Attendance:

Room: Jennifer Grady, Charea Mason, Latoshia, Nancy Koerber, Winona Houser, Belinda Pettiford, Kate Menard, Mary Kimmel, Lorrie Basnight, Amanda Murphy, Walidah Karim, Obi, Marty Mcaffreee, Martha Bordeaux, Jim Devente, Rhonda Lee, Kim Harper, Ashley Rodriguez, Rob Kurzydlowski, Sarah Dumas, Tara Shuler, Amy Williford, Melissa Joyner, _ NC pediatric society

Zoom: Alan, Corinna Miller, Daragh Conrad, Frieda Norris, JGuerrero, Kelly Kimple, KMC, Melissa Clayton, Melissa Poole, Rachel Elledge, SammolV, Tara Bristol Rouse, Velma Taormina, Rashida Ijdi

Phone: Azzie Conley, Tara Bristol Rouse, Corinna Miller, Roytesa Savage, Michaela Penix, Lisa Sammons, Velma Taormina, Kimberly DeBerry, Rachel Elledge, Mellissa clayton, Keith Cochran, Frieda Norris, Melissa Poole,

PSOC Spotlight: Tennessee – Margaret Major

- History
    - Created to develop a plan for newborn care, and amended shortly after to include mothers of high risk babies
    - Active since the 1970s
- Perinatal Advisory committee
    - Meets at least once a year (now 3 times)
    - Community members, providers, hospital workers
    - 3-4 different documents posted on the website including: guidelines for regionalization, guidelines for transportation, education objectives for perinatal social workers (level 3 &4), objectives for perinatal workers
    - Documents based on AAP/ACOG etc.
    - Voluntary system of hospitals designating a level of care, but creating a new facility requires applying for a certificate of need
    - 5 regional perinatal centers
        - 24 hour consultations
        - Professional education to hospital staff & other disciplines
            - Simulation training & regular classes
        - Transportation if needed (neonatal)
        - Site visits if requested
        - Follow up clinics after discharge
        - Funded through state Medicaid plan through CMS (TenCare)
- Current Projects
    - Implementing CDC LOCATe – working on sharing analysis with hospitals (50/50 match between self designation & actual level) → not regulatory, just informational
    - Involved with Perinatal Quality Collaborative—
        - contracts with Vanderbilt
        - 10 years old
        - Many birthing facilities participate, part of the larger initiative
        - Develops toolkits
    - Current workgroups –

        - Issue related to back transport – developing payment bundles
        - Supplementary guidance for emergency hospital staff – training, necessary supplies,
            - perinatal outreach educators recognized the need for ED training!!
        - Convening 2019: review & update transportation guidelines
            - Usually documents are reviewed every 5 years unless there's a need to update sooner.
- Releases fact sheets & documents annually; also a video posted online
- Questions?
    - Walidah: I've heard about follow-up clinics, can you speak more to that?
        - Response: each one is a little different, but center and some level III facilities have LBW and/or specialty clinics with different schedules. Intended for follow up with patients so we don't just send them home.
        - Walidah: same as interconception clinic?
        - Response: No, this is just for the baby. Offers multidisciplined specialized support for the baby that may or may not be available at their wake county level.
    - Kate: composition of the advisory committee? How is it supported? How is it integrated with the rest of Medicaid?
        - Response: No funding, 21 members, the statute dictates who is on it. Includes OB physicians, hospital administrators, consumer (parent currently), private practices, newborn practices, family practices, 2 nurses – OB & High Risk, and public health. Funding for travel comes out for MCH block grant. Central office in the department has no perinatal money.
        - Kate: Centers have OB providers on the committee?
        - Yes
    - Adam: in 50/50 self designation rate for LOCATe, do people usually self-designate at a higher level?
        - Response: not always. They did better in neonatal than OB, and sometimes, they designate at a lower level. We just started this yesterday though. Joint Hospital report is available online.
        - Adam: I think we're finding similar results in NC
    - Belinda: What kind of Medicaid money do you receive?
        - Response: it's handled through 50/50 admin in the CMS & State Medicaid plan. 3 years ago, we got a significant amount of money from appropriations that we designated for outreach/professional education… this was the first perinatal money since the 1990s. We transferred that money to Medicaid, and used the match to get 1 million distributed between each of the 5 centers.
    - Marty: Classification of neonates—have you always used the AAP criteria? Was it always the case, and what was the transition like? We are using old guidelines right now, and are in the process of updating.
        - Response: we've always used the AAP guidelines, and there's a bit of a lag as we update the guidelines, but we are always trying to update as its updated. Our

educators use the guidelines when they do training and during their discussion with staff.

- Adam: how much of the regionalization in Tennessee is done geographically?
  - Response: gets a little muddled on the eastern corridor. Centers are assigned to one but patients go to the other depending on MCO or patient choice. Some degree it has to do what the needs are for the patients—there's some transferring and coordinating. The centers on that side of the state work together to accommodate for these blurred lines.
- Belinda: can you share the actual statute for the perinatal advisory committee?
  - Response: I can email it to Rob – the reference should also be included with the guidelines.

PSOC Spotlight: Texas – Jane G. Guerrero

- Office of EMS & Trauma Systems… the designation program for neonatal & materal LOC were assigned to EMS because they do the trauma designations for all 22 regions. Really similar to the neonatal & maternal one, so got assigned to them.
- History
  - NICU council established in statutes.
    - Survey done for neonatal levels, maternal ones weren't established, and found that 40-60% of the hospitals did not classify themselves correctly.
    - Neonatal Care Capacity slide
  - In 2013, legislation created neonatal & maternal levels of care. Not regulatory, and not a guideline, but statutory.
    - Created perinatal regions – loosely give the task of transfer agreements. High level and undefined in the actual statutes.
    - Created perinatal advisory council (PAC) that is still in existence. Council of experts that advises the department.
    - Included a timeline by which all designations had to be completed
    - No certificate of need included
    - A facility has to be designated for Medicaid reimbursement
- PAC became active in developing the rules around perinatal health.
  - Started to meet monthly from across the state
  - Well represented across the state—rural, urban & frontier areas.
  - Took about 2 years to develop a administrative code based on the 6th addition of AAP guidelines. The first designation program to be rolled out.
  - Asked: how can we learn from trauma?
    - Trauma has a peer review process. PAC decided to have a onsite peer-review survey that is submitted along with the review tool as part of their application for designation.
    - Level I hospitals do a self audit.
    - Use the survey to determine if hospitals are meeting administrative code.
  - Submits survey and application to state every 3 years for resignation
  - Currently accepting maternal applications – designations are down the pipeline, to be completed by September 1 2020.

- Questions:
    - *Unrecorded.*

State Small Group Discussions

- Arizona
- Illinois –
    - They did do LOCATe—they're mandated by legislation, with oversight by outreach coordinators. Several months process.
    - Longstanding guidelines that are publicly available, but the ones currently in use aren't revised by most recent AAP / maternal guidelines. They have notes that they are planning on implementing 2019.
    - They have a perinatal advisory committee off 22 members—physicians, dieticians, consumers, health planners, social workers etc.—outlined in statutes
    - Unsure about 10 regional centers designated
    - PAC covers 100 % of births
- California – Comprehensive perinatal services program
    - Target to reduce low birth weight babies
    - Develop an individualized health plan
    - Doesn't really talk about Medicaid connection with perinatal quality program
    - Also the funding source not mentioned
- Washington
    - Statute mandated "healthy pregnancy advisory committee"
        - Composed of many of the typical stakeholders i.e. pediatricians, maternal providers, but no patients, nobody from a pharmacy
    - Focuses on tobacco, diet, contraception, breastfeeding, facility care for women with BMI >50
    - National text for baby campaign—text as an ability for patients to communicate with care organizers;
        - Kind of unsolicited texts, but solicited texts might be more valuable.
    - Doula reimbursement
- New York
    - Sheet was a little outdated – from 2016
    - North Carolina has already done much of what is outlined
    - Large gap in the communication between doctor and patients on early elective delivery that isn't reflected in NY or NC guidelines

Medicaid Transformation Changes & Q&A – Nancy Henley

- Medicaid Managed Care
    - Dental services, LEA, eyeglasses, child plan
    - Standard plans launch November 2019—Feb 2020
    - Standardization—to reduce administrative burden for clinicians

    - Advanced Medical Homes: pathway for practices to play a larger role in managing health outcomes and costs
    - Case Management strategy—appropriate, multidisciplinary, local, timely and complete, address unmet health needs, achieves quality outcomes
- Current programs Evolution
    - Pregnancy medical home → pregnancy management program
    - Obstetric care management → care management for high risk pregnancy
    - Care coordination for children → care management for at risk children
- *See slides online for additional details*
- Questions:
    - Q: How long are the contracts for? Where are we able to inject innovative strategies?
        - 3 years
        - We've asked them to innovate and do more as well—today I focused on stability. You will find a description of that ask in the proposals themselves. There's also a value added piece.
    - Q: do the PHP's work together? Share data?
        - I don't know that they will share data, but we have asked them to work together to meet specific goals and align with specific quality measures.
        - The exact mechanisms of those relationships is evolving still.
    - Q: excluded from care is family planning… how do these families get family planning?
        - There is a Medicaid eligibility service for these services for higher level threshold income. The current family planning benefits are also preserved.
    - Q: What work has been done on the IT side about glitches prevention?
        - "end to end" testing is being performed on fictitious patients
        - Readiness assessment on NC Medicaid

LoMC Verification Program—Christopher Zahn

- History:
    - Started in 1970s
    - Concept of NICU levels is popular now, but maternal mortality demonstrates that OB levels need to be popular too
    - Promote regionalization and coordination of care to get women to the right place at the right time.
    - Facilities can assess themselves for what they are/aren't capable of
    - Soon after publication, MFM/ACOG & CDC brainstormed ways to turn it into an implementable program
    - Ultimately the goal is to get outcome & administrative data from 45-46 states
    - Arizona perinatal system has been helpful in providing materials, teaching us how the programs work etc.
    - Compiled implementation program in 2017.
- Goal: toolkit in a box where everyone can implement a verification program across all hospital levels.

- Texas Pilot Program: 12 visits in 2018, 24 already on the books, anticipate another 40 in 2019.
    - Relatively complex process recruiting obgyn's, nurses, and midwives
    - Conducted several trainings. Medical director attends virtually every site visit. Has bee working amazingly well.
- Visited with other states & entities that are interested in levels of care – spoken with Georgia, Wyoming, Illinois, Pittsburgh hospital system, FL hospital system. Growing initiative
- Voluntary? Mandatory? Self-report v. verification? All questions asked as the program starts to expand in different places.
- Verification isn't the only step but its an important one.
- Questions…
    - Q: Danger of smaller/rural hospitals using this as an excuse to shut down their units?
        - A: Yes.. we have had some discussions with AAFP, National Rural Health Association & more. LoCs aren't the death nails for these hospitals. Levels have been around since 2015, there's no reason that hospitals should do this.
        - A: Actual documents are supportive of these hospitals – they promote regionalization, transfer agreements, etc., intended to support level 1 & 2, not eliminate.
        - A: Without LoC there's no framework for hospital standards of care. If a facility doesn't meet level 1 criteria, should they even provide the services? It's a matter of picking priorities: access or safety? It's a bigger discussion, and there's no clear answer, but there's a real conversation that needs to happen about this. Closure issue of smaller hospitals is a bigger issue than levels of care.
        - Comment: It does give an excellent framework for providers, but it does objectify things.
    - Q: can you comment about how the program has been received in Texas? Especially to the comment about rural/smaller hospitals?
        - A: so far, its been received incredibly well. There was a lot of push back in the beginning, and it took a while to write the rules. Over time, people have been increasingly convinced to address the statewide problem of maternal mortality.
        - A: patient safety sounds great, but nobody ever wants to pay for it. Arizona and Texas incorporate it into their Medicaid programs—it's not voluntary. That has probably contributed to positive responses. But overall, hospital feedback has been very positive around site visits, recommendations for improvements, and best practices. i.e. one hospital has a single call number manned 24/7 to coordinate maternal transport to the most appropriate facility. Designed to be supportive and instructional, not regulatory.
    - Comment: you can't judge a maternity unit by numbers of deliveries… they perform many obstetric services that prevent maternal morbidity and mortality and then the mother gets transferred for birth. But from an obstetric standpoint, they are important. Level 1 hospitals are extensions of the higher level unit… more than just a "level 1"

NICU Verification Program—Sunnah Kim & Dr. Stark

- *See slides online*
- Q: did you ever disagree with the level that sites designated themselves?

    - Yes, we had facilities that would want to be a level IV, but didn't actually meet all specifications. So at the summary meetings, we would specifically address what they had and what they didn't have… and that's all we could do. We send the report to the state to determine which level the site is. The state can send another survey if site wants to appeal the decision etc.
- Q: Did you have any parent involvement on your team?
    - No, not on the leadership team. But we met with parents at the sites, and engaged with really active parent organizations. Moving forward, having parent input will probably be a good thing.
- Q: Relating to surgical subspecialties?
    - Some of it them had surgical, some of them had medical subspecialties.
- Q: distinction between level III & IV?
    - Depends on the onsite availability.
    - IV has everything III doesn't have.