
Bree Collaborative | Perinatal Bundled Payment Model Workgroup

August 24, 2021 | 8:00-9:30

Virtual

Present

Trish Anderson, RN, Washington State Hospital Association

Mike Barsotti, MD, Providence Spokane

Blair Dudley, MPH, Purchaser Business Group on Health

Amita Rastogi, MD, Signify Health

Dale Reisner, MD, Swedish Medical Center

Beth Tinker, PhD, MPH, MN, RN, Health Care Authority

Mandy Weeks-Green, Officer of the Insurance Commissioner

Ginny Weir, MPH, Foundation for Health Care Quality

Josephine Young, MD, Premera Blue Cross

Valarie Higgin-Bottom, Providence Spokane

Beth Getz, MD, Coulee Medical Center

INTRODUCTIONS

Ginny Weir, MPH, Bree Collaborative, opened the meeting and those on the call introduced themselves.

GENERAL DISCUSSION

Ms. Weir, explained the goal to react to the extension of Medicaid eligibility to 12 months postpartum and to see if the

- Logic model of why to extend care: Primary reason was to extend to behavioral health services
 - Leading driver for deaths is behavioral health, suicide, homicide,
 - Person-centered primary care is what is needed
- Who is providing care – continuous, focus on behavioral health
 - Some cannot because of licensure (midwives)
 - Some cannot because of scope of practice
 - What are we asking of them? Are there two separate episodes?
 - What does that transition look like?
- Post-acute phase – more of a chronic disease management model. Some kind of per member per month.
 - As we think about building out an episode of care – how is this different than the HCA's primary care multi-payer model.
 - HCA – significant action in the last six weeks. Working on a scope of work for a vendor consultant. Have developed a project charter – is going forward.
- In absence of a bundle extending to one year – what are moms doing right now? Where are gaps?
 - 50% of Medicaid clients have any post-partum care (from claims data).
 - Most clients rolled onto family planning program.
 - Very low utilization in the remaining 10 months – maybe 15% had any services.
 - Having the eligibility does not mean folks are accessing services.
 - What happens to clients who live in an area where there are no providers who have decided not to offer this postpartum care for 12 months.
- Need to ensure we are addressing what needs to be addressed.
 - Are we trying to get patients to providers who have no experience managing this problem? Making sure the right resources are around that provider to managing the patient.
 - The dyad is so important – is a high-risk OB the right person to be managing that at nine months of life.
 - Provision that the neonatologist or pediatrician sees the baby the mother should be reviewed too. Interactions are more at the pediatrician rather than fam practice or OB level.

- Pediatricians are reluctant to screen for depression as there is not referral next step. In ambulatory pediatric practice as well. Ultimately the parent is not the patient for the pediatrician. You are stuck with encouraging the parent to seek care you cannot direct that care.
- For behavioral health care, screening and the added liability without a referral pathway is there for Obs.
- Increased ED use for substance abuse and mental health diagnoses.
- Gaps – lack of reach out. Ability to use doulas but no ability to pay for them. Need a different approach to reaching out to homes. Need creative ideas for in-home care checks – how could this further coverage work with a different model?
 - Successes for post-partum doulas.
 - Postpartum Doula's or Community Health Workers to do follow up visits (in home or virtual)? There would need to be access available in primary care if the Doula/CHW screening is positive for depression or other health concern.
 - Bereavement doulas do apply here, the PP expansion is for any end of pt outcome.
- More than 95% of parents take their babies in in the first 30 days. Very high.
- Other issues outside of behavioral health
 - Pelvic floor, diabetes, hypertension, etc. Want to also focus on other physical health issues.
- Newly eligible – if they move to state or have a reduction in income they can access care.
- How common mom and baby clinic is around the state. Does this enhance their care-seeking behavior?
 - Not a common thing that is offered.
 - Swedish has the Lidel center that can look at c-sections, take blood pressure.
 - Really helps with long-term breastfeeding.
 - Not every person who delivers with fam med sees them for baby.
 - Getting more care in closer proximity to the date of delivery. Is that a reachout to someone in their home?
 - In Spokane newborns are seen @ 3 days of life by FM or Peds if this is done around the state could this be an in home visit by ARNP/PA-C?
- Family connects – proprietary home visiting model. Nurse delivered. Goal is 3-4 weeks largely screening for mental health.
 - Oregon is struggling with nursing staff. Costs about \$800-\$1000/person. Pierce county is piloting family connects at St. Joseph's and an additional hospital.
 - What is the level of comfort with having people coming into their home from a privacy standpoint? Or readiness/desire for visitors? If we focus only on home visit, does this introduce another barrier?
 - Beth - do you know how Family Connects coordinates with existing home visiting programs?
 - They are explicitly referring to ongoing, more intensive home visiting for families who are interested. Problem here is are there home visiting slots/availability for families? I did some analysis and statewide by county between 5-10% of eligible families are enrolled in intensive home visiting programs. Not that all families want/need them, but the need is probably greater than this, I assume that it is.
 - In the Pierce County Family Connects pilot they are finding thus far that about 80% of families are accepting the home visit.
 - Perhaps we could modify the Family Connect approach with nurse and other trained roles working within a set algorithm. Hybrid approach is reasonable
 - MA did a homegrown family connects model.
- Evergreen added psych + counseling services – hybrid model. Doesn't need to be centered around the hospital.

- Nonclinical members of a care team that are value-added.
 - Doulas – Doula Coalition is writing a bill for this next session. Utilization of doulas in other states (OR, MN, NY) has been low.
 - Community health workers – popping up a lot at HCA.
- Individual support that modes into groups for peer support. Scaling the training and background with intensity of services over the year. Group approach is an adjunct. We cannot expect instantaneous results – need to get back to Legislature that we need funding. Most cost-effective and value-added. Multi-factorial approaches.
- Many obs have knowledge gap – about contraception and other resources.
- More ready resources for pediatricians would be useful. Being socialized to the idea that you can and should be seen sooner rather than later.
- Outreach to providers and outreach to clients about Medicaid extension.
- How do we incent utilization?
- Going back to the birthing hospital. Some RN home visits can only do 2 visits a day. Very difficult to get to rural areas.
 - Hospitals doing everything to get people out of the hospital and not come back. If we want people to participate in this are we putting up one more barrier. Trying to get follow-up clinics out of the hospital.
- Building in functional pathway of what resources actually are available to people.

CLOSING COMMENTS

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