

Maternal and Obstetric Care Challenges in Rural America from the National Advisory Committee on Rural Health and Human Services – 08/26/2020

Kristine Sande:

Good afternoon, everyone. I'm Kristine Sande, and I'm the Program Director for the Rural Health Information Hub, and I'd like to welcome you today to the webinar on Maternal and Obstetric Care Challenges in Rural America. We're delighted to be collaborating with the National Advisory Committee on Rural Health and Human Services on today's webinar.

Before we begin, I'll quickly run through a few housekeeping items. We do hope to have time for your questions at the end of the webinar. If you have questions for our presenters, please submit those at the end of the webinar using the Q&A button on the bottom of your screen. We've also provided a PDF copy of the presentation on the RHHub website, and that's accessible through the URL on your screen. We've also just sent that link through the chat function, so you can find it there. For technical issues during the webinar, please visit the Zoom help center at support.zoom.us.

To start us off today, our first speaker is Dr. Jeff Colyer, and he currently serves as the chair of the National Advisory Committee on Rural Health and Human Services. He is also a Board Certified Craniofacial Plastic Surgeon with a special interest in craniofacial and pediatric plastic surgery at K.U. and the Mid-America craniofacial teams.

Dr. Colyer brings a wealth of experience in public and private sector leadership. He was the 47th Governor of Kansas, and has started or helped to manage small companies, healthcare entities, large organizations, and complex international projects. He's also served on a variety of boards. I'll hand it over to Dr. Colyer and he'll tell you a little bit about the Committee as well as the rest of our speakers today. Dr. Colyer.

Jeff Colyer:

Great afternoon, everyone. I'm glad so many people have signed up already as we see more and more participants are coming in and we're very honored to have you join us for a really important piece of information that we think will be helpful for all of us.

I'd like to welcome you to the webinar. This is sponsored by the National Advisory Committee on Rural Health and Human Services, and we're going to provide a brief overview of the Committee, highlight some of the maternal health challenges and discuss some barriers to maternal healthcare and hear about the Committee's most recent site visit and policy recommendations.

As a little bit of background to the Committee, I want to thank you and I want to publicly thank the very professional staff that have done an extraordinary job backing this up. If we could take off the mute and video buttons and unmute them, we would all be giving you a standing ovation. I just want to say thank you. I've it's been an honor to work with them.

The Committee is a federally chartered independent citizens panel. Our charter is to advise the Secretary of HHS on healthcare challenges and social services challenges that affect rural Americans. The commission was formed in the late 1980s and has continuously advised the Secretary of HHS over the last 35 years. It consists of 21 members, including the chairman and a very diverse experience and expertise that represents a variety of rural health issues: public health, medicine, nursing, human services delivery, hospitalization, childcare, research, law, finance, business. It's an extraordinary group of individuals and I want to say thank you to all of them for their hard work in this.

Since this was originally formed, the Committee has continued to work to address additional issues and pertinent issues that affect the health and wellbeing of rural America, and we want to hear directly from rural stakeholders. So following the meetings, the Committee produces a policy brief which is presented to secretary of HHS with recommendations on policy and recommendations on regulatory matters that the Secretary oversees.

For the 87th meeting, it was convened at the end of March 2020, and the Committee met at an obscure federal agency that you probably haven't heard of recently in Atlanta, Georgia called the CDC. It focused on addressing maternal health challenges in rural areas as one of its two topics. During the meeting, the Committee also examined the causes of maternal mortality rates in rural areas and some of the federal programs that are currently being leveraged to address these issues. This was my first meeting, and over that two and a half days, the Committee first heard from a number of subject matter experts.

The Committee, tasked with the issue, then visited Mercer Medical School in Macon, Georgia, and met with a variety of health and human services providers throughout the state of Georgia. We've hyperlinked a brief that you can click on on the cover of this policy brief to find out the full details. There's also a link provided at the bottom of the slide.

Today we're going to have a few webinar speakers. The first we'll hear from is Darci Graves from the Center of Medicare and Medicaid Services. She joined CMS in the Office of Minority Health in 2015, and she assists in the coordination and implementation of priority office-wide programs and policies. In addition, she serves as a subject matter expert in a number of areas such as culturally appropriate services, rural health cancer and health disparities, and health equity as well.

Following Darci, we're going to hear from Dr. Jacob Warren, who will discuss the local frontline view of maternal health issues in rural Georgia, and that's where the Committee had its site visit. Dr. Warren is a behavioral epidemiologist at Mercer School of Medicine, and he is the endowed chair and director of their Center for Rural Health and Health Disparities, one of the unique institutions in the United States, and we're very honored to have him work with us on this. He was the founding director of the PhD program, Rural Health Sciences, and he's received more than 13 million in federal health funds to support his rural health equity focus work. He's published five books and over 60 peer reviewed journal articles. He was also the National Rural Health Association Researcher of the Year. And so we want to thank Jacob for his hard work.

Following Dr. Warren, we're going to hear from Sallie Poepsel. She was a past Committee member who's going to give us an overview of the brief and corresponding policy recommendations and the number of the policy considerations. Sallie has a broad based experience in healthcare, over 40 years, encompassing clinical, education and leadership and administrative practices. She has been providing anesthesia services in a level one trauma center in office space and rural hospital settings. She's focused her practice in rural critical access hospitals since 2000, has been an advocate for her profession and for access to healthcare services. She served on a number of committees internationally, including the Department of Health and Social Services task force on hospital licensure, and she's participated as the volunteer and the seizure provider in third world countries with Medical Missions Foundation, a great organization, I might add. So I want to thank Sallie for helping us out as well.

So with those three introductions, I'd first like to turn it over to Darci for the initial presentation on maternal and obstetric care challenges in rural America. Darci.

Darci Graves:

Thank you, Dr. Colyer and good afternoon, everyone. I'm just going to spend a little bit of time talking about something that many are probably familiar with, but the why maternal and obstetric care challenges in rural America are so important to look at.

More than 700 women a year die of complications related to pregnancy in the United States. What's most disturbing is that two thirds of these deaths are preventable. As of 2016, the U.S. pregnancy related mortality ratio was 16.9 per 100,000 live births. However, there are significant disparities within these calculated statistics between rural and urban populations. When we look at rural areas, they had a pregnancy related mortality ratio of 29.4 per 100,000 births compared to 18.2 in urban areas. If we look one year or two years earlier to 2014, we see that for every woman who died from pregnancy-related complications, 71 suffered from severe maternal morbidity.

Severe maternal morbidity includes unexpected outcomes of labor and delivery that result in a significant short or long-term consequences to a woman or infant health. Severe maternal morbidity has been steadily increasing and has affected well more than 50,000 women in the U.S. Furthermore, it's been postulated that the risk of maternal morbidity may be higher for rural women than those who reside in urban communities. One study found that when controlled for socio-demographic factors, as well as clinical conditions, rural residents had a 9% greater probability of severe maternal morbidity and mortality compared with urban residents.

Nationally, it is important to note that nationally, non-Hispanic black, American-Indian Alaska native, Hispanic and Asian residents of both rural and urban areas had at least 33% increased odds of severe maternal morbidity and mortality compared to their non-Hispanic white resident counterparts. Black women in rural areas are at especially high risk for poor outcomes. For instance, in Illinois, non-Hispanic black women were six times more likely to die of pregnancy-related conditions as non-Hispanic white women between the years 2014 and 2016.

Researchers have identified both clinical factors, including workforce shortages, as well as social determinants of health factors, such as transportation, housing, poverty, food insecurity, racism, violence, and trauma as significant challenges faced by rural patients. Both the rates of maternal mortality and of morbidity among rural residents highlight the importance of transforming our healthcare system to ensure that birth is not a deadly or traumatic experience for any woman, regardless of race, geographic location, socioeconomic status, and health insurance status. And understanding of the current programs and initiatives aimed at addressing rural maternal health will be helpful for both the Federal Office of Rural Health Policy, Department of Health and Human Services, as well as other stakeholders working to address the issues in these areas.

When we look at the accessibility of obstetric care and primary care, it's important to note that in large part, maternity care in rural areas is also dependent on hospital infrastructure. As most are aware, over 130 rural hospitals have closed their doors since 2010 and nearly 700 rural hospitals are financially vulnerable and are at high risk of closure. These hospital closures significantly affect rural maternal healthcare access. The percent of all rural counties in the U.S. without hospital obstetric services increased from 46% in 2004 to 55% in 2014. Furthermore, it is important to note that black communities have higher odds of hospital closures compared to their white counterparts, and these closures force millions of women of reproductive age to travel long distances to the nearest hospital, which may or may not provide obstetric services.

In the U.S., access to quality healthcare depends primarily on the patient's ability to acquire comprehensive insurance. In 2010, Medicaid covered 45% of babies born in the U.S., and rural areas, 50% to 60% of births were covered by Medicaid. While the federal statute requires coverage of prenatal care, delivery, postpartum care, and family planning through 60 days

postpartum, after that period individual states determine whether coverage through Medicaid continues. In several States, many new mothers become uninsured because they do not meet the state's Medicaid income eligibility requirements for parents. As a result, many of these women become uninsured after pregnancy related coverage ends 60 days postpartum.

The postpartum period is an important time for both mothers and infants. Women may be dealing with a host of medical conditions, such as maternal morbidity complications, pain, postpartum depression, and anxiety, all while caring for a newborn. In fact, women are more likely to die of pregnancy related conditions in the time following birth than during pregnancy or delivery. It seems that about a third of deaths, 31% happen during pregnancy, about a third, 36% happen at delivery or in the week after, and about a third, 33% happen one week to one year postpartum.

While I have everyone here, I also just want to mention a couple of the things that we've done, so there were efforts underway at CMS on the topic of rural maternal health. In 2019 we co-hosted with the Federal Office of Rural Health Policy and a number of other partners in an event called A Conversation on Maternal Healthcare in Rural Communities: Charting a Path to Improved Access Quality and Outcomes, as well as a related issue brief, and this is looking at access quality and outcomes before or after and during pregnancy. All of that, videos from the event, as well as the issue brief are available on our website.

In addition, earlier this year, and I'm sure many of you provided comments, but we issued a rural maternal request for information to gain more information from the stakeholders because that is of critical importance. In addition, we're currently hosting... well, a contractor is helping us with this, but we have convened a group of experts from the field to help us look at OB readiness in rural communities because, as I just mentioned, there are a number of hospital closures, there are a number of hospitals that are no longer providing maternity services, but that doesn't mean they're not delivering babies because as we all know, babies have a mind of their own when it's time to arrive, and even though you may have been trying to seek care at a further hospital, a baby may dictate that you need to show up at an emergency room that is closer to home, so figuring out what the baseline of rural OB readiness is.

So I want to thank you all again for the opportunity to speak on such an important topic, and now I would like to turn things over to Dr. Jacob Warren. Dr. Warren.

Jacob Warren:

So thank you very much Darci for that federal perspective. What I'll do now is zoom in on what you see happening in rural Georgia. As mentioned, my name is Jacob Warren. I'm the Director of Center for Rural Health and Health Disparities and Associate Dean for Diversity, Equity and Inclusion. The work that I'll be talking about is done in collaboration with my research partner, Dr. Bryant Smalley, who is our Associate Dean for Research. We were very honored to be asked by the National Advisory Committee to host their site visit down to Georgia right before the COVID outbreak to see what's happening on the ground. We just, again, want to thank everyone for coming to our state to learn what's happening here.

As was mentioned, we're in the middle of what can only be described as a maternal death crisis in the United States. The maternal death rates have doubled in the U.S. since 1987, and as a country, we rank 46th in the world. So we have the highest maternal mortality rate in the developed world. Part of the reason why I'm so passionate about this as a Georgian is that in its Deadly Delivery report, Amnesty International identified Georgia as 50th in the nation for maternal deaths. So Georgia has the unfortunate distinction of having the highest maternal mortality rate in the country with the highest maternal mortality rate in the developed world. So

we're really at the epicenter of what's happening. When we look at the rural parts of our state, it's even worse than what we see overall.

So rural women in Georgia have a significantly higher maternal mortality rate than in urban Georgia as we see in the rest of the nation as Darci mentioned, and we see the same effect play out with disparities. Unfortunately, what we're seeing in Georgia is that those disparities are widening. So what you see in this graph here is African-American maternal mortality rate versus white maternal mortality rate in the rural parts of our state. From the 13–15 to 15–17 span, you can see that while it has been decreasing for white women, it's remained fairly steady with African-American women in rural parts of Georgia. So this disparity is widening unfortunately. But what we see is that there are layers of risks, so we have the racial and ethnic disparities, but we do have a really stark geographic disparity as well, even when we look within racial and ethnic groups. So for example, in Georgia, rural African-American women have a 30% higher maternal mortality rate than their urban African-American counterparts, and for rural white women, it's 50% higher. So we have, again, this layering effect of what's happening within our state.

So when we think about this, I think it's important to look at that broader context because we frequently talk about population groups and the disparities that are associated with them, so we look at things in the bottom of this image. So we focus on income, age, parity, geography, race, and ethnicity. When we boil it down, that almost always comes back to inequities in these upper bands. So when we look at resources, access to care, social determinants of health, that's where we're seeing that the true effect of what's happening is not something core to an identity of being a rural woman or an African-American woman, it's these layers of risks that are applied and associated with being a member of different groups. And so that's, again, everything from, is there a labor and delivery in my county to what are the institutional racism effects that are present in my community. And so those come back to these fundamental barriers to healthy outcomes.

I know everyone is familiar with the social determinants, but I'm going to go into a few in more detail to highlight what we see in rural Georgia. So things like economic stability, we all know about rural persistent poverty, and that plays out in what we see happening in Georgia, education and health literacy, the general social and community context, health and healthcare in neighborhood and built environment, of course, but I wanted to go into detail about resources.

So what we see playing out in Georgia and nationwide is issues with transportation, with high rates of shift work that don't allow for time off or don't have paid time off, making it functionally impossible for women to seek out prenatal care even if it is available. We have a lack of supportive organizations, so we don't have a March of Dimes down the street that someone can go to to receive support. And we have a general lack of social services availability as well. And so what happens, unfortunately, is then we have baseline differences in health status that then translate into subsequent inadequate prenatal and postpartum care.

To give you some context on what this looks like in Georgia, Darci summarized really well what's happening with overall access to labor and delivery services. So this is a map of Georgia's 159 counties, and the white counties are those that are urban, the pink counties are rural counties that have a labor and delivery unit, and the red counties are those that have a labor and delivery unit. Every time I see this map, it makes my blood run cold because we have 93 rural Georgia counties that have no hospital with a labor and delivery unit, and in the past 20 years, 43% of our rural labor and delivery units have closed. So what this means is that two thirds of rural

Georgia births happen outside of their home county and you can just automatically realize what kind of effect that is going to have on our outcomes.

In addition, in rural Georgia, we have no maternal fetal medicine specialists that are located within rural communities. So if you end up with a high risk pregnancy, which you're at increased risk to have because of the other associated disparities and issues particularly related to diabetes and hypertension, you must leave your county to receive that care. And so that access becomes just a major, major barrier because as was mentioned, labor and delivery units in rural areas become the central point. So if you don't have access to prenatal care, to high risk OB services and to postpartum care, it's really unsurprising that we're seeing these outcomes. It prevents the establishment of continuity of quality care, and at the same time, it's happening within a context of a lack of preconception primary care, greater EMS response times, greater distance to hospitals. If the postpartum emergency occurs, all of that comes together to drive what we see in rural Georgia in particular.

So as Darci mentioned, depending on which subpopulation you're looking at, Medicaid covers more than 50% of birth. So in Georgia, it is more than 50% of all births are covered by Medicaid. Unfortunately, there's a widely held misconception that this covers all pregnancy needs. So as Darci mentioned, the federal mandate is that it must cover 60 days postpartum, but ACOG guidelines, of course, extend to one year postpartum to receive adequate postpartum care and to address maternal mortality issues. So in Georgia, we were one of those states that ended pregnancy Medicaid at 60 days after delivery. Fortunately, in the budget that was just passed, the governor will be implementing six months of postpartum coverage here in Georgia. So that's going to be revolutionary for maternal health. We still have six months gap there to get full postpartum coverage, but this has been a major issue for us in the past and we're excited to see this changing.

But the biggest piece of that is not only does it not cover the full post postpartum period, assuming that Medicaid covers all needs related to maternal mortality, ignores the entire history of that woman's life up to the point that she became pregnant. And so the lack of primary care for all of those years leading up to pregnancy has a really profound effect on outcomes. And so the need for improving access to health insurance is really critical when it comes to maternal mortality and severe maternal morbidity.

So I wanted to talk a little bit about some of what we're doing in Georgia to address this. We're very fortunate to have received funding through HRSA's Maternal and Child Health Bureau that built upon previous funding that we received from the Federal Office of Rural Health Policy to implement a multilevel initiative. These are very complex issues, what's happening in driving all of this. So we're working in seven counties in Southeast Georgia indicated in purple there to cover everything. So we're working in clinical care case management, health education, community engagement, workforce development, system change and research, all in one concentrated effort, and we're eternally grateful to HRSA for providing support for this kind of work. It's really helping us address both maternal and infant mortality in that region. To give you some context where we work, that's seven county region, African-American women, it's entirely rural, have a maternal mortality rate that is seven times the state average. Again, we have the highest state average in the nation, so we have extreme need here and we're very excited to have this work being done.

So there are three core issues that we've identified in Georgia and that extend beyond as well, and so that's how do we stop closures? How do we help people now? And then how do we fix the system that's led to where we are now? So when we think about stopping closures, every time a rural hospital or rural labor and delivery unit closes, it just widens the care desert that

already exists. So as I mentioned, two thirds of births in Georgia already happen outside of the rural home county. Unfortunately, due to COVID, we've had two additional rural hospitals in Georgia announced their closure. Neither of them had labor and delivery units, but we're all very concerned about the infrastructure here in the state and what COVID is going to do to hospitals that were already on the brink. If they have to sacrifice the labor and delivery units to keep the doors open as many have in the past, this crisis could really expand at a time when we all want it to be going the other direction.

And so the communities really need new models for preserving access to care when a hospital or labor and delivery unit close. So that's a really important thing to be developed, and we're very glad that HRSA's Office of Rural Health Policy is working on this so through their RMOMS addition of what different models of care can look like.

At the same time though we have to help women now. As we fix these larger structural issues, we have to ensure that women have access to care and that we're addressing the challenges that they face due to social determinant of health inequities. Because honestly, when you take a step back and look at the system, there's no other outcomes in stark maternal mortality disparities, and Georgia, we're a non-Medicaid expanded state. So if you have no health insurance coverage up to the time you become pregnant and up into just a few months to go, you were dropped after 60 days. This is the outcome that we're going to have until we change some of those systems. So working to support programs like Healthy Start, Headstarts, make the Home Visiting Programs, community health worker models, there are so many different ways to support women and that case management aspect is so critical to expand.

And then finally, the last thing I'll comment on is how we can change the system. It's obvious from the fact that in Georgia, nearly half of our labor and delivery units in rural areas have closed in 20 years, that traditional urban based OB care delivery models are neither sustainable nor designed for rural. So we need to come up with those new models and look at how those could be scaled out to other rural communities. At the same time in Georgia we're one of the last remaining states where nurse practitioners do not have independent practice privileges, and that's a very important expansion point for access to care. And so that combines with other workforce shortage issues that overly burden rural, and any opportunities to support workforce issues through loan repayment programs that are encouraging expansive scope of practice would be much, much appreciated in the state.

So I do always try to lead on something positive. So we're all working here in South Georgia to help the stark groups. We are excited to have a chance to highlight this to the National Advisory Committee to work for Georgia where all mothers and babies survive and thrive. I think that's what everyone on this webinar is hoping to achieve. So I thank you again for the time to talk with you about some of the needs that we see in the work that we're doing. With that, Dr. Poepsel will take over now.

Sallie Poepsel:

Thank you, Darci and Jacob for providing more context for the maternal health issues, both nationwide and in Georgia. To everyone on this seminar, this is Sallie. Welcome and thank you for tuning in today. I am delighted to present the Committee recommendations as a former member of the Committee myself. I served the Committee for four years, and the last meeting was my last year.

Before we go over the recommendation, I would like to talk more about the site visit that took place on the second day of the National Advisory Meeting. The Committee site visit to Macon was hosted by the Mercer Medical School. The Mercer University School of Medicine was founded in 1982 and accepts only Georgia residents into their MD program. The school's core

mission is to train primary care physicians and other health professionals for service in rural and medically underserved areas of Georgia. Furthermore, they have developed the Center for Rural Health and Health Disparities in order to implement community driven solutions to health disparities issues in rural areas of Georgia. This center is one of only two rural focus, NIH Centers for Excellence in the nation, and it operates numerous programs that not only focus on eliminating disparities in maternal and infant mortality, but also opioid overdose and chronic diseases.

During the community site visit at Mercer University, a dozen representatives all across Georgia were brought together to discuss both the human services and healthcare delivery perspectives regarding maternal health. Several major things emerged during the site visits. Stakeholders from South Georgia Healthy Start, Valdosta Healthy Start, Georgia Home Visiting Program of Lowndes County, and the Albany Area Primary Health Care Center, all expressed expanding Medicaid coverage from 60 days postpartum to 365 days postpartum as a critical change to improve maternal health outcomes in Georgia.

Now, given that maternal deaths are more likely to occur postpartum, extending Medicaid ensures that women have access to receive care and prevent both maternal mortality and morbidity. Extending Medicaid coverage would also alleviate postpartum depression among mothers, which is critical to address as it affects both the mother and the child. Furthermore, all the stakeholders commented that alleviating environmental stressors, such as lack of access to safe and affordable housing, transportation challenges and food deserts would greatly improve maternal health outcomes.

Now, these social determines of health greatly affect the overall health of women. Now, considering the cardiovascular conditions are the leading cause of maternal death, stakeholders emphasize the importance of addressing the conditions and factors that influence one's overall health. On a similar note, stakeholders also raise the importance of having more primary care providers to uphold the health and wellbeing of women before and during pregnancy. They stated that more primary care would reduce the amount of complications that occur during pregnancy, birth and the postpartum period.

The stakeholders also, from various Healthy Start programs in Georgia, also remarked that improving health literacy among people in the community would also greatly improve maternal health outcomes. Now, with this increased health literacy and connection with services and care, women's health greatly improves and they are more empowered during pregnancy to take care of their health and that other expected baby.

Regarding hospital care, stakeholders emphasize that midwifery restrictions need to be addressed so midwives are able to tend to their patients if they are admitted into the hospital. Midwives meet an essential gap in the lack of primary care physicians and OBGYNs in rural areas. With an expanded scope of practice, midwives can help improve care coordination, ultimately making it easier for rural women to access high quality care.

Stakeholders also have emphasized the necessity of implicit bias training within hospitals to improve care delivery for racial minorities, in particular, black women. Nurses and doulas on the panel spoke of numerous experiences where their patients experienced discrimination and lower quality of care during their birthing experience, indicating that implicit bias affects maternal health outcomes. With more training in quality measures, maternal mortality rates among black women and women of other racial minorities can be reduced.

Now, here are the policy recommendations. Over the course of the meeting and site visit, the Committee developed a sense of importance of expanding Medicaid, addressing the PCP and OBGYN physician shortage in rural areas, alleviating environmental stressors and improve health literacy to address rural maternal health issues. The Committee understands that both health and human services have an interconnected role in maternal health and had proposed policy recommendations that address both.

Both the national and state policy experts that presented to the Committee discussed the numerous programs that the federal government has implemented to address maternal health issues. This includes the Maternal and Child Home Visiting Program and Healthy and Headstart. On the final day of the meeting, the Committee concluded that health and human service programs should be designed to address social determinants of health and to improve both access and quality of care before, during, and after pregnancy. These themes laid the foundation for the framework for the Committee's recommendation.

First, the Committee recommends that the Secretary encourage the adoption of comprehensive, integrated and intensive case management within Healthy Start, Early Head Start, and the Maternal Infant, and Early Childhood Home Visiting Programs. The Committee consistently heard about the challenges rural women in Georgia face as they navigate pregnancy in the years following. Many women are single mothers and lack support from their family and no partners. Therefore, there is a great need to support social service programs such as Healthy Start, Early Headstart, and the Maternal Infant and Child Home Visiting Program as these human services provide holistic care for mothers and help them navigate the challenges that arise before, during and after childbirth. These programs address multiple social determinants of health for mothers as they provide a wide array of health and human services.

Now, given the importance of addressing social determinants of health to reduce maternal mortality, the Committee encourages HHS agencies to continue investing in human services programs within the Maternal and Child Health Bureau and the administration for children and families. During this visit, Committee members heard about the need for strengthened human service programs delivered by HHS.

Second recommendation. The Committee recommends the Secretary to develop guidelines and implement safety and treatment protocols in rural hospitals and clinics, both with and without OB services to respond to obstetric complications. Additionally, the Committee recommends that the Secretary encourage states to utilize and implement the Alliance for Innovation on Maternal Health bundles, AIM bundles, particularly the AIM Maternal Safety Bundle for the Reduction of Peripartum Racial/Ethnic Disparities.

Because of low patient volumes and lack of obstetric providers in rural areas, many rural hospitals, especially those without OB services are not prepared to handle complications that arise both during and after childbirth. The Committee believes treatment protocols should be developed and implemented in critical access hospitals in order to prevent both maternal mortality and morbidity. AIM is funded through a collaborative agreement with the Maternal and Child Health Bureau, and although they offer numerous Safety Bundles on ranges of issues, there is no bundle specifically addressing hospitals and clinics that do not have OB services. To increase the preparedness of rural hospitals, the Committee suggests its second recommendation.

Third recommendation, that the Secretary enhance CDC funding for both the CDC Levels of Care Assessment Tool program and Enhancing Reviews and Surveillance to Eliminate Maternal Mortality program to ensure that all states have standardized assessments of levels of maternal

and neonatal care and maternal mortality Review Committees. The Committee believes that there needs to be improvement in care coordination among health providers, especially as it relates to high-risk pregnancy. With improved care coordination and better risk assessment of pregnancies, the Committee believes maternal mortality and morbidity can be reduced.

Additionally, the Committee recognizes the importance of Maternal Mortality Review Committees as they bring together a wide range of professionals to facilitate an understanding of the drivers of maternal mortality and complications of pregnancy and the associated disparities. They also inform the implementation of initiatives in the right place for families and communities who need them the most. Currently, the CDC supports 25 states in the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality program, and the Committee believes that the ERASE mortality and morbidity program should be implemented in all states.

Fourth recommendation. The Committee recommends that the Secretary work with states to a standardized scope of practice laws between and within maternal healthcare providers and to expand the scope of practice for nurse midwives. This issue is of particular concern in rural areas, given the shortage of obstetric providers, and certified nurse midwives can play a very critical role if allowed to practice to the extent of their training.

Now, to improve healthcare delivery, rural communities need to leverage all providers from OBGYN to primary care physicians, to advanced practice nurses, to clinical nurse midwives. During the site visit at Mercer, the Committee consistently heard of the importance of certified nurse midwives as they often meet an essentially gap in the lack of both primary care physicians and OBGYNs. However, as discussed previously, nurse midwives face many restrictions in their scope of practice. The Committee believes that there are opportunities to standardize laws, both federally and among the states to ensure that women in rural communities have access to high quality maternal health. These standardizations as this one can improve care coordination with a wide variety of maternal healthcare providers, ultimately making it easier for rural women to access quality healthcare.

Fifth recommendation. The Committee recommends that the Secretary in support of the administration's broader graduate medical education goals include an expansion of the current statutory cap on Medicare supported residencies that allows for supportive rural residencies in high need areas like primary care and obstetrics. During the site visit, the Committee heard of the workforce shortages for maternal-fetal medicine physicians, OBGYNs, primary care physicians, nurses, midwives, and doulas that disproportionately affect rural communities. This shortage is critical to address as it exacerbates the lack of access to care for rural women and their families, which can contribute to poor health outcomes.

Now, although medical schools have been consistently increasing their class size, the number of residency spots happen to be relatively constant. Without increasing residency spots, the physician workforce shortage will continue to worsen. Now, while recognizing HHS has been examining the adequacy of residency positions and has proposed three forms to the graduate medical education system, the Committee sees the cap on residency spots as major barrier to inadequate rural healthcare workforce.

Last recommendation is that the Committee recommends that the Secretary address the obstetrical workforce shortage by working with Congress to increase support for the National Health Service Corps to expand the number of physicians, nurses, and certified nurse midwives working in rural and underserved areas. Additionally, to address the workforce shortage specifically rural areas, the Committee believes that it is necessary to support loan repayment programs.

Now, some of the issues that the Committee felt were more general, were not rural specific, have been included within the policy recommendations portion of the brief, and here they are. The Committee is aware that states now have the option to extend the period of Medicaid coverage to one year postpartum and would benefit from considering it as an option to improve maternal health outcomes. Second, the Committee suggest that the Secretary consider a visible support of the president's 2021 budget proposal to expand the rural obstetric medicine strategies program while supporting the perinatal service models that include midwifery, birth centers, maternal medical homes, doulas, peer counselors, and community health workers.

Thank you all for listening about the Committee's experience at Mercer Medical School and the policy recommendations and considerations put forward. I will now turn things back over to Dr. Colyer to provide his concluding thoughts. Dr. Colyer.

Jeff Colyer:

Great. Thank you so much to all of our panelists. We really appreciate the summary of the Committee's recommendations and the data behind it. I encourage you to read the entire policy brief in full for further details. If you remember, you can connect onto the link on the slide here. We can answer any questions that you have at the end of the webinar now.

Kristine Sande:

So at this point, you can put your questions into the Q&A section of the webinar, so there's a little button down at the bottom of your screen. If you click on that, the Q&A box will pop up and you can take your questions in there, and so we'll go ahead and open that up at this point.

So we do have one question that has come in, asking about the recommendation that hospitals, institute implicit bias training, which the questioner says might imply that providers discriminate in their quality of care. Just wondering if there's data to support that or... So I'll open that up to our panelists regarding the question of the implicit bias.

Jacob Warren:

I can weigh in there a little. The concept with implicit bias is not stating that there is overt and active intentional discrimination. It's reflecting a system that through overall education standard of practice and historical action leads to negative outcomes for one group versus the other. And so it's fairly well documented that this occurs across a wide variety of outcomes. I don't know, off the top of my head, the data for maternal mortality, but I believe it was just last week there was an article in the proceedings of the National Academy of Sciences of the U.S. that for infant mortality, that when a black infant is cared for by a black physician, infant mortality rates halved. And so there is some pretty robust evidence that there's something occurring. Again, not stating that it's over, but with implicit bias, it's just to help individuals navigate some assumptions that are made intrinsically and just to make sure everyone brackets any potential different treatment, not necessarily discriminatory treatment, but something that manifests in different treatment based on racial and ethnic group, even unintentionally.

Kristine Sande:

Great. Thank you. Here's another question. Has there been obstetric readiness surveys done in other states besides Georgia? Is anyone aware of that?

Jeff Colyer:

This is Jeff Colyer here. I'm not aware of those studies, but if anybody else on the panel is aware of some of them, that would be helpful.

Kristine Sande:

Yeah, it doesn't sound like anybody is aware. That's a question that you could certainly send to RHIhub's info@ruralhealthinfo.org email and they can do a search for you related to that question, if you'd be interested in that. Okay, another question is what are the best resources available for primary care providers to improve maternal health outcomes by addressing social determinants of health?

- Jacob Warren:** There are some materials put out by ACOG that discuss how to address those social determinants of health. And then within the Healthy Start program, the TA center, which is referred to as EPIC has a lot of good resources that I think would be applicable to primary care providers. So I would encourage anyone to look at a Healthy Start EPIC website that has really good resources for case management programs that I think would apply for primary care as well.
- Kristine Sande:** Great. It looks like we have a suggestion related back to the question about obstetric readiness, and it's referring folks to the Rural Health Research Gateway's recap on rural obstetric services and access. So somebody is expanding on the question of OB readiness, talking about, are those happening in EDs and urgent care? Darci, maybe you can tell us a little bit about what your CMS OB readiness folks are going to look at.
- Darci Graves:** Absolutely. So this work group has been tasked with looking at EMS. So first responder, individuals, as well as emergency department rooms and hospitals broader rural health... Anybody who can provide rural maternal services but aren't currently doing it because there's a lot of hospitals that have downsized things, but we're strictly looking at facilities that have previously provided services and are no longer doing it, or have never provided services and figuring out how we can help baseline them. But we're including EMS in the conversation as well as emergency room physicians and other clinicians as well.
- Kristine Sande:** Thank you. There's another question, "Wondering if the Committee looked at any recommendations around challenges for pregnant people with opioid use disorder or maybe other substance use disorders as well?"
- Darci Graves:** I don't think so.
- Kristine Sande:** Okay. Yeah. That is a good point. There certainly are challenges with that. People do have substance use disorders. Can somebody repeat what the LOCATe and ERASE MM tools are used for.
- Sallie Poepsel:** They are used as a standardized assessment for levels of maternal and neonatal care.
- Kristine Sande:** Great. Thank you. Another question is, transportation is a huge issue where this person is from, in Western North Carolina, and they're wondering if there is any piloted programs in Georgia for easing transportation issues.
- Jacob Warren:** We have some initiatives. Within our program, we provide some transportation vouchers. There are some regional systems in Georgia that have... they're essentially called medical buses that operate in our service region, five or six counties. The challenge sometimes comes that you have to cross more county lines than the service can cover, but that's some of what's been looked at here. There is a county in Southeast Georgia looking to implement small scale rural public transportation in partnership with surrounding counties as well. So those are being piloted.
- We also have in Georgia our perinatal health centers, which are where our MFMs are located and they have different transportation initiatives that are designed to bring in women from rural areas centrally to receive MFM services when needed. So there's some energy around that, but it remains a persistent issue for a lot of rural health outcomes.
- Kristine Sande:** Transportation is a hard one, especially I think with when it's time for delivery, that becomes especially a challenge. So yeah, that's definitely an important issue.

So at this time I think we will bring our webinar to a close. On behalf of the Rural Health Information Hub, I'd like to thank our speakers today for the great information and the insights. I'd also like to thank everybody working with the National Advisory Committee on Rural Health and Human Services. If any of you have questions that you would like to direct to the Committee staff, Paul Moore would be the contact for that. I think it was a couple of slides back his contact information was available. So definitely take the opportunity to contact Paul if you have bigger questions or comments on this.

The slides used in today's webinar are currently available at www.ruralhealthinfo.org/webinars. In addition, a recording and a transcript of the webinar will be made available on the RHHub website and sent to you by email in the near future so that you can listen again, or you can share the presentation with others. Thank you and have a great day.