External Quality Review

Fiscal Year 2018 – 2019

Obstetric Medical Home Record Review

Calendar Year 2018 Births
Final Report

Prepared for

Wisconsin Department of Health Services

Division of Medicaid Services

Prepared by

METASTAR

August 30, 2019

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
Project Manager
608-441-8226
lhintz@metastar.com

Danielle Sersch, BBA
Project Coordinator
608-441-8224
dsersch@metastar.com

Don Stanislawski, BA
Project Coordinator
608-441-8204
dstanisl@metastar.com

Table of Contents

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 2018-2019 for births occurring during calendar year 2018 (CY 2018). 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, 2018 – December 31, 2019. 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 994 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 2018, 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 members.

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 (SE) 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 (*i*Care)
	MHS
	Molina Healthcare of Wisconsin (MHWI)
	Network Health Plan (NHP)
	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 obstetrics (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. When reviewing and comparing results, the reader should take into account the number of records reviewed may vary year-to-year with some MCOs and/or clinics having less than 20 records reviewed.

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 994. 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	127
CCHP	SE WI	273
DHP	Dane/Rock Counties	276
GHC-SCW	Dane County	24
*i*Care	SE WI	15
MCHP	Rock County	25
MHS	Rock County/SE WI	24
MHWI	SE WI	96
NHP	SE WI	3
PPIC	Dane County	19
Quartz*	Dane County	33
Trilogy	SE WI	8
UHC	Rock County/SE WI	71
Total Records		**994**

*In 2016, the Office of the Commissioner of Insurance agreed to a proposed merger of Unity Health Plans (Unity) with another MCO. In March 2017, the merged organizations announced a new corporate brand, Quartz. Participation in the OBMH using the Quartz name began in CY 2018.

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 and MCO Affiliation – Total Records Reviewed

Medical Home Clinic	MCO	Total Records
Access Community Health Centers Dane County	DHP GHC-SCW PPIC Quartz	70
All Saints and All Saints Family Care Center* SE WI	Anthem CCHP MHS MHWI NHP UHC	63
Aurora Midwifery & Wellness Center SE WI	Anthem CCHP MHWI	48
Columbia St. Mary's Family Health Center SE WI	Anthem CCHP iCare MHS MHWI NHP	100
Dean Clinics Dane and Rock Counties	DHP	274
Froedtert East OB/GYN Residency Clinic SE WI	Anthem CCHP UHC	156
GHC-SCW Clinics Dane County	GHC-SCW	15
LifeTime OB/GYN** SE WI	Anthem CCHP NHP Trilogy UHC	68
Lisbon Avenue Health Center SE WI	Anthem CCHP iCare MHS MHWI UHC	85
Mercy Health Systems Clinics Rock County	MCHP	25

Medical Home Clinic	MCO	Total Records
Sixteenth Street Community Health Center SE WI	Anthem CCHP MHWI NHP UHC	43
St. Joseph's Hospital Women's Health Center SE WI	Anthem CCHP MHS MHWI NHP Trilogy UHC	26
Wheaton Franciscan Glendale Family Care Center SE WI	Anthem CCHP Molina NHP Trilogy	21
Total Records		**994**

*All Saints 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 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 LifeTime clinic locations changed the name to F&MCW CP OB/GYN. Because the final name change occurred in CY 2019, and this is a retrospective review, the report uses the previous name.

The DHS information system used to store 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 2017 results.

Table 4: Complete Medical Records Submissions by Clinic

Medical Home Clinic	Total Records	Complete	Incomplete	Rate Complete-2018	Rate Complete-2017
Access Community Health Centers	70	59	11	84.3%	95.4%
All Saints	63	50	13	79.4%	98.4%
Aurora Midwifery & Wellness Center	48	19	29	39.6%	79.4%
Columbia St. Mary's Family Health Center	100	97	3	97.0%	97.4%
Dean Clinics	274	202	72	73.7%	96.1%
Froedtert East OB/GYN Residency Clinic	156	152	4	97.4%	95.3%
GHC-SCW Clinics	15	12	3	80.0%	64.3%
LifeTime OB/GYN	68	60	8	88.2%	80%
Lisbon Avenue Health Center	85	53	32	62.4%	63.4%
Mercy Health Systems Clinics	25	15	10	60.0%	62.9%
Sixteenth Street Community Health Center	43	40	3	93.0%	92.9%
St. Joseph's Hospital Women's Health Center	26	25	1	96.2%	80%
Wheaton Franciscan Glendale Family Care Center	21	3	18	14.3%	17.6%
Total	**994**	**787**	**207**	**79.2%**	**83.8%**

After confirmation of the dataset, the MCOs worked with the clinics to submit or provide access to the medical records. Overall, almost 21 percent of records reviewed were incomplete during CY 2018, an increase from 16.2 percent during CY 2017. Analysis indicated the year-to-year difference in complete record submission rates is unlikely to be the result of normal variation or chance.

SECTION 1 - REVIEW FINDINGS BY MCO

VERIFICATION OF ENROLLMENT

Requirement: 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.

Results: 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 2018	Rate Requirement Met 2017
Anthem	127	117	10	92.1%	94.8%
CCHP	273	251	22	91.9%	95%
DHP	276	223	53	80.8%	88.9%
GHC-SCW	24	24	0	100%	100%
*i*Care	15	15	0	100%	100%
MCHP	25	25	0	100%	100%
MHS	24	23	1	95.8%	100%
MHWI	96	79	17	82.3%	93.5%
NHP	3	3	0	100%	100%
PPIC	19	19	0	100%	100%
Quartz	33	32	1	97%	100%
Trilogy	8	7	1	87.5%	85.7%
UHC	71	67	4	94.4%	94.7%
Total	**994**	**885**	**109**	**89.03%**	**93.9%**

Overall results for enrollees with the initial OBMH visit within the first 16 weeks of pregnancy reflect a decrease to 89.03 percent in CY 2018 from the CY 2017 rate of 93.9 percent. Individual MCO results varied in CY 2018 from CY 2017, though five remained the same at 100 percent. Rates for seven MCOs declined while one MCO demonstrated a small improvement in CY 2018 from CY 2017. Analysis indicated the year-to-year difference in the first medical home visit and enrollment within 16 weeks rate is unlikely to be the result of normal variation or chance.

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 2018 was 79.2 percent; this decreased from the CY 2017 compliance rate of 93.9 percent. Analysis indicated the year-to-year difference in the 10 appointments rate is unlikely to be the result of normal variation or chance.

Table 5B: 10 Appointments or More with OB Provider

MCO	Total Records	Met	Not Met	Rate Requirement Met 2018	Rate Requirement Met 2017
Anthem	127	98	29	77.2%	87.6%
CCHP	273	224	49	82.1%	83.6%
DHP	276	209	67	75.7%	88.1%
GHC-SCW	24	21	3	87.5%	100%
*i*Care	15	15	0	100%	100%
MCHP	25	21	4	84%	88.6%
MHS	24	20	4	83.3%	90%
MHWI	96	75	21	78.1%	82.1%
NHP	3	3	0	100%	76.9%
PPIC	19	12	7	63.2%	84.2%
Quartz	33	25	8	75.8%	100%
Trilogy	8	6	2	75%	85.7%
UHC	71	58	13	81.7%	84%
Total	**994**	**787**	**207**	**79.2%**	**93.9%**

Table 5C documents the number of records that met the requirement for enrollment through the postpartum period (60 days). This indicator includes all women who remained enrolled at least 60 days postpartum, regardless of whether follow-up care was received. (Scheduled appointments, postpartum visits beyond 60 days, and clinic encouragement to schedule postpartum appointments were included as met criteria for this indicator.) The overall compliance rate for postpartum enrollment decreased to 86.9 percent in CY 2018 from 87.7 percent in CY 2017. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

Table 5C: Enrolled Through 60 Days Postpartum

MCO	Total Records	Met	Not Met	Rate Requirement Met 2018	Rate Requirement Met 2017
Anthem	127	107	20	843%	79.1%
CCHP	273	238	35	87.2%	86.2%
DHP	276	245	31	88.8%	92.6%
GHC-SCW	24	22	2	91. 7%	100%
*i*Care	15	13	2	86.7%	80%
MCHP	25	25	0	100%	88.6%
MHS	24	22	2	91.7%	80%
MHWI	96	80	16	83.3%	86.2%
NHP	3	3	0	100%	92.3%
PPIC	19	15	4	78.9%	94.7%
Quartz	33	28	5	84.9%	87.1%
Trilogy	8	6	2	75%	85.7%
UHC	71	60	11	84.5%	94.7%
Total	**994**	**864**	**130**	**86.9%**	**87.7%**

VERIFICATION OF CARE COORDINATION

Requirement: 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.

Results: 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 decreased in CY 2018 to 25.96 percent, compared to the CY 2017 rate of 26.7 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	127	123	122	34	123	34
CCHP	273	260	261	88	262	87
DHP	276	274	273	20	273	13
GHC-SCW	24	24	24	9	24	9
*i*Care	15	15	15	11	15	10
MCHP	25	23	23	2	24	2
MHS	24	23	23	11	24	11
MHWI	96	85	85	36	84	34
NHP	3	3	3	2	3	2
PPIC	19	19	19	16	19	13
Quartz	33	32	32	18	32	18
Trilogy	8	6	7	3	8	3
UHC	71	68	69	8	69	6
Total Records	**994**	**955**	**956**	**258**	**960**	**242**
Total Rate 2018		**96.1%**	**96.2%**	**25.9%**	**96.6%**	**24.4%**
Total Rate 2017		**98.5%**	**98.3%**	**26.7%**	**98.6%**	**25.9%**

Overall the clinics have effective intake processes completing care plans that included nearly all identified needs, as demonstrated by the high rates of compliance for inclusion of intake items and self-management/self-care. Although the rate decreased from CY 2017, the compliance rates remain over 95 percent for both of these requirements. Incomplete medical record submission and incomplete documentation within the medical records continue to impact the rate of compliance for these indicators.

The medical record reviews rarely identified collaboration with the PCP. Over one-half of the records (55.7 percent) did not include documentation of an assigned PCP. When collaboration was noted, the reason in more than half of the occurrences was that the PCP provided the OB care. This was documented for 185 of the 242 (76.4 percent) met 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 declined in CY 2018.

Communication between providers on the members' OBMH teams continued to be limited. 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. This is reflected in the CY 2018 rate decrease to 24.4 percent from the CY 2017 rate of 25.9 percent. The rate was about the same for communication between providers and members (24.4 percent), as the collaboration between providers in developing a care plan (25.9 percent), and reflected the lack of documentation about a PCP (either identifying the PCP or documenting the communication with a PCP).

Table 6B shows, for each MCO, the number of records that documented members were offered home visits.

Table 6B: Care Coordination – Home Visits

MCO	Total Records	Home Visits Offered	Rate Met Requirement 2018	Rate Met Requirement 2017
Anthem	127	51	40.2%	52.3%
CCHP	273	134	49.1%	61.3%
DHP	276	224	81.2%	90.5%
GHC-SCW	24	22	91. 7%	94.7%
*i*Care	15	9	60%	80%
MCHP	25	14	56%	34.3%
MHS	24	13	54.2%	90%
MHWI	96	37	38.5%	65.9%
NHP	3	2	66.7%	76.9%

MCO	Total Records	Home Visits Offered	Rate Met Requirement 2018	Rate Met Requirement 2017
PPIC	19	19	100%	100%
Trilogy	8	3	37.5%	14.3%
Quartz	33	30	90.9%	100%
UHC	71	35	49.3%	65.3%
Total	**994**	**593**	**59.7%**	**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 with the record submission for review. Of the 401 records that did not meet the home visit element, 384 (95.8%) were due to incomplete documentation. Analysis indicated the year-to-year difference in the home visit rate is unlikely to be the result of normal variation or chance.

Only 140 members accepted a home visit. Of those, 98 had documentation in their records that at least one home visit occurred (70%), with 48 of the 98 members (49%) who received five or more home visits.

Verification of Postpartum Care Coordination and Discharge Planning

Requirement: 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 (PPV) 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.

Results: Tables 7A, 7B, 7C, 7D, and 7E document the results of the record review for 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 2018 was 71.33 percent, a decrease from 77.9 percent in CY 2017. The table also shows the number of records where communication with the member's PCP took place after delivery. The post-delivery communication with the PCP also declined from 36.4 percent in CY 2017 to 27.57 percent in CY 2018. However, this rate remains higher than PCP communication during the prenatal period.

Table 7A: Post-Delivery Requirements

MCO	Total Records	At Least One PPV	Communication with PCP
Anthem	127	93	33
CCHP	273	188	86
DHP	276	201	57
GHC-SCW	24	16	11
*i*Care	15	12	9
MCHP	25	23	2
MHS	24	20	12
MHWI	96	64	32
NHP	3	3	2
PPIC	19	8	13
Quartz	33	24	21
Trilogy	8	6	3
UHC	71	51	3
Total	**994**	**709**	**284**
Total Rate 2018		**71.3%**	**28.6%**
Total Rate 2017		**77.9%**	**36.0%**

Some clinics that use an EMR system may rely on internal messaging systems not accessible to MetaStar reviewers, thus contributing to lower PCP communication rates. In 55.7 percent of the member records, a PCP was not documented. This is an increase from CY 2017 when 40.2 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	127	123	109	120	107
CCHP	273	259	226	258	213
DHP	276	270	260	256	248
GHC-SCW	24	23	23	24	19
*i*Care	15	15	14	14	14
MCHP	25	24	23	25	20
MHS	24	24	21	22	20
MHWI	96	90	76	92	79
NHP	3	3	3	3	3
PPIC	19	19	19	18	16
Quartz	33	33	32	30	23
Trilogy	8	7	6	7	6
UHC	71	68	61	68	51
Total	**994**	**958**	**873**	**937**	**819**
Total Rate 2018		**96.4%**	**87.8%**	**94.3%**	**82.4%**
Total Rate 2017		**96.9%**	**92.8%**	**96.5%**	**92.5%**

Record review found MCO members continue to consistently receive information about key topics associated with postpartum care. MetaStar reviewers noted that education still takes place periodically throughout the prenatal period including encouraging members to attend classes offered by clinics and other public agencies. Rates of compliance for CY 2018 are lower for all educational elements than CY 2017.

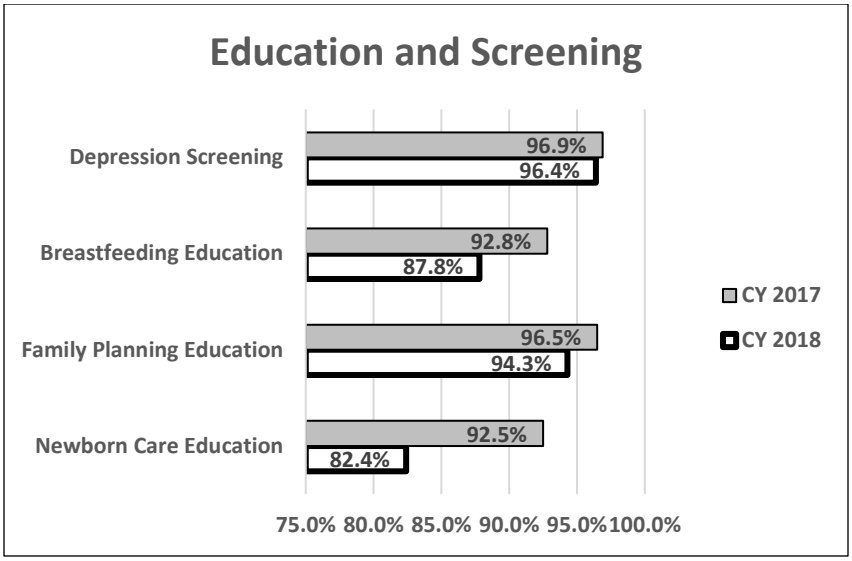


Table 7C identifies the number of members who received education or screening, the type received, and when during the pregnancy it occurred. The total records that included education or screening are greater than the total member records reviewed because members received education or screening for more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

Table 7C: Education and Screening Timing

Education or Screening Type	Prenatal	Postpartum	Prenatal and Postpartum
Depression Screening	164	75	719
Breastfeeding Education	353	91	429
Family Planning Education	122	195	620
Newborn Care Education	385	58	376
Total	**1024**	**419**	**2144**
Rate 2018	**28.6%**	**11.7%**	**59.8%**
Rate 2017	**27 %**	**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 (59.8 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	958	16.50%	7.55%	72.33%
Breastfeeding Education	873	35.51%	9.15%	43.16%
Family Planning Education	937	12.27%	19.62%	62.37%
Newborn Care Education	819	38.73%	5.84%	37.83%

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 health, and morbid obesity.

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	127	76	7	44
CCHP	273	163	12	98
DHP	276	188	3	85
GHC-SCW	24	18	1	5
*i*Care	15	10	0	5
MCHP	25	18	0	7
MHS	24	12	1	11
MHWI	96	66	13	17
NHP	3	2	0	1
PPIC	19	13	0	6
Quartz	33	23	1	9
Trilogy	8	3	0	5
UHC	71	47	4	20
Total	**994**	**639**	**42**	**313**
Total Rate (N=681)		**93.8%**	**6.2%**	**31.5%**
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, 31.5 percent of members (313 members) did not have a chronic condition. Of the 681 women who had a chronic condition, 338 (49.6 percent) had more than one condition. The most common chronic conditions included:

- Behavioral Health (363);
- Morbid Obesity/Obesity (188);
- Asthma (177) ,
- Hypertension (51);
- Substance Abuse (54);
- Diabetes (22);
- Genital Herpes (69); and
- Thyroid Conditions (31).

Some additional, but not all-inclusive, examples of chronic conditions diagnosed in members included: cardiac conditions, gastroesophageal reflux disease (GERD), migraines, Lupus, Fibromyalgia, Cerebral Palsy, Multiple Sclerosis, chronic obstructive pulmonary disease, hepatitis, epilepsy, and Crohn's disease. Twenty-six 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 118 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 107 women, but did not find sufficient information in the registry for 11 of the women. Of the 118 members without documentation of the outcome in the medical record, nine were identified with poor birth outcomes by the clinics in the registry. MetaStar identified 136 poor birth outcomes in the medical records for the remaining members in this reporting group, for a total rate of 14.59 percent (145 of 994 women, with available outcome information).

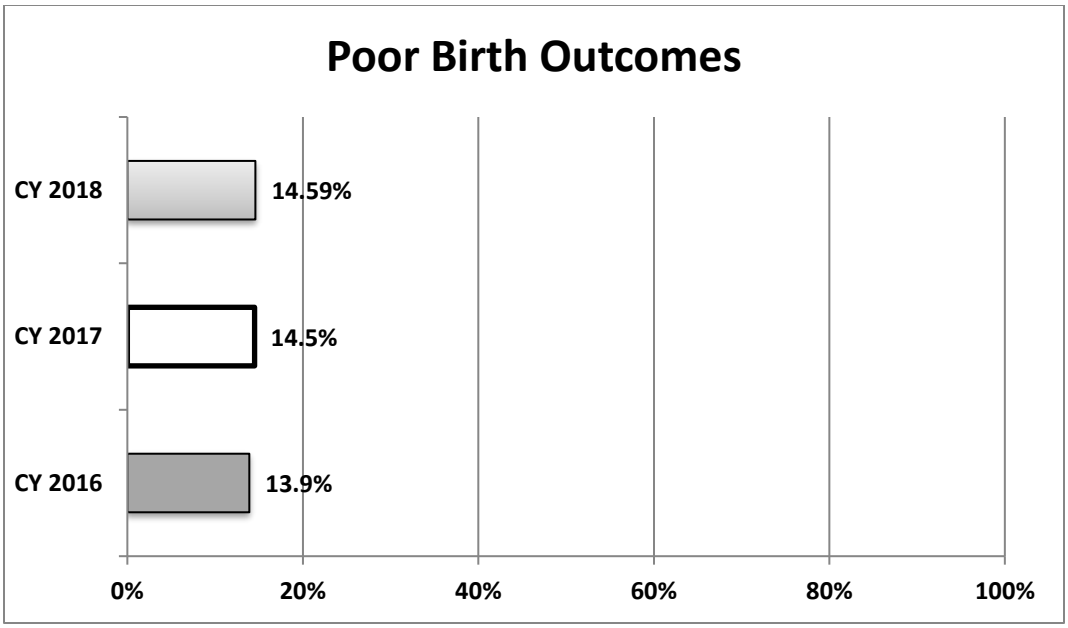
Table 8A below identifies the rates of healthy birth outcomes and poor birth outcomes verified in medical records and documented in the registry, as defined by DHS for this initiative.

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	127	102	17	8	7	1	0
CCHP*	273	208	41	24	20	0	4
DHP*	276	177	37	62	50	8	4
GHC-SCW	24	21	2	1	1	0	0
*i*Care	15	13	2	0	0	0	0
MCHP*	25	18	1	6	6	0	0
MHS	24	17	4	3	2	0	1
MHWI	96	72	15	9	8	0	1
NHP	3	3	0	0	0	0	0
PPIC	19	15	4	0	0	0	0
Quartz	33	31	2	0	0	0	0
Trilogy	8	6	0	2	2	0	0
UHC*	71	57	11	3	2	0	1
Total	**994**	**740**	**136**	**118**	**98**	**9**	**11**
Overall Rate 2018 (N=Total)		**84.3%**	**14.6%**				
Overall Rate 2017		**85.5%**	**14.5%**				

Notes: The overall rate of healthy and poor birth outcomes for both calendar years was calculated using unverified registry results. *Includes 10 sets of twins and one set of triplets delivered by mothers affiliated with these MCOs; 19 of the 23 infants had poor birth outcomes which are included in table 8B below.

The poor birth outcome rate increased slightly in CY 2018 (14.6 percent) compared to CY 2017 (14.5 percent), and is greater than the CY 2016 (13.9 percent) rate. Analysis indicated the year-to-year difference in the poor birth outcome rates is likely due to normal variation or chance.



The reasons associated with the poor birth outcomes in CY 2018 compared to CY 2017 are documented in Table 8B below.

Table 8B: Reasons for Poor Birth Outcomes

Poor Birth Outcome Reason	All Infants 2018*	All Infants 2017**
Pre-term birth	37	44
Pre-term and death	0	1
Pre-term and stillbirth	0	2
Low birth weight	32	28
Pre-term birth and low birth weight	70	72
Pre-term birth, low birth weight and death	9	2
Stillbirth	0	1
Neonatal death	2	3
Total Poor Birth Outcomes	**150**	**153**

*Includes 10 sets of twins and one set of triplets; 19 of the 23 infants had poor birth outcomes.

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

SECTION 2 - REVIEW FINDINGS BY CLINIC

VERIFICATION OF ENROLLMENT REQUIREMENTS

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 2018	Rate Met Requirement 2017
Access Community Health Centers	70	67	3	95.7%	100%
All Saints	63	54	9	85.7%	100%
Aurora Midwifery & Wellness Center	48	28	20	58.3%	91.2%
Columbia St. Mary's Family Health Center	100	98	2	98%	98.3%
Dean Clinics	274	221	53	80.7%	88.4%
Froedtert East OB/GYN Residency Clinic	156	149	7	95.5%	98%
GHC-SCW Clinics	15	15	0	100%	100%
LifeTime OB/GYN	68	67	1	98.5%	98%
Lisbon Avenue Health Center	85	81	4	95.3%	82.8%
Mercy Health Systems Clinics	25	25	0	100%	100%
Sixteenth Street Community Health Center	43	40	3	93.0%	89.3%
St. Joseph's Hospital Women's Health Center	26	21	5	80.8%	98.3%
Wheaton Franciscan Glendale Family Care Center	21	19	2	90.5%	86.3%
Total (All Clinics)	**994**	**885**	**109**	**89%**	**93.9%**

Overall results for enrollees with the initial OBMH visit within the first 16 weeks of pregnancy reflects a decrease increase to 89 percent in CY 2018 from 93.9 percent in CY 2017. The individual clinics year-to-year rate of compliance varied between CY 2018 and CY 2017. Of the 13 clinics that were included in both calendar years, 30.8 percent showed an increase in CY 2018 from CY 2017. Wheaton Franciscan showed the greatest increase, from 86.3 percent in CY 2017 to 90.48 percent in CY 2018. Aurora clinic indicated the largest decline at almost 33 percent.

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 2018	Rate Met Requirement 2017
Access Community Health Centers	70	51	19	72.9%	92.3%
All Saints	63	54	9	85.7%	92.1%
Aurora Midwifery & Wellness Center	48	19	29	39.6%	79.4%
Columbia St. Mary's Family Health Center	100	96	4	96%	98.3%
Dean Clinics	274	207	67	75.5%	88.4%
Froedtert East OB/GYN Residency Clinic	156	143	13	91.7%	94.6%
GHC-SCW Clinics	15	14	1	93.3%	100%
LifeTime OB/GYN	68	56	12	82.4%	84%
Lisbon Avenue Health Center	85	60	25	70.6%	63.4%
Mercy Health Systems Clinics	25	21	4	84%	88.6%
Sixteenth Street Community Health Center	43	40	3	93%	85.7%
St. Joseph's Hospital Women's Health Center	26	22	4	84.6%	85%
Wheaton Franciscan Glendale Family Care Center	21	4	17	19.1%	56.9%
Total (All Clinics)	**994**	**787**	**207**	**79.2%**	**86.2%**

The overall rate of compliance declined in CY 2018 (79.2 percent) from CY 2017 (86.2 percent). Two of the 13 clinics (15.4 percent) demonstrated improvement in the rates from year-to-year. Eleven clinics declined (84.6 percent). Sixteenth Street showed the largest increase, from 85.7 percent in CY 2017 to 93 percent in CY 2018. However, analysis indicated the year-to-year difference in the Sixteenth Street rates for this indicator is likely due to normal variation or chance.

Aurora showed the largest decrease from 79.4 percent in CY 2017 to 39.58 percent in CY 2018. Analysis indicated the year-to-year difference in Aurora's rate for this indicator is unlikely to be the result of normal variation or chance.

Table 9C documents the number of records that met the requirement for enrollment through the postpartum period (60 days). This indicator includes all women who remained enrolled at least 60 days postpartum, regardless of whether follow-up care was received. (Scheduled appointments, postpartum visits beyond 60 days, and clinic encouragement to schedule postpartum appointments were included as met criteria for this indicator.)

Table 9C: Enrolled Through 60 Days Postpartum

Medical Home Clinic	Total Number of Records	Met	Not Met	Rate Met Requirement 2018	Rate Met Requirement 2017
Access Community Health Centers	70	59	11	84.3%	90.8%
All Saints	63	53	10	84.1%	90.5%
Aurora Midwifery & Wellness Center	48	36	12	75%	82.4%
Columbia St. Mary's Family Health Center	100	95	5	95%	94.9%
Dean Clinics	274	243	31	88.7%	92.7%
Froedtert East OB/GYN Residency Clinic	156	145	11	92.9%	96.6%
GHC-SCW Clinics	15	15	0	100%	100%
LifeTime OB/GYN	68	56	12	82.4%	86%
Lisbon Avenue Health Center	85	70	15	82.4%	78.5%
Mercy Health Systems Clinics	25	25	0	100%	88.6%
Sixteenth Street Community Health Center	43	37	6	86.1%	89.3%
St. Joseph's Hospital Women's Health Center	26	22	4	84.6%	83.3%
Wheaton Franciscan Glendale Family Care Center	21	8	13	38.1%	64.7%
Total (All Clinics)	**994**	**864**	**130**	**86.9%**	**87.7%**

Four of the 13 clinics showed improvement in the compliance rate for this element (30.8 percent) when comparing CY 2018 to CY 2017. However, the overall rate of compliance was nearly the same; the CY 2018 rate was 86.9 percent while the CY 2017 rate was 87.7 percent.

Mercy Health Systems showed the greatest increase, 2018 from 88.6 percent in CY 2017 to 100 percent in CY. Analysis indicated the year-to-year difference in the Mercy Health Systems rates for this indicator is likely due to normal variation or chance.

Wheaton Franciscan had the largest decrease, from 64.7 percent in CY 2017 to 38.1 percent in CY 2018. Analysis indicated the year-to-year difference in Wheaton Franciscan's rate for this indicator is unlikely to be the result of normal variation or chance.

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 10A and 10B.

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	70	69	69	43	69	40
All Saints	63	61	61	16	63	16
Aurora Midwifery & Wellness Center	48	26	26	0	26	0
Columbia St. Mary's Family Health Center	100	100	100	94	100	94
Dean Clinics	274	272	271	18	271	11
Froedtert East OB/GYN Residency Clinic	156	153	154	18	154	21
GHC-SCW Clinics	15	15	15	5	15	5
LifeTime OB/GYN	68	64	64	7	65	4
Lisbon Avenue Health Center	85	84	84	47	84	40
Mercy Health Systems Clinics	25	23	23	2	24	2
Sixteenth Street Community Health Center	43	43	43	2	43	3
St. Joseph's Hospital Women's Health Center	26	26	26	2	26	2
Wheaton Franciscan Glendale Family Care Center	21	19	20	4	21	4
All Clinics	**994**	**955**	**956**	**258**	**961**	**242**
2018 Rates		**96.1%**	**96.2%**	**25.9%**	**96.7%**	**24.4%**
2017 Rates		**98.5%**	**98.3%**	**26.7%**	**98.6%**	**25.9%**

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 decreased in CY 2018 (96.08 percent) from CY 2017 (98.5 percent). Most clinics demonstrated over 90 percent compliance for these two elements.

Collaboration with the PCP was again seldom identified during the medical record reviews. Over half of the records (55.7 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 185 of the 242 (76.4 percent) positive results for this review element. Aurora Midwifery & Wellness Center again 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 decreased slightly in CY 2018. Six of the 13 clinics (46 percent) fully met this requirement. 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. The CY 2018 rate decreased to 24.35 percent from the CY 2017 rate of 25.9 percent. The rate was nearly the same for communication between providers and members (24.35 percent), as the collaboration between providers in developing a care plan (25.96 percent), and reflected the lack of documentation about a PCP (either identifying the PCP or documenting the communication with a PCP).

Table 10B shows, for each clinic, the number of records reviewed, and the number of records that documented members were offered home visits.

Table 10B: Care Coordination – Home Visits

Medical Home Clinic	Total Number of Records	Home Visit Offered	Rate Met Requirement 2018	Rate Met Requirement 2017
Access Community Health Centers	70	65	92.9%	100%
All Saints	63	54	85.7%	100%
Aurora Midwifery & Wellness Center	48	3	6.3%	2.90%
Columbia St. Mary's Family Health Center	100	74	74%	88.9%
Dean Clinics	274	222	81%	90.1%
Froedtert East OB/GYN Residency Clinic	156	108	69.2%	93.9%
GHC-SCW Clinics	15	14	93.3%	92.9%
LifeTime OB/GYN	68	2	2.9%	4%
Lisbon Avenue Health Center	85	14	16.5%	57%
Mercy Health Systems Clinics	25	14	56%	34.3%
Sixteenth Street Community Health Center	43	3	6.9%	57.1%
St. Joseph's Hospital Women's Health Center	26	20	76.9%	80%
Wheaton Franciscan Glendale Family Care Center	21	0	0%	2%
Total (All Clinics)	**994**	**593**	**59.7%**	**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 PNCC agencies, and those portions of the overall care provided are not consistently included submitted for inclusion in the review. Of the 401 records that did not meet the home visit element, 384 (95.8 percent) were due to incomplete documentation. For example, extremely low rates of compliance with this review element at Aurora Midwifery & Wellness Center, LifeTime OB/GYN, Sixteenth Street, and Wheaton Franciscan Glendale Family Care Center were all related to incomplete documentation.

Only 140 members accepted a home visit. Of those, 98 had documentation in their records that at least one home visit occurred (69.5 percent), with 48 of the 98 members (49%) 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.

Tables 11A, 11B, 11C, and 11D document the results of the record review for 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	70	43	43
All Saints	63	45	16
Aurora Midwifery & Wellness Center	48	24	0
Columbia St. Mary's Family Health Center	100	86	95
Dean Clinics	274	200	55
Froedtert East OB/GYN Residency Clinic	156	112	14
GHC-SCW Clinics	15	11	6
LifeTime OB/GYN	68	41	2
Lisbon Avenue Health Center	85	68	42
Mercy Health Systems Clinics	25	23	2
Sixteenth Street Community Health Center	43	35	2
St. Joseph's Hospital Women's Health Center	26	14	3
Wheaton Franciscan Glendale Family Care Center	21	7	4
Total (All Clinics)	**994**	**709**	**284**
Total Rate 2018		**71.3%**	**28.6%**
Total Rate 2017		**77.9%**	**36.4%**

Similar to the other requirements related to communication with PCPs, the rate for communication with PCP after delivery was low, although higher than communication during the prenatal care period. One factor contributing to the low rate may be that a PCP was not documented in 55.7 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 at least one PPV decreased to 71.33 percent in CY 2018 from 77.9 percent in CY 2017. The postpartum PCP communication also decreased, from 36.4 percent in CY 2017 to 28.6 percent in CY 2018.

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

Table 11B: Education and Screening

Clinic	Total Records	Depression Screening	Breastfeeding Education	Family Planning Education	Newborn Care Education
Access Community Health Centers	70	68	67	65	54
All Saints	63	62	54	61	61
Aurora Midwifery & Wellness Center	48	38	27	41	23
Beloit Clinic	0	0	0	0	0
Columbia St. Mary's Family Health Center	100	100	95	97	98
Dean Clinics	274	268	258	254	247
Froedtert East OB/GYN Residency Clinic	156	150	128	152	124
GHC-SCW Clinics	15	15	15	15	11
LifeTime OB/GYN	68	62	51	62	30
Lisbon Avenue Health Center	85	84	15	0	69
Mercy Health Systems Clinics	25	0	0	0	0
Sixteenth Street Community Health Center	43	43	6	0	37
St. Joseph's Hospital Women's Health Center	26	26	6	1	19
UW Health Arboretum	0	0	0	0	0
Waukesha Family Medicine Center	0	0	0	0	0
Wheaton Franciscan Glendale Family Care Center	21	18	8	4	6
Total	**994**	**934**	**730**	**752**	**779**
Total Rate 2018		**93.9%**	**73.4%**	**75.7%**	**78.4%**
Total Rate 2017		**96.9%**	**92.8%**	**96.5%**	**92.5%**

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 2018 are lower than CY 2017, but remain over 80 percent compliance for all educational elements.

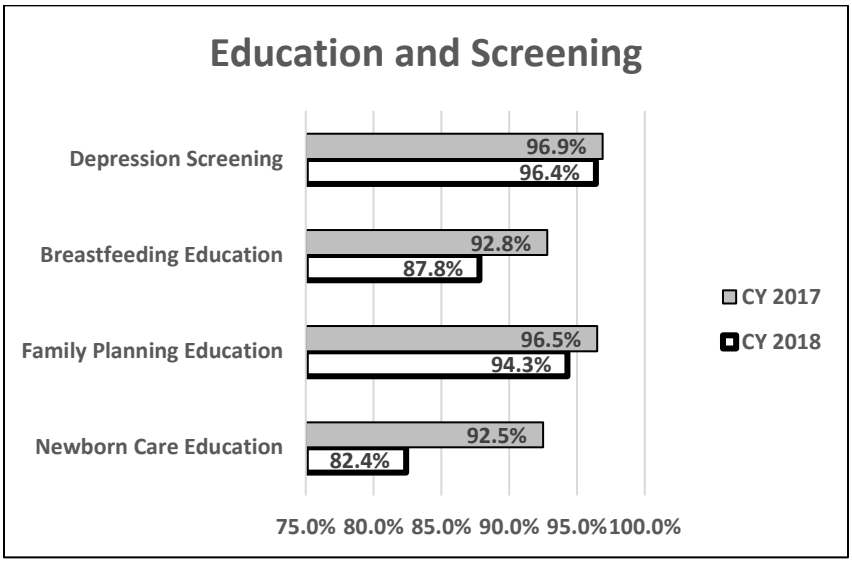


Table 11C identifies the number of members by clinic who received education or screening, the type received, and when during the pregnancy it occurred. The total records that included education or screening are greater than the total member records reviewed because members received education or screening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

Table 11C: Education and Screening Timing

Education or Screening Type	Prenatal	Postpartum	Prenatal and Postpartum
Depression Screening	164	75	719
Breastfeeding Education	353	91	429
Family Planning Education	122	195	620
Newborn Care Education	385	58	376
Total	**1024**	**419**	**2144**
Rate 2018	**28.6%**	**11.7%**	**59.8%**
Rate 2017	**27%**	**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 (59.77 percent) of screening and education was provided in both the prenatal and postpartum care periods.

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 health.

Table 11D 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 11D: 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	70	48	2	20
All Saints	63	47	2	14
Aurora Midwifery & Wellness Center	48	18	23	7
Columbia St. Mary's Family Health Center	100	58	0	42
Dean Clinics	274	186	3	85
Froedtert East OB/GYN Residency Clinic	156	102	4	50
GHC-SCW Clinics	15	12	0	3
LifeTime OB/GYN	68	30	4	34
Lisbon Avenue Health Center	85	56	3	26
Mercy Health Systems Clinics	25	18	0	7
Sixteenth Street Community Health Center	43	38	0	5
St. Joseph's Hospital Women's Health Center	26	16	1	9
Wheaton Franciscan Glendale Family Care Center	21	10	0	11
Total (All Clinics)	**994**	**639**	**42**	**313**
Total Rate 2018 (N=681)		**93.8%**	**6.2%**	**31.5%**
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, 31.5 percent of members (313 members) did not have a chronic condition. Of the 681 women who had a chronic condition, 338 (49.6 percent) were found to have more than one chronic condition. The most common chronic conditions included:

- Behavioral Health (363);
- Morbid Obesity/Obesity (188);
- Asthma (177) ,
- Hypertension (51);
- Substance Abuse (54);
- Diabetes (22);
- Genital Herpes (69); and
- Thyroid Conditions (31).

Some additional, but not all-inclusive, examples of chronic conditions diagnosed in members included: cardiac conditions, GERD, migraines, Lupus, Fibromyalgia, Cerebral Palsy, Multiple Sclerosis, chronic obstructive pulmonary disease, and hepatitis, epilepsy, and Crohn's disease. Twenty-six 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 118 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 107 women, but did not find sufficient information in the registry for 11 women. Of the 118 members without documentation of the outcome in the medical record, nine were identified with poor birth outcomes by the clinics in the registry. MetaStar identified 136 poor birth outcomes in the medical records for the remaining members in this reporting group, for a total rate of 14.59 percent (145 of 994 women, with available outcome information).

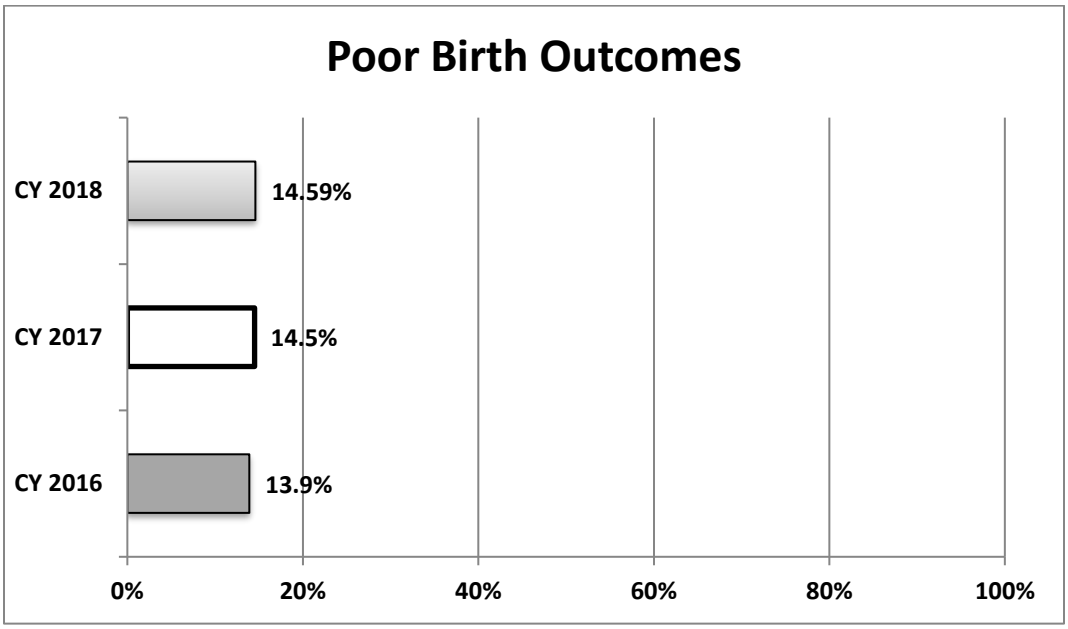
Table 12A below identifies the rates of healthy birth outcomes and poor birth outcomes by clinic, verified in medical records and documented by clinics in the registry, as defined by DHS for this initiative.

Table 12A: Birth Outcomes

Clinic	Total Records	Healthy Birth Outcome	Poor Birth Outcome	Unknown	Registry = Healthy Birth Outcome	Registry = Poor Birth Outcome	Registry = Unknown
Access Community Health Centers	70	61	8	1	1	0	0
All Saints	63	44	15	4	2	0	2
Aurora Midwifery & Wellness Center	48	31	5	12	11	0	1
Beloit Clinic	0	0	0	0	0	0	0
Columbia St. Mary's Family Health Center	100	86	13	1	1	0	0
Dean Clinics*	274	175	37	62	50	8	4
Froedtert East OB/GYN Residency Clinic*	156	128	25	3	3	0	0
GHC-SCW Clinics	15	13	1	1	1	0	0
LifeTime OB/GYN	68	59	7	2	1	0	1
Lisbon Avenue Health Center	85	65	18	2	1	0	1
Mercy Health Systems Clinics*	25	18	1	6	6	0	0
Sixteenth Street Community Health Center	43	37	2	4	3	0	1
St. Joseph's Hospital Women's Health Center	26	21	4	1	1	0	0
UW Health Arboretum	0	0	0	0	0	0	0
Waukesha Family Medicine Center	0	0	0	0	0	0	0
Wheaton Franciscan Glendale Family Care Center	21	2	0	19	17	1	1
Total	**994**	**740**	**136**	**118**	**98**	**9**	**11**
Overall Rate 2018 (N=Total)		**84.3%**	**14.6%**				
Overall Rate 2017		**84.6%**	**14.5%**				

Note: The overall rate of healthy and poor birth outcomes for both calendar years was calculated using unverified registry results. *Includes 10 sets of twins and one set of triplets delivered by mothers affiliated with these clinics; 19 of the 23 infants had poor birth outcomes which are included in table 12B below.

The poor birth outcome rate increased slightly in CY 2018 (14.6 percent) compared to CY 2017 (14.5 percent), and is greater than the CY 2016 (13.9 percent) rate. Analysis indicated the year-to-year difference in the poor birth outcome rates is likely due to normal variation or chance.



The reasons associated with the poor birth outcomes in CY 2018 compared to CY 2017 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 10 sets of twins and one set of triplets born during CY 2018, with 19 of the 23 infants experiencing a poor birth outcome.

Table 12B: Reasons for Poor Birth Outcomes

Poor Birth Outcome Reason	All Infants 2018*	All Infants 2017**
Pre-term birth	37	44
Pre-term and death	0	1
Pre-term and stillbirth	0	2
Low birth weight	32	28
Pre-term birth and low birth weight	70	72
Pre-term birth, low birth weight and death	9	2
Stillbirth	0	1
Neonatal death	2	3
Total Poor Birth Outcomes	**150**	**153**

*Includes 10 sets of twins and one set of triplets; 19 of the 23 infants had poor birth outcomes.
**Includes three sets of twins and one set of triplets; six of the nine 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.

- Most clinics document clear follow-through and treatment of chronic conditions that, if untreated or not monitored, could have a negative impact upon the pregnancy.
- Consistent with previous reporting years, the care coordination models and documentation of prenatal care coordination continue to vary by clinic. The documentation reflects some clinics have clear, detailed, and easy to understand 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 5 percent to over 90 percent.
- Documentation continues to show substance abuse and domestic violence concerns are increasing as chronic concerns within individual medical records across almost all clinics and MCOs.

OPPORTUNITIES FOR IMPROVEMENT AND RECOMMENDATIONS

Over half of the clinics demonstrated a decline in the submission of complete medical records. A medical record submission is considered complete when it includes clinic notes, prenatal care, postpartum care, PNCC documentation, and birth outcome information. MetaStar recommends these clinics:

- Complete a root cause analysis to identify barriers; then, conduct continuous cycles of improvement to mitigate the barriers.

Clinics contracting with external PNCC agencies continue to inconsistently provide the needed documentation during record review for complete medical record submissions. MetaStar recommends these clinics:

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

The decline in compliance rates of clinics offering home visits to its members was unlikely to be the result of normal variation or chance. As noted above, there is a correlation between this rate and the submission of complete medical records. MetaStar recommends the clinics:

- Conduct a root cause analysis including record submission, documentation practices, training, and care management processes to identify barriers. Then, conduct continuous cycles of improvement to mitigate the barriers.

The decline reported for members attending at least 10 prenatal visits was also unlikely the result of normal variation or chance. MetaStar recommends the MCOs:

- Collaborate with contracted clinics to identify the barriers to member engagement and implement efforts to overcome the barriers.

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 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 EQR of MCOs serving BadgerCare Plus (BC+), Supplemental Security Income, 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

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

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:

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.
4. 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

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.