External Quality Review

Fiscal Year 2016 – 2017

Healthy Birth Outcomes – Medical Home Enrollees

Calendar Year 2015 Report

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Division of Health Care Access and accountability

Prepared by

METASTAR

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Overview

This report summarizes calendar year (CY) 2015 results of the review 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.

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 BadgerCare Plus (BC+) or Supplemental Security Income (SSI) Medicaid. Information about the initiative can be found on these DHS websites:

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

During CY 2015, 12 MCOs contracted with clinics willing to implement OBMH in Dane and Rock counties and in Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties in southeastern Wisconsin.

The MCOs and their respective service areas are documented in the table below.

Table 1: MCOs and Service Areas

Service Area	Managed Care Organization
Dane County	Dean Health Plan (DHP)*
	Group Health Cooperative of South Central Wisconsin (GHC-SCW)*
	Physicians Plus Insurance Corporation (PPIC)*
	Unity Health Plan (Unity)*
Rock County	DHP
	MercyCare Health Plan (MCHP)*
	MHS Health Wisconsin (MHS)*
	United Healthcare of Wisconsin (UHC)*
Southeastern WI – Kenosha, Milwaukee, Ozaukee, 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)
	Trilogy Health Insurance (Trilogy)*
	UHC

*Denotes MCOs joining OBMH in the second half of CY 2014.

The most recent MCO enrollment data available at the time of the review and ongoing is posted to the following DHS website:
www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/managed%20care%20organization/reports_data/monthlyreports/index.htm.spage.

DHS contracted with its external quality review organization (EQRO), MetaStar, Inc., to gather information from medical records to verify that each MCO and its providers are meeting OBMH requirements described in the DHS-MCO contract. The requirements are specifically noted in the "Review Findings" sections of this report.

This report provides information about women who delivered infants between January 1, and December 31, 2015. In the last half of CY 2014, new MCOs joined the initiative for the first time and expansion into Dane and Rock counties took place. Due to low enrollments for the new MCOs and in those counties for the initial implementation period, the MCOs' compliance with requirements was not compiled or reported for CY 2014. As a result, comparative data by CY is not included in this report.

REVIEW METHODOLOGY

The review methodology and criteria are described in the Appendix.

REVIEW FINDINGS

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

DATASET AND RECORD SUBMISSION SUMMARY

During CY 2015, DHS delegated responsibility for dataset creation and MCO communications to MetaStar in an effort to obtain results for MCO compliance with requirements in a shorter timeframe. In addition, DHS changed the parameters beginning with the second quarter dataset, from inclusion of members who gave birth during the time period to members who had scheduled or attended a postpartum visit during the quarter.

Following confirmation of the members in the dataset, DHS and/or MetaStar requested medical records for each member. Some additional variances in the dataset were discovered for a few MCOs and as a result, with approval from DHS, those members were deleted from the dataset. The final, total number of women in the dataset for the report period was 972. The number of members in the dataset and their MCO affiliations and service areas are depicted in the table below:

Table 2: Medical Home and MCO Enrollment – Records Reviewed

MCO	Service Area	Number of Members in Dataset
Anthem	SE WI	122
CCHP	SE WI	323
DHP	Dane/Rock Counties	212
GHC-SCW	Dane County	12
*i*Care	SE WI	10
MCHP	Rock County	24
MHS	Rock County/SE WI	12
MHWI	SE WI	184
PPIC	Dane County	11
Trilogy	SE WI	7
UHC	Rock County/SE WI	38
Unity	Dane County	17
Total Records		**972**

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

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

Clinic	MCO	Total Records
Access Community Health Centers Dane County	PPIC	11
	Unity	17
All Saints and All Saints Family Care Center SE WI	Anthem	11
	CCHP	9
	MHWI	17
	UHC	6
Aurora Midwifery & Wellness Center SE WI	Anthem	7
	CCHP	27
	MHWI	32
Beloit Clinic Rock County	MHS	3
	UHC	9
Columbia St. Mary's Family Health Center SE WI	Anthem	24
	CCHP	41
	*i*Care	6
	MHS	2
	MHWI	22
Dean Clinics Dane and Rock Counties	DHP	212
Froedtert East OB/GYN Residency Clinic SE WI	Anthem	18
	CCHP	83
GHC-SCW Clinics Dane County	GHC-SCW	12
Life Time OB/GYN SE WI	Anthem	8
	CCHP	42
	*i*Care	3
	MHWI	32
	Trilogy	4
	UHC	11
Lisbon Avenue Health Center SE WI	Anthem	12
	CCHP	18
	MHWI	18
Marquette Neighborhood Health Center SE WI	Anthem	2
	CCHP	1
	MHWI	2
Mercy Health Systems Clinics Rock County	MHCP	24

Clinic	MCO	Total Records
Milwaukee Health Systems SE WI	CCHP	1
	MHWI	2
Sixteenth Street Community Health Center SE WI	Anthem	18
	CCHP	22
	*i*Care	1
	MHS	2
	MHWI	14
	Trilogy	1
	UHC	5
St. Joseph's Hospital Women's Health Center SE WI	Anthem	7
	CCHP	23
	MHS	4
	MHWI	27
	Trilogy	2
	UHC	4
Waukesha Family Medicine Center SE WI	Anthem	7
	CCHP	22
	MHWI	6
Wheaton Franciscan Glendale Family Care Center SE WI	Anthem	8
	CCHP	34
	MHS	1
	MHWI	12
	UHC	3
Total Records		**972**

Notes: All Saints operates two clinic sites, one in Racine and one named All Saints Family Care Center at an unknown location. Only two members were served at the Family Care Center, so the results for these members were added to the All Saints clinic results. 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 also combined.

The DHS information system used to house data for OBMH, maintained by Hewlett Packard Enterprise Services (HPE), includes documentation of whether a full or partial medical record was submitted for review (see the Appendix for more information). The medical record is considered complete when clinic, care coordination, and hospital or other records documenting the infant delivery are submitted to MetaStar, or are accessible to reviewers through an electronic medical record (EMR). Table 4 documents the number of complete and incomplete medical record submissions by clinic, and notes the overall rate of complete submissions.

Table 4: Complete Medical Records Submissions

Medical Home Clinic	Total Number of Records	Complete	Incomplete	Rate Complete
Access	28	20	9	**71.4%**
All Saints	43	9	34	**20.9%**
Aurora Midwifery & Wellness Center	66	33	33	**50.0%**
Beloit Clinics	12	5	7	**41.7%**
Columbia St. Mary's Family Health Center*	95	52	43	**54.7%**
Dean Clinics*	212	201	11	**94.8%**
Froedtert East OB/GYN Residency Clinic	101	78	22	**77.2%**
GHC-SCW	12	4	8	**33.3%**
Life Time OB/GYN *	100	69	31	**69.0%**
Lisbon Avenue Health Center	48	13	35	**27.1%**
Marquette	5	3	2	**60.0%**
Mercy	24	16	8	**66.7%**
Milwaukee Health Systems	3	0	3	**0.0%**
Sixteenth Street Community Health Center	63	42	21	**66.7%**
St. Joseph's Hospital Women's Health Center	67	27	40	**40.3%**
Waukesha Family Medicine Center	35	20	15	**57.1%**
Wheaton Franciscan Glendale Family Care Center*	58	8	50	**13.8%**
Total	**972**	**600**	**372**	**61.7%**

* Indicates EMR

The MCOs have improved medical record submission rates, in part due to implementation of a process where DHS requires MCOs to verify the dataset prior to the start of each quarterly review period. However, the contents of the medical records remain incomplete despite specific direction to the MCOs to obtain the clinic records, documentation of prenatal care coordination (PNCC) and hospital delivery information, if the delivery information is not documented in the clinic record. Some HMOs and clinics need to take additional steps to secure agreement with external PNCC agencies to provide the needed documentation. Some clinics have improved the rate of complete medical record submissions while others have declined. Table 5 documents the rates of complete medical record submissions for clinics that appeared in both the 2014 and 2015 datasets.

Table 5: Comparison of Complete Medical Record Submissions 2014 and 2015

Medical Home Clinic	Rate of Complete Records 2014	Rate of Complete Records 2015
Access	N/A	71.4%
All Saints	8.0%	20.9%
Aurora Midwifery & Wellness Center	23.0%	50.0%
Beloit Clinics	N/A	41.7%
Columbia St. Mary's Family Health Center*	71.0%	54.7%
Dean Clinics*	N/A	94.8%
Froedtert East OB/GYN Residency Clinic	79.0%	77.2%
GHC-SCW	N/A	33.3%
Life Time OB/GYN *	66.0%	69.0%
Lisbon Avenue Health Center	0%	27.1%
Marquette	68.0%	60.0%
Mercy	N/A	66.7%
Milwaukee Health Systems	75.0%	0.0%
Sixteenth Street Community Health Center	74.0%	66.7%
St. Joseph's Hospital Women's Health Center	4.0%	40.3%
Waukesha Family Medicine Center	47.0%	57.1%
Wheaton Franciscan Glendale Family Care Center*	4.0%	13.8%

* Indicates EMR

Section 1 - Review Findings by MCO

Verification of Enrollment Requirements

Article III., R., of the DHS-MCO contract dated January 1, 2014, through December 31, 2015, establishes that:

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

The review results for this set of requirements are documented in Tables 6A, 6B and 6C. Table 6A below shows, for each MCO, the number of records reviewed, and how many records met the criteria that enrollees make an initial OBMH visit within the first 16 weeks of pregnancy. The rate at which all MCOs met the criteria is also shown. In addition, the table notes the number and percent of records where MetaStar was unable to verify the criteria due to missing information, or incomplete record submissions.

Table 6A: Enrolled at 16 Weeks/First Medical Home Visit

MCO/Number of Records	Met	Not Met	Unknown	Rate Met Requirement
Anthem/122	112	10	0	**91.8%**
CCHP/323	299	22	2	**92.6%**
DHP/212	204	6	2	**96.2%**
GHC-SCW/12	12	0	0	**100%**
*i*Care/10	10	0	0	**100%**
MCHP/24	24	0	0	**100%**
MHS/12	10	2	0	**83.3%**
MHWI/184	169	12	3	**91.8%**
PPIC/11	11	0	0	**100%**
Trilogy/7	6	1	0	**85.7%**
UHC/38	37	1	0	**97.4%**
Unity/17	15	2	0	**88.2%**
Totals/972	**909**	**56**	**7**	
Total Rate	**93.5%**	**5.8%**	**0.7%**	

DHS required new MCOs to meet the 16-week enrollment threshold, while the original MCOs were able to ramp up to this standard, using 18- and 20-week enrollment target dates in the initial

years of implementation. The 16-week standard does not appear to pose a barrier for new MCOs as the rate in 2015, 93.5 percent, increased from the 2014 rate of 91.9 percent. Review results for new MCOs were not included in the CY 2014 report.

Table 6B identifies, for each MCO, the number of records reviewed; the number of records that documented the members had attended ten or more appointments with an OB provider. The rate at which MCOs, excluding new MCOs, met this requirement in CY 2014 was 77.1 percent.

Table 6B: 10 Appointments

MCO/Number of Records	Met	Not Met
Anthem/122	98	24
CCHP/323	255	68
DHP/212	188	24
GHC-SCW/12	12	0
*i*Care/10	10	0
MCHP/24	22	2
MHS/12	8	4
MHWI/184	140	44
PPIC/11	7	4
Trilogy/7	5	2
UHC/38	30	8
Unity/17	16	1
Totals/972	791	181
Total Rate	**81.4%**	**18.6%**

Table 6C documents the number of records that met the Enrolled Postpartum requirement. The Enrolled Postpartum indicator includes women who had any postpartum visit (beyond 60 days), as well as women who did not appear for scheduled appointments or did not schedule appointments despite encouragement from staff. The compliance rate for this review element also increased since CY 2014, when the rate was 77.4 percent, despite adding new MCOs to the program. The rate of unknown results decreased since CY 2014, from 22.6 percent to zero in CY 2015 and as a result no information about unknown results is displayed in the table below.

Table 6C: Enrolled Postpartum

MCO/Number of Records	Met	Not Met
Anthem/122	96	26
CCHP/323	280	43
DHP/212	200	12
GHC-SCW/12	12	0
*i*Care/10	10	0

MCO/Number of Records	Met	Not Met
MCHP/24	23	1
MHS/12	10	2
MHWI/184	141	43
PPIC/11	7	4
Trilogy/7	7	0
UHC/38	33	5
Unity/17	13	4
Totals/972	**832**	**140**
Total Rate	**85.6%**	**14.4%**

Verification of Care Coordination Requirements

Article III., R., of the contract referenced above 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 physician (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 this set of requirements are documented in Tables 7A and 7B. Table 7A below shows, for each MCO, the number of records reviewed, and how many records met the criteria to develop a care plan that documents all of a member's identified needs; reflects participation of the member, care coordinator, and PCP in its development; and includes a self-care component. Rates, when compared to CY 2014 data, remain in the 90th percentile for several of the elements in this category. Results for collaborative care plan development decreased slightly in CY 2015, compared to the CY 2014 rate of 14.2 percent.

Table 7A: Care Plan

MCO/Number of Records	Care Management Plan	Intake Items Included in Plan	Collaborative Care Plan Development	Plan Includes Self-Management/ Care
Anthem/122	115	112	26	110

MCO/Number of Records	Care Management Plan	Intake Items Included in Plan	Collaborative Care Plan Development	Plan Includes Self-Management/ Care
CCHP/323	307	304	56	302
DHP/212	210	207	4	207
GHC-SCW/12	9	9	5	11
*i*Care/10	10	10	2	10
MCHP/24	23	23	0	23
MHS/12	9	9	3	11
MHWI/184	160	156	25	156
PPIC/11	11	11	0	11
Trilogy/7	7	7	1	7
UHC/38	30	30	2	31
Unity/17	17	17	3	17
Totals/972	**908**	**895**	**127**	**896**
Total Rate	**93.4%**	**92.1%**	**13.1%**	**92.2%**

Clinics contracted with MCOs developed care plans that included nearly all identified needs using an effective intake process, as demonstrated by the high rates of compliance for these two elements. Some clinics did not meet the requirements for the care plan review element, because medical record documentation was incomplete. Similarly, incomplete documentation reduced the rate at which clinics succeeded at including intake items on the plans. Only nine plans associated with five clinics had a need documented as part of the intake process, but not included on the plan.

Collaboration with the PCP was seldom identified during the medical record reviews. Nearly one-half of the records (48.9%) did not include documentation of a PCP. When collaboration was noted, the reason was nearly always because the OB care was being provided by the PCP. This fact was documented for 84 of the 127 (66.1%) positive results for this review element.

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

Table 7B shows, for each MCO, the number of records reviewed, and the number of records that documented members received home visits or were offered home visits or visits in alternate community locations, but declined. The table also shows the number of records that met requirements for regular communication between the member, care coordinator, and medical providers.

Table 7B: Care Coordination

MCO/Number of Records	Monthly Home Visits	Communications Between Providers and Members
Anthem/122	24	29
CCHP/323	75	58
DHP/212	12	6
GHC-SCW/12	7	5
*i*Care/10	5	2
MCHP/24	20	1
MHS/12	3	3
MHWI/184	28	26
PPIC/11	1	0
Trilogy/7	1	1
UHC/38	9	1
Unity/17	10	3
Totals/972	**195**	**135**
Total Rate	**20.1%**	**13.9%**

MCO compliance with offers of home visits or visits in locations outside the clinic varied. See Section 2 for clinic-specific results. When the clinic did not meet the requirement, a frequent reason for non-compliance was no offer of an alternate location was made, when the member refused. For example, if Dean MCO would have offered an alternate location to the home after the member refused, the clinic's compliance rate would be nearly 100 percent. The overall rate of compliance with the home visit requirement declined from 27.6 percent in CY 2014.

The home visit compliance rate was also influenced by lack of documentation about home visits, or missing portions of medical records where the information may have been identified. The lack of medical record information for this review element may be related to the fact that some MCOs/clinics contract with external PNCC agencies, and those agencies did not share documentation with the clinic or the MCO for the purpose of this review. Information about the care management model at each clinic was not available for consideration in preparing this report.

Reviewers identified documentation that some members accepted the offer of a home visit, but were unable to verify that any home visits actually took place (67 of 195 members). Fifty-one members had at least one home visit with 39 members receiving five or more home or alternate location visits.

Communication between providers was limited. Rates were impacted because many records did not include documentation of the PCP in the record, or incomplete medical records limited

access to potential documentation of communication efforts. The rate was nearly the same as the collaboration between providers in developing a care plan rate. The CY 2015 rate dropped slightly compared the CY 2014 rate of 15.5 percent.

Verification of Postpartum Care Coordination and Discharge Planning

Article III., R., of 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 defined by the OBMH Care Guide which includes these items:

- 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 8A, 8B and 8C document the results of the record review for most of the requirements noted above. The rates for this postpartum review element specifically look for an actual postpartum visit day within the expected 60-day timeframe, and do not reflect missed appointments or efforts to support members in making appointments. The postpartum visit rate for CY 2014 was 60 percent.

Table 8A: Post-delivery Requirements

MCO/Number of Records	At least 1 Postpartum Visit	Communication with PCP
Anthem/122	84	31
CCHP/323	225	73
DHP/212	157	19
GHC-SCW/12	12	5
*i*Care/10	7	2
MCHP/24	20	1
MHS/12	7	3
MHWI/184	104	26
PPIC/11	6	2
Trilogy/7	4	1
UHC/38	27	2

MCO/Number of Records	At least 1 Postpartum Visit	Communication with PCP
Unity/17	11	3
Totals/972	**664**	**168**
Total Rate	**68.3%**	**17.3%**

Similar to the other review elements related to communication with PCPs, the rate for communication after delivery is low, although slightly higher than communication during the prenatal care period. Some clinics using EMR systems may rely on internal messaging systems not accessible to reviewers, thus contributing to low rates. In almost half of the member records (48.9%), a PCP was not documented.

Table 8B: Postpartum Education and Care

MCO/Number of Records	Family Planning Education	Depression Screening	Breastfeeding Education	Newborn Care Education
Anthem/122	109	104	96	101
CCHP/323	298	275	243	264
DHP/212	200	181	181	189
GHC-SCW/12	11	8	8	10
*i*Care/10	10	10	9	10
MCHP/24	24	24	21	22
MHS/12	8	8	7	8
MHWI/184	144	146	121	137
PPIC/11	11	10	11	11
Trilogy/7	7	7	5	5
UHC/38	34	29	27	32
Unity/17	15	14	15	14
Totals/972	**871**	**816**	**744**	**803**
Total Rate	**89.%**	**84.0%**	**76.5%**	**82.6%**

Record review found MCO members consistently receive information about key topics associated with postpartum care. Reviewers noted that education takes place periodically throughout the prenatal period, including encouraging members to attend classes offered by clinics and other public agencies. The rate for breastfeeding education may be lower than the other rates for educational topics, because when members express a preference for bottle-feeding based on previous experience, care providers do not always offer education about the benefits of breastfeeding to these members. The rate for depression screening was influenced by the fact that some clinics routinely screen for depression during the prenatal period as well as during postpartum care, and receive credit for both. Rates of compliance in CY 2014 were similar for

family planning and depression screening, in the 80th percentile, but lower for breastfeeding (69.3%) and newborn education (70.6%).

Table 8C identifies the number of members who received follow-up related to their chronic conditions, and the number who did not receive follow-up or who were not identified as subjects for this review criterion. The rate of compliance is nearly the same as CY 2014, when it was 58.9 percent. The number of members without a chronic condition in CY 2014 was 54.7 percent.

Table 8C: Post-delivery Requirements – Follow-up on Chronic Condition(s)

MCO/Number of Records	Met	Not Met	Did Not Have a Chronic Condition(s)
Anthem/122	29	25	68
CCHP/323	103	56	164
DHP/212	71	44	97
GHC-SCW/12	2	6	4
*i*Care/10	4	1	5
MCHP/24	13	2	9
MHS/12	6	5	1
MHWI/184	41	59	84
PPIC/11	3	2	6
Trilogy/7	3	1	3
UHC/38	5	13	20
Unity/17	6	3	8
Totals	**286**	**217**	**469**
Total Rate (N=503)	**56.9%**	**43.1%**	**48.3%**

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.

DHS specified the following chronic conditions as a focus in OBMH for this reporting period: asthma, cardiac disease, diabetes mellitus, hypertension, pulmonary disease, and behavioral/mental health. As documented in the table above, 48.3 percent of the members (469) did not have a chronic condition. For 52 of the 217 records that did not meet the follow-up requirement (24%), reviewers were unable to determine whether the member had a chronic condition due to incomplete documentation. Of the 503 members with chronic conditions, 246 had a behavioral/mental health condition, 115 had asthma, 39 had hypertension, 17 had diabetes, seven had a pulmonary disease diagnosis, and three presented with cardiac disease. Some additional, but not all inclusive, examples of chronic conditions diagnosed in members included: hypothyroidism, rheumatoid arthritis, colitis, lupus, and kidney disease.

IDENTIFICATION OF BIRTH OUTCOMES

Addendum VI., B. of 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 in Article III., R. 1. 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."

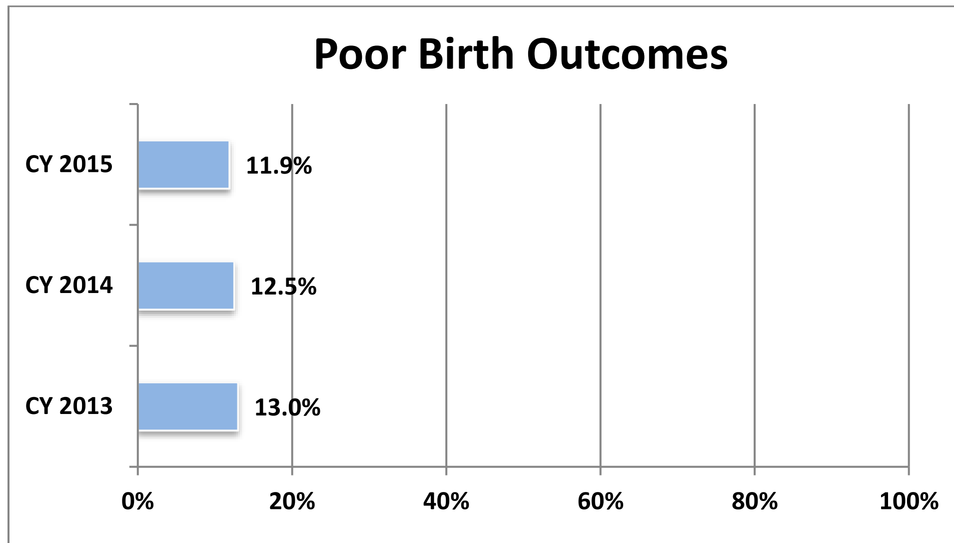
Insufficient information was available in the medical records to determine the birth outcomes for 110 members. In these instances, DHS directed MetaStar to review MCO self-declared information in the DHS registry to determine whether the woman experienced a poor birth outcome. Reviewers found sufficient information in the registry for all of the women. Of the 110 members, seven had poor birth outcomes. MetaStar identified 109 poor birth outcomes in the medical records for the remaining members in this reporting group, for a total rate of 11.9 percent (116 of 972 women). Table 10A below shows the rates of healthy birth outcomes and poor birth outcomes, as defined by DHS for this initiative. The poor birth outcome rate declined compared to the CY 2014 rate of 12.5 percent, and the CY 2013 rate of 13 percent.

Table 10A: Birth Outcomes

MCO/Number of records	Healthy Birth Outcome	Poor Birth Outcome	Unknown	Registry = Healthy Birth Outcome	Registry = Poor Birth Outcome
Anthem/122	89	13	20	18	2
CCHP/323	237	35*	51	47	4
DHP/212	191	21*	0	N/A	N/A
GHC-SCW/12	10	1	1	1	0
*i*Care/10	8	0	2	2	0
MCHP/24	20	3	1	1	0
MHS/12	4	3	5	5	0
MHWI/184	143	21	20	19	1
PPIC/11	4	2	5	5	0
Trilogy/7	6	1	0	N/A	N/A
UHC/38	31	5	2	2	0
Unity/17	10	4	3	3	0
Totals	**753**	**109**	**110**	**103**	**7**
Overall Rate	**88.1%**	**11.9%**			

Note: The overall rate of healthy and poor birth outcomes was calculated using unverified registry results. Rates may not equal 100 percent due to rounding.
*Includes six sets of twins and one set of triplets delivered by mothers affiliated with these MCOs; all the infants had poor outcomes. The rate is associated with the number of members who experienced a positive or poor outcome.

The poor birth outcome rate declined compared to the CY 2014 rate of 12.5 percent the CY 2013 rate of 13 percent.



The reasons associated with the poor birth outcomes in CY 2015 are documented in Table 10B below. The total number of outcomes exceeds the number of poor birth outcomes because the results include poor birth outcomes for infants associated with seven multiple births.

Table 10B: Reasons for Poor Birth Outcomes – 2015

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

Note: All of the infants associated with the CCHP and DHP multiple births had poor outcomes.

Section 2 - Review Findings by Clinic

Verification of Enrollment Requirements

Article III., R., of the DHS-MCO contract dated January 1, 2014, through December 31, 2015, establishes that:

- Women enrolled on or after January 1, 2014, had to 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.
- Members must remain enrolled and receiving services through the 60 days associated with the postpartum period.

The review results for this set of requirements are documented in Tables 11A, 11B and 11C. Table 11A below shows, for each clinic, the number of records reviewed, and how many records 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 11A: Enrolled at 16 Weeks/First Medical Home Visit

Clinic/Number of Records	Met	Not Met	Unknown	Rate Met Requirement
Access/28	26	2	0	**92.9%**
All Saints/43	42	1	0	**97.7%**
Aurora Midwifery & Wellness Center/66	57	9	0	**86.4%**
Beloit Clinics/12	12	0	0	**100%**
Columbia St. Mary's Family Health Center/95	93	2	0	**97.9%**
Dean Clinics/212	204	6	2	**96.2%**
Froedtert East OB/GYN Residency Clinic/101	98	3	0	**97.0%**
GHC-SCW/12	12	0	0	**100%**
Life Time OB/GYN/100	99	0	1	**99.0%**
Lisbon Avenue Health Center/48	40	8	0	**83.3%**
Marquette/5	4	1	0	**80.0%**
Mercy Care Health Systems/24	24	0	0	**100%**
Milwaukee Health Systems/3	0	0	3	**Unknown**
Sixteenth Street Community Health Center/63	60	3	0	**95.2%**
St. Joseph's Hospital Women's Health Center/67	59	7	1	**88.1%**

Clinic/Number of Records	Met	Not Met	Unknown	Rate Met Requirement
Waukesha Family Medicine Center/35	34	1	0	**97.1%**
Wheaton Franciscan Glendale Family Care Center/58	45	13	0	**77.6%**
Totals	**909**	**56**	**7**	
Total Rate	**93.5%**	**5.8%**	**0.7%**	

Table 11B identifies, for each clinic, the number of records reviewed; the number of records that documented the members had attended ten or more appointments with an OB provider; the number of records where members did not meet this requirement.

Table 11B: 10 Appointments

Clinic/Number of Records	Met	Not Met	Rate Met Requirement
Access/28	23	5	**82.1%**
All Saints/43	37	6	**86.0%**
Aurora Midwifery & Wellness Center/66	48	18	**72.7%**
Beloit Clinics/12	8	4	**66.7%**
Columbia St. Mary's Family Health Center/95	85	10	**89.5%**
Dean Clinics/212	188	24	**88.7%**
Froedtert East OB/GYN Residency Clinic/101	78	23	**77.2%**
GHC-SCW/12	12	0	**100.0%**
Life Time OB/GYN/100	92	8	**92.0%**
Lisbon Avenue Health Center/48	36	12	**75.0%**
Marquette/5	5	0	**100.0%**
Mercy Care Health Systems/24	22	2	**91.7%**
Milwaukee Health Systems/3	0	3	**0.0%**
Sixteenth Street Community Health Center/63	52	11	**82.5%**
St. Joseph's Hospital Women's Health Center/67	44	23	**65.7%**
Waukesha Family Medicine Center/35	31	4	**88.6%**

Clinic/Number of Records	Met	Not Met	Rate Met Requirement
Wheaton Franciscan Glendale Family Care Center/58	30	28	**51.7%**
Totals/972	**791**	**181**	
Total Rate	**81.4%**	**18.6%**	

Table 11C documents the number of records that met the Enrolled Postpartum requirement by clinic. The Enrolled Postpartum indicator includes women who had any postpartum visit (beyond 60 days) as well as women who did not appear for scheduled appointments or did not schedule appointments despite encouragement from staff.

Table 11C: Enrolled Postpartum

Clinic/Number of Records	Met	Not Met	Rate Met Requirement
Access/28	20	8	**71.4%**
All Saints/43	13	30	**30.2%**
Aurora Midwifery & Wellness Center/66	58	8	**87.9%**
Beloit Clinics/12	11	1	**91.7%**
Columbia St. Mary's Family Health Center/95	92	3	**96.8%**
Dean Clinics/212	200	12	**94.3%**
Froedtert East OB/GYN Residency Clinic/101	95	6	**94.1%**
GHC-SCW/12	12	0	**100.0%**
Life Time OB/GYN/100	89	11	**89.0%**
Lisbon Avenue Health Center/48	46	2	**95.8%**
Marquette/5	5	0	**100.0%**
Mercy Care Health Systems/24	23	1	**95.8%**
Milwaukee Health Systems/3	1	2	**33.3%**
Sixteenth Street Community Health Center/63	51	12	**81.0%**
St. Joseph's Hospital Women's Health Center/67	54	13	**80.6%**
Waukesha Family Medicine Center/35	19	16	**54.3%**
Wheaton Franciscan Glendale Family Care Center/58	43	15	**74.1%**
Totals/972	**832**	**140**	
Total Rate	**85.6%**	**14.4%**	

VERIFICATION OF CARE COORDINATION REQUIREMENTS

Article III., R., of the contract referenced above 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 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;
- Regular care coordination communications took place between the OB care provider, the PCP, and the care coordinator.

Table 12A below shows, for each clinic, the number of records reviewed, and how many records met the criteria to develop a care plan that documents all of a member's identified needs; reflects participation of the member, care coordinator, and PCP in its development; and includes a self-care component.

Table 12A: Care Plan

Clinic/Number of Records	Care Management Plan	Intake Items Included in Plan	Collaborative Care Plan Development	Plan Includes Self-Management/ Care
Access/28	28	28	3	28
All Saints/43	41	42	8	41
Aurora Midwifery & Wellness Center/66	63	62	0	62
Beloit Clinics/12	7	7	0	7
Columbia St. Mary's Family Health Center/95	95	94	75	94
Dean Clinics/212	210	207	4	207
Froedtert East OB/GYN Residency Clinic/101	100	100	3	99
GHC-SCW/12	9	9	5	11
Life Time OB/GYN/100	91	87	1	83
Lisbon Avenue Health Center/48	29	29	0	25
Marquette/5	5	5	0	5
Mercy Care Health Systems/24	23	23	0	24

Clinic/Number of Records	Care Management Plan	Intake Items Included in Plan	Collaborative Care Plan Development	Plan Includes Self-Management/ Care
Milwaukee Health Systems/3	0	0	0	1
Sixteenth Street Community Health Center/63	63	60	7	62
St. Joseph's Hospital Women's Health Center/67	57	55	1	58
Waukesha Family Medicine Center/35	35	34	9	35
Wheaton Franciscan Glendale Family Care Center/58	52	52	11	54
Totals	**908**	**894**	**127**	**896**
Total Rate	**93.4%**	**92.1%**	**13.1%**	**92.2%**

Clinics developed care plans that included nearly all identified needs using an effective intake process, as demonstrated by the high rates of compliance for these two elements. Some clinics did not meet the requirements for the care plan review element, because the medical record documentation was incomplete. Similarly, incomplete documentation reduced the rate at which clinics succeeded at including intake items on the plans. Only nine plans associated with five clinics had a single need documented as part of the intake process, but not included on the plan.

Collaboration with the PCP was seldom identified during the medical record reviews. Nearly one-half of the records (48.9%) did not include documentation of a PCP. When collaboration was noted, the reason was nearly always because the OB care was being provided by the PCP. This fact was documented for 84 of the 127 (66.1%) positive results for this review element.

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

Table 12B shows, for each clinic, the number of records reviewed, and the number of records that documented members received home visits or were offered home visits or visits in alternate community locations but declined. The table also shows the number of records that met requirements for regular communication between the member, care coordinator, and medical providers.

Table 12B: Care Coordination

Clinic/Number of Records	Monthly Home Visits	Communications Between Providers and Members
Access/28	11	3
All Saints/43	42	8
Aurora Midwifery & Wellness Center/66	1	0
Beloit Clinics/12	2	0
Columbia St. Mary's Family Health Center/95	22	69
Dean Clinics/212	12	6
Froedtert East OB/GYN Residency Clinic/101	41	3
GHC-SCW/12	7	5
Life Time OB/GYN/100	5	1
Lisbon Avenue Health Center/48	1	0
Marquette/5	2	0
Mercy Care Health Systems/24	20	1
Milwaukee Health Systems/3	3	0
Sixteenth Street Community Health Center/63	2	6
St. Joseph's Hospital Women's Health Center/67	15	0
Waukesha Family Medicine Center/35	9	9
Wheaton Franciscan Glendale Family Care Center/58	0	24
Total	**195**	**135**
Total Rate	**20.1%**	**13.9%**

Clinic compliance with offers of home visits or visits in locations outside the clinic varied. All Saints clinic had the highest rate of compliance with this indicator, with an individual rate of 97.7 percent. When a clinic did not meet the requirement, a frequent reason for non-compliance was failure to offer an alternate location when the member refused a home visit. For example, had Dean Clinic offered an alternate location to members who refused a visit to the home, the clinic's compliance rate would be nearly 100 percent.

The home visit compliance rate was also influenced by the lack of documentation about home visits or missing portions of medical records, where the information may have been identified.

For example, extremely low rates of compliance with this review element at Lisbon Avenue Health Center, Sixteenth Street Community Health Center and Wheaton Franciscan Glendale Family Care Center were related to incomplete documentation. The lack of medical record information for this review element may be related to the fact that some clinics contract with external PNCC agencies and those agencies did not share documentation with the clinic or the MCO for the purpose of this review. Information about the care management model at each clinic was not available for consideration in preparing this report.

Reviewers identified documentation that some members accepted the offer of a home visit, but were unable to verify that any home visits actually took place (67 of 195 members). Fifty-one members had at least one home visit, with 39 members receiving five or more home or alternate location visits.

Communication between providers was limited. Rates were impacted because many records did not include documentation of the PCP in the record, or incomplete medical records limited access to potential documentation of communication efforts. The rate was nearly the same as the collaboration between providers in developing a care plan rate.

Verification of Postpartum Care Coordination and Discharge Planning

Article III., R., of 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 defined by the OBMH Care Guide which includes these items:

- 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 13A, 13B and 13C document the results of the record review for most of the requirements noted above.

The rates for this postpartum review element specifically look for an actual postpartum visit day within the expected 60-day timeframe, and do not reflect missed appointments or efforts to support members in making appointments.

Table 13A: Post-delivery Requirements

Clinic/Number of Records	One Postpartum Visit	Communication with PCP
Access/28	17	5
All Saints/43	5	8
Aurora Midwifery & Wellness Center/66	49	2
Beloit Clinics/12	10	0
Columbia St. Mary's Family Health Center/95	84	70
Dean Clinics/212	157	19
Froedtert East OB/GYN Residency Clinic/101	77	7
GHC-SCW/12	12	5
Life Time OB/GYN/100	64	7
Lisbon Avenue Health Center/48	40	1
Marquette/5	5	0
Mercy Care Health Systems/24	20	1
Milwaukee Health Systems/3	0	0
Sixteenth Street Community Health Center/63	40	6
St. Joseph's Hospital Women's Health Center/67	40	1
Waukesha Family Medicine Center/35	15	9
Wheaton Franciscan Glendale Family Care Center/58	29	27
Totals	**664**	**168**
Total Rate	**68.3%**	**17.3%**

Similar to the other review elements related to communication with PCPs, the rate for communication with PCP after delivery was low, although slightly higher than communication during the prenatal care period. Some clinics that use an EMR system may rely on internal messaging systems not accessible to reviewers, thus contributing to low rates. In about half of the records reviewed (48.9%), a PCP was not documented.

Table 13B: Postpartum Education and Care

Clinic/Number of Records	Family Planning Education	Depression Screening	Breastfeeding Education	Newborn Care Education
Access/28	26	24	26	25
All Saints/43	37	43	38	39
Aurora Midwifery & Wellness Center/66	62	56	49	43
Beloit Clinics/12	8	5	4	7
Columbia St. Mary's Family Health Center/95	81	92	62	70
Dean Clinics/212	200	181	181	189
Froedtert East OB/GYN Residency Clinic/101	98	86	81	99
GHC-SCW/12	11	8	8	10
Life Time OB/GYN/100	80	79	72	68
Lisbon Avenue Health Center/48	46	40	38	41
Marquette/5	5	4	4	4
Mercy Care Health Systems/24	24	24	21	22
Milwaukee Health Systems/3	1	3	3	3
Sixteenth Street Community Health Center/63	57	59	44	60
St. Joseph's Hospital Women's Health Center/67	54	53	44	54
Waukesha Family Medicine Center/35	33	18	34	33
Wheaton Franciscan Glendale Family Care Center/58	48	41	35	36
Totals	**871**	**816**	**744**	**803**
Total Rate	**89.6%**	**84.0%**	**76.5%**	**82.6%**

Clinics were consistent in providing information to members about key topics associated with postpartum care. Reviewers noted that education takes place periodically throughout the prenatal period, including encouraging members to attend classes offered by clinics and other public agencies. The rate for breastfeeding education may be lower than the other rates for educational topics, because when members expressed a preference for bottle-feeding based on previous experience, care providers did not always offer education about the benefits of breastfeeding to these members. The rate for depression screening was influenced by the fact that some clinics routinely screen for depression during the prenatal period as well as during postpartum care, and receive credit for both.

Table 13C identifies the number of members by clinic who received follow-up related to their chronic conditions, and the number who did not receive follow-up or who were not identified as subjects for this review criterion.

Table 13C: Post-delivery Requirements – Follow-up on Chronic Condition(s)

Clinic/Number of Records	Met	Not Met	Did Not Have a Chronic Condition(s)
Access/28	9	5	14
All Saints/43	9	21	13
Aurora Midwifery & Wellness Center/66	16	4	46
Beloit Clinics/12	3	6	3
Columbia St. Mary's Family Health Center/95	31	10	54
Dean Clinics/212	71	44	97
Froedtert East OB/GYN Residency Clinic/101	45	14	42
GHC-SCW/12	2	6	4
Life Time OB/GYN/100	22	24	54
Lisbon Avenue Health Center/48	8	22	18
Marquette/5	0	0	5
Mercy Care Health Systems/24	13	2	9
Milwaukee Health Systems/3	0	3	0
Sixteenth Street Community Health Center/63	22	15	26
St. Joseph's Hospital Women's Health Center/67	18	22	27
Waukesha Family Medicine Center/35	8	4	23

Clinic/Number of Records	Met	Not Met	Did Not Have a Chronic Condition(s)
Wheaton Franciscan Glendale Family Care Center/58	9	15	34
Totals	**286**	**217**	**469**
Total Rate (N=503)	**56.9%**	**43.1%**	**48.3%**

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.

DHS specified the following chronic conditions as a focus in OBMH for this reporting period: asthma, cardiac disease, diabetes mellitus, hypertension, pulmonary disease, and behavioral/mental health. As documented in the table above, 48.3 percent of the members (469) did not have a chronic condition. For 52 of the 217 records that did not meet the follow-up requirement (24%), reviewers were unable to determine whether the member had a chronic condition due to incomplete documentation. Of the 503 members with chronic conditions, 246 had a behavioral/mental health condition, 115 had asthma, 39 had hypertension, 17 had diabetes, seven had a pulmonary disease diagnosis, and three presented with cardiac disease. Some additional, but not all inclusive examples, of chronic conditions diagnosed in members included: hypothyroidism, rheumatoid arthritis, colitis, lupus, and kidney disease.

Identification of Birth Outcomes

Addendum VI., B. of the DHS-MCO contract provides information about payments related to the Medical Home initiative and indicates DHS will define poor birth outcomes. DHS defines poor birth outcomes in Article III., R. 1. 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 record to determine the birth outcomes for 110 members. DHS directed MetaStar to review clinic self-declared information in the DHS registry to determine whether the member experienced a poor birth outcome. Reviewers found sufficient information in the registry for all of the   women. Of those 110 members, seven had poor birth outcomes. MetaStar identified 109 poor birth outcomes in the medical records for the remaining members in this reporting group, for a total rate of 11.9 percent (116 of 972 women). The table below shows the rates of healthy birth outcomes and poor birth outcomes, by clinic, as defined by DHS for this initiative. The poor birth outcome rate declined compared to the CY 2014 rate of 12.5 percent, and the CY 2013 rate of 13 percent.

Table 14A: Birth Outcomes

MCO/Number of records	Healthy Birth Outcome	Poor Birth Outcome	Unknown	Registry = Healthy Birth Outcome	Registry = Poor Birth Outcome
Access/28	14	6	8	8	0
All Saints/43	36	7	0	N/A	N/A
Aurora Midwifery & Wellness Center/66	60	5	1	1	0
Beloit Clinics/12	9	3	0	N/A	N/A
Columbia St. Mary's Family Health Center/95	56	8	31	31	0
Dean Clinics/212	191	21	0	N/A	N/A
Froedtert East OB/GYN Residency Clinic/101	81	17*	3	3	0
GHC-SCW/12	10	1	1	1	0
Life Time OB/GYN /100	78	12	10	8	2
Lisbon Avenue Health Center/48	42	6	0	N/A	N/A
Marquette/5	5	0	0	N/A	N/A
Mercy Care Health Systems/24	20	3	1	1	0
Milwaukee Health Systems/3	1	0	2	2	0
Sixteenth Street Community Health Center/63	52	6	5	4	1
St. Joseph's Hospital Women's Health Center/67	54	6	7	6	1
Waukesha Family Medicine Center/35	29	5	1	1	0
Wheaton Franciscan Glendale Family Care Center/58	15	3	40	37	3
Totals	**753**	**109**	**110**	**103**	**7**
Overall Rate	**88.1%**	**11.9**			

Note: The overall rate of healthy and poor birth outcomes was calculated using unverified registry results. Rates may not equal 100 percent due to rounding.
*Includes three sets of twins and one set of triplets delivered by mothers affiliated with this clinic; all the infants had poor outcomes. The rate is associated with the number of members who experienced a positive or poor outcome.

The reasons associated with the poor birth outcomes in CY 2015 are documented in the table below. The total number of outcomes exceeds the number of poor birth outcomes because the results include poor birth outcomes for infants associated with seven multiple births.

Table 14B: Reasons for Poor Birth Outcomes – 2015

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

Note: All of the infants associated with the CCHP and DHP multiple births had poor outcomes.

OBSERVATIONS AND RECOMMENDATIONS

OBSERVATIONS

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

- Care coordination models and documentation of PNCC continue to vary by clinic.
- OBMH teams at one clinic serving a large number of members (Columbia St. Mary's) conduct collaborative chart reviews at least twice during each member's pregnancy.
- A clinic serving between 50 and 100 members (Sixteenth Street) rarely documents offers of home visits. Reviewers noted that this clinic also uses a Certified Nurse Midwife to provide OB medical care as well as to serve as the care coordinator.
- One clinic (All Saints) was noted to have well-documented home visits with specifics about the types of education provided to the members.
- Members are noted as "refusing PNCC" at one clinic (Lisbon Avenue Health Center), yet appear to be enrolled in the OBMH. This documentation may be related to this clinic's status as a certified PNCC agency. The clinic may need a consultation with DHS to reconcile the requirements for PNCC agencies and the OBMH, if the requirements vary, to ensure understanding.
- Reviewers noted that at many clinics, referrals are made to specialty providers or to external agencies for smoking cessation or other education; however, limited follow-up about the success of those referrals is documented in the records.
- A new clinic (Dean) using an EMR has developed and implemented a well-organized structure for documentation of information about prenatal care.
- At many clinics, information about the benefits of breastfeeding is not apparently shared or documented, if the member states a preference for bottle-feeding based on past experience.

RECOMMENDATIONS

- DHS should prioritize work with the MCO OBMH liaisons to identify the reasons for incomplete medical record submissions to verify the actual rate of poor birth outcomes. In addition, complete record submissions will support evaluation of whether clinics providing care to mothers who had poor outcomes met the requirements for pre-natal care.
- Examine documentation practices related to PCP involvement in pre-natal care and determine if MCOs are meeting contract requirements associated with PCP assignment. In addition, seek further information from MCOs and their contracted clinics to determine if internal messaging systems/use of EMRs prevents verification of collaboration and communication between members of the team, including PCPs.
- Continue to evaluate care coordination models and strategies related to the occurrence and frequency of home visits. In particular, explore the reasons some clinics offer home visits and others do not document or offer this option. Clarify and communicate expectations for MCOs/clinics about the use of alternate community settings as a substitute for home visits. Seek examples of scripts used by care coordinators when offering home visits. Consider working with MCOs to standardize a script for communicating about home visits to increase the frequency of this component of the OBMH. The DHS plans for implementing a new MCO HBO annual report will provide much of the needed information.
- Engage clinics and MCOs in dialogue about the benefits of providing pre-natal care during home visits with members.
- Conduct a best practice seminar with MCOs and providers focusing on documentation practices, to foster improvement and support effective evaluation of the OBMH initiative.

APPENDIX

Requirement for External Quality Review

The Medical Home model for high risk pregnant women is a contract requirement for the Managed Care Organizations (MCOs) providing services for BadgerCare Plus (BC+) or Medicaid Supplemental Security Income (SSI) members in southeastern Wisconsin (including the following counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington, Waukesha), as well as in southern Wisconsin in Dane and Rock counties as of July 1, 2014. The terms of this agreement and requirements of the contract are located in Article III, R. of the DHS – HMO contract dated January 1, 2013 through December 31, 2015. The medical home must be a single clinic or network of clinics that is accountable for the total care of the member.

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, 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

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

Health Services (DHS). Some reviewers have worked in skilled nursing and acute care facilities and/or primary care settings. The EQR team also includes reviewers with quality assurance/quality improvement education and specialized training in evaluating performance improvement projects.

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

Review Methodology

Historically, on a quarterly basis, DHS provided the MCOs and MetaStar with a dataset identifying members enrolled in MCO Obstetric Medical Homes (OBMH), and with delivery dates between January 1, and December 31, 2015. The datasets were compiled primarily from information available to DHS through the OBMH data registry. In April 2016, MetaStar began pulling the dataset from the OBMH registry. DHS holds MCOs accountable for securing records from providers to submit to MetaStar.

MCOs and clinics submitted paper and scanned member records to MetaStar. Where possible, MetaStar developed arrangements with some clinics with electronic medical records (EMR) to secure remote, direct access to the EMR to conduct the record reviews. MetaStar enhanced its Medical Record Tracking System to document submissions and manage the medical records.

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

In April 2013, Hewlett Packard Enterprise Services (HPE), the DHS Medicaid Management Information System vendor, deployed a new system to capture the data abstracted from the reviews. HPE implemented changes to enhance the system in July 2014. These enhancements were designed to further improve data collection, retrieval, and analysis for program planning and evaluation. DHS directed HPE to provide MetaStar with a data extract for the quarterly review results during the first half of the year, because HPE had not yet transferred the data to the DHS data warehouse. MetaStar retrieved the necessary data extracts following implementation of the BORN universe in the DHS data warehouse.

MetaStar implemented an OBMH data registry for DHS in the second half of 2014. MCOs and clinics document a variety of data associated with members enrolled in the OBMH, including birth outcomes. MetaStar uses the registry to obtain information about birth outcomes when hospital delivery records are not submitted for the review, or when insufficient detail is present in the records to determine the outcomes. The additional information about birth outcomes is included in this report, but is not entered into the HPE system because it has not been verified in the members' medical records.

Review Criteria

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

Demographics
Member Medicaid Identification Number (MCI)
Member Last name
Member First name
Members Middle initial
Member date of birth
MCO Name
Medical Home Clinic Name
Name and credentials of primary care physician, if documented
Name and credentials of OB physician / provider, if documented
Name and credentials of Care Coordinator, if documented
Name and credentials of Certified Nurse Midwife, if documented
Name and credentials of other providers, if documented
Enrollment Requirements
The member must be enrolled in the medical home after 1/1/2014 and within the first 16 weeks of pregnancy. The reviewer will calculate the date at 16 weeks by entering the EDC via ultrasound date in the calculator, subtract 24 weeks and enter the result on the review tool. Use the first ultrasound date (usually around 20 weeks) for the calculation. http://www.timeanddate.com/date/dateadded.html?m1=11&d1=21&y1=2012&type=sub&ay=&am=&aw=24&ad If the EDC is unknown, the staff person who enters the data into the HPE 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 HPE 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 HPE system will automatically determine whether the postpartum visit date meets the 60 day requirement.

Verification of Care Plan Requirement

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

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

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

Verification of Care Coordination Requirements
The care management plan includes information regarding monthly home visits by nurse, social worker or care coordinator. The required monthly home visit is designed to help the care coordinator establish a personal relationship with the medical home member in a non-medical setting. It is also designed to help ensure a comprehensive assessment of the member's needs, including identification of any psycho-social issues. Home visits should be presented as an opportunity to help the member become an active partner in their care team and should be scheduled at the convenience of the member. Determine if home visits have been presented to the member by the care coordinator and if the member declines, that the care coordinator offered to meet at a more convenient neutral site, e.g., a library, a local restaurant, or a community center. Pregnancy support groups may be another alternative if the member agrees and has the opportunity to consult personally with the care coordinator. If the member agrees to home visits or visits at an alternate community location, document a positive result. In the event a member refuses to allow the home visit, the refusal and alternatives offered must be documented in the medical record in order for the reviewer to document a positive result for this element. The care management plan should include an indication of frequency of home visits. Count and record the number of actual home visits. The plan may reference home visits by the medical home care coordinator, the HMO, or by a PNCC provider. Count visits associated with agreements for alternate locations. Do not count postpartum home visits.
Regular Care Coordination communications between the OB-care provider, the PCP and the member must be documented in medical record. Document a positive result if evidence of communication with the PCP as part of the care plan development and as part of the discharge planning, at a minimum is present in the medical record. This communication may happen directly with the OB care provider or through the care coordinator. Ideally, communication between the OB care provider and the care coordinator should roughly coincide with the prenatal visits. Care plan updates showing results of prenatal or primary care visits and member contacts may also show evidence of communication.
Verification of Postpartum Care Coordination and Discharge Planning
At least one postpartum visit within 60 days post-delivery if the member had a healthy birth outcome. In addition to recording the date of the actual postpartum visit as described above, the reviewer will document any information related to the reasons for no postpartum visit, delayed or rescheduled postpartum visits (including the number of these events) and the types of outreach strategies that are used to encourage the member in securing postpartum care.

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.
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.
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 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.