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## Bree Collaborative | Perinatal Bundled Payment Model Workgroup

September 28, 2021 | 8:00-9:30

Virtual

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### Present

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Trish Anderson, RN, Washington State Hospital  
Association

Molly Firth, MPH, Patient advocate

Mark Schemmel, MD, Providence Spokane

Tami Hutchison, Signify Health

Jennifer Lambart, Signify Health

Dale Reisner, MD, Swedish Medical Center

Ginny Weir, MPH, Foundation for Health Care  
Quality

Amita Rastogi, MD, Signify Health

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

### INTRODUCTIONS

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

### GENERAL DISCUSSION

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Ms. Weir, reflected on the discussion at the August meeting and whether to continue the discussion of perinatal care 4-12 months.

- Whether we lose the incentive-aligning property of the bundle through extension.
- The HCA PMPM model integrates social needs and behavioral health with primary care. For the postpartum period this may meet our needs. Why create a new model? This has a team-based approach etc. The missing link is how to connect back the mother to the perinatal bundle. How to we integrate this?
- Consensus on the two-episode approach. Could more easily morph this into a mom-baby dyad more easily.
- Cardiovascular events also of concern. Build parameters of what should be in this year that are different – layering on these components that impact morbidity and mortality.
- Signify health – transitioning to a new bundle initiator. The ob/gyn is not necessarily taking on the second bundle. Someone must take responsibility for the second piece. Member id is the link.
  - Need to ensure that someone is taking on responsibility of care for this person.
- That MCOs are given a total cost of care budget under which to provide care. Incentive is there to make sure the person is not dropped.
- Whether we know percentages of who is providing ob care for the Medicaid population.
  - Midwives ~10% and of that 2% community births
  - Obs/fam med split will get back.
- Community health centers provide continuity of care from labor and delivery to postpartum care.
- Within Swedish, bulk of Medicaid births are Swedish-employed physicians.
- MCOs responsibility that transition happens and there is documentation of that transition.
  - All MCOs have a requirement that the person has a PCP.
  - Roll up whatever the expectation is for the individual provider for the MCO. You want the MCO to be required to do what the provider is required to do.
  - How to address when a person does not choose to follow-up – do not want to create an ask that is not possible to meet.
- Quality metric within the bundle to identify a source of care for the person receiving care if it is not them.
- Challenge of shared accountability and the challenge of creating capacity to see patients. Speaking from Spokane region, need to contend with access.

- Unintended consequences: are we making sure there is a PCP and automatically giving them a payment without any activity. In the HCA model there is a PMPM and a per encounter reimbursement.
  - Success is that someone is meeting with the dyad at least once or twice within the period.
  - Need to make this as palatable as possible for organizations to do since we are not in a space of universal coverage yet.
  - We cannot add must do monthly visits. Need to be strategic in requirements – whether mental health check in at 6 mo and 9 mo etc.
- What may come up within this second episode.
  - Bleeding episodes.
  - Need to create quality markers.
- When does the episode start – when they schedule an appointment? Or at month 4 when the PCP reaches out?
  - Outreach and assessment could be executed in number of ways.
- Providing cell phones also critical to make program successful.
- Can we reach EDs around the state to screen for behavioral health when they have an encounter and to receive information about the person.
  - Make system be more interactive instead of just telling a person to go see their PCP. We don't have integrated whole-person care. If we want PCPs to be responsible, we need to give them information.
  - Network of suppliers supplied to the provider of meeting social needs. Passing the information of if a visit happened. Aligning the incentives to do that from the PCP.
- For other states that have done bundled care is there anyone that has done 12 months?
  - Some chronic care models are 12 months. Not perinatal but can use some of the quality metrics and the administration.
  - What is the MCO role in following-up after an ED visit. Can be expectations of communication. Need to help Eds know this person has a PCP. Need to shore up two-way communication between ED and PCP communication in the same way we did for pediatric and ob providers.
- 20% of pregnant people are not managed care.
- Between 4 and 16 months what are we missing for the postpartum population: cardiovascular, thyroid, diabetes, pelvic floor issues, behavioral health.
- Requirements to establish care shouldn't include an in-person visit as so difficult to bundle up baby. Should we allow for a telehealth appointment? Should that require a video? Might not be possible in areas with poor internet access.
- How available are telehealth visits? Largest increase in telehealth is behavioral health.
- Need to think about provider and patient side. Video makes visit so much more robust. Audio-only is better than nothing.
- Quality metrics for bundle 2:
  - Depression, anxiety, substance use disorders, alcohol
  - Contraception
  - Social needs assessment
  - Cardiovascular? Not sure if there is a separate call-out or is part of the overall care of the person.
  - Follow-up after an ED visit.
- Exposure to liability for suicidal ideation.
  - Ordering an in-home evaluation.
  - How do we build this into the program.

- Is the screen really the goal? A patient-reported outcome is the dream. We are trying to incentivize care that is
- Universal home visiting? Copying the Oregon program? Want to focus
- Decision package from the HCA to fund Home Connects pilot with three tiers in two counties.
- HCA is convening a focus group of people who were on Apple Health to get their feedback. In November.
- Evaluating postpartum coverage – RWJ grant was not accepted – HCA data and analytics folks are interested in making an internal team.

Action Items:

- ADD: Quality metric within the first bundle to identify a source of care for the person receiving care if it is not them.
- Layer on top of the existing model HCA PMPM multipayor model:
  - List quality metrics as outlined previously
  - Communication requirement between ED and PCP.
- Get MCO perspective on what they are doing now in immediate perinatal time.

**CLOSING COMMENTS**

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