## Agenda – Mon, Oct 17 (3-5p)

<table>
<thead>
<tr>
<th>Introductions</th>
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<tr>
<td><strong>Review patient journey</strong></td>
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<td><em>Review material</em></td>
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<tr>
<td><em>Discuss</em></td>
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<tr>
<td><strong>Discuss opportunities to ensure effective care, quality, and patient experience</strong></td>
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Arkansas Healthcare Payment Improvement Initiative: A statewide, multi-payor effort

“Our goal is to align payment incentives to eliminate inefficiencies and improve coordination and effectiveness of care delivery.”

– Gov. Mike Beebe

Episodes have the potential to …
- Deliver coordinated, evidence-based care
- Focus on high-quality outcomes
- Improve patient focus and experience
- Avoid complications, reduce errors and redundancy
- Incentivize cost-efficient care
2011 Health System Challenge

Redesigning Payment to Maximize Value

- Better Outcomes
- Effective, Efficient Care
- Moving away from fee-for-service

Where/How to Start Discussion

- Today: Alpha Testing Version 1.0

Building Blocks

- Consistent Use of Evidence-Based Services
- Appropriate Use of Technology
- Patient and Provider Engagement
Objectives for today

▪ Discuss Concepts of Healthcare Value
  – Rewarding Outcomes vs Service Events
  – Overuse and Underuse
▪ Challenges of Episode Development
  – Patient Variability, Coordination, System Support
▪ Overview of Components of Perinatal Care
▪ Review Assumptions in Care Model
  – Explore Concepts of Accountability
  – Explore Aspects of Care Variation
▪ Outline Mechanisms to Enhance Value
▪ Barriers to Effective Care Today
  – Potential Systems Changes
The pregnancy workgroup will contribute to an effort with significant impact potential

<table>
<thead>
<tr>
<th>Patients</th>
<th>▪ ~40,000 liveborns in Arkansas per year</th>
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<tbody>
<tr>
<td>Payers</td>
<td>▪ ~10% of Medicaid clinical spend¹</td>
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<tr>
<td></td>
<td>▪ ~5% of Commercial clinical spend</td>
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<tr>
<td>Providers²</td>
<td>▪ ~200 OB/GYNs, and obstetrical family practice physicians and nurse practitioners</td>
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<tr>
<td></td>
<td>▪ ~20 Neonatologists</td>
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<tr>
<td></td>
<td>▪ ~70 hospital sites with delivery</td>
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1 SFY10 Medicaid claim spend based on primary ICD9 code; does not include cost settlements, Medicaid payments to Medicare, other non-attributable spend (e.g. HIFA waivers, Medicaid admin), waiver spend, nursing homes, and ICFMR settlement spend

2 Number of providers per specialty based on board certification
Patient care map

Early pregnancy (1st/2nd trimester)

Prenatal care
- Routine care, e.g. physical exam, basic screenings, targeted lifestyle interventions, identification and management of clinical complications
- Documentation of gestational age

No major clinical risk factors

Initial assessment

Significant clinical risk factors, e.g. history of pre-term birth (PTB), diabetes

Late pregnancy (3rd trimester)

Prenatal care
- Routine delivery risk screenings (group B strep, herpes)
- Plan for time and mode of delivery (e.g. vaginal vs. c-section)

Complications

Unplanned c-section

Delivery

Vaginal delivery\(^1\)
- Management of labor and delivery

Well baby care
- Basic neonatal care (Level 1)

Neonatal management

NICU
- Care for moderately ill neonates (Level 2)
- Intensive care (Level 3)

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1 Medical and physical conditions such as preeclampsia, gestational diabetes, placenta previa, hemorrhage, and infections may dictate delivery timing and method.
Variation in Arkansas practice and outcomes today
Preterm birth and low birthweight rates

PTB and LBW rates in Arkansas are higher than the national average

There is regional variability within Arkansas

<table>
<thead>
<tr>
<th></th>
<th>Arkansas average</th>
<th>National average</th>
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<tbody>
<tr>
<td>Preterm birth rate</td>
<td>13.1%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Low birthweight rate</td>
<td>8.9%</td>
<td>8.2%</td>
</tr>
</tbody>
</table>

SOURCE: National Center for Health Statistics, final natality data via March of Dimes Peristats report; Centers for Disease Control and Prevention, Arkansas Fact Sheet, 2009
Variation in Arkansas practice and outcomes today

Cesarean procedures

Percent of live Medicaid deliveries by C-section in Arkansas hospitals
(State Fiscal Year 2010, 48 hospitals representing ~17,000 deliveries)

SOURCE: HSAG analysis for Arkansas Division of Medicaid Services
Variation in Arkansas practice and outcomes today
Early elective delivery rates

Arkansas Medicaid early elective delivery rates
State fiscal year 2011, percent

Arkansas statewide rate = 25.71%

1 Arkansas statewide - providers who are participating in IQI program SFY2011
Variation in Arkansas practice and outcomes today
Neonatal outcomes across NICU levels of care

NICU Delivery Location for Infants <32 wks

<table>
<thead>
<tr>
<th>Level</th>
<th>%, Arkansas 2001-2008</th>
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<tbody>
<tr>
<td>Level 1</td>
<td>34</td>
</tr>
<tr>
<td>Level 2</td>
<td>28</td>
</tr>
<tr>
<td>Level 3</td>
<td>38</td>
</tr>
</tbody>
</table>

NICU Mortality Rates for Infants <32 wks

<table>
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<tr>
<th>Level</th>
<th>%, Arkansas 2001-2008</th>
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<tr>
<td>Level 1</td>
<td>13.6%</td>
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<tr>
<td>Level 2</td>
<td>10.9%</td>
</tr>
<tr>
<td>Level 3</td>
<td>6.8%</td>
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* Arkansas does not currently have a standardized NICU designation system. For the purposes of the ANGELS study, Level I NICUs were defined as having neither a neonatologist nor a maternal fetal medicine (MFM) specialist, Level 2 NICUs typically had neonatologists and pediatricians but not a certified MFM specialist or other on-site pediatric care, and Level 3 NICUs had board certified neonatologists, MFM specialists, and a broad range of on-site pediatric specialists.

Opportunities to ensure effective care delivery, quality, and patient experience

1. More effective prenatal care (low and high-risk pregnancies)
2. Decrease utilization of elective procedures
3. Ensure delivery in facilities with NICU appropriate for level of prematurity
4. Increase operational efficiency of NICUs
1 Discussion
Prenatal Care

<table>
<thead>
<tr>
<th>Low risk</th>
<th>High risk</th>
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<tbody>
<tr>
<td><strong>Define Accountable Care</strong></td>
<td><strong>Episode Subsets</strong></td>
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<tr>
<td>– PCPI Metrics</td>
<td>– Diabetes</td>
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<tr>
<td><strong>System Support</strong></td>
<td>– Eclampsia</td>
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<tr>
<td>– Early Appointments</td>
<td>– Previous Prematurity</td>
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<tr>
<td>– 24/7 Access</td>
<td><strong>System Support</strong></td>
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<tr>
<td>– Community Outreach</td>
<td>– 24/7 Access</td>
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<tr>
<td><strong>Technology Questions</strong></td>
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Discussion
Delivery

C Section vs Vaginal Delivery

– Nulliparous Patient
– Blended Rates
– Maternal, Neonatal Complications

Pain Management

Early Elective Delivery (Before 39 Weeks)

Location of Delivery

– Maternal vs Neonatal Transport

Accountable Care

– Anticipatory Guidance, Breastfeeding
Discussion
NICU efficiency

Resource Use
  - Per Day x # Days
  - Stratify By Gestational Age

Complications

32 Week Neonate

Discharge Planning
  - Accountable Care Components
Next steps

- **Synthesize** and post online the feedback and input from today’s discussion
- Circulate **follow-up questions**
- **Schedule** next workgroup meetings
Timing of initial prenatal care visit

Timing of Initial Prenatal Care Visit
\%
Arkansas 2008

- 1st trim.: 78.9%
- 2nd trim.: 16.6%
- Late (3rd trim.) or no prenatal care: 4.5%