TASK FORCE MEETING 2

Robert Kurzydlowski – Welcome & Discussion Recap

Question 1

Kate Menard: slide 1 doesn't necessarily capture providers for specialty services for women on Medicaid.

Lorrie Basnight: Transportation to prenatal care appointments

Kate Menard: we don't necessarily know why the maternal wards are closing

Question 2

Marty: we should get the facts on hospital reimbursement for Medicaid. There is currently incentive to self-designate as a higher level, even if it isn't a reimbursement incentive, there is a marketing incentive.

Question 3

Adam: we can discuss whether extended hours would be valuable for OB homes. There are state policies/ways to incentivize this.

Kate Menard: what is high-risk is a loaded question. The biggest question for keeping a mom well is during pregnancy.

Question 4

Lorrie Basnight: sick leave

__: getting women to the care they need during the first 6 weeks

Mary Kimmel: A lot of mother's need care after 6 weeks. It is a critical point of care during a time of confusion and adjusting. Does our scope need to be longer than 6 weeks?

Adam: we are more thinking about post-partum transition, we don't necessarily need to be dogmatic about 6 weeks.

Tara Owens Shuler: we need to highlight childbirth education and making sure they know how to receive the care they need.

Charea Mason: Explain the birthing process to the women.

Amanda Murphy – Spotlight Series Video

Q: Are the doulas paid or work on a volunteer basis?

Amanda: A grant provides administrative support for doulas in MAHEC. We are working on sustainability. We are the only place in NC that provides doulas within the clinic.

Kate: Medicaid recipients are screened with a tool since April 2011. If mom's trigger as high-risk, they are assigned a care manager that are based mostly in health departments. After a few years, data was reviewed to determine which risk factors were improved by care management. This review/analysis became known as impact-ability. However, it leaves some mothers without a case navigator. Doulas would provide a nice supplement for the women that do not receive a care manager.

Nancy: Community based doulas such as these also serve as health educators on nutrition, wellness, etc.

Tara: They also receive proper health education training services in NC.

Adam: We will definitely come back to this topic!

Azzie Conley – DHSR Rep, current NC guidelines

Currently, we are going through a standard review process (under 4305). They are up for review and the deadline of when we are making these changes fall within the time frame of 2022. The review process is tentatively set to start in November 2020. We are flexible in when those changes are made… We are interested in identifying pertinent stakeholders. We have an internal review process that addresses all the rules & regulations, and that committee also drafts the issues. We can send that process to you.

Kate: What other services are defined and regulated like this?

Azzie: Trauma, ER, Stroke Centers, DHSR-EMS handles review of stroke standards. Additional guidelines may impact the designations.

Kate: Is there a process for creating new levels of care i.e. maternal care?

Azzie: At any point, an individual can submit a suggestion to change the rules. This opens the discussion about what the best course of action should be. Now seems to be a good time to forward suggestions to their attention since they are currently under review.

Berkeley: are hospitals self- designated?

Azzie: Designations are verified by the state through a certificate of needs process. The process drives the designation of beds. Could be a site visit or an office review. There is an annual licensure renewal application but there is no annual review of the reported guidelines. EMS section handles compliance to guidelines/designations.

Kate: are designations readily available?

Azzie: The designations are all public information, individuals just need to call the office so we could provide the info. Down to surveys.

Adam: with state standards there are no comparative statistics readily available in a publicly consumable easy to find format.

Kate: a list of services and providers for specific services and where women and children can receive those services would be valuable. I can see a maternal care map posted online that would be valuable.

Berkeley: trauma has a similar map listed online!

Azzie: that level of detail isn't provided by our office. Documents are out there, it's a matter of what you're looking for, to what degree of detail, etc. We would be glad to see what we could do given specific details.

Tina Sherman: During my high-risk pregnancy, I had to ask questions to providers because there were no places I could find answers readily available.

Belinda: we could put neonatal self-designations into a map pretty easily.

Kate: it will be interesting to see how that data lines up with CDC LOCATe.

Adam: how would we make sure this map/information, if made available, stays current? We can look at this map to understand what's happening at least.

Azzie: can individuals from UNC & Vidant collect this information?

Kate: yes but there are still the remaining 4 regions.

Marty McCaffrey-- Achieving risk appropriate NICU Care

Belinda: What's the difference between NC's current guidelines & the 7th edition guidelines?

Marty: The information is in your sheets…

Adam: there's a lot less specificity in the NC version. i.e. no mention of personnel.

Kate: we should target higher than 84%. NC isn't in terrible shape. Also, very few babies require Level IV care, so we don't need to focus on that level necessarily.

Adam: are there hospitals in Level 2 & 3 that aren't providing the services they need to right now?

Marty: there are some places like this. Mostly the situation of claiming level 3 standards when they only have level 2 capabilities.

Kate Menard: Maternal Levels of Care

Kim: how do you communicate to moms they should go to a higher level hospital not just because the doctor says so, but because it is safer for them to do so?

Verification vs. designation – by ACOG vs. by the state

Andrea Catalano CDC Levels of Care Assessment Tool

- Get MMR Committee Report from Andrea

Wyoming: project ECHO—distance based learning protocol, hypertension protocols, potentially piloting a consumer education piece.

Illinois: difference in neonatologist availability on site etc., Working on legislation aligned with 2012 AAP guidelines

S.E Michigan: created a qualitative interview guide; helped them prioritize gaps i.e. transport, provider relation is etc. *** LOCATe provided numbers and data to help solve the problems

Puerto Rico: went out and collected data in person… and then Hurricane Maria hit and the data shifted. Leveraged LOCATe to highlight OB units as part of emergency preparedness.

Andrea, Kim & Kay LOCATe Panel

Kay: probably a combination of what Kim & Kay have done would be the ideal implementation of LOCATe across the state

Adam: Ideally, how often should a LOCATe assessment been done?

Andrea: the recommendation is give or take 3 years. But no one has done a second one yet, and the rec depends on the state.

Berk: when you are working in regions with competing hospitals, was there a sense of individuals wanting to know what level their "competitors" were at?

Kim: nope. The biggest concern is "is this regulatory?" Competition did not immediately come out during the assessments.

Kate: a lot of the effectiveness of these two roles is personal relationships & connectedness. Some hospitals required CEO review of information release. But, it didn't seem to be competitive.

Rachel : where does the data go?

Kay: the data is not publicly released.

Kate: maybe this committee discovers we should make this information available to all women. But that's not the focus right now.

Mary: does LOCATe currently ask about mental/behavioral health?

Andrea: no, not yet, primarily because there are no clear guidelines on either end. We could add questions, but you need a clear reason why and enough context.

Berkeley: What's your plan for mothers if they need a higher level of care

Kim: Usually the conversation comes up organically about where each hospital feeds into the system, what they do, etc.

Walidah: is the plan to go to the other regions eventually?

Belinda: well were using a small amount of MCM block grant funding. We will be reapplying in about 3 years, it depends on which sites apply. The long term goal is to do this statewide.

Kay: a representative with experience with LOCATe is important for meaningful implementation of the tool.

Berkeley: it sounds like you really need the outreach coordinator support.

Duncan: what're your opinions – is it better to come up with a kind of system that replicates trauma, or do we refer to our national professional societies for verification instead? It costs a lot of money to prepare for these reviews.. Also the levels of trauma or oppositely labelled.

Andrea: I think it depends on the state. Texas decided what works for them, and they were clever in utilizing both of the organizations. What NC needs is going to be different from other states based on geographical differences, availability of providers, etc.

Kate: I've noticed nationally that hospitals are becoming really enthusiastic about the tool. Need to make sure smaller hospitals have what they need for basic support, and a supported referral system is in place for higher levels of care.