

LAN Summit Session Transcript

11A: Improving the Delivery of Maternity Care Via Episode Payment: Opportunities and Challenges

[Presentation begins at 00:09.6 seconds]

[Cara Osborne]

So um... they're still ringing the bell out in the lobby, but I think in the interest of time and to leave time for questions at the end, uh if it's okay with everybody we'll go ahead and get started. If that sounds alright. Um... So I guess since I've just flown in, I remember most of it, but this is your last chance if maternity care episodic payment isn't the destination of choice, this is your last chance to leave before we take off on this um... flight here. My name's Cara Osborne. I'm a nurse midwife. My doctorate is in public health, specifically perinatal epidemiology. Um... I was lucky enough to be invited to be a part of the CEP Work Group um... and have been helping to craft the statement around maternity care um... episodic payment from the LAN. We're really lucky today to have 2 very distinguished panelists joining us, and I'll introduce them in just a second. This slide just gives the session objectives for today. I'll go over the work group's recommendations and our um... guidance that's coming out, has been released last Friday in the white paper that's available for public comment and then will be finalized in June. Um... we're gonna talk a little about the current innovations around paying for delivery of high quality care. Think a little about strategies for engaging patients and their families, particularly in maternity care because the range of experience can be so different it's important to really think about each individual person's experience of the episode as a marker of quality. And then we'll stop, I hope, in plenty of time to have a robust discussion at the end. This is just to try to help us keep on track.

I'm starting a little late, so I'm gonna try to speed it up and see if we can get through the whole thing, but we'll see how it goes. Feel free to stop me if you think I'm talking too much. Um... Okay. So just to start with the CEP work group, uhh... Lew Sandy is our Chair and he is the Senior Vice President for Clinical Advancement at UnitedHealth Group, so coming from the payer world. Um... The key activities of the group have been to develop the recommendations of the design of our person-centered um... episodic payment. We've chosen elective joint replacement maternity care and coronary artery disease. I hope that maternity care is what you're here to think about and talk about because that's what the majority of this is gonna be, but I will talk a little bit about how we came to those um... decisions about which things to look at. So, our CEP members include our Chair and 18 public and private stakeholders. The group was first launched in November of 2015. Our white paper around maternity care episode, as I said, came out last Friday. The period for public comment will close on May 23rd, so... you know... mark it on your calendar, find the time to help us with your comments and questions. The revisions and the final release date are planned for June.

One of the main concerns and challenges that the work group faced coming into this work was how, as a work group, we could add value to the field knowing that there's a lot of variety out there in terms of both the models of care being provided and the ways that they're being paid for. The LAN's goals are to accelerate the alignment and adoption of alternative payment plan models, so as such we heard that alignment part to meant that we should seek out models that exist and try to do what we could to pull out the pieces and parts of those things that are useful and that are working and then at the same time

do what we can to accelerate innovation so that we can drive better outcomes for the patients and do that at a lower cost. There's no existing model including the one that I'm gonna talk about that I live and breathe every day in maternity or otherwise that's perfect. There are pieces and parts and there's always room for improvement. And finally, we hope that we're gonna develop recommendations that are useful and provide a directional roadmap for a variety of stakeholders including providers, health plans, consumers and patients, the purchasers and the states, so in places where the state is the plan or the purchaser, um... to make sure that the state is not left out of those goals.

There are several reasons to really think about episodic payment as an alternative payment model particularly in maternity care. I'll talk a little bit about that and then our esteemed panelists, who I will introduce in just a second, will also be talking about those ways to really think about how value can be inserted into our maternity care situation. In terms of how we came to choose these episodes, we were looking for things that you see in front of you um... to help us figure out which conditions or interventions could be looked at. We looked for conditions or procedures for which there was a strong level of consumer or patient engagement already and ways to incorporate shared decision-making. We were looking for things that were currently high-cost and high-volume and certainly that's the case in maternity care. As you probably know there are about 4 million babies born in the U.S. every year and diagnosis codes around pregnancy, childbirth, and the newborn make up the biggest single line item contributor to the national health care spend.

We also think that it's important to consider where unexplained variation exists. If it is true that care is pretty uniform, the ability to effect that is somewhat limited. So looking for wide swings and if anybody saw the consumer reports um... data and metrics that came out around variations in maternity care you can see that there's certainly plenty of unexplained variation. It's also important to understand what the trajectory of care is. When there's a predictable path, even if there are several sort of swings that path can take, having an overall predictable path makes episodic payment viable in that you can determine when the start and stop dates should be and what the things to include in order to effect the outcomes might be. And then availability of quality measures. I don't think we have quality measures that are perfect for any version of health care, but we do at least have existent quality measures and benchmarks in maternity care as well as hip and knee and cardiac that let us say how an episodic um... initiative changes the trajectory of that episode once implemented.

So when we talk about what, what the um... episode design really looks like from the LAN what we're trying to do is 2 things. We're talking about design elements, so that's the green circle around the outside of the diagram and these address questions that the stakeholders need to consider when designing episodic payment models includes definition and duration of the episode and what services are to be included um... and then the operational considerations. So a great architect has his engineer in mind when he makes a house plan. So having a plan that's not something that can be operational isn't of much value. So in thinking about the operational considerations in the blue circles in the callout on the right, the broader issues related to actually implementing the episodic payment model have also been considered and pulled out. Certainly stakeholder perspective is important if the stakeholders don't buy into the episode design, then it's not got a chance, but the data infrastructure and regulatory environment have equal impact on the ability of the design elements to be implemented.

So in looking at what the goals of the episodes really are, the overall arching goal for the maternity episode is to improve the outcomes and the experience for a woman and her baby at a lower cost than

the current environment. Um... and within that the goals listed there are the specific things that we hope to um... address and improve upon. This slide just gives you the timeline of the um... episode. There have been a series of initiatives aimed at decreasing cost of labor and birth around things like early elective delivery and incentives for decreasing C-section rates. However, those things have not typically included the prenatal or postpartum parts of the episode. The work group felt very seriously about that and felt like it was short-sighted to not um... look through the whole prenatal care to see what led to what you're seeing in the labor and delivery aspect and then also having great prenatal care and a great labor and birth is only as good as the neonatal and postpartum outcomes for the mom.

So these design elements are discussed in depth in the paper and I won't take time to go through all of those, but when I say that in general we tried to include a wide population. So as many low-risk women as we could while also understanding that we needed to carve out cases that were likely to um... cause significant financial risk for a provider and would be deterrents to participation. So, because the episode is um... retrospective in that payment, for the design that has been proposed at least, payment is adjudicated after the birth has occurred. Things like pre-term births resulting in high NICU costs can be eliminated through a variety of stop-loss policies which have been suggested as design elements in the paper. Um... so I'll stop there with the work group part of the presentation and take a minute to introduce myself and my colleagues and then I'll switch hats for just a second and talk a little bit about the work that I do personally with Baby+Company. Um... Baby+Company is a network of 5 free-standing birth centers in 4 states. Um... as most of you know payer relationships tend to exist on a state level and so it's required a significant amount of work with our payer partners in order to get things up and running in the 4 states in which we're operating. Um... on the panel with me today, we have Karen Love. Karen joined, joined the Community Health Choice Organization in 2012 as its Senior Vice President for Strategic Planning and Partnerships. In her current role as EVP and Chief Operating Officer, she sees all of Community's provider membership operations, including network management claims, marketing, member services, medical affairs, and quality improvement. That's a big job, Karen. Prior to joining Community she served as the Founding Executive Director of the Harris County Healthcare Alliance and during her leadership of the alliance, the 45 member organization achieved major progress in coordinating the county's fragmented healthcare delivery system and improving access to care for the area's estimated 1.5 million uninsured and medically underserved through several key initiatives.

Um... I will let Karen tell you the rest of her very exciting work when she comes to, when she comes to talk about what she's doing around maternity care. Um... Likewise Maureen Corry is a Senior Advisor for Childbirth Connection Programs at the National Partnership for Women & Families. She joined the organization in January of 2014, when Childbirth Connection joined forces with the National Partnership to integrate maternity care policy, shared decision-making, and quality improvement into the National Partnership's program portfolio. Prior to this, Corry served for 18 years as the Executive Director of Childbirth Connection, which was first founded in 1918 as the Maternity Center Association and is very much the forbearer of the work that I do today at Baby+Company, as the Maternity Center Association led the birth center movement in many ways. Maureen is also a member of the AIM Safe Reduction of Primary Cesarean Births Bundle Work Group and the task force that developed the soon-to-be-released CMQCC Toolkit to support vaginal birth and reduce primary cesarean sections.

Um... So, you're in good company to hear about maternity here. On the Baby+Company side, um... this work really was a translational research project, so as any good academic does, I had written a big cross-sectional cohort study as a part of a research group from the American Association of Birth Centers.

Um... then took that experience and the work that came around, sort of, working through the trajectory of that study to the street, so to speak, in a brick and mortar center in Rogers, Arkansas. So um... the National Birth Center study too, which was the study that we did that um... was released in January of 2013 was a replication of a study that had been done in the late 80s looking at the outcomes and cost savings related to freestanding birth centers. And despite the wide swing in maternity care practice in the U.S., outcomes in birth centers had changed almost not at all between 1989 and the 2007 to 2010 data that we used in our study. So I... the question that I often get is: "if birth centers are so great, why don't we have them on every corner?" And I think um... payment mechanism is part of the answer to that question. What we, what we try to address every day is the following: this is not new news, our maternity care in the U.S. is high-cost. Women don't have a lot of options in most communities. Hospital care has been the default, so there's not a good system for out-of-hospital birth. Most women don't know that they have the option to deliver any other way than with a physician in the hospital. And the C-section rate has gotten, um... increasingly um... inflated to a place that, by whoever's recommendation, whatever agency you want to look to, whether it's the WHO or ACOG um... it's too high and we need to look at ways to lower it. And then thanks to Don Burwick we all have the Triple Aim to lean on. Um... I thank him for many things, not just that, but that's one of them and so having lower cost care that improves the customer satisfaction, the patient satisfaction, and improves clinical outcomes is the goal of Baby+Company as an organization. So once the initial demonstration project happened in Arkansas, we then went out to um... replicate that. We now have centers in North Carolina, Tennessee, and Colorado. Um... and it's only been in existence for a little less than 2 years, so it's moved relatively quickly, at least in health care terms. And I'll talk a little bit more about how we've gotten there but the value proposition that we take out with us when we talk to payers um... is in fact the Triple Aim, but the cost equation is this.

So this is coming from Truven Data, um... the cost of having a baby in the U.S., right? I totally understand that there's wild variation in costs in local markets and so if you're from the payer community and feel like this isn't reflective of what you see in your markets um... I understand that and also National data is the best we've got to go on. So we're looking at, sort of, the average um... charges for our service versus the average charges for uncomplicated vaginal birth in a hospital and presenting, you know, the possibility of about a 50% cost reduction. If you look at the C-section rate as not the only metric, but as a marker of level of interventional approach to low-risk care, we have um... about a 6% C-section rate, which was also what we found in the national study in low-risk women versus, you know, national average around 26.9. The care doesn't look exactly like typical prenatal care. Um... in talking about the episode, one of the things that you'll see in the white paper as you read it is concern over the ability to reimburse for services that have been well demonstrated in the body of the literature to increase um... the value of the care have better outcomes and have better experience things like doulas and intensive childbirth education, but also those things are often quite hard to um... be reimbursed for. So we have, sort of, a series of individual and group visits um... classes and workshops and then peer support groups. We also use a fair amount of telemedicine. The platform that we use is called TouchCare and that's something that can be downloaded from the app store to your phone so that it's really accessible for our families to use um... It's often the case that if you can see somebody, you can avoid an unnecessary trip in for them particularly when they have a new baby. And then we lean on a very interactive EHR called Maternity Neighborhood that lets us engage directly and also measure levels of engagement with our families.

It's a mirrored experience so that the provider and family are logging into the same record and it's setup in a timeline. A lot like Facebook so it's a user experience that people are familiar with. They're able to contribute to their own medical record directly rather than having a, sort of, patient portal that maybe gives them read access and lets them send messages, but doesn't let them do things like correct errors that may have been made in data entry that could, in fact, you know, effect care. Labor and birth, um... birth centers are, in sort of more generic terms, outpatient facilities. People come in and have a baby and then go home relatively quickly. Um... and then have home-based follow up. So, the big question that people usually come in with is "do you have epidurals?" we don't provide regional ataxia anesthesia in the freestanding birth center environment um... That doesn't mean that there's nothing. We use nitrous oxide for comfort, hydrotherapy, acupuncture, you know, a wide variety of um... comfort measures that are outside of anesthesia. Fetal monitoring, we use intermittent auscultation, which all of the literature says is just as good in terms of picking up changes in fetal heart rate as continuous electronic fetal monitoring and is likely one of the primary contributors to the decrease in cesarean rights. And then the postpartum and newborn part is maybe the part that looks the most different from, sort of, traditional hospital-based care in that um... you go home quite early, but then have um... TouchCare, so telemedicine follow-up, followed by a home visit, a one-week clinic visit, and then a normal 4 to 6-week postpartum visit. Because we have new manse groups that start at about a month out, we often are in weekly contact with our families for as many as 6 months after the birth um... and the midwives and nurses in our facilities are often also lactation consultants in addition to their underlying understanding from midwifery or nursing training so our breastfeeding success rates are quite good um... initiation of breastfeeding is almost 100% and then at 6 weeks and 6 months those rates are still quite high.

This is all kind of tiny print and it's in your slides, but the broad strokes on how we've worked with our payer partners is to say that we've tried really hard to um... approach it from really the same context that we've put forward in the white paper. Sort of an episodic rate um... It's not been easy to do that um... Our experience has been that because of the typical, sort of, fee-for-service approach rather than looking at births that are being shift, in that value equation that I showed you before, out of hospitals into a freestanding center. The rates are often pegged against birth center rates that were set some time in the 80s when birth centers were first, sort of, coming onto the market and the scene. And the individual um... sort of network administrators and contracting folks that we're dealing with at the local level have to go through a series of escalations to get to a place where they can even consider looking outside of the, sort of, suggested retail price for a birth center. Um... that being said, in the states where we are with the, potentially the exception of Arkansas, we've been able to cross those hurdles in a way that makes the birth center sustainable and allows for growth within the state.

Because transfers are looked at separately and the transfer rates are not insignificant if you're using stringent risk screening criteria, which we do, for safety um... reasons, then we can't just have a single episode. We can't just have the complete episode, but we also have to have rates that are set for intrapartum, so transfers during labor, and antepartum transfers prior to labor um... Which makes it interesting in terms of not just saying we want to set an episodic rate, but also there are 3 versions of episodic rate that really need to be set in order to make this contract viable. And then just as a last note before um... Karen and Maureen come to talk, we are also at this point a purchaser of healthcare. We have about 100 employees that we're providing health insurance for through a third-party administrator. Um... it's difficult because you have to balance what's best for your benefits overall, but

because we're a maternity care company it's particularly upsetting that the plan that we chose because it was best in general actually doesn't cover our services and we've been um... round and round about trying to make that happen and making it a carve out and whatever, but because we're, because we fall into the small employer bracket for our third-party plan, we don't actually have the ability to go outside the standard network without some pretty heavy lifting. So we're hoping that in our second year in the plan, we're able to do that, but we've, of course, been covering our services for our employers outside of the plan um... in order to avoid that, but as you might imagine when your employees are almost all midwives and nurses it comes up relatively often um... that someone is in need of maternity care and I feel really honored and flattered that, for the most part, they've chosen to have their babies with us as well.

Um... so it's just to say that as a provider and a purchaser um... maternity care is something that's um... in need of reform from a payment standpoint and something that I hope will um... have a leap forward with, sort of, the guidance and the recommendations coming out of the work group. I've run a bit over because we started late, but hopefully we'll still catch up. Karen...

[Karen Love]

The um... Medicaid Managed Care Organization in the greater Houston area. We cover about 20 counties and 360,000 um... lives. Ok, um... So after a learning journey with some of our sister community-based health plans, um... we decided to embark on a 2-year pilot um... with a maternity bundle. We, because we're in the Medicaid business, um... finance anywhere from 22 – 25,000 deliveries in any given year. It's our highest opportunity for cost savings as well as quality improvements. The range of costs you showed on your um... on your chart, my range is much wider. I have um... probably 560 OB's in my network and probably 60 hospitals where deliveries occur and so um... that's a, that's the reason we went this route. Um... we chose 2 of our academic providers, each of them deliver about 1,000 babies or more for us each year. Our pilot includes all of the relevant costs, hospital, facilities, ancillaries, um... everything that goes into a healthy mom and a healthy baby hopefully.

This picture should look a lot like the one that Cara showed. Um... our very able consultants with HCI3 um... are um... helping us do the analytic work for this and helped to put together what our bundle looks like, but we use the delivery as the trigger and then we go back and pick up all the prenatal care that occurred and go 60 days post-delivery for the mom and 30 days post-discharge um... for the infant. Um... the, we are doing both low and high-risk women. The only um... exclusions from our bundle um... initially would we decide to leave out babies who um... had to go to the level 4 NICU. So the highest level NICU babies were taken out as outliers. I'll tell you a little bit about what we've learned from that experience um... and how we're changing that for the year, for the second year.

We do patient-specific budgets. Um... we are continuing to pay these providers on a fee-for-service basis under their normal contract and what we're doing is a year-end reconciliation um... of, you know, total savings or total um... loss compared to expected budgets. Um... we are risk adjusting every one of those budgets and so this is one giant massive spreadsheet. Um... this is our quality scorecard um... happy to share that. My contact information is at the end. Um... this is the scorecard for um... for normal birth weight babies um... you can see that it includes prenatal metrics, delivery metrics, postpartum care, and baby care. This is the, the normal birth weight scorecard. The scorecard for the low birth weight babies of course has some additional metrics around um... sepsis and um... retinopathy. Those kinds of things.

Um... again, happy to share. Um... looks really neat and clean right there um... but this is really what it looks like on the spreadsheet and so in your notes and again if you'd like to have a copy I'm glad to provide it, each metric has um... has points assigned to it and so, for example, let me see, I think there's a way I can show... I think there's... this is um... gestational diabetes screening. So in this particular case 91 women out of 135 got the screening. That's about 67%. It's applied to the 5 points that are assigned to that metric and get a score of 3.37 and then we sum it all for the total um... for the providers.

We're giving them quarterly views of their data um... we've given them 2 quarters so far and um... about to give them their third, third one. We did establish um... a couple of thresholds for some of these metrics um... so um... for example, um... obstetrical trauma I think has a um... has a threshold. You don't get any points if that occurs more than 10% of the time. So it's not a pure percentage of, there are probably 4 I think of these metrics where we put um... thresholds where you get no points whatsoever.

Um... I'll have to tell you that um... I was surprised to find that patient reported outcome metrics were um... not well-known by our academic physician group partners. Um... of course they, you know, said "we do all this patient satisfaction surveys, all that kind of stuff" and didn't really understand what we meant when we started talking about this. Um... we were um... lucky enough to find um... the um... the Childbirth Connection Organization and the Listening to Mothers survey um... We actually made it, we took that survey and um... cut it down a little bit. It's still 43 questions um... but um... trying to make it a little more manageable for the population that we serve. Um... but certainly all of the, all the things that we want to um... ask those moms about. Um... what I'm learning here, I sort of knew this ahead of time, but what I'm learning at this conference is that, you know, we are not engaging our moms um... because we're using the provider groups and they're identifying the mom at delivery and then we're going back there's really no identification of the mom on the front end and so my response rate on my um... mom survey is really low. Um... probably if I were engaging my members on the front end that I might get a better response rate on that so that's certainly something I'm gonna take back as a lessons learned.

Um... this is the first quarter results for our um... 2 providers. You can see um... the top group is doing a little better than the bottom group. Let me see something here um... find my stats... So the top group um... has only about um... 12% of their um... episodes that are more than \$3,000 over budgets. Um... the other 88% are plus minus 3% or even more than um... plus minus 3,000 or even more than 3,000 under budget. So that, that group is doing better than budget by about 11%. The bottom group has a higher percentage of um... of episodes where they are more than \$3,000 over budget, that's about 19% and we think, you know, that accounts for the primary financial difference between what the 2 groups are experiencing there. They are over budget; this bottom group is over budget by about 8%.

So um... I told you we decided to do um... level 4 NICUs as the exclusion criteria for some of our babies but what we found is that that's not really as objective as we thought. Um... we see significant differences in the percentage of babies that go to level 4 NICUs amongst our, between the 2 provider groups. And so it's not, we're learning that's not the right way to think about outliers. Um... we saw some um... particular um... high-cost babies, um... one or two with birth defects that, you know, don't get them into, they're very costly, but they don't get them into the level 4 NICU and so um... we are going, we are making a recommendation, I've already talked to our providers, about going to a stop loss situation for year 2 as a way to identify the high-cost babies and do something different outside the bundle for them.

Um... our first year model is uh... sharing the gains uh... only with our providers. We'll add downside risk, we are adding downside risk. We're in the beginning part of the second year um... and then obviously in the third year we hope to move away from our current fee-for-service model and go to um... flat dollar amounts with some kind of periodic reconciliation. Um... this is to give you a picture, and it actually doesn't show the whole thing on there so I'm sorry you don't have that. Um... one of the things that we were, we're in the process of proposing that risk-sharing arrangement for year 2. What does the downside look like. And what we wanted was more of an asymmetrical model. There's not a possibility to um... deliver care for free, right? So we have to have some um... protection for the providers, and I want to get to my example so I can give you the actual. So this is what we're looking at proposing. The center column is the change in their, in their quality score. So this top line says that if from year 1 to year 2, their overall quality score for that provider goes down by 20 percentage points, um... if there's a loss, they would share 50% of the loss, but if there's a gain, they're not gonna get anything of the gain because their quality went down. What you can't see on the very bottom of that slide right here um... would be the opposite um... picture which says that if their quality scorecard goes up by 20 percentage points, then they, if there's a loss they only share 25% of the loss, but if there's a gain they get 75% of the gain. So we're trying to make it a um... a more um... palatable downside risk proposal for our providers.

Um... for us as primarily a Medicaid plan, there's really not anything else that comes close in terms of volume for bundles. So um... maybe a year of care for an asthmatic child, you know, might be something that we could look at a bundle for. Um... we only had 40,000 lives in the marketplace last year. This year it looks like we'll have about 100,000 so maybe we can start to look at some of the other bundles that many of you have been looking at for joint replacements and cardiac procedures. And I think that is it. Again, happy to share any of the materials that we've developed. Maureen...

[Maureen Corry]

Thank you. Good afternoon. Thanks for joining us. I'm Maureen Corry. I'm Senior Advisor for Childbirth Connection Programs at the National Partnership for Women & Families. And um... I'm pleased to tell you that the National Partnership is honored to be a Committed Partner um... organization from the onset. In fact, my colleague Carol Sakala, who is Director of Childbirth Connection Programs at the Partnership is next door. She's on the Episode group and she's next door presenting the joint replacement paper and Debra Ness, the President of the National Partnership is a member of the Guiding Committee.

So, today I'll be talking with you about our views on the implications of the recommendations for childbearing women and families. Especially on the elements of patient engagement. And I'll end with a quick overview of our programs, Childbirth Connection programs and resources that we think may be helpful to you as you go back to your respective uh... businesses and communities to implement recommendations. So I think Cara... Uh... Cara mentioned that we're going to be 100 years-old in 2 years. Um... and it's amazing how time flies [laugh] Um... it's really exciting we've uh... I joined the organization in 1998 and in 1995 and in 98 we launched a long-term national program to uh... promote evidence-based maternity care and then over time we evolved into much more of a policy and research focus.

Um... so we are um... supportive of the purpose and goals for maternity episode payment. Uh... we think they're well-stated and we've been saying a long time at Childbirth Connection that we believe, based

upon best evidence about safe and effective care that exists, that rapid gains in the quality outcomes and value of maternity care are within reach and we really feel like this episode paper really is going to help propel that forward. Um... we appreciate the design elements and operational considerations that they're based upon existing maternity episode models to date and we're pleased that it includes aspirational elements too and that is, someone said this morning, finding a balance between the short-term realism and long-term aspiration is a good thing, but a challenge as well. As for the operational design elements, we're pleased with the broad episode definition; encompassing prenatal through postpartum care timeframe as well as the episode timing as described by Cara earlier. Um... and as for the patient population, we're really pleased that the episode group has the belief that the model should be as inclusive as possible. Enabling as many women as possible to participate and benefit from incentives to improve care.

We agree that it's important to consider the 2 types of underused services that present challenges. Um... we think it's really essential that uncovered high-value services be considered and that decisions be made on whether to revise the benefit design for these purposes or to allow flexibility for the accountable entity to use these services to achieve goals. Also critical is to consider the type of provider and birth setting. As research shows, as Cara pointed to earlier, impressive benefits of midwifery-attended births, now comes in birth centers. Now I'll just turn to some strategies included in the paper for engaging women and families in their care which is really a focal point of the work that we do at Childbirth Connection and the National Partnership as a whole.

Um... as we all know, pregnancy and birth are pivotal events in a woman's life and it's a perfect opportunity to engage women in their care. Um... remembering that about 85% of women are healthy and at low-risk and have every reason to anticipate an uncomplicated birth and we have 9 months in which to engage them. So it's a really exciting opportunity that may be different from other issues in healthcare. Um... and we're pleased um... that episode maternity care was included because I think Cara alluded to the fact that existing maternity alternative payment models have largely overlooked the potential for consumer engagement to be a major driver of high-value care. So this is an area where this work can really make important contributions. And here's some of the more important high-impact strategies that we think are important. Um... helping women understand their choice of provider and birth setting and how they're interrelated and given the extent of practice variation that we talked about earlier, could greatly impact their care options, their experiences, and their outcomes.

And uh... to enable this, we must provide women with access to comparative quality data for decision-making on providers and birth settings and also provide support to the women for finding the information and interpreting it. Um... and it's great that we uh... will incent systems to build women's skills, knowledge, and confidence as they approach new birth and parenthood by um... I think it's alluded to in the paper um... by measuring change in activation scores using the patient activation measure developed by Judith Hibbert. Um... and we recommend that that would be done early in the pregnancy and later on to measure changes in activation levels and act accordingly to where that individual uh... woman is.

We think that integrating shared care planning into the episode is really important. It should include goal-setting, shared decision-making, followed by informed consent. Documenting preferences and uh... the right, the appropriate use of technology to make information available to women in CareTeam, like Maternity Neighborhood does, that Cara alluded to earlier. And also too, it's really important to provide

women with access to high-quality, evidence-based, non-biased childbirth education. We know that more and more women are not attending childbirth education classes, so we need to find a way to engage them and bring them back into that setting, which was so popular for years and um... with people's busy schedules it's sometimes hard to motivate them. So we need to find a new way to reach out to them and provide that education.

Um... it's important that we educate women about the benefits of Doula's continuously through labor and birth and include um... these as an enhanced service. Uh... also to consider other, other enhanced services including patient navigators, group prenatal care, and the maternity home, and I think the strong start results that should be out in the next year will be very valuable in telling us um... how uh... the importance and the impact of these um... these services. And also to provide online access to high-quality decision aids and uh... to enable uh... the use of those decision aids to take the woman and her family and her provider through a shared decision-making process that will um... focus not only on the benefits and harms of the particular intervention that's being discussed, but also put that into the context of the woman's values and preferences. Um... and as Cara alluded to, ready access to full health records would be ideal.

Um... we also hope that uh... those of you who implement this model will inform women at the receiving care within an episode payment and tell them the implications of such a care model for cost-sharing quality outcomes and participation. I think it's really, really important that women understand that providers and all the stakeholders are really interested in improving maternity care. Because there's a lot of negative press out there that would say the contrary to that. And if we don't educate women and let them know what we're doing, that, that's in their best interest, that we care about not just saving money, but improving quality of care, we'll be missing an opportunity.

Now I'd just like to spend a few minutes on quality metrics. Um... Childbirth Connection and the Partnership are very involved in performance measurement in a variety of ways. So, we all know that we want to prioritize parsimonious set of high-impact nationally-endorsed measures with low burden of collection um... that capture quality and that are aligned across programs. Um... some of the measures that we think are most important are listed here; gains in the patient activation scores that I mentioned earlier, cesarean section, especially NTSV for first-time mothers, exclusive breast milk feeding, unexpected newborn complications, um... which is going to be uh... is going through the NQF process right now. The name has been changed to healthy term newborns and it's a good balancing measure for cesarean section. Also contraceptive care in the postpartum period is really important in screening for clinical depression in follow-up.

Um... we also think it's important, and I think Karen alluded to this, um... that we do a better job of capturing patient-reported outcomes and functional status measures. We know from our national Listening to Mothers surveys that women um... suffer from a large number of postpartum um... morbidities that they, in their minds, they feel are associated with the birth process. So we need to really address that and try to find a way to make postpartum care more palatable and appealing to women than what they feel about it now, because many don't go to the postpartum visit. Also we would love to see, and have been working for a long time um... to, a call for an adaptation of the CAP survey to make it more appropriate for maternity care. Um... that's, it's a big stretch to, to see that happen, but um... we're really pleased that Karen, for example, you're using some of the Listening to Mothers questions to get, get at the maternity experience in a more fruitful way, I think.

So [clears throat] I'll shift over to talk a little bit about um... our programs and really some of the resources that we have that might be helpful to you as you go about your business. Um... our mission is to improve the quality and value of maternity care through consumer engagement and health systems transformation. We've over the years provided leadership on promoting safe and effective care, evidence-based care, improving maternity care policy and quality, and really focus a lot on our website especially on helping women navigate the complex healthcare system. We're currently focused on advancing effective strategies for maternity care quality improvement including innovative delivery systems, value-based payment systems, consumer engagement, and performance measurement. And we work across the continuum of clinical effectiveness resources and activities including with systematic views that really frame all of our work. Performance measures, decision aids, and clinical practice guidelines. And we also represent maternity care and health care consumers more generally on a broad range of advisory bodies and work groups and my colleague Carol Sakala who's next door delivering the joint paper is Co-Chairing the um... NQF Perinatal Reproductive Health Consensus Task Force that's meeting right now to review existing maternity measures and consider possible new measures to fill in gaps.

We also partner with organizations and agencies from diverse stakeholders uh... with diverse perspectives to advance high-value maternity care and health care. And uh... we recently, about 2 years ago, completed a partnership with the Informed Medical Decisions Foundation in Boston to develop 3 maternity care multimedia decision aids. 2 on, around induction and 1 on VBAC versus planned cesareans. And since that time, we joined the Partnership, the National Partnership and the Informed Medical Decisions Foundation merge with Healthwise. So um... multimedia decision aids are available through Healthwise if anybody's interested.

I want to shift uh... to sharing some specific uh... resources for women and health professionals that would support the design and implementation of episode payment models. Over the past decade we've conducted and reported 5 landmark national surveys that describe women's childbearing experiences. Um... pre-pregnancy through postpartum. And uh... the surveys were done on, well, a variety of samples, but close to 2,000 women, um... they were conducted by Harris Interactive and um... they really paint, the results paint a panoramic view of what's happening to women in um... in hospitals who give birth to healthy singleton birth. And I think if those of you interested in consumer engagement, if you could get a hold of those survey results and really take a look, it might be really helpful to you to see. It's really easy to answer a yes or no question, but we gave women an opportunity to answer some open-ended questions like "what are you, what's the best thing that's happened to you and what's the worst thing?" and on our website are a series, there must be 1,000 quotes from women, that really tell the story from uh... a consumer experience and I encourage you, if you're interested in this particularly, to check that out.

Um... we also um... whoops... We also commission Catalyst uh... Truven Health Analytics along with, we've partnered with Catalyst for payment reform and the Center for Health Care Quality and Payment Reform to commission a Truven Health Analytics report on um... the cost of having a baby and there's lots of really interesting material and in fact Jesse Bushman from CNN was telling me how he's been able to use the results of that report to uh... take a look at midwifery and cost issues around midwifery care. So if you're interested I encourage you to take a look at that. It's got many different models of cost, including maternal newborn C-section versus vaginal, Medicaid versus commercial, and also has state-level payment data for 5 states and I know one is California and I can't remember the rest right now

but... Um... Carol and I and uh... a physician named Tony Yang uh... issued this report: Maternity Care and Liability back in 2013. Uh... pressing problem substantive solutions because we had heard, you know, so many people were talking about liability concerns as driving um... overuse um... and so we did an analysis of all the empirical literature that we could get our hands on and it's all reported in this report. Um... and I think the major finding that makes us all feel really good is that rigorous quality improvement programs rapidly lead to plummeting of claims, payouts, and premiums and there's this series of fact sheets that um... may be helpful to you and um... your administrators and providers that break down all of the different aspects in the report, so you might want to check that out.

Um... we also issued a recent policy brief called Overdue Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health that talks about all the benefits of doula support in reducing c-sections um... and increasing satisfaction among other things uh... as compared to usual care. So um... really I urge you to take a look at the report and if you haven't considered providing, including doulas in your incentives, um... please think carefully about it. Um... in 2015 we released a commission report called uh... Hormonal Physiology of Childbearing: Evidence and Implications for Women, Babies, and Maternity Care and we commissioned a woman from, a physician from Australia to do this work because she had done a lot of, around the hormones of birth. And um... it's a 100-page report that talks about the hormones of birth and what happens when we interfere unnecessarily in those hormones through interventions during labor and delivery. Um... and there's also some guidelines and recommendations for how to address what we, what, the findings of the report. And there are infographics for both health professionals and for women and a series of fact sheets that breaks down what in some, sometimes is a very challenging portion to read, but I think we've done a fair job of bringing it down to uh... a way that most people would be interested. So check that out.

And we have some resources for women. Pathway to a Healthy Birth which kind of breaks down and communicates in a user-friendly way, the information that we learned from the hormonal physiology report. And basically what we're talking about is how to provide good labor support to women. Labor management to women in um... in the intrapartum period and promote support and protect physiologic birth, which hopefully will end in a safe vaginal birth for more mothers and babies. And we have a booklet *What Every Woman Needs to Know about Cesarean Section* as well. And um... that's it for now, thank you and I guess we can take some questions Cara.

[Cara Osborne]

Yeah, Jesse...

[Maureen Corry]

Do you want this over here?

[Cara Osborne]

I think we can probably take it from... Yeah, shoot.

[Jesse Bushman]

So, my name is Jesse Bushman and I work for the American College of Nurse-Midwives. Um... and I have a comment and a couple of questions. The first comment is that if I was a health plan, Cara, I would be banging on your door and with bended knee begging you to be in my network.

[Cara Osborne]

Yeah, it's funny how that's not how that happens.

[Audience Laughter]

[Jesse Bushman]

And, and if I was...

[Cara Osborne]

I would do that if I were a health plan too

[Maureen Corry]

They would do that if you were in Texas

[Cara Osborne]

Maybe I'll come to Texas

[Jesse Bushman]

If I was a woman having a baby, and I wanted to avoid a 10-inch incision across my abdomen and reduce my chances by a significant percentage, I would also be at the same spot.

[Cara Osborne]

Yeah

[Jesse Bushman]

Um... the question is, in your white paper, one of the models that you talk about is the possibility of, say, birth center or home birth midwives partnering with um... hospitals where there's a single bundle that's provided to this provider group, uh... single payment provided to the provider group.

[Cara Osborne]

Yeah

[Jesse Bushman]

So, the care starts at a lower level facility like the birth center

[Cara Osborne]

Yeah

[Jesse Bushman]

or a home birth if somebody wants that and then if there needs to be a transfer then, you know, between the providers they worked that out. And if I was a payer, I would look at that and say "this is awesome, I love this, right? To save me gazillions of dollars" and if I was a... and if I was a birth center or home birth midwife I would say "this is also awesome" um... but if I was a hospital I would look at it and say "not so awesome" um... market share.

[Cara Osborne]

Well, so it depends on the hospital. So that's actually part of the evolution of our relationship with the WakeMed system, which is in the research triangle in North Carolina. WE started as joint venture partners in the birth center and then now have pulled their employed practice and such that we've got a pretty continuous, sort of care episode. The midwives now have privileges in the hospitals so can keep more of those transfers themselves and are definitely working with the Wake ACO group to work toward a sort of flat rate that would be inclusive of facility fees, either in the birth center, in the hospital, and provider fees across settings.

[Jesse Bushman]

And, and I guess my question would be how did that happen? How do you get the hospital to start seeing this as something positive for them other than, as opposed to a loss of market share to other providers?

[Cara Osborne]

You gotta pick the right hospital. Um... I think, but also uh... maternity care for the grand majority of hospitals is a loss leader. It's like candy in the checkout aisle at the grocery store. They're in the maternity care business to bring families into their network who later are gonna need hips and knees and cardiac and things that generally carry more of a margin. Uh... and so in some of our hospital partner examples, for example with Vanderbilt in Nashville, Tennessee, they're way overcrowded and they brought us in to decamp volume out of the hospital so that they would have uh... room to take care of higher-risk regional referral cases. In the WakeMed example, it was really, actually meant frankly as a volume driver. A marketing hook. To say, you know, we're one of 3 or 4 hospitals in the triangle that do labor and delivery. We're the only one that's directly partnered uh... with a birth center. Um... the Chapel Hill center that's with UNC is not directly partnered and so the hospital involvement, never mind what the safety issues are, and certainly that's my priority in terms of concern, but also just from making sure the incentives are all aligned in the same direction um... you're exactly right. A situation in which there's a flat rate regardless of, sort of, ultimate provider and place of delivery is the, like, you know, sort of shining star to work toward.

[Jesse Bushman]

So my other question is for Karen, and that is on, when you guys are looking at the quality metrics that providers are producing, um... there's a problem that's kind of developing, that's actually been there from the inception with the accountable care organizations and that is that you're looking at somebody's performance relative to a benchmark and that benchmark is usually their own performance in some prior period. And then you have your performance period. You try really hard to improve and you do better and you get rewarded for it. And then there's your next performance period wherein your benchmark becomes your first performance period where you are trying to do really, really good, and now you're trying to beat yourself um... and you get into this spiral making it harder and harder to demonstrate improvement and I'm wondering if you guys have thought about that and how... what's a good way to respond to that?

[Karen Love]

Well I'd say first of all in our marketplace, um... we're a long way from getting close to that, you know, that floor, if you will. Um... so I think there's a lot of room for improvement year over year. Um... we

also, that was part of our thinking in doing that asymmetrical um... model of sharing so that um... so even at the, even at zero change in your, in your quality um... you still got a better percentage of the um... gain than you did if you, if you had a loss. Um... so trying to reward the quality improvement as well as the cost improvement but um... My answer right now is that we just have a long way to go before we're anywhere near the floor.

[Audience Member]

So I'm with the National Rural Health Association and I love all of the things you're talking about. About integrating women, but my concern isn't that yet because in rural America there's just not access to delivery services. More than 50% of rural counties don't have, either through a primary care provider or an OB-GYN, access to delivery services. Um... in rural America you're considered to have access if within a 2-hour drive you can go deliver a baby. Now, never delivered a baby, but it doesn't seem like something you want to do on a road trip. Um... and so [laughter] so um... You know that's really my big concern and my concern with this bundle concept, as much as I absolutely love it, is that it's going to make the access problem worse because it's going to make these patients less desirable in these sorts of bundles. Um... you know? When you're, you know, a 4-hour drive away from the only place where you can deliver in a non-emergency sort of way, you're looking at women who have to make the decision, ok do I take a couple of weeks off work um... and stay in a hotel so then I'm near the... near enough to the hospital or do I have family that I can stay with that's close enough that, that I would be near enough to that hospital. Um... you get a lot of women who elect to be induced or have elective C-sections, not because they want those services, but because there's just no access to care and so um... I have some huge concerns um... about this concept in that there are, you know, 20% of women that live in rural America um... already don't have the access to the service and what is this going to do um... to, kind of, moving in that direction.

[Cara Osborne]

Yeah, so just to start on that because... I'm from, I'm from eastern Kentucky and it doesn't get a lot more rural than that and uh... living and working in northwest Arkansas where we spend most of our days thanking God that Mississippi exists so that we're not last on most health care indicate. Texas always does better than us, but we can usually rely on Mississippi to help us out at the bottom of the list. Um... it's absolutely the case that people don't have access and often what they do have access to is something they don't want. So, um... we're the only birth center in the state of Arkansas and, honestly, I can tell you it's been an uphill fight the whole way and I'm not sure that it'll last a whole lot longer because we haven't been able to, sort of, get over a variety of the hurdles that make things hard in a state like Arkansas but uh... What I'll say about that is theoretically, should big payers and Managed Medicaid programs adopt this sort of bundled payment uh... structure it actually makes maternity care a more attractive business to be in. So for somebody like me that runs a business that's built to go serve people in not-that-easy-to-get-to places um... having an episodic payment structure that recognizes that what we're doing is um... of significant value rather than, sort of, saying "well birth centers cost less to run, so of course it should cost less and we're gonna pay you even less than..." rather than saying "it's a significant savings from hospital birth". I think um... one of the things that's happening really broadly in healthcare but I think even more acute in maternity care is the consolidation effect; particularly across rural counties where there's a real effort to, kind of, drive people to the centers rather than pushing services out into the communities and um... The good news for somebody like me is that leaves a lot of empty real estate in hospital buildings um... where things like uh... sort of, hospital-based midwifery

services or in-dwelling birth centers are a possibility. So I actually think it doesn't discourage um... additional maternity services, it just encourages a very particular sort of maternity service, which we hope would be higher value and better for those folks anyway.

[Audience Member]

Yeah and, you know, I do appreciate that um... I would like to see a little more on, kind of, uh... a stop gap to ensure that it doesn't further erode access issues I guess would be my comment.

[Mary Jo Condon]

Hi, um... my name is Mary Jo Condon. I work for um... the St. Louis Area Business Health Coalition. Um... we um... tried a couple of years ago to put together a maternity bundle and um... what stopped it um... was a lack of agreement on the population in the quality measures. So um... I so appreciate um... you all um... and the LAN putting forward kind of an overview or an outline of what that might look like um... and just texted my boss that we need to revive that idea now um... that we have this um... uh... 2 questions thought. Um... one is um... when going about the contracting for that, um... how do we make sure that our independent OB-GYNs are not left out? Um... and um... kind of keeping um... that level of patient choice um... as well in the mix and then also um... how do we convince people of um... the need for doulas as someone who hired a doula with my first pregnancy and plan to again um... A lot of people kind of look at you funny, so do you all have resources on that? Maybe that's a good question for Childbirth Connection.

[Maureen Corry]

Yes, we do. We um... Our website childbirthconnection.org has a whole section on labor support. And also we have the doula paper, but that's not written for consumers um... But anyway, go, yeah check it out at childbirthconnection.org. Um... I think it'll be very helpful. And it's written, you know, for women to be accessible based upon best evidence and there's like 30 years of evidence. I mean it's just, compared to usual care 28% reduction in C-section, other great things so. But doulas prob... one of the problems is the expensive doulas, you know? It's... in the New York area it can be as much as \$2,000 for a birth so I'm sure, I'm sure it ranges, you know, 500 and less, but a lot of hospitals going to community-based programs where um... they're given, it's a complimentary service and they engage the community. It's a great way to engage women who have had babies in the process um... to help other women in their communities so it's another way to think about it.

[Mary Jo Condon]

Karen, maybe you can talk about the contracting.

[Karen Love]

Yeah I do think that it's uh... it'll be a difficult thing to do because um... certainly there are lots of pressures that are forcing, you know, small physician group practices, you know, into larger groups. Um... part of the problem will come and um... if you want to make that single bundled payment to the accountable entity, that solo doctor probably doesn't have the capability of distributing that payment amongst the others that he or she participates in the care with. So how does that provider split the, you know, split the cost with the neonatologist if, you know, there's one involved in the early uh... stages and with the hospital. I don't know that I have a good answer for that. Um... I don't know that um... that solo practice provider um... is ever going to have the um... the margin to do some of the things that

we're talking about like with doulas or other services. I mean their margins on their businesses are so small, it doesn't matter if I'm making a bundled payment to them and I'm saying "you can use that bundle for anything that you want to, you know, you can hire a doula if you want to. You can use that payment any way that you want to" um... their margins are so small it's hard for them to, to bring those resources in. So I'm not sure that there is a good answer for the solo OB practice in this model.

[Betsy Wieand]

Uh... Betsy Wieand with the American Congress of OB-GYNs. Thank you so much for this presentation and for the white paper. Um... something I was very pleased to see, and I had some advanced notice that it would be in there, is that you guys really insisted on including the infant's outcomes and costs. Um... we've seen some really disturbing uh... multi-payer initiatives in certain states that only look at mom's costs and they don't look at the infant's costs or whether you're avoiding a NICU admission or just a bad birth outcome, whatever it may be. So one, thank you for uh... looking at the entire uh... point of giving birth. Um... and I've heard from those states that they just can't make the data linkages so, Karen could you talk about whether that was a problem for your uh... plan or whether you've heard, or any of you have heard that from other groups?

[Karen Love]

So I hear that's more of an issue for the commercial plans because um... we're primarily in the Medicaid business and we're only doing this pilot program right now with our Medicaid program, not the chip, or chip perinatal moms. Um... those babies are automatically, you know, assigned to us and so we know about them right away and we're able to use proxy numbers if we have to in, in the interim. But I do understand that that's, I mean I didn't know it until I got into this, but that has been a question for me almost everywhere I've gone. How do you link the mom and the baby?

[Unidentified Voice]

They're on the same plan.

[Karen Love]

Just not that hard for us.

[Cara Osborne]

Uh... just with my epidemiology hat on I'll say that um... that the issue tends to be that there's not a uh... cross-linking identifier from the mom's record and the baby's record which uh... unfortunately, even exists on like birth certificate data. You know it's really difficult to then say what the baby that was born against that birth certificate looked like or went on to do in life. Um... that being said, I see that one of the panels is about data and data use and data linkage. I think uh... as we, sort of, evolve the state health exchanges and those data warehousing exchanges, that's gonna exist for a few more years, but it's gonna be something that fades over time. It won't be a good excuse anymore.

[Betsy Wieand]

Um... Just one other quick question about uh... postpartum contraception and I know that was one of the high-value services that you recommended in the white paper. Um... I, can you just talk a little bit about um... how you handle it in your plan Karen?

[Karen Love]

So, it's only been within the last year that Texas Medicaid has covered LARCs. Um... so I don't have any, it's not built into the historical data and budgets. Um... I am uh... more than happy to include that in my bundle. I guess the question um... you know, for us as the plan is: what is it that we can do? Um... we can certainly provide um... educational resources uh... Maureen and I were talking about that ahead of time trying to better educate um... the women in our community um... working with our provider groups to be sure they're educated about it, they understand that it can be paid for. At this point I would just have to do a pass-through add on to my bundle payment just because it's not built into the history um... but I would absolutely be willing to do that if, if there were some way of encouraging it um... use. And one of the questions that maybe you, maybe I could, we could change, exchange cards afterwards. What I don't know to be able to do that um... that education is um... the evidence base to support doing it at the time, you know, right after delivery versus doing it some period postpartum and so

[Betsy Wieand]

Absolutely [laughter]

[Karen Love]

I need that education to be able to educate, you know, our moms.

[Betsy Wieand]

Okay.

[Magda Barini-Garcia]

Hi. I'm Magda Barini-Garcia. I'm at CMMI. Um... I'm an OB-GYN by training and I was wondering um... where VBAC, how does that... does that fit into this picture or is it part of a different picture?

[Karen Love]

So for us, built into the um... expected budgets was the um... historical mix of C-sections and, and vaginal births. Um... so the one provider that's doing a little better is, is doing more vaginal births uh... as a percentage compared to what they were historically, but I don't have a specific quality metric tied um... to VBAC. There, it's just, to the extent that that's a less-costly um... option, maybe a more um... a safer option um... then that's when they would, you know, have incentives to move in that direction.

[Maureen Corry]

I don't think there is a nationally-endorsed measure of VBAC that's included in the NQF measure set or the joint commission. So that's problematic. I don't know if anything will change as a result of their meetings over the next month or so, but it's really important in, in order to reduce the overall C-section rate for sure. Yeah.

[Magda Barini-Garcia]

And also, I mean I can volunteer and I was... volunteering in... [indistinguishable]

[Maureen Corry]

Our Listening to Mothers survey that was conducted in, or reported on in 2013 um... showed that among women with a prior C-section, something like 60 some odd percent seriously considered a VBAC, but they could not, they were unable to. 25% because of provider unwillingness and something like 18%

because of hospital unwillingness. So women are more and more interested. You can just see it in the media. You know, the interest is growing and the best evidence supports most women will have a successful VBAC. So it's certainly a viable option for women, but talk about the rural health issues that um... was mentioned earlier

[Unidentified Voice]

It's really a problem when women have to travel 2 to 3 hours to find a hospital even in major cities.

[Cara Osborne]

Yeah, in our area of Arkansas there's a de facto VBAC ban. The hospitals and obstetricians have come together to say that it's unreasonable to expect them to meet ACOG's statement around immediate access to emergency delivery. It always begs the question for me like, what do you do with all the other emergencies that are not a uterine rupture? You know? I mean a kid has fetal distress for any other reason, don't you still need availability of emergency cesarean? But from their standpoint, they've been able to lean pretty hard on the ACOG's statement as their reason to just not uh... provide the service.

[Maureen Corry]

And of course ACOG has updated that statement and talks about women should have the right to make that decision, but it really hasn't changed practice too much unfortunately.