

External Quality Review

Fiscal Year 2017 – 2018

Healthy Birth Outcomes – Medical Home Enrollees

Calendar Year 2017
Final Report

Prepared for

Wisconsin
Department
of Health
Services

Division of
Medicaid
Services

Prepared by

M E T A S T A R

September 28, 2018

External Quality Review Organization

MetaStar, Inc.
Suite 300
2909 Landmark Place
Madison, Wisconsin 53713

Prepared by staff in the
Managed Health & Long-Term Care Department

Primary Contacts

Jenny Klink, MA, CSW
Vice President
608-441-8216
jklink@metastar.com

Laurie Hintz, MA, CDP
Project Manager
608-441-8226
lhintz@metastar.com

Danielle Sersch, BBA
Administrative Assistant
608-441-8224
dsersch@metastar.com

Don Stanislawski, BA
Administrative Assistant
608-441-8204
dstanis@metastar.com



Table of Contents

Introduction and Overview	3
Review Methodology.....	3
Medical Home Profile.....	3
Contract Requirements.....	5
Results	6
Dataset and Record Submission Summary	6
Section 1 - Review Findings by MCO	10
Verification of Enrollment Requirements.....	10
Verification of Care Coordination Requirements	12
Verification of Postpartum Care Coordination and Discharge Planning.....	15
Identification of Birth Outcomes	19
Section 2 - Review Findings by Clinic	22
Verification of Enrollment Requirements.....	22
Verification of Care Coordination Requirements	25
Verification of Postpartum Care Coordination and Discharge Planning.....	28
Identification of Birth Outcomes	34
Conclusions	37
Observations	37
Recommendations.....	37
Appendix – Requirement for External Quality Review and Review Methodology	38
Requirement for External Quality Review	38
Review Methodology.....	38
Review Criteria	39

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 2017-2018 for births occurring during calendar year 2017 (CY 2017). 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 contract dated January 1, 2016 – December 31, 2017. Information from the data abstraction process is documented in a system implemented and maintained by the DHS Medicaid Information System vendor, DXC

Technology (DXC). MetaStar reviewed 1,056 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 collect data that supports potential future program refinements; and
- To collect data that supports program evaluation.

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
- <https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/OBMH/OBMHome.htm.spage>

During the time period associated with prenatal care for members who delivered infants in CY 2017, 13 MCOs contracted with clinics and established memoranda of agreements to implement the 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)
Southeastern WI – Kenosha, Ozaukee, Milwaukee, 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)
	Network Health Plan (NHP)*
	Trilogy Health Insurance (Trilogy)
	UHC

*NHP began participating in the OB Medical Home during CY 2017, therefore comparison data is not available.

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, clinic staff, 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. Results are reported in two sections, one section of aggregated data for each MCO and one section of 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 records in the dataset for the report period was 1,056. The number of members served by each MCO are depicted in Table 2 below.

Table 2: Medical Home and MCO Enrollment – Total Records Reviewed

MCO	Service Area	Total Records
Anthem	SE WI	153
CCHP	SE WI	318
DHP	Dane/Rock Counties	243
GHC-SCW	Dane County	19
iCare	SE WI	10
MCHP	Rock County	35
MHS	Rock County/SE WI	10
MHWI	SE WI	123
NHP	SE WI	13
PPIC	Dane County	19
Trilogy	SE WI	7
UHC	Rock County/SE WI	75
Unity	Dane County	31
Total Records		1056

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

Table 3: OBMH Clinics and MCO Affiliation – Total Records Reviewed

Medical Home Clinic	MCO	Total Records
Access Community Health Centers Dane County	DHP	65
	GHC-SCW	
	PPIC	
	Unity	
All Saints and All Saints Family Care Center* SE WI	Anthem	63
	CCHP	
	MHS	
	MHWI	
	NHP	
	UHC	
Aurora Midwifery & Wellness Center SE WI	Anthem	34
	CCHP	
	MHWI	
Beloit Clinic Rock County	Anthem	1
Columbia St. Mary's Family Health Center SE WI	Anthem	117
	CCHP	
	iCare	
	MHS	
	MHWI	
Dean Clinics Dane and Rock Counties	DHP	233
Froedtert East OB/GYN Residency Clinic SE WI	Anthem	148
	CCHP	
	UHC	
GHC-SCW Clinics Dane County	GHC-SCW	14
Life Time OB/GYN** SE WI	Anthem	100
	CCHP	
	NHP	
	Trilogy	
	UHC	
Lisbon Avenue Health Center SE WI	Anthem	93
	CCHP	
	iCare	
	MHS	
	MHWI	
	UHC	
Mercy Health Systems Clinics Rock County	MCHP	35

Medical Home Clinic	MCO	Total Records
Sixteenth Street Community Health Center SE WI	Anthem	28
	CCHP	
	MHWI	
	NHP	
	UHC	
St. Joseph's Hospital Women's Health Center SE WI	Anthem	60
	CCHP	
	MHS	
	MHWI	
	NHP	
	Trilogy	
	UHC	
Waukesha Family Medicine Center SE WI	Anthem	14
	CCHP	
	MHWI	
Wheaton Franciscan Glendale Family Care Center SE WI	Anthem	51
	CCHP	
	Molina	
	NHP	
	Trilogy	
Total Records		1056

***Note:** 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.

**** Note:** 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.



The DHS information system used to house data for the 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, notes the overall rate of complete submissions and provides comparison to the 2016 results.

Table 4: Complete Medical Records Submissions by Clinic

Medical Home Clinic	Total Number of Records	Complete	Incomplete	Rate Complete 2017	Rate Complete 2016
Access Community Health Centers	65	62	3	95.4%	90.5%
All Saints	63	62	1	98.4%	90.6%
Aurora Midwifery & Wellness Center	34	27	7	79.4%	87.9%
Beloit Clinic	1	0	1	0%	100%
Columbia St. Mary's Family Health Center*	117	114	3	97.4%	68.3%
Dean Clinics*	233	224	9	96.1%	93.9%
Froedtert East OB/GYN Residency Clinic	148	141	7	95.3%	94.1%
GHC-SCW Clinics	14	9	5	64.3%	91.7%
Life Time OB/GYN *	100	80	20	80%	53.8%
Lisbon Avenue Health Center	93	59	34	63.4%	18.5%
Mercy Health Systems Clinics	35	22	13	62.9%	57.5%
Sixteenth Street Community Health Center	28	26	2	92.9%	76.3%
St. Joseph's Hospital Women's Health Center	60	48	12	80%	70.3%
Waukesha Family Medicine Center	14	2	12	14.3%	39.5%
Wheaton Franciscan Glendale Family Care Center*	51	9	42	17.6%	11.8%
Total	1056	885	171	83.8%	71.2%

*Note: Indicates EMR

After confirmation of the dataset, the MCOs worked with the clinics to submit or provide access to the medical records. Overall, 16.2 percent of records reviewed were incomplete during CY 2017, a decrease from 28.8 percent during CY 2016.

SECTION 1 - REVIEW FINDINGS BY MCO

VERIFICATION OF ENROLLMENT

The DHS-MCO contract outlines that members must:

- Make the first medical home visit within the first 16 weeks of pregnancy;
- Attend a minimum of 10 appointments with the OB care provider; and
- Remain enrolled through 60 days postpartum.

The review findings for the above requirements are documented in Tables 5A, 5B, and 5C. Table 5A reports by MCO, the number of records reviewed, and the number of records that met the enrollment criteria. The rate at which all MCOs met the criteria is also shown.

Table 5A: First Medical Home Visit and Enrollment within First 16 Weeks

MCO	Total Records	Met	Not Met	Rate Requirement Met 2017	Rate Requirement Met 2016
Anthem	153	145	8	94.8%	87.0%
CCHP	318	302	16	95%	93.1%
DHP	243	216	27	88.9%	90.9%
GHC-SCW	19	19	0	100%	91.7%
iCare	10	10	0	100%	100%
MCHP	35	35	0	100%	95.0%
MHS	10	10	0	100%	77.8%
MHWI	123	115	8	93.5%	87.1%
NHP	13	13	0	100%	N/A
PPIC	19	19	0	100%	100%
Trilogy	7	6	1	85.7%	92.3%
UHC	75	71	4	94.7%	91.7%
Unity	31	31	0	100%	84.6%
Total Records	1056	992	64		
Total Rate 2017		93.9 %	6.1%		
Total Rate 2016		90.7%	8.5%		

Overall results for enrollees with the initial OBMH visit within the first 16 weeks of pregnancy reflect an increase to 93.9 percent in CY 17 from the CY 2016 rate of 90.7 percent. Individual MCO results varied in CY 2017 from CY 2016, though the majority improved while two declined.

Table 5B 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 CY 2017 was 86.2 percent; this increased from the CY 2016 compliance rate of 81.1 percent.

Table 5B: 10 Appointments or More with OB Provider

MCO	Total Records	Met	Not Met	Rate Met Requirement 2017	Rate Met Requirement 2016
Anthem	153	134	19	87.6%	83.1%
CCHP	318	266	52	83.6%	82.2%
DHP	243	214	29	88.1 %	84.8%
GHC-SCW	19	19	0	100 %	75.0%
iCare	10	10	0	100 %	76.9%
MCHP	35	31	4	88.6 %	80.0%
MHS	10	9	1	90 %	93.8%
MHWI	123	101	22	82.1 %	71.6%
NHP	13	10	3	76.9%	N/A
PPIC	19	16	3	84.2 %	93.8%
Trilogy	7	6	1	85.7 %	61.5%
UHC	75	63	12	84 %	81.3%
Unity	31	31	0	100%	80.8%
Total Records	1056	910	146		
Total Rate 2017		86.2%	13.8%		
Total Rate 2016		81.1%	18.4%		

Table 5C 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 changed only slightly to 87.7 percent in CY 2017 from 87.6 percent in CY 2016.

Table 5C: Enrolled Through 60 Days Postpartum

MCO	Total Records	Met	Not Met	Rate Met Requirement 2017	Rate Met Requirement 2016
Anthem	153	121	32	79.1%	85.7%
CCHP	318	274	44	86.2%	86.2%
DHP	243	225	18	92.6 %	94.7%
GHC-SCW	19	19	0	100 %	100%
iCare	10	8	2	80%	84.6%
MCHP	35	31	4	88.6 %	82.5%
MHS	10	8	2	80 %	88.9%
MHWI	123	106	17	86.2 %	83.9%
NHP	13	12	1	92.3%	N/A
PPIC	19	18	1	94.7 %	68.8%

MCO	Total Records	Met	Not Met	Rate Met Requirement 2017	Rate Met Requirement 2016
Trilogy	7	6	1	85.7%	61.5%
UHC	75	71	4	94.7 %	91.7%
Unity	31	27	4	87.1 %	88.5%
Total	1056	926	130		
Total Rate 2017		87.7%	12.3%		
Total Rate 2016		87.6%	12.2%		

VERIFICATION OF CARE COORDINATION

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 6A and 6B. Table 6A 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 results for collaborative care plan development increased in CY 2017 to 26.7 percent, compared to the CY 2016 rate of 18.3 percent.

Table 6A: Care Plan

MCO	Total Records	Care Management Plan	Intake Items Included in Plan	Collaborative Care Plan Development	Plan Includes Self-Management/Self-Care	Communication Between Providers and Members
Anthem	153	151	150	46	151	44
CCHP	318	314	314	89	315	88
DHP	243	240	239	25	240	27
GHC-SCW	19	19	19	8	19	8
iCare	10	10	10	10	10	10
MCHP	35	35	35	0	35	0
MHS	10	10	10	4	10	4
MHWI	123	123	123	46	123	45
NHP	13	13	13	4	13	4
PPIC	19	19	19	13	19	13
Trilogy	7	6	6	1	6	1
UHC	75	69	69	18	69	15
Unity	31	31	31	18	31	15
Total Records	1056	1040	1038	282	1041	274
Total Rate 2017		98.5%	98.3%	26.7%	98.6%	25.9%
Total Rate 2016		94.1%	92.6%	18.3%	95.2%	18.6%

Care plans that included nearly all identified needs indicated effective intake processes, as demonstrated by the high rates of compliance for inclusion of intake items and self-management/self-care. Some records 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 the records reviewed indicated success for including intake items on the plans.

Although the rate improved from CY 2016, collaboration with the PCP was again seldom identified during the medical record reviews. Almost one-half of the records (47.7 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 PCP provided the OB care. This was documented for 207 of the 282 (73.4 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. Overall, the rate of compliance for this element improved in CY 2017.

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 CY 2017 rate increased to 26.7 percent from the CY 2016 rate of 18.3 percent. The rate was nearly the same for communication between providers and members (25.9 percent), as the collaboration between providers in developing a care plan (26.7 percent), and reflected the lack of documentation of an assigned PCP.

Table 6B shows, for each MCO, the number of records that documented members received or were offered (but declined) home visits. DHS adjusted review criteria during the CY 2016 births, no longer requiring clinics to offer alternate locations for home visits. Therefore, the results from CY 2016 to CY 2017 are not comparable.

Table 6B: Care Coordination – Home Visits

MCO	Total Records	Home Visits Offered	Rate Met Requirement 2017
Anthem	153	80	52.3%
CCHP	318	195	61.3%
DHP	243	220	90.5%
GHC-SCW	19	18	94.7%
iCare	10	8	80%
MCHP	35	12	34.3%
MHS	10	9	90%
MHWI	123	81	65.9%
NHP	13	10	76.9%
PPIC	19	19	100%
Trilogy	7	1	14.3%
UHC	75	49	65.3%
Unity	31	31	100%
Total	1056	733	69.4%

MCO compliance with offers of home visits varied. (See Section 2 for clinic-specific results.) The home visit compliance rate was impacted by lack of details in medical records about home visits, or missing portions of medical records where the information may have been documented. Some MCOs/clinics contract with external prenatal care coordination (PNCC) agencies, and those portions of the overall care provided are not consistently included submitted for inclusion in the review. Of the 323 records that did not meet the home visit element, 306 (94.7 percent) were due to incomplete documentation.

Only 232 members accepted a home visit. Of those, 135 had documentation in their records that at least one home visit occurred (58.2 percent), with 66 of the 153 members (48.9 percent) who received five or more home 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 in mid-CY 2016, therefore the comparability of these elements to the CY 2017 results is limited.

Results: Tables 7A, 7B, 7C, 7D, 7E, and 7F document the results of the record review for most of the requirements noted above.

Table 7A 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 CY 2017 was 74.2 percent, an increase from 67.7 percent in CY 2016. The table also shows the number of records where communication with the member’s PCP took place after delivery.

Table 7A: Post-Delivery Requirements

MCO	Total Records	At Least One PPV	Communication with PCP
Anthem	153	118	50
CCHP	318	241	100
DHP	243	187	98
GHC-SCW	19	17	7
iCare	10	8	10
MCHP	35	31	0

MCO	Total Records	At Least One PPV	Communication with PCP
MHS	10	8	4
MHWI	123	101	44
NHP	13	12	5
PPIC	19	15	15
Trilogy	7	4	1
UHC	75	57	25
Unity	31	24	25
Total	1056	823	384
Total Rate 2017		77.9%	36.4%
Total Rate 2016		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 36.4 percent in CY 2017 from 23.4 percent in CY 2016. Some clinics that use an EMR system may rely on internal messaging systems not accessible to MetaStar reviewers, thus contributing to lower rates. In 40.2 percent of the member records, a PCP was not documented. This is a decrease from CY 2016 when 43.7 percent of member records did not include documentation of the member's PCP.

Table 7B identifies the number of records that contained evidence of depression screening and other education related to pregnancy.

Table 7B: Education and Screening

MCO	Total Records	Depression Screening	Breastfeeding Education	Family Planning Education	Newborn Care Education
Anthem	153	149	142	149	135
CCHP	318	304	285	305	278
DHP	243	235	233	233	236
GHC-SCW	19	18	19	18	19
iCare	10	10	10	10	9
MCHP	35	35	35	34	34
MHS	10	10	10	10	10
MHWI	123	122	112	121	119
NHP	13	13	12	13	13
PPIC	19	19	19	19	19
Trilogy	7	6	6	7	5
UHC	75	72	68	70	69
Unity	31	30	29	30	31
Total	1056	1023	980	1019	977
Total Rate 2017		96.9%	92.8%	96.5%	92.5%
Total Rate 2016		90%	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 continues to take place periodically throughout the prenatal period, including encouraging members to attend classes offered by clinics and other public agencies. Rates of compliance for CY 2017 are higher for all educational elements than CY 2016.

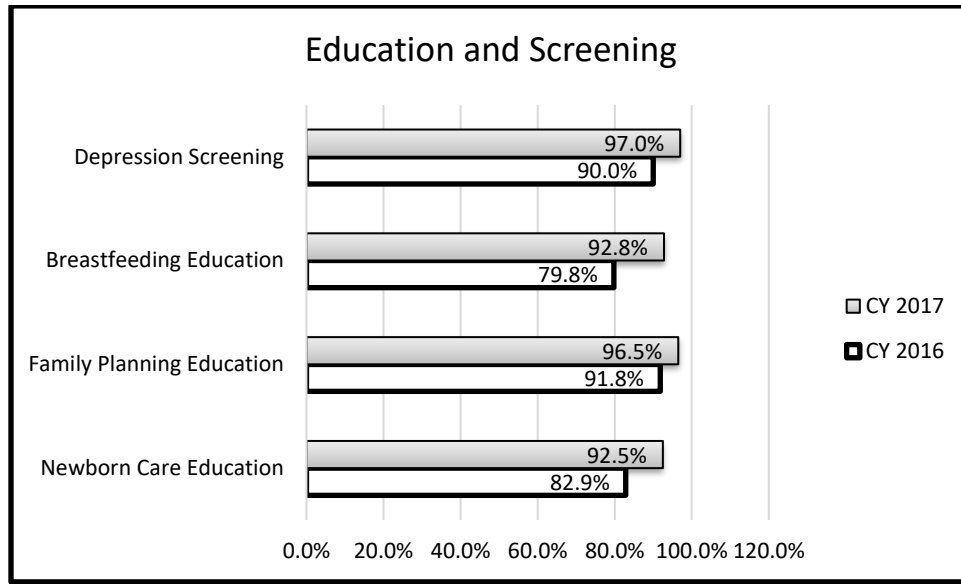


Table 7C identifies the number of members who received education or screening, the type received, and when during the pregnancy it occurred. The total records that included education or screening are greater than the total member records reviewed because members received education or screening for more than one topic.

Table 7C: Education and Screening Timing

Education or Screening Type	Prenatal	Postpartum	Prenatal and Postpartum
Depression Screening	203	71	749
Breastfeeding Education	405	51	524
Family Planning Education	150	116	753
Newborn Care Education	323	54	600
Total	1081	292	2626
Rate 2017	27.0%	7.3%	65.7%
Rate 2016	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 (65.7 percent) of screening and education was provided in both the prenatal and postpartum care periods.

Table 7D 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/screening was provided in both the prenatal and postpartum care periods.

Table 7D: Education and Screening Timing

Education or Screening Type	Met Requirement	Prenatal	Postpartum	Prenatal and Postpartum
Depression Screening	1023	19.8%	6.9%	73.2%
Breastfeeding Education	980	41.3%	5.2%	53.5%
Family Planning Education	1019	14.7%	11.4%	73.9%
Newborn Care Education	977	33.1%	5.5%	61.4%

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, behavioral/mental health and morbid obesity. The inclusion of morbid obesity as a chronic condition began in the middle of CY 2016 and results for follow-up were reported separately. Therefore, the results for CY 2017 to CY 2016 are not comparable.

Table 7E reports results for 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 7E: Follow-up on Chronic Conditions

MCO	Total Records	Met	Not Met	Did not have a Chronic Condition
Anthem	153	102	1	50
CCHP	318	225	4	89
DHP	243	185	4	54
GHC-SCW	19	11	0	8
iCare	10	9	0	1
MCHP	35	25	0	10
MHS	10	6	0	4
MHWI	123	80	1	42
NHP	13	7	0	6
PPIC	19	16	0	3
Trilogy	7	1	1	5
UHC	75	46	3	26
Unity	31	22	0	9
Total	1056	735	14	307
Total Rate (N=749)		98.1%	1.9%	29.1%

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, 29.1 percent of members (307 members) did not have a chronic condition. Of the 735 women who had a chronic condition, 335 (45.6 percent) had more than one condition. The most common chronic conditions included:

- Behavioral/Mental Health (395);
- Morbid Obesity/Obesity (222);
- Asthma (208) ,
- Hypertension (66);
- Substance Abuse (44);
- Diabetes (30); and
- Cardiac Conditions (16).

Some additional, but not all-inclusive, examples of chronic conditions diagnosed in members included: hypothyroidism, hyperthyroidism, gastroesophageal reflux disease (GERD), Von Willebrand disease, migraines, Lupus, Fibromyalgia, Cerebral Palsy, Multiple Sclerosis, chronic obstructive pulmonary disease, and Crohn’s disease. Twenty records also included domestic violence or other abuse as a continuing concern.

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 74 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 found sufficient information in the registry for all 74 women. Of the 74 members without documentation of the outcome in the medical record, two were identified with poor birth outcomes by the clinics in the registry. MetaStar identified 151 poor birth outcomes in the medical records for the remaining members in this reporting group, for a total rate of 14.5 percent (153 of 1056 women, with available outcome information).

Table 8A 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 8A: Birth Outcomes

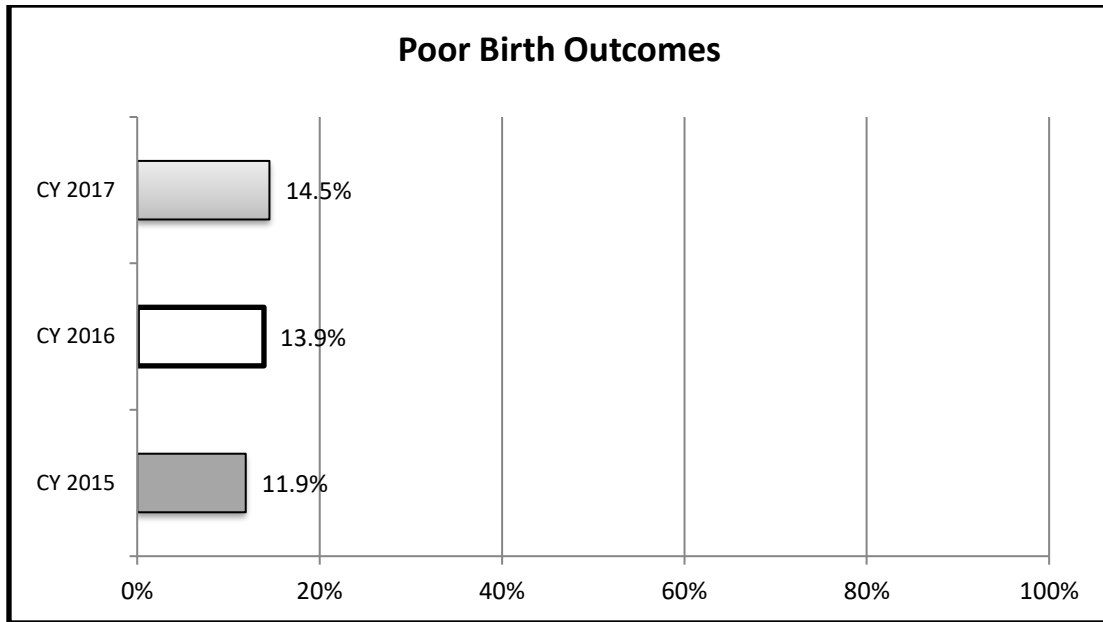
MCO	Total Records	Healthy Birth Outcome	Poor Birth Outcome	Unknown	Registry = Healthy Birth Outcome	Registry = Poor Birth Outcome	Registry = Unknown
Anthem	153	119	19	15	15	0	0
CCHP*	318	234	59	25	23	2	0
DHP	243	215	23	5	5	0	0
GHC-SCW	19	13	3	3	3	0	0
iCare	10	10	0	0	0	0	0
MCHP	35	23	2	10	10	0	0
MHS	10	6	3	1	1	0	0
MHWI*	123	97	18	8	8	0	0
NHP	13	8	3	2	2	0	0
PPIC	19	17	2	0	0	0	0
Trilogy	7	4	0	3	3	0	0
UHC	75	58	15	2	2	0	0
Unity	31	27	4	0	0	0	0
Total	1056	831	151	74	72	2	0
Overall Rate 2017		85.5%	14.5%				
Overall Rate 2016** (N=1,125)		86.1%	13.9%				

*Note: Includes three sets of twins and one set of triplets delivered by mothers affiliated with these MCOs; six of the nine infants had poor birth outcomes which are included in table 8B below.

**Note: The overall rate of healthy and poor birth outcomes for both calendar years was calculated using unverified registry results. The 2016 rates excluded the registry unknown results from the denominator.

The poor birth outcome rate increased in CY 2017 (14.5 percent) compared to CY 2016 (13.9 percent), and is greater than the CY 2015 (11.9 percent), CY 2014 (12.5 percent), and CY 2013 (13 percent) rates.





The reasons associated with the poor birth outcomes in CY 2017 compared to CY 2016 are documented in Table 8B below.

Table 8B: Reasons for Poor Birth Outcomes

Poor Birth Outcome Reason	All Infants 2017*	All Infants 2016
Pre-term birth	44	30
Pre-term and death	1	0
Pre-term and stillbirth	2	N/A**
Low birth weight	28	38
Pre-term birth and low birth weight	72	85
Pre-term birth, low birth weight and death	2	1
Stillbirth	1	6
Neonatal death	3	1
Total Poor Birth Outcomes	153	161

***Note:** Includes three sets of twins and one set of triplets; six of the nine infants had poor birth outcomes.

****Note:** CY 2016 birth outcomes did not include pre-term and stillbirth outcomes combined. As a result, the CY 2017 results are not comparable.

SECTION 2 - REVIEW FINDINGS BY CLINIC

VERIFICATION OF ENROLLMENT

The DHS-MCO contract requires that:

- Women 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 9A, 9B and 9C.

Table 9A 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 9A: First Medical Home Visit and Enrollment within First 16 Weeks

Medical Home Clinic	Total Number of Records	Met	Not Met	Rate Met Requirement 2017	Rate Met Requirement 2016
Access Community Health Centers	65	65	0	100%	90.5%
All Saints	63	63	0	100%	100%
Aurora Midwifery & Wellness Center	34	31	3	91.2%	97.0%
Beloit Clinic	1	1	0	100%	100%
Columbia St. Mary's Family Health Center	117	115	2	98.3%	99.0%
Dean Clinics	233	206	27	88.4%	90.9%
Froedtert East OB/GYN Residency Clinic	148	145	3	98%	97.5%
GHC-SCW Clinics	14	14	0	100%	91.7%
Life Time OB/GYN	100	98	2	98%	93.5%
Lisbon Avenue Health Center	93	77	16	82.8%	70.4%
Mercy Health Systems Clinics	35	35	0	100%	95.0%
Sixteenth Street Community Health Center	28	25	3	89.3%	94.9%
St. Joseph's Hospital Women's Health Center	60	59	1	98.3%	76.9%
Waukesha Family Medicine Center	14	14	0	100%	94.7%
Wheaton Franciscan Glendale Family Care Center	51	44	7	86.3%	85.3%
Total	1056	992	64		
	Total Rate 2017	93.9%	6.1%		
	Total Rate 2016	90.7%	8.5%		



Overall results for enrollees with the initial OBMH visit within the first 16 weeks of pregnancy reflect an increase to 93.9 percent in CY 2017 from 90.7 percent in CY 2016. The individual clinics year-to-year rate of compliance varied between CY 2017 and CY 2016. Of the 15 clinics that were included in both calendar years, 73.3 percent showed an increase in CY 2017 from CY 2016. St. Joseph's showed the greatest increase to 98.3 percent in CY 2017 from 76.9 percent in CY 2016. Aurora and Sixteenth Street clinics indicated the largest decline at almost six percent for each clinic.

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 9B 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 9B: 10 Appointments or More with OB Provider

Medical Home Clinic	Total Number of Records	Met	Not Met	Rate Met Requirement 2017	Rate Met Requirement 2016
Access Community Health Centers	65	60	5	92.3%	85.7%
All Saints	63	58	5	92.1%	90.6%
Aurora Midwifery & Wellness Center	34	27	7	79.4%	83.3%
Beloit Clinic	1	1	0	100%	100%
Columbia St. Mary's Family Health Center	117	115	2	98.3%	89.1%
Dean Clinics	233	206	27	88.4%	84.8%
Froedtert East OB/GYN Residency Clinic	148	140	8	94.6%	95.8%
GHC-SCW Clinics	14	14	0	100%	75.0%
Life Time OB/GYN	100	84	16	84%	82.8%
Lisbon Avenue Health Center	93	59	34	63.4%	65.4%
Mercy Health Systems Clinics	35	31	4	88.6%	80.0%
Sixteenth Street Community Health Center	28	24	4	85.7%	78.0%
St. Joseph's Hospital Women's Health Center	60	51	9	85%	69.2%
Waukesha Family Medicine Center	14	11	3	78.6%	86.8%
Wheaton Franciscan Glendale Family Care Center	51	29	22	56.9%	54.4%
Total	1056	910	146		
Total Rate 2017		86.2%	13.8%		
Total Rate 2016		81.1%	18.4%		

The overall rate of compliance increased in CY 2017 (86.2 percent) from CY 2016 (81.1 percent). Nine of the 15 clinics (60 percent) demonstrated improvement in the rates from year-to-year. Five clinics declined, with one demonstrating no change in rates of compliance for this measure. GHC-SCW showed the largest increase to 100 percent met in CY 2017 from seventy-five percent in CY 2016. Waukesha Family Medicine showed the largest decrease from 86.8 percent in CY 2016 to 78.6 percent in CY 2017. 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 9C 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 9C: Enrolled Through 60 Days Postpartum

Medical Home Clinic	Total Number of Records	Met	Not Met	Rate Met Requirement 2017	Rate Met Requirement 2016
Access Community Health Centers	65	59	6	90.8%	85.7%
All Saints	63	57	6	90.5%	83.0%
Aurora Midwifery & Wellness Center	34	28	6	82.4%	78.8%
Beloit Clinic	1	0	1	0%	0%
Columbia St. Mary's Family Health Center	117	111	6	94.9%	89.1%
Dean Clinics	233	216	17	92.7%	82.1%
Froedtert East OB/GYN Residency Clinic	148	143	5	96.6%	83.9%
GHC-SCW Clinics	14	14	0	100%	91.7%
Life Time OB/GYN	100	86	14	86%	98.9%
Lisbon Avenue Health Center	93	73	20	78.5%	79.0%
Mercy Health Systems Clinics	35	31	4	88.6%	82.5%
Sixteenth Street Community Health Center	28	25	3	89.3%	64.4%
St. Joseph's Hospital Women's Health Center	60	50	10	83.3%	78.0%
Waukesha Family Medicine Center	14	0	14	0%	28.9%
Wheaton Franciscan Glendale Family Care Center	51	33	18	64.7%	75.4%
Total	1056	926	130		
Total Rate 2017		87.7%	12.3%		
Total Rate 2016		87.6%	12.2%		

Ten of the 15 clinics showed improvement in the compliance rate for this element (66 percent) when comparing CY 2017 to CY 2016. However, the overall rate of compliance was nearly the same; the CY 2017 rate was 87.7 percent while the CY 2016 rate was 87.6 percent.

Sixteenth Street showed the greatest increase to 89.3 percent met in CY 2017 from 64.4 percent met in CY 2016. Life Time OB/GYN had the largest decrease to 86 percent met in CY 2017 from 98.9 percent in CY 2016. 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

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 10A 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 10A: Care Plan

Medical Home Clinic	Total 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	65	65	65	40	65	37
All Saints	63	63	63	24	63	24
Aurora Midwifery & Wellness Center	34	34	34	0	34	0
Beloit Clinic	1	0	0	0	0	0
Columbia St. Mary's Family Health Center	117	117	117	115	117	115
Dean Clinics	233	230	229	19	230	21
Froedtert East OB/GYN Residency Clinic	148	147	147	9	147	11
GHC-SCW Clinics	14	14	14	5	14	5
Life Time OB/GYN	100	91	90	11	93	3
Lisbon Avenue Health Center	93	91	91	41	91	41
Mercy Health Systems Clinics	35	35	35	0	35	0
Sixteenth Street Community Health Center	28	28	28	2	28	1
St. Joseph's Hospital Women's Health Center	60	60	60	1	60	0
Waukesha Family Medicine Center	14	14	14	3	14	3
Wheaton Franciscan Glendale Family Care Center	51	51	51	12	50	13
Total	1056	1040	1038	282	1041	274
Total Rate 2017		98.5%	98.3%	26.7%	98.6%	25.9%
Total Rate 2016		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. Overall, the rate for care management plan increased in CY 2017 (98.5 percent) from CY 2016 (94.1 percent). All clinics demonstrated over 90 percent compliance for these two elements.

Although the rate improved from CY 2016, collaboration with the PCP was again seldom identified during the medical record reviews. Almost one-half of the records (40.2 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 PCP provided the OB care. This was documented for 205 of the 282 (72.7 percent) positive results for this review element.

Aurora Midwifery & Wellness Center, Mercy Health Systems Clinics and Beloit Clinic had the lowest rates of compliance (zero percent) for this element.

Care teams engaged women in a variety of self-management activities with high rates of compliance for this review element. Overall, the rate of compliance for this element improved in CY 2017. Nine of the 15 clinics fully met this requirement (100 percent). Incomplete documentation (e.g. lack of details in a record or gaps in documentation) remained the primary reason for clinics not meeting this requirement.

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 CY 2017 rate increased to 26.7 percent from the CY 2016 rate of 18.6 percent. The rate was nearly the same for communication between providers and members (25.9 percent), as the collaboration between providers in developing a care plan (26.7 percent), and reflected the lack of documentation of an assigned PCP.

Table 10B 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 adjusted review criteria during the CY 2016 births, no longer requiring clinics to offer alternate locations for home visits. Therefore, the results from CY 2016 to CY 2017 are not comparable.

Table 10B: Care Coordination – Home Visits

Medical Home Clinic	Total Number of Records	Home Visits Offered	Rate Met Requirement 2017
Access Community Health Centers	65	65	100%
All Saints	63	63	100%
Aurora Midwifery & Wellness Center	34	1	2.9%
Beloit Clinic	1	0	0%
Columbia St. Mary's Family Health Center	117	104	88.9%
Dean Clinics	233	210	90.1%
Froedtert East OB/GYN Residency Clinic	148	139	93.9%
GHC-SCW Clinics	14	13	92.9%
Life Time OB/GYN	100	4	4%
Lisbon Avenue Health Center	93	53	57%
Mercy Health Systems Clinics	35	12	34.3%
Sixteenth Street Community Health Center	28	16	57.1%
St. Joseph's Hospital Women's Health Center	60	48	80%
Waukesha Family Medicine Center	14	4	28.6%
Wheaton Franciscan Glendale Family Care Center	51	1	2%
Total	1056	733	
Total Rate 2017		69.4%	

A lack of details about home visits, or missing portions of medical records (where home visit information may be documented) continue to impact the home visit compliance rates. Additionally, some clinics contract with external prenatal care coordination (PNCC) agencies, and those portions of the overall care provided are not consistently included submitted for inclusion in the review. Of the 323 records that did not meet the home visit element, 306 (94.7 percent) were due to incomplete documentation. 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, Waukesha Family Medicine Center, and Wheaton Franciscan Glendale Family Care Center were all related to incomplete documentation.

Only 232 members accepted a home visit. Of those, 135 had documentation in their records that at least one home visit occurred (57.2 percent), with 66 of 135 members (48.9 percent) who received five or more home 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 11A, 11B, 11C, 11D, and 11E, document the results of the record review for most of the requirements noted above.

Table 11A 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 11A: Post-Delivery Requirements

Medical Home Clinic	Total Number of Records	At Least One PPV	Communication with PCP
Access Community Health Centers	65	48	49
All Saints	63	49	23
Aurora Midwifery & Wellness Center	34	24	0
Beloit Clinic	1	0	0
Columbia St. Mary's Family Health Center	117	101	115
Dean Clinics	233	161	91
Froedtert East OB/GYN Residency Clinic	148	107	35
GHC-SCW Clinics	14	13	5
Life Time OB/GYN	100	62	14
Lisbon Avenue Health Center	93	68	39
Mercy Health Systems Clinics	35	30	0
Sixteenth Street Community Health Center	28	20	0
St. Joseph's Hospital Women's Health Center	60	31	1
Waukesha Family Medicine Center	14	0	2
Wheaton Franciscan Glendale Family Care Center	51	28	10
Total	1056	742	384
Total Rate 2017		70.3%	36.4%
Total Rate 2016		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. One factor contributing to the low rate may be that a PCP was not documented in 43.7 percent of the member records. Additionally, some clinics that use an EMR system may rely on internal messaging systems not accessible to MetaStar reviewers. The rate for one PPV increased to 70.3 percent in CY 2017 from 67.7 percent in CY 2016. The postpartum PCP communication increased to 36.4 percent in CY 2017 from 23.4 percent in CY 2016.

Table 11B on the next page identifies the number of records that contained evidence of depression screening and other education related to pregnancy.

Table 11B: Education and Screening

Medical Home Clinic	Total Number of Records	Depression Screening	Breastfeeding Education	Family Planning Education	Newborn Care Education
Access Community Health Centers	65	62	63	63	65
All Saints	63	63	63	63	62
Aurora Midwifery & Wellness Center	34	32	27	33	32
Beloit Clinic	1	0	0	0	0
Columbia St. Mary's Family Health Center	117	117	117	117	117
Dean Clinics	233	226	223	224	226
Froedtert East OB/GYN Residency Clinic	148	143	141	145	142
GHC-SCW Clinics	14	14	14	13	14
Life Time OB/GYN	100	93	79	89	69
Lisbon Avenue Health Center	93	91	79	90	81
Mercy Health Systems Clinics	35	35	35	34	34
Sixteenth Street Community Health Center	28	28	27	26	28
St. Joseph's Hospital Women's Health Center	60	57	53	60	60
Waukesha Family Medicine Center	14	14	14	12	13
Wheaton Franciscan Glendale Family Care Center	51	48	45	50	34
Total	1056	1023	980	1019	977
Total Rate 2017		97%	92.8%	96.5%	92.5%
Total Rate 2016		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 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 CY 2017 are higher than CY 16 and over 90 percent compliance for all educational elements.

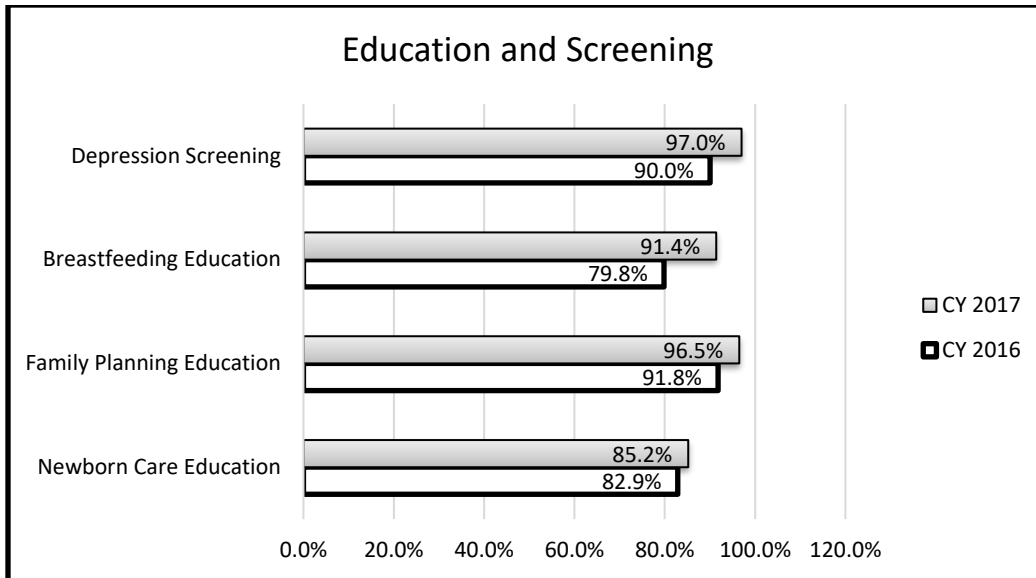


Table 11C identifies the number of members by clinic who received education or screening, the type received, and when during the pregnancy it occurred. The total records that included education or screening are greater than the total member records reviewed because members received education or screening for more than one topic.

Table 11C: Education and Screening Timing

Medical Home Clinic	Total Number of Records	Prenatal	Postpartum	Prenatal and Postpartum	Total
Access Community Health Centers	65	63	18	172	253
All Saints	63	32	3	216	251
Aurora Midwifery & Wellness Center	34	55	6	63	124
Beloit Clinic	1	0	0	0	0
Columbia St. Mary's Family Health Center	117	55	19	394	468
Dean Clinics	233	241	41	617	899
Froedtert East OB/GYN Residency Clinic	148	160	20	391	571
GHC-SCW Clinics	14	18	7	30	55
Life Time OB/GYN	100	97	95	138	330
Lisbon Avenue Health Center	93	145	15	181	341
Mercy Health Systems Clinics	35	33	7	98	138
Sixteenth Street Community Health Center	28	37	13	59	109
St. Joseph's Hospital Women's Health Center	60	34	13	183	230

Medical Home Clinic	Total Number of Records	Prenatal	Postpartum	Prenatal and Postpartum	Total
Waukesha Family Medicine Center	14	43	0	10	53
Wheaton Franciscan Glendale Family Care Center	51	68	35	74	177
Total	1056	1081	292	2626	3999
Total Rate		27.0%	7.3%	65.7%	

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 (65.7 percent) of screening and education was provided in both the prenatal and postpartum care periods.

Table 11D 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/screening was provided in both the prenatal and postpartum care periods.

Table 11D: Education and Screening Timing

Education or Screening Type	Prenatal	Postpartum	Prenatal and Postpartum
Depression Screening	203	71	749
Breastfeeding Education	405	51	524
Family Planning Education	150	116	753
Newborn Care Education	323	54	600
Total	1081	292	2626
Rate 2017	27.0%	7.3%	65.7%
Rate 2016	29.8%	12.0%	58.2%

The following chronic conditions continued as a focus in the OBMH for this reporting period: asthma, cardiac disease, diabetes mellitus, HIV/AIDS, hypertension, morbid obesity, pulmonary disease, morbid obesity and behavioral/mental health. The inclusion of morbid obesity as a chronic condition began in the middle of CY 2016 and results for follow-up were reported separately. Therefore, the results for CY 2017 to CY 2016 are not comparable.

Table 11E on the following page 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 11E: Follow-up on Chronic Conditions

Medical Home Clinic	Total Number of Records	Met	Not Met	Did not have a Chronic Condition
Access Community Health Centers	65	49	0	16
All Saints	63	55	0	8
Aurora Midwifery & Wellness Center	34	19	0	15
Beloit Clinic	1	0	1	0
Columbia St. Mary's Family Health Center	117	94	0	23
Dean Clinics	233	178	4	51
Froedtert East OB/GYN Residency Clinic	148	110	1	37
GHC-SCW Clinics	14	7	0	7
Life Time OB/GYN	100	48	4	48
Lisbon Avenue Health Center	93	60	1	32
Mercy Health Systems Clinics	35	25	0	10
Sixteenth Street Community Health Center	28	24	0	4
St. Joseph's Hospital Women's Health Center	60	35	0	25
Waukesha Family Medicine Center	14	8	0	6
Wheaton Franciscan Glendale Family Care Center	51	23	3	25
Total	1056	735	14	307
Total Rate 2017 (N=749)*		98.1%	1.9%	29%

*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, 29 percent of members (307 members) did not have a chronic condition. Of the 735 women who had a chronic condition, 335 (45.6 percent) were found to have more than one chronic condition. The most common chronic conditions included:

- Behavioral/Mental Health (395);
- Morbid Obesity/Obesity (222);
- Asthma (208) ,
- Hypertension (66);
- Substance Abuse (44);
- Diabetes (30); and
- Cardiac Conditions (16).

Some additional, but not all-inclusive, examples of chronic conditions diagnosed in members included: hypothyroidism, hyperthyroidism, gastroesophageal reflux disease (GERD), Von Willebrand disease, migraines, Lupus, Fibromyalgia, Cerebral Palsy, Multiple Sclerosis, chronic obstructive pulmonary disease, and Crohn’s disease. Twenty records also included domestic violence or other abuse as a continuing concern.

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 74 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 found sufficient information in the registry for all 74 women. Of the 74 members without documentation of the outcome in the medical record, two were identified with poor birth outcomes by the clinics in the registry. MetaStar identified 151 poor birth outcomes in the medical records for the remaining members in this reporting group, for a total rate of 14.5 percent (153 of 1056 women, with available outcome information).

Table 12A 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 12A: Birth Outcomes

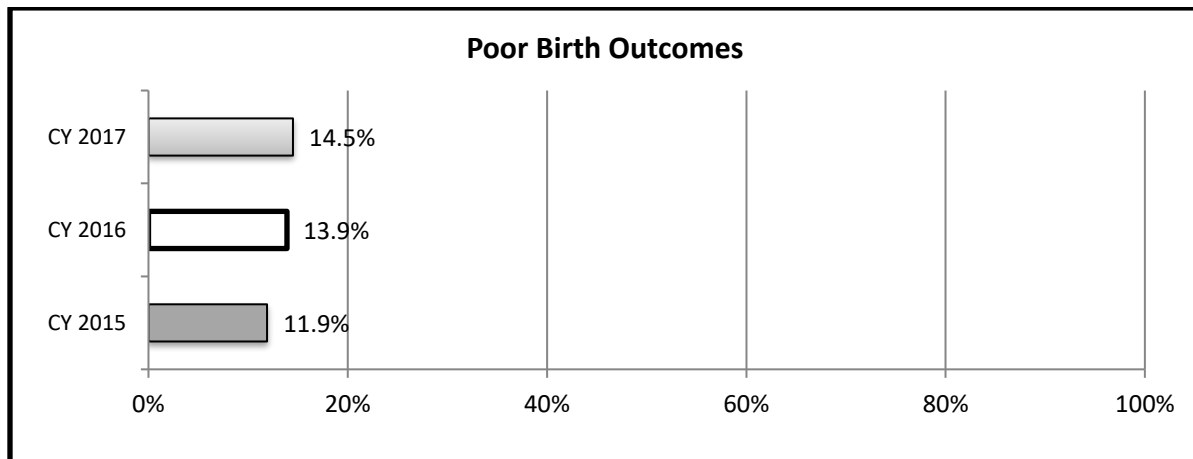
Medical Home Clinic	Total Number of Records	Healthy Birth Outcome	Poor Birth Outcome	Unknown	Registry = Healthy Birth Outcome	Registry = Poor Birth Outcome	Registry = Unknown
Access Community Health Centers	65	59	6	0	0	0	0
All Saints	63	45	17	1	1	0	0
Aurora Midwifery & Wellness Center	34	31	2	1	1	0	0
Beloit Clinic	1	0	0	1	1	0	0
Columbia St. Mary's Family Health Center	117	105	10	2	2	0	0
Dean Clinics	233	205	23	5	5	0	0
Froedtert East OB/GYN Residency Clinic	148	116	31	1	1	0	0
GHC-SCW Clinics	14	8	3	3	3	0	0
Life Time OB/GYN	100	86	12	2	2	0	0
Lisbon Avenue Health Center	93	69	23	1	1	0	0
Mercy Health Systems Clinics	35	23	2	10	10	0	0
Sixteenth Street Community Health Center	28	21	6	1	1	0	0

Medical Home Clinic	Total Number of Records	Healthy Birth Outcome	Poor Birth Outcome	Unknown	Registry = Healthy Birth Outcome	Registry = Poor Birth Outcome	Registry = Unknown
St. Joseph's Hospital Women's Health Center	60	41	12	7	7	0	0
Waukesha Family Medicine Center	14	12	1	1	1	0	0
Wheaton Franciscan Glendale Family Care Center	51	10	3	38	36	2	0
Total	1056	831	151	74	72	2	0
Overall Rate 2017		84.6%	5.4%				
Overall Rate 2016** (N=1,125)		86.1%	13.9%				

***Note:** Includes three sets of twins and one set of triplets delivered by mothers affiliated with these clinics; six of the nine infants had poor birth outcomes which are included in table 12B below.

****Note:** The overall rate of healthy and poor birth outcomes for both calendar years was calculated using unverified registry results. The 2016 rates excluded the registry unknown results from the denominator.

The poor birth outcome rate increased in CY 2017 (14.5 percent) compared to CY 2016 (13.9 percent), and is greater than the CY 2015 (11.9 percent), CY 2014 (12.5 percent), and CY 2013 (13 percent) rates.



The reasons associated with the poor birth outcomes in CY 2017 compared to CY 2016 are documented in table 12B 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 three sets of twins and one set of triplets born during CY 2017, with six of the nine infants experiencing a poor birth outcome.

Table 12B: Reasons for Poor Birth Outcomes

Poor Birth Outcome Reason	All Infants 2017*	All Infants 2016
Pre-term birth	44	30
Pre-term and death	1	0
Pre-term and stillbirth	2	N/A**
Low birth weight	28	38
Pre-term birth and low birth weight	72	85
Pre-term birth, low birth weight and death	2	1
Stillbirth	1	6
Neonatal death	3	1
Total Poor Birth Outcomes	153	161

***Note:** Includes three sets of twins and one set of triplets; six of the nine infants had poor birth outcomes.

****Note:** CY 2016 birth outcomes did not include pre-term and stillbirth outcomes combined. As a result, the CY 2017 results are not comparable.



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.

- Consistent with previous reporting years, the care coordination models and documentation of prenatal care coordination continue to vary by clinic. Some clinics are noted to have clear and detailed records, while others are sparse, unclear, or incomplete.
- Clinics continue to vary greatly in documentation of home visits with compliance rates ranging from less than 10 percent up to 100 percent.
- Substance abuse and domestic violence concerns are noted more frequently as chronic concerns within individual medical records across almost all clinics and MCOs.

OPPORTUNITIES FOR IMPROVEMENT AND RECOMMENDATIONS

Although most review elements demonstrated improvement for CY 2017, the rate of poor birth outcomes was the highest (14.5 percent) for any given year since the CY 2013 reporting period.

- Consider a root cause analysis to determine contributing factors to increased poor birth outcomes.

Some clinics continue to experience high rates of incomplete documentation. MetaStar recommends these clinics:

- Complete a root cause analysis, including policies, training, and practices to identify barriers. Then, conduct continuous cycles of improvement to mitigate the barriers.

Clinics contracting with PNCC agencies do not consistently provide the needed documentation during record review for complete medical record submissions. MetaStar recommends:

- Consider taking additional steps to secure agreement with the external PNCC agencies to provide the needed documentation at the time of review.

APPENDIX – REQUIREMENT FOR EXTERNAL QUALITY REVIEW AND REVIEW METHODOLOGY

REQUIREMENT FOR EXTERNAL QUALITY REVIEW

The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate pre-paid inpatient health plans and managed care organizations (MCO) to provide for external quality reviews (EQR). 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 EQR of MCOs operating Medicaid managed long-term programs, including Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly. In addition, the company conducts EQR of MCOs serving BadgerCare Plus, Supplemental Security Income, Special Managed Care, and Foster Care Medical Home Medicaid recipients in the State of Wisconsin. MetaStar also conducts EQR of Home and Community-Based Medicaid Waiver programs that provide long-term support services for children with disabilities. MetaStar 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 physical therapist, a recreational therapist, a counselor, 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, schools, home health agencies, community-based residential settings, and the Wisconsin

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

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 the Obstetric Medical Homes (OBMH), with delivery dates occurring during the previous quarter. The datasets are compiled from the OBMH data registry.

The datasets are shared with the identified MCO for confirmation of eligibility for review and subsequent delivery of the applicable medical records. DHS holds MCOs accountable for securing records from clinics for submission to MetaStar. MCOs and clinics submit member records to MetaStar. Where possible, MetaStar develops arrangements with clinics that have electronic medical records (EMR) to establish 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:

- Enrollment; including program eligibility, date of enrollment and prenatal visit requirements.
- Care Coordination; including identification of the care coordinator, member education, and follow-up for any chronic conditions.
- Care Planning; including assessment, creation of the care plan and communication of the care plan.
- Discharge Planning; including coordination with the primary care provider, documentation of the birth outcome, postpartum visit and member education regarding depression, newborn care, breast feeding and family planning.

The review team also collected data regarding immunizations and smoking cessation efforts for all enrollees. This additional data was not used to determine contract compliance.

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 requested by DHS for program planning and evaluation.

Demographics
Member, MCO, clinic and care provider demographics recorded as available.
Enrollment Requirements
<p>The member must be enrolled in the medical home after 1/1/2014 and within the first 16 weeks of pregnancy.</p> <p>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.</p> <p>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).</p> <p>Record the date of the member’s last menstrual period (LMP), if found in the record.</p> <p>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.</p> <p>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.</p>
Prenatal Visits
<p>Members must attend a minimum of 10 appointments with the OB care provider.</p> <p>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.</p>

<p>Postpartum Visit</p> <p>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.</p>
<p>Verification of Care Plan Requirement</p> <p>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.</p>
<p>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.</p>
<p>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.</p>
<p>Verification of Care Coordination Requirements</p> <p>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.</p> <p>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</p>

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.