Fostering Partnerships to Eliminate Rural Obstetric Care Deserts

Many rural communities are maternal and obstetric care deserts, with people in labor having to drive 90 minutes to reach a delivery room or even routine prenatal care. With more rural hospital and obstetric unit closures, not only are drive times becoming longer, but maternal and infant outcomes are getting worse.

"Maine is one of the most rural states in the country, and we have lost well over one-third of our hospitals and maternity units," says Dora Anne Mills, M.D., chief health improvement officer, at MaineHealth.

"We have the largest section of I-95, which runs all the way from the Canadian border to Key West, Fla., without a maternity hospital. In just under two hours of driving, you will pass two hospitals, but neither has maternity services, and if you are high-risk, our tertiary care hospital is at the very southern tip of the state in Portland"

–Dora Anne Mills, M.D.

The Federal Office of Rural Health Policy at the Health Resources and Services Administration (HRSA) launched the Rural Maternity and Obstetrics Management Strategies (Rural MOMS) program in fiscal year 2019 with the goals of preserving and enhancing access to the continuum of maternal and obstetrics care in rural communities through novel networks and practice innovations that can deliver risk-appropriate care in a financially sustainable manner.

"We are also seeing a higher complexity among our pregnant

patients," says Caroline Zimmerman, director of child and family health at MaineHealth, the grant lead for the only multi–health system, statewide Rural MOMS initiative in the country. "When patients have hypertension, diabetes, or obesity, it creates the need for a higher level of care, which makes it even harder to keep care close to home."

Applying the Power of a Network

"The challenges of worsening maternal morbidity and mortality are occurring nationally, but certainly impact rural areas, which have the added challenge of a numbers issue — low volumes of births make it hard to sustain services," says Tom Morris, associate administrator for rural health policy at HRSA. "We have been funding community-based grantees for a long time using a philosophy of grant-making that we developed in concert with the Georgia Health Policy Center that can be best thought of as a network approach. We thought we could take that same approach toward maternity care — to think beyond a single point of care setting and across the spectrum of all the people that are caring for that pregnant mom and baby during pregnancy and then after delivery. How could they all work together in a more cohesive manner, even if they were not part of a single health care system?"

The Rural MOMS program uses a network approach that brings together a broad spectrum of clinical providers and support services, including rural hospitals and the state Medicaid agency.

While MaineHealth is the largest health care system in the state, they thought a statewide approach was needed and brought every rural hospital in the state with a labor and delivery unit onto the network board, as well as a Federally Qualified Health Center, the statewide home visiting program, MaineCare (the state's Medicaid program), and the Maine Division of Public Health.

Much like how the Rural MOMS sites bring a network of partners, HRSA recognizes that the programs' success also relies on partners' complementary activities.

"We would be remiss if we just talked about Rural MOMS, because it is part of a suite of maternal and child health activities that we have across HRSA," explains Morris. "One of the things we asked our grantees to do is to work, if possible, with the other HRSA-funded entities, like community health centers, Healthy Start grantees, and the federal home visiting programs, which are all key players in ensuring successful pregnancies and deliveries, as well as early development of that child. We are helping to connect them for the most impact on outcomes of that child."

Building Financial Sustainability From Day 1

"HRSA funding is basically startup dollars to help rural communities test out these ideas with the ultimate goal of improving coordination of care and outcomes," Morris says. "But from the very minute they start, they have got to think about leveraging this time and funding to sustain the program beyond the federal grant."

Early Rural MOMS sites have had success partnering with rural health clinics and Federally Qualified Health Centers to provide the bulk of their prenatal services because these settings get an enhanced Medicaid rate, which covers the full cost of providing those services.

Medicaid pays for more than 40% of the births in this country overall and accounts for an even higher percentage in rural communities, which is why state Medicaid was viewed as an important player to involve in the process of thinking about a model of maternal and obstetric care going forward.

"Maine received the Maternal Opioid Misuse grant a number of years ago, and so we partnered closely with MaineCare, the state's Medicaid, to integrate perinatal care, substance use disorder treatment, and wraparound services," Zimmerman says. "We had a really positive relationship with

Medicaid through the development of that model of care, so Rural MOMS is a nice opportunity to continue the collaboration. We see benefits to having MaineCare at the table from the start when we are creating a model that needs to consider reimbursement. They have been very collaborative that way."

Part of what it takes to be successful is a willingness to experiment with a lot of strategies simultaneously to achieve sustainability both financially and in practice.

Implementing Practice Innovations

"We started this program during the pandemic, so simultaneously telehealth utilization and coverage really exploded," says Morris. "This put us in better shape, because people are more accepting of telehealth now, so we are seeing that all our grantees are using telehealth to provide some kind of service."

In Maine, the network has used telehealth to expand access to services, including the specialty services of psychiatry and nutrition counseling, and has launched remote patient monitoring for postpartum hypertension.

"Whether it is through a doula, a community health worker, or a patient navigator, I think that the more we can provide wraparound services for these women, and make sure they get into prenatal care as early as possible on the front end, the better the outcomes we will have on the back end," Morris says. "There should be no wrong door to enter; you can start with any challenge they may have."

But there are some workforce shortages that cannot be solved, even with telehealth.

"For the longer term, the next five to 10 years, we are making the investment that will help stem the tide of rural maternity units closing because of a lack of providers in those areas, but that will take a change in the care model," Mills says. "Right now, it is very based on obstetricians, and I think we have to expand the base of providers, such as nurse midwives and family physicians, who have done obstetrical fellowships and are trained to do C-sections. The technical assistance provided by GHPC has been instrumental in helping us look at different care models and workforce issues and linking us to other resources — experts and other peer grantees — throughout the country."

The challenge is that there are no doula or nurse midwife certification or family physician obstetrical fellowship programs in Northern New England. So efforts are underway to collaborate with neighboring states to potentially establish new training programs close to where the need is greatest.

"If this was easy, we would not need this grant program in the first place. We know it is challenging, and yet we know it can be done," Morris says. "We are figuring out the finances and the workforce piece and providing communities with the opportunity to test out their ideas and then, really, just getting out of the way to learn. We all have a stake in it and are all learning from each other, but mostly from the communities, about what is possible."

Rural MOMS by the Numbers

As of June 2024, there are **11** active Rural MOMS grantees with a total of **14** four-year awards in **13** states funded since fiscal year 2019.