MaineMOM
Model of Care for Perinatal Patients with Opioid Use Disorder

MaineMOM Advisory Group

September 15, 2020

9:30-10:30am

MaineMOM Objectives

- “No wrong door" screening, welcoming, and engaging women in care
- Supporting treatment and recovery of mothers with group-based Medication Assisted Treatment (MAT)
- Increasing the capacity of integrated teams to deliver evidence-based care, including through telehealth
- Coordinating care across the system and within the community
- Conducting a public outreach campaign aimed at increasing awareness of treatment and reducing stigma

MaineMOM Timeline

- January 2020 – June 2021 (Year 1): Plan and Design Services
  - Implement advisory structure to garner input and feedback from healthcare providers, community programs, and women in recovery
  - Launch educational support and public outreach and awareness campaign
    - RFP for Communication & Outreach Vendor Due 9/29/20
- July 2021 – June 2022 (Year 2): Test and Implement MaineCare Policy
  - Implement MaineMOM Services with six partner organizations to test and improve services
  - Incorporate MaineMOM services into the MaineCare Benefits Manual
- July 2022 – June 2023 (Year 3): Expand Services
  - Open expansion to other healthcare sites to deliver MaineMOM services
- July 2023 – July 2024 (Year 4): Improve Services
- July 2024 – June 2025 (Year 5): Evaluate Outcomes

CradleME Referral System

CradleME

A Referral System
for All Birthing Families
in Maine

Call: 1-888-644-1130
Fax: 207-287-4577

If you are pregnant or have a new baby, CradleME services are available for free. CradleME referrals currently include, referrals to Public Health Nursing, Maine Families, and WIC. CradleME helps connect you with the right home-based services for you and your baby. CradleME is a partnership between two programs: Public Health Nursing and Maine Families.

http://cradleme.org/

Quarterly Performance Monitoring
Beginning July 2021

ENROLLMENT DATA

- # of enrolled members
- # of continued enrollment
- # of disengaged beneficiaries

MONITORING MEASURES

- **Depression Screening**
  - % screened; and if positive w/ follow-up plan
- **Tobacco Screening**
  - % screened 7 days from enrollment and at end of pregnancy; and if positive received tobacco cessation intervention

Quarterly Performance Monitoring
Beginning July 2021

PERFORMANCE MILESTONES

- **Continuity of pharmacotherapy**
  - % who had pharmacotherapy at least 90 days prior to delivery and were also on pharmacotherapy at end of pregnancy
- **Gains in Patient Activation Measure (PAM) scores**
  - Average change in PAM scores from baseline and 90 day assessment
- **Health-Related Social Needs (HRSN) Screening**
  - % screened with HRSN tool within 7 days of enrollment
- **Maternal engagement in OUD Treatment**
  - % who had two or more OUD treatment services w/in 34 days of enrollment
- **Postpartum care and family planning**
  - % with postpartum visit w/in 60 days of end of pregnancy w/ conv of family planning

Quarterly Performance Monitoring
Beginning July 2021

Overview of Model reporting requirements

- Awardees and ~~care-delivery partners (CDPs)~~ are required to submit beneficiary-level data quarterly through the MOM Model Data Submission Portal
- Data are expected to come primarily from patient medical records, rather than claims/encounter data
- Data should include patient-level identifiers (namely Medicaid ID and a MOM Model-specific ID)
- Awardees/CDPs will need to obtain necessary patient consent to ensure data can be used for monitoring and evaluation

Slide information from 9/14/20 CMS MOM Model TA Office Hours Call

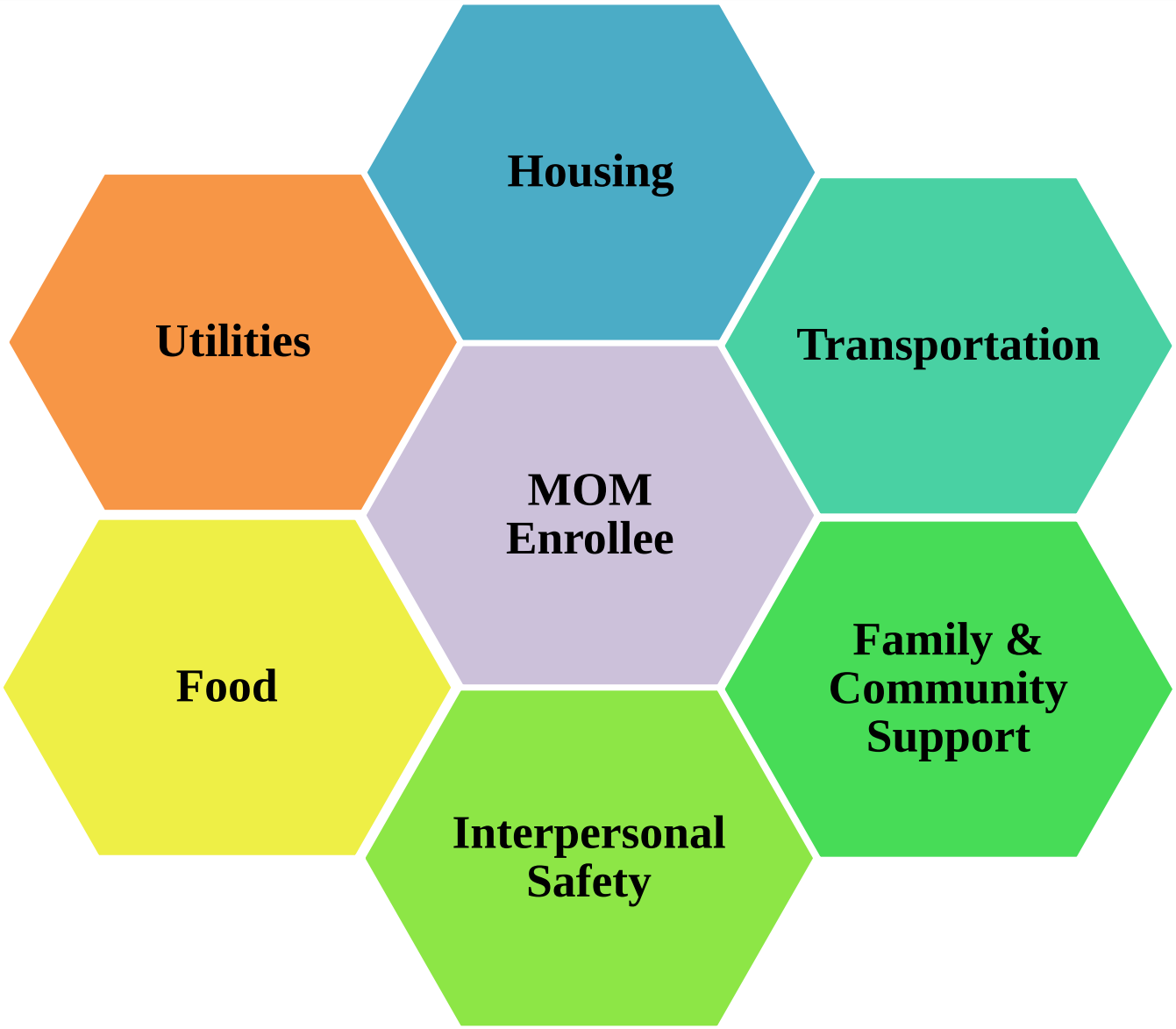
Quarterly Performance Monitoring
Beginning July 2021

Resources coming soon

1. **Mid-September:** Milestones and measures manual
2. **Fall 2020:** Data dictionary (version 2)
3. **Fall 2020:** Frequently Asked Questions
4. **Fall 2020:** Webinar on reporting requirements
5. **Winter 2020/2021:** Data submission user guide: Part 1
6. **Spring 2021:** Data submission template and user guide: Part 2
7. **Spring 2021:** Webinar on data submission template

Slide information from 9/14/20 CMS MOM Model TA Office Hours Call

Health Related Social Needs Screening Tool



CMS Accountable Health Communities Health-Related Social Needs Screening Tool Core Questions+

- 12 Questions
- Addresses 6 domains of health-related social needs
  - Food, Living Situation, Transportation, Utilities, Safety, Community and Family Supports
- Visual cues for social health-needs
- Validated Screening Questions (not just the tool as a whole)
- Additional Validated Questions available on:
  - Education, Physical Activity, Financial Strain, Employment, Substance Use, Mental Health, Disabilities

CMS Accountable Health Communities Health-Related Social Needs Screening Tool Core Questions+

Housing:

1) What is your living situation today?

2) Think about the place you live. Do you have problems with any of the following?

Food:

3) Within the past 12 months, you worried that your food would run out before you got money to buy more.

4) Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

Transportation:

5) In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

CMS Accountable Health Communities Health-Related Social Needs Screening Tool Core Questions+

Utilities:

6) In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

Safety:

How often does anyone, including family and friends…

7) Physically hurt you?

8) Insult or talk down to you?

9) Threaten you with harm?

10) Scream or curse at you?

Family and Community Support:

11) If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?

12) How often do you feel lonely or isolated from those around you?

The Accountable Health Communities Health-Related Social Needs Screening Tool

https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

MaineMOM Data & Outcomes

MaineMOM Contacts

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MaineMOM Webpage
https://www.maine.gov/dhhs/oms/about-us/projects-initiatives/maine-maternal-opioid-model

This program is managed by the Office of MaineCare Services Value-Based Purchasing Unit and funded by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS).

MaineMOM
Model of Care for Perinatal Patients with Opioid Use Disorder

MaineMOM Clinical Committee

September 15, 2020

11:00 am – 12:00pm

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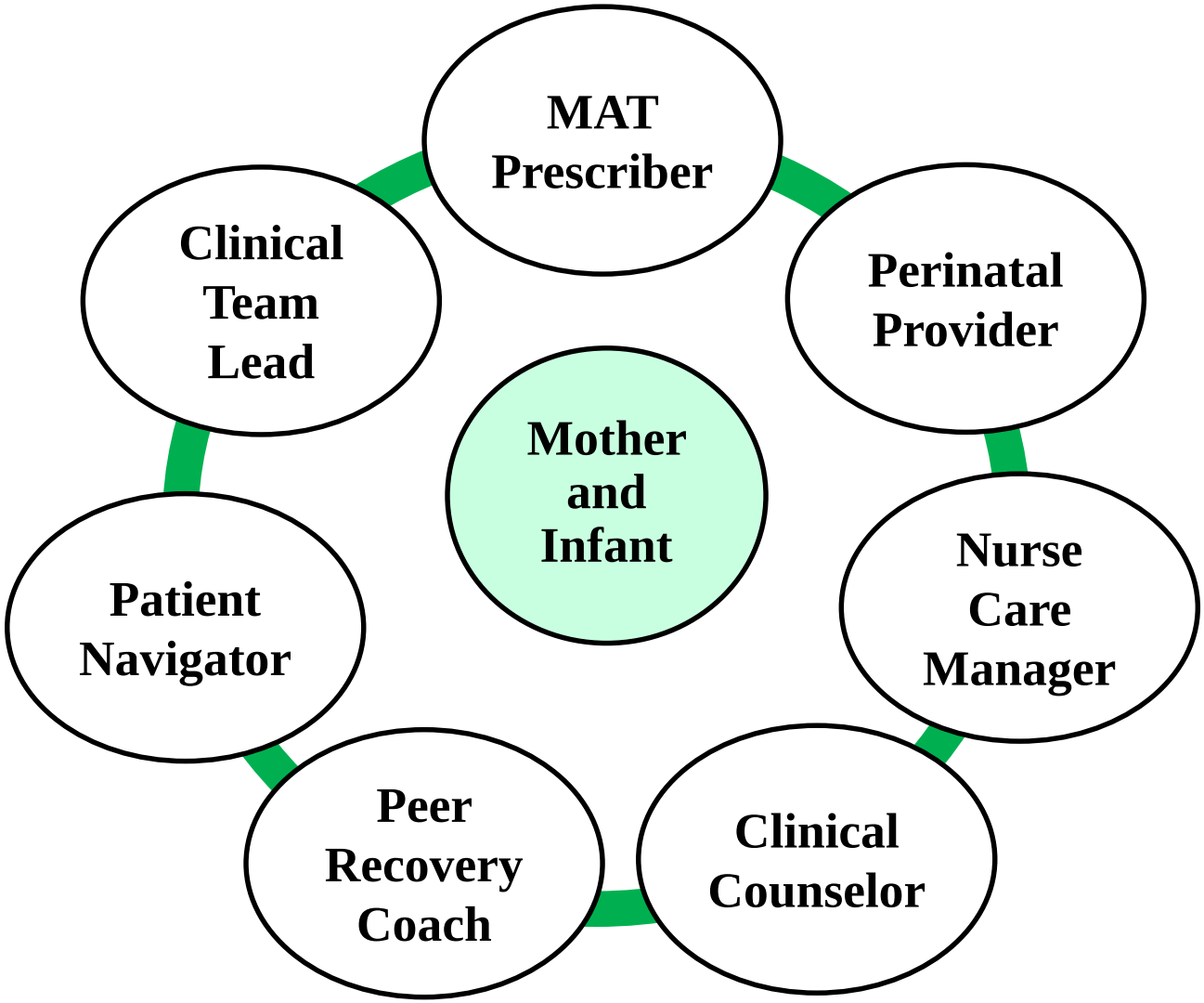
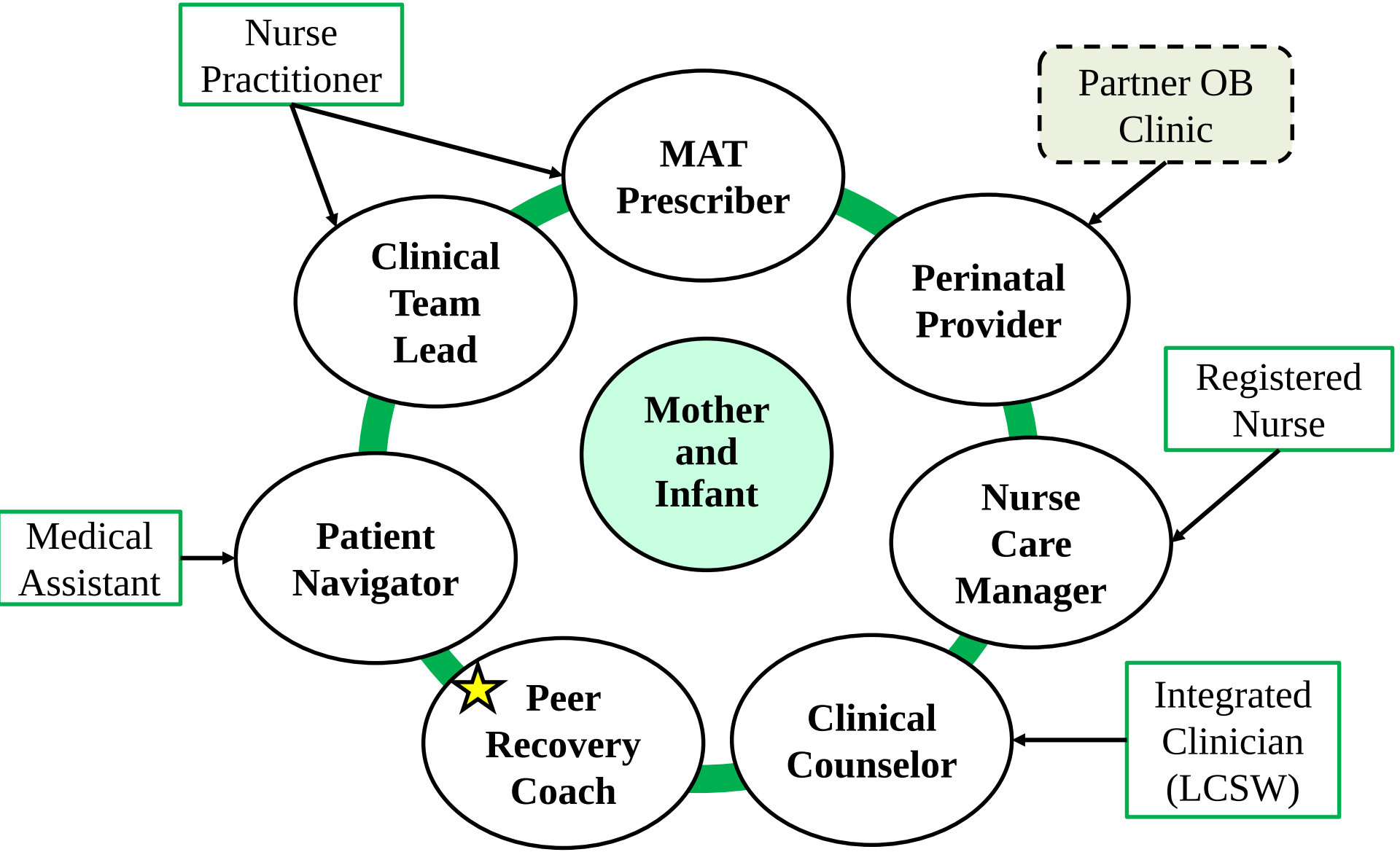
MaineMOM
Patient Centered Team Based Care



Example of a MaineMOM Team



Clinical Team Lead

Qualifications

- Licensed clinical professional with significant experience treating individuals with SUD
  - Physician
  - Physician's assistant
  - Advanced practice registered nurse
  - Psychologist
  - Licensed clinical social worker (LCSW)
  - Licensed clinical professional counselor (LCPC)
  - Licensed Alcohol and Drug Counselor – Certified Clinical Supervisor (LADC-CCS)

Function

- Coordinate care management activities across MOM
- Ensure a current plan of care for each member
- Ensure there is appropriate supervision of the Peer Recovery Coach

This content is a proposed description for this role in the development of the MaineMOM model services. This role will be refined and finalized during the pre-implementation period of the MaineMOM initiative.

Medication Assisted Treatment (MAT) Prescriber

Qualifications

- Licensed health care professional with the authority to prescribe buprenorphine, buprenorphine derivatives, and naltrexone
- Hold the appropriate X-DEA license to prescribe buprenorphine in an office-based setting

Function

- Provide services for opioid treatment, including medication prescribing
- Involved in team meetings
- Assisting with the coordination of care across specialty and primary care providers
- Assessing risk of and discussing with the member potential medication interactions
- Providing assistance and guidance in ensuring physical and behavioral health issues are addressed

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Perinatal Provider

Qualifications

- Licensed health care professional with significant experience caring for women during the prenatal, intrapartum, and postpartum periods
  - Obstetrician
  - Family physician
  - Certified nurse midwife,
  - Advanced practice registered nurse

Function

- Provide care for women during the prenatal, intrapartum, and postpartum periods
- If the Perinatal Provider doesn't provide intrapartum care, the MOM program must develop an alternative to ensure optimal coordination of care

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Nurse Care Manager

Qualifications

- Registered nurse OR advanced practice registered nurse
- Has completed the eight-hour SAMHSA training for an X-DEA license within six months of initiating service delivery for MOM members

Function

- Contribute to implementation, coordination, and oversight of each MOM member's plan of care
- Assist in coordination of care with outside providers
- Communicate barriers to adherence as appropriate to the team
- Involved in overseeing and participating in all aspects of MOM services

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Clinical Counselor

Qualification

- Certified Alcohol and Drug Counselor (CADC) or Licensed Alcohol and Drug Counselor (LADC)

OR

- One of the following professions
  - Licensed Clinical Social Worker (LCSW)
  - Licensed Master Social Worker- Conditional Clinical (LMSW-CC)
  - Licensed Clinical Professional Counselor (LCPC)
  - Licensed Clinical Professional Counselor – Conditional (LCPC-C)
  - Licensed Marriage and Family Therapist (LMFT)
  - Licensed Marriage and Family Therapist – Conditional (LMFT-C)

Who has completed a minimum of 60 hours of education in SUD treatment within either five years prior or following the initiation of service delivery for MOM

Function

- Provide group or individual outpatient therapy for SUD and behavioral health needs

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Patient Navigator

Qualifications

- Minimum of one year of job experience in a health/social services or behavioral health setting and hold an Associate's degree;
- Mental Health Rehabilitation Technician/Community (MHRT/C) with at least one year of related work experience
- Bachelor’s degree
- Medical assistant
- Licensed practical nurse
- Registered nurse
- Be the Nurse Care Manager
- Clinical Counselor
- Community Health Worker (CHW) with certification or training

Function

- Work with the member to coordinate health care, mental health and social services to help support the member in their recovery
- Primary provider of care coordination, health promotion, individual and family support services, and referral services

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Peer Recovery Coach

Qualifications

An individual who is in long-term recovery from SUD and willing to self-identify on this basis with MOM members, who completes

- Connecticut Community for Addiction Recovery (CCAR) training

  OR
- Other Department approved Recovery Coach training

Function

- Life experience and recovery allow them to provide recovery support so that others can benefit from their experiences

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