Board of Directors Report H to the 2019 Congress of Delegates

Maternal Morbidity and Mortality

Background

(1) The 2018 American Academy of Family Physicians (AAFP) Congress of Delegates (COD) adopted two resolutions related to maternity care as follows:

- Resolution No. 408 – Support Measures to Decrease Maternal Mortality in the United States which states:
  RESOLVED, That the American Academy of Family Physicians supports state and federal level review of maternal morbidity and mortality, and be it further

  RESOLVED, That the American Academy of Family Physicians develop a task force to report back to the 2019 AAFP COD, including but not limited to the following:
  - Evidence-based methods to decrease maternal morbidity and mortality
  - Methods to increase recognition of implicit bias and reduce disparities in maternal morbidity and mortality
  - Strategies to improve resident education and support practicing family physicians in providing full scope reproductive and maternity care.

- Resolution No. 210 – Address the Growing Loss of Rural Obstetrical Services which states:
  RESOLVED, That the American Academy of Family Physicians work with the National Rural Health Association (NRHA), the American College of Obstetricians and Gynecologists (ACOG), and other engaged groups to address the growing loss of rural obstetrical services which could include:
  - Working with the Centers for Medicare and Medicaid Services to provide adequate Medicaid reimbursement for obstetrical services.
  - Working with the NRHA and the American Hospital Association to assist in providing educational and training opportunities to maintain obstetrical knowledge and skills of hospital staff.
  - Working with the Society of Teachers of Family Medicine, the Association of Departments of Family Medicine, and the Association of Family Medicine Residency Directors, to assure basic and advanced obstetrical education is available to those seeking to provide obstetrical services.
  - Working with health systems and educational centers to support family physicians, with advanced skills (such as performing cesarean sections) in low volume settings, maintaining these skills through strategies such as spending time at high-volume centers, and participating in obstetrical care to maintain assessment and procedural competency.

(2) Resolution No. 408 called on the AAFP to create a task force to collaborate with key stakeholders and explore solutions to decrease maternal morbidity and mortality. As a result, the AAFP created a task force to address maternal morbidity and mortality, including implicit bias and disparities, and the loss of rural obstetrical services. The task force was charged with the following objectives:

1. Evaluate evidence-based methods to decrease maternal morbidity and mortality
2. Review methods to increase recognition of implicit bias and reduce disparities in maternal morbidity and mortality
3. Develop strategies to help improve resident education and support practicing family physicians in providing maternity care
4. Address the growing loss of rural obstetrical services across the nation

(3) Collaborating organizations participating on the task force include the following:

American College of Obstetricians and Gynecologists (ACOG)
National Rural Health Association (NRHA)
American Hospital Association (AHA)
American College of Nurse-Midwives (ACNM)
Society of Teachers of Family Medicine (STFM)
Association of Departments of Family Medicine (ADFM)

(4) The task force met twice—in April and June of 2019—and submitted its recommendations for consideration by the AAFP Board of Directors at its July 2019 meeting.

(5) Due to the significant scope of each of the four objectives, the task force developed a series of recommendations for both the AAFP and for the participating organizations to address as a collaborative effort (see **Appendix A**). In the course of discussions, it became clear that additional efforts are needed to truly move the needle on each of these important issues. While each participating organization has been working independently to address maternal health, the Board of Directors agreed that it is imperative for the organizations to address these issues collectively and with one voice. Additional time is needed to formalize the group's composition and scope going forward. Ideas include using a structured form of collaboration called the "Collective Impact" model.

Appendix A

Introduction

The maternal mortality rate in the United States is one of the highest in the developed world. In recent years, U.S. maternal mortality rates have worsened, increasing from 20.6 maternal deaths per 100,000 live births in 2008-2009 to 25.4 maternal deaths per 100,000 live births in 2013-2014.[1]

Approximately 700 women die from pregnancy-related complications annually in the United States.[2] Pregnancy Mortality Surveillance System (PMSS) data reviewed by Centers for Disease Control and Prevention (CDC) indicated that more than 60% of these deaths were preventable. It was also noted that 31% of deaths happened during pregnancy, 36% occurred at delivery or the week after, and 33% happened one week to one year postpartum. Many other women suffer complications that do not result in death but place their health at significant risk. The leading causes of pregnancy-related morbidity and mortality include hemorrhage, infection, cardiovascular conditions, preeclampsia, eclampsia, and embolism.

Significant disparities exist, with higher maternal mortality rates occurring among black women, women who have a low income, and women living in rural areas. The maternal mortality rate for black women is 40 deaths per 100,000 live births.[3] This is more than three times higher than the rate for white women, which is 12.4 deaths per 100,000 live births.

Evidence-Based Methods to Decrease Maternal Morbidity and Mortality

Background

Current evidence-based methods are being used to address maternal morbidity and mortality at the national and state levels. These methods include, but are not limited to, Alliance for Innovation on Maternal Health (AIM) maternal safety bundles, maternal mortality review committees (MMRCs), and California Maternal Quality Care Collaborative (CMQCC) toolkits.

AIM Maternal Safety Bundles

The AIM program is designed to “to equip, empower and embolden every state, perinatal quality collaborative, hospital network/system, birth facility and maternity care provider in the U.S. to significantly reduce severe maternal morbidity and maternal mortality through proven implementation of consistent maternity care practices that are outlined in maternal safety bundles (action systems).”[5] The AIM maternal safety bundles represent best practices for maternity care and are developed and endorsed by national multidisciplinary organizations. The AIM program has been used concurrently with recent maternal safety initiatives, including MMRCs. The AAFP helps develop the AIM maternal safety bundles through its participation in ACOG’s Council on Patient Safety in Women’s Health Care, a collaboration of professional organizations in women’s health care.

Maternal Mortality Review Committees

Maternal mortality review committees play an important role in collection and dissemination of maternal health data. Many U.S. states have begun the process of implementing MMRCs, with a goal of collecting information that will help researchers, policymakers, and medical clinicians identify the key factors found in maternal deaths. MMRCs study local maternal death cases to identify strategies for making pregnancies safer and preventing tragic outcomes. It is important for all stakeholders to support these committees and for family physicians to participate in these collective efforts.

As MMRCs have emerged, it has become evident that defined data standards would allow better access to population health data across state lines. The CDC partnered with MMRCs and subject matter experts to create the Maternal Mortality Review Information Application (MMRIA).[6] MMRIA provides standardized data that can be used for surveillance, monitoring, and research related to maternal mortality. It also provides a common data language to help MMRCs collaborate in case review and analysis.

The AAFP supports MMRCs and strongly advocated for the successful passage of the Preventing Maternal Deaths Act, which incorporated provisions of the Maternal Health Accountability Act. According to *Health Affairs*, "this legislation sets up a federal infrastructure and allocates resources to collect and analyze data on every maternal death, in every state in the nation. The bill is intended to establish and support existing [MMRCs] in states and tribal nations across the country through federal funding and reporting of standardized data."[7]

CMQCC Maternal Quality Improvement Toolkits
According to the California Maternal Quality Care Collaborative, Maternal Quality Improvement Toolkits "aim to improve the health care response to leading causes of preventable death among pregnant and postpartum women[,] as well as to reduce harm to infants and women from overuse of obstetric procedures. All toolkits include a compendium of best practice tools and articles, care guidelines in multiple formats, a hospital-level implementation guide, and a professional education slide set. The toolkits are developed in partnership with key experts from across California, representing the diverse professionals and institutions that care for pregnant and postpartum women."[8]

Recommendations from the MMM Task Force
The task force suggests that the following objectives should be completed by the AAFP in the next year to promote evidence-based methods to decrease maternal morbidity and mortality:

1. Support the dissemination and adoption of existing evidence-based tools and resources (e.g., California Maternal Quality Care Collaborative [CMQCC] toolkits, Alliance for Innovation on Maternal Health [AIM] maternal safety bundles) within hospital and physician practices for practicing physicians and those in training

2. Support the development, implementation, and sustainability of Maternal Morbidity Review Committees (MMRCs) and educate members on the importance of family physicians' participation

3. Advocate for the standardization of data collection and reporting around maternal mortality (e.g., Maternal Mortality Review Information Application [MMRIA]) by MMRCs and other stakeholders

In addition, the task force determined the following objectives could be completed together as a collaborative:

1. Further define data collection needs through additional review of existing data and identification of gaps in current research that could be addressed (e.g., cost and impact of maternity deserts and hospital closures, identification of "near-miss" situations)

2. Identify and engage key stakeholders that are currently collecting maternal morbidity and mortality data

3. Create a cohesive narrative and issue a joint statement to show support and alignment of key advocacy and educational objectives related to maternal morbidity and mortality

4. Develop and support public education and engagement

5. Explore the creation of a recognition for high-quality maternal health centers

6. Support the alignment of quality measures and payment

Implicit Bias and Health Disparities in Maternal Morbidity and Mortality

Background
Implicit bias is pervasive among all health care professionals and has deleterious effects on patient health.[9] Implicit biases modify the physician-patient relationship by reducing trust, self-efficacy, understanding, and satisfaction. For patients, this affects their ability to manage their own health and adhere to treatment. For physicians, implicit bias limits their level of cultural proficiency, patient-centeredness, and job satisfaction. The academic medical community recognizes that to limit the impact of implicit biases on patient health outcomes, medical education and training must develop approaches rooted in both theory and research to change students' and residents' knowledge, behaviors, and practice.

Studies examining the health outcomes of implicit bias have revealed significant effects. For example, studies have found that students harbor implicit biases toward minority patients when they enter medical school and that their level of bias remains constant or increases over time.[10] In a sample group of white medical students and residents, half endorsed beliefs that there are biological differences in levels of pain for black and white patients.[11] As a result, they viewed the black patients' pain levels as lower than white patients' pain levels and made less accurate treatment recommendations for black patients. A study of gender bias among cardiologists revealed significant variability in simulated clinical decision-making for suspected coronary artery disease.[12]

The implicit biases of health care professionals toward women of color, particularly African-American women, have been indicated as a contributing factor to racial/ethnic disparities in adverse maternal and child health outcomes. For example, studies have demonstrated that the implicit biases of health care professionals affect rates of racial/ethnic disparities in contraception use[13]; access to and quality of prenatal care[14-16]; and clinical decision-making in the intrapartum and postpartum periods.[17]

In addition, the implicit biases of health care professionals and discrimination against people of color stem from a long, sordid history of institutionalized racism perpetuated by the U.S. health care system. Institutionalized racism is a system that permits the establishment of patterns, procedures, practices, and policies within organizations that consistently penalize and exploit people because of their race, color, culture, or ethnic origin. The system of racism within organizations affects the attitudes, beliefs, and behaviors of one individual (the physician) toward another (the patient). Efforts aimed at addressing the implicit biases of health care professionals must also consider the historical and contemporary contexts of treatment toward women of color in the health care setting.

Current AAFP Training Activities on Addressing Implicit Bias
In 2017, the AAFP launched the Center for Diversity and Health Equity (CDHE) to support its strategic priority of striving for health equity by taking a leadership role in addressing diversity and the social determinants of health as they impact individuals, families, and communities across their lifespan. The CDHE provides education and training resources to AAFP members and other stakeholders to raise awareness and develop physician leaders who can provide solutions for patients and work to eliminate the social inequities that cause disparities. The CDHE focuses its work in four core areas: advocacy, workforce diversity, multisector collaborations, and education/training.

The CDHE supports physician education and development by creating and disseminating health equity-focused education and practice tools that are evidence based and align with accepted educational standards. Between January and June of 2018, the CDHE began piloting in-person training on addressing implicit bias, which was later made available online for use by AAFP members and other health care professionals to support in-service training needs. The following are the training's learning objectives:

- Define "implicit bias" and describe how it operates in the health care setting
- Use online tools to self-assess individual biases
- Describe and demonstrate debiasing techniques

Challenges and Opportunities

Formal medical education and training curricula are often void of content that provides a framework for identifying and mitigating implicit biases in clinical practice. Faculty who seek to incorporate this topic in training are often faced with barriers, such as the limited number of subject matter experts who can provide instruction; a lack of opportunities for participants to observe and demonstrate mitigation strategies in practice; and a lack of opportunities to engage with patients who can share experiences of encountering implicit bias in the delivery of prenatal care. Results from the 2017-18 Council of Academic Family Medicine (CAFM) Program Directors Diversity Survey indicated that only 64% of family medicine residency programs offered training for both faculty and residents on addressing implicit bias.

To reduce the impact of implicit bias on maternal mortality, health care professionals need to know the following:

- The purpose of implicit bias self-assessments and how to use them
- How to interpret findings of implicit bias research
- The pervasiveness of implicit bias among all health care professionals
- How to apply techniques for mitigating the effects of implicit bias
- How implicit bias affects patients and their interactions with health care professionals before, during, and after pregnancy

To address these needs, the CDHE is developing a new evidence-based training on implicit bias that will also include a train-the-trainer component for faculty to facilitate the dissemination and implementation of training across the medical education continuum. The primary goal of this training is to promote awareness of implicit bias among all members of the health care team and to provide resources for mitigating the negative effects of implicit bias on patient care. The core components of the training include an overview to describe what implicit bias is and how it operates; tools for self-assessment; and strategies that can be used to reduce biases within the clinic and/or health care system.

Training activities include self-assessments, application of skills to case-study examples, small-group discussions, and the development of an implementation plan. The training format incorporates both online modules and in-person activities. Learning objectives of this training include the following:

- Demonstrate conscious mitigation strategies to overcome implicit bias
- Reflect on the results of the implicit bias self-assessment to increase self-awareness
- Apply implicit bias research to case-study examples
- Associate the effect of implicit bias with real-life patients

Recommendations from the MMM Task Force
In addition to the AAFP's current and emerging activities, the task force suggests that the following objectives should be completed by the AAFP in the next year to address implicit bias:

1. Collaborate with the Association of Standardized Patient Educators (ASPE) on the development and dissemination of curriculum and training resources that include the topic of implicit bias

2. Communicate to health information technology stakeholders the potential risk for artificial intelligence and machine learning to perpetuate disparities and bias

3. Develop an AAFP policy that defines birth equity and provides practice recommendations for family physicians

In addition, the task force determined the following objectives could be completed together as a collaborative:

1. Each organization should incorporate goals and objectives that focus on achieving health equity into its strategic plan.

2. Each organization should include continuing medical education and other training activities on topics such as implicit bias and health/birth equity in its national, regional, and local meetings.

3. Develop a learning collaborative for local/nonprofit organizations that have demonstrated impact in reducing racial/ethnic disparities in maternal morbidity and mortality in order to support their sustainability and dissemination of best practices

4. Involve patients and patient advocacy groups in the development of community-based participatory research and practice-based research that focuses on maternal morbidity and mortality

5. Advocate for Medicaid expansion to increase access to care for all women across their reproductive life course

6. Support the evaluation and implementation of a standardized patient experience measure to assess patient interactions with health care professionals and systems

7. Conduct research on universal training for all health care professionals who encounter patients

8. Collect data on the race/ethnicity of patients and the workforce

Growing Loss of Rural Obstetrical Services

Many challenges of living in a rural area may impact maternal morbidity and mortality. Access to rural hospital obstetrical (OB) services is of significant concern. In 1985, 24% of rural counties lacked hospital-based OB services.[18] As of 2014, 54% were without hospital-based obstetrics.[19] More than 200 rural obstetrical units closed between 2004 and 2014, with additional rural units at risk. In addition to lack of facilities, there are complex issues such as lack of transportation, increased poverty, increased rate of chronic diseases, and difficulty recruiting and retaining physicians to live and work in rural communities.

Levels of Maternal Care, a consensus document from *ACOG* and the Society for Maternal-Fetal Medicine (SMFM), seeks to address regionalization of services in which higher-level facilities support those that have fewer resources.[20] This guidance calls for standards at each level of maternal care and a robust transfer network. The AAFP continues to collaborate with ACOG to ensure that the levels of maternal care are relevant to rural settings while providing high-quality obstetrical care at the local level. A key concern is the need for the levels of maternal care to address support and training for lower-resource hospitals and hospitals that have no obstetrical services.

Through the recent introduction of the Rural Physician Workforce Production Act of 2019 (S 289), Congress has also acknowledged the rising loss of rural health care providers. This bill would provide federal support for rural residency training, which will help alleviate physician shortages in rural communities. Evidence indicates that one of the most promising ways to recruit physicians to practice in rural areas is through rural experiences during their residency training.[21,22] Supported by the AAFP, ACOG, and NRHA, the bill would provide new robust financial incentives for rural hospitals (including critical access hospitals) to provide the training opportunities that the communities they serve need. Currently, numerous incentives in the Medicare program discourage hospitals—even those in communities that desperately need new physicians—from providing such opportunities. The financial incentives specified in the Rural Physician Workforce Production Act would also extend to urban hospitals for the purpose of growing the number of residents in rural training tracks.

Another major factor in the growing loss of obstetrical services in rural communities is the rising cost of liability insurance premiums.[23] Higher premiums threaten the viability of some rural hospitals that have chosen to eliminate high-risk services (e.g., obstetrics, certain surgeries). As a result, patients have to travel farther for this care or be transferred to a facility that provides needed services. High premiums can also make it difficult for rural areas to recruit or retain an adequate number and mix of physicians, especially in certain subspecialties. Through the Federal Tort Claims Act (FTCA), the federal government offers a way for certain rural health centers to lower their malpractice insurance costs. The FTCA affects rural health through the creation of a medical malpractice insurance program for federally qualified health centers (FQHCs). This program offers comprehensive medical malpractice protection at no cost to grantees who participate. Reducing the need for FQHCs to purchase private medical malpractice insurance makes more funds available for clinical services. Section 10608 of the Patient Protection and Affordable Care Act (ACA) expands FTCA protections to a FQHC's nonmedical personnel. The ACA also authorizes malpractice demonstrations by the states (Section 10607). Expansion of the FTCA could help eliminate a major barrier for rural communities that are struggling to provide high-risk services due to the increasing cost of private medical malpractice insurance.

According to the National Center for Health Statistics (NCHS), 43% of all births in 2017 had Medicaid as the source of payment for the delivery.[24] In 19 states, Medicaid maternity coverage ends at 60 days postpartum, leaving women without access to care or support for problems during this critical time.[25] Studies have shown that more than 60% of maternal deaths occur postpartum.[26] Statistics show a clear need to extend Medicaid coverage for women up to one year after delivery.

Recommendations from the MMM Task Force

The task force suggests that the following objectives should be completed by the AAFP in the next year to address the growing loss of rural obstetrical services across the nation:

1. Support retention of family physicians and other clinicians providing obstetrical services in rural communities, focusing on improved payment, medical malpractice reform, and loan repayment expansion

2. Advocate for the expansion of current loan repayment programs or incentives, including the National Health Service Corps (NHSC) and the federal Public Service Loan Forgiveness Program, to obstetrical care providers such as family physicians, OB-GYNs, certified nurse-midwives, labor and delivery nurses, and community health centers

3. Advocate to allow rural obstetrical providers, and potentially rural hospitals, to be eligible for Federal Tort Claims Act (FTCA) medical malpractice liability protection

4. Advocate for the funding of additional graduate medical education opportunities for family physicians and obstetricians to train in rural communities

In addition, the task force determined the following objectives could be completed together as a collaborative:

1. Support retention of family physicians and other clinicians providing obstetrical services in rural communities and issue a joint statement on the importance of access to obstetrical care for affected communities

2. Develop a framework to support and provide training for lower-resource hospitals and communities that no longer provide obstetrical services to become “OB ready”

3. Explore resources on helping practice teams develop and maintain competency in providing maternity care

4. Explore the development of key competencies and recommended credentialing for facilities and health care providers with low obstetrical volumes

5. Develop a joint commentary on the American College of Obstetricians and Gynecologists (ACOG)/Society for Maternal-Fetal Medicine (SMFM) *Levels of Maternity Care*, defining and implementing a bidirectional relationship between Levels 3 and 4 to support Levels 1 and 2

6. Advocate for Medicaid to extend coverage of mothers to one year postpartum and provide adequate reimbursement for obstetrical services

7. Explore improved payment opportunities specific to rural facilities and providers, including alternative payment models

Educational Strategies to Support Family Physicians Providing Maternity Care

Research findings published in the *Annals of Family Medicine* showed that physicians who graduated from residency between 2010 and 2013 had a narrower scope of practice than those who graduated between 1996 and 1999.[27] While graduates feel more prepared than previous cohorts, family medicine graduates are providing significantly less OB care. A separate study showed that among recent graduates who intended to practice obstetrics, having lifestyle concerns and finding a job that did not include obstetrics were the most significant reasons that respondents did not end up with the scope of practice they intended.[28]

Family medicine residency programs vary in the obstetrical training and opportunities they offer, as well as in how they meet the Review Committee for Family Medicine (RC-FM) requirements. There are opportunities to work with family medicine residency educators on models of training that provide core competency while also providing higher volume, acuity, and comprehensive obstetrical training.[29]

One strategy to encourage medical students and residents to train in and provide OB care is to offer opportunities to experience the full scope of family medicine practice in a broad range of settings. State and local preceptorship programs have shown significant results in influencing medical students to choose primary care.[30] However, over the years, these programs have suffered due to decreases in funding that limit the opportunities for exposure. Preceptorship programs, including STFM's Preceptor Expansion Initiative, have struggled to recruit family physicians who provide obstetrical care.

The AAFP and ACOG both have courses to educate and build skills focused on recognizing obstetrical emergencies. The courses blend didactic learning with simulations of various obstetrical emergencies and they have a focus on team-based care. The AAFP's Advanced Life Support in Obstetrics (ALSO®) is an evidence-based, interprofessional, and multidisciplinary training program that equips the entire maternity care team with skills to effectively manage obstetrical emergencies. This comprehensive course encourages a standardized team-based approach among physicians, residents, nurse-midwives, registered nurses, and other members of the maternity care team to improve patient safety and positively impact maternal outcomes.

Basic Life Support in Obstetrics (BLSO™) is designed to improve the management of normal deliveries, as well as obstetrical emergencies, by standardizing the skills of first responders, emergency personnel, and maternity care providers. The BLSO curriculum is designed to train pre-hospital care providers; first responders and emergency personnel; and medical, nursing, and physician assistant students.

The ACOG Emergencies in Clinical Obstetrics (ECO) course has been created from the most updated evidence-based literature to train all levels of providers to work together during obstetrical emergencies. It features simulation stations that allow participants to get hands-on practice for individual skills and to practice the communication skills and critical teamwork that are required during an obstetrical emergency. Standardized lectures provide necessary background information, and participants also get clinical checklists for reference during the course and for use at their institutions.

Recommendations from the MMM Task Force

The task force suggests that the following objectives should be completed by the AAFP in the next year to support practicing and future family physicians in providing full-scope maternity care:

1. Explore and disseminate best practices for family physicians to re-train and gain privileges to provide obstetrical care again

2. Support family medicine preceptorship programs for medical students, including funding to expand opportunities into rural communities

3. Work with the Society of Teachers of Family Medicine (STFM) to enhance its Preceptor Expansion Initiative to include family medicine/obstetrics preceptors

In addition, the task force determined the following objectives (in addition to those listed above) could be completed together as a collaborative:

1. Collaborate with the Society of Teachers of Family Medicine (STFM), the Association of Departments of Family Medicine (ADFM), the Association of Family Medicine Residency Directors (AFMRD), and other members of the maternal health coalition to develop family medicine maternity care workforce goals and action plans for recruitment, job placement, retention, and continuing education

2. Work with STFM to ensure basic and advanced obstetrical education is available to those seeking to provide obstetrical services

3. Review the content of the Advanced Life Support in Obstetrics (ALSO)/Basic Life Support in Obstetrics (BLSO) and Emergencies in Clinical Obstetrics (ECO) programs to identify gaps that could be addressed collaboratively for practicing physicians and those in training

4. Explore available education on the impact of trauma-informed care, mental health, and substance use disorder as they relate to maternal morbidity and mortality, and identify areas for potential collaboration

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