

May 31, 2020

Department of Health and Human Services (HHS)
Centers for Medicare & Medicaid Services (CMS)
Office of Minority Health (OMH)
Attn: ruralmaternalrfi@cms.hhs.gov

Re: Request for Information Regarding Maternal and Infant Health Care in Rural Communities

The National Association of County and City Health Officials (NACCHO) appreciates the opportunity to respond to the Request for Information regarding opportunities to reduce health disparities by improving healthcare access, quality, and outcomes for women and infants in rural communities before, during, and after pregnancy.

NACCHO represents the nation's nearly 3,000 local health departments, that work every day to protect the public in their jurisdictions. More than half of local health departments are in rural areas serving populations of less than 25,000 individuals. Given the unique needs of rural populations, NACCHO established the Rural Health Section, through which NACCHO members and partners work together on specific rural public health issues across multidisciplinary and programmatic expertise.

Local health departments play key roles in supporting maternal and infant health. According to NACCHO's 2016 *National Profile of Local Health Departments*, 72% of rural health departments operate the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), 64% engage in home visiting programs, about one-third directly provide prenatal and well-baby care, and 6% provide obstetric care.¹ In many areas local health departments are a consistent, and sometimes the only, source of support for low-income and minority women and infants at the highest risk for mortality and morbidity, especially in rural communities. In addition to providing the services listed, local health departments have been on the front lines in reducing maternal and infant mortality; many lead or participate in maternal or fetal and infant mortality reviews, interdisciplinary panels that investigate fetal, infant, and maternal deaths to identify gaps in systems and services and encourage preventive measures.

NACCHO's response to the Request for Information is the result of decades of work supporting rural communities and addresses the four questions posed:

1. **What barriers exist in rural communities in trying to improve access, quality of care, and outcomes in prenatal, obstetrical, and postpartum care?**

To improve health outcomes for women and infants, strategic investments must be made that address barriers in systems, infrastructure, and workforce. These barriers are complex and multiplicative and therefore require a coordinated, comprehensive response. For pregnant and postpartum families specifically, the following represent the most pressing burdens:



Systems

- Gaps in the continuity of care between community and hospital support illustrate the need for the collective engagement of local stakeholders to implement supportive interventions. Quality improvement efforts are typically implemented in healthcare settings, while the majority of the preconception, prenatal, and postpartum period is supported by community-based providers and services. Strengthening the continuity of care, increasing the capacity of community-based providers to identify and address maternal and infant health risks, and enhancing coordination between systems regarding data-sharing, decision-making, and healthcare planning is essential to improving health outcomes in rural communities.
- Across the United States, structural racism and implicit bias contribute to poor health outcomes for women and infants of color.² Racial and ethnic disparities in combination with higher rates of adverse birth outcomes in rural communities place women and infants of color at higher risk for maternal mortality and morbidity. Additionally, research indicates that delivery location is a key factor in maternal mortality and morbidity and that Black women are more likely to deliver in hospitals with higher severe maternal morbidity rates even if there are hospitals with better outcomes in the same jurisdiction.³ Moreover, stigma and implicit bias affect health-seeking behavior and the provision of care; Black and Native American women are most likely to be impacted by implicit bias, which impacts patient-provider interactions, health communication, and health outcomes.⁴ Women who use substances during the prenatal and postpartum period are also significantly impacted by such biases, stigma and fear of losing custody of their children. As a result, pregnant women who use substances can be less likely to seek prenatal care or to self-disclose substance use to their medical providers.⁵ Despite similar rates of drug use between Black and White women, Black women are significantly more likely to be reported to social services for mistreatment or neglect of children as a result of drug usage.⁶

Infrastructure

- Quality obstetric care facilities are becoming a rarity in rural America. Forty-five percent of rural U.S. counties had no hospital obstetric services from 2004-2014, and during that same period, another 9% of counties lost all hospital obstetric services. Rural counties with a higher percentage of African-American and lower income residents are even less likely to have access to hospital obstetric services.⁷ Limited rural obstetric services contribute directly to maternal and infant mortality and morbidity as pregnancy and postpartum complications cannot be addressed in the time that such emergencies require.
- Weak infrastructure and limited internet access for telehealth make it challenging for rural residents to receive the healthcare they need. Managing chronic conditions and receiving high-quality prenatal and postpartum care require routine appointments yet getting to and from health centers in rural areas can be expensive between mileage and taking off work. In addition, rural residents without cars are particularly isolated due to the lack of public transportation options. Many medical visits can be addressed through telehealth, particularly to triage risks that might require in-person visits. While expanding telehealth is important, in-person visits are still essential, particularly for patients with risk factors. For example, while pregnant patients can monitor their own blood pressure and report symptoms, they miss the opportunity to provide urine samples for preeclampsia tests, which are critical for early diagnosis. Funding or

transportation services must be made available to ensure that all patients are able to receive in-person services as required. Because patients with transportation challenges are more likely to have unaddressed chronic conditions that impact maternal and infant health outcomes, this issue is all the more pressing.

- Rural residents are more likely to live in food-insecure households than urban residents.⁸ They are also more likely to be obese and report less physical activity.⁹ Associated chronic conditions, such as hypertension and diabetes, increase risks for maternal mortality and poor infant health outcomes. While efforts to prevent and treat chronic conditions typically center around healthy behaviors and personal responsibility, food insecurity must be addressed as a social determinant of health.

Workforce

- Since 2008, local and state health departments have lost nearly a quarter of their workforce, shedding over 50,000 jobs across the country. This deficiency is compounded by the age of the public health workforce—55% of local public health professionals are over age 45, and almost a quarter of health department staff are eligible for retirement. Projections suggest that nearly half of the local and state health department workforce might leave in coming years.¹⁰ At the same time, competition with the private sector, low pay, and geographic challenges contribute to difficulty recruiting new talent with key public health skills; this is an acute issue in rural jurisdictions. Given the critical roles that public health systems play in coordination, surveillance, and the delivery of maternal and child health services, bolstering and maintaining this workforce is key to addressing health outcomes of women and infants.
 - NACCHO supports legislation including the Strengthening the Public Health Workforce Act (S. 3737) and provisions included in the HEROES Act to create a public health loan repayment program that would help to recruit and retain public health professionals in local, state and tribal health departments, including in rural areas.
- There is a limited availability of general maternal and child health providers (e.g., OB/GYNs, pediatricians, and midwives) and specialty providers (cardiologists, neonatal intensivists, dentists, endocrinologists, ENTs, mental health providers, nutritionists, and lactation consultants).^{11,12} Workforce limitations, coupled with limited quality obstetric facilities in rural areas, create a healthcare system that is unable to meet the needs of rural women and infants.

2. What opportunities are there to improve the above areas (i.e., access, quality, and outcomes?)

To improve health outcomes for women and infants in rural communities, service delivery must be transformed to reduce as many barriers as possible and to reflect unique cultural contexts. Opportunities to improve barriers related to systems, infrastructure, and workforce are centered around understanding community needs, improving healthcare accessibility, and investing in the public health workforce.

Understanding community needs

Every rural community requires different resources. To improve access, quality, and outcomes, services must be coordinated, non-duplicative, and culturally responsive. They should be guided by community health assessments, collaborative efforts in which a variety of leaders and

stakeholders are represented, and community members are involved in planning and implementation.¹³ In many communities these assessments are led by local health departments and map systems and gaps in continuity of care, identify opportunities for service innovation, and ensure that all residents, particularly those with the least amount of resources, are considered in service delivery planning. To account for health inequities in existing resources, it is imperative that community assessments are disaggregated by race and ethnicity.

Improve Healthcare Accessibility:

Due to a myriad of reasons such as transportation barriers, distance between services, and internet availability, rural community members simply have a more difficult time accessing health services. To ameliorate accessibility barriers, rural communities should have access to the following:

- Providers should collaborate to integrate multiple services into “one-stop shopping” experiences for families, such as integrating prenatal or pediatric visits with WIC enrollment, social services, safe sleep, childbirth, and breastfeeding education.^{14,15}
- Invest in technology to provide HIPAA-compliant telehealth services and sharing of patient health information to provide coordinated health education, monitor conditions, and improve two-way communication for rapid response to timely issues that can be addressed remotely through phone, video, or text. Moreover, in communities with limited internet access or phones, families should be provided with both to receive the highest quality care and resources.
- Ensure continuity of care from the hospital to the community. Encourage implementation of Baby-Friendly Hospital Initiatives and case management care plans for each family from the prenatal period through a child’s second birthday so families know what to expect and how to access services.

Enhance Workforce Capacity

Many rural communities are in health professional shortage areas.¹⁶ There are several opportunities to expand a talented workforce, leverage public health systems, and improve data modernization.

- There are not enough skilled health professionals in rural areas. Opportunities to recruit, retain, and improve the quality of the rural health workforce can be achieved in several ways. The first is through the implementation of a loan repayment program for public health professionals who agree to serve two years in a local, state, or tribal health department, addressed above in the workforce section in Question 1. Similarly, medical students, residents, and other advanced clinicians can receive loan forgiveness for participating in field rotations to rural areas. Finally, there are opportunities to expand the role and scope of practice for nurses, midwives, and other allied health professionals so they can provide more services without physician supervision.^{17,18} In addition to increasing the available workforce, new and existing providers must be trained in implicit bias and culturally humility to improve the quality of care, particularly for racial and ethnic minorities.
- Transforming service delivery and community engagement in rural areas requires sustained commitment from many stakeholders. Adaptive leadership, a practical framework that helps individuals and organizations adapt and succeed in challenging environments, has been successfully applied to workforce development, in addition to addressing social determinants of health. Leading adaptive change requires public health agencies and their partners to mobilize the stakeholders

involved to step into the uncertainty together, take carefully calculated risks, and ultimately learn their way into creating new organizational relationships and strategies that improve population health and help communities achieve health equity.¹⁹

- Public health agencies need the appropriate expertise and skills to navigate the complex landscape of public health data modernization, particularly in the areas of data sharing, governance, and infrastructure. Examples of expertise and skills include establishing and maintaining partnerships with stakeholders that possess data and systems of interest or authority over them and understanding the multitude of data systems that currently exist and the opportunities or barriers for connecting them in an interoperable manner. For example, strengthening the continuity of care requires the integration of different program data systems (e.g., WIC, immunization, prenatal care) that contain information on the same individuals. Strengthening data modernization at the local public health level is foundational to transforming service delivery to be coordinated and responsive.

3. **What initiatives, including community-based efforts, have shown a positive impact on addressing barriers or maximizing opportunities?**

NACCHO is pleased to share a number of community-based efforts, implemented through or in partnership with local health departments, that have shown a positive impact on addressing barriers or maximizing opportunities. While some of these are in urban areas, they are adaptable to rural settings.

- Breastfeeding is a proven strategy to reduce several health risks for mothers and their infants. NACCHO and its members actively support community-led approaches to breastfeeding protection, promotion, and support. Through NACCHO's Reducing Breastfeeding Disparities grant, the S2AY Rural Health Network, a coalition of seven local health departments, health providers, and community-based organizations, conducted a joint Community Health Assessment and Community Health Improvement Plan (CHA/CHIP) and identified improving the health of mothers and babies and reducing obesity as priorities. Together, they implemented a network of Baby Cafes (evidence-based breastfeeding programs), trained providers and community members, and incorporated breastfeeding education and support role into routine job responsibilities. They also lead activities to promote community engagement and worked to build breastfeeding-friendly spaces and workplace support policies. To learn more, visit <https://nacchovoice.naccho.org/2018/09/07/naccho-exchange-summer-2018-breastfeeding/>.
- The Arkansas Breastfeeding Coalition partnered with a local health department in a rural community to increase breastfeeding rates among communities of color. They hired a culturally responsive peer counselor to provide home and hospital visits, utilized videoconference to advance clinical breastfeeding support when needed, and connected clients to other public health initiatives, such as community health worker home visits, safe sleeping, and immunization.
- In 2019, NACCHO and the Centers for Disease Control and Prevention (CDC) recognized excellence in rural communities that are committed to addressing social determinants of health through the ASPIRE Award. Identifying successful strategies that could be

replicated to maternal and child health populations in other rural communities should be a first step in developing maternal mortality prevention interventions.

- The Baltimore City Health Department (MD) has augmented the state of Maryland's Maternal Mortality Review Process with a Baltimore-focused severe maternal morbidity review process. For every maternal death, there are significantly more near misses that greatly impact the lives and health of mothers and their babies. The health department's relationships with local hospitals allow for facility-based reviews, citywide aggregation of data, and selected maternal interviews designed to transform how obstetric care is provided.
- The Champaign-Urbana Public Health District (IL) aims to improve maternal health through early identification of risk factors during pregnancy and the postpartum period. They currently conduct research examining racial differences in perinatal depression and explore how depressive symptoms and other risk factors contribute to adverse birth outcomes.
- Alameda County (CA) held "Club Mom" baby showers in neighborhoods with the highest levels of adverse birth outcomes and raffled off baby supplies while connecting women to the county's prenatal services.

4. **How can CMS/HHS support these efforts?**

CMS/HHS is well positioned to support growth and transformation in the areas of workforce development, insurance coverage, infrastructure, and funding opportunities. NACCHO recommends that CMS/HHS support the improvement of maternal and infant health outcomes in rural communities in the following ways:

- Dedicate funding to improving the maternal and child health workforce in both public health and healthcare settings with a specific focus on recruitment and retention in rural areas. Such funding should utilize adaptive leadership or other change management methods.
- Dedicate funding to data modernization for public health in rural areas. Such efforts would include infrastructure improvements, staff training, coordination strategies, and sharing of best practices.
- Strengthen state and local collaboration in Maternal and Child Health (MCH) programs. In a recent request for information among local health departments, NACCHO identified a lack of collaboration between state and local MCH programs. Local health departments reported limited opportunities to receive training and technical assistance, provide input into programs and decision-making, and enhance coordination among funded agencies.
- Invest in telehealth by expanding reimbursements for wraparound services, promoting best practices and models, and continuing to fund broadband expansion efforts and telehealth equipment purchases. This must include purchasing phones, devices, and data plans for families.
- Expand postpartum Medicaid coverage to one year. Many women with Medicaid lose their coverage 60-days postpartum, which does not allow them to continue receiving care for conditions that emerge after this period or require further management. Some states are working to expand this period, and a one-year period was proposed for

mothers who use substances. All states should be given the flexibility to offer an extended postpartum coverage period regardless of condition.

- Allow for or increase reimbursement for community-based midwives and doulas in health plans.
- Continue to support the Maternal, Infant, and Early Childhood Home Visiting Program with added flexibility for resources and services that would best serve rural jurisdictions and enhanced local involvement in conducting needs assessments.
- Require community health assessments to be conducted as a condition of funding to ensure that services are coordinated, non-duplicative, and culturally responsive.
- Require implicit bias and culturally responsive workforce training for rural community healthcare providers.
- Dedicate funding to address social determinants of health, defined by Healthy People 2020 as conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.²⁰ Critical to maternal and infant health are the built environment, food insecurity, transportation, and racial inequities.

NACCHO appreciates the opportunity to comment and applauds CMS's efforts to improve health outcomes for women and infants in rural communities. We look forward to continuing to work with you to reduce maternal and infant mortality across the United States, particularly among disproportionately impacted populations. Please contact Samantha Ritter, Director of Maternal, Child, and Adolescent Health, for more information at 202-756-0162 or sritter@naccho.org.

Sincerely,



Lori Tremmel Freeman, MBA
Chief Executive Officer

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