

Mathematica Webinar #3 Decreasing Fragmentation in Maternal
Substance Use Disorder Screening and Treatment-20240625 1801-1

[Lekisha Daniel-Robinson] Welcome everyone to another in the CMS Summer Maternal Health Webinar Series. The focus of this webinar is Decreasing Fragmentation in Maternal Substance Use Disorder, Screening, and Treatment. Before we begin, I'll turn it over to today's event producer to review a few technical instructions and housekeeping items. Rick.

[Rick Stoddard] Thanks, Lekisha. All participants are muted upon entry for the best sound quality possible. Closed captioning is available via the CC icon in the lower left corner of your screen. You may also press Control, Shift, A on your keyboard to enable closed captioning. We welcome audience questions throughout today's presentation via the Q&A panel, which is located at the bottom right corner of your screen. You may submit your questions there. We'll be monitoring the Q&A throughout the webinar, and we'll address as many questions as possible.

If you have any technical issues, you may also use that same Q&A panel. I will work to address any issues you encounter and will correspond via that panel there. At the end of the webinar, a survey will pop up in your browser window, in an internet browser window. Please respond and provide feedback so that we may improve future webinars. We also want to let everybody know that today's webinar is being recorded. We'll send an email to all meeting registrants when the slides and recordings are posted on Medicaid.gov.

Here's an illustration addressing how you could submit questions and comments throughout today's webinar. I'll give you a moment to review that. And now, I'd like to turn it back over to Lekisha Daniel-Robinson from Mathematica. Lekisha, back to you.

[Lekisha Daniel-Robinson] Great. Thank you. Kristen Zycherman from CMS will open today's webinar with the session's objectives and background. Then we will review the scope of the issue and recommended clinical and systems strategies, followed by presentations from representatives of Indiana and Maine Medicaid agencies who will discuss their respective state approaches to improve the systems of care for pregnant and postpartum people impacted by substance use disorders. Questions and discussion will follow. So you can begin to submit those questions as you have them using the instructions that Rick just outlined. But we'll reserve time at the end for those responses. I'll now like to turn it over to Kristen Zycherman from CMCS.

[Kristen Zycherman] Thank you Lekisha. Hello, everyone, and on behalf of CMS, welcome to our third installment of the Maternal Health Summer Webinar Series. If you're interested in revisiting the previous two webinars, slides and recordings can be found on our Maternal Infant Health Initiative webpage. We are so happy that you are all here and that there is so much interest in this very important topic and so glad you could join us. We know you share our passion for improving maternal mental health and SUD and all maternal health outcomes.

The objectives for today's webinar are to provide an overview of the CMS Maternal and Infant Health Initiative and opportunities to improve maternal health outcomes in Medicaid and CHIP. To describe maternal substance use disorder challenges for individuals covered by Medicaid and CHIP. And our colleagues from Indiana and Maine Medicaid will share some of their state strategies to address maternal SUD.

As a bit of history, as I'm sure many of you have heard in these webinars before, we launched the Maternal and Infant Health Initiative or MIHI in 2014. Now, we are 10 years into the initiative, and as you all know, still in the midst of a maternal health crisis. So, we are using this summer webinar series, which will be followed by two fall affinity groups, to address leading drivers of maternal mortality. Mental health and substance use, which is the leading cause of maternal mortality, and maternal hypertension and cardiovascular health, which is the leading cause of Black maternal

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mortality. If you're interested in more on this and other demographic utilization and disparities data, I encourage you to check out our Medicaid and CHIP beneficiaries at a glance maternal health infographic. Some of which Lekisha will share later in this presentation.

This graphic represents our life course approach and how addressing maternal health has repercussions beyond any particular pregnancy episode and affects the overall health status of a person. We'd like to keep in mind that healthy people make healthier pregnant people and postpartum people. And likewise, improved outcomes for pregnant and postpartum people go on to be improved health outcomes for people in the long run. And now, I'll hand it back to Lekisha. Thank you.

[Lekisha Daniel-Robinson] Thanks Kristen. Now, we'll dive into some of that data that Kristen mentioned. We start with a brief review of the leading causes of pregnancy-related deaths as identified through maternal mortality review data in 36 states. Of note here is that the top cause of death for Hispanic, Latino, and White groups are behavioral health conditions, which include mental health and substance use disorder. These conditions may, of course, co-occur. So, there is a significant opportunity to address how we care for people during this vulnerable time and to minimize the loss and devastation on impacted families. This slide does not include very specific data for some population groups because of low numbers, so some of that information was suppressed because of statistical reliability and data quality.

Here, we present information on the beneficiaries of reproductive age in Medicaid and CHIP, who self-report the use of substance use disorder during the past year, broken down by adults as well as adolescents and then total rates. You can see the impact of various types of substances in this slide. We have illicit drugs, and a little less in terms of alcohol use disorder, but certainly still seeing an impact.

Here, we wanted to focus on individuals who are pregnant and report use of substances in the past month. This is a snapshot view for each of the four years presented; 2017 through 2020. Among illicit drug use, marijuana use is increasing, and tobacco use is going down. We know there's been a lot of public health and Medicaid focus on this topic, and it seems to be having an impact. While a lot of recent focus may not be on alcohol use, there seems to be some level of usage among pregnant individuals, and certainly the risk remains for birth outcomes with alcohol use.

Here, we wanted to focus on substance use in the past month by coverage type, private and Medicaid or CHIP. You can see that there is a significant burden of usage in Medicaid except for alcohol use, where individuals covered by private insurance show a higher usage amount. But there is certainly some significant burden there.

Finally, we wanted to go to maternal opioid-related diagnoses. We're showing this by race and ethnicity, as the use of substances affects all race and ethnic groups. Between the last two slides, you see that we're covering quite a bit of socioeconomic groups. And therefore, it is essential for strategies that are universal to impact the outcomes for pregnant and postpartum individuals.

To reduce stigma and ensure that we are addressing pregnant and postpartum individuals across the health system, it is essential according to ACOG Screening Guidance, that there is universal substance use screening at the first comprehensive obstetric visit in partnership with the pregnant individual. There are a number of validated tools that may be used for screening. There's the NIDA, the 4Ps, CRAFFT, the T-ACE is another one. And they are indicated for different subgroups, so the CRAFFT, for example, is targeted for individuals 26 years or younger.

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Here we represent the treatment barriers for pregnant people with substance use disorders. There's certainly some care fragmentation across multiple systems. Workforce challenges impact the availability and capacity for individuals to treat pregnant and postpartum folks, and access to medically-assisted treatment, which is the appropriate and recommended treatment modality for pregnant individuals. And then there is lack of some of the specialized and prioritized support services and resources. During the next part of today's webinar, we will hear from states who will share how they are addressing some of these barriers and attempting to reduce the fragmentation within their states for care for maternal substance use disorders. I'd now like to turn it to Elizabeth Wahl from Indiana Family and Social Services Administration. Elizabeth?

[Elizabeth Wahl] Thank you Lekisha. Thank you for having me today. I am happy to share some of Indiana's key strategies for improving care coordination and removing barriers.

This graphic comes from our latest maternal mortality report, and you can see that substance use and overdose is the number one contributing factor to maternal deaths in our state. And many of these deaths include mothers who were Medicaid beneficiaries. Given this data, we knew we had to do more in our state.

In 2020, Indiana was one of 10 original states to be awarded the Maternal Opioid Misuse (MOM) model funds to improve outcomes for mothers and infants impacted by the opioid epidemic. I want to acknowledge our funders and note that this presentation reflects Indiana's experience with the CMMI MOM model and is not representative of the model as a whole.

Here in Indiana, we used the MOM model funds to establish the Indiana Pregnancy Promise Program. Promise is an acronym for Promoting Recovery from Opioid use, Maternal Infant Support and Engagement. This is a free voluntary program available statewide for pregnant Medicaid members who have current or past opioid use. Enrollees receive enhanced case management and care coordination services from a Pregnancy Promise Program case manager through their Medicaid health plan, which we refer to as managed care entities; MCEs or MCOs. You can see the goals of the program here on the slide. I'll talk more about what this looks like in practice in just a minute.

The three eligibility criteria for the program are that individuals must be pregnant or within 90 days of the end of their pregnancy to enroll in the program. They must identify as having current or previous opioid use. And they must be eligible for or receiving Medicaid health coverage.

The Indiana Medicaid health plans already had the infrastructure in place to offer case management programs and services to Medicaid members. However, the federal MOM model funds allowed Indiana to enhance case management and care coordination services for this population. We cultivated a team of highly skilled nurse or social work case managers with expertise and experience in perinatal and SUD care. Many of our Pregnancy Promise case managers have previous experience on labor and delivery units within our hospitals.

So, what are the benefits of the program? We say that it's all about connection, coordination, and prevention. Participants are matched with a highly competent case manager who offers confidential support during the prenatal and postpartum period to be sure mothers and babies receive the care and resources that they need in order to be healthy and well. I like to say that our team of Pregnancy Promise nurse case managers are truly fierce advocates for our participants. They lead with compassion and empathy. Our team takes a trauma-informed approach. We use harm reduction strategies. We employ motivational interviewing skills. I can't speak highly enough of the team of statewide Pregnancy Promise case managers. Our case managers also work with

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participants in their team of physicians and other family support providers to coordinate care and identify community resources.

When we're engaging with participants, the conversations include, I see on Monday you have an appointment with your OB for prenatal care visit. On Tuesday, you have an appointment with the Community Mental Health Center. On Wednesday you have an appointment at WIC. Perhaps Thursday you have a court date. Let's make sure you have transportation to and from all of these appointments. Let's be sure if you're having any concerns with your medications or your dosages that we are able to communicate that with your prescriber if it's someone other than your OB, for example. At the end of the day, we really want to prevent pregnant individuals from some of the negative consequences that are associated with substance use, whether that's getting ahead of concerns to prevent our state child protective services from needing to get involved. In some cases, we've been able to impact the justice system and work with mothers who have been previously incarcerated.

This is what the program looks like from the participant's experience. We do have multiple ways to identify or for individuals to be referred to the program. Our Medicaid health plans are continuously doing data mining of their members who are identified as newly pregnant and cross-referencing the claims data to see if they have a history of substance use or opioid use, and then outreaching those members to see if they'd be interested in enrolling in the program. We also have a public-facing website where anyone can make a referral to the program any day of the week, any time of day or night. It's truly universal access.

Once an individual has been identified or referred, our team begins outreach to see if they would be interested in participating in the program. We commonly outreach up to eight or nine times before we might successfully reach an individual. We know our participants are facing a lot of barriers. They may be in crisis. So, we put a lot of emphasis on those outreach attempts. Once we've successfully reached a potentially eligible individual, we do obtain consent to participate and to receive the individual's permission to share data about themselves and their infant de-identified with our federal partners.

Once consent has been completed, that is when the initial screenings and assessments occur, and it is the Pregnancy Promise case managers who are administering verbal screenings. We use the five Ps for substance use, alcohol, and tobacco use. We use the PHQ-9 for depression, the GAD-7 for anxiety, and the CMS accountable health communities, health-related social needs screening tools upon enrollment. These comprehensive screenings help our team to develop a very individualized care plan with the participant's goals around substance use treatment, mental health care, parenting goals, employment, and other goals that they may have for themselves and their family.

After that care plan is written, our pregnancy promise nurse case manager is reaching out frequently throughout the prenatal and postpartum period to ensure that our member is getting the care that they need and getting the resources to help them be successful, whether that's ensuring they have transportation, addressing any food insecurity, those types of things. The interaction may be by phone, it may be in person, it may be through a virtual platform. An important component of what we offer is parental education. Our Pregnancy Promise case managers are versed in tobacco cessation interventions, infant safe sleep practices, lactation support as some examples. It is important throughout the pregnancy and postpartum period that we are continuously reassessing and repeating the screenings to understand how a family's needs have changed or address any crises that may come up, make referrals as needed, and help the families acquire resources as needed. And I want to say we really do take a dyadic approach; the case management and care

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coordination. It's one nurse case manager for both the mother and the infant through 12 months postpartum.

We are also helping to coordinate the infant's needs as well, whether that's referrals to a pediatric specialist or part C, early intervention, or whatever the infant might need, ensuring that they also have a pediatric medical home. Because we know that the program is going to end at 12 months postpartum, we're always planning ahead for program exit, ensuring a warm handoff and ensuring that the mother and infant are connected with other programs and resources after that first year so that families do not experience a service or support cliff.

I really want to emphasize that because the stakes are so high, we know that this really is about saving lives. We have no "three strikes, you're out" policy. So, if we do have a member who perhaps hasn't been able to be successfully reached by phone or in person, we work that much harder to reengage them and make sure they're okay and make sure they're getting back into care and back into the treatment and recovery services and supports that they need.

I wanted to just note the infrastructure that we have in place that has really helped us drive results. The enhanced case management practices, the dyadic approach, the support for mother and baby through 12 months postpartum, the in-person visits, the emphasis on outreach and screening has been key. All of these enhanced case management practices are laid out in a program manual for our MCE partners to follow and consistently implement. We have had amazing collaboration across our Medicaid health plans.

Through this initiative, we are all united behind a common mission to improve outcomes for mothers and infants and function as one statewide Indiana Pregnancy Promise Program team. We participate in joint meetings together, our Indiana Medicaid administration and our MCE partners. We participate in training and professional development. We share successes, challenges, and de-identified case presentations. It's been a true collaboration. Also, we have created a statewide outreach campaign. We've created partnerships with other state agencies. We have 92 counties in Indiana, so the state has really put effort into creating opportunities for more awareness about this program, not only for the public, but also for our provider and family support communities. I mentioned we have a public facing website and an online referral platform.

We receive dozens of referrals every week. We've received, since launching the program in July of 2021, thousands of individuals who have self-referred to the program through the website. It is mobile-phone-friendly. It takes about two to three minutes to complete that online referral. And again, really has created universal equitable access. We also have an online data collection platform where our partners enter data in real time at point of care, and that data collection platform feeds daily dashboards. So as the program administrator, my team and I can see up-to-date real-time information about how many mothers have enrolled in this program, how many infants are born to date, how many of our participants have gotten to that important postpartum follow-up care, that type of thing.

We also have a really exciting policy in place with our Office of Childcare that oversees the CCDF funds. They have agreed that for participants in our program, in order to access those childcare vouchers, all of their treatment and recovery and healthcare needs are considered the service need for childcare, whereas typically employment or education would be the service need for those childcare funds. Finally, we are advised and guided by a statewide steering committee made up of individuals with lived experience, state agency representatives, Indiana Recovery Network, Indiana Minority Health Coalition, and many other key stakeholders.

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I want to point out that our program has grown in the last three years. We are up to almost 900 enrollees across the state of Indiana. We are very encouraged by the fact that we are improving enrollment rates among mothers from diverse racial and ethnic backgrounds. We are well aware of the existing disparities in maternal and infant outcomes and are going in the right direction in terms of program participation.

I want to feature a few key outcomes that we're seeing so far with this program. I apologize that the infant outcomes are not listed on this slide. You can see we have high rates of mothers who are currently being prescribed medications to treat opioid use disorder. We have very high rates of mothers who have sustained recovery through that 12-month postpartum period with no reported return to use or relapse. We have very high rates of mothers and infants who are being discharged home from the hospital following labor and delivery without our Department of Child Services needing to step in for safety concerns.

We have about 80% of infants born at a healthy birth weight. About 75% of infants that have that typical hospital stay to monitor for signs and symptoms of neonatal abstinence syndrome. The majority of our infants are avoiding a lengthy NICU stay. I want to just note any loss of life is too much when it comes to these issues. The fact that we have such high survival rates, noting that it's very, very rare that participants in this program experience loss of life during pregnancy or the postpartum period, all while managing multiple co-occurring mental health conditions in addition to substance use disorder.

I want to end by saying that we hear stories from participants all the time telling us that if you had told me 14 months ago, I would be in recovery, parenting a healthy infant, have my own apartment, have employment, and be reunified with my older children who are in foster care, I never would've believed it was possible. But through these relationships with the Pregnancy Promise Program and the case managers who believe in the mothers, they really have improved their own health and wellbeing as well as that of their family. Lekisha, that is all I have. I apologize if I went over time, but I will turn it back to you.

[Lekisha Daniel-Robinson] No, this is great. The enrollee testimonies really are a testament to the value of the program. Just as a reminder, the slides will be available so you will have the opportunity to review those testimonies when the slides are posted within a couple of weeks. Now I'd like to turn to our team from Maine, Lisa Tuttle and Maggie Jansson of the Office of MaineCare Services. Thank you.

[Lisa Tuttle] Thank you so much. This is Lisa Tuttle and I am the Maine MOM Program Manager here in our Maine Medicaid office. We call that MaineCare. We are also a Maine MOM CMS CMMI funded program. We really love what Indiana's doing, so it was great to have Elizabeth go first. We are grateful to CMS and CMMI for the work that I'm about to tell you about that we've been able to do in Maine MOM.

I'm going to quickly give you an overview of Maine. Our state population is about 1.4 million. In Medicaid, we have about 416,000 members and about 5,000 live births annually. About 10% of those, we believe, are living with OUD, opioid use disorder. So, the opioid epidemic was a big deal for Maine as a small rural state. I think both the high deaths, the high risk to vulnerable pregnant people and postpartum people, in conjunction with the separate quote here about the drug mix on the street, just very, very complicated.

So why did Maine go for a MaineMOM program? These are some more examples. You've heard the beginning of the slideshow here. Just really troubling and concerning consequences on Maine mothers.

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We know from the evidence, as well as some local qualitative studies and local data, that the opioid epidemic is hitting vulnerable pregnant and postpartum people in ways that I don't think we fully understand yet. These are the data that we were able to pull together. I use these types of data to talk about the importance of enrolling into our program. We are seeing better outcomes around the babies in Maine, but we're still really concerned about what's happening with vulnerable pregnant and postpartum folks.

In addition to the opioid burden for morbidity and mortality, we, like many other states, are also seeing a shrinking of our birthing infrastructure. So, when we try to map access, we have a lot of dynamics going on in the state. This is just testimony to the fact that pregnancy is a profoundly motivating time. If you go on to the next quote, it actually comes from a local qualitative study in New Hampshire. I love this quote because it shows how important screening for substance use disorder is with pregnant people. Just the fear and the trouble -- Elizabeth really did a good job talking about her program. Talking about all the reasons why it might be very hard for vulnerable pregnant people living with opioid use disorder to make it to the clinic for care. But when they make it there and they have a compassionate, experienced, supportive healthcare team, then the real magic can happen.

We rolled out MaineMOM as a Medicaid health home model. Maine doesn't really have the penetration of Medicaid managed care as many other states do. We have always delivered our public health services, immunization, and indeed our health home models through the private healthcare delivery sector. You see a little map of our current MaineMOM care delivery providers here. Those are from most of our major health systems in Maine. We have one little FQHC, and then we have three other partners who are from the major health systems. Fortunately, I have a meeting later this week to see if we can get another really important health system on board.

We're so happy that in December of 23, our MaineMOM Medicaid rule was adopted. Maine has a long experience with rolling out health home models of care that provide a home, a locus of care for different populations. Then those wraparound services that Elizabeth did such a great job describing in her model, care coordination, case management, SDOH screening, trauma-informed screening, etc., Those are the typical health home services that are delivered as part of our model. You'll see that shortly.

We can cover anyone, any age from the point of pregnancy as long as they are living with an OUD and they're Medicaid eligible on through to 12 months postpartum. So, the first important bullet is that MaineMOM is high quality healthcare. It's delivered through the healthcare delivery system in the market. It's the same as any other high-quality healthcare that people in the state are able to receive. Then they're expected to add these supplemental services. Group counseling. They must provide ready access to medications for opioid use disorder.

As I said, they do all of these health home functions. And then we also align with other important initiatives like Eat, Sleep, Console. There's some belief that that's why the babies are doing better. And of course, the evidence-based protocols. I'll go through this because I really want you to hear from my colleague, Maggie Jansson, because she was a member of the MaineMOM clinical team before she joined us here at the Office of MaineCare Services.

This is an example of our team. This is the expanded model of MaineMOM. In addition to the typical perinatal providers that a pregnant and postpartum person would require, we also require integration with an MOUD provider. Those could be co-located, fully integrated sites, or they could be partnership where they're not co-located. You'll see that in a minute when you see our service models.

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In addition to that intense integration between the MOUD provider and the perinatal provider, we require the MaineMOM team to have these other functional roles. Nurse care manager is really important, and Maggie is going to talk about her role as a nurse care manager. We require clinical counseling for both SUD as well as mental health and other behavioral health issues. Then we require these two starred roles. The addition of a patient navigator, that could be a community doula, that could be a community health worker. And the addition of a peer recovery coach in the clinical model. These roles are integrated into the clinical team.

These are the different service models. A MaineMOM provider would fill out a little application. We have one provider who's in this pathway right now. Then they have to demonstrate that they're able to deliver the model. You can deliver an integrated services model. These are co-located services, co-located integration between perinatal and MOUD provider. Same systems, same everything. It should be completely integrated care. You could deliver it in a partnership model where the opioid use treatment provider is the key provider. They develop a formal relationship with prenatal and perinatal care to deliver the perinatal services. They still must have shared electronic care planning. They have to accomplish all of the shared services. But in this model, the locus of control is with the MOUD provider. In the final model, the perinatal navigation services, that's the beautiful model that Elizabeth described. This would be those health home services. Coordination, care management, screening, etc.

Each of these models has a rate. The MaineMOM as a health home model, we pay an enhanced per member, per month for those different models. The integrated model, these are examples with our 2024 with the COLA, the cost of living increases. Just to show you the different models. For example, in the last model, the other services, these are just claims for care coordination. It's about \$678 a month that you could get for each MaineMOM number in your panel. Then fee for service would cover the other services in this type of model. So just to quickly talk you through that. Let's go to the next slide, which has some of our enrollment numbers on it.

This is a year of enrollment. Julia Dudley is also in the call. She's our data and quality manager. And you can see we have served so far about 224 individuals. We believe that there's another 250 people that we could reach to. That is a stretch goal I'm pushing our care providers to reach and engage. You see we're getting folks a little bit late in care. We would really like to have them as soon as they know they're pregnant, and we would like to have them for those full 12 months postpartum.

Julia Dudley, our data and quality manager, did some preliminary findings looking at the Medicaid data. It's looking promising for the MOM model in our state. Just quickly, you can see that we have better adherence to MOUD than folks who are Medicaid and pregnant and living with an OUD, but not in MaineMOM. We have better outcomes with folks who are able to engage during pregnancy than those who are not in the model and those who engage postpartum. Logically, we do have higher rates of NALS among the infants who are enrolled in the model that follows the higher rates of MOUD treatments. The MOM participants had higher rates of well child checks, which is a really nice finding.

Then the last slide is just noting that we have a centralized referral pathway. We have a couple of them. This is quality improvement work that we're doing right now to try to get referral forms integrated into electronic health records so they have a universal approach in their system, etc.. We have also done quality improvement work around access to care. Our MaineMOM providers are beginning to use their grant funds to figure out how to go out into the community and engage with folks in mobile units.

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We have a lot of quality improvement issues around duplication of services. We're trying to create pathways to sort through that for providers. And we're working on one this year to improve the quality of information that Child Protective Services and the care teams explore. I want to point to my colleague, Maggie Jansson, to talk to you about how this model from her observation as a clinician has reduced some of the fragmentation in care. You could pop back to that team slide for Maggie to talk from. Thank you so much. I'm sorry if I rushed that, but I really want you to hear from Maggie who has been a clinician in the model.

[Maggie Jansson] Thank you. I'm glad we have this slide up. Like Lisa said, my name is Maggie Jansson and I am now at the Office of Maine Care Services. But for the last four years, I've been working as a nurse care manager within the MaineMOM program at a care delivery partner at one of the large health systems here in Maine. It is a large health system with a lot of separate departments delivering care to patients. So, care happening in lots of different locations. It is what we would term a partnership model.

That second model on the slide that Lisa was showing you of the three different types of models that MaineMOM reimburses under. We had a MOUD treatment occurring in a separate clinic from the Women's Health Clinic, for example. But everybody would share the same umbrella name for the organization and the same electronic health record, for example. Prior to the establishment of MaineMOM, I had been working in that health system.

Prior to the establishment of MaineMOM, it was very common to see our perinatal patients with substance use having multiple appointments scheduled per week, sometimes per day, with different providers, at different clinics, all over the city. Those, of course, were very often Medicaid patients who were already struggling daily to find reliable childcare, transportation, housing. All of this was creating a heavy load on our Medicaid-funded transportation system. There were many cancellations, no-shows, and missed appointments. There was just an increased strain and stress on patients and on the providers as a whole. We also were seeing fragmentation and inconsistency of medical messages received during care.

For example, as a lot of you know, many pregnant people complain of constipation as a very common symptom of pregnancy. And constipation is also a common side effect of patients on buprenorphine, a common MOUD. When you have a pregnant patient on buprenorphine, what do you think her number one complaint is going to be? It's going to be constipation. Prior to MaineMOM, you would have that patient going to see her MOUD prescriber once a week, or once every two weeks, and talking about the constipation that she was experiencing. She would receive one recommendation from that prescriber and possibly a prescription, and then she would show up at her OB's office three days later and talk about the constipation again there and get another recommendation and maybe another prescription. We were finding that providers just weren't talking to each other. They were prescribing over each other. They were confusing the patients. And ultimately, the patient's care was compromised. And that was just all around something as relatively benign as constipation. You can imagine what could and sometimes did happen when you had a patient that was suffering from depression, anxiety, or hypertension.

Once MaineMOM started and the nurse care manager role began, my priority was really to facilitate communication. I saw this as an excellent opportunity to cut down on that fragmentation and inconsistency amongst the medical messaging. To facilitate communication not only between the various clinics that were serving our patient population, but I also wanted to work on the communication between patients and their providers. One thing that I began to do is at the start of each week, I would do a chart review within our EMR system for each of our patients to see who had been seen over the last week, and who was scheduled to be seen in the upcoming months.

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If I was able to see any potential for combined transportation to and from visits, I would help patients arrange that. If I saw an opportunity to put visits back-to-back to help decrease stress on the patient or stress on the transportation system, I would help facilitate that. I also began convening monthly case review meetings between our MOUD provider staff and the women's health staff to discuss care of mutual patients with complex medical and particularly social needs to better take better care of them. That seemed to really reduce a lot of the stress. Not only on the patients, but for the providers.

Besides facilitating communication between clinics, I found that working as the nurse care manager was also very much about establishing a meaningful and trusting relationship with the patient. Because you're going to be who the patient sees the most. Even though they're seeing the providers on a regular basis, it can be a different provider sometimes. Oftentimes they're seeing that provider for a 15-minute period. But we as the nurse care manager get to see them quite a bit more, and more frequently. I was able to help create a connection between the patients and their providers as a result. I did that not only in the clinic, but also with frequent phone calls between visits to check in. I did troubleshoot issues for them. I acted, I like to say, as their own personal bulldozer in some ways. When issues came up with pharmacies, or insurance, or transportation, I would help troubleshoot those. I also acted as a sounding board for personal issues that would come up for those patients. Then I would pass that along to the providers.

For example, I can't tell you how many of my patients I got started on contraception because they disclosed to me first that they were starting a new relationship, you know, six months postpartum. So that was a nice connection. Then the ability to treat the patient's need in the moment after the providers do see the patient. I was there to help with any questions or concerns that lingered where I could make some phone calls with the patient, connect them to community resources. I found that extremely helpful. I know we're running out of time, so that will be it for me now. I will hand it back to the organizers so we can start with some questions.

[Lekisha Daniel-Robinson] Thank you. Yes, a number of questions have come in. We'll try to address as many as we can. I'll start with a couple that came in for Indiana. One, you mentioned the centralized referral platform. Could you say more about how the referrals are disseminated to the appropriate health plan?

[Elizabeth Wahl] Sure. The referral platform essentially was created within the Indiana Medicaid organization. We get an immediate alert when a referral has been submitted. We are then able to check in the Medicaid data system, does this individual who submitted a referral already have Medicaid coverage? Are they already assigned to one of our MCE partners? If yes, then we push that referral right over to the MCE partner. If they do not yet have Medicaid coverage, I have a team member who's a licensed insurance navigator who walks them through that pregnancy Medicaid application. Then when they're assigned to a Medicaid health plan, we send that referral to the corresponding team.

[Lekisha Daniel-Robinson] Thank you. As a testament to the programs that you both are running, there's a question that came in that started with a compliment. Your programs are amazing. How are you thinking about services for mental health conditions in the mothers that you are treating? Are you billing, receiving funding for these services? Maybe we can start with Maine for this one.

[Lisa Tuttle] Mental health treatment is in our rule. Access to mental health treatment is a required part of our model that would, I believe, go under fee-for-service in MaineCare with this model, but they must provide access to it. As I said before, the health home model and those wraparound services really do have a lot of screening and referral requirements for a whole bunch of different conditions.

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[Lekisha Daniel-Robinson] Excellent. Thank you. Let me go back to Indiana for a question about how you're managing the fear of involvement with Child Protective Services and the potential engagement commitment and participation in the program.

[Elizabeth Wahl] Right. For context, here in Indiana, our Child Protective Services agency does not become involved during the prenatal period. Within our program, we have the ability to create a prenatal plan of safe care where we're really working with the mom on relapse prevention, maintaining OUD treatment, getting important behavioral health care, working with a certified peer recovery coach. We're documenting all of that in a care plan throughout the prenatal period and encouraging mom to bring that plan with her to the hospital for labor and delivery. Our hospitals have slightly different policies around testing moms and newborns for substances, and then slightly varying policies for making a report to DCS.

We really encourage the parent, in the event those things occur. In some cases, a report is made if a parent is taking prescribed medications, such as methadone or buprenorphine. We really equip the mom to say, please contact my Pregnancy Promise Program case manager. I'll sign a release. That individual can talk to you about all the work that I've been doing around treatment, recovery, my own health care. And making sure I have important things like a crib for infant safe sleep, or a caregiver that I can rely on. Whether it's a family member, or a neighbor, that type of thing. We really focus on that prenatal plan of safe care and encouraging our moms to sign releases if, and when, the Department of Child Services makes an inquiry.

[Lekisha Daniel-Robinson] Okay, thank you for that. A question about how you are engaging MCOs in your efforts, if you could say more about that. That one is for you, Elizabeth.

[Elizabeth Wahl] Sure. We already had an infrastructure in place, and the state Medicaid agency already had contracts with our managed care entities to provide case management and care coordination services for a whole host of Medicaid beneficiaries with varying conditions. So, we had the ability to enhance our contract language, enhance practices, enhance some data reporting, outreach screening for the population of pregnant and postpartum Medicaid beneficiaries with opioid use and other substance use. We really leveraged our existing contracts and that structure to implement a consistent program statewide across four different MCE partners.

[Lekisha Daniel-Robinson] Perhaps this can be our last question for the Maine team. Can you say more about your infant outcomes?

[Lisa Tuttle] Our infant outcomes. I wonder, Julia, if you have any information. We didn't pull infant outcomes for this session. I know we have a lot fewer births than Indiana does.

[Lekisha Daniel-Robinson] That's fair. If you're not prepared, we can move on.

[Lisa Tuttle] We do know that there's been a very close following to infants with neonatal abstinence syndrome. We know that our rates for infants are improving. We know that the amount of infants who require medications -- it could be benzos, it could be, other MOUD -- other types of medications, is declining as well. Our infants are looking better and better in Maine, which is great. To Elizabeth's point about using the plan of safe care and then the Eat, Sleep, Console, Maine hospitals have really invested in some of those methodologies.

[Lekisha Daniel-Robinson] Thank you. I wanted to share that the feedback in the Q&A has been tremendous, and everyone is very appreciative of the details that you've shared about your various programs. I did want to note that, again, the slides will be posted, and we'll send a notification when they are posted on Medicaid.gov. Included in the slides will be information about how you can reach

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our wonderful presenters from today. We will close the Q&A at this point, and I'll review some upcoming events and opportunities.

There are two more sessions in the Maternal Health Webinar Series this summer. The next one will be on July 16th, Addressing Hypertension Before, During, and After Pregnancy. Followed by, on August 20th, Medicaid and CHIP Program Collaboration with Hospitals on AIM Bundles.

Kristen alluded to affinity groups that will be launched in the fall related to both the Maternal Mental Health and Substance Use topic, as well as Maternal Hypertension Control. Stay tuned for more information. There will be a webinar on August 6th with more information about how you can participate in those programs.

Finally, we referenced the Maternal Health infographic. There will be a link that you can access once you are able to connect with the slides, as well as the landing page for Addressing Maternal Mental Health and Substance Use Care and Outcomes. From there, you can navigate to more information about the web series and access the recordings. In either case, we will disseminate the information about the location and posting of the webinar as they happen. I wanted to thank both of our presenters for their wonderful presentations today. Hopefully you'll stay tuned for other sessions in the series. Thank you again.