unknown	Rate Met Requirement
Anthem/154	134	13	7	**87.0%**
CCHP/377	351	25	1	**93.1%**
DHP/263	239	24	0	**90.9%**
GHC-SCW/12	11	1	0	**91.7%**
*i*Care/13	13	0	0	**100%**
MCHP/40	38	2	0	**95.0%**
MHS/18	14	4	0	**77.8%**
MHWI/155	135	18	2	**87.1%**
PPIC/16	16	0	0	**100%**
Trilogy/13	12	1	0	**92.3%**
UHC/48	44	4	0	**91.7%**
Unity/26	22	4	0	**84.6%**
Total/1,135	**1,029**	**96**	**10**	
Total Rate	**90.7%**	**8.5%**	**0.9%**	

Overall results for enrollees with the initial OBMH visit within the first 16 weeks of pregnancy reflect a decline to 90.7 percent in CY 16 from the CY15 rate of 93.5 percent. Individual MCO results varied in CY16 from CY15.

Table 6B identifies, for each MCO, the number of records reviewed, the number of records that documented the members had attended 10 or more appointments with an OB provider, and the number of records that did not meet the requirements. The rate at which MCOs met this requirement in CY16 was 81.1 percent; this changed only slightly from the CY15 compliance rate of 81.4 percent.

Table 6B: 10 Appointments or More with OB Provider

MCO/Number of Records	Met	Not Met	Unknown	Rate Met Requirement
Anthem/154	128	21	5	**83.1%**
CCHP/377	310	67	0	**82.2%**
DHP/263	223	40	0	**84.8%**
GHC-SCW/12	9	3	0	**75.0%**
*i*Care/13	10	3	0	**76.9%**
MCHP/40	32	8	0	**80.0%**
MHS/18	15	3	0	**93.8%**
MHWI/155	111	44	0	**71.6%**
PPIC/16	15	1	0	**93.8%**
Trilogy/13	8	5	0	**61.5%**
UHC/48	39	9	0	**81.3%**
Unity/26	21	5	0	**80.8%**
Total/1,135	921	209	5	
Total Rate	**81.1%**	**18.4%**	**0.4%**	

Table 6C documents the number of records that met the requirement for enrollment through the postpartum period (60 days). This indicator includes women who had a postpartum visit (even beyond 60 days postpartum), did not attend scheduled appointments, or did not schedule an appointment despite encouragement from clinic staff. The overall compliance rate for postpartum enrollment increased to 87.6 percent in CY16 from 85.6 percent in CY15.

Table 6C: Enrolled Through 60 Days Postpartum

MCO/Number of Records	Met	Not Met	Unknown	Rate Met Requirement
Anthem/154	132	21	1	**85.7%**
CCHP/377	325	52	0	**86.2%**
DHP/263	249	14	0	**94.7%**
GHC-SCW/12	12	0	0	**100%**
*i*Care/13	11	2	0	**84.6%**
MCHP/40	33	7	0	**82.5%**
MHS/18	16	2	0	**88.9%**
MHWI/155	130	25	0	**83.9%**
PPIC/16	11	4	1	**68.75%**

MCO/Number of Records	Met	Not Met	Unknown	Rate Met Requirement
Trilogy/13	8	5	0	**61.5%**
UHC/48	44	3	1	**91.7%**
Unity/26	23	3	0	**88.5%**
Total/1,135	**994**	**138**	**3**	
Total Rate	**87.6%**	**12.2%**	**0.3%**	

Verification of Care Coordination Requirements

The DHS-MCO contract also describes the following requirements related to documentation of care coordination:

- A care management plan developed as a result of an initial intake process where all needs are identified;
- The OB care provider developed the care management plan in conjunction with the care coordinator, the primary care provider (PCP), and the member;
- A care management plan that includes a self-management/self-care component;
- A care management plan that includes information regarding monthly home visits by nurse/social worker/care coordinator; and
- Regular care coordination communications took place between the OB care provider, the PCP, and the care coordinator.

The review results for these requirements are documented in Tables 7A and 7B.

Table 7A shows, for each MCO, the number of records that included a care management plan; the number of records in which the care management plan documented all of a member's needs identified during the intake process; the number of records that reflected participation of the member, care coordinator, and PCP in the development of the care management plan; and the number of records that included a self-care component.

The table also includes the number of records that demonstrated compliance for regular communication between the member, care coordinator, and medical providers. Overall, CY16, rates remain in the 90th percentile for several of the elements in this category when compared to CY15 data. Overall results for collaborative care plan development increased in CY16 to 18.3 percent, compared to the CY15 rate of 13.1 percent.

Table 7A: Care Plan

MCO/Number of Records	Care Management Plan	Intake Items Included in Plan	Collaborative Care Plan Development	Plan Includes Self-Management/ Self-Care	Communications Between Providers and Members
Anthem/154	136	134	35	142	32
CCHP/377	356	350	61	358	64
DHP/263	259	257	20	256	19
GHC-SCW/12	12	12	3	12	3
*i*Care/13	11	11	9	12	9
MCHP/40	39	39	6	39	8
MHS/18	18	18	6	18	6
MHWI/155	139	134	39	145	42
PPIC/16	16	15	9	15	7
Trilogy/13	12	12	0	12	0
UHC/48	44	43	3	45	3
Unity/26	26	26	17	26	18
Total/1,135	**1,068**	**1,051**	**208**	**1,080**	**211**
Total Rate	**94.1%**	**92.6%**	**18.3%**	**95.2%**	**18.6%**

Contracted clinics developed care plans that included nearly all identified needs using an effective intake process, as demonstrated by the high rates of compliance for inclusion of intake items and self-management/self-care. Some clinics did not meet the requirements for development of the care plan, because the medical record submission for the member was incomplete. Similarly, incomplete details in documentation reduced the rate at which clinics succeeded at including intake items on the plans.

Collaboration with the PCP was seldom identified during the medical record reviews. Nearly one-half of the records (43.7 percent) did not include documentation of an assigned PCP. When collaboration was noted, the reason noted in more than half of the occurrences was that the OB care was being provided by the PCP. This was documented for 127 of the 208 (61.1 percent) positive results for this review element.

Care teams engaged women in a variety of self-management activities with high rates of compliance for this review element. Incomplete documentation (e.g. lack of details in a record or gaps in documentation) remained the primary reason for clinics not meeting this requirement at 100 percent.

Communication between providers on the members' OBMH teams continued to be limited. Again, rates were impacted because many records did not include documentation of the assigned PCP in the record, or incomplete medical records limited access to potential documentation of communication efforts. However, some improvement was identified; the CY16 rate increased to

18.6 percent from the CY15 rate of 13.9 percent. The rate was nearly the same for communication between providers and members (18.6 percent), as the collaboration between providers in developing a care plan (18.3 percent), and reflected the lack of documentation of an assigned PCP.

Table 7B shows, for each MCO, the number of records that documented members received or were offered (but declined) home visits. DHS changed its directions for the MetaStar reviewer guidelines beginning with the review dataset that included members with postpartum visits (PPVs) scheduled July 1, 2016 and after. For members with PPVs scheduled prior to July 1, 2016, MetaStar reviewers looked for documentation of offers of visits in alternate community locations when a member refused a home visit. For members with PPVs July 1, 2016 and after, DHS directed MetaStar to note only whether a home visit was offered to the member at some time during her prenatal care. Because of the difference in requirements, the results below are separated January 1, 2016 through June 30, 2016 and July 1, 2016 through the end of the year. When the PPV date was unknown, members with delivery dates May 1, 2016 and after were assigned to the group with documented PPV visits July 1, 2016 and after.

Table 7B: Care Coordination – Home Visits

MCO/Number of Records	Monthly Home Visits (PPV 1/1/16 – 6/30/16; 443 records)	Monthly Home Visits (PPV 7/1/16- and after; 692 records)
Anthem/154	3	45
CCHP/377	18	109
DHP/263	38	137
GHC-SCW/12	1	6
*i*Care/13	1	6
MCHP/40	8	15
MHS/18	2	6
MHWI/155	10	39
PPIC/16	0	9
Trilogy/13	0	1
UHC/48	5	13
Unity/26	9	15
Total/1,135	**95**	**401**
Total Rate	**21.4%**	**57.9%**

MCO compliance with offers of home visits or visits in locations outside the clinic varied. (See Section 2 for clinic-specific results.) Compliance overall increased following the change in reviewer guidelines, which may be due to elimination of the alternate location requirement. Of the 398 records with PPV dates prior to July 1, 2016, 180 (45.2 percent) did not offer an alternate location.

The home visit compliance rate was also influenced by lack of details in medical records about home visits, or missing portions of medical records where the information may have been documented. The lack of medical record information for this review element may be related to the fact that some MCOs/clinics contract with external prenatal care coordination (PNCC) agencies, and those agencies did not share documentation with the clinics or the MCOs for the purpose of this review. Of the 639 records that did not meet the home visit element, 598 (93.6 percent) were due to incomplete documentation.

Only 140 of the 496 members who accepted a home visit or visit in an alternate location (if applicable) had documentation in their records that at least one home visit occurred (28.2 percent), with 93 members (66.4 percent) who received five or more home or alternate location visits.

Verification of Postpartum Care Coordination and Discharge Planning

The DHS-MCO contract includes the following requirements related to documentation of discharge planning and postpartum care. DHS asked MetaStar to evaluate records to determine whether members received satisfactory care as defined by the OBMH Care Guide, which includes:

- At least one postpartum visit within 60 days post-delivery if the member had a healthy birth outcome;
- Communication with the PCP post-delivery if the PCP is other than the OB provider;
- Member education on inter-conception care specific to the member's needs related to family planning preferences;
- Depression screening;
- Member education regarding breastfeeding;
- Member education regarding newborn care; and
- Follow-up care for any member with a chronic condition.

DHS requested MetaStar collect data about the timing of the depression screening and education offered to members beginning with the review dataset that included mothers who had scheduled PPVs July 1, 2016 and after.

Tables 8A, 8B, 8C, 8D, 8E, and 8F document the results of the record review for most of the requirements noted above.

Table 8A shows the rates for this postpartum review element, which specifically looks for an actual PPV date within the required 60-day timeframe, and does not reflect missed appointments or efforts to support members in making appointments.

The PPV rate for CY16 was 67.7 percent, down slightly from 68.3 percent in CY15. The table also shows the number of records where communication with the member's PCP took place after delivery.

Table 8A: Post-Delivery Requirements

MCO/Number of Records	At Least One PPV	Communication with PCP
Anthem/154	108	33
CCHP/377	257	74
DHP/263	187	55
GHC-SCW/12	11	4
*i*Care/13	11	9
MCHP/40	10	6
MHS/18	31	6
MHWI/155	92	44
PPIC/16	13	12
Trilogy/13	4	0
UHC/48	25	3
Unity/26	20	20
Total/1,135	**769**	**266**
Total Rate	**67.7%**	**23.4%**

Similar to the other requirements related to communication with PCPs, the rate for communication with PCP after delivery was low, although slightly higher than communication during the prenatal care period. However, the postpartum communication with the PCP increased to 67.7 percent in CY16 from 17.3 percent in CY15. Some clinics that use an EMR system may rely on internal messaging systems not accessible to MetaStar reviewers, thus contributing to low rates. In 43.7 percent of the member records, a PCP was not documented. This is a decrease from CY15 when 48.9 percent of member records included documentation of the member's PCP.

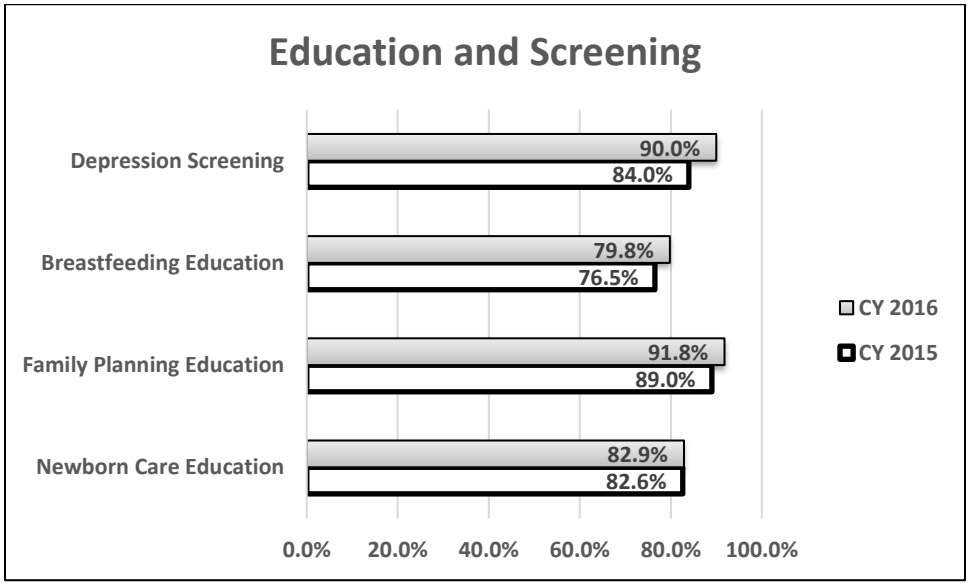
Table 8B identifies the number of records that contained evidence of depression screening and other education related to pregnancy.

Table 8B: Education and Screening

MCO/Number of Records	Depression Screening	Breastfeeding Education	Family Planning Education	Newborn Care Education
Anthem/154	128	113	140	124
CCHP/377	355	288	351	303
DHP/263	238	243	251	259
GHC-SCW/12	11	7	11	6
*i*Care/13	12	11	13	12
MCHP/40	37	35	39	28
MHS/18	18	17	18	17
MHWI/155	132	113	134	115

MCO/Number of Records	Depression Screening	Breastfeeding Education	Family Planning Education	Newborn Care Education
PPIC/16	14	15	16	13
Trilogy/13	11	9	9	10
UHC/48	39	30	35	30
Unity/26	26	25	25	24
Total/1,135	**1021**	**906**	**1042**	**941**
Total Rate	**90.0%**	**79.8%**	**91.8%**	**82.9%**

Record review found MCO members consistently receive information about key topics associated with postpartum care. MetaStar reviewers noted that education takes place periodically throughout the prenatal period, including encouraging members to attend classes offered by clinics and other public agencies. The rate for breastfeeding education may be lower than the other rates for educational topics, because when members expressed a preference for bottle-feeding based on previous experience, care providers did not always offer education about the benefits of breastfeeding to these members. The rate for depression screening was influenced by the fact that some clinics routinely screen for depression during the prenatal period as well as during postpartum care, and therefore were in compliance. Rates of compliance for CY16 are higher for all educational elements than CY15.



For the 692 members who had PPVs scheduled July 1, 2016 or after, MetaStar reviewers identified when the education or screening services were provided. Table 8C identifies the number of members who received education or screening, the type received, and when during the pregnancy it occurred. The total records that included education or screening are greater than the

total member records reviewed because members received education or screening for more than one topic.

Table 8C: Postpartum Education and Screening Timing

Education or Screening Type	Prenatal	Postpartum	Prenatal and Postpartum
Depression Screening	147	91	404
Breastfeeding Education	231	32	302
Family Planning Education	105	140	393
Newborn Care Education	241	29	315
Total	**724**	**292**	**1,414**
Rate	**29.8%**	**12.0%**	**58.2%**

The rates included in the table above indicate the percentage of education or screening that occurred during the prenatal period, postpartum period, or both. The majority (58.2 percent) of screening and education was provided in both the prenatal and postpartum care periods

Table 8D identifies each type of education and screening, the total number of records with PPVs July 1, 2016 and after that met the requirement for each type, and the percentage of education or screening that occurred prenatal, postpartum, or both. The majority of education/screening was provided in both the prenatal and postpartum care periods.

Table 8D: Education and Screening Timing (692 members)

Education or Screening Type	Met Requirement	Prenatal	Postpartum	Prenatal and Postpartum
Depression Screening	642	22.9%	14.2%	62.9%
Breastfeeding Education	565	40.9%	5.7%	53.5%
Family Planning Education	638	16.5%	21.9%	61.6%
Newborn Care Education	585	41.2%	5.0%	53.8%

The following chronic conditions continued as a focus in the OBMH for this reporting period: asthma, cardiac disease, diabetes mellitus, HIV/AIDS, hypertension, pulmonary disease, and behavioral/mental health. Morbid obesity was added as an additional chronic condition with the DHS-MCO contract for 2016-2017 and MetaStar reviewers evaluated for the condition with reviews beginning with the dataset that included members with PPVs scheduled July 1, 2016 and after (692 of the 1,135 members).

Table 8E reports results for the 443 members with a postpartum visit scheduled January 1, 2016 through June 30, 2016. The table identifies the number of members who received follow-up related to their chronic conditions, the number who did not receive follow-up, and members who did not have a chronic condition requiring follow-up identified during the review.

Table 8E: Post-Delivery Requirements – Follow-up on Chronic Conditions PPV January 1, 2016 – June 30, 2016 (443 members)

MCO	Total Records	Met	Not Met	Did not have a Chronic Condition
Anthem	55	15	4	36
CCHP	147	42	12	93
DHP	112	51	8	53
GHC-SCW	6	1	0	5
*i*Care	2	0	0	2
MCHP	8	4	0	4
MHS	4	0	0	4
MHWI	68	22	13	33
PPIC	7	5	0	2
Trilogy	8	3	0	5
UHC	20	8	5	7
Unity	6	2	0	4
Total	**443**	**153**	**42**	**248**
Total Rate (N=195)		**78.5%**	**21.5%**	**56.0%**

Note: The rates for "met" and "not met" were calculated excluding the members who did not have a chronic condition. The rate for those without chronic conditions was calculated using the total dataset.

As documented in the table above, 56.0 percent of members (248 members) did not have a chronic condition. For 40 of the 42 records that did not meet the requirement for follow-up (95.2 percent), MetaStar reviewers were unable to determine whether the member received follow-up for a chronic condition due to incomplete documentation. Ten of the 42 records scored "not met" were because reviewers were unable to determine if the member had a chronic condition.

Of the 195 members with chronic conditions, 91 had a behavioral/mental health condition, 64 had asthma, seven were diagnosed with morbid obesity or obesity, 20 had hypertension, seven had diabetes, one had a pulmonary disease diagnosis, and one presented with aortic stenosis.

Table 8F reports results for the 692 members with a postpartum visit scheduled July 1, 2016 and after. The table identifies the number of members who received follow-up related to their chronic conditions, and the number who did not receive follow-up, or who were not identified as subject for this review criterion.

Table 8F: Post-Delivery Requirements – Follow-up on Chronic Conditions PPV July 1, 2016 and After (692 members)

MCO	Total Records	Met	Not Met	Did Not Have a Chronic Condition
Anthem	98	55	2	41
CCHP	230	123	13	94
DHP	150	88	4	58
GHC-SCW	6	2	2	2
*i*Care	11	8	0	3
MCHP	32	24	3	5
MHS	14	9	1	4
MHWI	88	58	7	23
PPIC	9	5	0	4
Trilogy	5	2	0	3
UHC	29	20	1	8
Unity	20	18	0	2
Total	**692**	**412**	**33**	**247**
Total Rate (N=445)		**92.6%**	**7.4%**	**35.7%**

Note: The rates for "met" and "not met" were calculated excluding the members who did not have a chronic condition. The rate for those without chronic conditions was calculated using the total dataset.

As documented in the table above, 35.7 percent of the members (247 members) did not have an identified chronic condition. For all 33 records that did not meet the follow-up requirement (100 percent), MetaStar reviewers were unable to determine whether the member received follow-up for a chronic condition due to incomplete documentation. Two of the 33 records scored "not met" were because reviewers were unable to determine if the member had a chronic condition.

Of the 445 members with chronic conditions, 135 had a behavioral/mental health condition, 121 had asthma, 109 were diagnosed with morbid obesity or obesity, 45 had hypertension, 18 had diabetes, 17 had an anemia diagnosis, and two presented with lupus.

Of the 640 women in both reporting groups who had a chronic condition, 263 (41.9 percent) were found to have more than one chronic condition. Changes in the review criteria between the two reporting periods were identified. The compliance rate for the first reporting period (PPV January 1, 2016-June 30, 2016) increased to 78.5 percent and the rate increased to 92.6 percent in the second reporting period (PPV July 1, 2016 and after) from 56.9 percent.in CY15 Morbid obesity/obesity was added to the list of chronic conditions in the second reporting period. The possible reasons for the rate increases were not examined in the preparation of this report.

Some additional, but not all-inclusive, examples of chronic conditions diagnosed in members included: hypothyroidism, hyperthyroidism, gastroesophageal reflux disease (GERD), Sjojen syndrome, celiac disease, chronic obstructive pulmonary disease, and Crohn's disease.

Identification of Birth Outcomes

The DHS-MCO contract provides information about payments related to the OBMH initiative and indicates DHS will define poor birth outcomes. DHS defines poor birth outcomes as follows:

- A birth that took place prior to 37 weeks gestation, or "pre-term birth;"
- A baby that weighed less than 2500 grams at the time of birth, or "low birth weight;"
- A stillborn baby delivered after 20 weeks; and
- An infant death within 28 days of birth, or "neonatal death."

Insufficient information was available in the medical records to determine the birth outcomes for 141 members. In these instances, DHS directed MetaStar to review MCO self-declared information in the DHS registry to determine whether the woman experienced a poor birth outcome. MetaStar reviewers did not find sufficient information in the registry for 10 of the 141 women. The absence of birth outcome information in the registry was most frequently noted as due to member disengagement, relocation, or other similar issues. Of the 141 members without documentation of the outcome in the medical record, 16 were identified with poor birth outcomes by the clinics in the registry. MetaStar identified 140 poor birth outcomes in the medical records for the remaining members in this reporting group, for a total rate of 13.9 percent (156 of 1125 women, with available outcome information).

Table 9A below identifies the rates of healthy birth outcomes and poor birth outcomes verified in medical records and documented in the registry, as defined by DHS for this initiative.

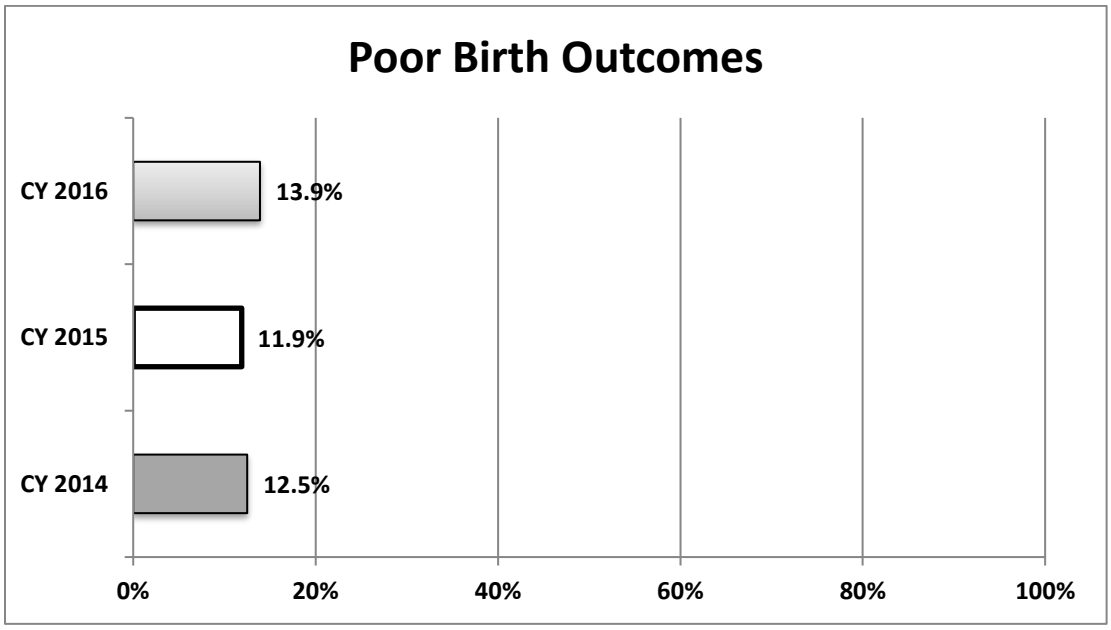
Table 9A: Birth Outcomes

MCO/Number of records	Healthy Birth Outcome	Poor Birth Outcome	Unknown	Registry = Healthy Birth Outcome	Registry = Poor Birth Outcome	Registry = Unknown
Anthem/154	110	23*	21	19	1	1
CCHP/377	276	43*	58	45	8	5
DHP/263	232	27	4	3	0	1
GHC-SCW/12	7	4	1	1	0	0
*i*Care/13	10	2	1	1	0	0
MCHP/40	28	5*	7	6	1	0
MHS/18	9	4	5	4	1	0
MHWI/155	111	17*	27	22	4	1
PPIC/16	14	2	0	N/A	N/A	N/A
Trilogy/13	4	1	8	8	0	0

MCO/Number of records	Healthy Birth Outcome	Poor Birth Outcome	Unknown	Registry = Healthy Birth Outcome	Registry = Poor Birth Outcome	Registry = Unknown
UHC/48	30	9	9	6	1	2
Unity/26	23	3	0	N/A	N/A	N/A
Total/1,135	**854**	**140**	**141**	**115**	**16**	**10**
Overall Rate (N=1,125)	**86.1%**	**13.9%**				

Notes: The overall rate of healthy and poor birth outcomes was calculated using unverified registry results and excludes the unknown results from the denominator. *Includes seven sets of twins delivered by mothers affiliated with these MCOs; 11 of the 14 infants had poor birth outcomes which are included in table 9B below.

The poor birth outcome rate increased in CY16 (13.9 percent) compared to the CY15 rate of 11.9 percent, and is greater than both the CY14 (12.5 percent) and CY13 (13 percent) rates.



The reasons associated with the poor birth outcomes in CY16 compared to CY15 are documented in Table 9B below.

Table 9B: Reasons for Poor Birth Outcomes

Poor Birth Outcome Reason	All Infants 2016*	All Infants 2015
Pre-term birth	30	30
Pre-term and death	0	2
Low birth weight	38	29
Pre-term birth and low birth weight	85	59
Pre-term birth, low birth weight and death	1	3
Stillborn	6	1

Poor Birth Outcome Reason	All Infants 2016*	All Infants 2015
Neonatal death	1	0
Total Poor Birth Outcomes	**161**	**124**

*Includes seven sets of twins; 11 of the 14 infants had poor birth outcomes.

SECTION 2 - REVIEW FINDINGS BY CLINIC

VERIFICATION OF ENROLLMENT REQUIREMENTS

The DHS-MCO contract requires that:

- Women enrolled on or after January 1, 2014, must make the first medical home visit within the first 16 weeks of pregnancy;
- Members must attend a minimum of 10 appointments with the OB care provider; and
- Members must remain enrolled and receiving services through the 60 days associated with the postpartum period.

The review findings for the above requirements are documented in Tables 10A, 10B and 10C.

Table 10A reports by clinic, the number of records reviewed, and the number of records that met the criteria that enrollees make an initial OBMH visit within the first 16 weeks of pregnancy. The rate at which all clinics met the criteria is also shown. In addition, the table notes the number and percent of records where MetaStar was unable to verify the criteria due to missing information, or incomplete record submissions.

Table 10A: First Medical Home Visit and Enrollment within First 16 Weeks

Clinic/Number of Records	Met	Not Met	Unknown	Rate Met Requirement
Access Community Health Centers/42	38	4	0	**90.5%**
All Saints/53	53	0	0	**100%**
Aurora Midwifery & Wellness Center/66	64	2	0	**97.0%**
Beloit Clinic/2	2	0	0	**100%**
Columbia St. Mary's Family Health Center/101	100	1	0	**99.0%**
Dean Clinics/263	239	24	0	**90.9%**
Froedtert East OB/GYN Residency Clinic/118	115	3	0	**97.5%**
GHC-SCW Clinics/12	11	1	0	**91.7%**
Life Time OB/GYN/93	87	6	0	**93.5%**
Lisbon Avenue Health Center/81	57	24	0	**70.4%**
Mercy Health Systems Clinics/40	38	2	0	**95.0%**
Milwaukee Health Systems/8	5	0	3	**62.5%**
Sixteenth Street Community Health Center/59	56	3	0	**94.9%**
St. Joseph's Hospital Women's Health Center/91	70	14	7	**76.9%**
Waukesha Family Medicine Center/38	36	2	0	**94.7%**
Wheaton Franciscan Glendale Family Care Center/68	58	10	0	**85.3%**
Total/1,135	**1,029**	**96**	**10**	
Total Rate	**90.7%**	**8.5%**	**0.9%**	

Overall results for enrollees with the initial OBMH visit within the first 16 weeks of pregnancy reflect a decline to 90.7 percent in CY16 from the CY15 rate of 93.5 percent. The individual clinics year-to-year rate of compliance varied between CY16 and CY15. Of the 16 clinics that were included in both calendar years, 62.5 percent showed a decrease in CY16 from CY15. All Saints showed the greatest decline to 80.3 percent in CY16 from 92.9 percent in CY15. When reviewing and comparing results, the reader should take into account the number of records reviewed may vary year-to-year with some clinics having less than 10 records reviewed.

Table 10B identifies, for each clinic, the number of records reviewed, the number of records that documented the members had attended 10 or more appointments with an OB provider, and the number of records that did not meet the requirements.

Table 10B: 10 Appointments or More with OB Provider

Clinic/Number of Records	Met	Not Met	Unknown	Rate Met Requirement
Access Community Health Centers/42	36	6	0	**85.7%**
All Saints/53	48	5	0	**90.6%**
Aurora Midwifery & Wellness Center/66	55	11	0	**83.3%**
Beloit Clinic/2	2	0	0	**100%**
Columbia St. Mary's Family Health Center/101	90	11	0	**89.1%**
Dean Clinics/263	223	40	0	**84.8%**
Froedtert East OB/GYN Residency Clinic/118	113	5	0	**95.8%**
GHC-SCW Clinics/12	9	3	0	**75.0%**
Life Time OB/GYN/93	77	16	0	**82.8%**
Lisbon Avenue Health Center/81	53	28	0	**65.4%**
Mercy Health Systems Clinics/40	32	8	0	**80.0%**
Milwaukee Health Systems/8	4	4	0	**50.0%**
Sixteenth Street Community Health Center/59	46	13	0	**78.0%**
St. Joseph's Hospital Women's Health Center/91	63	23	5	**69.2%**
Waukesha Family Medicine Center/38	33	5	0	**86.8%**
Wheaton Franciscan Glendale Family Care Center/68	37	31	0	**54.4%**
Total/1,135	**921**	**209**	**5**	
Total Rate	**81.1%**	**18.4%**	**0.4%**	

Results showed similar improvement and decrease in CY16 from CY15. However, the overall rate of compliance was nearly the same; the CY16 rate was 81.1 percent while the CY15 rate was 81.4 percent. GHC-SCW had the greatest decrease to 75 percent met in CY16 from 100 percent in CY15. Milwaukee Health Systems showed the largest increase to 50 percent met in CY16 from zero percent in CY15. When reviewing and comparing results, the reader should take into account the number of records reviewed may vary year-to-year with some clinics having less than 10 records reviewed.

Table 10C documents the number of records that met the requirement for enrollment through the postpartum period (60 days). This indicator includes women who had a postpartum visit (even beyond 60 days postpartum), did not attend scheduled appointments, or did not schedule an appointment despite encouragement from clinic staff.

Table 10C: Enrolled Through 60 Days Postpartum

Clinic/Number of Records	Met	Not Met	Unknown	Rate Met Requirement
Access Community Health Centers/42	37	4	1	**85.7%**
All Saints/53	50	3	0	**83.0%**
Aurora Midwifery & Wellness Center/66	52	14	0	**78.8%**
Beloit Clinic/2	0	1	1	**0.0%**
Columbia St. Mary's Family Health Center/101	84	16	1	**89.1%**
Dean Clinics/263	229	34	0	**82.1%**
Froedtert East OB/GYN Residency Clinic/118	107	11	0	**83.9%**
GHC-SCW Clinics/12	12	0	0	**91.7%**
Life Time OB/GYN/93	92	1	0	**98.9%**
Lisbon Avenue Health Center/81	75	6	0	**79.0%**
Mercy Health Systems Clinics/40	33	7	0	**82.5%**
Milwaukee Health Systems/8	7	1	0	**62.5%**
Sixteenth Street Community Health Center/59	46	13	0	**64.4%**
St. Joseph's Hospital Women's Health Center/91	80	11	0	**78.0%**
Waukesha Family Medicine Center/38	31	7	0	**28.9%**
Wheaton Franciscan Glendale Family Care Center/68	59	9	0	**75.4%**
Total/1,135	**994**	**138**	**3**	
Total Rate	**87.6%**	**12.2%**	**0.3%**	

The compliance rate for ten of the 16 clinics (62.5 percent) decreased when comparing CY16 to CY15. The overall rate increased only slightly to 87.6 percent in CY16 from 85.6 percent in CY15. Waukesha Family Medicine Center had the largest decrease to 28.9 percent met in CY16 from 54.3 percent met in CY15.

Milwaukee Health Systems showed the greatest increase to 62.5 percent met in CY16 from 33.3 percent met in CY15. When reviewing and comparing results, the reader should take into account the number of records reviewed may vary year-to-year with some clinics having less than 10 records reviewed.

Verification of Care Coordination Requirements

The DHS-MCO contract also identifies the following requirements related to documentation of care coordination:

- A care management plan developed as a result of an initial intake process where all needs are identified;
- The OB care provider developed the care management plan in conjunction with the care coordinator, the PCP, and the member;
- A care management plan that includes a self-management/self-care component;
- A care management plan that includes information regarding monthly home visits by nurse/social worker/care coordinator; and
- Regular care coordination communications took place between the OB care provider, the PCP, and the care coordinator.

The review results for these requirements are documented in Tables 11A and 11B.

Table 11A below shows by clinic, the number of records reviewed; the number of records that included a care management plan; the number of records in which the care management plan documented all of a member's needs identified during the intake process; the number of records that reflected participation of the member, care coordinator, and PCP in the development of the care management plan; and number of records that included a self-care component. The table also shows the number of records that met requirements for regular communication between the member, care coordinator, and medical providers.

Table 11A: Care Plan

Clinic/Number of Records	Care Management Plan	Intake Items Included in Plan	Collaborative Care Plan Development	Plan Includes Self-Management/ Self-Care	Communications Between Providers and Members
Access Community Health Centers/42	42	41	26	41	25
All Saints/53	53	53	4	52	3
Aurora Midwifery & Wellness Center/66	66	66	1	65	1
Beloit Clinic/2	2	2	0	2	0
Columbia St. Mary's Family Health Center/101	100	99	88	99	86
Dean Clinics/263	259	257	20	256	19

Clinic/Number of Records	Care Management Plan	Intake Items Included in Plan	Collaborative Care Plan Development	Plan Includes Self-Management/ Self-Care	Communications Between Providers and Members
Froedtert East OB/GYN Residency Clinic/118	118	118	5	116	8
GHC-SCW Clinics/12	12	12	3	12	3
Life Time OB/GYN /93	89	87	2	86	2
Lisbon Avenue Health Center/81	44	37	7	65	10
Mercy Health Systems Clinics/40	39	39	6	39	8
Milwaukee Health Systems/8	5	5	3	8	3
Sixteenth Street Community Health Center/59	59	58	9	59	7
St. Joseph's Hospital Women's Health Center/91	78	78	0	80	0
Waukesha Family Medicine Center/38	38	38	14	38	14
Wheaton Franciscan Glendale Family Care Center/68	64	61	20	62	22
Total/1,135	**1,068**	**1,051**	**208**	**1,080**	**211**
Total Rate	**94.1%**	**92.6%**	**18.3%**	**95.2%**	**18.6%**

Contracted clinics developed care plans that included nearly all identified needs using an effective intake process, as demonstrated by the high rates of compliance for the inclusion of intake items and self-management/self-care Some clinics did not meet the requirements for development of the care plan, because the medical record documentation was incomplete. Similarly, incomplete documentation reduced the rate at which clinics succeeded at including intake items on the plans. Nine clinics associated with 11 plans had at least a single need documented as part of the intake process, but not included on the plan. Lisbon Avenue Health Center had the lowest individual compliance rates for care management plan at 54.3 percent and intake items at 45.7 percent. All of the Lisbon Avenue Health Center records that did not meet the requirement for care plan and intake items were attributed to incomplete documentation.

Collaboration with the PCP was seldom identified during the medical record reviews. Nearly one-half of the records (43.7 percent) did not include documentation of an assigned PCP. When collaboration was noted, the reason noted in more than half of the occurrences was that the OB care was being provided by the PCP. This was documented for 127 of the 208 (61.1 percent) positive results for this review element. Columbia St. Mary’s documentation for this element exceeded the average at 87.1 percent.

Care teams engaged women in a variety of self-management activities with high rates of compliance for this review element. Incomplete documentation remained the primary reason for clinics not meeting this requirement at 100 percent. Lisbon Avenue Health Center also had the

lowest compliance rate for self-management at 80.2 percent; all 16 records for this clinic that did not meet this element were attributed to incomplete documentation.

Communication between providers on the members' OBMH teams continued to be limited. Again, rates were impacted because many records did not include documentation of the assigned PCP in the record, or incomplete medical records limited access to potential documentation of communication efforts. The rate was nearly the same for communication between providers and members (18.6 percent) as the collaboration between providers in developing a care plan (18.3 percent).

Table 11B shows, for each clinic, the number of records reviewed, and the number of records that documented members received or were offered (but declined) home visits. DHS changed its directions for the MetaStar reviewer guidelines beginning with the review dataset that included members with postpartum visits (PPVs) scheduled July 1, 2016 and after. For members with PPVs scheduled prior to July 1, 2016, MetaStar reviewers looked for documentation of offers of visits in alternate community locations when a member refused a home visit. For members with PPVs July 1, 2016 and after, DHS directed MetaStar to note only whether a home visit was offered to the member at some time during her prenatal care. Because of the difference in requirements, the results below are separated January 1, 2016 through June 30, 2016, and July 1, 2016 through the end of the year. When the PPV date was unknown, members with delivery dates May 1, 2016 and after were assigned to the group with documented PPV visits July 1, 2016 and after.

Table 11B: Care Coordination – Home Visits

Clinic/Number of Records	Monthly Home Visits (PPV 1/1/16 – 6/30/16; 443 records)	Monthly Home Visits (PPV 7/1/16-and after; 692 records)
Access Community Health Centers/42	2	31
All Saints/53	16	38
Aurora Midwifery & Wellness Center/66	1	0
Beloit Clinic/2	1	0
Columbia St. Mary's Family Health Center/101	7	47
Dean Clinics/263	38	137
Froedtert East OB/GYN Residency Clinic/118	6	66
GHC-SCW Clinics/12	1	6
Life Time OB/GYN /93	1	12
Lisbon Avenue Health Center/81	0	6
Mercy Health Systems Clinics/40	7	16

Clinic/Number of Records	Monthly Home Visits (PPV 1/1/16 – 6/30/16; 443 records)	Monthly Home Visits (PPV 7/1/16-and after; 692 records)
Milwaukee Health Systems/8	6	1
Sixteenth Street Community Health Center/59	2	11
St. Joseph's Hospital Women's Health Center/91	3	16
Waukesha Family Medicine Center/38	4	6
Wheaton Franciscan Glendale Family Care Center/68	0	8
Total/1,135	**95**	**401**
Total Rate	**21.4%**	**57.9%**

Clinic compliance with offers of home visits improved after elimination of the alternate location requirement for PPV dates July 1, 2016 or later. When a clinic did not meet the requirement for PPV dates prior to July 1, 2016, a frequent reason for non-compliance was failure to offer an alternate location when the member refused a home visit.

The home visit compliance rate was also influenced by lack of details in medical records about home visits, or missing portions of medical records where the information may have been documented For example, extremely low rates of compliance with this review element at Aurora Midwifery & Wellness Center, Beloit Clinic, Life Time OB/GYN, Lisbon Avenue Health Center, Sixteenth Street Community Health Center, St. Joseph's Hospital Women's Health Center, and Wheaton Franciscan Glendale Family Care Center were all related to incomplete documentation. The lack of medical record information for this review element may be related to the fact that some clinics contract with external PNCC agencies, and those agencies did not share documentation with the clinics or the MCOs for the purpose of this review. Information about the care management model at each clinic was not available for consideration in preparing this report. Of the 639 records that did not meet the home visit element, 598 (93.6 percent) were due to incomplete documentation

Only 140 of the 496 members who accepted a home visit or visit in an alternate location (if applicable) had documentation in their records that at least one home visit occurred (28.2 percent), with 93 members (66.4 percent) who received five or more home or alternate location visits.

Verification of Postpartum Care Coordination and Discharge Planning

The DHS-MCO contract includes the following requirements related to documentation of discharge planning and postpartum care. DHS asked MetaStar to evaluate records to determine whether members received satisfactory care as defined by the OBMH Care Guide, which includes:

- At least one postpartum visit within 60 days post-delivery if the member had a healthy birth outcome;
- Communication with the PCP post-delivery if the PCP is other than the OB provider;
- Member education on inter-conception care specific to the member's needs related to family planning preferences;
- Depression screening;
- Member education regarding breastfeeding;
- Member education regarding newborn care; and
- Follow-up care for any member with a chronic condition.

DHS requested MetaStar to collect data about the timing of the depression screening and education offered to members beginning with the review dataset that included mothers who had scheduled PPVs July 1, 2016 and after.

Tables 12A, 12B, 12C, 12D, 12E, and 12F document the results of the record review for most of the requirements noted above.

Table 12A shows the rates for this postpartum review element, which specifically looks for an actual PPV date within the required 60-day timeframe, and does not reflect missed appointments or efforts to support members in making appointments. This table also shows the number of records where communication with the member's PCP took place after delivery.

Table 12A: Post-Delivery Requirements

Clinic/Number of Records	At Least One PPV	Communication with PCP
Access Community Health Centers/42	33	32
All Saints/53	41	5
Aurora Midwifery & Wellness Center/66	44	1
Beloit Clinic/2	2	0
Columbia St. Mary's Family Health Center/101	77	87
Dean Clinics/263	187	55
Froedtert East OB/GYN Residency Clinic/118	89	18
GHC-SCW Clinics/12	11	4

Clinic/Number of Records	At Least One PPV	Communication with PCP
Life Time OB/GYN /93	53	2
Lisbon Avenue Health Center/81	57	12
Mercy Health Systems Clinics/40	31	6
Milwaukee Health Systems/8	5	3
Sixteenth Street Community Health Center/59	32	7
St. Joseph's Hospital Women's Health Center/91	60	1
Waukesha Family Medicine Center/38	9	13
Wheaton Franciscan Glendale Family Care Center/68	38	20
Total/1,135	**769**	**266**
Total Rate	**67.7%**	**23.4%**

Similar to the other requirements related to communication with PCPs, the rate for communication with PCP after delivery was low, although slightly higher than communication during the prenatal care period. Some clinics that use an EMR system may rely on internal messaging systems not accessible to MetaStar reviewers, thus contributing to low rates. In 43.7 percent of the member records, a PCP was not documented. The rate for one PPV decreased to 67.7 percent in CY16 from 68.3 percent in CY15. However, the postpartum communication with the PCP increased to 23.4 percent in CY16 from 17.3 percent in CY15.

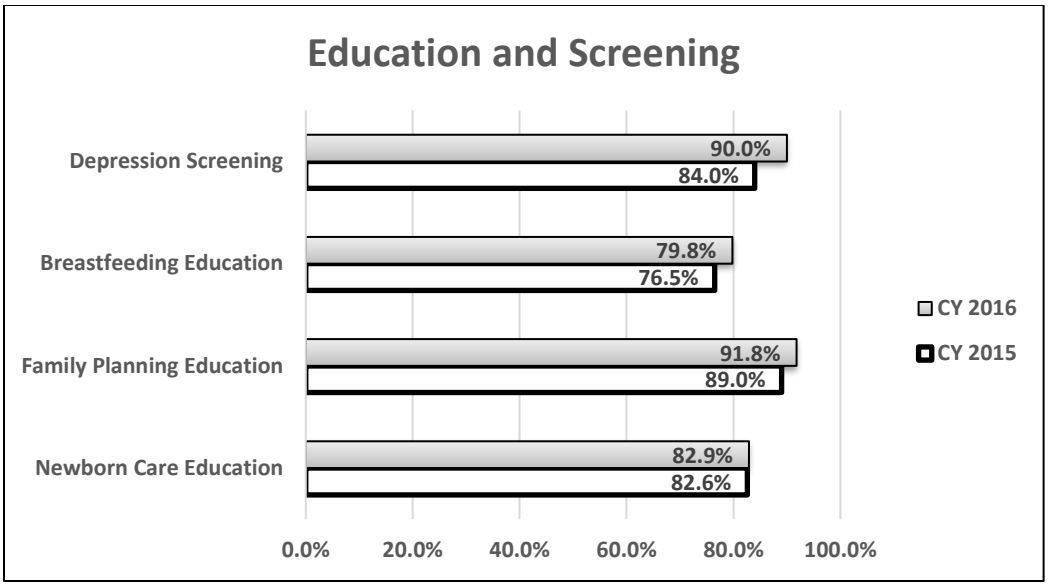
Table 12B identifies the number of records that contained evidence of depression screening and other education related to pregnancy.

Table 12B: Education and Screening

Clinic/Number of Records	Depression Screening	Breastfeeding Education	Family Planning Education	Newborn Care Education
Access/42	40	40	41	37
All Saints/53	52	52	51	52
Aurora Midwifery & Wellness Center/66	56	52	60	60
Beloit Clinics/2	1	2	2	1
Columbia St. Mary's Family Health Center/101	96	86	94	88
Dean Clinics/263	238	243	251	259
Froedtert East OB/GYN Residency Clinic/118	116	112	116	117
GHC-SCW/12	11	7	11	6

Clinic/Number of Records	Depression Screening	Breastfeeding Education	Family Planning Education	Newborn Care Education
Life Time OB/GYN /93	81	43	69	43
Lisbon Avenue Health Center/81	74	45	77	51
Mercy Care Health Systems/40	37	35	39	28
Milwaukee Health Systems/8	8	7	5	8
Sixteenth Street Community Health Center/59	55	46	50	49
St. Joseph's Hospital Women's Health Center/91	80	62	83	73
Waukesha Family Medicine Center/38	22	34	35	32
Wheaton Franciscan Glendale Family Care Center/68	54	40	58	37
Total/1,135	**1,021**	**906**	**1,042**	**941**
Total Rate	**90.0%**	**79.8%**	**91.8%**	**82.9%**

Record review found clinics consistently provide information to members about key topics associated with postpartum care. MetaStar reviewers noted that education takes place periodically throughout the prenatal period, including encouraging members to attend classes offered by clinics and other public agencies. The rate for breastfeeding education may be lower than the other rates for educational topics, because when members expressed a preference for bottle-feeding based on previous experience, care providers did not always offer education about the benefits of breastfeeding to these members. The rate for depression screening was influenced by the fact that some clinics routinely screen for depression during the prenatal period as well as during postpartum care, and therefore were in compliance. Waukesha Family Medicine Center had the lowest rate of depression screening at 57.9 percent. Improvement for this clinic could increase the overall compliance rate over 90 percent. Rates of compliance for CY16 are higher for all educational elements than CY 15.four indicators increased in CY16.



Beginning with postpartum visits scheduled after July 1, 2016 MetaStar reviewers examined records for when the education or screening was provided. Of the records that scored positive for education and screening, over 50 percent documented when the education or screening was provided.

Table 12C identifies the number of members by clinic who received education or screening, the type received, and when during the pregnancy it occurred. The total records that included education or screening are greater than the total member records reviewed because members received education or screening for more than one topic.

Table 12C: Postpartum Education and Screening Timing

Clinic/Number of Records	Prenatal	Postpartum	Prenatal and Postpartum	Total
Access Community Health Centers/42	27	6	72	105
All Saints/53	13	1	57	71
Aurora Midwifery & Wellness Center/66	27	2	39	68
Beloit Clinic/2	2	3	1	6
Columbia St. Mary's Family Health Center/101	26	29	174	229
Dean Clinics/263	188	61	360	609
Froedtert East OB/GYN Residency Clinic/118	86	19	192	297
GHC-SCW Clinics/12	4	10	2	16

Life Time OB/GYN /93	87	22	57	166
Lisbon Avenue Health Center/81	65	49	82	196
Mercy Health Systems Clinics/40	19	12	78	109
Milwaukee Health Systems/8	0	0	4	4
Sixteenth Street Community Health Center/59	51	11	69	131
St. Joseph's Hospital Women's Health Center/91	36	23	136	195
Waukesha Family Medicine Center/38	53	3	37	93
Wheaton Franciscan Glendale Family Care Center/68	40	41	54	135
Total	**724**	**292**	**1414**	**2430**
Rate	**29.8%**	**12.0%**	**58.2%**	

The rates included in the table above indicate the percentage of education or screening that occurred during the prenatal period, postpartum period, or both. The majority (58.2 percent) of screening and education was provided in both the prenatal and postpartum care periods.

For the 692 members who had PPVs scheduled July 1, 2016 or after, MetaStar reviewers identified when the education or screening services were provided.

Table 12D identifies each type of education and screening, the total number of records that met the requirement for each type, and the percentage of education or screening that occurred prenatal, postpartum, or both. The majority of education was provided in both the prenatal and postpartum periods.

Table 12D: Education and Screening Timing (692 members)

Education or Screening Type	Met Requirement	Prenatal	Postpartum	Prenatal and Postpartum
Depression Screening	642	22.9%	14.2%	62.9%
Breastfeeding Education	565	40.9%	5.7%	53.5%
Family Planning Education	638	16.5%	21.9%	61.6%
Newborn Care Education	585	41.2%	5.0%	53.8%

The following chronic conditions continued as a focus in the OBMH for this reporting period: asthma, cardiac disease, diabetes mellitus, HIV/AIDS, hypertension, pulmonary disease, and behavioral/mental health. Morbid obesity was added as an additional chronic condition with the DHS-MCO contract for 2016-2017 and MetaStar reviewers evaluated for this condition for reviews beginning with the dataset that included members with PPVs scheduled July 1, 2016 and after (692 of the 1,135 members). DHS asked MetaStar reviewers to include women with obesity as a diagnosis as well as morbid obesity in examining follow-up for chronic conditions in the member records.

Table 12E reports results for the 443 members with a postpartum visit scheduled January 1, 2016 through June 30, 2016. The table identifies the number of members who received follow-up related to their chronic conditions, the number who did not receive follow-up, and members who did not have a chronic condition requiring follow-up identified during the review.

Table 12E: Post-Delivery Requirements – Follow-up on Chronic Conditions
PPV January 1, 2016 – June 30, 2016 (195 members)

Clinic	Total	Met	Not Met	Did not have a Chronic Condition
Access Community Health Centers	13	7	0	6
All Saints	23	11	3	9
Aurora Midwifery & Wellness Center	32	10	2	20
Beloit Clinic	0	0	0	0
Columbia St. Mary's Family Health Center	42	11	0	31
Dean Clinics	112	51	8	53
Froedtert East OB/GYN Residency Clinic	42	12	0	30
GHC-SCW Clinics	6	1	0	5
Life Time OB/GYN	37	5	4	28
Lisbon Avenue Health Center	27	12	3	12
Mercy Health Systems Clinics	8	4	0	4
Milwaukee Health Systems	6	0	3	3
Sixteenth Street Community Health Center	24	5	7	12

Clinic	Total	Met	Not Met	Did not have a Chronic Condition
St. Joseph's Hospital Women's Health Center	37	16	7	14
Waukesha Family Medicine Center	12	2	2	8
Wheaton Franciscan Glendale Family Care Center	22	6	3	13
Total	**443**	**153**	**42**	**248**
Total Rate (N=195)		**78.5%**	**21.5%**	**56.0%**

Note: The rates for "met" and "not met" were calculated excluding the members who did not have a chronic condition. The rate for those without chronic conditions was calculated using the total dataset.

As documented in the table above, 56.0 percent of the members (248 members) did not have a chronic condition. For 40 of the 42 records that did not meet the requirement for follow-up (95.2 percent), MetaStar reviewers were unable to determine whether the member received follow-up for a chronic condition due to incomplete documentation. Ten of the 42 records scored "not met" were because reviewers were unable to determine if the member had a chronic condition.

Of the 195 members with chronic conditions, 91 had a behavioral/mental health condition, 64 had asthma, seven were diagnosed with morbid obesity or obesity, 20 had hypertension, seven had diabetes, one had a pulmonary disease diagnosis, and one presented with aortic stenosis.

Table 12F reports results, by clinic, for the 692 members with a postpartum visit scheduled July 1, 2016 and after. The table identifies the number of members who received follow-up related to their chronic conditions, and the number who did not receive follow-up, or who were not identified as subject for this review criterion. These results include the addition of morbid obesity/obesity as a chronic condition during pregnancy.

Table 12F: Post-Delivery Requirements – Follow-up on Chronic Conditions PPV July 1, 2016 and After

Clinic	Met	Not Met	Did not have a Chronic Condition	Total
Access Community Health Centers	23	0	6	29
All Saints	23	2	5	30
Aurora Midwifery &	17	1	16	34

Clinic	Met	Not Met	Did not have a Chronic Condition	Total
Wellness Center				
Beloit Clinic	2	0	0	2
Columbia St. Mary's Family Health Center	44	0	15	59
Dean Clinics	89	4	58	151
Froedtert East OB/GYN Residency Clinic	40	2	33	75
GHC-SCW Clinics	2	2	2	6
Life Time OB/GYN	28	2	26	56
Lisbon Avenue Health Center	26	12	16	54
Mercy Health Systems Clinics	24	3	5	32
Milwaukee Health Systems	0	0	2	2
Sixteenth Street Community Health Center	24	0	11	35
St. Joseph's Hospital Women's Health Center	39	0	16	55
Waukesha Family Medicine Center	18	0	8	26
Wheaton Franciscan Glendale Family Care Center	13	5	28	46
Total	**412**	**33**	**247**	**692**
Total Rate (N=445)	**92.6%**	**7.4%**	**35.7%**	

Note: The rates for "met" and "not met" were calculated excluding the members who did not have a chronic condition. The rate for those without chronic conditions was calculated using the total dataset.

As documented in the table above, 35.7 percent of the members (247 members) did not have a chronic condition. For all 33 records that did not meet the follow-up requirement (100 percent), MetaStar reviewers were unable to determine whether the member received follow-up for a

chronic condition due to incomplete documentation. Two of the 33 records scored "not met" were because reviewers were unable to determine if the member had a chronic condition.

Of the 445 members with chronic conditions, 135 had a behavioral/mental health condition, 121 had asthma, 109 were diagnosed with morbid obesity or obesity, 45 had hypertension, 18 had diabetes, 17 had an anemia diagnosis, and two presented with lupus.

Of the 640 women in both reporting groups who had a chronic condition, 263 (41.9%) were found to have more than one chronic condition. The compliance rate for the first reporting period (PPV January 1, 2016-June 30, 2016) increased to 78.5 percent and the rate increased to 92.6 percent in the second reporting period (PPV July 1, 2016 and after) from 56.9 percent in CY15. Morbid obesity/obesity was added to the list of chronic conditions in the second reporting period. The possible reasons for the rate increases were not examined in the preparation of this report.

Some additional, but not all-inclusive, examples of chronic conditions diagnosed in members included: hypothyroidism, hyperthyroidism, GERD, Sjojen syndrome, celiac disease, chronic obstructive pulmonary disease and Crohn's disease.

Identification of Birth Outcomes

The DHS-MCO contract provides information about payments related to the OBMH initiative and indicates DHS will define poor birth outcomes. DHS defines poor birth outcomes as follows:

- A birth that took place prior to 37 weeks gestation, or "pre-term birth;"
- A baby that weighed less than 2500 grams at the time of birth, or "low birth weight;"
- A stillborn baby delivered after 20 weeks; and
- An infant death within 28 days of birth, or "neonatal death."

Insufficient information was available in the medical records to determine the birth outcomes for 141 members. In these instances, DHS directed MetaStar to review MCO self-declared information in the DHS registry to determine whether the woman experienced a poor birth outcome. MetaStar reviewers did not find sufficient information in the registry for 10 of the 141 women. The absence of birth outcome information in the registry was most frequently noted due to member disengagement, relocation, or other similar issues. Of the 141 members without documentation of the outcome in the medical record, 16 were identified with poor birth outcomes by the clinics in the registry. MetaStar identified 140 poor birth outcomes in the medical records for the remaining members in this reporting group, for a total rate of 13.9 percent (156 of 1125 women, with available outcome information).

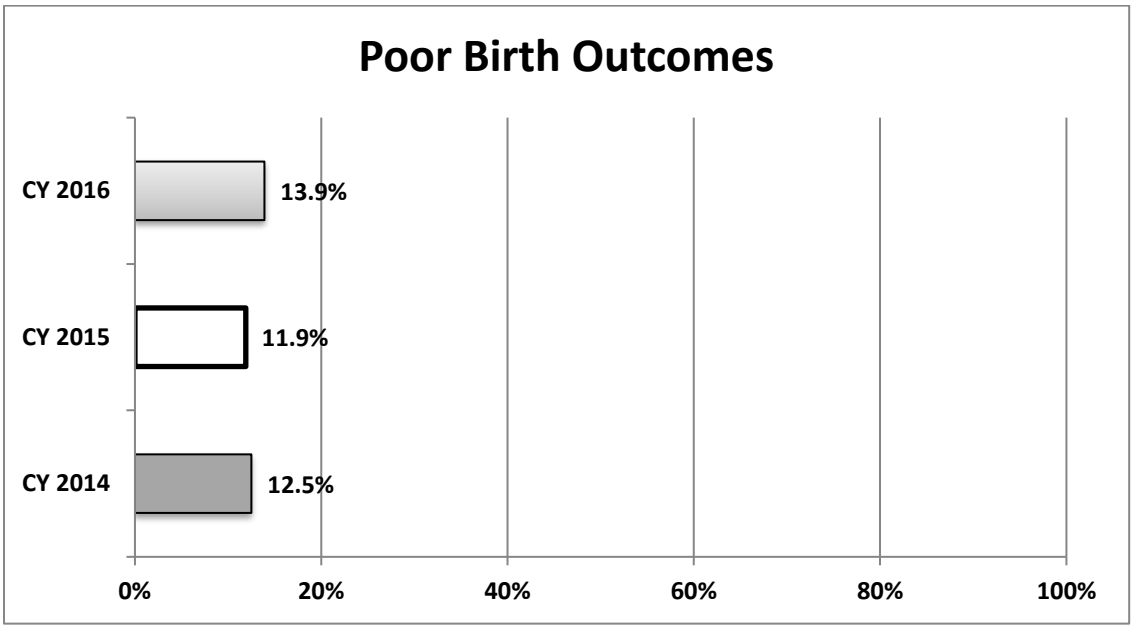
Table 13A below identifies the rates of healthy birth outcomes and poor birth outcomes by clinic, verified in medical records and documented by clinics in the registry, as defined by DHS for this initiative.

Table 13A: Birth Outcomes

Clinic/Number of records	Healthy Birth Outcome	Poor Birth Outcome	Unknown	Registry = Healthy Birth Outcome	Registry = Poor Birth Outcome	Registry = Unknown
Access Community Health Centers/42	17	12	13	11	1	1
All Saints/53	47	4	2	2	0	0
Aurora Midwifery & Wellness Center/66	49	11*	6	6	0	0
Beloit Clinic/2	0	0	2	0	0	2
Columbia St. Mary's Family Health Center/101	60	19	22	15	4	3
Dean Clinics/263	212	20	31	28	3	0
Froedtert East OB/GYN Residency Clinic/118	93	18*	7	5	1	1
GHC-SCW Clinics/12	12	0	0	0	0	0
Life Time OB/GYN /93	90	3	0	0	0	0
Lisbon Avenue Health Center/81	60	15*	6	5	1	0
Mercy Health Systems Clinics/40	28	5*	7	7	0	0
Milwaukee Health Systems/8	5	1	2	1	1	0
Sixteenth Street Community Health Center/59	34	13	12	7	4	1
St. Joseph's Hospital Women's Health Center/91	75	4*	12	12	0	0
Waukesha Family Medicine Center/38	20	6	12	11	0	1
Wheaton Franciscan Glendale Family Care Center/68	52	9	7	5	1	1
Total/1,135	**854**	**140**	**141**	**115**	**16**	**10**
Overall Rate (N=1,125)	**86.1%**	**13.9%**				

Note: The overall rate of healthy and poor birth outcomes was calculated using unverified registry results and excludes the unknown results from the denominator. *Includes seven sets of twins delivered by mothers affiliated with these clinics; 11 of the 14 infants had poor birth outcomes which are included in table 13B below.

The poor birth outcome rate increased in CY16 (13.9 percent) compared to the CY15 rate of 11.9 percent, and is greater than both the CY14 (12.5 percent) and CY13 (13 percent) rates.



The reasons associated with the poor birth outcomes in CY16 compared to CY15 are documented in table 13B below. The total number of outcomes exceeds the number of poor birth outcomes because an infant may have more than one poor birth outcome. There were also seven sets of twins born during CY16, with 11 of the 14 infants experiencing a poor birth outcome.

Table 13B: Reasons for Poor Birth Outcomes

Poor Birth Outcome Reason	All Infants 2016	All Infants 2015
Pre-term birth	30	30
Pre-term and death	0	2
Low birth weight	38	29
Pre-term birth and low birth weight	85	59
Pre-term birth, low birth weight and death	1	3
Stillborn	6	1
Neonatal death	1	0
Total Poor Birth Outcomes	**161**	**124**

Note: Includes seven sets of twins; 11 of the 14 infants had poor birth outcomes.

CONCLUSIONS

OBSERVATIONS

Following data abstraction for each clinic, MetaStar reviewers recorded observations about patterns of care and related documentation. These observations are not compared or analyzed relative to the other results in the report at this time.

- Care coordination models and documentation of PNCC continue to vary by clinic. Some clinics are noted to have clear, detailed, and easy to understand records, while others are sparse, unclear, or incomplete.
- Evidence of communication with the PCP continues to be minimal across all clinics and MCOs. Some improvement was noted in communication with PCPs (when identified) following delivery of the infants.
- One larger clinic rarely documents offers of home visits during prenatal care. However, some records documented a home visit shortly after birth.
- Some PNCC visits were conducted via telephone or text messaging. One clinic had little documentation of face-to-face visits with members, which seems contrary to the OBMH model of care.
- One clinic was found to have good documentation and specific patient education completed by OB and PNCC providers. This clinic was also noted to have care coordination documentation that demonstrated multiple communications between providers, the public health nurse, and a lactation specialist.
- Another clinic included scanned copies of all patient education hand-outs rather than a simple listing or notes about the members' responses to the information. Patient-specific education was evident and well documented in records at this clinic.
- Routine home visits conducted by the PNCC as well as evidence of PNCC intake assessments were found clearly documented for one larger clinic. MetaStar reviewers noted the clinic appeared to demonstrate a successful approach to home visits for the OBMH.
- A larger clinic using an EMR has developed and implemented a well-organized structure for documentation of information about prenatal and postpartum care. This system is noted to have clear, easy to understand evidence of communication among providers particularly postpartum (if a PCP is identified).
- At many clinics, information about the benefits of breastfeeding is still not clearly shared or documented, if the member states a preference for bottle-feeding based on previous experience.
- The rates of compliance with follow-up on chronic conditions increased greatly when compared to CY15. The rate of compliance associated with the first CY16 reporting

period was 78.4 percent and the second reporting period was 92.6 percent, while the CY15 rate was 56.9 percent.

RECOMMENDATIONS

- DHS should continue working with the MCO OBMH liaisons to identify the reasons for incomplete medical record submissions to verify the actual rate of poor birth outcomes. In addition, complete record submissions will support the evaluation of whether clinics providing care to mothers who had poor outcomes met the requirements for prenatal care.
    - Some MCOs and clinics may need to take additional steps to secure agreement with external PNCC agencies to provide the needed documentation for complete medical record submissions.
- Clinics with high rates of incomplete documentation need to conduct a root cause analysis, including policies, training, and practices, then identify barriers. Clinics should then conduct continuous cycles of improvement to mitigate the barriers.
- DHS should examine documentation practices related to PCP involvement in prenatal care and determine if MCOs are meeting contract requirements associated with PCP assignment. In addition, seek further information from MCOs and their contracted clinics to determine if internal messaging systems/use of EMRs prevents verification of collaboration and communication between members of the team, including PCPs. Determine if some clinics transfer primary care to the OB provider during the term of the pregnancy resulting in lack of prenatal care coordination.
- Continue to evaluate care coordination models and strategies related to the occurrence and frequency of home visits. Clinics should conduct a root cause analysis to identify barriers to the offer and provision of home visits.
- Consider and evaluate the overall postpartum depression screening rate and compare to research studies to determine if the 77.1 percent rate is cause for DHS concern.
- Conduct further analysis of the changes in rates associated with the follow-up for chronic conditions indicator to determine the reasons for the increases, especially for the period associated for reviews of mothers with postpartum visit dates July 1, 2016 and after. The rate of compliance associated with the second reporting period in CY16 was 92.6 percent and the CY15 rate was 56.9 percent .
- Continue to conduct an annual best practice seminar with MCOs and providers focusing on documentation practices, to foster improvement and support effective evaluation of the OBMH initiative.

Appendix – Requirement for External Quality Review and Review Methodology

Requirement for External Quality Review

The Medical Home model for high risk pregnant women is a contract requirement for the Managed Care Organizations (MCOs) providing services for BadgerCare Plus (BC+) or Medicaid Supplemental Security Income (SSI) members in southeastern Wisconsin. The counties included are Dane, Kenosha, Milwaukee, Ozaukee, Racine, Rock, Washington, and Waukesha. The terms of this agreement and requirements of the contract are located in the DHS–MCO contract. The medical home must be a single clinic or network of clinics that is accountable for the total care of the member.

The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate pre-paid inpatient health plans and MCOs to provide for external quality reviews (EQRs). To meet these obligations, states contract with a qualified external quality review organization (EQRO).

MetaStar - Wisconsin's External Quality Review Organization

The State of Wisconsin contracts with MetaStar, Inc., to conduct EQR activities and produce reports of the results. Based in Madison, Wisconsin, MetaStar has been a leader in health care quality improvement, independent quality review services, and medical information management for more than 40 years, and represents Wisconsin in the Lake Superior Quality Innovation Network, under the Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organization Program.

MetaStar conducts EQRs of MCOs operating managed long-term care programs, including Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly. In addition, the company conducts EQRs of MCOs serving BC+, SSI, Special Managed Care, and Foster Care Medical Home Medicaid recipients in the State of Wisconsin. MetaStar also provides other services for the state as well as for private clients. For more information about MetaStar, visit its website at www.metastar.com.

MetaStar Review Team

The MetaStar EQR team is comprised of registered nurses, a clinical nurse specialist, a nurse practitioner, a physical therapist, licensed and/or certified social workers, and other degreed professionals with extensive education and experience working with the target groups served by the MCOs. The EQR team is supported by other members of MetaStar's Managed Health and Long-Term Care Department as well as staff in other departments, including a data analyst with an advanced degree, a licensed Healthcare Effectiveness Data and Information Set

(HEDIS®)[1]auditor, certified professional coders, and information technologies staff. Review team experience includes professional practice and/or administrative experience in managed health and long-term care programs as well as in other settings, including community programs, home health agencies, community-based residential settings, and the Wisconsin Department of Health Services (DHS). Some reviewers have worked in skilled nursing and acute care facilities and/or primary care settings. The EQR team also includes reviewers with quality assurance/ quality improvement education and specialized training in evaluating performance improvement projects.

Reviewers are required to maintain licensure, if applicable, and participate in additional relevant training throughout the year. All reviewers are trained annually to use current EQR protocols, review tools, guidelines, databases, and other resources.

Review Methodology

On a quarterly basis, MetaStar pulls a dataset that identifies members enrolled in MCO Obstetric Medical Homes (OBMH), and with delivery dates occurring during the previous quarter. The datasets are compiled primarily from information available through the OBMH data registry. DHS holds MCOs accountable for securing records from providers to submit to MetaStar.

MCOs and clinics submit scanned member records to MetaStar. Where possible, MetaStar develops arrangements with clinics that have electronic medical records (EMR) to secure remote, direct access to conduct the record reviews.

MetaStar continues to use a review tool and guidelines for OBMH reviews developed in partnership with and agreed upon with DHS. Reviewers abstract relevant data from medical records, regardless of whether the MCO submitted an entire or partial medical record.

Review Criteria

The review team used a review tool and reviewer guidelines based on the DHS-MCO contract and agreed upon with DHS. The review evaluated four indicators that reviewers used to evaluate compliance with the OBMH requirements. The indicators and elements within include:

1. Enrollment; including program eligibility, date of enrollment and prenatal visit requirements.
2. Care Coordination; including identification of the care coordinator, member education, and follow-up for any chronic conditions.
3. Care Planning; including assessment, creation of the care plan and communication of the care plan.

[1] "HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)."

4. Discharge Planning; including coordination with the primary care provider, documentation of the birth outcome, postpartum visit and member education regarding newborn care, breast feeding and family planning.

MetaStar reviewers used 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

Member, MCO, clinic and care provider demographics recorded as available.

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 date calculator, subtract 24 weeks and enter the result on the review tool. Use the first ultrasound date (usually around 20 weeks) for the calculation.

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.

Beginning with the dataset for members with post-partum visits scheduled July 1, 2016 and after, reviewers did not look for evidence that an offer of an alternate location to a home visit was made after the member refused.

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.

Poor Birth Outcome
From the available medical records determine if the birth outcomes fit the DHS definitions of a poor birth outcome as follows:
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
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. 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. Beginning with the dataset associated with members who scheduled post-partum visits July 1, 2016 and after, reviewers were directed to document when the education and screening was provided during the prenatal, postpartum or both care periods.
Member education regarding breastfeeding and newborn care 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. Beginning with the dataset associated with members who scheduled post-partum visits July 1, 2016 and after, reviewers were directed to document when the education was provided during the prenatal, postpartum or both care periods.
Follow-up care for any member with a chronic condition 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 is 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. Beginning with the dataset associated with women who scheduled a post-partum visit July 1, 2016 and after, reviewers were directed to also consider morbid obesity and obesity as chronic conditions.