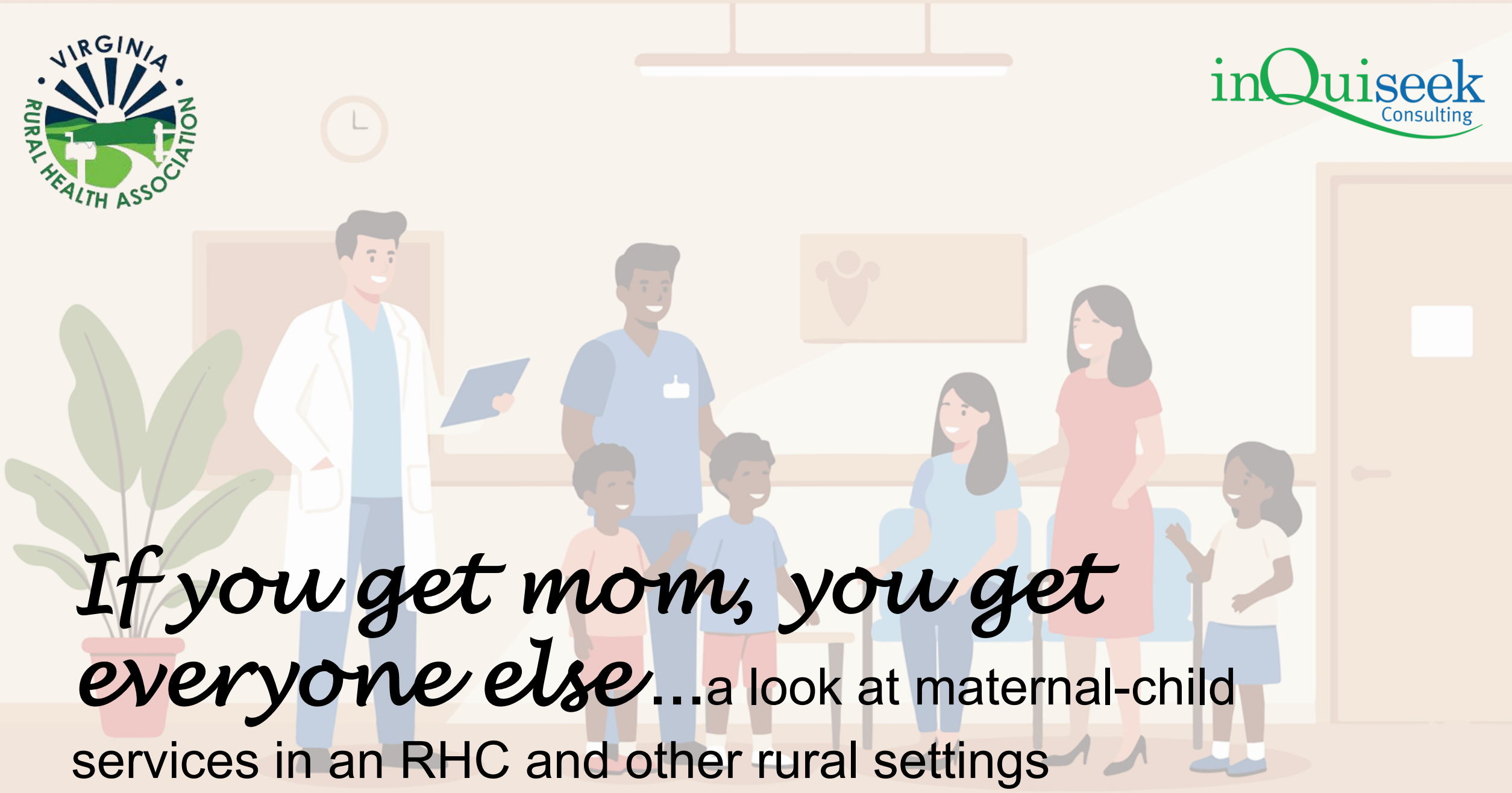


If you get mom, you get everyone else...a look at maternal-child services in an RHC and other rural settings

Discussion Points for this session

- The role that women play in family/friend healthcare
- Maternal deserts & other rural health stats
- Paradigm Shift in Care Models
- Collaborative and Cooperative Models for Care
- Challenges Surrounding Newer Care Models
- Should maternal-child health services be standalone service lines?

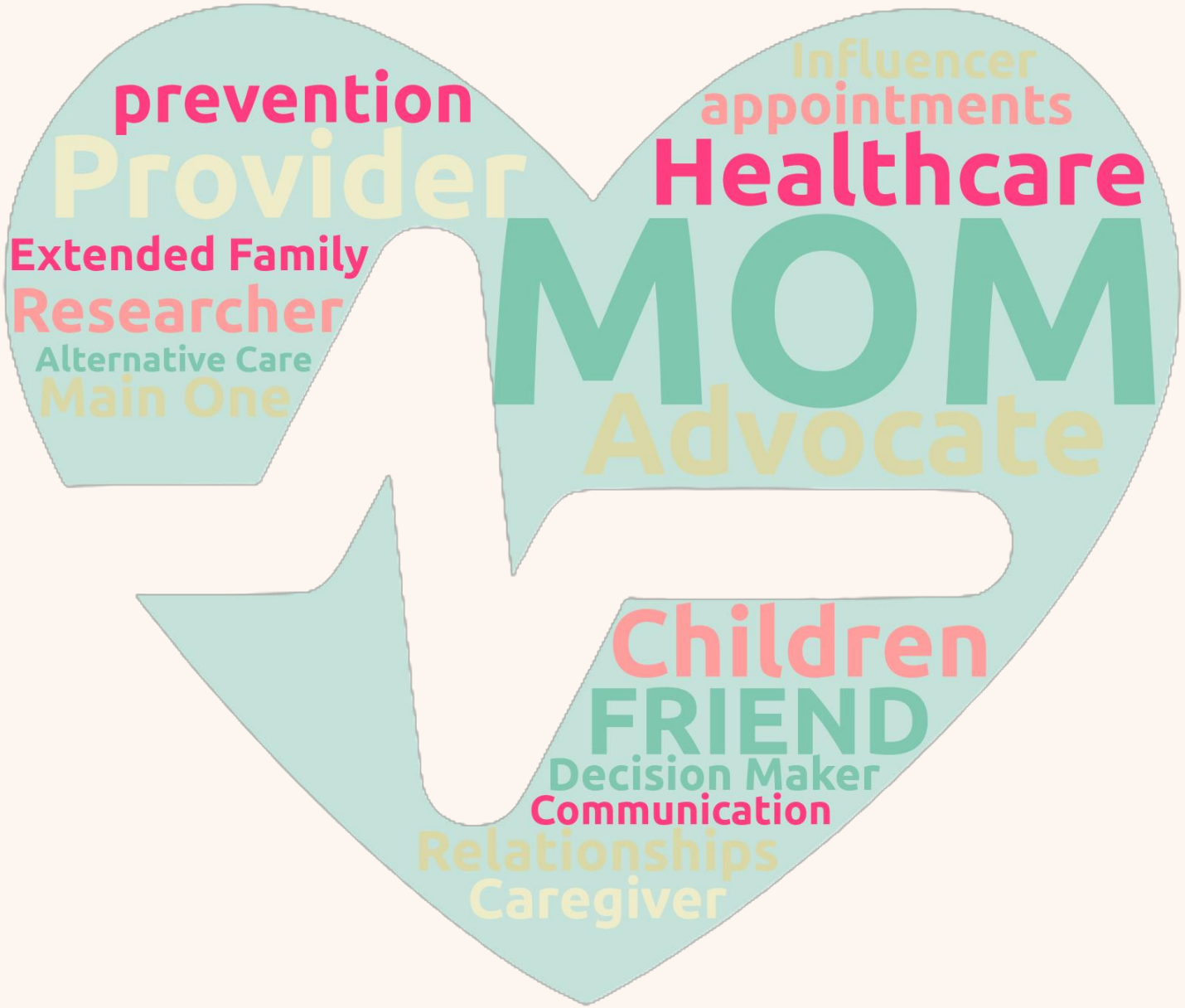
Soundbites... the role of women in healthcare decision-making

“Women in the United States make approximately 80% of the health care decisions for their families’” --PubMed: Matoff-Stepp, et al.

“American women are often in the role of being a health advocate, guide, or guardian for family and friends.” –Frontiers in Communication, 04 October 2023

“Women’s reproductive health care needs, their central roles managing family health as parents and as family caregivers, and their longer lifespans, albeit with greater rates of chronic health problems and functional limitations than men, all shape their relationships with the health care system.”--Kaiser Family Foundation, October 8, 2025

“Women are also more likely to consult a greater variety of resources, including friends, family, and alternative health professionals. In addition, women are more likely to search for information for both themselves and on behalf of others.”--Rowley J, Johnson F, Sbaffi L. Health Informatics J 2015;21:316–327

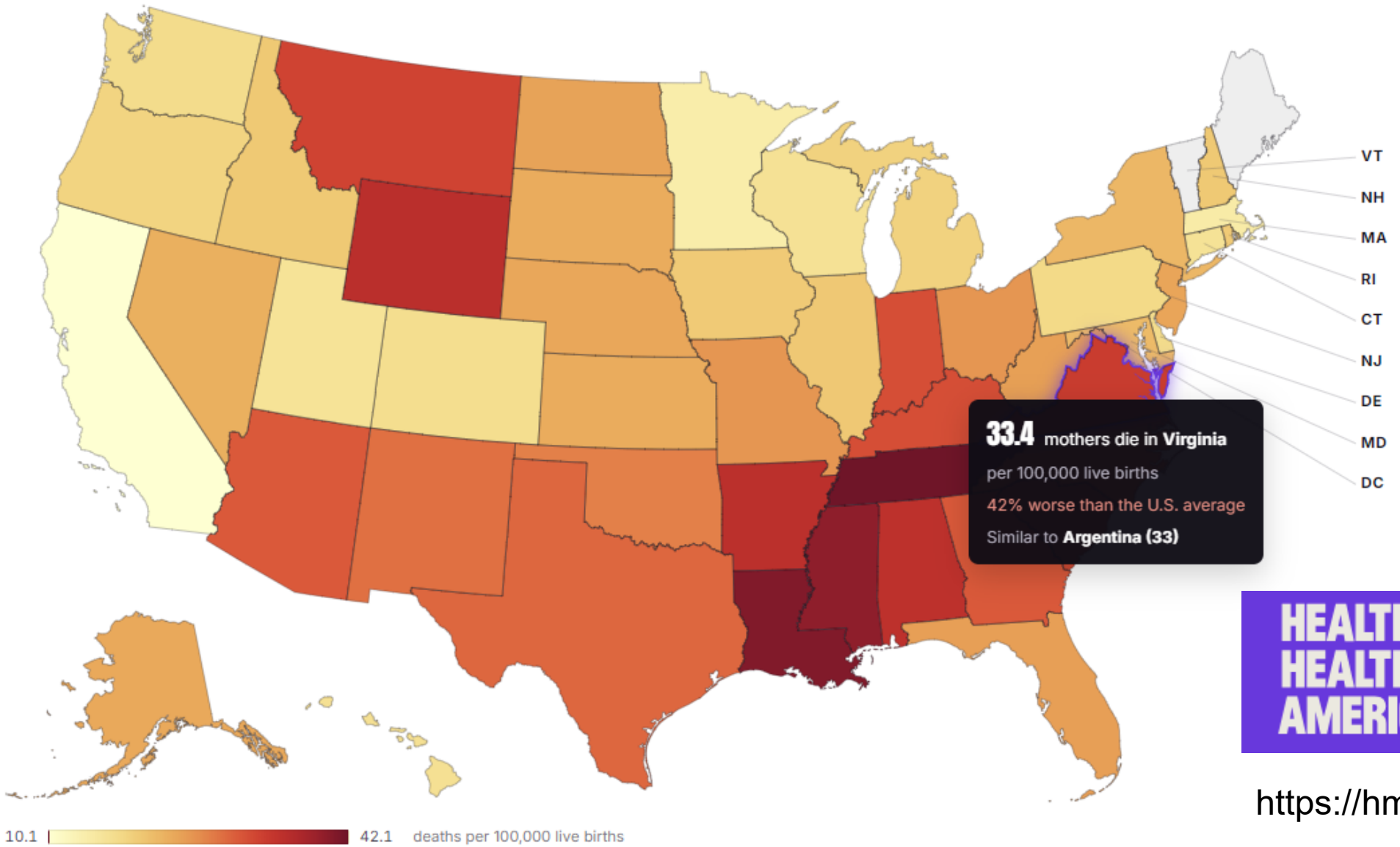

prevention
Provider
Extended Family
Researcher
Alternative Care
Main One
Influencer
appointments
Healthcare
MOM
Advocate
Children
FRIEND
Decision Maker
Communication
Relationships
Caregiver

Maternal Deserts & Other Stats

Virginia

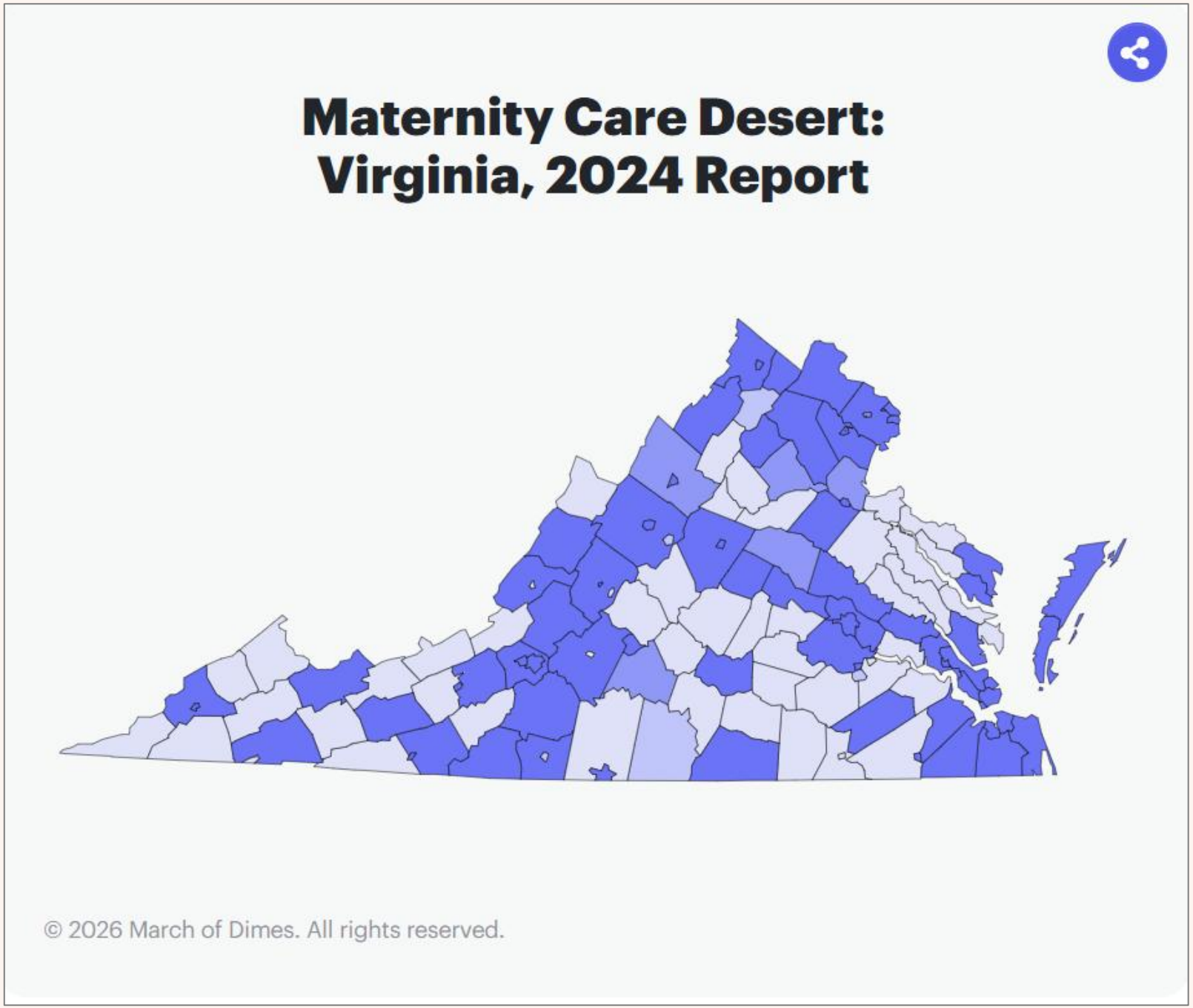
WHERE YOU LIVE CAN MEAN THE DIFFERENCE BETWEEN LIFE AND DEATH

Maternal mortality varies by more than 4× across U.S. states. Tap or hover any state for its rate, the U.S. comparison, and the country with the closest national rate.



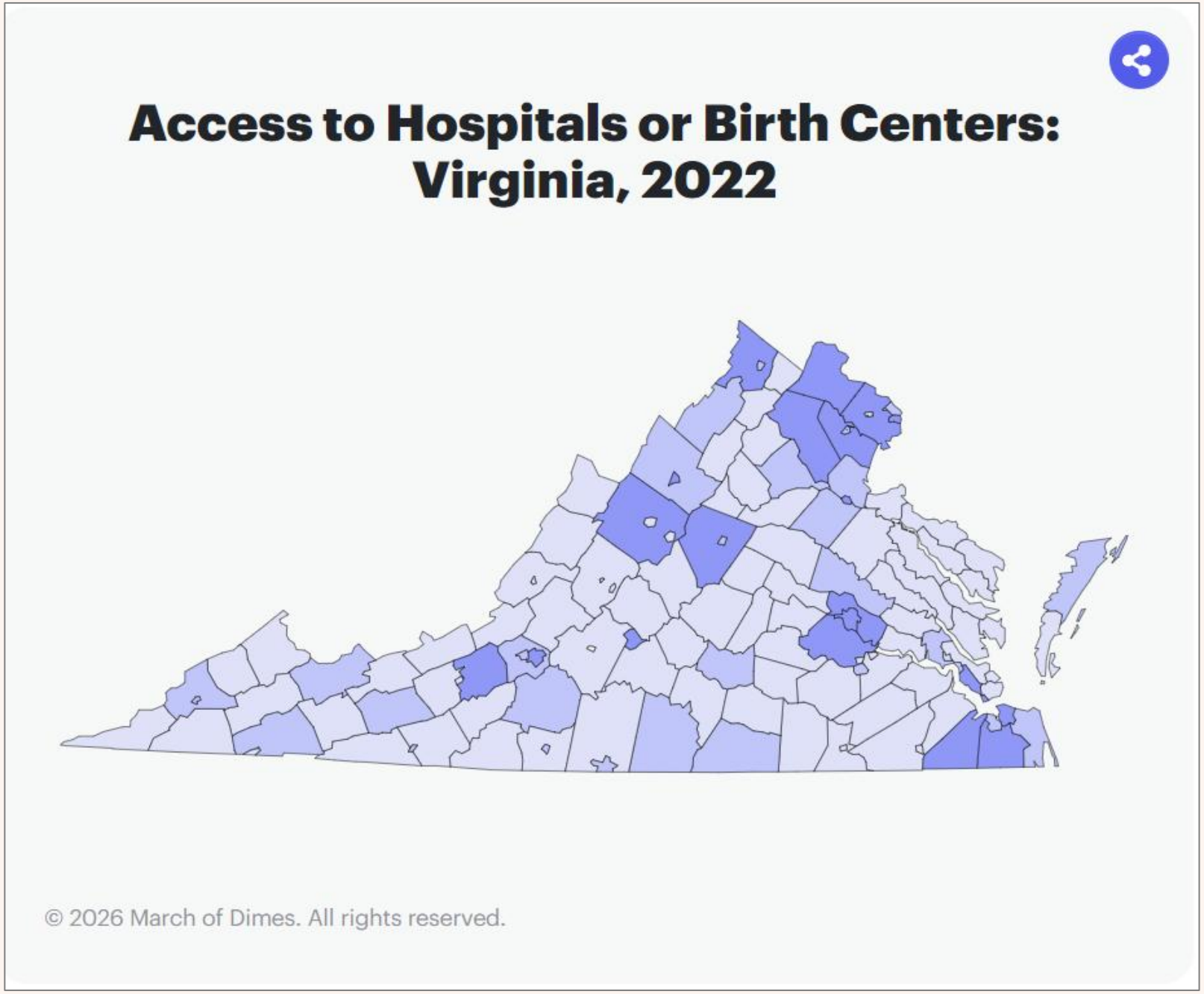
HEALTHY MOMS HEALTHY BABIES AMERICA

https://hmhba.org/

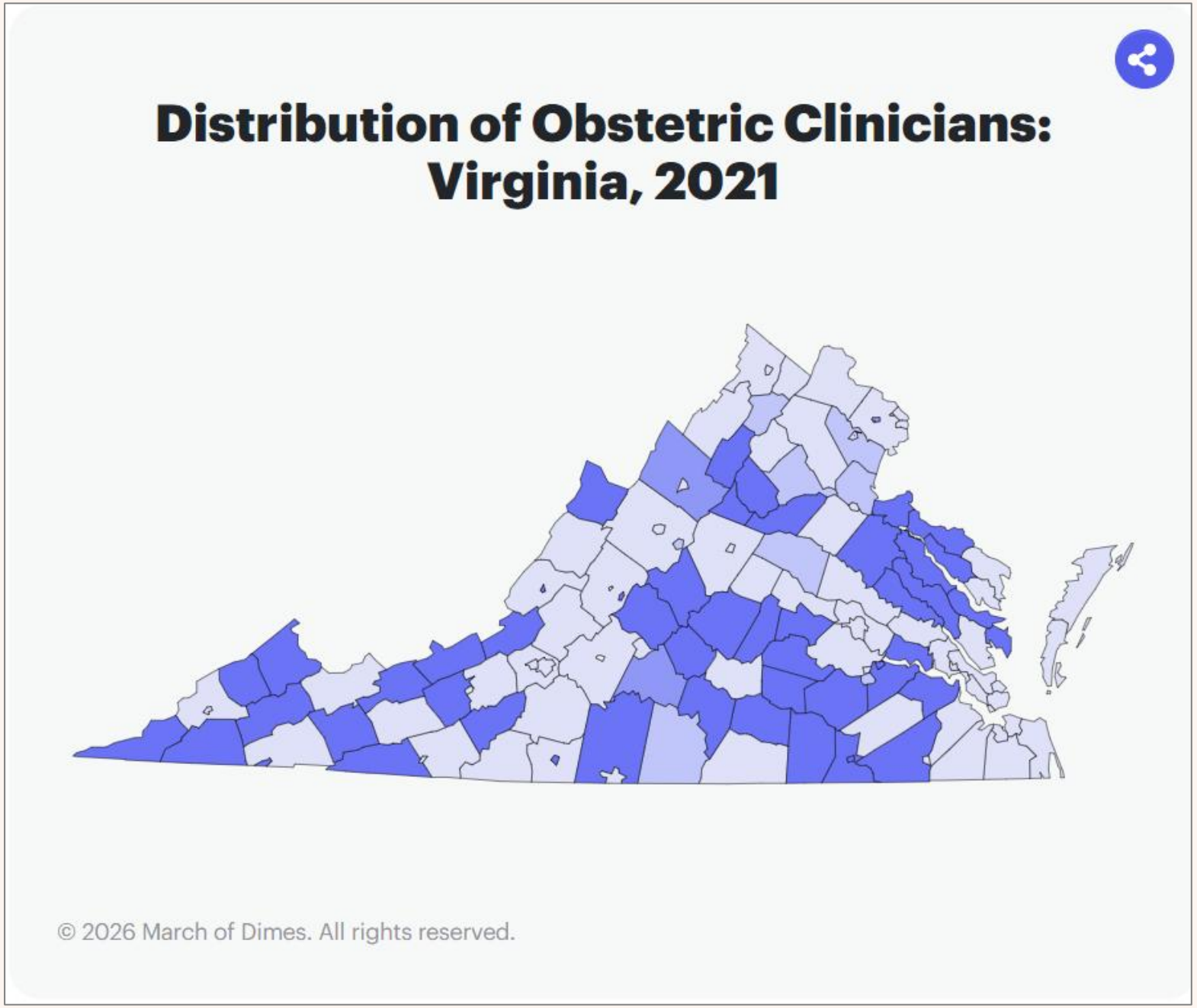


In Virginia, 37.6% of counties are maternity care deserts.

In Virginia, 8.3% of counties have low or moderate, not full, access.



In Virginia, 63.2% of counties have no hospital or birth center offering maternity care.



In Virginia, 38.3% counties have not a single obstetric clinician.

Defining Maternal Health

Maternal health refers to a woman's health and well-being before, during, and after pregnancy and encompasses aspects of physical, mental, emotional, and social health. The Centers for Disease Control and Prevention (CDC) defines maternal health as:

> "women's health and well-being during pregnancy, childbirth, and postpartum (after childbirth)."

Maternal health also includes the absence of maternal morbidity, severe maternal morbidity, and maternal mortality. Maternal morbidity refers to health conditions that complicate pregnancy and childbirth or that have a negative impact on a woman's health and well-being. Severe maternal morbidity (also called acute maternal morbidity) refers to outcomes of labor and birth that result in significant negative short- or long-term consequences to a woman's health. Maternal mortality refers to the death of a woman directly related to complications of pregnancy, birth, or within 12 months of giving birth.

https://www.ruralhealthinfo.org/toolkits/maternal-health/1/definition

Rural MOMS Program Fiscal Year 2025 (FY 25) Cohort

Organization	City	State	Award Amount	Service Area
University of Alabama at Birmingham	Birmingham	AL	$1,000,000*	Barbour, Bullock, Choctaw, Clarke, Conecuh, Dallas, Escambia, Macon, Marengo, Monroe, Washington, and Wilcox counties
University of Arkansas for Medical Sciences	Little Rock	AR	$999,951*	Ashley and Union counties
Virginia Rural Health Association	Luray	VA	$1,000,000*	Bland, Buchanan, Carroll, City of Galax, City of Norton, Dickenson, Grayson, Lee, Russell, Tazewell, Scott, Smyth, Wise, and Wythe counties

Rural Maternity and Obstetrics Management Strategies (RMOMS) Program

We fund the RMOMS program to increase access to maternal and obstetrics care in rural communities. This improves health outcomes for mothers and infants.

Why did we create the RMOMS program?

Rural mothers have more trouble getting care:

- More than half of all rural U.S. counties lack hospital obstetric services.[1]
- Closures are more common in small hospitals and communities with a limited obstetric workforce.[2]
- Maternal mortality and morbidity are rising.[3, 4]

These challenges highlight the need for innovative, flexible models of care.

What does the RMOMS program do?

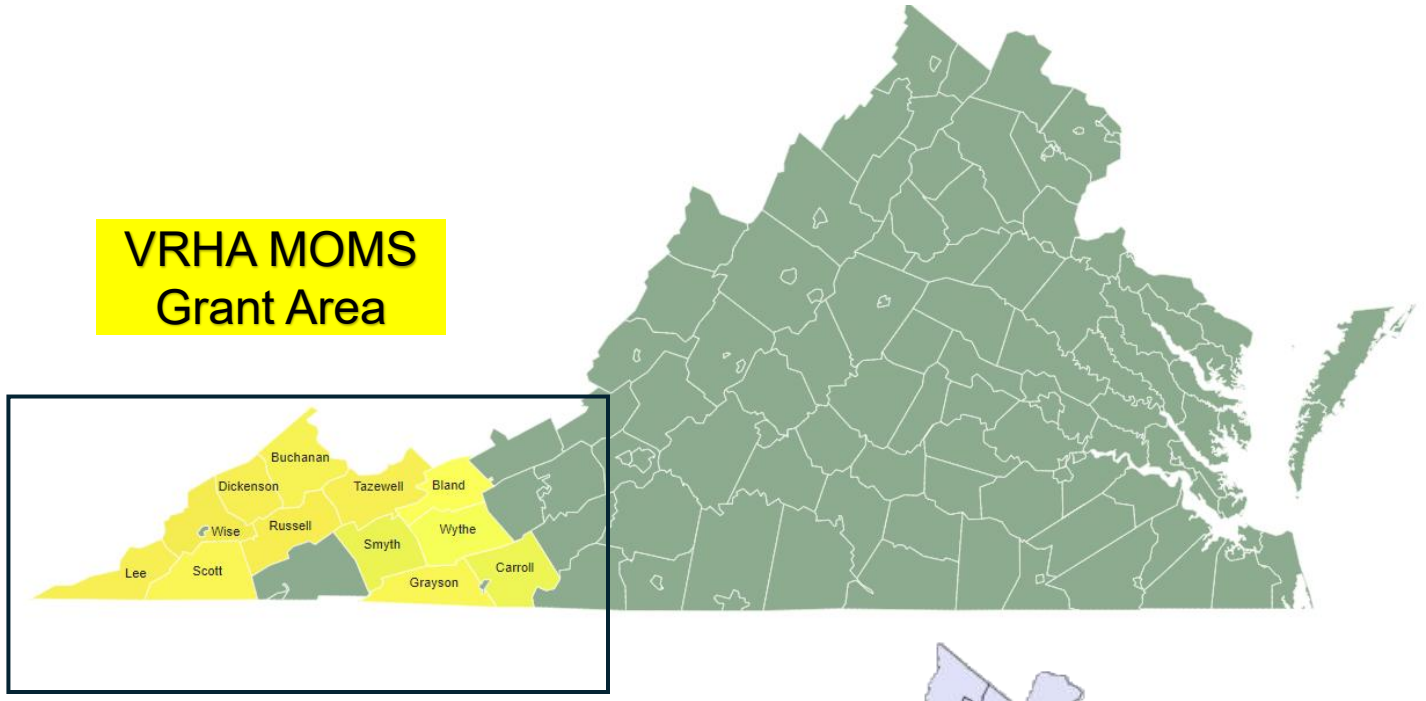
RMOMS improves maternal care in rural communities by:

- Collecting data on rural hospital obstetric services;
- Building networks to coordinate continuum of care;
- Leveraging telehealth and specialty care; and
- Improving financial sustainability.

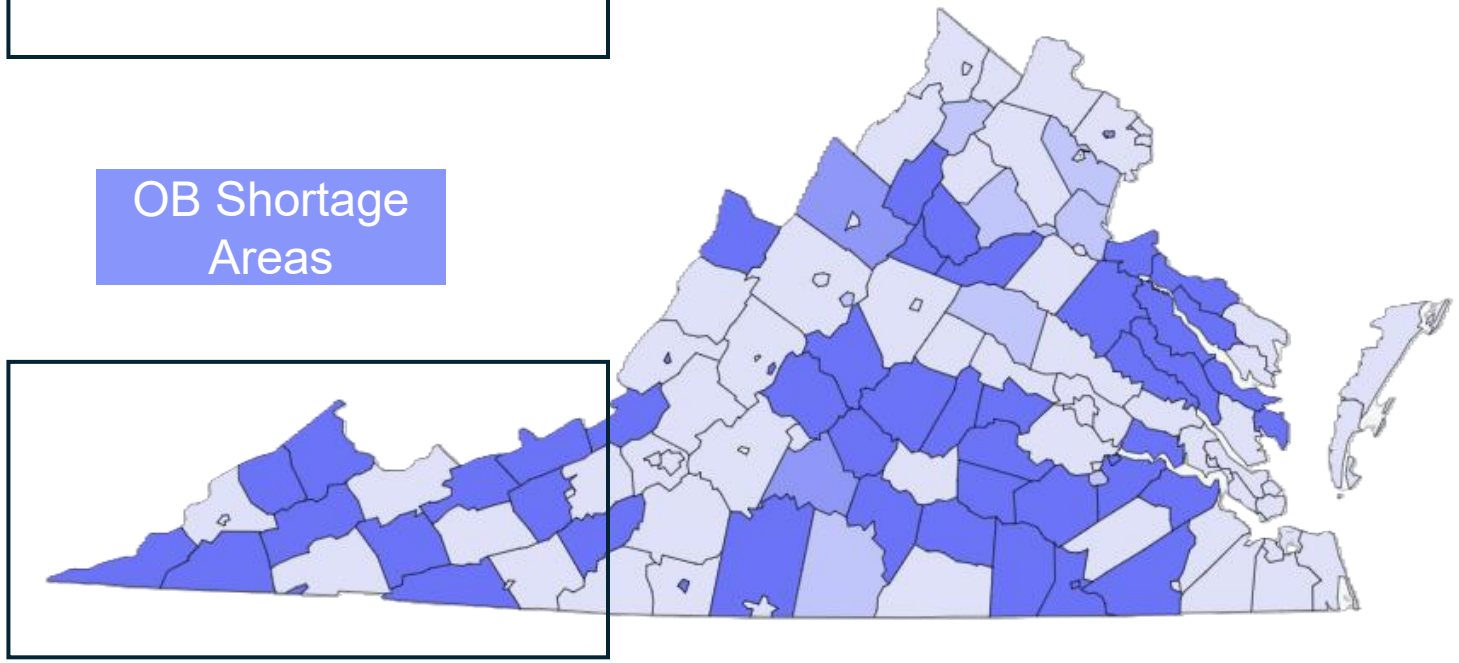
If the programs are successful, they can serve as a model for other rural networks.

HRSA
Health Resources & Services Administration

VRHA MOMS Grant Area



OB Shortage Areas



Comparison of VRHA/HRSA MOMs Grant Counties and the March of Dimes Obstetric Provider County Map

Paradigm Shift in Care Models

Last Updated: 6/4/2025
Published: 5/17/2021

Rural Maternal Health Toolkit

Welcome to the Rural Maternal Health Toolkit. The toolkit compiles evidence-based and promising models and resources to support rural communities implementing maternal health programs across the United States.

The modules in the toolkit contain resources and information focused on developing, implementing, evaluating, and sustaining rural programs to address the factors that affect and influence maternal health. Many factors can affect maternal health outcomes, including health status, health behaviors, access to healthcare and social services, and quality of healthcare, among other factors.

TMaH (Transforming Maternal Health) Model

The Transforming Maternal Health (TMaH) Model supports participating state Medicaid agencies (SMAs) in the development of a whole-person approach to pregnancy, childbirth, and postpartum care. By addressing the physical, mental health, and social needs experienced during pregnancy, the model aims to improve outcomes and experiences for mothers and babies, while also reducing overall program expenditures.

The TMaH Model is voluntary and will run for 10 years (2025-2034).

Key Points

- **Problem:** The United States has one of the highest maternal mortality rates among high-income countries which disproportionately impacts Medicaid populations.
- **Solution:** The model supports state Medicaid agencies and holds them accountable to implement evidence-based strategies for expanding access to maternal care, while also integrating behavioral health, social drivers of health, and continuity of care in the postpartum period, including building a bridge between clinical and community-based care.
- **Outcomes:** The model aims to improve maternal and infant health outcomes, such as reduce rates of low-risk cesarean section (c-section), severe maternal morbidity (SMM), and incidence of low birthweight infants and improve overall care experiences for pregnant women.
- **Strategy:** The model aligns with CMMI strategy to promote preventive care by increasing engagement in prenatal and post-partum care, expanding the perinatal health care team, and screening for and managing co-morbidities, as well as empowering patients by increasing their access to health information through technology and data, telehealth, and home monitoring.

Aims

The TMaH Model provides participating state Medicaid agencies with cooperative funding to support implementation of evidence-based interventions to:

- Improve maternal health outcomes and patient experiences at the state level for mothers and babies covered by Medicaid and the Children's Health Insurance Program (CHIP)
- Expand access to midwives and doulas, improve prenatal care for chronic conditions like diabetes and hypertension, and reduce complicated procedures like c-sections for low-risk mothers
- Foster a positive, supportive care experience that allows mothers to play an active role in the development of their birth plan and postpartum care

Design

The TMaH Model design centers on three components:

1. Access, Infrastructure, and Workforce
    - Increase access to birth centers and midwives
    - Increase access to community health workers and doulas
    - Enhance data collection
2. Quality Improvement and Safety
    - Reduce avoidable procedures like c-sections for low-risk mothers
    - Promote shared decision-making between mothers and providers
3. Whole-Person Care Delivery
    - Institute evidence-based medical and social risk assessments
    - Promote risk-appropriate care
    - Screen for depression, anxiety, and substance use during prenatal and postpartum periods
    - Promote telehealth for conditions like gestational diabetes and hypertension that can cause complications in pregnancy

Transforming Maternal Health (TMaH) Model

Jaya's Pregnancy Journey with TMaH

Jaya, 25, is currently enrolled in Medicaid. Jaya has a high risk pregnancy due to her Type 2 diabetes, and has food and housing insecurity.

PRENATAL

Jaya meets with a **midwife** who learns about her **health, wellbeing and social needs**.

Jaya is then connected with a care team that includes: :

- **Doctor** who collaborates with the **midwife** to manage her type 2 diabetes and support her pregnancy.
- **Doula** who provides information and encouragement throughout pregnancy and helps her prepare for birth.
- **Social Worker** who helps Jaya move to a secure home and enroll in a healthy food program.

Jaya works with her care team to create a birth plan that feels right for her.

Jaya feels safe and supported, and controls her diabetes with a healthy diet throughout her pregnancy.

BIRTH

Jaya and her care team discuss where she will give birth and Jaya decides on a hospital. They work together to follow through on Jaya's birth plan.

Jaya's **midwife and doula** are with her at every step in the birth process. After birth, her doula helps Jaya to feel comfortable caring for her new baby.

Jaya's **social worker** visits her at the hospital to help with the childcare plan and make sure Jaya's housing is secure.

Jaya and her baby are scheduled for follow up medical appointments with her **midwife** before they leave the hospital. Jaya's **doula** has already helped her prepare her home for the baby's arrival.

Jaya feels supported by her care team and prepared to go home. She and her baby are doing well because of the person-centered, team-based care she has received.

POSTPARTUM

Jaya has 12 months of Medicaid coverage including access to her doctor, midwife, and doula. Jaya and her baby receive regular postpartum care and monitoring of her diabetes via telehealth and office visits throughout the year.

Jaya's **doula** visits her and the baby several times at their home. The doula answers questions, checks on their wellbeing, and helps Jaya know the signs of postpartum depression.

Jaya's **social worker** connects her to virtual group parenting classes and ensures that she continues to have healthy food and a stable home.

One year later, Jaya and her baby are thriving, eating well, and live at home. Jaya successfully cares for her baby and herself, thanks to the ongoing support she received from her care team.

Examples of New Care Models

‘Even if a community is not planning on providing maternity care, they still are going to be providing maternity care, but they won’t be ready for obstetrical emergencies.”

John Cullen, M.D.
Family physician in Valdez, Alaska

UNC Chatham Hospital Model

In 2020, the UNC Chatham Hospital Maternity Care Center (MCC) reopened as a Level 1 maternity care center certified to provide low risk perinatal and maternal care after the original labor and delivery unit closed in 1991. UNC Chatham is a critical access hospital that features a community-integrated model that includes **full-spectrum family medicine and OB/GYN care**, **leveraging partnerships with the larger UNC system, local health services, and community health care organizations and focusing on culturally competent care to address disparities in maternal health outcomes**. To address maternal and infant morbidity and mortality, the MCC created EMBRACe (Equity for Moms and Babies Realized Across Chatham) to assess the needs of the community and coordinate community health initiatives.

https://www.milbank.org/2024/09/innovations-in-rural-obstetrics-to-maintain-access-to-care/

Manaska Health Model

Mahaska Health is a **critical access hospital** with a strong culture of being physician and nurse led. The hospital received a state grant that helped expand maternity care services and in recent years has started to provide perinatal mental health care in addition to general and specialty maternal and obstetric care. As a part of the Iowa Perinatal Quality Collaborative, **the birthing center has standardized protocols for postpartum hemorrhage and preeclampsia management to provide high quality care**. The birthing hospital is a designated regional trainer for Advanced Life Support in Obstetrics (ALSO) and provides certifications to nurses and physicians. Mahaska Health has reported volume increases driven by patients attracted to its emphasis on high quality care.

https://www.milbank.org/2024/09/innovations-in-rural-obstetrics-to-maintain-access-to-care/

Goodall-Witcher Hospital Model

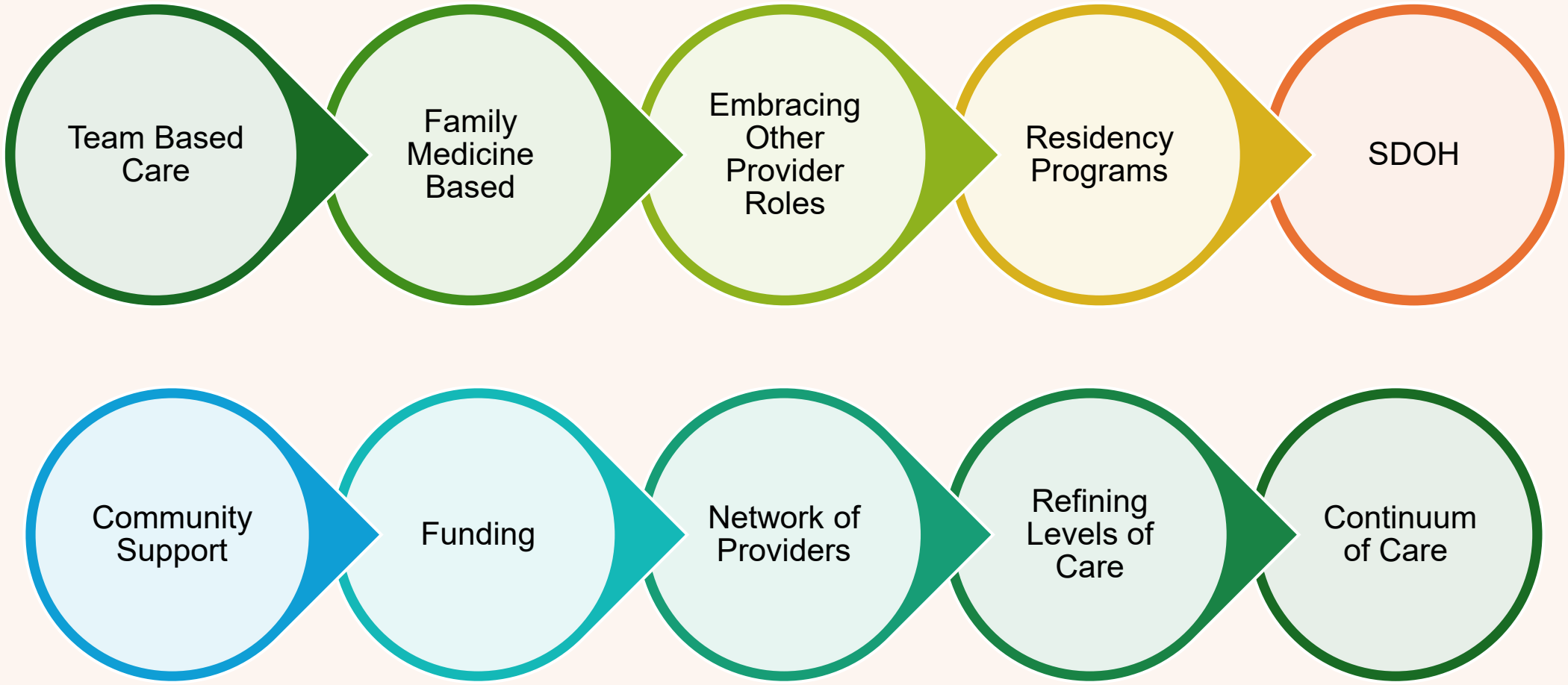
In 2018, financially strapped Goodall-Witcher Hospital transitioned from the Goodall-Witcher Healthcare Foundation to a **municipal hospital district supported by an elected board of community members with the authority to impose property taxes to fund the hospital**. Goodall-Witcher invested in **updating their facilities** and **recruiting family medicine physicians with surgical obstetric training** to staff deliveries and **deliver care across multiple clinical services.** These investments have reduced provider turnover, increased patient satisfaction, and improved community perception. The critical access hospital is recognized for providing personalized and comprehensive care; now many patients choose to travel to the hospital for obstetric care. Goodall-Witcher views maternity care to generate long-term patients across its service lines.

https://www.milbank.org/2024/09/innovations-in-rural-obstetrics-to-maintain-access-to-care/

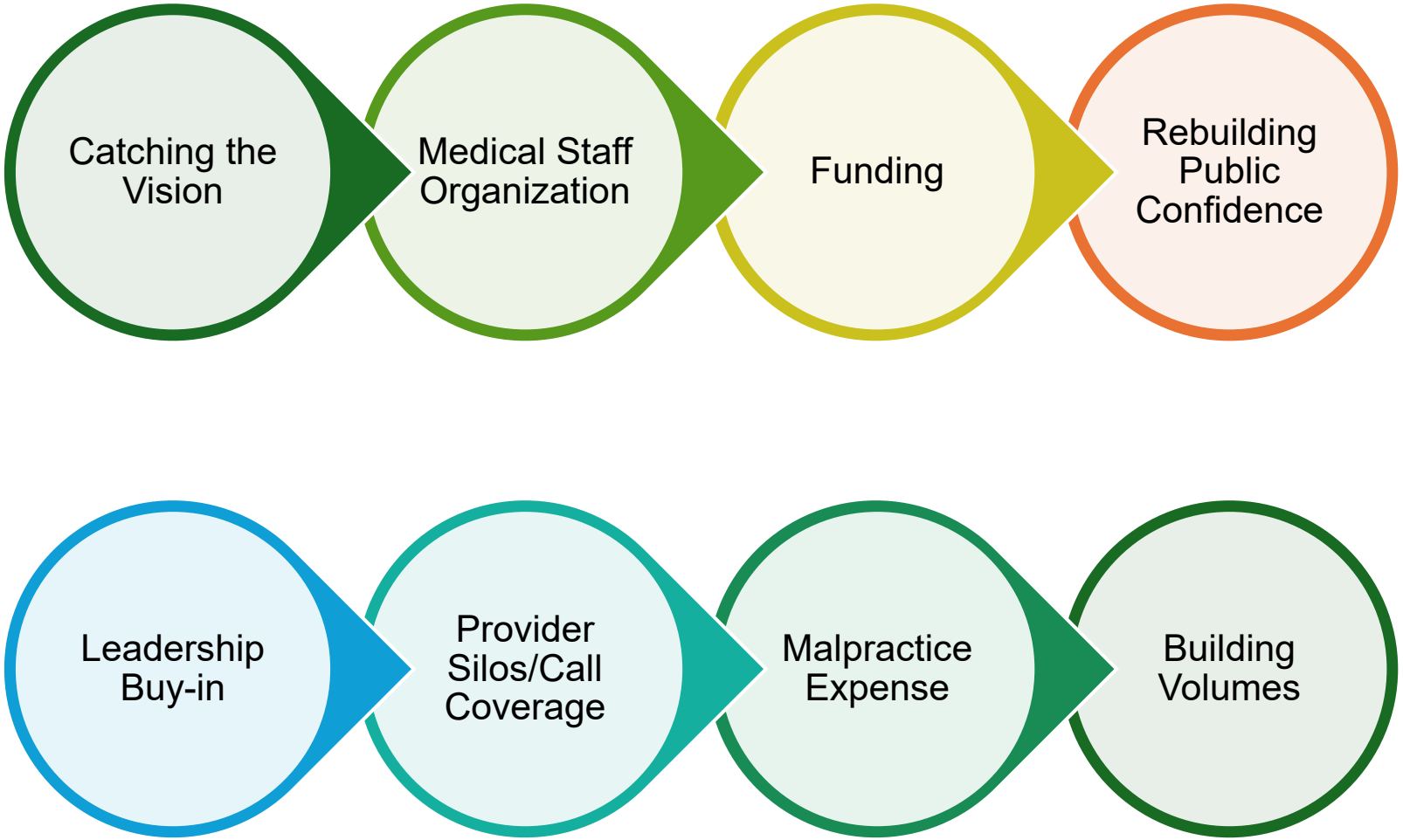
Southcentral Foundation Model

Southcentral Foundation (SCF) provides maternity health care services to the Alaska Native Community from across Alaska. The Tribal Health System in Alaska relies on a **team-based approach to obstetric care that leverages the expertise of community health aides, doulas, nurse midwives, family medicine physicians, OB-GYN and maternal fetal medicine physicians**, **nurse case managers, and other specialists to provide coordinated care for pregnant women from across the state**. To overcome the access barriers related to the remoteness of the region, SCF partners closely with providers from regional Tribal Health Organizations to help provide care in rural settings. If a woman is considered to have a high-risk pregnancy, she will be transferred to a higher level of care in Anchorage. SCF is dedicated to being **culturally aligned** with the Alaska Native Community. For example, SCF supports indigenous birth practices by providing no-cost Indigenous doula services through a community grant.

https://www.milbank.org/2024/09/innovations-in-rural-obstetrics-to-maintain-access-to-care/


Team Based Care
Family Medicine Based
Embracing Other Provider Roles
Residency Programs
SDOH
Community Support
Funding
Network of Providers
Refining Levels of Care
Continuum of Care

Challenges Surrounding Newer Care Models


Catching the Vision
Medical Staff Organization
Funding
Rebuilding Public Confidence
Leadership Buy-in
Provider Silos/Call Coverage
Malpractice Expense
Building Volumes

Brainstorming: What else?

Share your experience: what worked, what didn’t, why

Should maternal-child-family health services be standalone service lines?

Why, Why Not?

- Although we have begun shifting our care delivery models to an integrated, team-based approach, traditional ways of reporting revenue and expenses for healthcare accounting has not shifted to align with the clinical models.

- We don’t always have a good way of attributing the upstream and downstream financial activities in a way that can demonstrate the value of integrated, team-based care.

- Compensation models keep service lines siloed as far as revenue. Who is going to get credit for doing what?

- Cost-based reimbursement for CAHs and RHCs requires that direct expenses and other related costs be put into cost centers or subunits. Who is going to get credit for what it cost us to do this?

- This is biggest issue with CAHs and RHCs adopting quality programs or doing demonstration projects. We can’t get everything in the right bucket.

But, if we get the mom, we are able to provide services for the entire family and for those people in her sphere of influence.

We prevent out-migration and restore the community's confidence in our safety net rural providers. We build a more stable economic base for the service area and prevent maternal and child mortality.

Patty Harper, RHIA, CHC®
pharper@inquiseek.com
318-243-2687