Presentation Overview

MOMS Project Background, Resources, and Findings
Dr. Mary Applegate, Ohio Department of Medicaid
Dr. Mark Hurst, Ohio Department of Mental Health and Addictions Services

Obstetrical Perspectives
Dr. Michael Marcotte, Good Samaritan Hospital
Dr. Mona Prasad, The Ohio State University Wexner Medical Center

Behavioral Health Perspectives
Alex Meyer, CompDrug
In 2014, Medicaid was the payer for approximately 90.8% of NAS inpatient hospitalizations.

In 2014, treating newborns with NAS was associated with over $105 million in charges and nearly 26,000 days in Ohio’s hospitals.
The Maternal Opiate Medical Supports (MOMS) project is a two-year quality improvement initiative.

MOMS seeks to:

- **Improve** maternal and infant outcomes
- **Promote** family stability
- **Reduce** costs of Neonatal Abstinence Syndrome (NAS)

**Strategy:** Provide treatment to pregnant mothers with opiate issues during and after pregnancy through a Maternal Care Home (MCH) model of care. This team-based healthcare delivery model emphasizes care coordination and wrap-around services.
Ohio NAS Inpatient Hospitalization

Rate per 10,000 live births, Ohio, 2004-2014

Source: Ohio Hospital Association
Project Aims

**Identify**
best practices to develop and implement a clinical and patient toolkit to guide process improvement work.

**Implement**
the Maternal Care Home (MCH) model to engage/empower expecting mothers in coordinated care and wrap-around services including pre-and post-natal care, addiction treatment, counseling, Medication Assisted Treatment (MAT), recovery support, and care management.

**Establish**
a quality improvement structure involving monthly technical assistance calls to share and discuss best practices, quarterly clinical learning sessions, and individual coaching calls.

**Develop**
a rapid cycle quality improvement feedback process.
Project Partners

State Sponsors

- Ohio Governor's Office of Health Transformation
- Ohio Department of Medicaid

Pilot Sites

- CompDrug
- First Step Home
- Health Recovery Services
- MetroHealth Medical Center

Project Management and Data Infrastructure

- Ohio Colleges of Medicine Government Resource Center

Quality Improvement Vendor

- Health Services Advisory Group

Evaluation Vendor

- University of Cincinnati College of Education, Criminal Justice, and Human Services
MOMS Program: Implementation Strategy

Maternal Care Home Model
Patient-centered & team-based healthcare delivery model to engage/empower expecting mothers in coordinated care

- Early engagement in pre-natal care
- Addiction treatment & counseling
- MAT
- Care management
- Postpartum & interconception care
- Housing & recovery supports

Four Implementation Models:

- Urban, BH provider-driven, residential treatment
- Urban, OB provider-driven, access to BH, MAT and housing support
- Urban, BH provider-driven, partnership with children’s hospital
- Rural, BH provider-driven, access to housing support
TIMELINE:

EVENTS AFFECTING MOMS

2013
- MOMS Funding Awarded

2014
- Project Kick-Off Meeting
- First Early Adopter Meeting
- Managed Care Plan Engagement – streamline process for enrollment, consent and Buprenorphine preauth and transportation benefits
- Performance Measurement and Data Feedback begin
- Trainign on MAT Guidelines and Core Elements of MCH Model
- Mandatory OARRS Reporting

2015
- Housing resources and instructions to address housing needs at every visit
- Training on MAT Guidelines and Core Elements of MCH Model
- Child Welfare Engagement - pilot sites instructed to report all exposure
- Managed Care Plan Engagement
- Collaborative Meetings and PM Data Feedback End

2016
- Extend Medicaid and Enroll Members in Managed Care
- NAS Project results show that only 50% of babies need pharmacologic treatment
- Performance Measurement and Data Feedback End
SMART Aims

**Improve Outcomes & Stability**
- Improve maternal and fetal outcomes and family stability

**Improve Retention**
- 30% improvement in 12-month treatment retention rates of opiate-dependent pregnant women

**Reduce NICU Length of Stay**
- 30% reduction in average Neonatal Intensive Care Unit (NICU) length of stay

**Reduce Low Birth Weight Rate**
- 30% reduction in the rate of low birth weight infants
Quality Improvement Measures

Monthly customized performance measure data feedback focusing on:

- Use of Plan Do Study Act (PDSA) to test improvement strategies and support MCH model fidelity
MOMS Resources

Developed by clinical experts
Available on www.momsohio.org

Topics
- Readiness Lists
- Assessment
- Psychosocial Services
- Labor and Delivery

Audiences
- Prescribers
- Clinicians
- Patients
- Community Agencies

Types
- Decision Trees
- Evidence-Based Guidelines and Resources
- Fact Sheets
- Shared Decision-Making Module

Care Coordination
MAT Services
Prenatal and Postnatal Care
Outpatient Care
Healthcare Provider Resources

Decision Trees for Care of Opiate-Dependent Women
Training Tool: Building Partnerships with Child Welfare
Quick Video Podcasts
Shared Decision-Making Module

Building teams for healthy moms and babies
MOMS Care Coordination Model

Step 1: MOMS Readiness Process
Step 2: Patient Presents to MOMS Entry Point
Step 3: Care Delivered by MOMS Care Coordination Team

First Contact Assessment Tree
Care Coordination Team Tree
BH Entry to MAT Services Tree
OB/GYN Assessment Tree

SECOND VISIT
BH Assessment Tree
Person Centered Care Planning Tree

FOLLOWING ASSESSMENT
BH Prenatal MAT Services Tree
OB/GYN Prenatal Care Tree
New Patient Presents Labor Triage or ED

PRENATAL
OB/GYN Labor & Delivery Tree
BH Labor & Delivery MAT Management Tree
OB/GYN & BH Post Delivery Care Trees

Client
Client’s family and support system
Care coordinator(s)
Obstetrics and Gynecology (OB/GYN)
Behavioral Health (BH)
Medication Assisted Treatment (MAT)
Pediatricians
Primary care
3rd party case management
- Medicaid managed care
- Private insurance
OB/GYN Assessment Tree (OB.1-OB.4)

OB.1 Initial Assessment
- Timely assistance, scheduling flexibility, and appropriate empathy and optimism for change are needed from first contact.
- Provide trauma informed care (See Training)
- Check patient history in OAIRS
- Focused medical history and obstetrical history and exam
- Complete physical examination
- Confirmatory pregnancy testing (confirmation of gestational age) and assess fetal well-being
- Laboratory tests (See Recommended Panel)
  - TB testing
  - HIV testing
  - Urine drug testing (or opt results)
  - STD testing (including syphilis testing - RPR or VDRL)
  - Hepatitis testing (Hep. B surface antibody/surface antigen; Hep. C antibody followed by quantitative RNA if positive)
- Notify MAT provider of labs drawn and results

OB.2
Is patient appropriate for MAT services? (ASAM Checklist)

OB.3
Refer to appropriate level of care (i.e., if patient presents potential threat to self or others, refer for emergency psychiatric evaluation) (State procedural - emergency petition)

OB.4
Refer to MAT services

Proceed to Person Centered Care Planning Tree
Toolkit for Moms and Moms-to-Be

Building teams for healthy moms and babies
Encourage
Encourage women to consider their needs and seek help by participating in MOMS programs.

Educate
Educate clinicians to engage patients in a manner consistent with the MOMS Care Coordination Model.

Engage
Interactive, electronic tool with care questions to engage women and build trust and willingness to dialogue about key needs. Encourage women to consider their needs and seek help by participating in MOMS programs. Educate clinicians to engage patients in a manner consistent with the MOMS Care Coordination Model.
Connecting Child Welfare & Community Workers

Child Welfare and MOMS: Building Partnerships to Improve Care

Overview

<table>
<thead>
<tr>
<th>Child Welfare</th>
<th>MOMS Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Prefers to keep babies with their mothers whenever possible and safe</td>
<td>- Coordinates all program partners needed to fully support recovery for opioid-dependent women</td>
</tr>
<tr>
<td>- Is required to ensure a plan of safe care is developed; this does not necessarily mean a &quot;care&quot; will be opened</td>
<td>- Ensures safe and stable housing, employment, and other supports for the health and safety of mom and baby</td>
</tr>
<tr>
<td>- Might be able to provide additional resources to support a client's recovery</td>
<td>- Gathers many resources in the health and human services arena</td>
</tr>
</tbody>
</table>

How Child Welfare Can Help

Partner with MOMS Sites
- Reassure clients that collaborative partnerships support recovery and better ensure babies’ safety
- Jointly develop and monitor the plan of safe care and/or case plan
- Understand the client’s treatment plan
- Provide additional resources to support client recovery
Evaluation Plan

Implementation Effectiveness

- Model Fidelity
- Care Coordination
- Patient Engagement

Lessons Learned

- Barriers
- Effective Strategies

Impact on service utilization, maternal, and infant outcomes

- Low Birth Weight
- NICU Length of Stay
- Treatment Retention
- Housing
- Family Stability
MOMS Enrollment
Data as of June 30, 2016

Total Active Women: 115
Total Women Enrolled: 281
88.0%
## Preliminary Findings: Retention

Source: Medicaid Administrative Claims

<table>
<thead>
<tr>
<th>Total Enrollment</th>
<th>Site A</th>
<th>Site B</th>
<th>Site C</th>
<th>Site D</th>
<th>All Pilot Sites Combined</th>
<th>Comparison Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total enrolled</td>
<td>10</td>
<td>51</td>
<td>24</td>
<td>17</td>
<td>102</td>
<td>306</td>
</tr>
<tr>
<td>Trimester 1</td>
<td>0%</td>
<td>31%</td>
<td>42%</td>
<td>35%</td>
<td>31%</td>
<td>24%</td>
</tr>
<tr>
<td>Trimester 2</td>
<td>40%</td>
<td>53%</td>
<td>75%</td>
<td>53%</td>
<td>57%</td>
<td>36%</td>
</tr>
<tr>
<td>Trimester 3</td>
<td>100%</td>
<td>96%</td>
<td>79%</td>
<td>71%</td>
<td>88%</td>
<td>38%</td>
</tr>
<tr>
<td>Mos 0 - 3 post-partum</td>
<td>90%</td>
<td>82%</td>
<td>88%</td>
<td>53%</td>
<td>79%</td>
<td>45%</td>
</tr>
<tr>
<td>Mos 4 - 6 post-partum</td>
<td>50%</td>
<td>61%</td>
<td>54%</td>
<td>59%</td>
<td>58%</td>
<td>37%</td>
</tr>
</tbody>
</table>
Preliminary Findings: MAT Use

Source: Site Reported Quality Improvement Data (June, 2016)

<table>
<thead>
<tr>
<th>MAT</th>
<th>Site A</th>
<th>Site B</th>
<th>Site C</th>
<th>Site D</th>
<th>All Pilot Sites Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td># enrolled, Jun-16</td>
<td>40</td>
<td>33</td>
<td>21</td>
<td>42</td>
<td>136</td>
</tr>
<tr>
<td># receiving MAT</td>
<td>28</td>
<td>29</td>
<td>16</td>
<td>10</td>
<td>83</td>
</tr>
<tr>
<td>% receiving MAT</td>
<td>70%</td>
<td>88%</td>
<td>76%</td>
<td>24%</td>
<td>61%</td>
</tr>
</tbody>
</table>
Trust

Value a nonjudgmental and caring medical team; trusting caregivers is imperative.

Access to Mental Health & MAT

Value mental health services to deal with stress, addiction, and previous trauma.
Access to MAT is valued and encourages enrollment in programs offered at the sites.

Care Coordinator

Having a point person to organize the appointments and goals during this stressful time is important.
Provide motivation to keep mother engaged in and remain in treatment.

Consistent Provider

Mothers like that they see the same set of care team providers, since they report trust with providers they see consistently.
Mothers report consistent care with people they trust.

Social Support, Parenting Education, & paperwork

Parenting classes provide valuable new information.
Patient navigators and the medical team provide support and assistance with paperwork.
Lessons Learned

- **Formalize partnerships among OB, MAT, and BH**
  - Designate one care coordinator
  - Establish process for consent to share information
  - Schedule regular team meetings

- **Collaborate with MCPs and child welfare**
  - Establish process for timely authorization of MAT
  - Assure access to transportation
  - Reduce need for out of home placement while protecting child safety

- **Improve access to safe and stable housing options**
Lessons Learned

- Connect MOMS with NAS
  - Establish care continuum from prenatal through post-partum and neonatal care

- Improve prenatal and postpartum treatment retention

- Expand workforce to provide integrated services and MAT
Maternal Addiction Program
• Behavioral Health Therapy
• Inpatient Residential Care
• Intensive Outpatient Therapy
• Wrap Around Services

HOPE
• Prenatal Care/ Case Management
• Inpatient MAT induction
• Referral to community MAT and addiction treatment
• Enhanced Prenatal Care
• Delivery
• Enhanced Postpartum Care

Medication Assisted Treatment
• Medication Assisted Treatment
• Outpatient Buprenorphine Therapy
• Addiction Medicine
Cincinnati MOMS Project

First Step Home-Maternal Addiction Program-lead agency

178 women enrolled (63% of total MOMs population—281 mothers)
  – 117 completed treatment (66%)
  – As of August 31, 88% had delivered

MAT: > 90% on some form
  – Used both methadone and buprenorphine

Behavioral Health Therapy: both residential and intensive outpatient offered

Prenatal care: Most enrolled in HOPE program at Good Samaritan Hospital Cincinnati and delivered there
Patient-Provider-Partnership

New Paradigm

Motivational Interviewing

- Learn your patient’s goals
- Educate about evidence-based best practice
- Allow time for patient to process choices
- Clarify patient’s choice
- No preset expectations
- Flexible creativity by provider
- Being willing to begin again
## OPQC OB Survey Results - Screening

as of 8/26/16, n=24 Centers

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our OB clinic or prenatal clinic asks all pregnant women about opioid use</td>
<td>96% Yes</td>
</tr>
<tr>
<td>● At the first visit?</td>
<td>100% Yes</td>
</tr>
<tr>
<td>Our OB clinic or prenatal clinic performs urine testing on all pregnant women for opioid use.</td>
<td>48% Yes</td>
</tr>
<tr>
<td>● At the first visit?</td>
<td>92% Yes</td>
</tr>
<tr>
<td>Does your primary hospital perform urine drug testing on all pregnant women for opioid use at admission for delivery (Universal maternal urine drug testing)?</td>
<td>41% Yes</td>
</tr>
<tr>
<td>Does your OB clinic or prenatal clinic care for women who are opioid dependent?</td>
<td>96% Yes</td>
</tr>
<tr>
<td>Our OB clinic or prenatal clinic does not have a population of patients that require screening or treatment for opioid dependence.</td>
<td>96% Not Agree</td>
</tr>
</tbody>
</table>
# OPQC OB Survey Results - Treatment  
as of 8/26/16, n=24 Centers

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our OB clinic or prenatal clinic provides Medication Assisted Treatment (MAT) for opioid dependence (methadone or buprenorphine).</td>
<td>37% Yes</td>
</tr>
<tr>
<td>Women cared for in our OB clinic or prenatal clinic who are on MAT also receive services from a Behavioral Health Specialist.</td>
<td>52% Yes</td>
</tr>
<tr>
<td>Our OB clinic or prenatal clinic refers women to programs in the community for MAT.</td>
<td>85% Yes</td>
</tr>
<tr>
<td>MAT program serves pregnant and non-pregnant women</td>
<td>87% Yes</td>
</tr>
<tr>
<td>We are working with neonatologists to identify newborns who may be at risk of NAS.</td>
<td>78% Yes</td>
</tr>
<tr>
<td>Do you have a provider in your system is currently working with opioid-dependent pregnant women or is interested in working with the population of opioid dependent pregnant women?</td>
<td>70% Yes</td>
</tr>
</tbody>
</table>
Franklin County Site Description

- Multiple partners
- Maternal Infant Recovery Clinic (MIRC)- ‘one-stop shop’ for all services during pregnancy
- One day/week- Thursday afternoon
Franklin County Care During Pregnancy

Maternal Infant Recovery Clinic (MIRC)
500 E. Main St.

- Pregnant Woman
- Tobacco cessation & job counseling
- 6-week postpartum & RL visit
- Initial Meeting with Neo at 36 wks GA
- Mentor Support
- Prenatal Obstetrical Care
- Clinic staff
- Nursing
- Group & Individual AOD Counseling
- MAT-Suboxone
Franklin County Care Post-Delivery

- MAT AOD/MH- CompDrug
- Well-baby care- Nationwide Children’s or OH Health
- Mom’s primary care- Ohio Health
Franklin County - Lessons Learned

- Co-location is a strength
- Combination of OB + AOD services is effective in enhancing compliance
- High-risk complicated patient population combined with multiple organizations providing services requires: clear clarity of roles, data reporting plan, clear accountability
- High level of continuous coordination of care is critical
- Clearer pathway to higher level of addiction care (i.e. residential) is still needed
- Engagement of additional agencies should continue
- Increase in physician provider trained + willing to work with this population required
Franklin County -
Key Elements for Positive Outcomes

• Co-location of services
• Implementation of contingency management plan
• Baby Care - Focus on self-assessment by mom of ability to soothe infant + assessment of weight gain in hospital; rooming-in with mom
Questions? Contact Us

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Visit Us on the Web: www.momsohio.org