

# Recommendations from the NCIOM Risk-Appropriate Perinatal System of Care Task Force

Task Force convened in partnership with the  
NCDHHS, Division of Public Health, Women's  
and Children's section, to respond to Session  
Law 2018-93 and Goal 3E of North Carolina's  
Perinatal Health Strategic Plan

Adam Zolotor, MD, DrPH  
President & CEO North Carolina Institute of Medicine  
NCGA Joint Legislative Oversight Committee for Health and  
Human Services  
March 10, 2020

# NC Institute of Medicine

- Quasi-state agency chartered in 1983 by the NC General Assembly to:
  - Be concerned with the health of the people of North Carolina
  - Monitor and study health matters
  - Respond authoritatively when found advisable
  - Respond to requests from outside sources for analysis and advice when this will aid in forming a basis for health policy decisions

*NCGS §90-470*



# What is the problem?

- LM-1<sup>st</sup> baby born premature and transferred to a different hospital NICU at birth. 2<sup>nd</sup> pregnancy deemed high risk and Obgyn would not accept her care and could not help her find an alternative. Commercial insurance.
- JJ-Severe postpartum depression. Inadequate mental health coverage and frequent network changes made continuous provider treatment difficult. Husband lost job due to increased caretaking responsibilities. Lost insurance. Long lag before qualifying for Medicaid.
- MV-Patient at health department. Found to be HIV positive. Uninsured immigrant. No MFM specialist willing to see her within 100 miles.
- ST-uninsured patient with poorly controlled hypertension and diabetes. Does not qualify for Medicaid or ACA subsidy due to income. Presents to FQHC pregnant with uncontrolled pre-existing medical conditions. Qualifies for Medicaid.
- AR-patient at health department with controlled hypertension. Requires monthly growth ultrasounds in third trimester. Cost \$750 each. Can't afford them. Uninsured immigrant.
- JM-On buprenorphine for chronic pain. Gets pregnant. Seeing only OB group county. No rostered providers willing/able to treat her during pregnancy. Has Tricare.

NC Resident Infant Mortality Rates, 1997-2016



In infant mortality

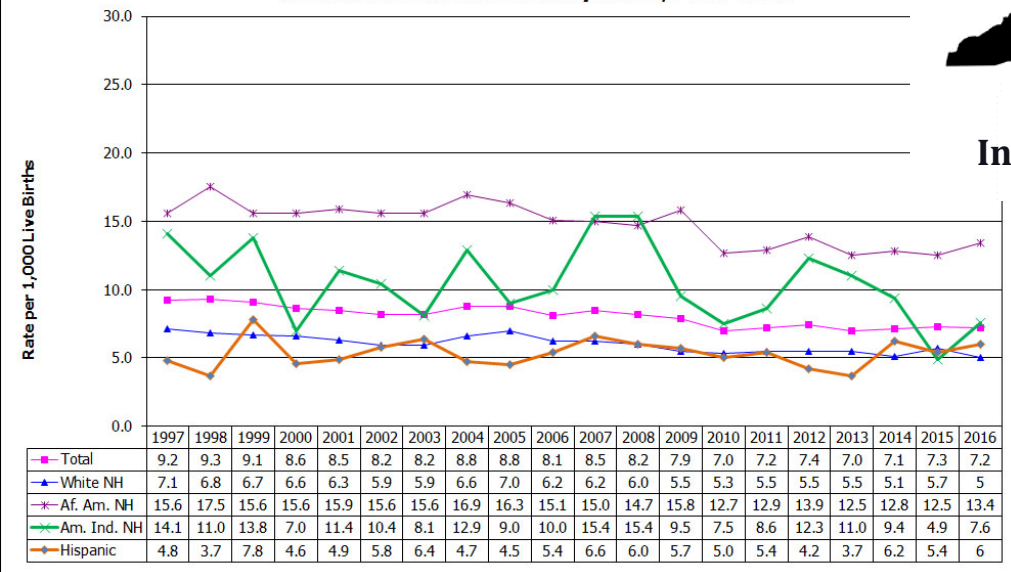
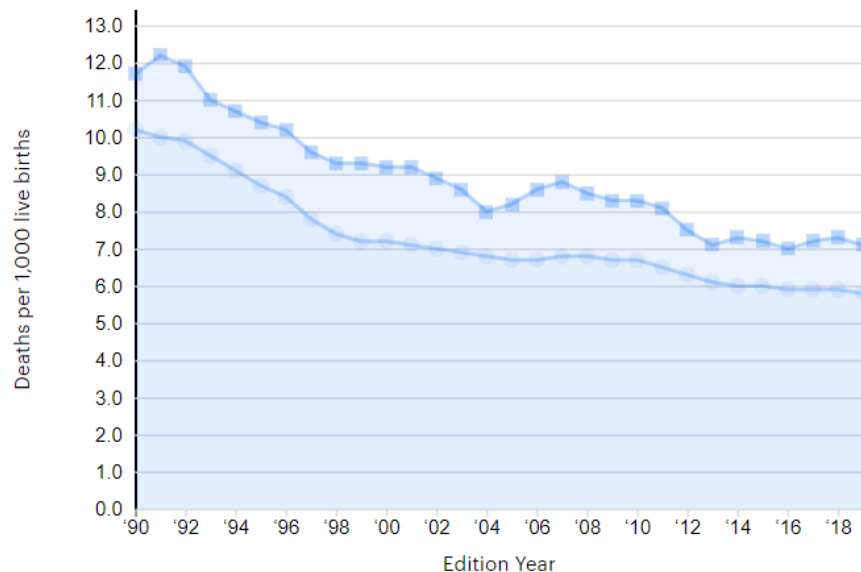
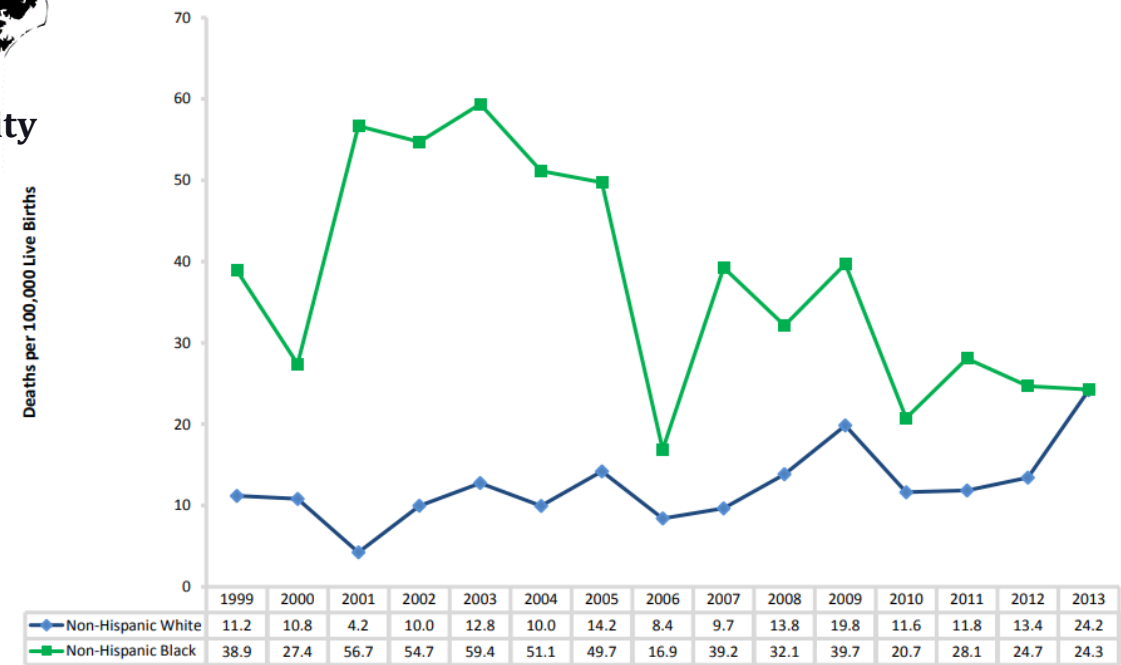
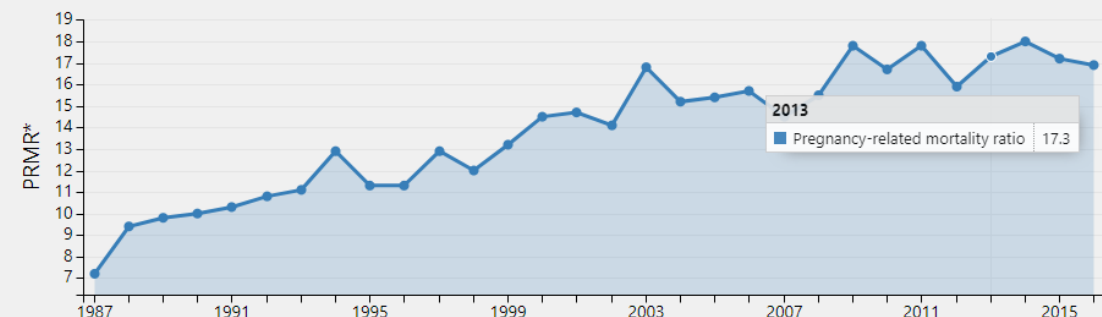


Figure 4. Non-Hispanic White and Non-Hispanic African-American Pregnancy-related Mortality Rates by Year  
North Carolina Residents 1999-2013



Trends in pregnancy-related mortality in the United States: 1987-2016



\*Number of pregnancy-related deaths per 100,000 live births per year

# Leadership of Task Force

The Child Fatality Task Force (CFTF) proposed a study bill to the North Carolina General Assembly (NCGA) to develop a risk appropriate perinatal system of care in the state.

June 2017, Session Law 2018-93 passed

## Co-Chairs:

**Walidah Karim, DNP, CNM**

Obstetrics/Gynecology

Cone Health Medical Group –

Center for Women's Healthcare at Women's Hospital

**Kate Menard, MD, MPH**

Professor, Vice Chair for

Obstetrics and Director

UNC Maternal-Fetal Medicine

**Kelly Kimple, MD, MPH, FAAP**

Section Chief

NC Department of Health and

Human Services, DPH –

Women and Children's Health

Section

**Latoshia Rouse**

Parent, Speaker and Parent

Advisor

Newborn Individualized

Developmental Care and

Assessment Program (NIDCAP)

There were 44 additional members of the Task Force



# Session Law 2018-93

## DIRECTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES PERTAINING TO HIGH-QUALITY, RISK-APPROPRIATE MATERNAL AND NEONATAL CARE



1. The complexity levels of care currently being provided by all delivering hospitals in caring for birth mothers and newborns.
2. How current systems of referral and transport to different facilities and specialty providers based on patient risk are being managed.
3. Disparities in access to risk-appropriate maternal and hospital care.
4. Service gaps.
5. Issues that impact the ability to most appropriately match patient need with provider skill.
6. Recommendations for actionable steps that can be taken in North Carolina to best ensure that pregnant women receive quality prenatal care and that mothers and newborns are cared for in a facility that can meet their specific clinical needs.
7. Any other issues the Department deems relevant to this study.



# Perinatal Strategic Plan

IN 2014 THE NORTH  
CAROLINA DIVISION OF  
PUBLIC HEALTH DEVELOPED  
NORTH CAROLINA'S  
PERINATAL HEALTH  
STRATEGIC PLAN FOR 2016-  
2020



Goal 3E: Ensure that pregnant women and high-risk infants have access to the risk appropriate level of care through a well-established regional perinatal system.

- Assess the levels of neonatal and maternity care services for hospitals using the consensus recommendations of the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), and the Society for Maternal-Fetal Medicine (SMFM)





# Recommendations: Birthing Facilities



THE COMPLEXITY LEVELS OF CARE CURRENTLY BEING PROVIDED BY ALL DELIVERING HOSPITALS IN CARING FOR BIRTH MOTHERS AND NEWBORNS

## 2.1 Adopt National Maternal and Infant Risk-Appropriate Level of Care Standards

- DPH and DHSR should utilize the rulemaking process to update levels of care
  - NC does not have maternal levels of care; neonatal levels have not been updated in 30 years
  - Would bring NC in alignment with ACOG and AAP guidelines

## 2.2 Form Multi-Disciplinary Assessment Teams to Utilize CDC LOCATe Tool

- NCHA advising birthing facility members to establish assessment teams and use CDC LOCATe tool to assess level of care according to ACOG & AAP guidelines

## 2.3 Require External Verification of Birthing Facilities' Maternal and Neonatal Level of Care Designations (NCGA)

## 2.4 Re-establish North Carolina's Perinatal and Neonatal Outreach Coordinator program (NCGA-Allocation)

- National standards require level IV maternal/neonatal centers to act as regional outreach centers
- Up to 10 maternal & 10 neonatal coordinator positions, funded ½ by NCGA, ½ by level IV centers
- Mostly focused on outreach, education, and training among birth facilities, but also a role in establishing connections among outpatient prenatal care providers

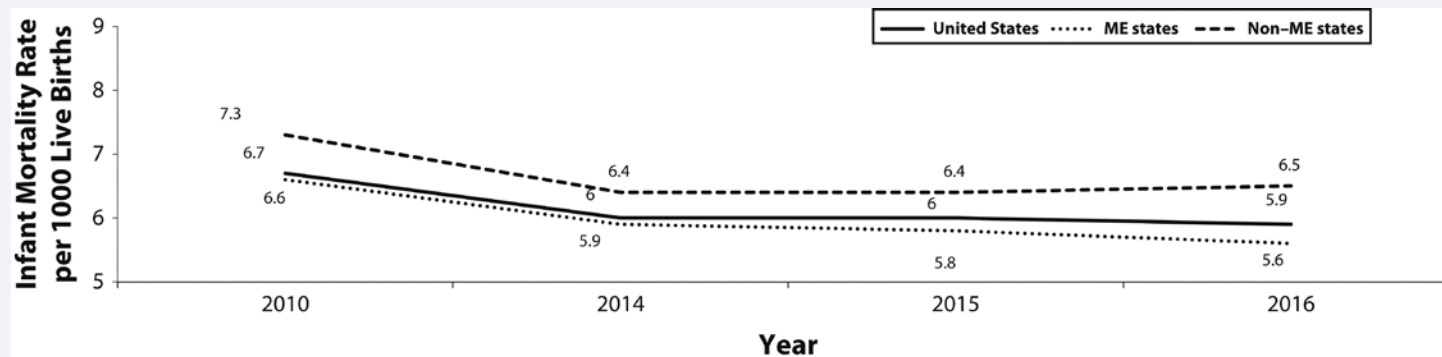




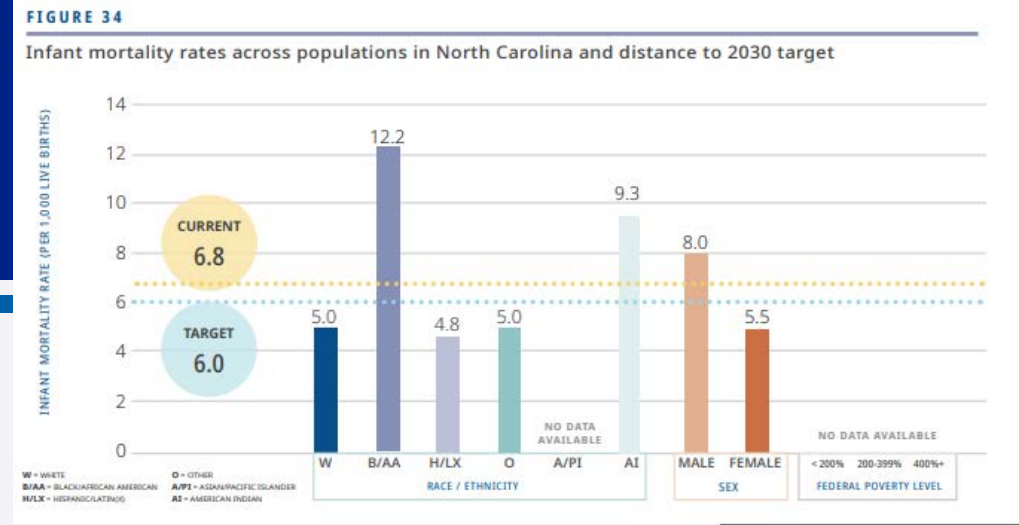
# 3.1 Coverage Gap

## 3.1 NCGA should expand access to health services for uninsured residents

- TF focused on pre-conceptional care and post partum care (1-2 years) as critical for maternal and infant health.
- Consider closing Medicaid coverage gap as most efficient mechanism.
- Medicaid expansion states have had much greater decrease in infant mortality since 2010!
- Could result in a decrease (6.8/1000 to 6.4/1000 or about 47 fewer infant deaths per year)



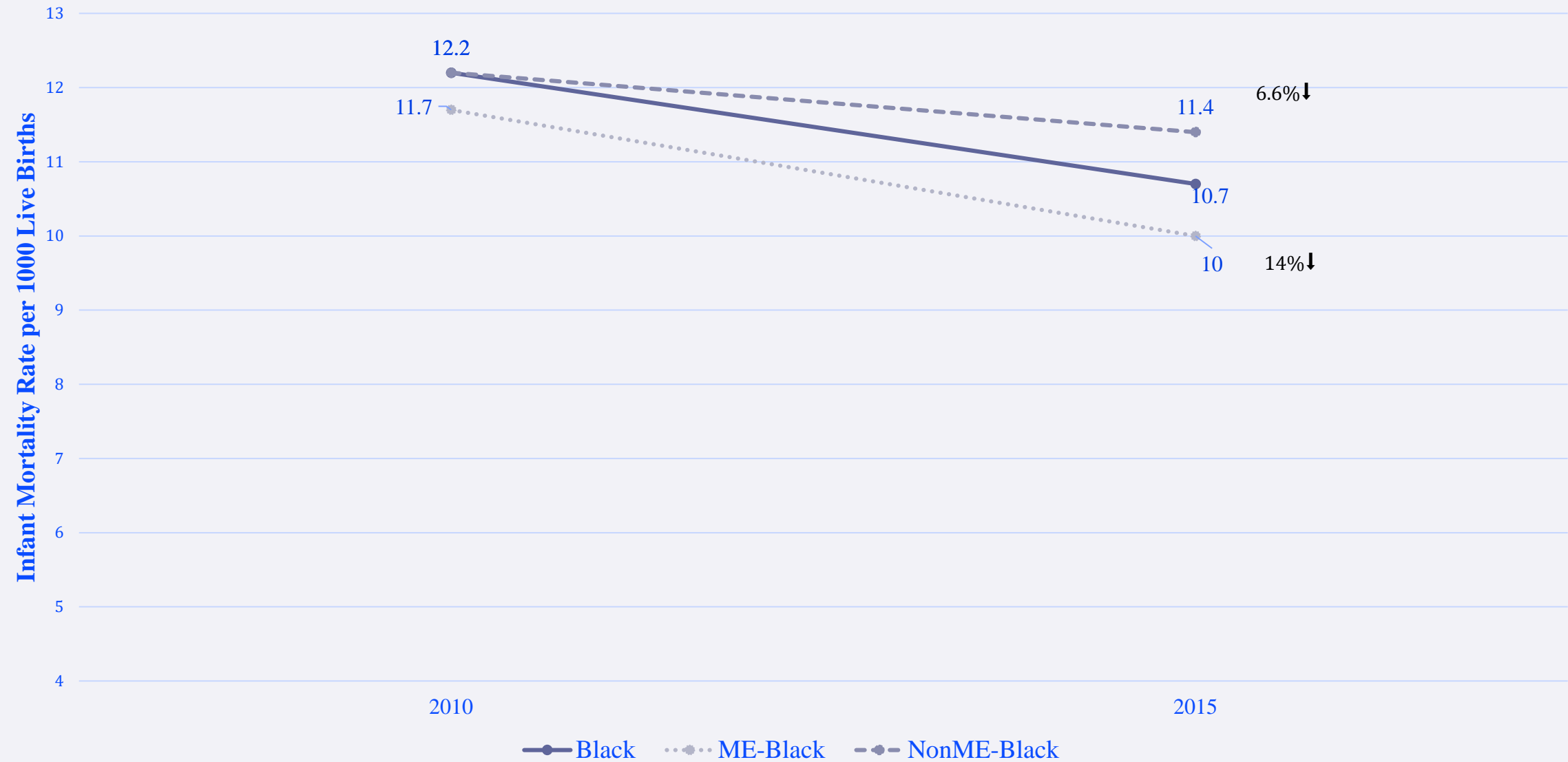
Bhatt CB and Beck-Sague CM. AJPH, 2018.



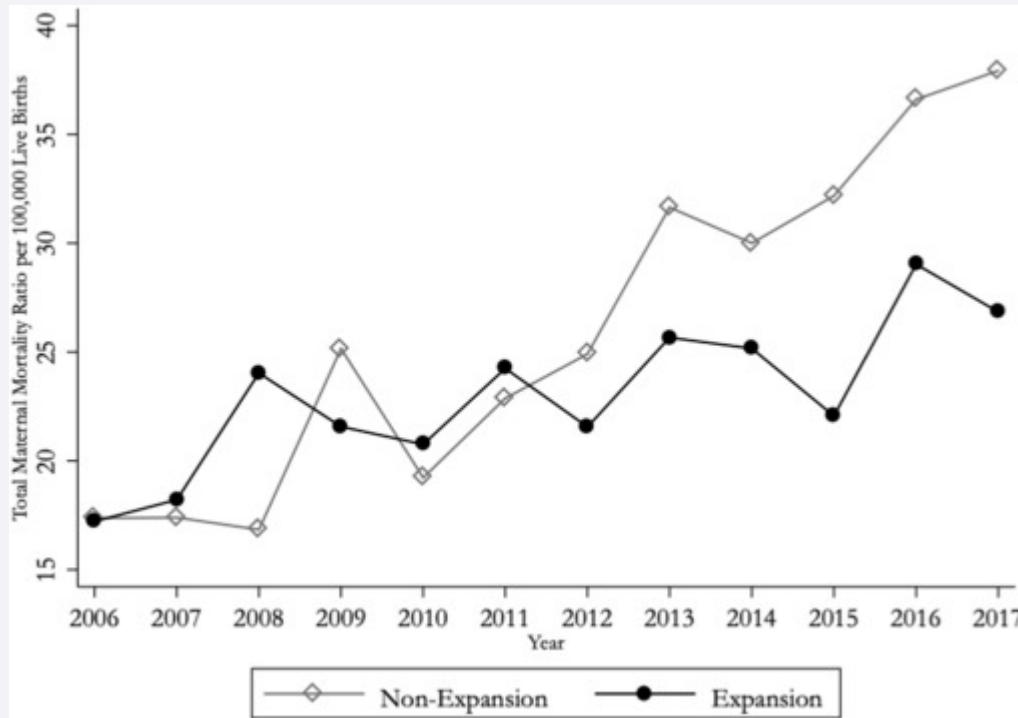
	2010	2014	2016
ME	7.3	6.4	6.5
Non-ME	6.6	5.9	5.6
NC	7	7.1	7.2



Figure A: Infant Mortality Rate in African-American/Blacks in United States by Medicaid Expansion and Years 2010 and 2015



# And Maternal Mortality



- Used data from 2006 to 2017.
- Expansion associated with 7.01 fewer maternal deaths per 100,000.
- If late maternal deaths are excluded, the decrease is 6.65/100,000.
- Most pronounced among African American mothers (16.27/100,000).

Eliason EL. Women's health Issues, 2019.

## 3.2 CHIP option

### **3.2: Expand Access to Comprehensive Prenatal Care for Undocumented Immigrant Women**

- The NCGA should adopt the Children's Health Insurance Program option to provide comprehensive prenatal, labor, delivery, and immediate postpartum care to undocumented immigrant women.
- NC tax payers could save about \$4 million with a decrease in the Hispanic IMR to 3.8/1000 or 10 babies saved!

# States Taking CHIP option are not alike



- CMS designates this as unborn child option
- Bipartisan agreement that babies born as US Citizens should have every opportunity to be healthy

## 3.2 CHIP option

- Current state: most undocumented immigrants
  - 2 months of care covered by PE (avg 3 visits, labs, US)
  - L and D covered by emergency Medicaid
  - Estimated cost \$6818. NC taxpayers \$2250 (FMAP 67%)
- CHIP option
  - Full pregnancy coverage, labor, delivery, labs, US, specialty services
  - Estimated cost \$7988. NC taxpayers \$1837\* (because of enhanced CHIP match of 77%)
- Benefits
  - Reduced ELBW babies 1.5/1000 (potential large savings not calculated)
  - Reduced IMR 1/1000
  - Babies are more likely to have recommended screenings and vaccines
  - Save taxpayers \$4,000,000

Swartz JJ et al., Obstetrics and Gynecology, 2017



# Prenatal Care

## **3.3: Extend coverage for group prenatal care and doula support**

- Private insurers and prepaid health plans
- Medicaid clinical coverage policies

## **3.4: Increase utilization of childbirth education (DHHS)**

## **3.5: NCGA should pass laws supporting full practice authority for certified nurse midwives**

## **3.6: Education for providers on substance use in pregnancy (perinatal centers) and development of clinical pathways (Medicaid advisory board and PHPs)**



# Recommendations : Quality Improvement



## **4.1 Collect and Report Data on Maternal and Infant Outcomes by Race and Ethnicity**

- Insurers, health care systems, providers should collect and review maternal and infant outcomes data by same categories as PHPs

## **4.2 Engage Insurers in Quality Improvement Efforts that Address Racial and Ethnic Disparities in Care**

- DHB quality improvement strategy focused on reducing infant mortality disparity- endorses QI plan as outlined in Medicaid transformation requirements and recommends similar QI happen for those remaining in traditional Medicaid
- Private health insurers should review maternal and infant data by same categories as PHPs, develop QI plans to address disparities, develop payment models to hold providers accountable for reducing disparities

## **4.3 Engage Birthing Facilities in Quality Improvement Efforts to Address Racial and Ethnic Disparities in Care (NCHA)**

- ENRICH Carolina technical assistance program

## **4.4 Support Outpatient Risk-Appropriate Perinatal System of Care (regional centers and DPH)**

- engage with outpatient prenatal care providers to develop pathways to risk-appropriate outpatient care

## **4.5 Implement Patient and Family Advisory Councils (Hospitals)**

## **4.6 Align perinatal regional maps with Medicaid Transformation maps (DHHS)**



# Supporting Postpartum Women, Infants, and Families

## SERVICE GAPS



## 5.1 Implement Parent Navigators in Birthing Facilities

- Parent navigator programs can provide navigation and peer support to women and families receiving care, particularly important for those with extended stays

# Support for Pregnant Women, Infants, and their Families

- **6.1: Use Community Health Workers to Support Pregnant Women in Their Communities (ORH and DPH)**
- **6.2: Implement Family-Friendly Workplace Policies**
  - North Carolina employers, including the state, should provide pregnancy accommodations such as paid family and medical leave, paid sick days, and pregnancy and breastfeeding accommodations.

# Questions

- Websites: [www.nciom.org](http://www.nciom.org)  
[www.ncmedicaljournal.com](http://www.ncmedicaljournal.com)
- Key contacts:
  - Adam Zolotor, MD, DrPH, President and CEO, NCIOM  
919-445-6150 or [adam\\_zolotor@nciom.org](mailto:adam_zolotor@nciom.org)

