

Maternal Healthcare in Rural Communities: Panel 2

American College of Obstetricians and Gynecologists (ACOG)



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Framing the Issue

- Maternal morbidity and mortality on the rise
 - Recent MMWR statistics (MMRC findings from 13 states)
 - › “Changes” in causes and timing
 - › Differences in populations (disparities)
- Rural maternal health challenges
 - Facility closures/closures of services
 - Provider shortages and maldistribution
 - Political and financial challenges
 - › Lack of system coordination
 - Access to care
- Impacts not only labor and delivery
 - Antenatal and postpartum care



ACOG's Efforts: Closing the Gap

- ACOG-AAFP-NRHA meeting
 - Major issues identified:
 - Workforce
 - Implicit bias
 - Medicaid coverage; 12 months postpartum, expansion in all states
 - Incentivize providers to work in obstetric deserts
 - Telemedicine
 - Reimbursement models
- AIM bundles
- MMRC's, PQC's
- Level of maternal care



Perinatal Quality Collaboratives (PQC's)

- State and regional networks of multidisciplinary teams
- Supported by CDC and National Network for PQC's (NNPQC)
- Move established guidelines into practice
- Mobilize health systems and communities
- Scale up best practices and improvements to statewide levels



Maternal Mortality Review Committees (MMRC's)

- State- or regional-level (city) committees to identify and review maternal deaths within one year of pregnancy
 - Multidisciplinary but with local input
 - Represent clinical and psychosocial specialization
 - Bring representation from diverse communities and different geographic regions
- Review multiple information sources
- Develop actionable recommendations
- Rationale - systematic review done to:
 - Inform effective actions to improve processes, systems, and knowledge
 - Identify opportunities for prevention
 - Prioritize and target interventions, resources, and QI efforts



MMRC's

- Determine preventability
- Focus shifting from exclusively clinical factors to population health influence
 - Social and non-medical contributors
- Findings address risk factors among individuals, communities, the clinical environment, and health systems
- Example: Illinois
 - 2018 MMRC report: across the state, pregnancy-associated mortality was highest for women in rural counties and in the city of Chicago



Cross-Collaboration: MMRC's and PQC's

- MMRC findings can/should be key drivers for local and state PQC's
- Examples:
 - Florida Pregnancy-Associated Mortality Review: urgent mortality message regarding accreta and hemorrhage to improve clinical recognition and community awareness
 - Florida PQC implemented a QI project in all hospitals to reduce morbidity/mortality from hemorrhage
 - Michigan Maternal Mortality Surveillance Injury Committee collaborated with the PQC to address SUD-related mortality



PQC's and Rural Health

- Independent rural hospitals
 - May not be part of a system
 - May be difficult to engage with a PQC
 - › May not have dedicated OB units or staffing
 - › Challenging to implement or maintain QI initiatives
- Those in systems: more able to participate
 - Some systems reach out to rural facilities
 - Strategies include interactive webinars for meetings
- ECHO programs: improve rural hospital engagement in PQC's
 - Utah Perinatal Collaborative: bi-monthly ECHO programs for rural members
 - › Has also annexed in 6 Wyoming hospitals
 - New Mexico PQC: beginning ECHO programs for rural hospitals
 - › To train on hemorrhage maternal safety bundles



MMRC's and Rural Health

- MMRC's established at the state or regional level
- Most states include a rural component
 - 49 states pay particular attention to review mortality from rural locations
 - Evaluate issues related to access, treatment of chronic conditions, poverty
- MMRC's are especially important in states with rural communities:
 - Mortality is low, thus a low rate
 - › Rate may not reflect issues in a rural area
 - But factors are critically important to understand for prevention strategies



Postpartum Care

- Recent ACOG efforts: changing the paradigm
- Presidential initiative: re-defining postpartum care
- Rationale:
 - Reduce morbidity and mortality
 - › Recent MMWR highlights the need to move past a single 6-week visit
 - › “Window” to future health; interconception and life-long care
 - Examples: preeclampsia and lifelong hypertension; gestational diabetes and life-long risk
- “Shift” to earlier visit to identify potential urgent conditions and those needing early follow-up
 - Including perinatal mental health
- Subsequent “well-woman” or co-existing condition follow-up



Telemedicine/Telehealth

- Also a recent Presidential initiative
 - Clinical guidance and systematic review in preparation
- Telemedicine/Telehealth Expert Work Group also formed
- Critically important to improve access and care for rural communities
 - Extends access
 - Extends reach for specialty and subspecialty providers
- Technology exists, but several challenges
 - Reimbursement, documentation, liability
 - But can be overcome!!



ACOG/SMFM: Levels of Maternal Care



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Society for
Maternal-Fetal
Medicine



OBSTETRIC CARE CONSENSUS

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Levels of Maternal Care

Abstract: In the 1970s, studies demonstrated that timely access to risk-appropriate neonatal and obstetric care could reduce perinatal mortality. Since the publication of the *Toward Improving the Outcome of Pregnancy* report, more than three decades ago, the conceptual framework of regionalization of care of the woman and the newborn has been gradually separated with recent focus almost entirely on the newborn. In this current document, maternal care refers to all aspects of antepartum, intrapartum, and postpartum care of the pregnant woman. The proposed classification system for levels of maternal care pertains to birth centers, basic care (level I), specialty care (level II), subspecialty care (level III), and regional perinatal health care centers (level IV). The goal of regionalized maternal care is for pregnant women at high risk to receive care in facilities that are prepared to provide the required level of specialized care, thereby reducing maternal morbidity and mortality in the United States.



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ACOG/SMFM Obstetric Care Consensus

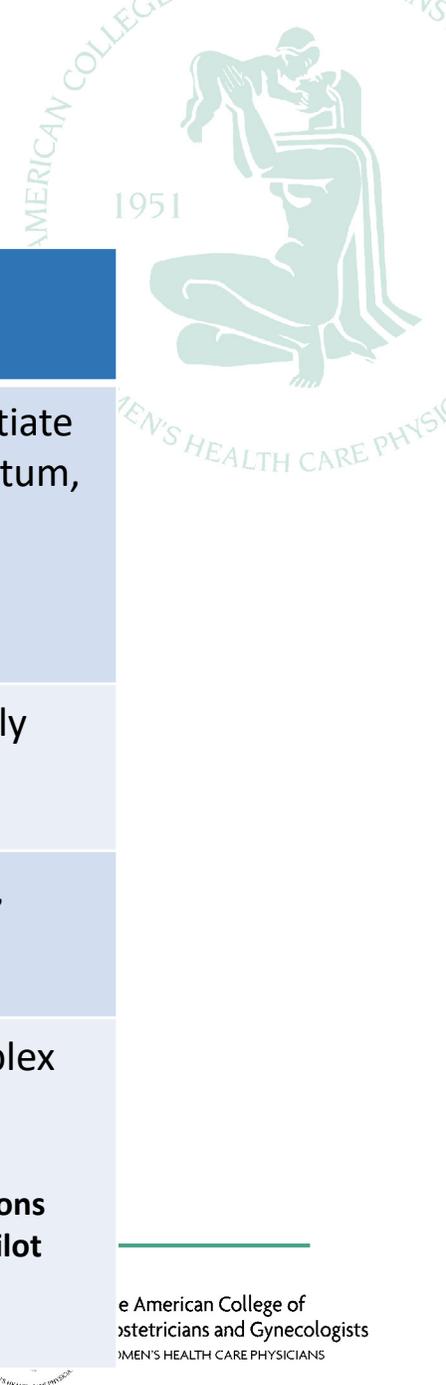
February 2015

- Established Levels of Maternal Care
- Standardized definitions and nomenclature
- Consistent guidelines for use in quality improvement and health promotion
- Equitable geographic distribution of full-service maternal care facilities and systems
 - Promote proactive integration of risk-appropriate antepartum, intrapartum, and postpartum services
- Complementary but distinct from levels of neonatal care
- Endorsed by AABC, ACNM, AWHONN, Commission for the Accreditation of Birth Centers



Levels of Maternal Care Definitions

Level	Definition
Level I - Basic Care	Uncomplicated pregnancies with the ability to detect, stabilize, and initiate management of unanticipated problems that occur during the antepartum, intrapartum, or postpartum period until patient can be transferred.
Level II - Specialty Care	Level I facility plus care of appropriate high-risk conditions, both directly admitted and transferred from another facility.
Level III - Subspecialty Care	Level II facility plus care of more complex maternal medical conditions, obstetric complications, and fetal conditions.
*Level IV - Regional Perinatal Center	Level III facility plus on-site medical and surgical care of the most complex maternal conditions and critically ill women and fetuses. *ACOG/SMFM Obstetric Care Consensus guidelines recommend these four designations for levels of maternal care. We will carefully review the categories again, following pilot assessment studies, and use the findings to further improve the guidelines and level designations.



Levels of Maternal Care (LoMC): Program Partners

American College of Obstetricians and Gynecologists

Society for Maternal-Fetal Medicine

Centers for Disease Control and Prevention

Arizona Perinatal Trust

National Perinatal Information Center



LoMC Partners: Developed a Verification Program

- Created an assessment tool
- Developed a site survey process
 - Pre-survey: completion of forms, policies and procedures made available for review
 - Survey: site visit team meets with facility personnel
 - › Review hospital resources and capabilities according to the assessment tool
 - › Also provides constructive suggestions and identifies highlights and “best practice”
 - Post-survey: verification report according to LoMC criteria
 - › Includes comments, highlights, suggestions
 - › Facility submits feedback survey



Pilot Sites

Between March and September 2017, the LoMC verification tool and site visit process were piloted at 14 hospitals in Georgia, Illinois, and Wyoming.

Level	Number of Hospitals Visited
Level 1	3
Level 2	7
Level 3	4
Level 4	0



Next Steps

- Convened a “post-pilot” meeting to:
 - Evaluate the site visit process
 - Review/edit all related forms
 - Critically edit the on-site assessment tool
- Goal: to “package” these materials for “roll out” on a larger scale
 - Healthcare system, state, DoH
 - To facilitate implementation



LoMC



Levels of Maternal Care



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Texas and LoMC

- All Texas hospitals that provide OB care will need maternity state designation by **August 31, 2020** to receive Medicaid funding
- TX rules align closely with Levels of Maternal Care OCC criteria, but provide more specificity in some areas
- All hospitals applying for Levels 2, 3, or 4 require site surveys
 - *Includes rural facilities*



Texas and LoMC

- Opened a Houston-based office with Texas staff
- Engaged key Texas organizations
- Recruited and trained team of Texas-based surveyors to verify compliance with Texas rules
- ACOG's goal extends beyond its survey services
 - Quality initiative: ACOG is collaborating with hospitals to improve care and address unique challenges in TX
- Launched in summer 2018
 - Over 50 visits accomplished/scheduled so far



More Next Steps....

- Implementation meeting (December 2018)
 - Attendees: SMFM, CDC, CWISH, AHA, NRHA
 - To address issues such as clarification, providing examples, addressing challenges
 - Concept: develop an “implementation guide” (like FAQ’s...)
- Meeting with AAFP and NRHA
 - Discussed challenges and areas to address
 - Many issues overlapped with those identified in the implementation meeting
 - To develop a co-authored commentary



Commentary Issues

- LoMC provides a “capability framework”
 - Important for facilities to identify their resources and capabilities
 - Facilities should also identify risk levels
- Importance of family physicians in obstetric care
 - Particularly in rural settings
- Balance of safety and access
- Payment reform
- Defining regionalization
 - More than just transport
- Importance of consultation and coding
- Data analysis



LoMC and Rural Facilities

- Hospital/service closure: complex issue, multifactorial
- LoMC has provisions to **support** Level 1 and 2 facilities, not threaten them
- How?? **Regionalization**
 - Requirement that Level 3 and 4 facilities provide outreach education and support for coordination of care
 - Includes transport, QA/QI coordination, education
- Supporting Level 1 and 2 facilities helps keep women in their communities
 - Reinforces potential for maintaining the patients' support network



Thank You!!!



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