Workgroup I: Pregnancy, Delivery, Neonatal Intensive Care

The first session of the Arkansas Healthcare Payment Improvement Initiative Pregnancy workgroup convened on October 17, 2011 to discuss perinatal care issues and patient management, with an emphasis on enhancing value of services and outcomes in Arkansas. The workgroup meeting was the first in a series of discussions, which will inform the design and implementation of a new payment model.

Approximately 70 Arkansas healthcare professionals and patients were in attendance at the first workgroup, representing perspectives of patients, providers (Neonatologists, OB/GYNs, Family Practitioners, Nurse Practitioners, Registered Nurses, Public Health Nurses), hospital administrators, nonprofit administrators, and government administrators.

Key components of the first Pregnancy workgroup discussion are summarized below.

KEY COMPONENTS OF WORKGROUP 1 DISCUSSION

- There was general agreement around the core components of patient care to emphasize in the episode of care model. In particular, workgroup participants highlighted potential system changes and challenges in Arkansas to:
  - **Decrease rates of preterm birth and low birthweight infants.** Discussions included effective management of high-risk conditions, such as progesterone treatment for women with history of preterm birth, management of preeclampsia, smoking cessation counseling, and management of gestational diabetes.
  - **Consider elements of accountable care,** including clinically recommended prenatal screens, interventions, and patient education to detect and address identifiable and modifiable risk factors.
  - **Continue to focus on decreasing utilization of elective procedures in Arkansas,** such as c-sections and early elective deliveries.
  - **Encourage delivery of infants in settings with appropriate neonatal care** in cases when delivery can be arranged in advance to promote lower infant mortality rates for low birthweight and preterm birth infants.
  - **Establish systems support, infrastructure, and technology** to support more efficient and effective care provision, including 24/7 patient
support centers, telemedicine, community outreach, and centralized medical records.

Other potential opportunities discussed were interconception planning, immunizations and lifestyle modifications to promote better maternal health, and increasing operational efficiency of NICUs.

Workgroup participants acknowledged that payment improvement is a critical component of the overall solution and that payment innovation can manage over- and underutilization of services by aligning incentives and increasing accountability over process and outcomes within the boundaries of the episode definition.

The workgroup discussed the need for payment design and implementation to take into account several important elements, including:

Provider accountability – Payment design should consider the extent to which providers can be held accountable for specific aspects of clinical management. While acknowledging the patients’ role in ensuring outcomes, the payment model should encourage appropriate provider behavior and processes, which drive optimal outcomes and serve a critical role in encouraging appropriate patient behavior.

Resource allocation – Resources will need to be appropriately allocated to encourage optimal provider behavior and outcomes. This may entail a greater concentration of resources in early, preventive care to decrease identifiable and modifiable complications, a reduction in practice variation, and incentives for optimal processes and outcomes.