Bree Collaborative | Maternity Care Bundled Payment Model Workgroup
May 9th, 2019 | 8:00-9:30
Foundation for Health Care Quality

Members Present

Carl Olden,* MD, Family Physician, Pacific Crest Family Medicine (Chair)
David Buchholz,* MD, Medical Director, Collaborative Health Care Solutions, Premera
Molly Firth, MPH, Patient Advocate
Neva Gerke,* LM President Midwives Association of Washington
Rita Hsu, MD, FACOG, Obstetrics and Gynecology, Confluence Health
Lisa Humes-Schulz,* MPA, Director of Strategic Initiatives, Planned Parenthood of the Great Northwest and Hawaiian Islands
Janine Reisinger,* MPH Director, Maternal-Infant Health Initiatives Washington State Hospital Association
Dale Reisner,* MD, Obstetrics and Gynecology, Swedish Medical Center
Mark Schemmel,* MD, Obstetrics and Gynecology, Spokane Obstetrics and Gynecology, Providence Health and Services
Vivienne Souter, MD, Research Director, Obstetrics Clinical Outcomes Assessment Program
Judy Zerzan,* MD, Chief Medical Officer, Washington State Health Care Authority

Staff and Members of the Public

Shannon Blood,* MA, Washington State Health Care Authority
Blair Dudley,* Pacific Business Group on Health
Jonathan Fischer,* Washington State Health Care Authority
Ellen Kauffman,* MD, OBCOAP
Alicia Parris, Bree Collaborative
Suzanne Swadener,* Washington State Health Care Authority
Shawn Quigley,* Proliance Surgeons
Mandy Weeks-Green*
Ginny Weir, MPH, Bree Collaborative

* By phone/web conference

INTRODUCTIONS AND APPROVAL OF MINUTES

Carl Olden, MD, Family Physician, Pacific Crest Family Medicine (Chair), and Ginny Weir, MPH, Bree Collaborative, opened the meeting and those present introduced themselves. Dr. Olden then thanked Rosie Fitzgibbon and Kelsie Brewer for the literature review.

Motion: Approve 4/11/2019 minutes
Outcome: Passed with unanimous support pending addition of information on how many women remain on Medicaid postpartum

WASHINGTON STATE HOSPITAL ASSOCIATION DATA

Janine Reisinger, MPH Director, Maternal-Infant Health Initiatives Washington State Hospital Association, and Dale Reisner, MD, Obstetrics and Gynecology, Swedish Medical Center, presented data to help define a lower risk population. The data can be risk adjusted and is from CHARS (Comprehensive Hospital Abstract Reporting System) data from 2016 from 76,965 births:

- Diagnostic codes are from delivery point does not include prenatal care
    - Included any degree of obesity
- Example of a minor severity of index diagnostic code might include:
    - Abnormal glucola but normal glucose tolerance test

    - Transient hypertension
- Mothers 18-34 with minor severity of index diagnoses at time of delivery made up 45%
    - All hospital births
- Mothers 18-37 with minor severity of index diagnoses at time of delivery made up 32% of deliveries
    - Only included uncomplicated vaginal delivery
    - Removed obesity code
        - Obesity codes do not specify minor or moderate degrees
- Might help to see what percentage of patients will fall into the group likely to have a relatively smooth pregnancy, deliver at term, with relatively few complications. Also to determine the percentage of the population likely to be included or excluded based on certain criteria
    - Data can be broken down in different ways if the group finds it useful
- Vivienne Souter, MD, Research Director, Obstetrics Clinical Outcomes Assessment Program, asked Dr. Reisner to explain to the group what the DRG is and what it includes in terms of diagnostic criteria and procedures
    - High level statewide CHARs data
    - Accuracy depends on coding properly
    - Only code groups. Doesn't include procedures outside of C-section or not
    - Ms. Reisinger explained that the APR DRG Severity of illness CHARS data that is run through a complex algorithm and classified by severity of illness
        - 4 severity of illness classifications
- Dr. Souter suggested using CHARS data may be a challenge due to it looking backward, where the group is attempting to look at early pregnancy diagnoses
- Dr. Hsu Rita Hsu, MD, FACOG, Obstetrics and Gynecology, Confluence Health, reiterated the difference between previous Bree bundles like Hip and Joint replacement, single episode of care and single care team, so prospectively predicting who may be high risk is very difficult
- Ms. Weir suggested basing inclusion on cost, along with patient specific factors (e.g. active cancer treatment) to produce a bundle that includes the majority of women that and provides protection for the accountable entity
    - Based on literature review, the combination of cost and patient specific factors was common

DEFINING A CARE PATHWAY

The workgroup viewed Draft Maternity Bundle and discussed:

- Ms. Weir noted that few of the other existing bundles included a care pathway. Majority are a payment structure with quality metrics. Group could make a bigger impact by defining a pathway within the shell of a bundle, with the biggest impact in the post-partum space.
- Dr. Souter emphasized the importance of supporting physiological birth in low risk patients and avoiding unnecessary interventions which could be affected during the intra-partum phase
    - Dr. Hsu agreed this is important especially in the wake of the ARRIVE (A Randomized Trial of Induction Versus Expectant Management) trial. Which led to more elective inductions at 39 weeks
        - Led to much longer labors
    - Included language from the 2012 Bree recommendations on labor management
- Ms. Reisinger, shared that the Safe Deliveries Roadmap will be updating their Labor Management Bundle. Will be completed in the fall. May include revised language in response to the ARRIVE trial
- Dr. Olden advised approaching expanding elective inductions with a lot of caution outside of academic medical centers conducting trials.
    - Additionally, most hospitals don't have the capacity and staffing
    - 2 out of 3 women initially considered were excluded
    - Average age in ARRIVE trial was 23

- Dr. Reisner advised any language addressing the ARRIVE trial should include specific reference to the patient population
    - American College of Nurse-Midwives has language around giving context to the ARRIVE trial
    - Due to wide publishing of the ARRIVE trial, Dr. Reisner suggest directly addressing in the pathway

Action Item: Dr. Reisner will send ACNM language on ARRIVE trial

- Dr. Souter suggested the 35/39 Trial (Randomized Trial of Labor Induction in Women 35 Years of Age or Older) may be a more relevant patient population
    - Medicaid population is typically younger so ARRIVE trial is potentially relevant
- Dr. Reisner suggested a shared decision making conversation so that patients understand trial age and excluded and included population
    - No current decision aids exist that take into account the ARRIVE trial

Action Item: Dr. Reisner will share WSHA Safe Deliveries Roadmap one pager on induction

- Dr. Souter referenced the jump in elective inductions and advised balance in the conversation as the long-term effects of oxytocin is unknown

- Group agreed on the importance of alignment with WSHA recommendations
    - Dr. Reisner pointed out that in the context of a bundle elective inductions will be very costly
    - Judy Zerzan, MD, Chief Medical Officer, Washington State Health Care Authority, pointed out that Medicaid required to pay for the least costly alternative and failure to do so could potentially result in a loss of federal funds
    - Dr. Hsu suggested including language that explains that while the ARRIVE trial demonstrated no increase in C-section rate in the studied population, no data exists that it is broadly applicable to the general population.

Action Item: Dr. Hsu will send draft language

- Dr. Souter suggested that induction is not an effective way to reduce cesarean sections, and rather to focus on supporting physiological birth
    - Suggested including ACOG guideline on avoiding unnecessary intervention, and Bree guidelines on later admission and spontaneous labor along with other ways to support progress
        - Non-pharmacological pain relief
        - Allowing adequate time
        - Avoiding interventions of uncertain benefit

Action Item: Dr. Souter will send draft language

- Dr. Reisner suggested including language on for Medicaid's requirement of the least expensive alternative along with AIM (Alliance for Innovation on Maternal Health) recommendations
    - If complications occur there may be options less invasive than an operative birth
- Ms. Weir asked group to consider adding doulas to the recommendation for the next meeting

The workgroup viewed ACOG Optimizing Postpartum Care and discussed:

- Ms. Reisinger suggested including something similar to the IMPLICIT Network (The Interventions to Minimize Preterm and Low Birth Weight Infants through Continuous Improvement Techniques)
    - Co-locating services for mother and baby

        - Incorporating check-ins for mood disorders, breast feeding or any other needs in well-baby visits
    - Medicaid provides reimbursement for pediatricians doing depression screens of new mothers
        - Has not spread amongst pediatricians
        - Removing barriers of reimbursement for pediatricians who are attempting to bill for such services to influence commercial insurers
    - Dr. Hsu suggested disseminating information on how the pediatric provider can screen and bill for the mother under the current payment model through the Perinatal Collaborative
    - Dr. Olden mentioned the additional subject of postpartum hypertension
        - Customizing a postpartum care plan covered under Medicaid
        - Dr. Reisner asked to also include Emergency Room recommendations for depression and hypertension

Action Item: Ms. Reisinger will look into Emergency Nurses Association training or protocols for ED staff around maternal emergencies

- Dr. Souter asked about geographical, economic, and racial disparities as barriers to postpartum care
    - Reducing these disparities through use of phones, texting or home visits is crucial to reducing maternal mortality
    - Ellen Kauffman, MD, OBCOAP mentioned an article on texting for postpartum hypertension
    - Lisa Humes-Schulz,* MPA, Director of Strategic Initiatives, Planned Parenthood of the Great Northwest and Hawaiian Islands, reminded the group of the need to ensure a strong referral network so that action is taken beyond depression screening
        - Additionally including vaccination education
    - Dr. Hsu suggested the underutilized service of Health Care Authority's Maternity Support Services that allows for a nurse case manager
        - Could meet many of the goals of the workgroup
        - Focusing on the goal and allowing for creative solutions
        - In prenatal care section, changing title to OB Provider rather than Nurse Midwife
            - Less specific about who is providing the care to serve rural areas
    - Ms. Reisinger suggested the Oregon Family Wellbeing Assessment
        - Identifying needs and providing specific links to referrals and resources
    - Dr. Souter suggested the CDC screening tool
        - Obstetricians are being asked to do more and more and are near max efficiency of screening and having a simple plan will be very important
            - A dedicated case manager could help in this area
            - Support staff
            - Group visits add to efficiency
- Neva Gerke, LM President Midwives Association of Washington, asked the group to consider problems with payment and the MCO structure
    - Reimbursement variations, certain pediatric groups not accepting certain MCO contracts
        - Serious limits to access to urgently needed services
    - Pediatricians are sometimes paying to see patients
    - If asking pediatricians to do more, reimbursement needs to be clear and easy

NEXT STEPS AND PUBLIC COMMENTS

Carl Olden and Ginny Weir asked for final comments and thanked all for attending. The meeting adjourned.