A Conversation on Maternal Healthcare in Rural Communities: Charting a Path to Improved Access, Quality, and Outcomes

June 12, 2019

EXTERNAL SUMMARY

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OVERVIEW

The Centers for Medicare & Medicaid Services (CMS) and partners hosted an interactive "Conversation on Maternal Healthcare in Rural Communities: Charting a Path to Improved Access, Quality, and Outcomes" Rural Maternal Health Event on Wednesday, June 12, 2019, in Washington, D.C., at the Kaiser Family Foundation's Barbara Jordan Conference Center.

The event was hosted in collaboration with the Health Resources and Services Administration, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, National Birth Equity Collaborative, National Rural Health Association, Centers for Disease Control and Prevention, and U.S. Department of Health and Human Services Office on Women's Health. The event drew participants from 43 states and the District of Columbia, as well as from varied stakeholder groups including government, providers, hospitals, insurers, associations, non-profits, and community health centers.

The objectives of the event were to:

- Provide an overview of the state of maternal healthcare in rural communities, with a focus on access to maternal health services before, during, and after pregnancy and disparities in maternal health outcomes.
- Share existing promising practices and areas of opportunity to improve access to maternal health services and achieve health equity within rural communities.
- Develop priorities and next steps for a plan of action to inform options to improve access to maternal health services, the quality of care provided, and maternal health outcomes in rural communities, as well as reduce disparities.

Three expert panels focused on (1) the current state of rural maternal healthcare in the United States, (2) the advancement of systems of maternal healthcare in rural America, and (3) the improvement of policies that impact rural maternal health. Attendees were invited to share their top priorities for improving access to maternal health services during a working lunch and engage in a facilitated discussion to develop a collective action plan.

This report summarizes the forum speeches and panels and captures the high-level feedback from attendees during the working lunch and facilitated discussion.

WELCOME

The event began with a video vignette highlighting the personal story of a patient in Iowa and the challenges she faced in accessing maternal healthcare, as well as introductory remarks from Seema Verma, CMS Administrator; Kellyanne Conway, Assistant to the President and Senior Counselor; and Congresswoman Debbie Dingell. (VIDEO LINK)

Access to Maternal Health Care in Rural Communities: A Patient's Personal Story, is a five-minute video played at the opening of the forum that features a first-person account of a patient and obstetrician's perspectives on accessing maternal health services in rural Iowa. Jenny, a mother of two, who has a two-week old newborn, shared that her history of pulmonary embolism made it challenging to find a provider with adequate resources to care for her as a high-risk patient. She also described challenges related to traveling three hours to visit her obstetrician, Dr. Kimberlee McKay of Avera Health in Sioux Falls, South Dakota. Dr. McKay stated that half of the patient population across South Dakota, Minnesota, Iowa, and Nebraska has Medicaid as a primary or secondary insurance. It also is a diverse population that includes 25% racial or ethnic minorities, including 15% who are American Indian. She noted that care planning for her patients can be difficult due to the distance her patients need to travel to for their prenatal visits. Dr. McKay and Jenny both noted that expansion of telehealth services such as video conferencing calls would reduce some of the burdens related to traveling for prenatal visits.

Caption 1. Attendees at Maternal Health Forum watch Access to Maternal Health Care in Rural Communities: A Patient's Personal Story.

Seema Verma, Administrator, Centers for Medicare & Medicaid Services, delivered opening remarks highlighting the U.S. government's commitment to improving maternal health outcomes, particularly in rural America. In her remarks, she noted that pregnancy-related deaths have almost doubled in the past 30 years, and the death rate is even higher for women living in rural areas and for women of color. Administrator Verma emphasized the current administration's commitment to improving maternal healthcare access and quality to include increasing access to telehealth services and the release of the first Medicaid scorecard, which includes 12 maternity measures. She spoke of the CMS Rural Health Strategy as part of the Rethinking Rural Health Initiative and noted that impact on rural communities is now considered in everything CMS does. Administrator

Caption 2. Seema Verma, Administrator for CMS.

Verma concluded her remarks by emphasizing that CMS needs input and ideas from individuals in the field and on the front lines and looked forward to hearing those ideas during the event.

Kellyanne Conway, Assistant to the President and Senior Counselor, emphasized that the United States is the only developed country in which maternal mortality has not declined. Ms. Conway described some of the initiatives and policies that the White House is supporting to improve maternal healthcare in rural areas, including:

- A recent investment of $20 billion in rural internet infrastructure to improve telemedicine capabilities;
- The Caring Recovery for Infants and Babies (CRIB) Act, which allows state Medicaid programs to cover residential pediatric recovery services for infants with neonatal abstinence syndrome;
- The Maternal Opioid Misuse (MOM) model, which aims to improve the care of pregnant and postpartum Medicaid beneficiaries with opioid use disorder.

Ms. Conway concluded her remarks by stating that the discussions at the forum will be important in helping the White House improve health outcomes in rural communities.

Debbie Dingell, U.S. Representative of Michigan's 12th District and Member of the Congressional Health Subcommittee, affirmed that maternal mortality in this country, particularly among rural women and women of color, must be addressed. Representative Dingell asserted that the quality of the care you receive should not depend on your skin color, geography, or ability to pay, and that together we need to break down barriers that prevent women from receiving prenatal and well-baby care. Representative Dingell remarked that improving our maternity leave and sick leave policies could also help improve health outcomes and that this event was an opportunity for participants to tell leaders what is needed to support these efforts.

Cara James, Ph.D., Director, CMS Office of Minority Health, and Co-Chair, Rural Health Council, Centers for Medicare & Medicaid Services, provided an overview of the event, including its agenda and objectives. Dr. James also gave special thanks to CMS's collaborating partners and MoMMA's Voices, a program of the Preeclampsia Foundation, and outlined opportunities and guidance for all participants to engage in the discussion throughout the day.

SUMMARY OF PANEL 1: FRAMING MATERNAL HEALTH IN RURAL AMERICA

Objective: To discuss the current state of rural maternal healthcare in the United States, including challenges in accessing maternal health services, healthcare quality, disparities, and areas of needed research. Panel 1 consisted of Katy B. Kozhimannil (panelist and moderator), Wanda D. Barfield, Peiyin Hung, and Alina Salganicoff. (**VIDEO LINK**)

Katy B. Kozhimannil, PhD, MPA, Associate Professor, Division of Health Policy and Management, School of Public Health, University of Minnesota, noted that rural women in the United States are diverse but share challenges in accessing healthcare. Approximately 18 million women between the ages of 18 and 44 live in non-metropolitan U.S. counties. About 12% of rural women have no health insurance, and almost 19% of rural women live at or below the Federal Poverty Line. Rural counties are racially and ethnically diverse, and diversity varies by region. Some South Western U.S. rural counties are predominantly Hispanic; some South Eastern U.S. counties are predominantly non-Hispanic Black, and some Mid-Western and Alaskan counties are predominantly American Indian/Native Alaskan. Dr. Kozhimannil emphasized that racial disparities and unequal access to maternal healthcare are both local and global problems, with variability across regions, states, and counties. Dr. Kozhimannil shared that, among rural communities, the highest rates of premature death occur in rural counties with a larger proportion of non-Hispanic Black or American Indian/Native Alaskan residents. Turning back to a focus on childbirth, Dr. Kozhimannil noted that there are nearly half a million births each year in rural U.S. hospitals. She also highlighted that 6% of rural births are preterm, but only 40% of those births occurred at a hospital with a neonatal intensive care unit (NICU). Based on her research, Medicaid beneficiaries, non-Hispanic black, and younger women were less likely to deliver their pre-term infants at hospital with a NICU. Dr. Kozhimannil then discussed the current staffing challenges in rural hospitals, which include scheduling, training, recruitment and retention, census fluctuation, and intra-hospital resource sharing. She ended her remarks by highlighting the opportunity to improve maternal health and well-being in rural communities.

> WE ARE TALKING A LOT ABOUT MATERNAL MORTALITY AND MATERNAL MORBIDITY, BUT IT'S NOT JUST ABOUT HOW WOMEN DIE BUT HOW RURAL WOMEN LIVE AND ACCESS CARE IN RURAL AMERICA. WE NEED TO HOLD OURSELVES TO A HIGHER STANDARD IN MATERNITY CARE THAN DID YOU DIE, OR DID YOU NOT DIE. WE CAN DO BETTER THAN THAT AND WE CAN SEE COMMUNITIES WHERE MATERNITY CARE IS FLOURISHING AND WHERE EVERY BIRTH IS WELL SUPPORTED AND A SAFE ONE.
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> Katy B. Kozhimannil, PhD, MPA, Associate Professor, Division of Health Policy and Management, School of Public Health, University of Minnesota

Wanda D. Barfield, MD, MPH, Rear Admiral U.S. Public Health Service, Director, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC), highlighted that 15% of the U.S. population (46 million) live in rural areas and that maternal and infant health are closely linked. Infants born in rural areas have a higher likelihood of dying as compared to infants born in urban areas. Dr. Barfield noted that in 2014,

the infant mortality rate in rural counties was 6.55 per thousand which is 6% higher than the rate for small and medium urban counties and 20% higher than the rate for large urban counties. Dr. Barfield also noted that 700 women in the U.S die from pregnancy complications each year and Black and American Indian/Alaskan Native women are over three times as likely to die from pregnancy-related complications as White women. Dr. Barfield proposed that systematic prevention of maternal mortality can be achieved by gathering more data to better understand the drivers of maternal mortality and pregnancy complications; identifying impactful interventions at the patient, family, provider, facility, system, and community levels; and implementing those interventions in the right places at the right times. Dr. Barfield shared that the CDC is currently supporting the collection of robust data and resources to translate these data to action through several initiatives: Review to Action, the Maternal Mortality Review Information Application, Maternal Mortality Review Committees (MMRCs), Perinatal Quality Collaboratives (PQCs), and the CDC Levels of Care Assessment Tool (LOCATe), and emphasized that better data can reveal drivers of disparities and gaps in rural care to inform strategies to improve outcomes for all mothers and babies.

Peiyin Hung, PhD, Assistant Professor, Health Services Policy and Management, Arnold School of Public Health, University of South Carolina, remarked that hospital obstetric (OB) unit closures have been a pressing concern, particularly in rural America. Dr. Hung noted that childbirth is the top reason for hospitalizations. She described the potential effects related to hospital OB unit closures, including poor prenatal care; adverse birth outcomes; and more traveling, costs, complication risks, and stress. Some reasons for closure included staffing issues (trouble recruiting and retaining OB providers), low birth volume, low reimbursement due to high proportions of patients on Medicaid, and financial issues. Dr. Hung also indicated that in nine geographically dispersed states, OB unit closures forced rural mothers to travel twice as far, on average, to reach the nearest hospital OB care. Dr. Hung highlighted disparities minority women face with hospital OB unit closures; black communities, in particular, are disproportionally affected by hospital OB unit closures.

Alina Salganicoff, PhD, Senior Vice President and Director, Women's Health Policy, Kaiser Family Foundation, reiterated that where women live affects their maternity coverage before, during, and after pregnancy. Dr. Salganicoff noted that national averages mask diversity within rural communities and the South has a higher share of African American women, while the West and Southwest have a higher share of Hispanic women. She discussed the types of coverage held by women of reproductive age, sharing that most women of reproductive age have private insurance, which now has many protections for pregnant women, but those women who have high-deductible plans may have significant out-of-pocket costs. She also noted the critical role that Medicaid plays in financing maternity care for low-income women in rural communities. In 2017, 26% of women in rural communities had Medicaid or other public insurance and 13% of women were uninsured. She noted that state policies, particularly the adoption of Medicaid expansion, result in fewer uninsured women pre- and post-pregnancy; however, the scope of covered services varies by states, and even if covered, services are not always available to women in rural communities.

Panel 1 Q&A Session

The attendees discussed a range of topics during the Panel 1 Q&A Session, including:

Men. Attendees emphasized the critical role of men and fathers. Previous research has indicated that father involvement reduces the risk of adverse outcomes by reducing risky behavior and increasing

healthy behaviors (i.e. breastfeeding), ultimately improving health outcomes by supporting their partners and helping to secure the types of services they need. The CDC's Pregnancy Risk Assessment Monitoring System for Dads pilot project collects data on the experiences of fathers before, during, and after a recent live birth to help inform gaps. Attendees emphasized the need for more research to determine the engagement of men by ethnicity, learn how to change program language to be more inclusive, and define partnering and parenting within the healthcare system.

Telemedicine and telehealth. Attendees discussed telehealth policies in the United States, indicating the need for policies to support and reimburse telehealth in the context of maternal care. They mentioned the need for new solutions to get women where they need to be; for example, establishing pre-existing arrangements between facilities and/or frontier states in case of emergencies with high-risk patients.

Planned or unplanned nonhospital births. Attendees mentioned the lack of information related to births happening outside of facilities, whether they were planned or unplanned births, and how many of these births were high risk. Attendees also discussed rural counties without obstetric services and their association with increased births outside of hospitals.

Rural residency training. One panelist highlighted how physicians in rural areas are being trained differently; for example, training for scenarios in which help is on the way, but the physician is the only resource available to support the mother and baby.

SUMMARY OF PANEL 2: ADVANCING SYSTEMS OF MATERNAL HEALTHCARE IN RURAL AMERICA

Objective: To share areas of opportunity to improve systems of maternal healthcare in rural America through a health equity lens, including strategies related to interdisciplinary collaboration, regionalization of care, and integration of medical home models. Panel 2 consisted of Tom Morris, Associate Administrator, Federal Office of Rural Health Policy, Health Resources and Services Administration (moderator); Lee Wilson; Diana Jolles; John Cullen; Jean Howe; and Chris Zahn. (**VIDEO LINK**)

Lee Wilson, MA, Senior Advisor, Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA), discussed HRSA's mission to improve health outcomes and address health disparities through access to quality services; a skilled health workforce; and innovative, high-value programs. Mr. Wilson highlighted HRSA's maternal health efforts, including the Health Center Program, Health Workforce Program, and Rural Maternity and Obstetrics Management Strategies Program. Mr. Wilson noted that there was a 17% increase over the last five years in the number of obstetricians, gynecologists, and certified nurse midwives in the Health Center Program. Mr. Wilson also noted that HRSA's Maternal & Child Health Bureau aims are to improve the health of America's mothers, children, and families. Its primary programs include the Title V Maternal and Child Health Services Block Grant; the Maternal, Infant, Early Childhood Home Visiting Program; Healthy Start; the Alliance for Innovation on Maternal Health; the Women's Preventive Services Initiative; Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program; Bright Futures; Remote Pregnancy Monitoring Challenge; and Opioid Use Disorder Challenge.

Diana Jolles, PhD, CNM, Instructor, Frontier Nursing University; Nurse-Midwife, El Rio Community Health Center/Tucson Medical Center; Chair, American Association of Birth Centers Research Committee, shared lessons regarding rural health: (1) the root cause of low surge capacity in rural America is our reimbursement system and its current focus on funding procedures over quality; (2) increase the value for, access to, and reimbursement of basic care as an enhanced primary care model appropriate for 85% of childbearing women; and (3) the need to question our assumptions and embrace both the strengths of the rural workforce and the high-quality care they are delivering. Healthcare equity starts in the community with a diverse workforce. Dr. Jolles noted that the National Quality Strategy Levers are essential, specifically measurement and feedback, public reporting, learning and technical assistance, certification, accreditation and regulation, payment, and innovation and diffusion. Dr. Jolles described the CMMI Strong Start for Mothers and Newborns, a CMS initiative. Almost 46,000 pregnant Medicaid and CHIP beneficiaries across the country are enrolled in group prenatal care, maternity care homes, or birth centers. Approximately 70% of the women were from minority groups, over half were unemployed and not in school, a fifth suffered from food insecurity, and a fourth screened positive for depression. The project evaluated pregnancy outcomes for women and their infants and found that birth center participants had significantly lower rates of preterm birth, low birthweight infants, and cesareans relative to a risk-matched comparison group. Mother-infant dyads also had lower average expenses from birth through the first year. The birth center model is scalable

and Strong Start, particularly, demonstrated the triple aim of improved quality, value, and client satisfaction.

John Cullen, MD, FAAFP, President, American Academy of Family Physicians, noted that rural and frontier hospitals care for major traumas, pregnancies, and surgical cases with limited medical staff and transportation options due to time, distance, and weather. Dr. Cullen reminded the audience that pregnancy complications occur throughout pregnancy and for the year after delivery, and those complications occur within the communities where women live. This means that hospitals that do not plan on providing maternity care will continue to provide maternity care but will not be ready for emergencies. Furthermore, pregnant women transferred to metropolitan areas for their delivery do worse than those who stay in the communities they live in for their delivery. Dr. Cullen detailed personal stories of his professional experiences and remarked that telemedicine is only a tool; having a workforce and a facility to practice in is a solution. Dr. Cullen stated that communities have more confidence in their medical care if babies can be delivered there. He reported that 18% of family physicians live and provide care in rural communities and that Family Medicine medical students and Family Medicine residents are interested in both rural family medicine and in providing maternity care. We just need to get them into the field.

Jean Howe, MD, Chief Clinical Consultant for Obstetrics and Gynecology, Indian Health Service, highlighted that Indian health sites have a range of programs to support pregnant women within their communities, including multidisciplinary clinics, midwifery care, public health nursing, home visitation, breastfeeding support, and mental/behavioral services. Births on Indian lands, however, have declined nearly 30% over 12 years due to smaller desired family size and rural-to-urban migration. This has resulted in birth facility closures. The most urgent challenge that women face is access to informed care in an emergency. Dr. Howe noted that prenatal care must be provided close to home, safe delivery services should be strategically located across rural America, and emergency department readiness is essential.

Chris Zahn, MD, Vice President, Practice Activities, American College of Obstetricians and Gynecologists (ACOG), observed that maternal health challenges have multiple factors and several possible solutions, including PQCs and MMRCs, which should be translated to PQCs that can improve outcomes in rural America. Dr. Zahn commented that pregnancy is a stress test and "window" to future healthcare. ACOG is redefining postpartum care to include earlier visits to identify high-risk cases and recently developed a program to verify hospital compliance with level of maternal care criteria.

Panel 2 Q&A Session

The attendees discussed a range of topics during the Panel 2 Q&A Session, including:

Social determinants of health (SDoH) in rural communities. Rural physicians are aware of social determinants, in part because their patients are friends and neighbors. SDoH factors should be incorporated into electronic health records. Collaboration among Level 1-4 facilities can also maintain access by providing quality initiatives that assimilate community health workers, peer counselors, and other mental/behavioral support (e.g., yoga/healing studios) into the current healthcare payment structure. Transporting rural women to cities for care can result in poorer health outcomes due to the stress of being away from their support structures. Empowering rural women with access to better

information will likely enable them to find needed services and support within their communities. Communities with closed hospital obstetric units lose money overall, because without OB resources, there are fewer young families, schools, and businesses. Telemedicine allows providers to communicate and extend specialized services to patients, but having prenatal care close to home is essential, and emergency departments need to be prepared for deliveries.

Rural staffing and training. Loan repayment is incredibly important because it can motivate medical residents in rural areas to stay, resulting in communities receiving high returns on their investment in loan repayment. Most new residency graduates in rural areas also undergo an additional three-year training/mentorship process with a seasoned physician. Training programs need to train community members to serve their community. Hospitals need more financial support to pay salaries in addition to loan repayment. Some participants felt that rural midwives provide high-quality prenatal care and are often trusted by their patients. Evidence suggests that interprofessional teams including midwives (CNMs, CMs, CPMs), nurse practitioners, family practice physicians, social workers, doulas, and lactation consultants are effective in providing comprehensive care that is culturally appropriate and identifying clients who need a higher level of care.

WORKING LUNCH: STAKEHOLDER PRIORITIES FOR IMPROVING ACCESS TO MATERNAL HEALTH SERVICES

Objective: To gather top priorities for improving access to maternal health services from all attendees. The working lunch began with remarks from Dorothy Fink. (VIDEO LINK)

Dorothy Fink, Director and Deputy Assistant Secretary for Women's Health of the HHS Office on Women's Health, spoke about the Office on Women's Health's commitment to maternal health. She also stressed the importance of the social determinants of health and encouraged attendees to participate in the working lunch.

Caption 3. Dorothy Fink, Director and Deputy Assistant Secretary for Women's Health of the HHS Office on Women's Health.

Working Lunch

Throughout the morning, all attendees (both in-person and virtual) were encouraged to share their top priorities for improving access to maternal health services during a working lunch. They were provided with an "Opportunities to Improve Access to Maternal Healthcare in Rural Communities" worksheet that displayed nine topic areas:

- Clinical/Quality Improvement
- Health Disparities
- Innovation/Telehealth
- Legislation
- Payment
- Public Education/Public Health
- Social Determinants of Health
- Workforce
- Other/Miscellaneous

Caption 4. Attendees at Maternal Health Forum.

In-person attendees were invited to write their top priorities on sticky notes and place them on the most appropriate poster outside the conference room, each of which was labeled with one of the nine topic areas. Virtual attendees were invited to submit their top priorities via the online chat box or email them to ruralhealth@cms.hhs.gov. See the "Our Path Forward Section" below for a brief summary of participant contributions during the working lunch.

SUMMARY OF PANEL 3: IMPROVING POLICIES THAT IMPACT RURAL MATERNAL HEALTH

Objective: To discuss opportunities to improve federal and state policies and legislation impacting rural maternal health. Panel 3 consisted of Joia Crear-Perry, President of the National Birth Equity Collaborative (moderator); Lisa Hollier; Pooja Mehta; Alan Morgan; Alicia Belay; and Jonathan Webb. (VIDEO LINK)

Lisa Hollier, MD, MPH, Interim Chief Executive Officer (CEO) and Immediate Past President, ACOG, discussed the policy proposals targeted specifically at closing the rural access gap, which include supporting rural residency training tracks and rural electives, enhancing existing loan repayment programs (e.g., National Health Service Corps) in rural areas, and increasing Medicaid reimbursement to cover the cost of care.

Pooja Mehta, MD, Chief Clinical Innovation Officer, Louisiana Medicaid, LSUHSC-Louisiana Department of Health Center for Healthcare Value and Equity; Assistant Professor, Schools of Medicine & Public Health, Louisiana State University Health Sciences Center, shared the story of a 17-year-old pregnant woman suffering from addiction in rural Louisiana, who died after several emergency room visits, a 10-day hospital stay, telehealth sessions with a psychiatrist, and several home visits. Dr. Mehta proposed three levers to address maternal health: (1) policies that support rural hospitals; (2) continuous quality improvement; and (3) moving support and care out of hospitals.

> ...AT A TIME WHEN OUR OVERALL MORTALITY RATES IN WOMAN OF REPRODUCTIVE AGE ARE RISING, NOT JUST IN MOTHERS, BUT IN ALL WOMEN OF REPRODUCTIVE AGE, WE HAVE TO START WHERE WE HAVE THE MOST INFORMATION, AND THAT HAPPENS TO BE AROUND THE CONDITIONS THAT WOMEN ARE LIVING IN DURING THEIR PREGNANCIES.
>
> Pooja Mehta, MD, Chief Clinical Innovation Officer, Louisiana Medicaid, LSUHSC-Louisiana Department of Health Center for Healthcare Value and Equity; Assistant Professor, Schools of Medicine & Public Health, Louisiana State University Health Sciences Center

Alan Morgan, MPA, CEO, National Rural Health Association, discussed broad-based policy recommendations: (1) support, enhance, and encourage CMS leadership as our rural advocate; (2) federal push for rural-relevant research; (3) rural residency training programs; and (4) new payment models and delivery types. Dr. Morgan emphasized that these recommendations must be addressed collaboratively by national organizations and clinicians.

Alicia Belay, PHD, MPH, Director of Maternal Child & Health and Government Affairs, March of Dimes, discussed the invisible disparities in health outcomes for women due to structural racism and historical trauma. Dr. Belay indicated that reimbursement for group prenatal care and doula support are opportunities for improvement. Dr. Belay noted that rural people know what their communities need; they just need support (e.g., infrastructure, timelines).

Jonathan Webb, MBA, MPH, CEO, Association of Maternal and Child Health Programs (AMCHP), highlighted that AMCHP aims to protect and promote the optimal health of women, children, youth, families, and communities. AMCHP's current challenges include access, workforce, and data. Mr. Webb suggested several paths forward, including policies that support expansion of telehealth services, the Improving Access to Maternity Care Act, policies/funding that will incentivize work in under-resourced communities, policies/reimbursement models that support non-physician healthcare professionals, and addressing the rising malpractice premiums that are making it difficult to keep practices and hospitals open.

Panel 3 Q&A Session

The attendees discussed a range of topics during the Panel 3 Q&A Session, including:

Hospital closures. Attendees mentioned hospitals as the largest employers in rural communities and their ability to address structural racism and drive social change. A few attendees mentioned the need to understand why programs and solutions are built on a faulty framework, and then engage appropriate stakeholders to help close the gaps. Other solutions mentioned were related to Medicaid expansion and using improvement over time as a metric for value-based payment.

Rural staffing and training. One participant mentioned The Medical College of Georgia and its proposed program called 3+3+6: medical school for three years, residency for three years, and six years in a rural community for medical school loan forgiveness. Attendees also mentioned the need to identify rural physicians not by Medical College Admissions Test score, but by their rural experience and desire to stay rural. One participant highlighted the need for incentives for residency programs to pilot the collaborative model. For example, residents should train with midwives on low-risk births, and midwifery schools can coexist with OB training.

Liability. Attendees discussed the frequency of litigation and its impact on obstetric units. One attendee mentioned litigation reform helping improve access to care in Texas. Attendees highlighted the need for interprofessional collaboration at the training level and the importance of all providers practicing at their full scope of practice.

Maternal care coverage. Seventy-five percent of reproductive-age women on Medicaid are also on managed care arrangements. Many Medicaid managed care organizations want to be part of this discussion and improve outcomes using the additional levers that they have.

Other sectors of care. Attendees expressed the need for new payment methodologies to address housing and transportation issues, which are critical in rural areas. Managed-care organizations are also more accountable for addressing social determinants of health and driving down costs. Attendees also said that promising state initiatives indicate that partnering with community-based organizations can impact pregnancy outcomes in short periods of time. Agencies from other sectors were mentioned as a means of understanding the issue and identifying solutions.

CHARTING OUR PATH FORWARD: IDENTIFYING PRIORITY ACTIONS

Working Lunch Report Out

As previously mentioned, throughout the morning, all attendees (both in-person and virtual) were encouraged to share their top priorities for improving access to maternal health services during a working lunch. Collectively, the attendees submitted 112 priorities for improving access to maternal health services in rural communities. The total number and percentage of those priorities are categorized by the nine topic areas in Table 1 below.

Caption 5. Attendees participating in the Working Lunch.

Table 1. Number and Percentage of Attendee Priorities by Topic Area

Topic Area	Total Number of Priorities	Total Percentage of Priorities*
1. Payment	21	19%
2. Workforce	21	19%
3. Legislation	17	15%
4. Clinical/Quality Improvement	15	13%
5. Health Disparities	14	13%
6. Public Education/Public Health	8	7%
7. Innovation/Telehealth	8	7%
8. Social Determinants of Health	4	4%
9. Other	4	4%
Grand Total	112	100%

Note: Percentages have been rounded.

The attendees then heard a brief synthesis of these priorities as a report out prior to the Our Path Forward facilitated discussion.

Facilitated Audience Discussion

After receiving an overview of the top priorities identified by the working lunch participants, all attendees engaged in a facilitated audience discussion. For the sake of time and by a show of hands, the in-person attendees collectively identified three top priorities for further discussion. Table 2 lists the top priorities.

Caption 6. Attendees participating in the Facilitated Audience Discussion.

Table 2. Top Priorities Identified by Attendees for Discussion

Topic Area	Top Priorities Identified by Attendees
Payment	Provide Medicaid funding for telehealth, transportation, doula services, interstate referrals, housing, and cost-based reimbursement for critical access hospitals.
Workforce	Provide loan repayments and training for a diverse rural workforce.
Clinical/Quality Improvement	Support care coordination, including team-based care and coordination with remote delivery providers.

For each of these top three priorities, the discussion participants identified and discussed key levers (e.g., legislative action, state or local policies, needed resources), relevant stakeholders, barriers, facilitators, time frame, indicators of success, impact/effort, and next steps. Participant input was synthesized and displayed in real time to help both in-person and virtual participants follow and add to the discussion. The next steps for each priority that participants identified and discussed during the event are listed in Table 3.

Table 3. Next Steps Identified by Attendees

Topic Area	Next Steps Identified By Attendees
Payment Priority: Provide Medicaid funding for telehealth, transportation, doula services, interstate referrals, housing, and cost-based reimbursement for critical access hospitals	• Define rurality depending on data and stakeholder needs; there is a need to navigate multiple federal definitions of rural. • Access more data; a lot of data is held by private insurers and is not publicly available for analysis. • Find a payer-provider partnership that has a fair contract for both sides to feature as a model. • Conduct policy-relevant research, recognizing that state legislators want to understand costs, benefits, and impacts on state budgets; identify cost-benefit evidence to complement the available clinical evidence. • Reach out to doula organizations, particularly those that address minority communities and voices, for more information on doula costs, training, and certifications. • Explore payment opportunities for interprofessional teams and birth centers.
Workforce Priority: Provide loan repayments and rural training	• Review different loan forgiveness program data to determine what works. • Involve graduate education programs (e.g. midwifery, family medicine, nursing, social work). • Expand loan repayment programs past three years (to five years) to encourage healthcare professionals to more fully integrate into the communities.
Clinical/Quality Improvement Priority: Support care coordination, including team-based care and coordination with remote delivery providers	• Encourage states to implement AIM bundles for consistent quality of care. • Ensure that funding and funding models also involve investing in community organizations. • Increase funding; it is tough to be creative without funding, particularly for hospitals with cost-based payments such as critical access hospitals. • Establish pilot programs that coordinate care across multiple services with payment models. • Explore regionalization, getting support from tertiary care hospitals to rural communities. • Update definitions (e.g., underserved) in ways that make sense for rural areas. • Provide risk-appropriate care that addresses social determinants of health and primary prevention.

CLOSING REMARKS

Cara V. James, **PhD, Director, CMS Office of Minority Health, and Co-Chair, Rural Health Council, CMS**, closed the event, stating that this was one step toward improving access to maternal healthcare in rural communities. CMS will continue to engage with the community and consider options for improving access to maternal health services in rural America. (VIDEO LINK)

Caption 7. Attendees at Maternal Health Forum.