Maternal Healthcare Hospital CEO Conference

Facilitated Discussion Summary

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On March 6, 2020, CEOs, OB Nurse Managers, hospital administration, and providers from 50 of Iowa's hospitals with a labor and delivery unit gathered to discuss the current state of maternal health care in Iowa. University of Iowa Department of Obstetrics and Gynecology staff provided an overview of the maternal health crisis in Iowa and shared detailed work of the grant with attendees. IDPH staff attended and facilitated small group discussions over lunch to capture additional information from attendees about their experiences, concerns, and perspectives on maternal healthcare. Participants were also asked to share ideas for potential solutions. This summary outlines key points from these discussions. *Please note, all comments are derived directly from participant discussions.*

Qualitative data recorded by each facilitator were combined into a spreadsheet and organized by topic(s) addressed. These topics are summarized below.

Workforce

Workforce-related issues specific to the nursing workforce, including staffing and training, were mentioned most frequently among all topics. Comments specific to obstetrical (OB) providers and maternal-fetal medicine (MFM) specialists were most frequently related to training and adequacy. General workforce concerns outside of OB nurses, staffing, and training included recruitment and retention concerns, as well as experience and competency. Concerns related to adequate staffing, training, and provider-specific issues were frequently mentioned as well and are summarized in their respective categories below.

Recruitment of appropriate providers, such as obstetricians/gynecologists (OB/GYN) and nurses, was noted as a concern in relation to competition between hospitals. Specific examples

mentioned by participants include: hospitals on Iowa's borders lose providers to hospitals in states with a malpractice cap, recruiting providers to rural areas, and smaller hospitals cannot afford to pay providers as much as larger health systems. Participants also voiced concerns regarding balance between pay vs. student debt.

These factors impact the ability of hospitals to attract younger physicians, making upcoming retirements a concern as well. Changes to the workforce, such as aging physicians, upcoming retirements, and new graduates without adequate experience were mentioned several times. One particular issue, echoed by nurse managers and executives alike, was that younger providers (including physicians, advanced practice providers and nurses) have an expectation that their work schedules will be balanced with their home lives. It was noted that this makes it difficult to replace a physician who has been working a traditional schedule with a new provider as the new provider wants more flexibility but expects the pay to stay the same. Hospitals reported that they are doing whatever they could to keep these young physicians.

Interprofessional issues were discussed specific to OB/GYN physicians' willingness to work with other professionals such as Certified Nurse Midwives (CNM) and, in some cases, family practice providers who deliver babies. This comment was in relation to CNMs' and family practice physicians' lack of time in the profession/experience with delivering babies. It was also noted that there is a fear of losing family practice physicians who deliver babies in some areas of Iowa as there is an increasing demand from the mothers in the area to have home births attended by CNMs.

Overall, provider retention was mentioned several times as well. Participants had concerns about provider burnout for those frequently on call or covering multiple hospitals in rural areas. The inability to recruit and/or retain providers impacts patients, who may go to another hospital for more consistent care. This example was provided by an Iowa hospital that recently closed their L&D unit

Staffing

Workforce concerns related to adequate staffing of labor and delivery units were frequently mentioned as well. The variety of providers needed to maintain a fully staffed labor and delivery unit can be a challenge, particularly in rural areas and for small hospitals. Anesthesiologists, general surgeons with c-section training, OB/GYNs, OB nurses, and pediatricians were all specifically mentioned as staffing needs and concerns with keeping labor and delivery units open. Reasons for staffing shortages include challenges recruiting new providers due to reasons mentioned in the previous workforce section, provider retirements, providers moving out of state due to major hospital systems leaving the area, and requirement for providers to be on call, especially if they are also required to see patients on a regular schedule.

Additional comments related to staffing were that a nearby hospital stopped accepting Medicaid-covered patients, requiring the hospital to transfer high risk patients with Medicaid

coverage much farther away for care. Labor and delivery staff travel with patients during these transfers, which causes the labor and delivery staff to be absent from their home units for long periods of time. Additionally, having higher level providers such as OB/GYNs brings in higher acuity patients, however not all nursing staff members are equipped or trained to treat these patients.

Several participants indicated they have increased the use of midwives to support OB providers and will need to hire additional midwives to keep up with the needs of the community. They also mentioned telehealth as a potential resource, but there is still a need for staffing within the hospital, and patients have concerns about the potential to be transferred to another facility further from their home.

Training

Training across a variety of topics was mentioned by many participants as a need and a barrier to providing high quality labor and delivery services. Specific topics mentioned included a lack of training resources and access to simulations and drills, the ability to maintain provider competency, OB training received (or not received) by family practice residents, and a need for more experiential training. Examples provided by participants related to these issues included limited internships once in providers' careers and brief residency training specific to OB services. Participants felt that other areas such as newborn care offer significantly more training opportunities than OB.

Training, experience and competency for providing c-sections was also mentioned by several participants, and included multiple provider types (family medicine providers, general surgeons, locum tenens providers, midwives). For example, several participants indicated that obstetricians do all c-sections and deliveries, and do not refer to family medicine doctors, either due to provider beliefs or concerns about competency. Other participants mentioned it can be difficult for family medicine doctors to maintain training and competency related to c-sections due to low volume, and it is difficult for them to obtain training at other hospitals due to malpractice concerns. Once locum tenens providers are able to obtain a license, which is time-consuming, they also cannot get enough experience providing c-sections due to low volume and/or specific hospital policies. Orienting and training OB/GYN providers and nurses is time-consuming and costly to ensure adequate staff available to train as well as expenses for classes. This concern also relates to provider retention, as hospitals may spend significant amounts of time and money to provide orientation and training, yet the OB/GYNs leave shortly thereafter.

Provider Specific Concerns

It was noted by participants that workforce and cost concerns are further compounded by the need for additional specialists to support full L&D services, such as pediatricians to care for the infant, a general surgeon, and anesthesiologists to ensure the capacity to do a C-Section is always available. Several participants indicated a need for more midwives to support OB

providers. Midwives and residents need clinical experience, however, for hospitals with lower volumes it can be difficult to find nearby hospitals who will take on a provider for training due to liability and hospital privilege barriers. For communities where the family medicine providers do prenatal care, there is a need for general surgeons who can perform c-sections. Additionally, there is a need for more family medicine providers who can also provide OB services, both to support OB providers and to make up for the OB provider shortage. Barriers to having more OB-trained family medicine providers mentioned included: OB providers who will not refer to family medicine providers, and lack of experience of family medicine providers to ensure competency and confidence.

Another frequently mentioned concern was patient acuity rising across Iowa. When women are diagnosed as high risk in their pregnancies, they often need the care of a maternal fetal medicine specialist (MFM). Iowa has few MFM providers, and they are not available to all hospitals. Additionally, MFM specialists are in short supply across the United States making recruitment even more challenging. The need to recruit more MFMs to Iowa was echoed by many in relation to the increasing acuity seen in pregnant women.

All facilitators reported hearing specific concerns related to OB nurses. Most discussions were related to not having adequate nursing staff with specific obstetrical care training and/or experience. In general, participants had concerns about having enough nurses on staff with OB training and experience. Participants also discussed difficulties recruiting nurses to rural areas or small hospitals, abilities to pay competitive wages in comparison to larger hospitals and neighboring states, and training nursing staff. Ability to pay competitive wages also influences hospital capacity to incentivize nurses to work nights and weekends and retaining nurses to help build the provider/nurse relationship. Once younger nurses have experience in labor and delivery they tend to leave for clinic positions where they do not have to work nights and weekends and are often paid higher wages.

Providing and ensuring adequate training for nurses was reported as a barrier as it is time consuming and costly. Additionally, if the volume of births at the hospital is too small, it takes a significant amount of time for nurses to obtain adequate clinical experience, and, similar to advanced practice providers, it is challenging to send nurses to other facilities to obtain experience due to liability concerns and hospital policies. Increases in high-acuity patients also require more experienced nurses.

Financial Factors

Financial factors, including the high cost of providing OB services and inadequate reimbursement for obstetrical services were mentioned frequently by participants. Low reimbursement is a common theme with Medicaid eligible patients. The maximum reimbursement rates for Medicaid OB services limits the amount providers can bill. The OB billing structure is not in place for other provider types like anesthesia providers. For some rural providers the Medicaid billing structure remains difficult because a high percentage of their

population are on Medicaid. It was noted that Critical Access Hospitals' overall reimbursement payment system is adversely impacted by Medicaid reimbursement for obstetrical patients, making it difficult to financially maintain services. One hospital CEO stated they would soon be closing maternity services as they have incurred a $3 million loss from OB in the past three years. It was also mentioned that county hospitals are increasing tax rates to cover the cost of OB services. A predominant theme among participants was the need to fix Medicaid reimbursement issues so that they can continue to provide care for Medicaid patients. As mentioned in the staffing section of this summary, participants noted that an out of state provider is refusing to take Iowa Medicaid clients due to low reimbursement rates. Additional remarks included: one hospital is seeing an increasing number of Medicaid eligible patients because a health system nearby is refusing to take OB patients with Medicaid; reimbursement levels continue to worsen to unsustainable levels; and low reimbursement from private insurance companies, in addition to low reimbursement from Medicaid, also impacts hospitals.

Poor reimbursement for OB services makes it difficult to recruit and retain the OB healthcare providers that are needed. Rural areas have difficulty affording sign on bonuses and competing with larger health systems regarding wages and benefits for nurses. Urban areas can offer nurses's two to three dollars more per hour as well as support safer staffing ratios. However, even in urban areas in Iowa it is hard to recruit nurses because RN salaries in Iowa are ranked 50th in the nation.

Recruiting for healthcare providers who deliver babies is also a financial challenge. A huge issue is provider pay and on-call pay. One hospital shared their recent maternity services closure was largely due to difficulty in provider staffing. The hospital only had one OB/GYN and they hired a consulting firm that told them they needed 5-6 health care providers to deliver babies for the size of their community as well as to cover the on-call schedule. The hospital spent thousands of dollars for over a year trying to recruit an obstetrician and failed. At the same time, they had to hire locum tenens physicians during that year,causing additional financial loss. The situation also led to a loss of patients since there were many different locum tenens physicians and patients were not satisfied with their care. Wanting to develop a relationship with their physician, patients transferred their care to other nearby health care systems which further contributed to the financial loss.

The cost of malpractice insurance and related concerns were mentioned several times in relation to malpractice caps in Iowa and neighboring states as well as in terms of families suing at a seemingly higher rate.

Systems and Policy Issues

Additional concerns mentioned by participants included systems-level and policy-level barriers to providing labor and delivery services. System-level hospital factors include physical layout barriers, hospital policies, transport concerns, adequate patient volume, and competition with other hospitals outside of workforce issues. Layout factors mentioned included a lack of infant

security on the postpartum medical surgery floor, not having 24/7 ultrasound, lack of beds, lack of equipment, and the OB unit needing physical updates, causing patients to go to other hospitals.

Vaginal birth after c-section (VBAC) was mentioned several times in terms of individual hospital factors. Some participants commented that c-sections rates should be lower and VBACs should be encouraged. Access to VBACs in Des Moines was specifically mentioned as patients must travel to Iowa City after they have had two c-sections and want to try VBAC. Two hospitals shared their hospital policy is to do VBAC on women with low risk, following guidance from ACOG. One hospital mentioned they have a 78% success rate with no adverse events. Both hospitals said their C-Section rates were less than 20%.

Specific mentions related to transferring patients included a poor experience with a larger hospital, a need for transfer agreements with nearby hospitals, small facilities with high risk transfers (patients may go to a higher level hospital but then return to the smaller hospital), and increased requests for maternal transport. Geographical distance between hospitals with labor and delivery units was also mentioned several times as a concern, particularly in rural areas. One example provided was if a patient is not able to deliver at the place they have been seeking care (i.e commuting to a metro area from a rural area), the client could end up in the emergency room. The medical team would not have any history on the patient or the baby, which can lead to negative outcomes.

Patient volume was another concern expressed by several participants. Concerns were related to fluctuating patient volumes, volumes that are too low, and increases due to nearby labor and delivery unit closures. One of the most frequently mentioned issues was not having enough patients for providers to maintain competency and to obtain enough reimbursement to offset the high costs of maintaining a labor and delivery unit.

Solutions

Participants were also asked to discuss possible solutions to the issues presented. Recommendations and suggestions are listed below:

- Several participants indicated a high need for additional midwives
- Dedicate funds to encourage residents to remain in Iowa and practice in rural areas
- State tax breaks for workforce
- Increase state loan repayment opportunities
- Grow other departments to make up for the financial loss of OB/GYN department (grow ortho/cardiac services, for example)
- Allow Medicaid coverage for 2-day hospital stay post partum
- Focus on both short-term and long-term viability of labor and delivery units
- Statewide transport service that is hospital-based and centralized

- Profit-sharing pertaining to transfers for complex births (both the transferring and receiving hospital profit)
- Telemedicine to improve accessibility to specialists
- Engage the ECHO Model™, if possible. The ECHO Model™ connects groups of community providers with specialists at centers of excellence in regular real-time collaborative sessions. The sessions, designed around case-based learning and mentorship, help local workers gain the expertise required to provide needed services. Providers gain skills and confidence; specialists learn new approaches for applying their knowledge across diverse cultural and geographical contexts.
- Support education for nursing staff to build and retain competency of delivery services; have a camera in birthing units so specialists can assist in resuscitation and other care
- Build and maintain provider trust by involving them in decisions
- Ensure staff are confident in labor and delivery skills - one hospital starts nurses in mom/baby care and then moves them to L&D
- One hospital reported that they implemented a “no cuts” protocol (to hold open positions) - they have the ability to maintain open positions until qualified applicants available
- Hire new grads and provide an extended orientation time (5-6 months)
- Higher reimbursement for OB service to cover the cost
- Improve c-section coverage and training for providers; recruit OB/GYNs to train family medicine specialists to provide c-sections
- Increase training and simulation opportunities
- Funding should go to incentives for bringing in providers and keeping them in rural Iowa