Article IV

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

The OB Medical Home for high-risk pregnant women is a care delivery model that is patient-centered, comprehensive, team-based, coordinated, accessible and focused on quality. The initiative is available in the following counties: Dane, Kenosha, Milwaukee, Ozaukee, Racine, Rock, Washington, and Waukesha. The care team is responsible for meeting the patient's physical, behavioral health and psychosocial needs. A key component of the OBMH is enhanced care coordination provided early in the prenatal period through the postpartum period (60 days after delivery). Care coordination is defined as the deliberate organization of patient activities between two or more individuals involved with the patient's care to facilitate the delivery of appropriate services.

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

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

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

Requirements

1. Target Population

   The target population for the OB Medical Home Initiative is pregnant BadgerCare Plus and Medicaid SSI members who are at high-risk for a poor birth outcome. A poor birth outcome is defined as:

- Preterm birth – gestational age less than 37 weeks
- Low birth weight – birth weight less than 2,500 grams (5 lbs. 8 oz.)
- Neonatal/early neonatal death – death of a live-born infant within the first 28 days of life
- Stillbirth – a fetal demise after 20 weeks gestation

2. Members eligible to participate in the OBMH Initiative

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

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

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

3. Payment Structure

   Enhanced payments are available for clinics for pregnant women that meet the defined eligibility criteria above and the criteria for delivery of services articulated below. The Department currently issues payments to the HMOs and the HMOs subsequently issue the enhanced payment on to the OB medical home site.

   Medical record reviews by the Department's External Quality Review Organization (EQRO) will be used to verify eligibility. If the EQRO is unable to verify any of the criteria as required by the OB Medical Home Initiative, the clinic is ineligible for the enhanced payment for those women. To receive the initial $1,000, at minimum, the clinic must clearly document that all the following criteria are met. The member:

- Has had a pregnancy-related appointment with a health care provider within the first 16 weeks of her pregnancy.

  She must also be enrolled in the OB Medical Home within 20 weeks of her pregnancy (the clinic is responsible for obtaining all medical records for documentation). Enrollment in the OB Medical Home means being entered into the OBMH registry.

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

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

- Has been continuously enrolled in the OB medical home and receiving services during her pregnancy, and

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

The Department will issue an additional $1,000 (for a total of $2,000) if the mother has a healthy birth outcome as defined by the Department.

Pregnancy loss prior to 20 weeks will not be eligible for the OBMH incentive, as limited care coordination and delivery of other services has occurred. Providers will still receive payment for the medical prenatal care through the usual claim submission process.

4. External Quality Review

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

   The Department's EQRO will conduct chart reviews that:

   - Verify enrolled members meet the defined contract requirements;
   - Collect data to support potential future program refinements; and
   - Collect data to support program evaluation.

The HMO is responsible for working with the medical home sites, external PNCC providers, hospitals and any other care provider that may or should have documentation of OB medical home services to ensure required documentation is submitted to the Department's EQRO in a timely manner. For medical home sites that provide remote access to records, the EQRO will access records that have been specified as OBMH ~~participant~~members. If the patient is not on the record review list, the EQRO will not access those records.

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

5. HMO Responsibilities

a. HMO representative

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

b. HMO Outreach and Member Engagement

HMOs must actively seek to identify and engage eligible members for participation in the OBMH. At a minimum, this should include a variety of strategies, e.g., working with existing organizations having similar goals, increasing public awareness about the OB Medical Home Initiative and its services, screening new members for eligibility, reviewing the BORN report periodically and working with colleagues to develop and implement creative strategies such as health fairs or street teams.

c. OB Medical Home Sites

HMOs must distribute communications from DHS to its participating clinics and are accountable for ensuring contracted OB medical home sites meet the requirements below.

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

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

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

- Use an electronic health record system to manage patient data to:

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

- Provide appropriate best practice medical care for high-risk pregnant women, which may include:

    - Consultation from a maternal fetal specialist and close monitoring and surveillance;

- To the extent it is covered by ForwardHealth (such as through in person consultation per ForwardHealth Topic 510), HMOs may encourage OBMH providers to use telehealth services to identify problems early in the pregnancy and provide treatment to avoid further complications and preterm labor. HMOs have the flexibility to use administrative funding to support more enhanced telehealth services like store and forward (asynchronous) and remote patient monitoring;

- Progesterone therapy, as appropriate;

- Plan for interconception care, including educating members on options for long-acting reversible contraception post-delivery as part of "LARC First practice." This is the practice of a prescriber who promotes awareness and use of long-acting reversible contraception as the first-line contraceptive option for women, including teens.

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

  - Asthma
  - HIV/AIDS
  - Cardiac disease
  - Diabetes mellitus
  - Hypertension
  - Pulmonary disease
  - Behavioral health, including
    - Depression
    - Smoking
    - Substance Abuse
  - Morbid Obesity

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

- Develop guidelines to ensure that screening for social factors (that could have a negative impact on pregnancy outcome and newborn health) is a routine part of care to the pregnant and postpartum member. The guidelines should address the following:

    - Integrating initial and periodic screening into information gathering

    - Incorporating identified social needs (and strengths) into the comprehensive care plan

    - Effective strategies for addressing social factors, including the following,

        - Identifying pertinent community resources, including personal supports;
        - Referral to community health worker services;
        - Developing effective working/referral relationships with these resources;
        - Communication and information sharing (e.g., obtaining written authorization from the member where necessary);
        - Obtaining periodic feedback from members and community resources to ensure identified resources continue to be relevant and appropriate.

    - Systematic electronic tracking and follow-up on community and social determinants of health referrals to ensure referral completion.

- Actively support and promote patient self-management.

- Demonstrate cultural competency among provider and office staff.

6. Care Coordination – General Requirements

   A key component of the OB Medical Home Initiative is the coordination of care for the member. Each medical home site must have a designated care coordinator

on-site (located where the member's OB care provider is located) to do the following:

- Establish a relationship with the member and maintain regular face-to-face contact throughout the pregnancy;

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

- Make referrals to appropriate services (e.g., physical, dental, behavioral health and psychosocial) and provide follow up.

The care coordinator may be an employee of the medical home site or of the HMO, under contract, or under a Memorandum of Understanding/Agreement. All care coordinators must be easily accessible on a regularly established schedule for members participating in the OB medical home.

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

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

a. Information Gathering and Comprehensive Assessment of Need

   Prior to the development of a comprehensive care management plan, the OB care provider must communicate with pertinent health care providers, the member and others as appropriate, to identify the member's strengths and care coordination needs. Information gathering activities include:

   - Obtaining pertinent information from the initial prenatal clinic visit, the OB care provider, the member's PCP, HMO or other source;

- Taking the member's history to identify social factors that could have a negative impact on the health and well-being of the mother and baby;

- Identifying the member's strengths and social support.

b. Comprehensive Care Plan

The care coordinator must ensure that each medical home member has a comprehensive care plan. The OB care provider must be central to the development of the care plan. To the maximum extent possible, the member and the member's PCP (if different from the OB care provider) must also be included in the development of the care plan.

The care plan must address the medical and non-medical needs identified during the information gathering process and must include:

- A listing of key health and community resources specific to the member's needs;

- A prioritized plan of action that reflects the member's preferences and goals;

- Timeframes for addressing (and following-up on) each identified need;

- Strategies to encourage patient self-care and adherence to treatment recommendations (e.g., assisting the member in identifying self-management goals and in communicating with her obstetric care provider, offering home visits, checking in with the member between visits, referring members to group classes, and sharing culturally sensitive and appropriate materials).

The care coordinator should offer home visits. Best practice suggests that the home visit occur within 30 days of enrollment in the medical home. Members, who decline the initial offer, should be asked again throughout the pregnancy. The offer attempts and refusals must be documented in the medical record.

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

The care plan must be developed by the OB care provider, the care coordinator, and the member. The provider must attest to the agreement and understanding of the care plan by the respective parties and document, including the date, within the EHR. The plan must be reviewed and updated as the member's health and circumstances change.

c. Ongoing Monitoring and Follow-up

Ongoing monitoring and follow-up include activities and contacts that are necessary to implement and maintain the care plan. These activities include:

- Ensuring services are being furnished in accordance with the member's care plan;
- Making referrals, which includes related activities such as assisting with scheduling follow-up appointments;
- Tracking and following up on all referrals, including referrals to community resources;
- Flagging critical referrals to ensure immediate follow-up on overdue reports (e.g., following up on laboratory and imaging results to determine the need for additional services).
    - Referrals are not complete without timely follow up with the member and/or with the service provider to track the results of the referral.
- Communicating with the member, the OB care provider and other individuals instrumental to the member's care and support, to assess the usefulness of key community

resources and to ensure the care plan is meeting the member's needs.

- Reviewing and updating the care plan, as necessary, following each health care encounter or home visit.

- Assisting in removing barriers to care, e.g., offering flexible scheduling and assessing and addressing communication gap between the health care provider and the member.

d. Transition Plan (Transfer of Care)

All members shall remain enrolled and receiving services as needed within the OB medical home for 60 days postpartum. Regardless of birth outcome, the medical home provider should do the following to minimize disruption during the transfer of care:

- Engage the member in the transfer of care, to the maximum extent possible.

- Collaborate with the HMO to ensure continuity of care for the mother and newborn following medical home discharge. For example, the medical home could summarize and share issues related to the need for ongoing support, outstanding test results, community referrals, upcoming appointments, and any unmet needs or concerns from the member's care plan.

- Ensure that each member has a transition plan, as described below.

    - Healthy Birth Outcome

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

        - The member shall have at least one postpartum follow-up appointment with the OB care provider that meets all American Congress of Obstetricians

and Gynecologists (ACOG) or other applicable postpartum guidelines.

- Ensure that the member is connected to a PCP and has an appointment as appropriate with a PCP.

- Ensure that the member has identified a PCP for the newborn and has made an initial appointment.

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

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

- Poor Birth Outcome

In addition to items listed under healthy birth outcome above, for members who have a poor birth outcome, as defined by the Department, the HMO is responsible for the following:

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

- Conduct follow up with the mother to ensure that the initial referral appointments with other providers are kept.

- To the extent feasible, maintain ongoing contact with the mother following the birth to ensure the

mother and child are receiving appropriate care. HMO responsibility for follow up ends when the member is no longer enrolled in the HMO.

7. Reporting

   The HMO must submit a report (using the template provided) to the Department annually evaluating its OB Medical Home initiative. The report is due the first business Monday of June (reporting from April of the previous year through March of the current year).

   Additional reporting of program compliance by the HMO and/or medical home sites may be requested by the Department outside of the annual report, as needed.

8. Learning Collaborative

   In addition to providing comprehensive, quality care, a second goal of the OB Medical Home Initiative is to provide care that meets the unique needs of each member. Prior experience in implementing the Initiative demonstrates the efficacy of OB medical home sites learning from each other. To facilitate this process, the HMOs and clinic sites must identify and/or develop and participate in at least one collaborative learning opportunity per year. Such opportunities must address identified needs of the clinics serving as OB medical homes and the members they serve.

   These forums shall be described and reported in the required HMO annual report.