The Minnesota Rural Health Advisory Committee's Rural Obstetrics Work Group

2012 Minnesota Rural Health Conference

Project Overview & Recommendations

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Today we will cover…

- Rural Health Advisory Committee
- Rural Obstetrics Work Group
  - Purpose/Members
  - Background Issues
  - Work Group Focus Areas
  - Recommendations

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Rural Health Advisory Committee

- Statewide forum for rural health interests.
- Fifteen members compose the Committee
  - Health care providers (7)
  - Higher education (1)
  - Legislators (4)
  - Consumers (3)

- RHAC advises the Commissioner of Health and leaders in other state agencies on rural health issues.

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Rural Health Advisory Committee

- RHAC workgroups/report topics
  - Rural Population Health (2011)
  - General Surgery (2011)
  - Telemental Health (2010)
  - Rural Health Care Delivery Models (2009)
  - Language Access Services (2008)
  - Health Care Reform (2007)
  - Healthy Aging (2006)
  - Mental Health & Primary Care (2005)
  - www.health.state.mn.us/divs/orhpc/rhac/index.html

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Rural Obstetrics Work Group

- Purpose
  - To discuss obstetric services in rural Minnesota and develop recommendations for addressing identified issues and barriers.
- Focus Areas
  - Education, training and residency
  - Workforce issues
  - Hospital issues
  - Patient & community issues

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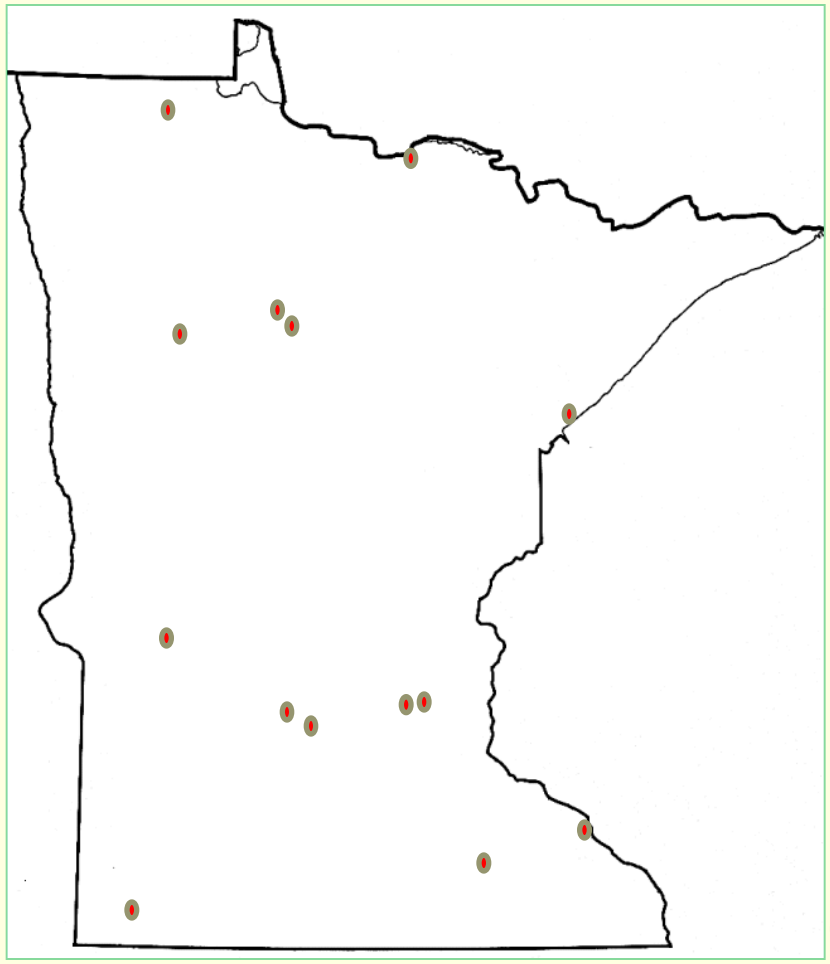
Rural OB Workgroup Members

- 24 work group members/key informants
  - 2 doulas
  - 3 midwives
  - 7 nurses
  - 5 physicians
    - 1 OB/GYN
    - 3 family practice
    - 1 psychiatrist
  - 2 rural hospital CEOs
  - Other
    - Medical social worker
    - 3rd year medical student
    - MN Hospital Association
    - MN Board of Nursing
    - HIT consultant



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Setting the Scene:

Obstetric Services in Rural Minnesota

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Obstetric Services in Rural Minnesota

- Rural Hospital Survey (2008)
  - Of the 101 rural hospitals in Minnesota, 76% offered obstetrical services
  - Of the 79 hospitals in towns under 10K people, 71% offered obstetrical services
  - 91.7% hospitals with obstetric services have family medicine physicians providing services

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Obstetric Services in Rural Minnesota

- Recruiting family physicians into OB
  - General decline in number of medical students choosing primary care
  - Fewer family physicians doing OB
  - Family physicians doing OB are retiring
  - Requires better OB training for rural family physicians

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Obstetric Services in Rural Minnesota

- Factors contributing to Discontinuation of Obstetrical Services in Rural Hospitals

1. Too few deliveries
2. Not enough female providers, no OB/GYN, no anesthesia/general surgeon
3. FP retirement/new FP no OB
4. Inadequately trained support staff
5. Large conglomerate bought clinic
6. Aging community
7. Insufficient technology

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Rural Obstetrics Workgroup

Focus Area One:
Education, training & residency

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Education, training & residency

- Topics discussed
  - General and rural-specific training and residencies in Minnesota
    - Family practice MDs (UMN-TC & Duluth)
    - General surgeon MDs (3 residency programs)
    - Certified nurse midwives (UMN)
- Related activities
  - Aspiring obstetrics provider roundtable

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Aspiring OB provider roundtable

1. What are unique characteristics of medical students who wish to do family medicine with OB?
2. Do medical students who do not want to do OB have biases or preconceived notions about the profession?
3. What is your perception of the role of CNMs in the provision of obstetric services?
4. What is your perception of the role of traditional midwives or doulas in the provision of rural obstetric services?
5. What is your reaction to a shared care team model where a team takes on the same patients and shares the call schedule?

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Education, training & residency

Review of draft recommendations

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Education, training & residency

A. Support an appropriate number of new medical graduates to meet future rural obstetric care needs.
B. Support a system for medical school admissions that considers rural provider perspectives and a student's inclination towards a rural obstetrics practice.
C. Provide more opportunities for rural family medicine doctors to receive training in the provision of cesarean sections.
D. Analyze and address the impact of newer federal work hour restrictions on rural medical residents.
E. Support rural obstetric teams' involvement in educational offerings that supplement their labor and delivery skills.

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Rural Obstetrics Workgroup

Focus Area Two:
Rural Obstetrics
Workforce Issues

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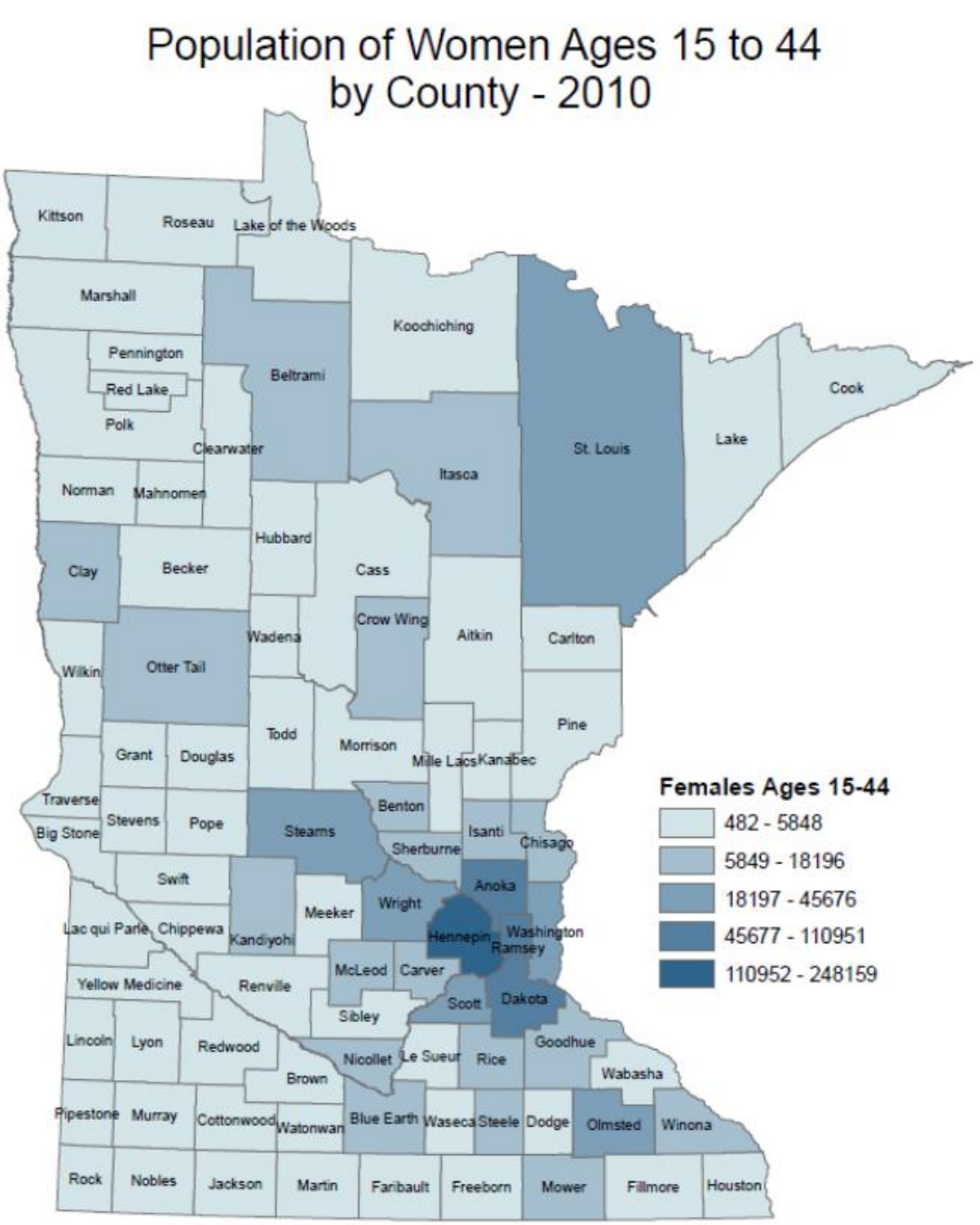
Rural OB Workforce Issues

Statewide in 2010:

Live Births = 54,655

Women Ages 15-44 = 846,327

Fertility Rate = ~65 births/1000 Women



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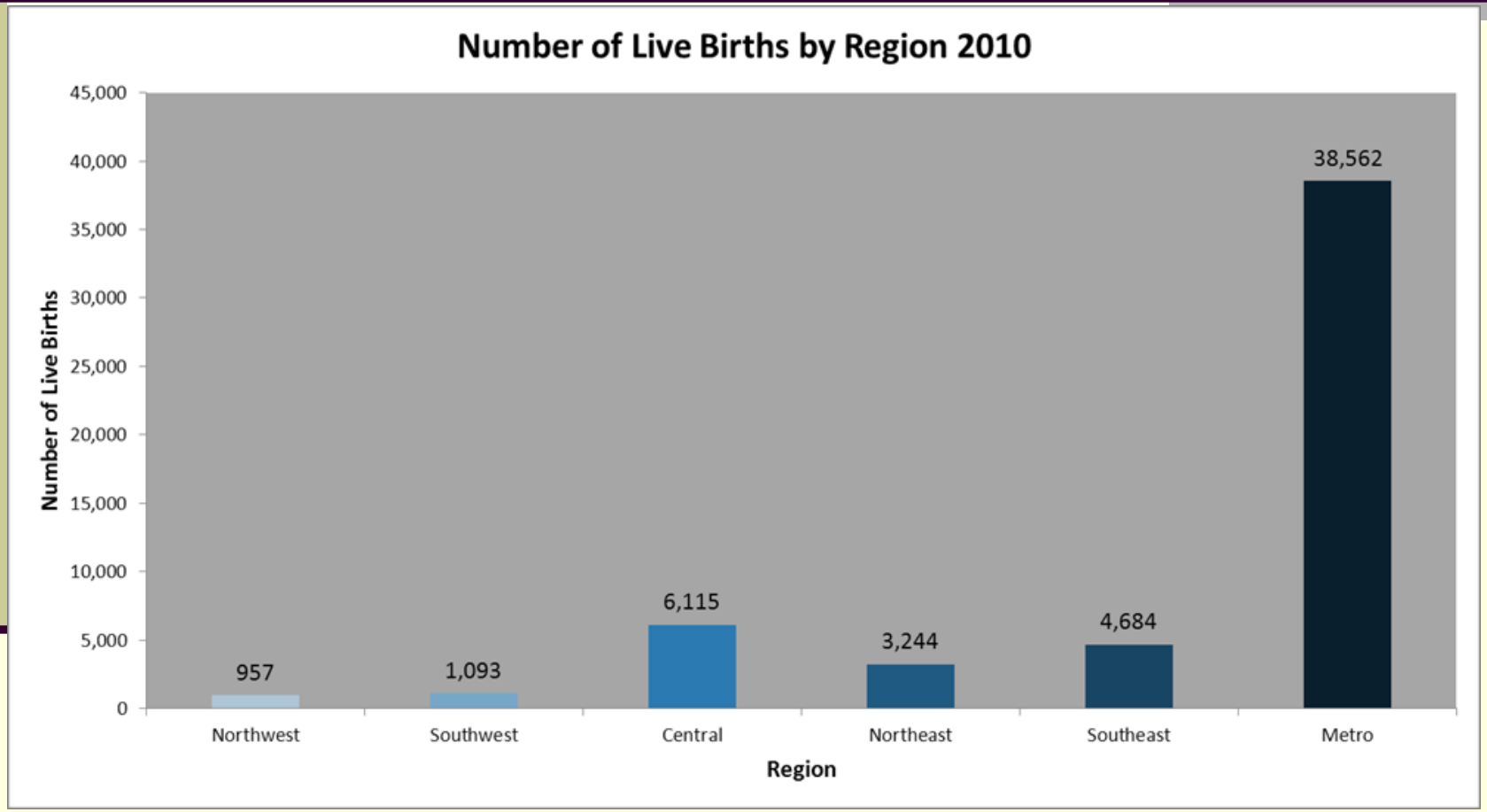
Rural OB Workforce - 2010



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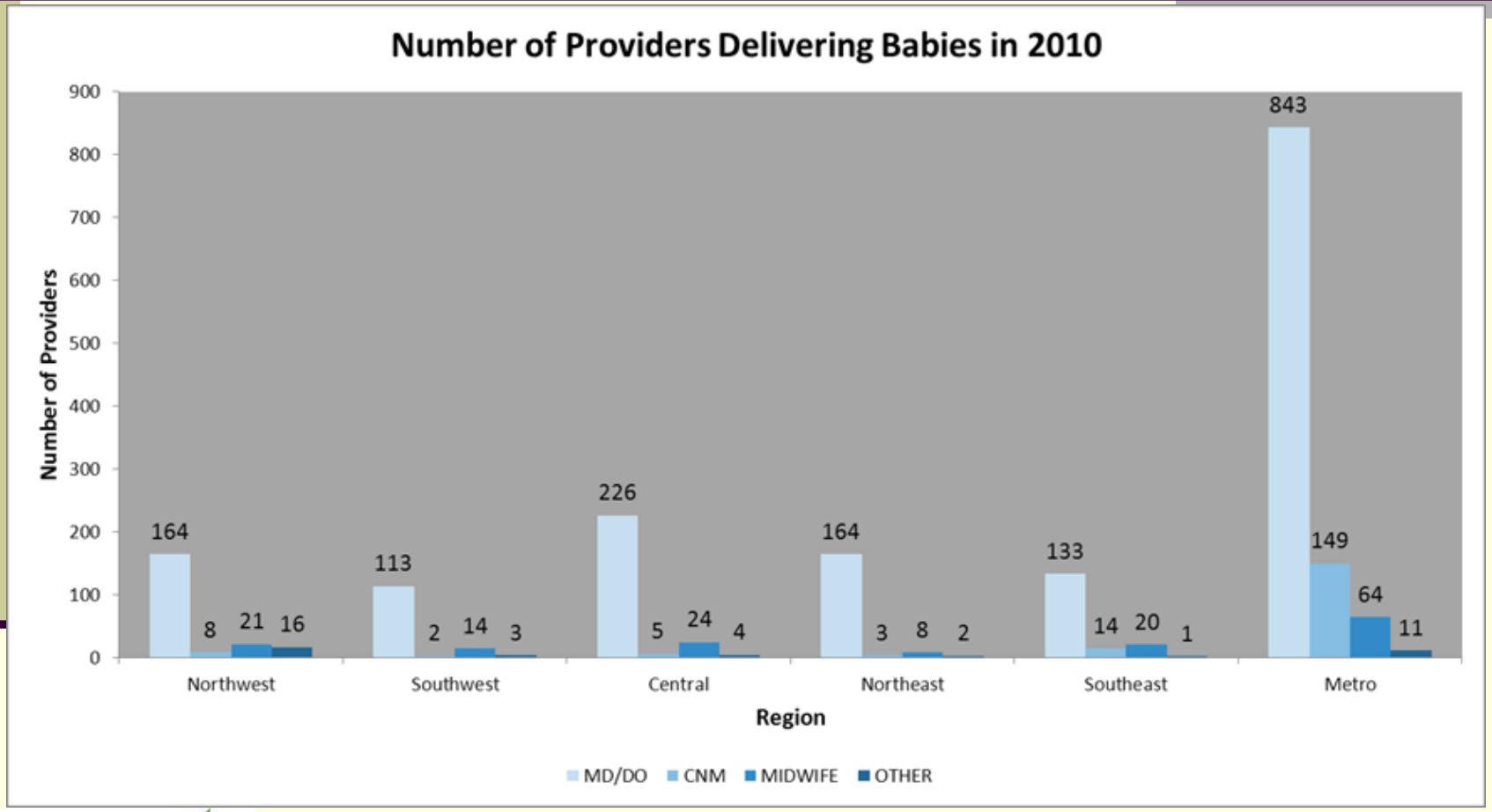

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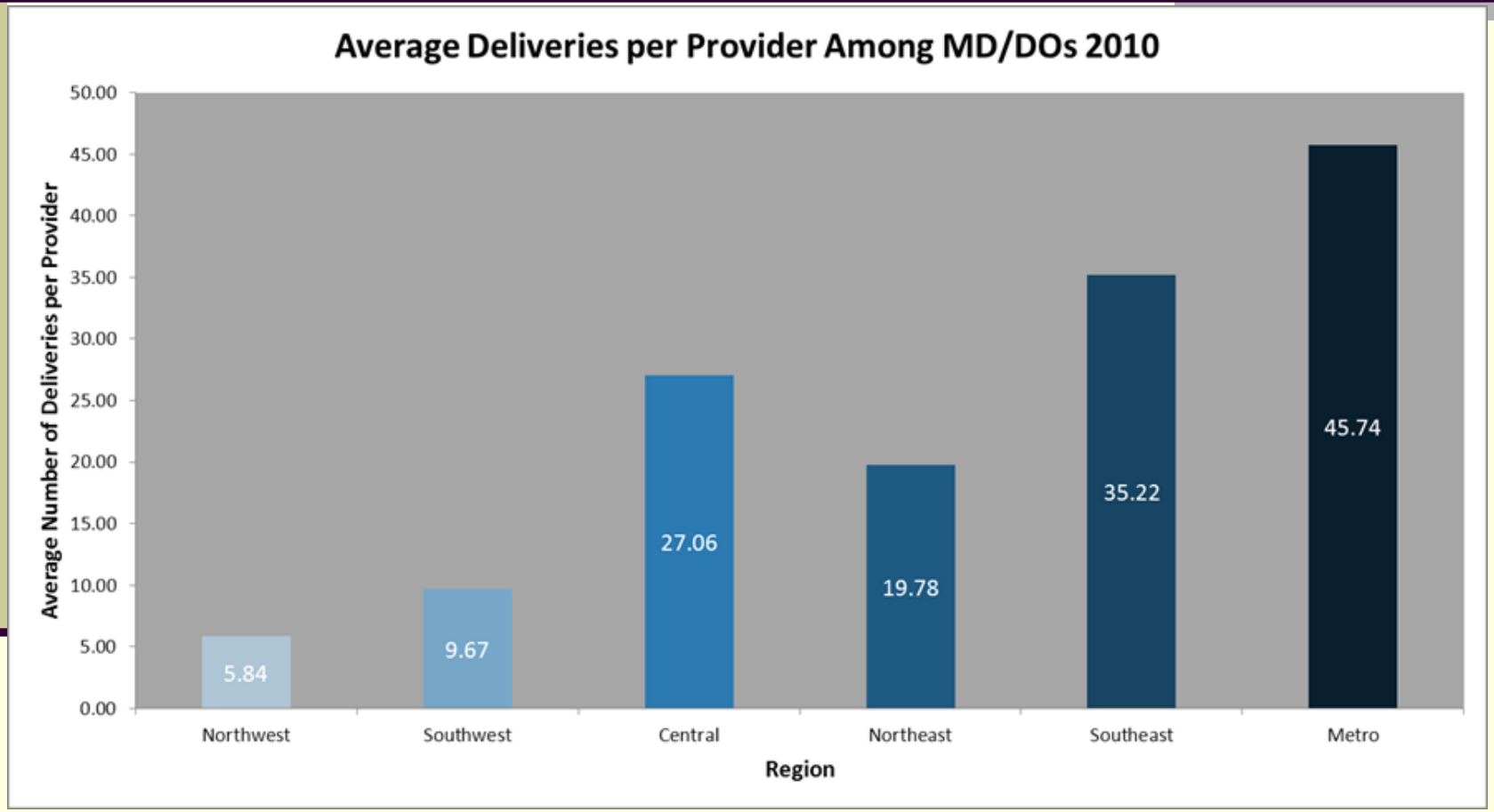
Rural OB Workforce - 2010



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Rural Obstetrics Workforce

Review of draft recommendations

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Rural Obstetrics Workforce

F. Address ongoing challenges related to workforce shortages in rural obstetrics.

G. Address regulatory barriers to practice at federal, state and hospital levels for certified nurse-midwives.

H. Support the well-being of obstetric providers in rural areas, the majority of which are female.

I. Support collaborative efforts to maintain local obstetric services and share successful models.

J. Support loan forgiveness programs for obstetric providers in small and isolated rural areas.

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Focus Area Three:
Hospital Issues

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Rural OB Hospital Issues

- Topics discussed
  - CAH challenges to rural OB programs
    - Training and maintaining OB skill sets
    - Liability, risk management
    - Technology and infrastructure
    - Recruitment and retention
- Related activities
  - CAH administrator perspectives
    - Renville County Hospital (Olivia)
    - Swift County-Benson Hospital (Benson)
    - Sanford Thief River Falls Medical Center

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Rural OB Hospital Issues

Review of draft recommendations

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Rural OB Hospital Issues

K. Support improvements to Medicaid reimbursement for rural obstetrics.
L. Protect Minnesota's low cost liability and malpractice insurance environment for obstetric providers.
M. Promote a set of best practices for rural hospitals that encounter obstetric emergencies with limited obstetric staff or resources.
N. Expand awareness of the impact of local obstetric services on patient safety and quality.
O. Develop and pilot a rural obstetrics telehealth model.

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Focus Area Four:
Rural Obstetric Patient and Community Issues

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Rural OB Patient Issues

- Topics discussed
  - Costs and travel
  - Access to prenatal care
  - Cesarean deliveries
  - Support for high-risk pregnancies
  - Cultural considerations
- Related activities
  - Tribal Doula roundtable discussion

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Barriers to Prenatal Care in Greater Minnesota (2009-2010)

- 35% - No money/insurance to pay for visits
- 33% - Didn't know pregnant
- 30% - MD/health plan did not start care early
- 29% - Couldn't get an appointment
- 26% - No Medicaid, MA, or MinnesotaCare
- 12% - Pregnancy secret
- 12% - too busy
- 6% - no transportation
- 6% - no time off work or school
- 3% - no child care
- 2% - Didn't want prenatal care

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Prenatal Care Discussion Topics in Greater Minnesota (2009-2010)

- 90% - safe medications during pregnancy
- 88% - tests for birth defects or diseases
- 85% - breastfeeding
- 85% - birth control following pregnancy
- 82% - what to do if labor starts early
- 82% - signs and symptoms of preterm labor
- 79% - what to do if depressed during/after pregnancy

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Prenatal Care Discussion Topics in Greater Minnesota (2009-2010)

- 72% - how smoking affects fetal development
- 71% - how drinking affects fetal development
- 71% - mercury in fish/safe eating guidelines
- 61% - how illegal drugs affect fetal development
- 61% - getting tested for HIV
- 59% - using a seatbelt during pregnancy
- 59% - physical abuse by husbands or partners

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Cesarean Deliveries (2009)

- U.S. cesarean rate = 33%
  - Fetal distress (most common)
  - Position of baby (breech)
  - Placenta previa (1 in 200 pregnant women)
  - Uterine rupture (1 in 1500 births)
  - Placental abruption (1% pregnant women)
  - Birth defects, diabetes, active herpes
- Minnesota c-section rate = 27%
  - 39% c-sections in rural hospitals were performed by family practice physicians (2007)

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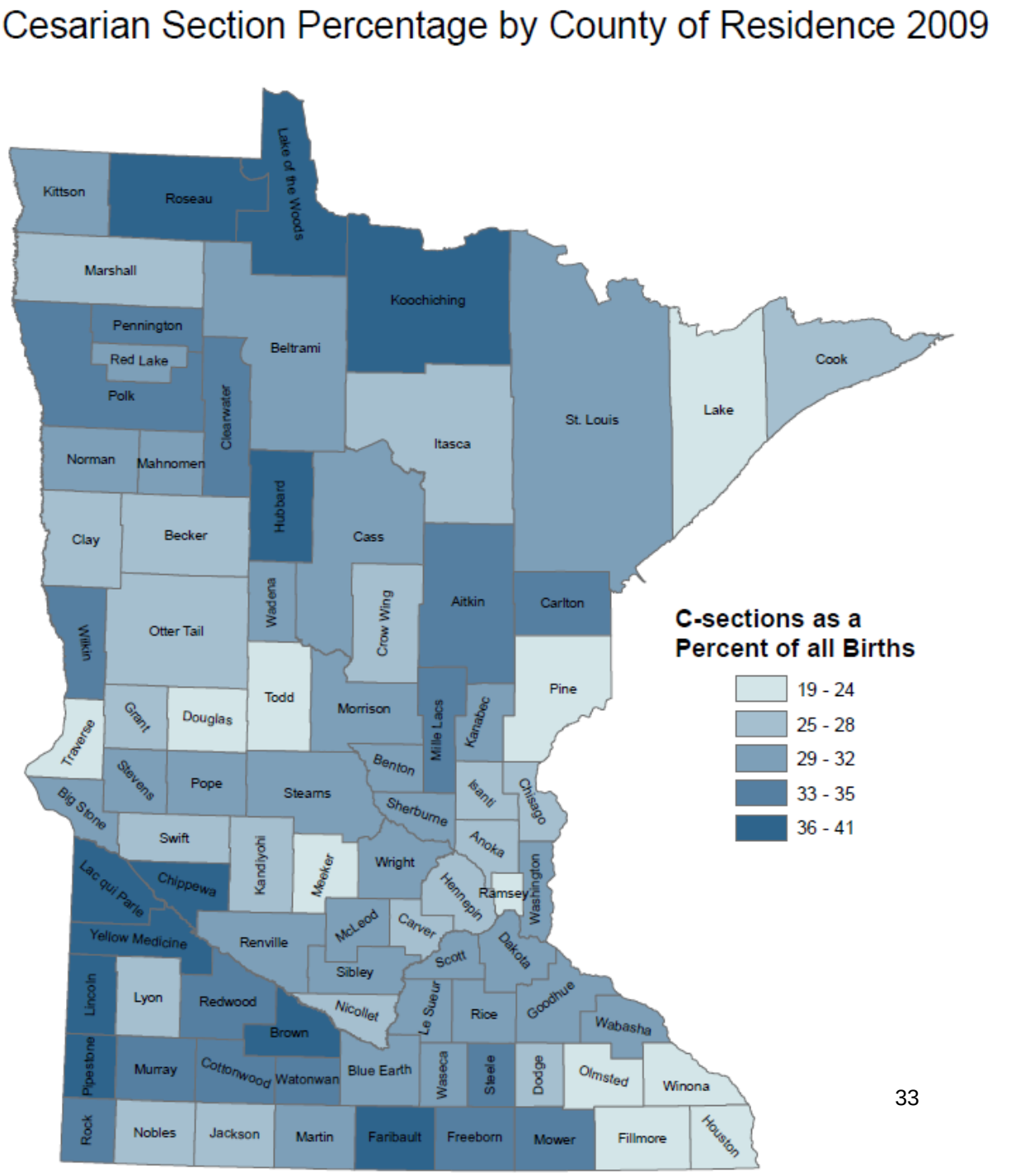
C-Section Rate by County of Residence



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Tribal Doula Perspectives

- Revitalization of Ojibwe traditional birth
  - Incorporate spiritual or cultural aspects into the birth process, document the birth story
- Traditional births are possible in a woman's home, birth lodge, or a hospital setting
  - Family presence in the birthing space
  - Smudge with cedar or sage throughout labor
  - Traditional medicines during/after birth
  - Placenta

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Rural OB Community Issues

- Topics discussed
  - Access to local obstetric services
    - In Minnesota, 43% of births take place in non-metro areas
  - Local competition vs. collaboration
    - Recruitment
    - Call coverage; surgical coverage
  - Care coordination across systems
  - Telehealth support for rural obstetric practices

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Patient and Community Issues

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Patient and Community Issues

P. Educate rural providers and hospital staff about ways to better serve American Indian women.

Q. Educate rural providers and hospital staff about the role of doulas.

R. Encourage collaboration between rural obstetric providers and local public health nurses to maximize the use of local resources available to pregnant women and new parents.

S. Ensure the inclusion of obstetrics as a necessary service in health care delivery models such as Accountable Healthcare Organizations.

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QUESTIONS?

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