WISCONSIN DEPARTMENT of HEALTH SERVICES

Obstetrics Medical Home Best Practices

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2021 OBMH Model Annual Survey

HMO and Clinic Report Summaries

Agenda: 2021 OMBH Model Annual Survey

- OBMH Model Annual Survey Background
- Annual Survey Outline
- Survey Report Key Takeaways
- 2021 OBMH Annual Survey Summary Results
  - OBMH Participating Partner Clinic Survey Report Summary
  - Participating OBMH HMO Survey Report Summary
- OBMH Initiative Recommendations
- Next Steps

Background: OBMH Model Annual Survey

- ***Source*** - The Obstetrics Medical Home (OBMH) Model Annual Survey OBMH Model Annual Survey is a survey designed by the DMS' Bureau of Programs and Policy Quality and Special Initiatives Section.

- ***Purpose -*** OBMH Model Annual Survey is constructed to monitor and evaluate the past year's registry and systems information, care structure and processes, challenges and successes across HMOs and clinics.

- ***Goal -*** The survey is used to promote programmatic improvements for pregnant women in the OBMH program.

- DHS did not collect the OBMH Model Annual Survey report in 2020 due to COVID. The 2021 survey had more tailored questions on how COVID impacted the OBMH program during 2020.

Outline: 2021 OBMH Model Annual Survey

- Survey completed annually by BC+ and SSI HMOs and their participating partner clinics in the OBMH.

- Online survey was administered from August 16th to September 30th, 2021
  - One survey completed per HMO; 40 maximum questions per HMO survey
  - Each participating OBMH partner clinic filled out only one survey; 37 maximum questions per clinic survey
  - Mix of yes/no, open-ended, and closed-ended questions

- Data of this report is self-reported by HMOs and their partner clinic and is reflective of April 2020 - March 2021 activities.

Key Takeaways: OBMH Model Annual Survey

- COVID-19 hindered outreach, recruitment and retention in OBMH for clinics and HMOs
  - Telehealth services were helpful for some HMOs/clinics/members but a challenge for others
  - Improved relationships with Public Health and community organizations to address patient drivers of health (e.g., transportation, housing, childcare, food insecurity, etc.)
- Communication a barrier
  - Effective and more communication between HMOs and clinics, and government programs and HMOs would enhance OBMH Initiative, and improve care management
- Adding staff to care teams, having established processes for in-person and home visits, adding texting to EHR for multi-providers improved care coordination

Key Takeaways: OBMH Model Annual Survey (cont.)

- Standardizing care plans, enhancing EHR for texting and automating referrals and resources improves OBMH initiative and communication across teams
- Creating culturally effective plain language documents and trainings for staff and leadership helpful for member and in addressing structural racism
- Better data collection and sharing between clinics, HMOs, and DHS needed and desired
- WISHIN Pulse and Ping is helpful

OBMH Enrollment Data Summary

- 13 OBMH Partner Clinics
- 12 OBMH HMOs

Totals	# Women Screened	# Women Enrolled	% Women Enrolled	% Assessed: Stress	% Assessed: Mental Health	% Received COVID-19 Vaccine
Clinic Totals	4,277	1,181	28%	88%	91%	6%
HMO Totals	3,571	526	14.7%	N/A	N/A	N/A

Clinics: Outreach Methods that Lead to Successful Enrollment

Successful Outreach Method
In person meeting
Staff responsible for identifying potential participants
Telephone calls
Coordination with HMO
Engage potential participates in a variety of ways
Community flyers or program promotion at community events
Enrolling every qualified member
Enrollment letter or information mailed
Protocols for referrals
Service promoted via social media
HMO enrollment encouraged for eligible women without HMO

Clinics: Barriers to Outreach, Recruitment, and Retention

Barriers
Fears or restrictions for doing outreach activities, group classes, coming into the clinic, or doing home visits due to COVID-19
Enrollment requirements of 16-weeks limits eligibility. Requirement specifically impacted by COVID and with teens moms revealing pregnancy later have been impacted by this
Patients declining services, not responding to communication, or not following through
Retention concerns if member must be transferred out for high-risk medical conditions or need C-sections
Short staffed
Retention concerns if member chooses mid-wife and needs to be transferred
Transportation services limited or cut due to Covid
Difficulty updating patient charts
Retention impacted by outside PNCC agencies recruiting patients

Clinics: Successes and Barriers with High-Risk Groups

High Risk Group	Barrier	Success
Homeless Patients	Difficulty reaching patients	Housing referrals, emergency shelters, and relationship with Public Health
Women with Opioid Use Disorder	Difficulty reaching patients	Being able to provide MAT care
Teen Moms	Transportation, commitment, and good prenatal care	
High-Risk Covid-19 Groups	Vaccinating members	

Clinics: Methods to Improve Care Coordination and Member Response

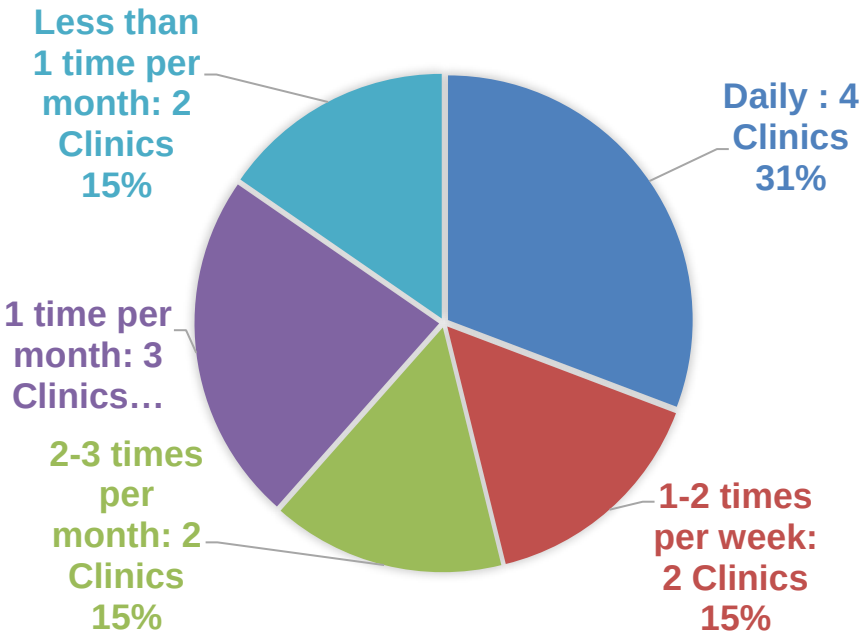
Methods
Adding different staff to team: Community Health Workers, Clinical Learning Specialist, Provider as lead; HMO Case Manager
Multiple methods to connect with patients including my chart, in person, text, phone
Processes for in-person visits and home visits

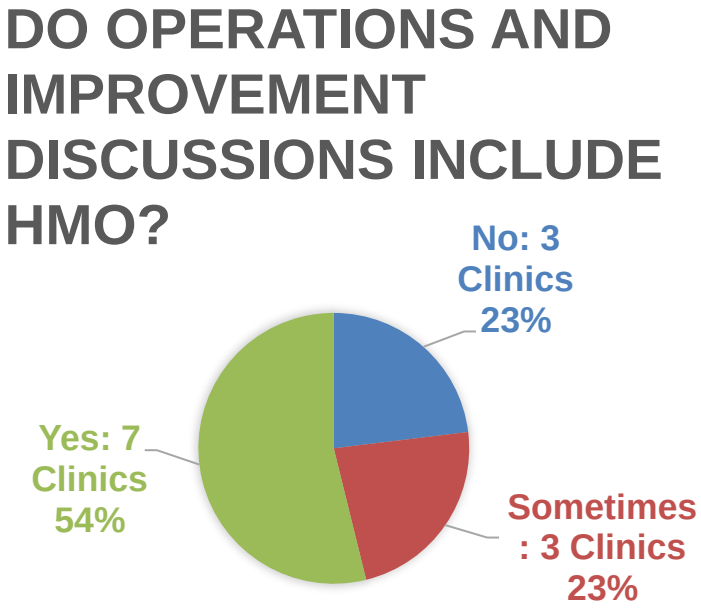
Other Methods highlighted by individual clinics:

- Monthly team meetings
- Stork's Nest Program
- Getting full prenatal history
- Warm hand offs to providers
- Addressing transportation
- Coordination with PNCC
- Abbreviated care coordination plan when patients decline full benefit

Clinics: Care Team Meeting Frequency and HMO Collaboration

Figure 1: Care Team Meeting Frequency

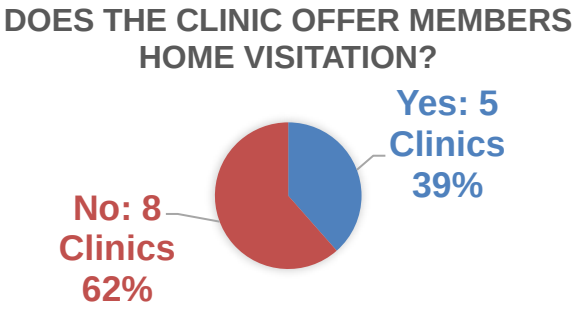




Clinics: Barriers with PNCC Agency

- 6 of the 13 clinics reported barriers with the PNCC Agency
- 3 clinics reported concerns with communication with the agency
- Other concerns highlighted by individual clinics:
  - Covid-19 limiting home visits
  - Obtaining case notes
  - Waitlist; especially for non-English speaking patients
  - Outside PNCCs recruiting patients already enrolled internally
  - Patients refusing PNCC services

Clinics: Home Visitation



Home Visit Barriers
Members not interested or comfortable (often due to COVID)
Clinic reduced or stopped home visits due to Covid

Home Visit Success
Greater insight into the member's home life
MOU and coordination with public health to provide visits
Eliminates transportation and child-care barriers

Other Home Visit Changes due to Covid
Conducted via telehealth
Only conducted if clinic lost contact with member
Only offered via partner agencies
No availability for PNCC created waiting list

Clinics: Telehealth for Care Management

Use of Telehealth
Telehealth for post-partum visits (helped when transportation with a baby was a barrier for many)
PNCC intakes done virtually
Telephone for nurse visits or other appointments
Virtual visits for low-risk members or most members who were not due for labs
1st, 2nd, and 3rd trimester education provided via telehealth
Offered telehealth early in pregnancy
Available if the person cannot come in person

Clinics: Successful Care Coordination Strategies, Programs, & Projects

- Programs:
  - First Breath
  - WIC
  - Stork's Nest
  - Well Badger
  - Pregnancy Helpline
  - City of Milwaukee Cribs for Kids
  - LIHF Pilot Program
  - Health Disparities Reduction Project
- Common Strategies and Projects:
  - Monthly OB Chart Reviews
  - Providing a variety of services within OBMH
- Other strategies or projects
  - Trainings, staff communication, flexibility in scheduling, in person visits, care plan template development, MAT initiation in clinic

Clinics: Care Coordination: Barriers or Shortcomings

Barriers or Shortcomings Listed by Multiple Clinics
Staff Concerns: Limited nursing staff (RN role requires high effort, limited staff impacts care plan individualization), not enough staff to maintain database, unclear roles
Patient follow through (including cancelled appointments) and outdated or incorrect contact information
Program criteria is too limiting (which can impact teen patients and other high-risk pregnancies)
Invoices: Turn around time and redundant information with database

Clinics: Care Coordination: Non/Medical Social Determinant Factors (cont.)

Non-Medical / Social Determinant Factors the Clinic is Addressing
Food insecurity
Housing Insecurity / Living Environment
Domestic violence
Transportation
Socioeconomic status / financial needs
Behavioral Health (substance use, smoking, or crisis care, etc.)
Stress
Dental Health
Parenting / Childcare / Family Supports
Cultural or language needs
Employment and Education

Clinics: Care Coordination: Non/medical Social Determinant Factors (cont.)

Methods to Address Non-Medical / Social Determinant Factors
Referrals to CBOs
Connected to clinic social worker
Assistance, education, or services provided by clinic for certain needs
Baby or lactation items provided by clinic (such as a gift bag or incentive program)
Free transportation if MTM cannot accommodate
Closer follow up by clinic
Dental hygienist is available
Connecting with HMO to address transportation

Clinics: OB Registry Data Entry Process

- Only 1 of 12 clinics share OB registry data entry responsibilities with HMO

Position that enters data in registry
OB Nurse Case Manager or RN
Nurse Practitioner
BadgerCare Coordinator / Advocate
PNCC enters data
OBMH Care Team
HMO is responsible
Administrative Assistant
Program Manager
Patient Access Service Representation

Frequency of Data Entry
Member specific timeline
Weekly
Monthly

Clinics: Program Monitoring: Process

- Clinics reported various staff responsible for tracking
  - Badgercare Coordinator, PNCC, OB Nurse Case manger, OB Case Management team, OB RN
- Clinics reported various data systems used for monitoring:
  - Spreadsheets, Google sheets, or excel files, Care Everywhere, SharePoint, Internal database, Electronic Medical Record
- Additional items tracked by some clinics
  - Referrals, community resources, doula or home visiting provider visits, various complications, breastfeeding status, patient survey feedback, partner information, mental health, employment, programs enrolled in (PCP, Dental, etc.) HMO Sponsored cab rides

Clinics: Program Monitoring Improvement

How Results Are Used to Improve Programs
Working with community and community resources
Staff / Teams review to make process improvements
Addressing Drivers of Health
Relaying information to providers (OB, PNCC, etc.)
Developing relationships with patients
Working with the County
Enhancing tracking and patient file information
PNCC monitors for compliance
Data justifies rationale for in house PNCCs
Do not currently use results for improvement

Clinics: Successful Program Monitoring Practices

Successful Monitoring or Evaluation Practices
Regular OBMH team meetings / staff interaction
Tracking in EMR (Tapestry, Epic, etc.)
Member Survey results
Monthly chart reviews
Unknown
Patient tracking in SharePoint
Frequent patient monitoring and phone calls
UDS measures used to examine performance

Clinics: Program Monitoring Barriers

Barriers to Monitoring or Evaluation
Clinics reported concerns with evaluating effectiveness of the program or low correlation between meeting requirements and birth outcomes
Different EMRs can be difficult for providers
Difficulty tracking patients from provider to provider
Changes in member phone number and addresses
Delay in accessing notes related to services
Staff availability for tracking
Tracking is time consuming

Clinics: Program Success Stories

Key Themes in Success Stories
Meeting needs related to trauma, mental health, and substance use
Access to needed items and resources (baby items, food, housing, community resources, etc.)
Addressing transportation concerns
Successfully breastfeeding

Clinics: Additional OBMH Best Practices

Best Practices or Processes (not addressed in other questions)
Enhancements to EHR including creating a standardized care plan in EPIC and a texting in “chat format” for multi-providers to increase care coordination
Creating culturally effective plain language documents for the entire clinic (not just OBMH)
Scheduling the post partum visit during 26-week appointment

Clinics: Additional OBMH Barriers

Additional Barriers (not addressed in other questions)
Need training on impacts of racism and cultural appropriate interactions for all staff
MetaStar Audits do not always reflect the amount of time and effort as some staff do not enter notes in EHR
Lack of communication from HMOs
State funded, financial incentives to members as hospitals have barriers to providing financial incentives

What Clinics Say DHS Can Do To Strengthen the OBMH Initiative

What could DHS do to strengthen OBMH initiative?
Pay for transportation including partners and family members to attend appointments
Reimbursement changes (such as requiring HMO to reimburse in quarter or reimbursing Community Heath Workers)
Allow OBMH enrollment at any stage of pregnancy
Remove 10 OB visit requirement
Better communication and instructions
Provide outcomes and/or results of this survey

What Clinics Say DHS Can Do (cont.)

Additional Suggestions by Individual Clinics
Gather and utilize input from communities of color
Funding and incentives for developing community partnerships
Remove race as qualifier for program
Allow hospital specialist visits to count as OB visit even if not OBMH provider
Incorporate guided support groups for women into OBMH model
Allow case manager to go OB appointment and count as a home visit
More flexibility in meeting program objectives on case-by-case basis
Require HMO to share list of in-network behavioral health and dental resources
Allow all Medicaid members not just those in HMO to participate
Provide gift packages to be given to moms when meeting prenatal care visits

Clinics: Summary of Main Ideas from Clinic Annual Reports

- DHS needs to evaluate if the program is effective. Is the criteria required actually improving birth outcomes?
- Policy change consideration:
  - Consensus that the criteria is too restrictive
  - 16-week gestational period entry requirement: Women who start later would benefit from program (teen moms, individuals enrolling later may be at higher risk for poor outcome)
  - 10 visit requirement is too high and not member specific
  - There should be more flexibility in home visit criteria (such as allowing the case manager going to appointment to count)
  - Is input from the communities of color considered and included in program design?

Clinics: Summary of Main Ideas from Clinic Annual Reports (cont.)

- Other Main Barriers not related to program requirements
  - Transportation concerns specifically not reimbursing transportation for children and partners
  - Burdensome entry / tracking requirements (which is more difficult given the current staffing shortages)
  - Reimbursement concerns: HMOs do not reimburse timely, include reimbursement for community health workers
  - Need better communication and instructions from DHS and/or HMOs

- Major impacts of Covid
  - Home visits and in-person clinic visits limited by clinic policy or member comfort
  - Staffing shortages

HMOs: Successful Enrollment Outreach Methods or Processes

Successful Outreach Methods or Processes
Telephonic outreach
Members notified by health care providers (e.g., RN)
Notice of Pregnancy (NOP) Assessment or other Assessment
Utilizing BORN report to identify members
Working w/clinic program coordinator/advocate
Case management letter, mailings
Face-to-face visits; in-person home visits
Claims

HMOs: Outreach, Recruitment, and Retention Barriers or Issues

- Policies preventing anyone other than patients from attending in-person appointments
- Lack of pregnancy notification from OB registry; Untimely notifications
- Transferred out of OBMH (e.g., high-risk patients)
- Lack of midwives who can deliver babies
- Pre-established prenatal care providers w/non-OBMH sites
- Inaccurate demographics
- Disinterest in switching providers
- Home visits/face-to-face visits placed on hold due to COVID-19
- Lack of engagement in OB Case Management
- Telephonic unresponsiveness; invalid contact info
- No telehealth services or telehealth technological challenges
- SDOH barriers
- Loss of HMO coverage
- Difficulty identifying members prior to establishing w/an OBGYN or within the first 16 weeks of pregnancy

HMOs: High-risk Groups Successes and Barriers

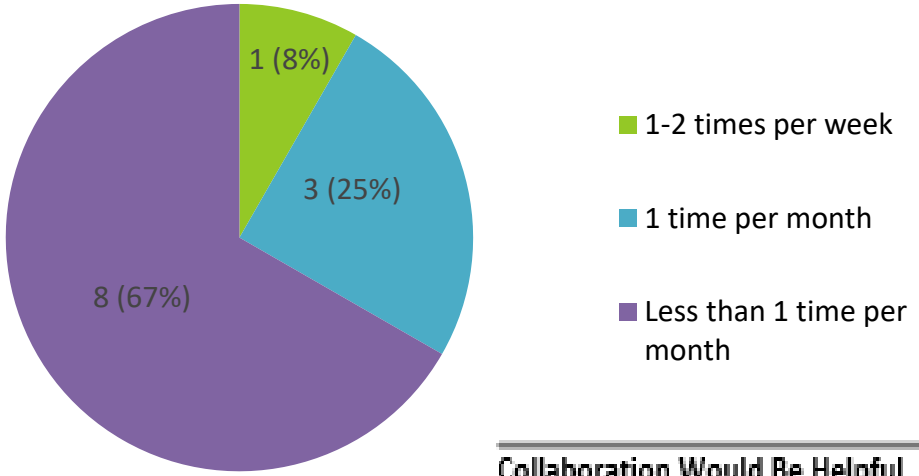
High Risk Group	Barrier	Success
Homeless patients	Unaffordable housing, unsafe housing during pregnancy, unstable housing	Establishing good relationships with Public Health; housing referrals and emergency shelters; meeting patients in person; participating in care coordination
Patients w/limited financial resources	Little to no access to internet, Wifi, phones, or cell phone data to have e-visit; libraries or other communal places w/free Wifi unavailable; members traveling out of state	OBMH visits in person; connecting with community agencies to identify solutions to members drivers of health

HMOs: Effective Care Team Methods, Staff Involvement, or Processes That Improved Care Coordination and/or Positive Member Response

- Use of internal instant messaging between the OBMH team
- Warm handoffs processes to behavioral health and clinic social workers.
- Ability to send mychart messages to members who are otherwise difficult to reach
- Implementation of member satisfaction survey's specific to OBMH
- Badgercare Coordinator taking on all direct referrals to outside organizations and documenting in EMR
- Creation of a SharePoint page that is used by all OBMH staff, so they can track who is in the program, what referrals have been sent and what the status of those are.
- Adding a Provider lead to the OBMH team
- Monthly OBMH team meetings to discuss care plan changes, updates, opportunities for improvement and trainings
- Assignment of a Clinical Learning Specialist to the OBMH team, to assist with workflow development
- Development of a welcome letter and discharge letter for members who enrolled in the program.
- Organizational presentations on OBMH, what it is, why we do it and providing positive patient experiences to staff

HMOs: OBMH Model Operations and Improvement Collaborations

Figure 2: Meeting Frequency of Stakeholders



Collaboration Would Be Helpful	Percent
Yes	66.7%
No	33.3%

HMOs: Helpful HMO-Clinic Collaborative Activities

Activities
Effective Communication (e.g., care plans, case management processes, transferring care)
Continued/Enhanced collaboration across HMOs and clinics
DoH data sharing
Member education
Continued/Enhanced collaboration across HMOs and clinics
Utilize Wishin Pulse

HMOs: Barriers or Issues With PNCC Agencies

Issues or Barriers With PNCCs
Frequent Changes in PNCC programs (e.g. changes in county staffing without notification, PNCC turnover)
Effective communication with PNCC agencies (e.g., delays in returning members' phone calls in timely fashion)
Return of Memorandum of Understanding delays
Frustrating PNCC billing practices for members
Quality of care provided by PNCC agencies
Lack of standardized process and procedures for OBMHs being notified of member's enrollment into PNCC

HMOs: Home Visitation Challenges and Successes

Challenges
Home visitation offered to MKE county residents only
Locating members experiencing homelessness
Member engagement
Inaccurate member demographics
Unable to offer home visits
Other DoH or barriers (childcare, work schedules)

Successes
MOU with public health to provide home visits through PNCC and NFP programs
Meeting in clinic rather in member's home
Better member engagement
Home environment assessment
Identifying social and support factors
Racially and ethnically diverse HMO staff
Utilizing CHWs to conduct home visits
Bringing gifts to prenatal visits to build rapport

HMOs: COVID-19 Home Visits Changes

Home Visit Changes
Telehealth to relive stress of members with visits
Home visits paused and decreased interests
HMO lack capability to offer telehealth visits
Technology access a barrier
Send resources and other communications via mail or email as needed

HMOs: Leveraging Telehealth for Care Management

Approaches to Leverage telehealth
Phone calls (e.g., for visits, assessments, etc.)
Text messaging/ emails
Video visits to manage members care, discuss care goals, develop plans
No change in approach
Fully supported practitioner to use telehealth throughout the COVID-19 pandemic; waving cost for all 2020
Expanded use of data sources such as LexusNexus and WISHIN registries to find more reliable or current contact information for members

HMOs: Successful Care Coordination Strategies, Programs, or Projects

Successful Strategies
Home visitations
Financial incentives
Leveraging Health Disparities Reduction project
OBMH improvement trainings (e,g, care plan templates, birth plans
Open communication
Care coordination completed by OBMH team at each clinics
Providing transportation assistance
Educational videos
Screening for DoH
WISHIN Pulse and Ping

HMOs: Care Coordination Barriers or Shortcomings

Barriers or Shortcomings
Follow-up timeline w/ members
Overwhelmed Provider workloads
Unresponsiveness of members
DoH barriers (housing shortages, lack of transportation, food insecurity, etc.)
Language barriers
Member retention
Lack of resources for smaller counties

HMOs: Addressing Non-Medical/Social Determinant Factors in OBMH Care Coordination

Approaches
All non-medical/social determinant factors are addressed
Referrals made out to the community in making sure the member is getting their needs met
Handout information provided (food pantry's, diaper pantry's, Section 8 housing)
Non-medical/social determinant factors addressed but not within OBMH
HMO provides member with newborn, infant and child supplies for urgent needs
Intake assessment to assess for drivers of health

HMOs: Obstetrics (OB) Registry Data Entry

Data entered in OB registry	Percent	# of HMOs
Yes	25.0%	3
No	75.0%	9
Totals		12

Variety of ways HMOs coordinate data entry in the OB registry with clinic partners.

- Case managers are responsible for data entry in the registry for all members that enroll at the clinic site
- No data entry is done by clinic staff by several HMOs
- BadgerCare Coordinator/Advocate enters data into the OB registry for allclinics
- HMO enters data of member enrolled clinic into the registry and send a welcome letter to members with a copy to the OB/GYN

HMOs: Approaches to Monitoring OBMH Program and Birth Outcomes

OBMH Program Monitoring Approaches
Frequently checking OB Registry
Utilize birth registry for outcomes
Informing staff that an HMO member is part of the OBMH program
Badgercare Coordinator/Advocate maintains a spreadsheet for coordination and tracking of all members enrolled in OBMH (Tracking birth outcomes, enrollment info, and referrals made to address drivers of health
Review of HMO, OB Case Management and OBMH birth outcomes for trends and interventions
Validation of invoices
Monitor medical records for labor and delivery for adverse outcomes
Outcomes monitored for and through payment of services
Payments are tracked and warehoused on an on-going basis

HMOs: Improving OBMH Program Using Birth Outcomes Results

HMO Approaches
Allowing communities of color to lead the way in improving birth outcomes
OBMH Coordinator conducts analysis during the annual review to identify general trends regarding birth outcomes
Monitoring the birth outcomes and providing feedback to PNCC services and clinic providers.
Educate HMO staff who work with the OBMH clinic regarding the outcome of the members and identify opportunities to better serve them
Using data from the Registry, and internal tracking tool, to determine next steps for potential needs or improvements for the upcoming year
Partnering with clinic care delivery team as needed
NICU program that helps to follow members with infants that are in the NICU due to poor birth outcomes
Communication with the OB Medical Home is initiated for collaboration for improvement
Collaboration with the OBMH care coordination team to locate resources and provide coordination of services during the pregnancy and postpartum period

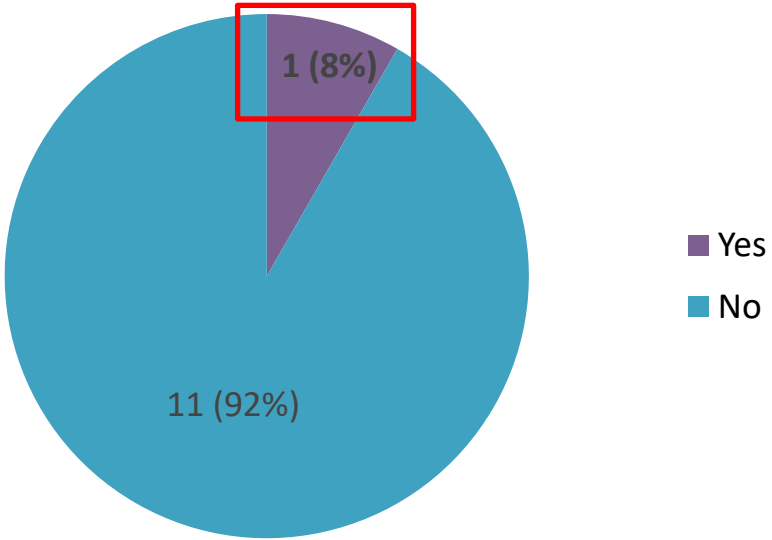
HMOs: Monitoring or Evaluation Barriers

- Communication
- DHS not sharing birth outcome data that compares those enrolled in OBMH to those who are not, across all HMOs
- Small member population participating in program
- Untimely feedback from DHS or Metastar to help reinforce expectations
- Burdensome program expectations; not addressing health disparities first
- Slow and cumbersome OBMH reimbursement and reconciliation process
- Misalignment with reimbursement criteria and Metastar's audits
- Case management internal tracking tool and staffing constraints
- Case managers not meeting w/OBMH members face-to-face; not offering virtual communication
- Registry network update delays; clinic's failure to close records
- Unresponsive to Medical Records access w/clinics
- Electronic records transfers portal unable to accommodate large files at once
- Non-uniformity in provider documentation of birthweight and outcome in birthing person's EMR (usually documented in baby's chart that MetaStar can't access)

HMOs: Successful Monitoring or Evaluation Practices

- OBMH Liaison is also the Badgercare Coordinator/Advocate and OBMH Coordinator
- OBMH team and Provider Lead reviews the Metstar audit results, and identify changes needed running program
- Monitoring registry to ensure data availability for MetaStar OBMH Audit; monitoring for enrollment, closure, and continued care coordination
- Telephonic outreach attempts when member disengages or becomes unresponsive
- Chart review in conjunction with reviewing information for ACHC invoice payments
- Integration of Tapestry to clinic medical records system
- Monitoring all case management programs by the percentage of goals being met and reevaluating programs if a metric decline is observed
- Monthly meetings between Government Programs and Care Management departments to touch base and evaluate program needs
- Biannual review of enrollment and birth outcomes; Monitoring of prospective payment, enrollment and invoicing; Sharing MetaStar Annual Report with clinics
- Home visits

HMOs: OB Provider Terminations In Past Year Resulting In Limited Member Access to OB Care



Have alternate providers been found?

One HMO had seven OB providers leave their OBMH sites.

One provider had been hired as a replacement (effective August 2021).

The HMO also had two providers shift to other clinics with high OB patient case loads to help assist and treat patients.

HMO: Additional OBMH Program Best Practices / Process Success

- Utilization of WISHIN and Patient Ping to address inpatient or emergency room visits as well as a reference tool for member medical and demographic information
- Use of nurses for post-partum visits
- Use of EPIC to automate referrals when resources and transportation are needed, standardize care plans
- Creating culturally effective plain language documents, providing recommendations to senior leadership
- Having nurses meet with members
- OB provider and another team member meeting a woman experiencing homelessness due to domestic violence issues into a local shelter
- Reducing postpartum care utilization disparity through a specialized education pilot program (postpartum care increased from 75% to 90%)
- Completion of a postpartum visit is documented in the member's medical chart, and also tracked and validated through MetaStar's OB Registry for all OBMH enrollees
- Mailing postpartum handouts to members and/or calling members regarding post partum care
- Annual review of OB Medical Home requirements with clinics
- Communication across HMOs and providers whenever program changes occur, including staffing updates
- Participation in the OB Medical Home Virtual Best Practice Seminar in October.

HMO: OBMH Program Barriers / Issues and Solutions

Potential solutions and current activities to address barrier/issues

- Covid-19 Pandemic
- Ignorance of racism and its effects on communities of color – annual training and practice for anyone working with OB patients; culturally appropriate dialogue with members
- Purpose of the OBMH program and its goals – Clear communications on what the OBMH program hopes to accomplish
- Transportation - Taxi Service; virtual visits, case management interactions with members
- Face-to-Face case managers meeting members – Offering virtual communication; continue offering telephonic support; providing mailing/email materials and resources
- Effective follow-up w/providers via email - utilize a point of contact for communications and needed member collaborations
- Care beyond 16 weeks – prorated payment to clinic based on the # of requirements met
- Care coordinator sending member resources for primary care doctor when clinics has access to primary care doctor

Recommendations to Strengthen OBMH Initiative

- Provide up to date data on program outcomes
- Strengthen collaboration
- Clarify roles and expectations for clinics and HMOs
- Have DHS work directly with clinics
- DHS offer voucher or reimbursement for childcare, transportation
- Tie pass-through payment to OB Medical Homes to meet all HEDIS measures
- Ask communities of color what they need to achieve a goal and be prepared to act on it.
  - For example, if communities of color tell you that they need flexibility in the care they need, then allow it. If they say doulas will impact the outcomes in their community, then cover it.
- Provide funding and incentives for HMOs or clinics that develop community partnerships that respond to the needs within each community
- Allow enrollment into OBMH at any stage during pregnancy. The later in pregnancy someone is before starting prenatal care, the higher the risk of a poor outcome.
- Remove the requirement of attending 10 OB visits as the standard. The goal should be what the member and their provider feel is needed or wanted to have a healthy outcome.
- Remove race as a qualifier for the program.
- Allow hospital specialists visits to count as an OB visit, even if it is not the designated OBMH provider.

Next Steps

- Digest survey summary recommendations
- Internal DHS meetings
  - Use results to identify policy recommendations and other opportunities to enhance OBMH initiative
- Identification of OBMH Learning Collaborative topics

Questions