Bree Collaborative | Perinatal Bundled Payment Model Workgroup
September 22nd, 2020 | 9:00-10:30
Virtual

Present

Rita Hsu, MD, FACOG, Obstetrics and Gynecology, Confluence Health
Janine Reisinger, MPH Director, Maternal-Infant Health Initiatives Washington State Hospital Association
Dale Reisner, MD, Obstetrics and Gynecology, Swedish Medical Center
Blair Dudley, Pacific Business Group on Health
Ginny Weir, MPH, Bree Collaborative
Alex Kushner, Bree Collaborative
Beth Tinker, PhD, MPH, MN, RN, Health Care Authority
Mike Barsotti, MD, Neonatologist, Providence Medical Group Hospitalists
Josephine Young, MD, Premera Blue Cross
Edna Maddalena, Program Manager, Washington Chapter of the American Academy of Pediatrics
Mark Schemmel, MD, Obstetrics and Gynecology, Providence Health
Mia Nafziger, Senior Health Policy Analyst, Washington State Health Care Authority
Kate McLean, MD, MPH, FACOG, Director of Clinical Programs, Quilted Health
Mandy Weeks-Green, Senior Health Policy Analyst, Officer of the Insurance Commissioner
Maggie Bolton, CNM, ARNP, Clinical Program Manager, Quilted Health
Judy Zerzan, MD, MPH, Chief Medical Officer, Washington State Health Care Authority
Francois De Brantes, Senior Vice President, Commercial Business Development, Signify Health
Molly Firth, MPH, Patient Advocate

INTRODUCTIONS

Ginny Weir, MPH, Bree Collaborative, opened the meeting and those present introduced themselves and gave their background.

GENERAL DISCUSSION

Ms. Weir began the conversation by bringing up the issue of defining the role of the pediatrician.

- Mike Barsotti, MD, Neonatologist, Providence Medical Group Hospitalists, spoke about thinking of the pediatrician's role in two domains—the clinical role and the administrative role.
    - We know what to expect from the clinical side—taking care of newborn, taking care of discharge timing, follow up. Pediatricians know what they are in charge of on the clinical side.
    - Admin side is more difficult in a bundle payment. Depending on the model that a group uses, the bundle care could involve many different types of services and, depending on the size of the clinic, could involve referral to outside care.
    - Group needs to decide on 30 days vs 60 days
- The group discussed a language problem in the report, under the "2-5 days of birth" bullet (page 2 of draft). There is a bullet that says that there should be a full physical exam within 48 hours for babies discharged less than 48 hours after delivery; this would make it hard to discharge on Friday in many cases.
    - While bigger health systems would be able to see a baby on the weekend, some rural systems might not have that capacity.
    - Additionally, most people do not stay for more than 48 hours for a normal vaginal birth right now (COVID also makes people want to get home quickly).
    - Language changed to say that the pediatrician would *ideally* see the newborn within 48 hours of discharge in this situation.

        - The group does not want to have language that would encourage delaying appropriate discharge.
- Dale Reisner, MD, Obstetrics and Gynecology, Swedish Medical Center, commented that some of the items under the bullet on newborn physical examinations (page 2 of draft), are not essential for the pediatrician to perform. Suggested working on this list and consulting pediatricians who do newborn exams.
    - Ms. Weir suggested working on this list offline and then bringing it back to the group next time.
- Dr. Barsotti raised a concern over how/if the bundle would address problems outside of delivery—for example, parental non-follow up.
- Ms. Weir asked the group about workflow. Communication and relaying information to all providers has to be built into this bundle system. Does the group want to be prescriptive about how information is documented?
    - In the past Bree has not been prescriptive—depending on where a provider is located, their options for communication might be very different.
    - Group agreed that the recommendation should say that communication must happen, but not how it has to happen. A couple of members suggested an appendix with examples of types of information that should be communicated.
        - The group agreed on this—appendix to show what info pediatric provider needs from OB and what OB needs from pediatric.
- Ms. Weir returned to the question of 30 days versus 60 days and weighing the benefit of more days where baby and mother are covered as a dyad versus the burden of an extended bundle.
    - Dr. Barsotti: the further you get out from birth, the more mother and child become distinct entities needing care. Medical pathways become more divergent after 30 days.
- Question asked about whether things like fever would be covered under the bundle—would new acute illnesses be included?
    - Francois De Brantes, Senior Vice President, Commercial Business Development, Signify Health, said that, typically, only the care that is relevant to the pregnancy is considered to be in the bundle. Typically for the newborn, everything is covered, but for mother it is only the relevant care. He explained that there is typically a baseline of care defined in a bundle that has acute illnesses baked in that are covered. He also spoke more about how payers would determine who is in a bundled program.
- Rita Hsu, MD, FACOG, Obstetrics and Gynecology, Confluence Health, commented on the quality minimum that would be in place to be part of the bundle. She said that the group does not want to penalize providers whose baseline quality is already high and wants to design the bundle to encourage improvement from a provider's baseline.
- The group discussed what would happen if a patient risks out of care. Ms. Weir: if a patient risks out, they would still receive care, just not under the bundle.
    - Dr. Hsu asked if this would incentivize a patient to take their care somewhere else (potentially far away) where they would not risk out.
    - Mr. De Brantes said bundles can be designed to account for this problem. The bundle would be designed with winterizing" which would set a cutoff amount above which the OB provider would not have to pay. And patients would hopefully not have to worry about going to a larger system if their OB could not take them on.
- Changing subjects, Ms. Weir returned to 30 days vs. 60 days of coverage—the group agreed on 30 days.
    - Dr. Barsotti added that it might be worth giving advice to small systems about how to blend hospital care with other types of providers. Recommendations could also address the role of the family in accessing care.
- Dr. Hsu asked about Maternity Support Services (MSS) and Infant Care Management (ICM) and said that they are helpful in rural areas.

    - Two attendees from the HCA said that the HCA is thinking about cutting funding for those in this year's budget due to budget constraints.
- Dr. Reisner spoke about home visits—these are important to health. Patients prefer postpartum home visits. Is there a way to make a bundle that includes things like doulas and other services that are helpful but not available in areas with health disparities? This will make the bundle more appealing.
    - Dr. Hsu added that MSS and ICM really help our most vulnerable populations and help OBs adhere to high standards.
        - However, the group may need to table that conversation for now due to budget problems on the HCA side
- Ms. Weir to reach out to a few members to do some follow up work between now and next month's meeting. Any changes will be presented at the next meeting.

CLOSING COMMENTS

Ms. Weir thanked all for attending. The meeting adjourned.