WISCONSIN DEPARTMENT *of* HEALTH SERVICES

2023 OBMH Annual Reports

HMO and Clinic Report Summaries

Obstetrics Medical Home Best Practice Seminar

Danielle Washington

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.

- The OBMH Model Annual Survey report was not collected in 2022. In the 2023 survey report, DHS had more tailored questions on the impact of the public health emergency (PHE) unwinding on the OBMH program at both the clinic and HMO levels.

Outline: 2023 OBMH Model Annual Survey

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

- Online survey was administered from June 1st to July 3rd, 2023.
  - One survey completed per HMO; 46 maximum questions per HMO survey
  - Each participating OBMH partner clinic expected to fill out only one survey; 44 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 2022 - March 2023 activities.

Key Takeaways: OBMH Model Annual Survey

- Normal / Pre-COVID OBMH outreach, recruitment and retention methods for clinics and HMOs resumed
  - Telehealth routinely offered to some OBMH HMOs and clinics while used as a last resort for others
  - Routine screening for and addressing members drivers of health (DoH) help with enrollment and retention in OBMH program
- Communication still a barrier
  - Waitlists; especially for non-English speaking patients for PNCC services; lack of interpreters
  - Improved communication and coordination between HMOs, PNCC agencies, DHS, and clinics desired
  - Offering various ways for members to connect (i.e., in-person, phone visits, telehealth, text message communication) improves communication and engagement
- COVID-19 lingering effects
  - Staffing turnover
  - Nursing shortages
  - Lack of trust between members and providers a barrier

Key Takeaways: OBMH Model Annual Survey (cont.)

- A refresher or orientation course to OBMH, resources and expectations is wanted to reduce confusion about the initiative
- Enhanced EHRs for texting and messaging multiple providers improves communication and care coordination across teams
- Promoting OB services through PNCC printed and distributed flyers, website, Facebook, and social media announcements are beneficial advertisement and recruitment practices
- Improved information and data sharing between clinics, HMO, and DHS needed for better monitoring of program and outcomes
- Working with IMPACT Connect and Unite Us are helpful resources for connecting members with resources and tracking community-based resource referrals

OBMH Enrollment Data Summary

- 17 OBMH Partner Clinics
  - 54.8% response rate
- 12 OBMH HMOs
  - 100% response rate

↑ Denotes an increase from 2021 survey report.

↓ Denotes a decrease from 2021 survey report.

Totals	# Women Screened	# Women Eligible	# Women Enrolled	% Women Enrolled	% Assessed: Stress	% Assessed: Mental Health	% Received COVID-19 Vaccine
Clinic Totals	5,063 ↑	1,959	1,114 ↓	56.8% ↑	93.4% ↑	99.4% ↑	35.8% ↑
HMO Totals	4,542 ↑	978	553 ↑	56.5% ↑	N/A	N/A	N/A

Clinics: Outreach Methods that Lead to Successful Enrollment

Successful Method or Process
Staff responsible for identifying potential participants
In person meetings
Engage potential participants in a variety of ways
Telephone calls
Enrolling every qualified member
Coordination with HMO
Using Community Health Workers (CHWs) to do outreach at community events
Community flyers or program promotion at community events
Enrollment letter or information mailed

Clinics: Barriers or Issues to Outreach, Recruitment, and Retention

Barriers or Issues with Outreach, Recruitment, and Retention
Communication methods (i.e., disconnected phone numbers and address changes)
Patients dropping out of the program or no shows (e.g., jail time, switching to another HMO, being suddenly dropped from an HMO)
Transportation
Patients unable to get in the full ten appointments if delivering early or scheduling an induction
Members change providers to a clinic that is not an OBMH site or will move out of the area and not report it to DHS
Decline in patients seeking prenatal care in the first trimester; more patients seeking care after 16 weeks or maximum gestation
Confusion about the program and services
OB Staffing Challenges (e.g., OB provider shortages, lack of staffing, male providers only, FTE reduction, large PNCC staff turnover)
Sustaining patient engagement in care

Clinics: Successes and Barriers with High-Risk Groups

High Risk Group	Barriers	Success
Patients with Substance Use Disorder (SUD)	- Difficult to maintain enrollment and communication - Inconsistent participation and prenatal care	- Getting prenatal care - Initiating and/or staying on Medication Assisted Treatment (MAT) - Being treated as a worthwhile human being - Staying off opioids - Having continuity for difference care needs within one clinic
Pregnant women <18 or ≥38 years old	- Transportation with teen moms	- Offering of virtual or phone visits
Homeless Patients	- Not making or attending appointments	
History of Mental Health Illness	- Unreliable forms of communication - Transportation	

Clinics: Methods, Staff, and Processes to Improve Care Coordination and Member Response

Care Team Methods	Staff	Processes
Creating a care plan during the initial contact for all pregnant patients; maintaining frequent contact with the patient during their pregnancy	OB Case Management team	OB Case Management team makes referrals to Social Services, Behavioral Health, WIC, Dental, Nutrition, SSCHC Chronic Care outside services, etc. OB Case Management Team assists patients in determining a pediatrician prior to delivery. After delivery, the staff will help new mothers schedule newborn and postpartum appointments.
Using EPIC	OBMH Liaison/BadgerCare Coordinator	OBMH HMO and Clinic staff send messages to each other through EPIC to alert of any concerns or issues
Complete a monthly OB Chart Review for each patient at their 20- and 32-week gestation, and those deemed higher risk	Director of Maternal and Child Health, the patient’s OB provider, OB Nurse Case Manager and Clinic Social Worker, and occasionally the Director of Behavioral Health	Director of Maternal and Child Health, OB Nurse Case Manager and Clinic Social Worker notify high risk patient’s individual provider of risks, needs, or recommendations
Clinic staff are co-located in the same area of each building to facilitate coordination discussions	Care Coordinator	Care Coordinator initiates phone calls to patients enrolled in OBMH clinic and schedules regular clinic visits with patients
Written and verbal communication to keep others informed/updated	OBMH and clinic staff	Collaboration between OBMH and clinic staff
Using prenatal checklists and team approach	Nursing staff and providers	Having a triage RN and check-ins with NP

Clinics: Methods, Staff, or Processes to Improve Care Coordination and Member Response Highlighted by Individual Clinics

Care Team Methods
Combining Medical Home program with PNCC
Offer a variety of communications methods (i.e., telehealth services, phone visits, and text messaging)
Frequent face to face meetings including seeing patients at their prenatal appointments
Using persistence and non-judgmental approach
Leaving packets and making follow up phone calls to avoid gaps in care and for continuity if member's visit is after care coordinator hours
Engaging patients with clinical care and/or community resources

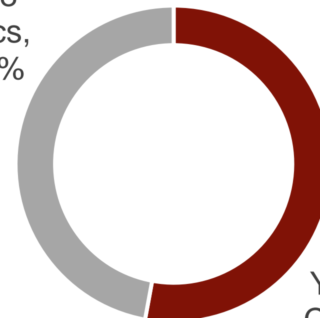
Processes
Provider, CHW, and PNCC staff discuss PNCC services with patients
Staff talk to patient about the services during the initial phone assessment
Having a triage RN and check-ins with NP

Staff
Nurses
PNCC Staff, CHW, and provider
Nursing staff and providers

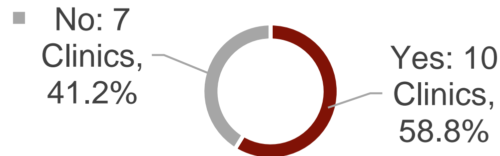
Clinics: Care Team Meeting Frequency and HMO Collaboration

Meeting Frequency	Percentage	# Clinics
Daily	11.8%	2
3-4 times per week	11.8%	2
1-2 times per week	5.9%	1
2-3 times per month	17.6%	3
1 time per month	23.5%	4
Less than 1 time per month	29.4%	5
		Totals: 17

DO OPERATIONS AND IMPROVEMENT DISCUSSIONS INCLUDE HMOs?



Clinics: Home Visitation



Home Visit Barriers
Reluctance of home visitations since COVID-19 pandemic
Difficult to reach patients (i.e., patients have work or school during the day, disconnected phone numbers, unresponsive patients)
Transportation
Childcare
Comfort level of other's living in the home having a RN enter their home leading to issues with recruitment and/or retention

Home Visit Successes
County PNCC/NFP (Nurse Family Partnership) programs are offered at every visit along the pregnancy continuum, while simultaneously offering home visitations to members
Communication and sharing of information between the nurses doing visits and OBMH providers
Collaboration on resolution of health concerns and SDOH needs
Access to member through text messages
Visitations at the hospital after delivery
Further assessment of patient needs including examination of patient home environment

Clinics: Telehealth for Care Management

Use of Telehealth
Used only as a last resort for OBMH patients
Offered with the same frequency as prior to the pandemic
Incorporated telehealth visits into new EHR system making it readily available and accessible to patient population
Lack of reimbursement for telehealth caused telehealth to be discontinued
Dieticians/diabetes educators offer telehealth visits
PNCC does telephonic care management
Three-week postpartum phone call check is implemented, and more virtual OB visits offered to patients
All pregnant patients have been having in-person OB visits during the past year of the pandemic

Clinics: Telehealth for Care Management (cont.)

Use of Telehealth
In-person, telehealth, or video visits offered for behavioral health
Following up on mental health and blood sugar monitoring for gestational diabetic patients
Shifted to some telehealth visits for patients, primarily those early in their pregnancy, that didn’t require labs, fundal height requirements or fetal heart tones readings
Telehealth offered in the beginning of pandemic but now all pregnant patients have in-person OB visits and postpartum visits at the clinic
Telehealth offered on a limited basis if there is a need
Virtual postpartum checkups conducted if desired, but in-person preferred
MyChart video appointment available
Mostly in person but telehealth is offered, strong use of MyHealth patient portal for communication with patients

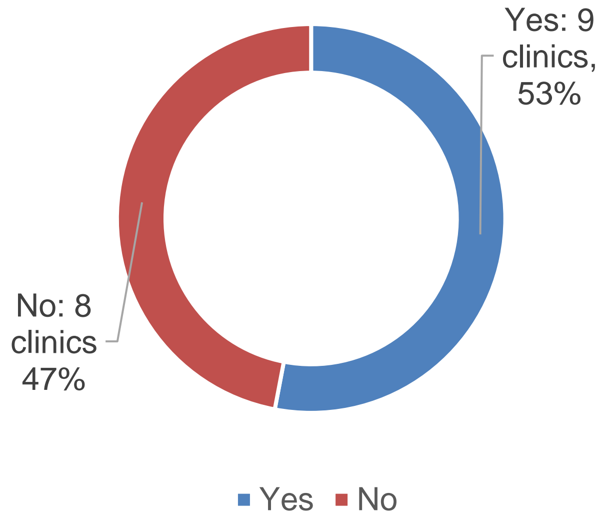
Clinics: PHE Unwinding - Telehealth for Care Management

Post COVID-19 Plans to Leverage Telehealth in Care Management
Will offer on a limited basis as long as it is approved/covered
Shared decision-making
Continue offering in-person/in home/telehealth/phone visits based on members preferences and needs; meeting patients where they are
Some phone calls will continue but appointments with the medical provider done in person; Continue three weeks postpartum phone calls
Telehealth used only as a last resort for OBMH patients; offered only when in-person visits cannot be accomplished
No plans for continued use
N/A

Clinics: PHE Unwinding - OBMH Program Concerns

OBMH Pandemic Health Emergency Unwinding Programmatic Concerns
Coverage issues; members who have a primary insurance over their BC+ insurer if their incomes are higher than allowable amount
Impact of decrease in Food Share benefits on patients
Telehealth or phone calls being discontinued
Difficult to reach patients may not receive mail in time due housing instability
SDoH needs (i.e., housing, finances, food) worsening as funding for several programs related to SDoH supports being cut

Clinics: PHE Unwinding - Anticipated OBMH Programmatic Supports



Anticipated post-COVID-19 PHE OBMH Programmatic Supports
Helping clinics educate the patient population on the importance of COVID-19 vaccinations post-pandemic
HMOs to continue supporting telehealth/phone visits for OBMH patients
Ability to have some financial assistance to help patients (i.e., gift cards, some funding, baby supplies, support groups)
Communicating member enrollment needs
Community resources for food, childcare, housing and employment/job skills training
Quality PNCCs and PNCC programs are needed
More trainings on nutrition and breastfeeding

Clinics: COVID-19 Home Visit Changes

- Decline in the number of families accepting home visits from the clinic
- Home visits were temporarily paused, and everything was done virtually or by phone.
- Home visiting nurses are back up to full staff and while some phone visits are needed, visits are generally done at patient homes or a community location.
- Patients more comfortable with phone or in-person visits at the clinic since the COVID-19 pandemic
- Adopted telehealth visits for patients early in their pregnancy and did not require labs, fundal height measurements or fetal heart tones readings during COVID
- Completed critical visits for patients that had a lapse in care, could not reach, etc.
- Not a lot of availability for PNCC through Dane Co Public Health during 2022 due to their increased focus on COVID-19
- Virtual visits
- Most PNCC partners switched from home visits to telephonic care coordination though some have resumed home visits
- Home visits have not resumed since pandemic
- Back to normal
- N/A

Clinics: Successful Care Coordination Strategies, Programs, and Projects

Successful OBMH care coordination strategies, programs, and projects
Health Disparities Reduction program
Monthly contacts (or more) with the patients to determine and address their needs
Created a family-friendly environment for patients
Closely communicate member needs and ensure scheduling for all OB appointments
Addressing social determinants of health
Having a relationship with public health
Offering various methods engagement (i.e., phone, in-person, or telehealth visits)
Flexibility in scheduling and rescheduling of appointments
Nurses have remote access to a patient’s medical record and are able to use the record when providing education and care coordination
Created a new role for Maternal Child health care coordination to focus on OBMH patients who has more face-to-face time with patients
Implemented a texting system to improve ability to contact patients

Clinics: Successful Care Coordination Strategies, Programs, & Projects (cont.)

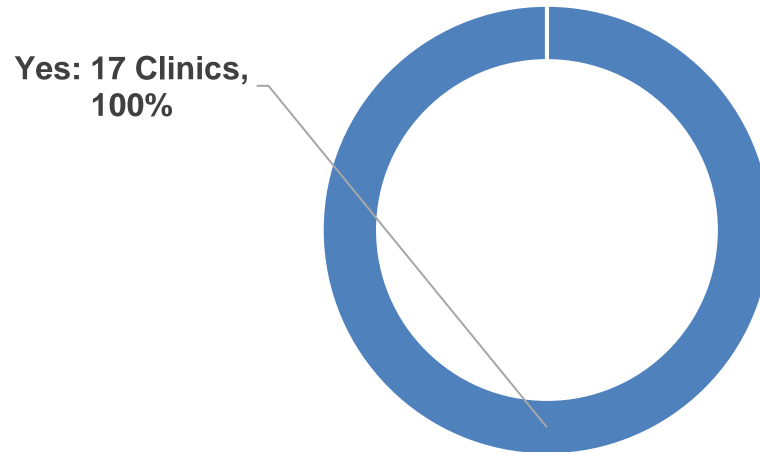
Successful OBMH care coordination strategies, programs, and projects
Organized a 3rd trimester care conference
Utilizing all local resources. WIC, Women's Willow Center, Pregnancy Helpline, First Breath
Revising OBMH workflow and reassigning tasks and job duties
Team using reports, chart reviews, and communications within EMR
Developed an individual face sheet and care plan for each patient
Face-to-face contact throughout pregnancy
Direct communication (i.e., emails, phone calls) between OBMH RN and clinic RNs
Huddles, and meetings to ensure appropriate coordination and engagement with care
Tracking of appointments using index card, Cardex-system
Combining a woman's postpartum visit with their newborn's 1 month well child check to decrease chances of no-showing when a patient delivers but has not scheduled a postpartum visit two weeks post-delivery
**Program needs a lot of improvements.

Clinics: Care Coordination Barriers or Shortcomings

Barriers or Shortcomings Listed by Clinics
Limiting the enrollment requirement to less than 16 weeks gestational age leaves some teenage patients without the program's benefits; Most pregnant teens reveal their pregnancy to their parents and health provider much later than older pregnant patients
Patients meeting the 10 OB visits to qualify for reimbursement
Developing trusting relationships
Mutual communication / Lack of patient follow through
Members who experience homelessness and intimate partner violence do not have many options for housing
Being able to communicate with the member when there is no consistent phone number or address
Appointments are sometimes challenging to schedule due to staffing concerns
Staff shortage / lack of time
OBMH and clinic are in two different buildings
Patients feel care coordination takes too much time
Reducing barriers to care while still requiring patients to be accountable
Ensuring cases get closed in a timely manner
PNCC availability
Transportation
Patients initiating services

Clinics: Care Coordination – Non-Medical Social Determinant Factors

Is the clinic addressing any non-medical/social determinant factors in OBMH care coordination?



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

Non-Medical / Social Determinant Factors Addressed by Clinics

- Lead Poisoning
- Mood
- Crime
- Violence
- Racism
- Education
- Poverty
- Childcare
- Safe Driving (Car Seats)
- Transportation
- Housing
- Utilities
- Phone
- Internet
- Financial Stressors / Financial Security
- Job Training / Work
- Relationships
- Counseling Support
- Family / Other Children
- Parenting Classes
- Intimate Partner Violence
- Partnering Support
- Living Situations
- Household Supplies
- Clothing
- Baby Cribs
- Food Security and Nutrition
- Breastfeeding and Pump Coverage
- WIC
- Food Share
- W-2
- Immigration

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

Methods to Address Non-Medical / Social Determinant Factors
Screen OBMH enrolled members for SDoH
Connected to clinic social worker for complex situations
Community partners to assist members
Participating in health disparities reduction project
Contracted an economic support specialist to get patients enrolled in BC
Nurse staff training, continuing education and community meetings to address non-medical social determinants
Referrals, resources, assistance provided by clinic to patients as needed (housing, on site food pantry, WIC, referrals to W2, local addiction treatment center, bus tickets, pay for cabs, etc.)
Offering phone or telehealth visits for patients who have childcare and transportation issues
Incentive program for mothers to earn baby items
BC+ Coordinator part of the care coordination team to get necessary resources to members
Assistance, education, staff training, or services provided by clinic for certain needs including mental health services

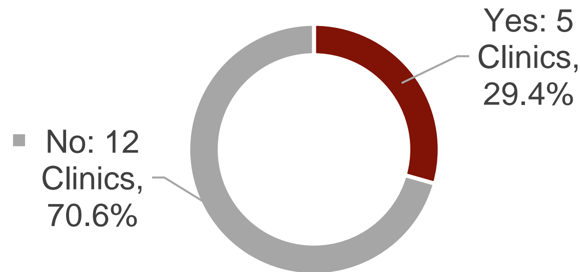
Clinics: OB Registry Process

Position that enters data in registry
OB Nurse Case Manager or RN
Nurse Practitioner
BadgerCare Coordinator / Advocate
OBMH RN / Care Coordinator
OBMH Care Team
OBMH Liaison
Program Manager

Process
Data entered at enrollment
After referral is received and patient deemed eligible
At patient’s first appointment/ prenatal visit
Uses weekly report
Potential OBMH patient data entered
Nurse / RN advises staff who then enters data

Clinics: OB Registry Data Entry Process

Does the clinic share OB registry data entry responsibilities with any HMOs



Work Distribution	# of Clinics
Work is not divided because they are both insurance and clinic systems, so the work does not need to be divided	1
Work is not divided because they are one integrated system	3
Medicaid Advocate receives weekly report of new OBMH members and enters the data into the MetaStar Registry	1

Clinics: Program Monitoring Process

- Clinics reported various staff responsible for tracking
  - Nurse Case Managers, OBMH Liaisons, BadgerCare Coordinators, Care team, OBMH provider, Nurses, Care Coordinators, Director of Maternity Care for poor birth outcomes, MAs, Program Managers
- Clinics reported various data systems used for monitoring:
  - EPIC Flowsheet, Clinic database, OBMH database, Homegrown tracking systems, Chart reviews, Internal database, Medical records and documents, Spreadsheets, Logbooks
- Additional items tracked by some clinics
  - Teams page on organization’s intranet, patient survey, Prenatal checklist, Manual tracking process of due dates

Clinics: Program Monitoring Improvement

How Results Are Used to Improve Programs
Narrative for portraying healthy birth outcomes
Reviewed to make care delivery, coordination, process improvements, and address issues
Addressing drivers of health
Planning for OB in-service lectures and resident development around OB risk factors and outcomes
Shared internally and externally
Outreach and communication with clinical staff/providers
Used to justify PNCC employment

Clinics: Successful Program Monitoring Practices

Successful Monitoring or Evaluation Practices
Monthly audits
Including provider liaison and Clinical Learning Specialist on OBMH team
Recording and review birth outcomes data with staff
Monthly chart or list reviews
Tracking in EMR; updating MA and HMO benefits in EMR (Epic, MyChart, etc.,)
Unknown/Work in progress
UDS measures used to examine performance
Paper chart
Care plan and documentation review

Clinics: Program Monitoring or Evaluation Barriers

Barriers to Monitoring or Evaluation
Staff/Time constraints
Not receiving results of DHS audits on a timely basis prevents clinic from identifying issues they need to address to improve their programs
Provider disagreement on healthy birth/poor birth outcome definition
Patient contact changes without clinic notification
Patient load on monthly audit completion timeliness
Losing track of a patient
Proving payment is warranted if reconciliation/recoupment is needed; payments should be reviewed case by case PRIOR to payment; more information should be provided on invoice or registry to prove criteria is met (i.e., date of enrollment, visit dates, phone call f/u
Telehealth for care coordination
Clinic did not report any barriers

Clinics: Additional OBMH Barriers

Additional Barriers (not addressed in other questions)
Criteria and requirement for the program are based on patient's actions not services provided by clinic
Transportation concerns (i.e., VEYO is not always available; working on bus/taxi voucher account)
Significant competition from community based PNCC programs that offer incentives for enrollment
Some community-based programs do not offer the expected extensive case management that patients need
Untimely invoices turnaround time/invoice process
Busyness in clinic
Lack of staff and time
# of visits required regardless of gestation, emphasis on postpartum visit completion, and having the same requirements for multiple gestation as singletons
No progress is acknowledged by DHS if a patient had two deliveries less than 30 weeks and now makes it to 36 weeks – not seen as meeting the requirements and goals of the program
Getting someone enrolled who wasn't a HMO member from the start of their pregnancy – refugee patients
Confusing enrollment time frames
Latinx community not automatically included in OBMH
Streamlining internal audit procedure and workflows to better manage high caseloads

Clinics: Additional OBMH Best Practices

Best Practices or Processes (not addressed in other questions)
Scheduling nurse visits in conjunction with provider visits to give extra time for teaching and address health literacy concerns
Standard templates for each expected OB visit
Screen for SDOH at each visit
Providers assess patient for need at every visit and meet with care team when need is identified
Integrated behavioral health and co-location of services to quickly support patients in need of mental health support; PHQ-9'a frequently done throughout pregnancy
Shadowing other clinics and receiving advice on how to make their own clinics more successful
Certified OBMH clinic site with WWHF First Breath
Internal phones and Webex meetings
Including OBMH nursing staff on the same email and in the EMR to improve information sharing
Established connection with African American Breastfeeding Network and offer their services to all pregnant patients
Connecting patients with doula services
EHR system capable of messaging multiple providers in texting or 'chat' format – Care coordination
Using internal communication systems, MyChart messages to members – Care coordination
First prenatal booklets with all community resources flyers
Promote OB Services through PNCC printed and distributed flyers; website, Facebook, and social media announcements
Assist patient in determining a pediatrician who is documented in care plan

Clinics: Program Success Stories

Key Themes in Success Stories
Patient developing trusting and/or safe relationships with clinic staff
Meeting needs related to mental health, trauma, substance use, etc.
Successful use of care coordination to manage chronic conditions and delivery health birth outcome
Access to needed items and resources (i.e., housing, food, diapers, clothing, emergency rent and shelter, safety plan, etc.,)
Good communication with OBMH Care team when member moved out of OBMH area
Using doulas

Clinics: Strengthening the OBMH Initiative

What could DHS do to strengthen OBMH initiative?	# of Clinics
Flexibility in lowering the number of prenatal visits required for members who deliver at 37 weeks or slightly earlier	3
Allowing enrollment for members who are over 16- or 20-weeks gestation and just coming for prenatal care	3
Not having the audit rebuttals due at the same time as the registry update and annual survey	2

HMOs: Successful Enrollment Outreach Methods or Processes

Successful Outreach Methods or Processes
Telephonic outreach
Members notified by health care providers (i.e., RN, OBMH provider)
Notice of Pregnancy (NOP) Assessment or other Assessment
Utilizing BORN report to identify members
Case management letter, mailings, texts
Face-to-face visits; in-person home visits
Motivational Interviewing Techniques
Claims

HMOs: Outreach, Recruitment, and Retention Barriers or Issues

- Lack of pregnancy notification from OB registry; Untimely notifications due to time to process claims data
- 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 program or switching providers
- Lack of engagement in OB Case Management
- Telephonic unresponsiveness; invalid contact info
- SDOH barriers
- Loss of HMO coverage; change in HMOs or providers
- Global billing for maternity make it difficult to easily identify potential members
- Difficulty identifying members prior to establishing w/an OBGYN or w/ in first 16 weeks of pregnancy
- No interpreters for members who spoke a second language
- Lack of trust between members and providers
- Enrolled members not attending post-partum visits w/ clinics
- Too much contact between members and HMO

HMOs: High-risk Groups Successes and Barriers

High Risk Group	Barriers	Successes
Any OBMH Patient	- Staff turnover - Nursing shortages - Relationship builders at clinic	- More likely to attend postpartum visit' more involved with decision-making with providers and nurse - Connecting them with BC+ Coordinator/OBMH Liaison
Patients experiencing Substance Use Disorder (SUD)	- Seek care late or not at all - Difficult to engage - Limited resources - Members not knowledgeable about their own health conditions - Falling out of care and unable to contact	- Ongoing care coordination w/OB providers and their teams - Vivify program participant. - Completing online assessments - Submission of NOP forms by providers to identify high risk members - Building trust w/care coordinators - Referral to substance use counselor or comprehensive service program offers members assistance with housing, cell phones and food insecurity
History of Mental Health Illness	- Members not knowledgeable about their own health conditions - Refused to seek further medical care	- Building trust w/care coordinators
African American Members	- Seek care late in pregnancy - Enrollment deadline passed	- Connecting with doulas
Members Facing SDoH		- Dependent upon member's willingness to engage - Housing navigator - Using Aryv to set up transportation so that member attends their appointments

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

Methods / Staff Involvement / Processes	Outcomes
Using Epic to it’s full potential (i.e., staff send messages to each other to alert staff of any concerns or issues)	Improved care coordination
OBMH Liaison/BadgerCare Coordinator send MyChart messages to members	Increases member timely responses and allow care team to track all conversations with enrolled members
Making three efforts to reach pregnant members early in their pregnancy and screen for SDoH, behavioral, substance abuse, and medical needs	Results in appropriate referrals for member needs and follow up by provider and care coordinator for positive screens
Established care management contact processes	Promotes engagement and develop relationship with members
Needs stratification during annual assessments	Identifies areas of needs and opportunities for care coordination to help meet those needs
OBMH Coordinator and OBMH Case Management collaboration	Increased telephonic outreach Improved member engagement with High-Risk OB Case Management Planning
Monthly OBMH meeting w/HMO and clinic staff and monthly reports to OB providers	Improved Care Coordination

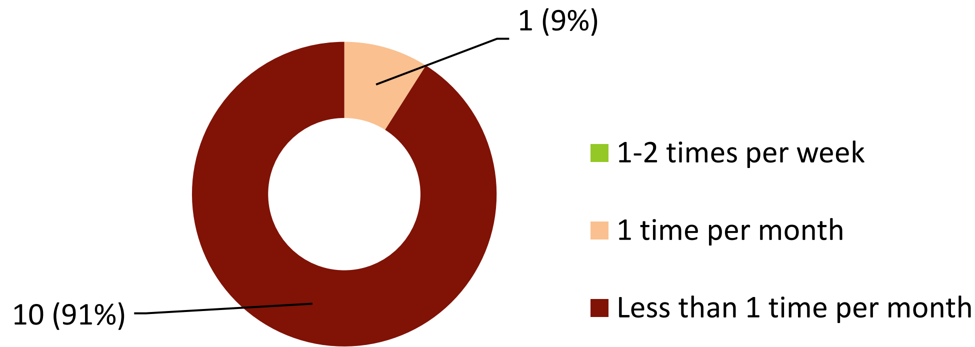
HMOs: Successful Interventions to Address Barriers with Outreach, Recruitment, and Retention

- Cross collaboration, partnership, working as a team (provider, OBMH RN, and BC+ Coordinator)
- Addressing SDoH needs, especially transportation
- Improving claims review process to more quickly identify pregnant members
- Outreach in each trimester and during postpartum period
- Pilot CHW at clinic to engage with members
- Providers who schedule emergent transportation needs for missed or acute appointments through HMO vendor w/Medicaid transportation benefit cannot meet the need to remove transportation as a barrier to care
- Established effective relationships w/OBMH and PNCC providers to promote recruitment and retention in those programs
- Use telephonic and mail outreach
- Staff members whose roles is to engage early on in pregnancy
- Offering care management services to coordinate members needs
- HMO remind member of incentives for completion of NOP and post-partum assessment
- Improved communications to members (texting members for reminders about appts and calls, having the HMO identified to members when calling
- Encourage member to contact HMO for case management needs beyond OB needs
- Face-to-face visits
- Use of Care Coordination forms by clinic partners; use of Prenatal Assessment tools
- Refer members to PNCC agencies and Doula services
- Communicating with member and OB provider through MyChart
- Verifying member demographic directly with clinic

HMOs Experiencing Successes or Barriers With Certain High-Risk Groups

Experience	Percent	HMOs
Successes	9.1%	1
Barriers	18.2%	2
Both	72.7%	8
		Totals: 11

HMOs: OBMH Model Operations and Improvement Collaborations



Collaboration Would Be Helpful	Percent	# of HMOs
Yes	54.5%	6
No	45.5%	5
Totals		11

HMOs: Helpful HMO-Clinic Collaborative Activities

- Communication with all providers to decrease time it takes to identify pregnant members
- Member education
- Removing barriers to attending prenatal and postpartum appointments
- Improving plan understanding of SDOH and how they affect members
- Allowing HMOs and/or MetaStar EMR access to facilitate quarterly record retrieval
- HMOs and Provider/clinics communicating in person their model of care to potentially improve processes and care for members
- OBMH, PNCC, and WIC workflows
- Interfacing with other HMO's and clinics
- Brainstorming ideas for resolving issues that are being faced by others
- Increasing the number of submissions of Care Coordination Forms by providers
- Increase Notification of Pregnancy Form submissions, development of notification of members transferring care or when a member is unable to be reached prior to being closed/disenrolled from the OB Medical Home

HMOs: Barriers or Issues With PNCC Agencies

- Communication
  - Lack of communication from some agencies
  - Confusion caused by Communication and coordination between PNCCs and HMOs (untimely notifications)
- Duplication of Work
  - HMO care coordinators duplicating the work of the PNCC agency
- Influx of providers and inconsistent processes between PNCC agencies/PNCC providers and inconsistent processes between PNCC agencies/PNCC providers
- Inconsistencies
  - Lack of consistent oversight and processes between and of PNCC agencies/PNCC providers
  - Lack of consistencies in place for OB Medical Homes to be notified of a member's enrollment into PNCC
- Agencies unable to provide some of the expected services
- PNCC agencies suspended
- PNCC agency lacked workers to deliver quality care referred members
- Workflows need to be better understood by all
- Large number of external PNCC's – current MOU's with over 250 MOUs
- PNCC's do not notify when working with members or notify only after member has delivered

HMOs: Home Visitation Challenges and Successes

Challenges
Members having time to meet with PNCC partners during the day due to work or school (can these services be offered 2nd shift?)
Phone numbers getting disconnected
Members fearful of having another person in their house due to the pandemic
Inaccurate member demographics
Members declining the offer for in-home visits
HMO temporary or indefinitely stopped home visits since the pandemic*

Successes
Connecting without interruptions
Working together to address barriers to care
Meeting in clinic rather in member's home
Better member engagement
Home environment assessment
Identifying social and support factors
Offering telephonic visits
Referrals for PNCC services or other resources and needs
Creating rapport
Better coordination of member's care plan
Consistent offering and explanation of benefit to home visit

HMOs: COVID-19 Home Visits Changes

- Home visits temporary stopped, and everything was done virtually or telephonically
- Nurses are now back up to full staff
- Most visits are done at a member's home or a community location
- Embraced a telephonic model and does not conduct home visits
- Restructure of plan at the corporate level resulted in removal of direct oversight of CHW position and ability to complete OBMH home visits
- Telehealth and virtual options offered to members
- Working w/ OB providers to address the needs of members
- Nurses made visits to high-risk members to assess their needs and address any identified risks
- Members did not often have the capability to participate in telehealth opportunities
- Health Plan is unable to offer virtual/telehealth visits like care delivery systems are able to
- During COVID, Health Plan facilitated contactless home visits to provide necessary supplies
- Home visits have been removed from scope of OBMH program
- Outreach has been moved fully to telephonic approach
- "Less interest/willingness for home visits since COVID. It dropped off during COVID, and we have not seen the level of interest rebound since. It seems that members are requesting the convenience of telephonic visits instead."

HMOs: Leveraging Telehealth for Care Management

Use of Telehealth
All member outreach completed telephonically; HRA telephonically completed
Telehealth is rarely used for OBMH patients and is reserved for last resort
Use alternate data sources (e.g., WISHIN registries, hospital intake and discharge paperwork) and data shared with case management associates via utilization management systems
Member change in condition and annual screening assesses member's access to technology/telehealth
No change – always offered telehealth for care management
Used whenever able to
HMO OBMH case managers lack access to telehealth/virtual visits for OBMH care coordination programs
Care delivery may use telehealth for visits
HMO OBMH case managers can contact members by telephone, face to face visits, mailings, and text message

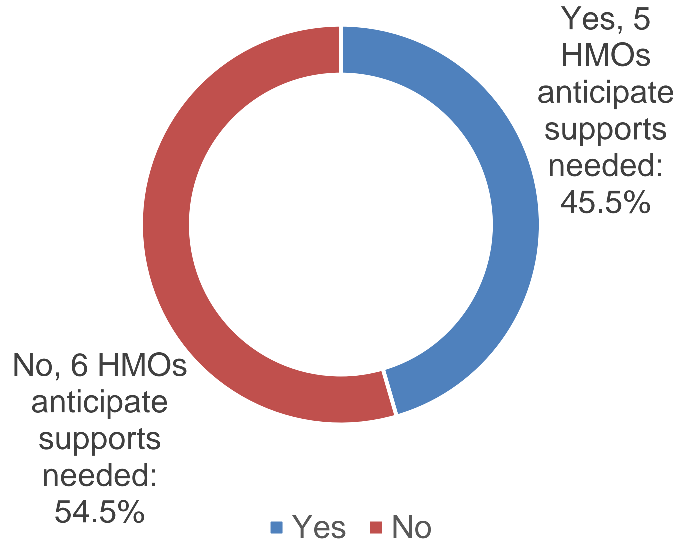
HMOs: PHE Unwinding - Telehealth for Care Management

Post-COVID-19 Telehealth Usage
Care management to continue using both telephonic and in-person options depending on member's needs or if they could benefit from arrangement; offer onsite at HMO or member provider office
Use in rural areas, or circumstances where a member prefers virtual visits or unwilling to accommodate a home visit
Telephonic workflow only
N/A
No plans for continued use

HMOs: PHE Unwinding - OBMH Program Concerns

PHE Unwinding Concerns
Minimal concerns about members who have another insurance over BC+ who will fall off BC+ mid pregnancy because their incomes are higher than the allowable amount
Identification of Pregnant members earlier in their pregnancy
Redetermination/Re-enrollment processes
Loss of Medicaid eligibility/coverage for high-risk members
Loss of continuity of care
Members preference of virtual visits
Decrease in or loss of Food Share/SNAP or additional benefits and its impact on members
Communication / Member engagement with difficult to reach patients
Increases in SDoH needs as some of the extra PHE funding have come to an end

PHE Unwinding: Anticipated OBMH Programmatic Supports



Needed anticipated post-COVID-19 OBMH programmatic supports
Better collaboration between clinics and HMO
Continuing to encourage timely access to prenatal and postpartum care, building connections with community resources such as WIC
Support for both re-enrollment and SDOH needs
Continued access to MetaStar point of contact to help answer and eliminate barriers

HMOs: Successful Care Coordination Strategies, Programs, or Projects

- Direct communication between the HMO's care coordinators and the clinic coordinators
- Early, multiple attempts at outreach in 1st, 2nd, and 3rd trimester and postpartum
- Offering a telehealth option to remove childcare as a barrier
- Using CHW within HMO to do home visits under critical conditions, if members was within visiting distance
- Care coordination is completed by the OBMH team at each clinic
- Correctly identify staff contacts at the partner clinics
- Collaboration and referrals to internal health plan case management team members and external community services/resources for helping members receive resources and support

HMOs: Successful Care Coordination Strategies, Programs, or Projects (cont.)

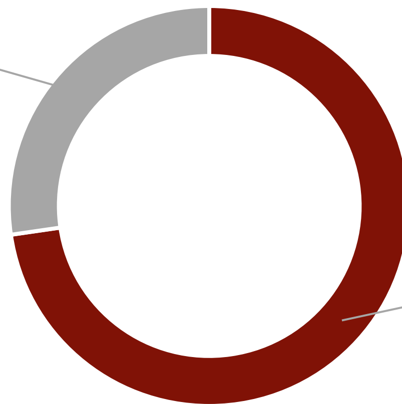
- Collaboration with providers and care delivery team about member's needs and concerns
- Providing a list of network providers for BH, dental etc.
- Calling clinics for availability of appointments and making appointments when possible.
- Providing care coordination support during the pregnancy
- HMO helps with any ongoing needs for the member, or the new infant related to their health once they are notified when the patient delivers
- Care coordination is provided by the BC+ Coordinator and the OBMH RN at the staff model clinics
- Closely communicate member needs to ensure scheduling for all OB appointments and address SDoH
- The Health Disparities Reduction program enhances the assistance provided to OBMH members

HMOs: Care Coordination Barriers or Shortcomings

- Members who experience homelessness and intimate partner violence do not have many options for housing
- Challenging for both member and HMO to coordinate care
- Communication (due to IPV and homelessness and lack of consistent phone number or address)
- Developing trusting relationships with the OBMH care team because of poor communication
- Untimely appointments for members
- Duplication of work causing confusion to member
- Many people outreaching regarding pregnancy
- Engaging and retaining members
- HMO doesn’t provide in person care coordination
- Limited number of members who engage in care coordination
- Difficult connect with members using telephonic and mail outreach
- Limited ability to be on site at various clinics
- Limitations to care delivery technology and tools for identifying patient appointments
- Relying on care delivery partners to resolve problems with technology and referral reports
- Wait times

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

If the HMO provides care coordination services directly, is the HMO addressing any non-medical/social determinant factors in OBMH care?



HMOs: Addressing Non-Medical/Social Determinant Factors in Care Coordination (cont.)

Approaches

- Providing members w/community resources or educational materials
- Screening all OBMH members at specific intervals during their pregnancy and at the postpartum visits for SDoH
- Immediately direct members to resources who screen positive (e.g., transportation, food, housing, safe shelter, baby supplies, clothing, housing supplies, tobacco cessation programs and resources, mental health screenings and resources SUD screening and resources, physical activity/ability and plans)
- Including social risk factors of concern in members care plan
- Refer members to internal case management partners and external community partners and resources
- CHWs, RNs, and case managers focus on interventions with members
- Housing program to assist with stable housing needs
- Supporting mom’s/baby’s immediate needs (e.g., diapers, pack n' plays for safe sleep options, hygiene products, blankets, and clothing)

HMOs: Obstetrics (OB) Registry Data Entry

Data entered in OB registry	Percent	# of HMOs
Yes	27.3%	3
No	72.7%	8
Totals		11

Variety of ways HMOs coordinate data entry in the OB registry with clinic partners
• OBMH Liaison enters all members into the OBMH registry.
• Medicaid Advocates receives a weekly report of enrolled OBMH members. The data is then entered into the MetaStar OBMH registry.
• Case managers enter data in the registry for members they enroll at all HMO OBMH sites.

HMOs: Approaches to Monitoring OBMH Program and Birth Outcomes

OBMH Program Monitoring Approaches
Frequently checking OB Registry
Utilize birth registry to monitor birth outcomes
Informing staff that an HMO member is part of the OBMH program
BadgerCare Coordinator/Advocate/ HMO Care management staff maintains a spreadsheet for coordination and tracking of all members enrolled in OBMH and outcomes
Review of HMO, OB Case Management and OBMH birth outcomes for trends and interventions
Validation of invoices
Monitor medical records for labor and delivery and associated adverse outcomes
Outcomes monitored for and through payment of services
Payments are tracked and warehoused on an on-going basis
Conduct quarterly audits on OBMH enrollment
Regularly checking reporting system for birth outcomes, tracking trends, and identifying necessary interventions
Needs assessment performed post-pregnancy to identify new or ongoing care management needs
Use EPIC to call program members after delivery and flowsheets to document calls and birth information

HMOs: Improving OBMH Program Using Birth Outcomes Results

Approaches
Drive strategic initiatives (e.g., data demonstrated need for food program to improve birth outcomes for food insecure members)
Outreaching to pregnant members each trimester
Monitor data trends at HMO and clinic site for quality improvement activities and to improve birth outcomes
HMO has not done much with results on how to improve OBMH program
Frequently share the results with internal and external stakeholders (OB Providers, population health staff, task force)
Identifying members for ongoing care coordination post-delivery

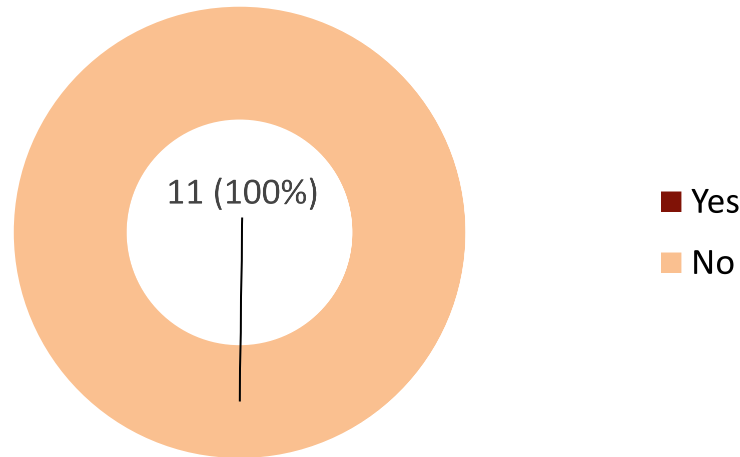
HMOs: Monitoring or Evaluation Barriers

Monitoring or Evaluation Barriers
Inefficiencies within workflow and care coordination between the provider and HMO caused by utilizing EQRO dashboard
Clinic delayed response time
Need for additional reminders for updated information to members
Inconsistent monitoring caused by staff turnover
Barrier with getting direct member feedback on the program.
OBMH clinics often do not update the Registry or close records (including reasons) when appropriate
Real time record reviews
Payment of pass through should be done after the MetaStar Medical Record Review in order to eliminate recoupments, under payments and eliminate the need for reconciliation
Current or up to date data from the state
Clinic reluctance for Plan/MetaStar EMR access to aid in quarterly record review
Lack of communication from some OBMH clinics
hard to evaluate if we are meeting DHS expectations or requirements when we do not receive the results of the audits on a timely basis
Disagreements between medical community and DHS on definition of a poor or healthy outcome (i.e., baby born less than 37 weeks or 5.5 lbs.)

HMOs: Successful HMO Monitoring or Evaluation Practices

Successful Monitoring or Evaluation Practices
Including a knowledgeable provider liaison on the OBMH team
Telephonic assessments and outreach
Data exchange through WISHIN
Direct communication with MetaStar to ensure member eligibility and resolve any issues
Monitor outcomes to make improvements to interconception program
Daily monitoring of ER and inpatient utilization for OBMH members.
Monitoring Registry for enrollment, closure, birth outcomes, and continued care coordination
Using MetaStar Annual Report to address strengths and gaps
Using state Prenatal Assessment tools to identify social determinants that cause poor birth outcomes
Surveying members post-program completion to assess value of the program
Monitoring member engagement
RN care coordinators and OBMH clinic staff collaborate on services and care coordination efforts to assist members and address process issues
Implemented standard practice for RNs to follow
Integrated a Clinical Learning Specialist on the team to ensure consistency program is coordination across clinics

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



In the last year, zero OB provider terminations occurred limiting member access to OB care.

HMOs: Additional OBMH Program Best Practice / Process Success

Additional OBMH Best Practices and Processes
Complete social determinants of health screeners more than once during pregnancy for all members
Have BC+ Coordinator or Member Advocate as part of any OBMH care team
Complex OB cases brought to weekly Case management meetings
Medical Director, Behavioral Health Medical Director, and Pharmacy Director included in each case management meeting
Review of OBMH requirements with clinics completed annually or more often if needed
Quarterly meetings with OBMH partners (increased collaboration and conversation)

HMOs: OBMH Program Barriers/Issues and Solutions

Additional OBMH Program Barriers / Issues
Direct provider forum with OBMH focus
Limited face-to-face contact with providers, access, and bandwidth but are working through their HMO point of contact with providers
Administrative burden on HMOs during Reconciliation process, with limited guidance from DHS on process expectations.
Improving communication between care coordinators and data sharing
Resources – Working with Impact Connect/Unite Us to connect resources together and better automate/track community-based resource referrals
Members not interested in switching providers - Allow any provider who provides pre/postnatal care to participate without being designated as an OBMH model site.
Members who seek care beyond 16 weeks may not be afforded all of the benefits of the OBMH so a prorated payment to clinic based on the number of requirements met - round robin leadership of the OBMH HMO Collaborative
Transportation – Using a taxi service, virtual visits where available, and case management interaction with the member to identify natural supports to address transportation
Technology (i.e., Wi-Fi access) – Finding work arounds so staff can efficiently use technology and be out in the community or in clinics

HMOs: Program Success

Key Themes in Success Stories
Getting high-risk member in Foster Care MA enrolled in OBMH due to experienced/ well knowledgeable BC+/BC Liaison
Meeting needs related to mental health, trauma, substance use, etc.
Patient developing trusting and/or safe relationships with clinic staff
Access to resources/ baby supplies / addressing SDoH (i.e., transportation) / providing safe environment for mother and baby
Team approach to care coordination
Providing culturally and linguistically appropriate care to members
Informing members of their benefits (i.e., State transportation benefit)
Variety of communication methods used to reach members
Member used doula
Use of CHW to connect member with healthcare and identify non-medical social needs
Successful use of care coordination to manage chronic conditions and delivery health birth outcome
Access to needed items and resources (i.e., housing, food, diapers, clothing, emergency rent and shelter, safety plan, etc.,)

"Discussed member barrier related to transportation. Member was unaware of State transportation benefit. HMO was able to refer and connect member to transportation vendor. HMO confirmed member was able to attend rescheduled appointment."

Recommendations to Strengthen OBMH Initiative

- Have DHS survey all HMOs as it pertains to OBMH barriers to share amongst other plans for lessons learned and allow improvements for member and Require Providers to all submit to MetaStar the same way
- A refresher/orientation to OBMH and HMO resources and expectations; quarterly or twice a year sessions
- Make some process improvements
- Revise the OBMH program requirements for eligibility to be less restrictive (e.g., drop the requirements that a member has to be enrolled by a certain week of pregnancy, in the registry by a certain week, etc.)
- Expand who can be involved as the OBMH care team to include doulas or doula groups
- Tying the pass-through payment to OB Medical Homes to meet all HEDIS measures
- Provide an annual report demonstrating the outcomes of the program and identified best practices.
- Add a column to the registry for OBMHs to add the name of the OBMH care coordinator working with that member
- Share responses at Best Practice Seminar to the inquiries from clinics/HMOs that are made on the most recent State Annual Report (Survey) or post an FAQ as a follow up on Annual Report to clinics and HMOs
- Consider flexibility in lowering the number of prenatal visits required, especially for members who deliver at 37 weeks or slightly earlier