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Maternal Child Access Issues - ND

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Center *for* Rural Health

- Established in 1980, at The University of North Dakota (UND) School of Medicine and Health Sciences in Grand Forks, ND
- One of the country's most experienced state rural health offices
- UND Center of Excellence in Research, Scholarship, and Creative Activity
- Home to seven national programs
- Recipient of the UND Award for Departmental Excellence in Research

Focus on

- Educating and Informing
- Policy
- Research and Evaluation
- Working with Communities
- American Indians
- Health Workforce
- Hospitals and Facilities

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National Issues

- 2.2 million women of child bearing years live in a maternity desert
- Pregnancy related mortality rate
  - 1987 7.2%
  - 2018 17.3%
- Over 50% of rural US counties have no hospital that conducts births
- 1 in 3 urban women also live in and OB desert
- Rural women have a 9% greater probability of severe maternal morbidity or mortality
- Over 50% of rural women (in comparison to 7% of urban women) must travel more than 30 minutes to reach a hospital with OB services

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National Issues

- Extensive travel contributes to increased risks of infant mortality
- American Indian/Alaska Native and black women are 2 to 3 times more likely to die from pregnancy related causes
- Rural counties with the highest percentage of minority populations were more likely to lose OB access
- Barriers
  - Availability of OB services
  - Distance to service (location) transportation
  - Costs and safety
  - SDOH
    - Income, education, insurance, transportation, health literacy, housing, food, mental health

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North Dakota Issues

- 1 in 10 babies in ND born pre-term
- Higher for AI, Hispanic, black, and Asian relative to white
- 1 in 15 babies low birth rate
- 1 in 17 women of child bearing age no insurance (state uninsured rate 8%
- (2019) 78 infants died before reaching their first birthday, an infant mortality rate of **7.5 per 1,000 live births**.
- (2020) 27% of ND births were caesarian deliveries (in comparison 39 states had worse rates – highest Mississippi 38.2 %, Louisiana 36.8%, Alabama 35%, and Texas 34.7% (source CDC)
- 22% of infants born with inadequate prenatal care
- March of Dimes ND grade – C+

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North Dakota Issues

- ND has about 1,800 practicing physicians with 961 being specialists (not primary care).
- There are 93 OB/GYN (74 urban) –about 5% of physicians
  - Burleigh County 21
  - Cass County 31
  - Grand Forks County 13
  - Ward County 9

  - Rural counties – only 19 Ob's in 8 rural counties
  - 5 Rural Counties have hospitals that deliver babies (out of 36 Critical Access Hospitals).

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North Dakota Issues

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- Prenatal and post partum care is primarily local to the rural community.
- However, a number of "urban" systems keep the mom and baby after birth (care does not return to the local) – "give you a choice of urban pediatricians and many moms decide to follow advice and stay."
- Some rural facilities have visiting OB/GYN:
  - Wishek and final four weeks moms start seeing providers in Bismarck
  - Grafton and Northwood visiting OB from Altru
  - Some facilities offer prenatal and some do not
  - Rural try to set up follow up care with the mom, but again many are "captured" by urban
  - "It just depends on the rural facility and the tertiary, how they do things"

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North Dakota Issues

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- Scheduling birth depends on the mom (have to consider time of year, weather, place to stay, child care set up).
- If organized and prepared – make urban connections and you go there early.
- Most OB do not like to schedule C sections or induce want to go to term (better, healthier) so it is "on the mom" to make sure she gets there on time.
- But there are emergency rural births too. Hospital representative said "we do not deliver babies on purpose."
- If high risk pregnancy the rural providers try to help the moms to do prenatal care with the delivery hospital and providers. Try to get connected early.

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North Dakota Issues

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- Competency, confidence, and safety – Have to do X number of deliveries a year to be safe, feel safe, as there are not enough rural births.
- Most ND rural counites have less than 50 births a year, many 30 or less.
- Volume – low volume and cannot staff- medical and nursing, CRNA, surgeon on site.
- Community Health Needs Assessment – All non-profit hospitals every 3 years under the ACA- all hospitals in ND are non-profit. CRH works with most of the rural
  - Top out of 25 are BH and MH. Maternity is identified but does not make the top 4 issues when ranked.

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North Dakota Issues

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- **Barriers**
  - Quality and safety when maybe less than 50 births a year in county.
  - Cost cannot justify offering full OB.
  - Staffing – medical, nursing, CRNA, surgeon – significant workforce shortages.
  - Travel, distance, weather – maybe an hour or two one way once and then twice a week.
- **Ideas**
  - More outreach to rural areas from tertiaries.
  - More telehealth options for prenatal care.
  - More patient education to moms – not just prenatal care but for their knowledge of options, their rights, responsibility to take appropriate control.
  - Cannot force rural providers to do delivery as volume not there –need working relationships between rural and urban – networks?

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North Dakota Issues

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- **Ideas**
  - NDDHHS – Medicaid
  - Moving Medicaid into a value based payment process (rely less on fee for service)- not volume based. Focus on improved population health (improved care, improved health, and lowered costs). Address SDOH and pay providers for improved outcomes not just encounters.
  - For next 3 or so years this involves the urban hospitals and clinics (not CAH).
  - Start with gathering data and having providers report -two metrics:
    - Well child visits
    - Post partum care
    - So starting to rethink how we pay for care

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National Options

- **CMS Office of Minority Health Rural Maternal Health Initiative**
  - Rural Maternal Health Forum
  - Issue Brief
  - Quality Improvement discussions
  - Rural Health Stakeholder Policy Priorities
  - Rural Obstetric Readiness Workgroup
  - CMS Rural Maternal Health Workgroup
- **RMOMS (Rural Maternity and Obstetric Management Strategies) -2019**
  - Senator Heitkamp (ND) “Maternal Health Accountability Act” and RMOMS -2
  - HRSA process and grant
  - 3 years with 3 awardees each year.
  - Focus is forming regional networks to address the issues (PC, OB, and others).
  - Must involve Medicaid

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National Options

- **RMOMS (Rural Maternity and Obstetric Management Strategies) -2019**
  - Continuum of care
  - Telehealth and specialty care
  - Improve Financial Stability.
  - Example: **New Mexico Rural OB Access and Maternal Services (ROAMS)**
    - Network of providers covers 10,000 square miles.
    - 9,400 women of child bearing age.
    - High poverty, high minority, number of maternal health issues.
    - Satellite clinics (4) – telehealth, pre-natal and post partum checkups, connect to support systems in the communities, (more wrap around), lactation specialists, patient navigation support to help moms, and more.
    - Option for ND to explore grants. Network of urban and rural, and understanding and support with Medicaid.

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Open Discussion

- How do you see the issue? How do you react?
- What are the concerns?
- What are ideas on how to address the problems?
- What are action steps? Partners? Approach?

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Contact us for more information

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