TASK FORCE MEETING 3

**Welcome & Overview – Rob Kurzydlowski**
Question 2
Marty McCaffrey: these are open points.. it seems like from what we talked about last time, we could make some recs, but we aren't there yet.
Rob: yeah, we can make recommendations based on what we see moving forward
Adam: Typically we draft recommendations, bring them to steering committee, and then we bring them to you. This presentation is just the feedback you provided last week.
Marty: at a minimum we should be adopting national guidelines. Everyone should be on same page on levels of care and what they mean. AAP & ACOG have laid those out well.
Kate: agree—updating neonatal guidelines is essential. Working on maternal, but we also know LOCATe isn't establishing any guidelines, or intended to assign levels of care. LOCATe starts the convo, it's good, but somewhat superficial. An additional verification process is needed.
Keith: how do you reconfigure the system to support smaller LOC's to be able to fund backtransports etc.? In the current climate, it's hard to approve them for even larger hospitals. What happens in a managed care environment? Who makes these decisions?
Kate: if we are careful of defining criteria, and infrastructure policies, and payer alignment, it could work.

Question 3
Rob: Kimberly sent me the tool, and I will send it out to everybody. You will be able to see the questions and evaluate them for yourselves.

**Spotlight Series: Amanda Walker**
*Recorded and posted on TF Website.*
Question: were you okay with the multiple transfers?
Amanda: yes, there was only one time where they transferred rooms without mentioning me. Had they transferred her to another facility, things would've been different.
Comment: consent usually needed for transfer.
Marty M. : vast majority of pcp don't have contracts with hospitals these days. How big of a deal that your pcp should come to the hospital? Scale of 1-10?
Duncan: it's important in establishing that relationship with the doctor. Important for them to meet you and keep doctors informed.
Adam: when I visit families in the hospital its because I hear it from them. It can be hard for pediatricians to visit, but it means a lot. Even a fax, or a function in EPIC for communication would be valuable. The information is usually transferred during discharge.
Duncan: we should be putting the families at the top of the pyramid not the pediatricians
Amanda: parents are in survival mode, shock. They aren't thinking about contacting the pcp, but it would help to have them.
Kay: did anybody in the team tell you or prompt you to call your pediatrician/pcp?
Amanda: no, it was a missed opportunity.
Tina: Thank you for sharing your story.

Lorrie Basnight: I will reinforce from a pediatrician end we would like to know when the mothers are in the hospitals. It's an honor to be with a family when they are first starting and we would love the opportunity to be involved.
Comment: from a training perspective, it would be wonderful to hear transport teams etc., hear you talk. Low cost low hanging fruit to have that mandatory training.
Tara Shuler: a birth experience stays with a women for a lifetime—it was part of my training, and your story reemphasizes how true that is.
Amanda: I was able to turn to my established therapist to regroup but it still took a really long time.
Joanna Cartwright: the birth certificate piece is a real problem – more so on the availability of moms.
Marty: PQCNC is working on making this more effective right now.
……
Kate: unless we as doctors recommend a therapist, its not really something that is thought of. Thanks for bringing that out.

**Panel: intrapartum & Neonatal Transfers**
**Stacie Walker**
Generally haven't had any serious difficulties
barrier: availability of transfer, difficult to call multiple agencies; lower nurse to staffing ratio adds to complexity of doing tasks such as calling the agencies;
billing—transferring facility usually responsible for this except for Duke LifeLight. Most often go to Duke, but have also had experience with UNC & WakeMed, based on bed availability.
Adam: How much time does it take to call 3-4 different transport agencies?
Stacie: its nervewracking. Directly to Duke means ~20-30minutes. Transport teams are more time costly – 2 are reliable, and it's an additional 30 minutes. This brings it to 2-3 hours including time to get the patient stable.
Kate: the first call is to Duke… do they consider in triage the different needs or do you go straight to Level 4?
Stacie: usually go straight to Level 4. The process to a lower level is a little arduous because the hospitals don't take transfers usually from other hospitals outside the Duke system.
Kate: that was my question. Another question – is there a process for reviewing transfers, adverse events, etc. that is built into your relationship with level 4?
Stacie: if there is I haven't been a part of it
Kate: it's aspirational… I don't think a big system like that exists in NC
**Michael Sylvia**
Adam: do you ever get pushback for choice of institution?
Michael: no, not really. If duke has a place, we will transfer there. If Duke doesn't have a bed, I discuss which place parents want to go. UNC—chapel hill, WakeMed—raleigh etc. most of my parents don't care. Most parents will put aside issues they have with particular institutions
Tina Sherman: when are the conversations about which facility beginning to happen?
Michael: we can't plan for most instances. We are delivering mothers at least 35 weeks & above, and plan for that. We are usually in the situation where something has already happened. If there is a premie, we can have the conversations beforehand, and we try to. But

maternal stability is being sought after at the same time so its hard to have that conversation with her, and very rarely do I get the chance.
Stacie: I do have that conversation with mothers beforehand. Duke is the assumed location because we are a Duke Lifepoint location.
Tina: I am wondering if it's possible to make those calls an understanding upon them walking in.
Michael: it could be a conversation that could be built into the standard admission process… it's not been particularly looked at because it hasn't been on the forefront for parents. Affluent populations seem to want more control over things.
Tina: I hear you, but as a parent advocate I have to push back. I would say it is the providers and administrators responsibility to fully inform the patients. And know whether they are affluent or not, whether they need that info or not. It would be helpful to hear from parents to understand what their perspective is. Getting that information to the parents is where the system starts to push back.
Amanda: would you ever consider trying a different hospital that could take both mother and baby? If duke couldn't?
Michael: it's typically a bed related issue, not insurance. It is hard in a situation when time is an issue. I am the sole provider, and I don't necessarily have the luxury of time to make those phone calls. If there was a centralized place it would be really nice.
Berkeley: did the old bed locator tool have information about maternal bed availability?
Group: no… but maternal bed availability is much more fluctuating.
Belinda: you mentioned challenges with staffing, and being a level 2 even though you may not be functioning this way… do you make those decisions? Do you tell somebody the staffing isn't whole?
Michael: the determination as the level 2 is something the facility applied for and was granted a few years ago. The status has maintained. Whether we keep or transfer the babies depends on staff available. 90% of the time we just aren't staffed appropriately. I would rather transfer a mother baby intact. We don't notify anyone. I usually make the transfer determination based on how severe, how much staff efforts will be required, what the patient load looks like, and what the nursing director says about the coming hours.
Latoshia: As a parent, you see the time and staffing changes happen. People have a different experience when hospitals are stretched and when they aren't. maybe there needs to be something or someone for parents to go to particularly when the hospitals are stretched thin.
**Kate Menard**
These decisions are complex and time sensitive.
There's a transfer logistics center that stays on the phone with you that handles all the transfers. Its not always in five minutes, but its designed to be quick. The other end makes a judgement to see if the transport is safe, or what the safest option may be.
Duncan: you seem to say its quality, location, geography over business relationships, and that needs to be explicitly included in our recommendations somehow.
Kate: yes, exactly. We have different payers etc., but we need a system from a patient perspective that hovers above all of those relationships somehow. It's not simple but its important.
Kelly Holder: one of the things we mentioned earlier is trying to have transfer teams available or come before the baby is delivered?

Kate: I am told the reason for that because we don't have a crystal ball for how quickly they deliver.
Kelly: that makes sense for vaginal delivers, but for C-sections I know exactly when that baby is going to be there.
Kate: we can look at including this in the recommendations… we are hearing this theme.
Marty Mcaffrey: sometimes they won't because of billing. This is something we need to discuss or bring up.
Kate: its rare for us to have to say no for maternal transports. There is data we could look at for this. If we had a system where all hospitals were clearly functionally labeled we could look at this problem with a planning lens for an effective system.
Joanna Cartwright: there are states that do this, i.e. montana.
Kate: maybe we can look at other states and learn from them. Our geographic quadrants are pretty good, so we should be able to be one of the best if our resources were aligned well.
Adam: How often do you say no because there isn't a NICU bed available?
Kate: our neonatologists bend over backwards to maintain availability and plan ahead. We have to support and maintain relationships with rural hospital! As they reach capacity, they start to see where the healthier nicu babies can be transferred to maintain availability. So right now, its just once a month.
Marty: this system relies heavily on back transport.
Walidah: what is neonatal back transport?
Kate: if a premature baby or baby with some other medical condition needs a higher level of care, they come to duke/unc to receive care. At some point, the baby stabilizes, but still needs some kind of nutritional or O2 support that he/she might be able to get at a level 2 hospital significantly closer to the mother. They get the hospital services they need, but do not need the higher levels of care.
Walidah: so insurers don't pay for that?
Part of the question is who pays for the transport on the way back? Maybe the insurers think they've already paid for the whole package and don't want to pay for it.
Marty/Kate: it's a flaw in the payment model/DRG system.
Berkeley: how is the confidence in level 4 places that a level 2 Is actually a level 2? Is it realistic to think doctors would actually be willing to send patients to lower levels of care without verification?
Amy: this is a different conversation—nonemergent. There is time to talk to the pediatrician at the level 2 to determine whether there are the resources etc.
Marty: we don't really communicate to families nearly as well. It can be difficult ot tell families that the system wants to back transport them at the 11$^{th}$ hour.
Kate: a conversation happens at unc. It starts when they come in saying we are trying to get you closer to home. In 2018, around 130 babies were backtransported, which seems like a good system that families seem to accept.
Berkeley: who pays for this?
Kate: that's not my arena.
Marty: sometimes systems think they've covered all the costs, so when the back transport costs come up, payers are unwilling.
Kate: DRGs are complicated.

Lorrie Basnight: do hospitals not get paid sometimes if they DRG is used up?
Marty: they do, just maybe not as much.
Kate: certificate of need system sometimes limits how many beds places can have.
Belinda: the system isn't flexible enough to take beds from an understaffed location etc.

**Historical Perspective**
Adam: was it strictly financially reasons the program ended?
Belinda: yes
Kim: there's a lot of openness, urge, and need for additional support and connections
Adam: it seems like we need to find out how to reconfigure the program
Velma: the education is happening in an office setting now instead of the hospitals, in an outpatient setting.
Walidah: it sounds like the gap is region is—in that its not being disseminated across the board.

**Current State: Angela stills**
Question: I noticed some of the larger neonatal hospitals have some of the smallest transfer rates why is that?
Angela: I think it has to do with relationships & availability

**Group discussion:**

1. Bed locator tool ..

Adam: what was the platform this sat on?
Belinda: they used the phone. They had a system so twice a day, they'd report back.
Berkeley: is referring hospital responsible for costs?
Sarah Dumas: at women's birth & wellness center, we have a treatment that they hospital services our babies as an inborn baby. We get them there through orange county ems.
Amy Williford: if we say we don't have a transport team available, we still try and figure out a way to get the baby transported. We don't say no and then let it be.
Berkeley: that's not what Michael said… it seems like he's making multiple calls?
Marty: if we get a call and we don't have a bed, then they have to find someone else. If we have a bed but no transport, we will help find transport.
Comment: bed and transportation finding are two different problems.
Sarah: when Michael describes the problem, there are sometimes only 2 people helping him. You are on speaker talking to people, your attention is diverted into different places. I would like to find a way to streamline this process. When its you, 2 people, and a critically ill patient, calling for help, the barriers to transport are crucial.
Nancy: we have a similar problem. We are starting to collaborate with EMS to figure out transport but it's a big problem. Each individual is differently trained.
Kim: it would be helpful to have this convo with EMS people—there's different levels to who responds first and when.
Kate: we have ambulances at my child's football games… where are we putting our resources?
Adam: do we need a similar tool for labor & delivery beds?
Group: yes!
Adam: figuring out how to keep it up would be hard, but maybe its a technology system?

Amanda: when looking at the diad, it would help to see often mom's are turned away?
Kelly: it is rare to call and not have a bed, but it does happen, and it is something that should be addressed. When you call 2 hospitals and none of them have a bed its really difficult.
Angela: it really ruins relationships with providers when hospitals say no! you don't want to say no.
Sarah: just a system that's avoiding a step.
Angela: I don't want my physicians to have an additional step. I want them to go to a single resource.
Mary: it's about having a conversation and thinking about hwo you can move things around.
Angela: this center wouldn't be an absolute but a resource. You wouldn't have to use it, it's a resource.
Berkeley: would it be easier to have a one stop phone call?
Angela: yes