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Rural Maternal Health Series: Engaging with Perinatal Quality Collaboratives for Rural Hospitals

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Rural Maternal Health Series: Engaging with Perinatal Quality Collaboratives for Rural Hospitals

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- Slides are available at www.ruralhealthinfo.org/webinars/perinatal-quality-collaboratives
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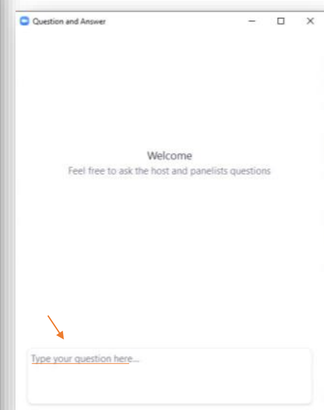

Rural Maternal Health Learning Series
Welcome and Introductions

Dr. Kristen Dillon, MD, FAAFP, Chief Medical Officer
Federal Office of Rural Health Policy (FORHP)
Health Resources and Services Administration, U.S. Department of Health and Human Services

Vision: Healthy Communities, Healthy People

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Featured Speakers

Jacqueline Wallace MD, MPH, Perinatal & Infant Health Team, Maternal and Infant Health Branch, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC)

Caroline Sedano, Perinatal Unit Coordinator at the Washington State Department of Health

Annie Glover, PhD, MPH, MPA, Senior Research Scientist at the University of Montana Rural Institute for Inclusive Communities and a Research Associate Professor at the University of Montana School for Public and Community Health Sciences

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STATEWIDE PERINATAL QUALITY COLLABORATIVES

Maternal Health Learning Series
Federal Office of Rural Health Policy
March 26, 2024

JACQUELINE WALLACE MD, MPH
MEDICAL OFFICER, PERINATAL QUALITY COLLABORATIVE PROGRAM
PERINATAL & INFANT HEALTH TEAM
MATERNAL AND INFANT HEALTH BRANCH, DIVISION OF REPRODUCTIVE HEALTH

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

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OUTLINE

- Setting the stage
- Quality Improvement in Maternal/Child Health
- Working with Perinatal Quality Collaboratives

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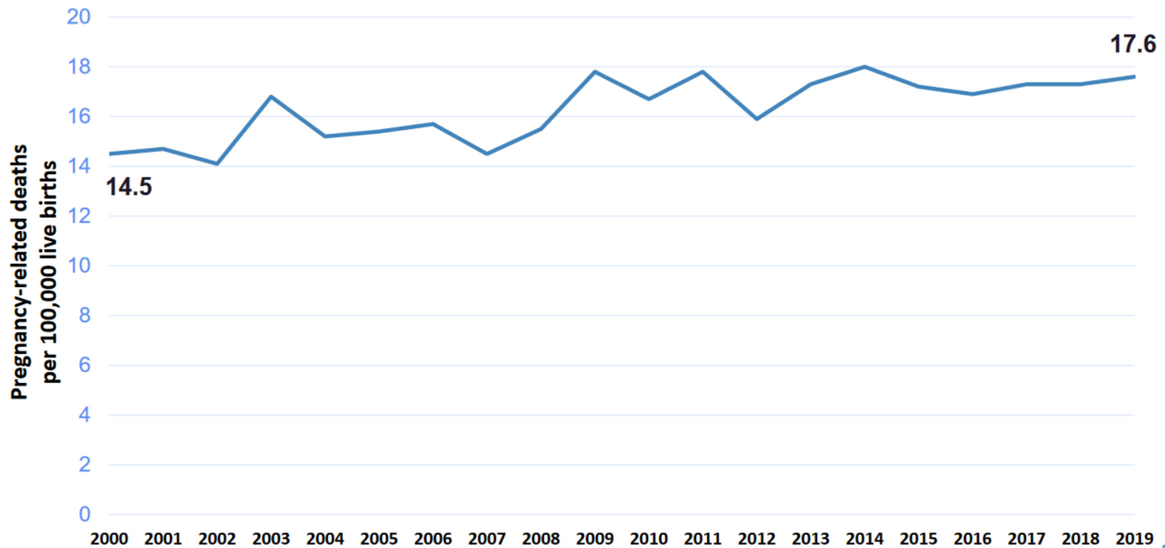
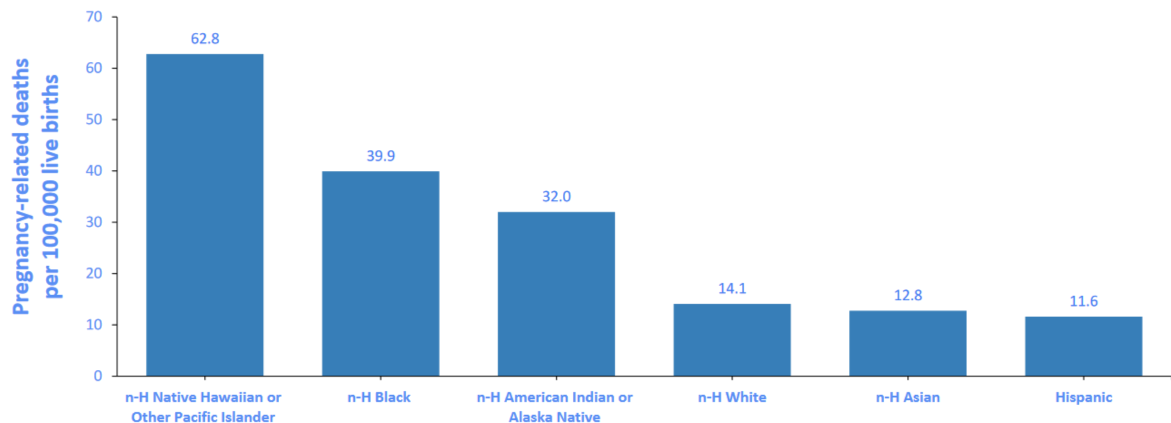
Pregnancy-related Mortality Ratio by Year: 2000-2019, PMSS*



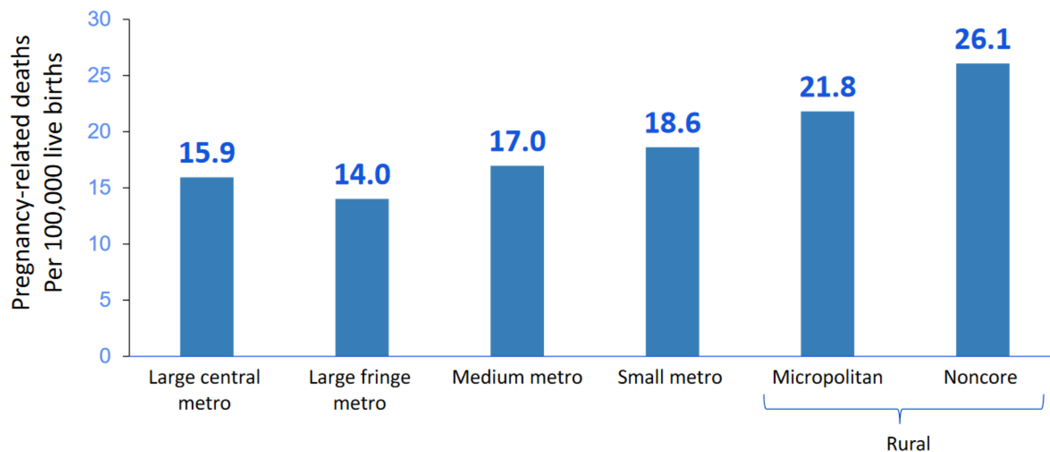
*CDC Pregnancy Mortality Surveillance System. https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm

Pregnancy-related Mortality Ratio by Race-ethnicity: 2017-2019, PMSS*



Multiracial PRMR for 2018-2019 = 7.1 pregnancy-related deaths per 100,000 live births.
Race or ethnicity was missing for 1.4% of pregnancy-related deaths in 2017-2019; PRMRs for non-Hispanic Other Race were not calculated due to small numbers.
*CDC Pregnancy Mortality Surveillance System. https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm

Pregnancy-related Mortality Ratio by Urban-Rural Classification: 2017-2019, PMSS*



Urban-rural classification was missing or unknown for 2.4% of pregnancy-related deaths in 2017-2019.
*CDC Pregnancy Mortality Surveillance System. https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm

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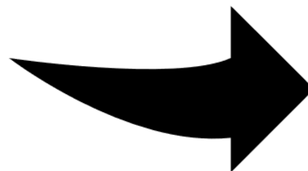
MMRCs Determined:



84% of pregnancy-related deaths were determined to be preventable

https://reviewtoaction.org/

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BIRTHING FRIENDLY HOSPITAL DESIGNATION

- CMS designation to describe high-quality maternity care
- To earn designation, hospitals or health systems are required to respond to:
  - **Question**: Does your hospital or health system participate in a Statewide and/or National Perinatal Quality Improvement Collaborative Program aimed at improving maternal outcomes during inpatient labor, delivery and post-partum care, **and**
  - has implemented patient safety practices or bundles related to maternal morbidity to address complications, including, but not limited to, hemorrhage, severe hypertension/preeclampsia or sepsis?
  - **Answer Choices**: (A) Yes, (B) No, or (C) N/A (our hospital does not provide inpatient labor/delivery care)

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BRIEF HISTORY OF PERINATAL QUALITY IMPROVEMENT (QI)

1990s
- New emphasis on QI
- 1997: first PQC formed, California Perinatal Quality Collaborative

2000s
- Growth of perinatal QI movement, spearheaded by states, private & professional organizations

2010s
- CDC begins providing support to PQCs in 2011
- 2016: National Network of PQCs (NNPQC) launched, supported by CDC

2020s
- A PQC exists in every state
- 2022: 4th iteration of CDC funding for PQCS begins, supporting 27 PQCs & coordinating center for NNPQC
- 2023 CDC provides funding for nine additional PQCs

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PERINATAL QUALITY COLLABORATIVES (PQCs)

- **State or multi-state** networks
- **Multidisciplinary teams**
- **Population-level impact**
- Advance **evidence-based** clinical practices and processes
- **Quality improvement (QI) principles**

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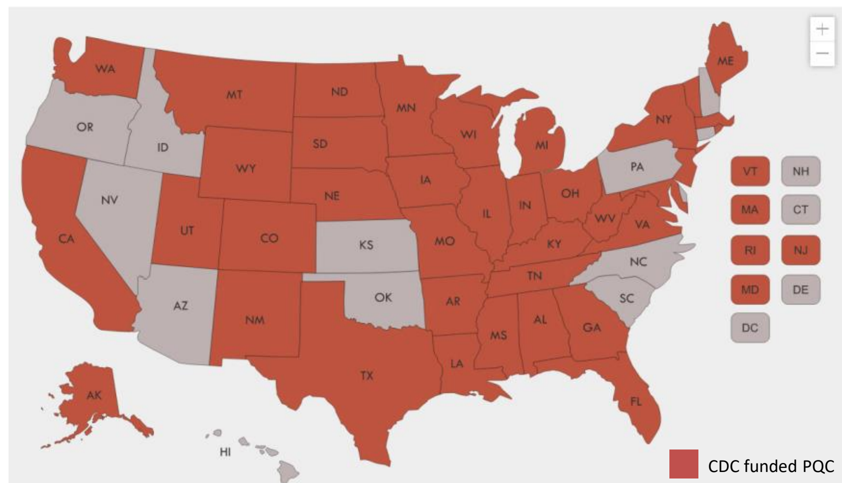
PQCs ACROSS THE NATION

- PQC exists in every state and Washington, DC
- Institutional home of PQCs varies
- PQC quality improvement (QI) initiatives vary
- Interactive map https://nnpqc.org/



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THREE PILLARS OF PQC QI INITIATIVES

Collaborative Learning

Rapid Response Data

Quality Improvement Science Support

Achieve improvements in population-level maternal and infant health outcomes

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THREE PILLARS OF PQC QI INITIATIVES

Collaborative Learning

- Webinar series
- Simulation training
- Kickoff meetings
- Newsletters
- Podcasts

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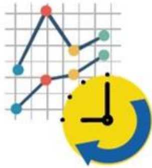
THREE PILLARS OF PQC QI INITIATIVES



- PQC analyzes hospital level, de-identified data
  - Aggregate, disaggregate
- Summary reports
  - De-identified comparison across state, regions or nationally

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THREE PILLARS OF PQC QI INITIATIVES

- Coaching calls
- Quality Improvement methods training
- Site visits

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PQCs MOVING FORWARD

- Emphasis on **Health Equity**
- Engage all facilities providing prenatal, delivery, postpartum or infant care
- Increase **patient/community engagement**
- Increased **emphasis on partnerships and collaborations**

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WAYS TO CONNECT…..

- Identify who is working on perinatal QI in your network or health system and what they are working on
- Identify who could make up a Quality Improvement Team
- Contact your state PQC
- Read your state MMRC report

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Thank You!

Jackie Wallace
Medical Officer
Perinatal Quality Collaborative Program
jacqueline.wallace@cdc.hhs.gov

Centers for Disease Control and Prevention

National Center for Chronic Disease Prevention and Health Promotion

Division of Reproductive Health

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

CDC

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WASHINGTON STATE
DEPARTMENT OF HEALTH

MATERNAL HEALTH LEARNING SERIES: RURAL HOSPITALS, MARCH 2024

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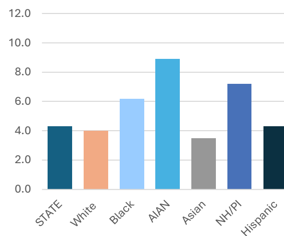
Maternal, Child and Family Health in Washington

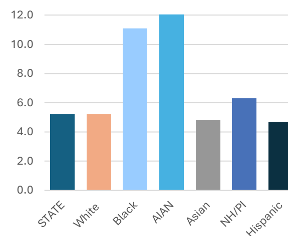
74.5% pregnant people receive prenatal care in the 1st trimester

Average 85,000 births/year
48% covered by Medicaid

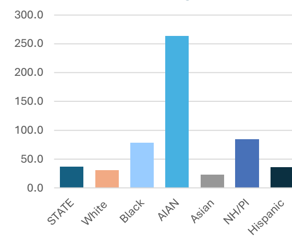
Infant Mortality 2020-2021 Rate per 1,000 Live Births



Fetal Death 2019-2021 Rate per 1,000 Live Births



Maternal Death 2014-2020 Rate per 100,000 Live Births



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Maternal Mortality Report, 2023

Key Findings

- 80 percent of pregnancy-related deaths in Washington were preventable and occurred after the end of pregnancy
- Leading causes of pregnancy related deaths were behavioral health conditions
- Substance use was associated with 20 percent of pregnancy-associated deaths
- American Indian/Alaska Native people face higher maternal mortality rate than any other race or ethnicity

Recommendations

- Undoing Racism and Bias
- Address Mental Health and Substance Use Disorder
- Enhance Healthcare Quality and Access
- Strengthen Clinical Care
- Meet Basic Human Needs
- Address and Prevent Violence

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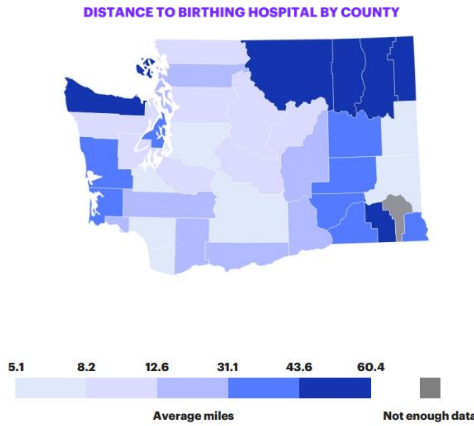
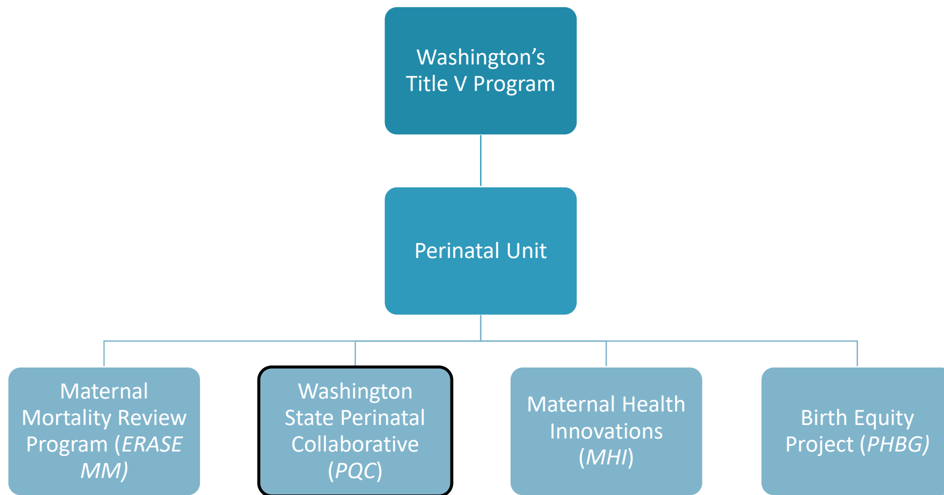
Rural Maternal Health



- 41% of rural hospitals offer obstetrical labor and delivery services
- 11% decrease in birthing hospitals between 2018 and 2023

Washington PQC: Washington State Perinatal Collaborative (WSPC)



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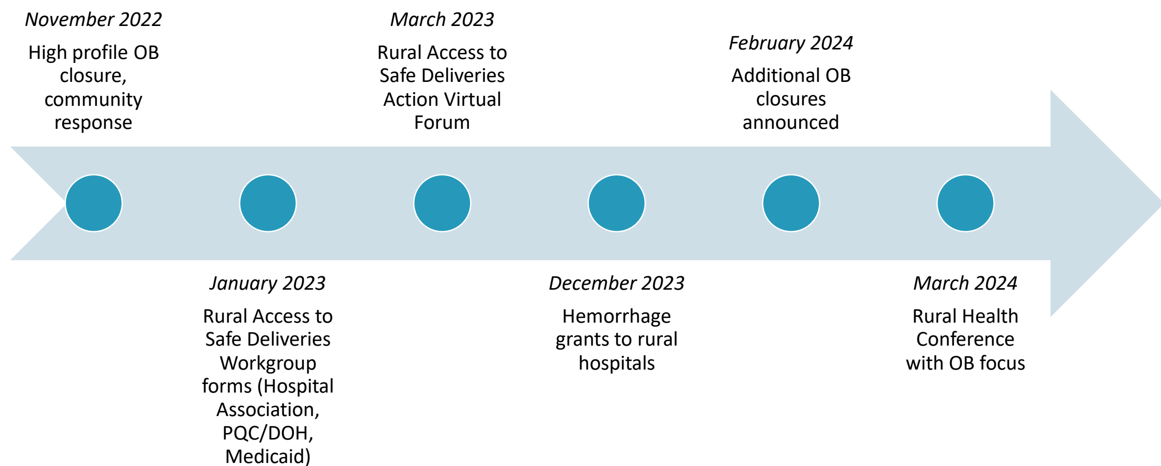
Response to rural health access concerns



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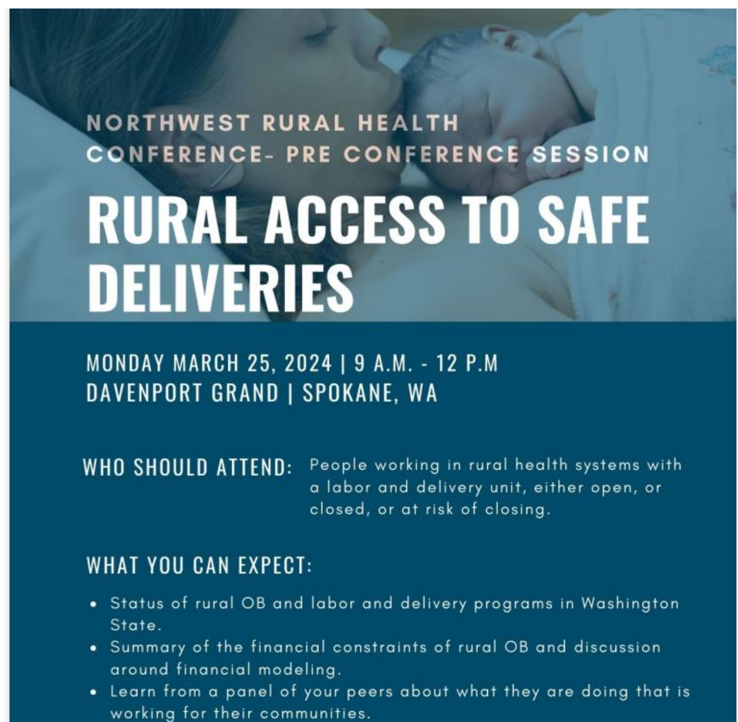
Landscape assessment of rural providers

Why are rural OB L&D services closing?

- **Not enough deliveries** to maintain the nursing staff or provider skills, resulting in increased risk deemed as unacceptable to the clinical team members.
- **Workforce shortages** and failed recruitments for qualified providers and nursing staff. Low volumes can also affect provider retention and recruitment. For example, new family medicine graduates often want to go where they can practice their OB skills. An OB may not be able to earn an acceptable income.
- **Expense** and low Medicaid reimbursement, with a large percentage of Medicaid lives in some rural communities.

Facilitated by

- Washington State Department of Health – *Sate Office of Rural Health and WSPC*
- The Rural Collaborative
- Washington State Hospital Association
- The Health Care Authority/Medicaid



Ongoing PQC efforts to address rural health access

Maintaining provider skill

- Simulation training for 44 rural/critical access hospitals (*Hospital Association*)
- Hemorrhage grants: $5,000 grants for rural hospitals (*PQC*)
  - Improve hemorrhage programs, purchase equipment ("Jada System" or hemorrhage carts), or staff training including
  - Exploring grants for birthing centers
- *Exploring* regional training centers for rural providers (*PQC*)

Workforce shortages

- *Exploring* Rural Provider Advisory workgroup (Family Practice and OB)
  - Chaired by WSPC clinical lead (*PQC*)

Expense

- *Exploring* financial modeling technical assistance to support OB care, statewide rural health conference topic

Thank you!

Caroline.Sedano@doh.wa.gov

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Engaging Rural Hospitals in the Montana Perinatal Quality Collaborative

Annie Glover, PhD, MPA, MPH
Director / Principal Investigator, Montana Perinatal Quality Collaborative, Montana Alliance for Innovation in Maternal Health
Senior Research Scientist, University of Montana Rural Institute for Inclusive Communities
Research Associate Professor, University of Montana School of Public & Community Health Sciences

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Healthcare Landscape in Montana

Montana has 62 total hospitals, including:

- 25 hospitals with OB units (14 CAHs, 1 IHS facility)
- 35 hospitals without OB units (all CAHs)
- 3 Indian Health service units

In 2021, we implemented, through the MHI grant, the CDC's Levels of Obstetric Care Assessment Tool (LOCATe) with 25 of 26 birthing facilities (one facility has closed its OB unit since the assessment).

- 68% of birthing facilities in Montana LOCATe-assessed at Level 1 or lower.
- Recommendations from this assessment included **engaging in education and training of providers** and **enhancing care through evidence-based practice with the Montana PQC.**

CDC-Assessed Levels of Maternal Care
MT LOCATe Conducted July 2021 to October 2021

Facility Level (N=25)	Locate Assessment n (%)
<Level I	6 (24.0)
Level I	11 (44.0)
Level II	6 (24.0)
Level III	1 (4.0)
Level IV	1 (4.0)

Critical Access Hospital Capacity in Responding to Obstetric Emergencies
World Health Organization Emergency Obstetric Care Indicators

Emergency Obstetric Care Ability (N=30) Hospital has the capacity to…	n (%)
Administer magnesium sulfate for severe preeclampsia and eclampsia	26 (86.7)
Perform basic neonatal resuscitation	26 (86.7)
Conduct blood transfusion	23 (76.7)
Administer uterotonic drugs [a]	16 (55.2)
Provide and interpret fetal heart tracing in an emergency setting [a]	10 (34.5)
Perform assisted vaginal delivery with a soft cup vacuum extractor	4 (13.3)
Manually remove a placenta	4 (13.3)
Remove retained products of delivery	4 (13.3)
Hospital has a plan or policy for an emergency cesarean in the case of a life-threatening obstetric emergency	1 (3.3)

Emergency Obstetrics Survey conducted October 18, 2021, to December 10, 2021
[a] – N=29, one response missing

MPQC-AIM Initiatives

AIM Obstetric Sepsis Bundle (2023-2024)

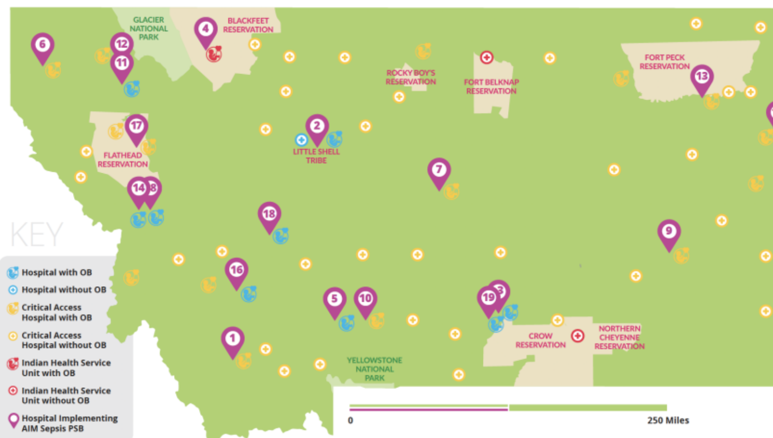
- 19 of 26 birthing facilities participating

CAH Participation in MPQ-AIM (2021-2024)

- 16 Montana CAH are birthing facilities
- 1 IHS is a birthing facility
- 14 CAH and 1 IHS have implemented at least one PSB through PQC since 2021

HOSPITALS ACROSS MONTANA

Perinatal Quality Collaborative Reach and Montana's Maternal Health System



Fun facts:

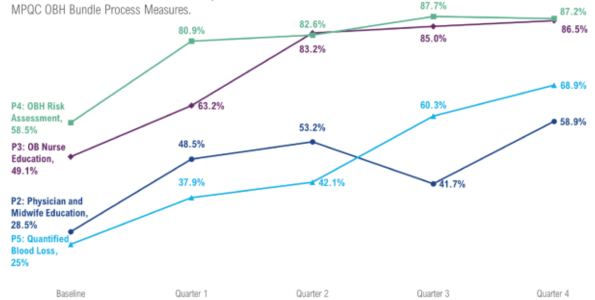
Fort Peck (3,270 sq. miles), Blackfeet (3,000 sq. miles), and Crow (3,593 sq. miles) are each larger than the state of Delaware (2,489 sq. miles.)

Flathead (1,938 sq. miles) is larger than the state of Rhode Island (1,545 sq. miles).

MPQC-AIM SEPSIS IN OBSTETRIC CARE BUNDLE COLLABORATIVE

1) Barrett Hospital & Healthcare
2) Benefis
3) Billings Clinic
4) Blackfeet Community Hospital
5) Bozeman Health
6) Cabinet Peaks Medical Center
7) Central Montana Medical Center
8) Community Medical Center
9) Holy Rosary Healthcare
10) Livingston Healthcare
11) Logan Health Kalispell
12) Logan Health Whitefish
13) Northeast Montana Health Services
14) Providence St. Patrick Hospital
15) Sidney Health Center
16) St. James Healthcare
17) St. Luke Community Hospital
18) St. Peter's Health
19) St. Vincent's Intermountain Health

MPQC-AIM Initiatives

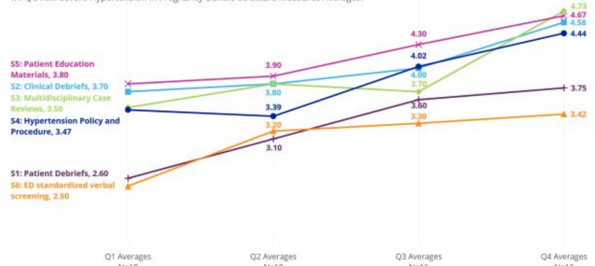


AIM Obstetric Hemorrhage Bundle

- 10,794 total live births in 2020
- **8,110** (75.1%) births occurred in PQC hospitals participating in the OBH Bundle
- 17 of 26 birthing facilities participated

AIM Severe Hypertension in Pregnancy Bundle

- 11,231 total live births in 2021
- **8,267** (73.6%) births occurred in PQC hospitals participating in the Hypertension Bundle
- 19 of 26 birthing facilities participated



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Emergency Obstetric Care in Montana

- Nearly half of Montana's CAH have closed their obstetric units in the last twenty years.
- Due to distance to care, pregnant people might seek care or deliver at a facility without an obstetrics unit.
- AI/AN pregnant people in Montana are 20 times more likely to give birth at a facility without an obstetrics unit (Thorsen et al., 2022).
- MPQC-AIM will start implementing AIM Obstetric Emergency Resource Kit in 2024 through PQC funding due to enormous need expressed by our non-birthing CAHs

Roundup Memorial Delivers First Baby in 8 Years

November 10, 2021

Roundup hospital had its first baby delivery in 8 years today! SummerLee Rose Greenberg was born to Jesse Lee Greenberg and Madisyn Magreggor on November 08-2021. After the delivery mom and baby were transported to Billings by ambulance for after care and hit a deer on the way!! Both are doing well!!! Thank you Roundup Hospital!!!!!

Thorsen ML, Harris S, McGarvey R, Palacios J, Thorsen A. Evaluating disparities in access to obstetric services for American Indian women across Montana. The Journal of Rural Health. 2022;38(1):151-160. doi:10.1111/jrh.12572

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Engaging Montana's Rural Facilities

Key Partnerships

State MHI Program

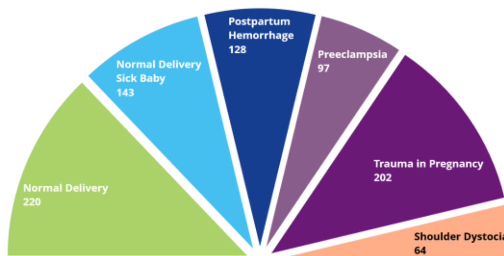
- Supported the pilot year of MPQC in 2021, LOCATe and EO initiatives, capacity mini-grants, PSB concordance between simulation training and MPQC-AIM Implementation

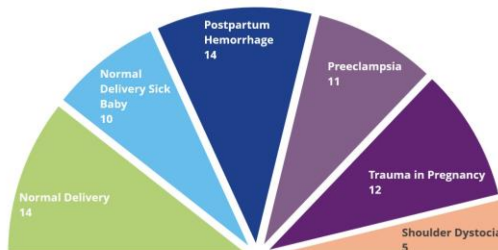
Montana Hospital Association

- Essential for creating relationships, biggest advocates for QI for most MT facilities. Representative serves on the MPQC-AIM Steering Committee

Montana Perinatal Association

- Laid the groundwork for the MPQC through neonatal initiatives, has been a big support system of the maternal health initiatives. Representative serves on MPQC-AIM Steering Committee.





Engaging Montana's Rural Facilities

Key Implementation Strategies for Rural Hospitals

Data Support

- PQC hospitals report process and structure measures to us quarterly through user-friendly REDCap system
- Coaching done through Simple QI for PDSA cycle tracking
- DUA with Montana Hospital Association for outcomes / surveillance measures
- We report to AIM Data Center on behalf of hospitals

Accessible Learning Opportunities

- Synchronized with MHI simulation program
- Learning Sessions conducted on Zoom and recorded
- Innovative remote learning, such as table-top simulations and case-based learning

Individualized QI Coaching

- All calls (orientation, learning sessions, and team calls) are held through synchronous Zoom calls
- Include content in each Learning Session specifically aimed at addressing rural hospital needs (i.e. staffing, resources available, etc.)
- Encourage partnerships between neighboring facilities, using the same EHR system, etc., through protected collaborative time
- We listen to evaluations and modify in response to facility feedback
- Launching new partnership with Montana State University College of Nursing DNP Program! DNP students will do their doctoral QI project as live QI coach for PQC sites.

Recommendations from Montana

My nephew made his entrance a few weeks early in a PQC CAH with OB.

He and mama were transported to a larger PQC facility after delivery; he spent several days in the NICU.

Both hospitals had implemented three PSBs with MPQC-AIM.

Mama and baby are home and doing well!

Nephew says…

- Rural OB care matters!
- Strong transport networks needed to facilitate high quality risk appropriate care inclusive of remote communities.
- CAHs, with and without OB units, are critical parts of the maternal health system.
- Rural hospitals need specialized supports to ensure operating at the top of their capacity.
- Must adapt PSBs for rural OB, rural ED, and transport realities.

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Questions?

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