Transforming Maternal Health and Perinatal Rural Regional Planning

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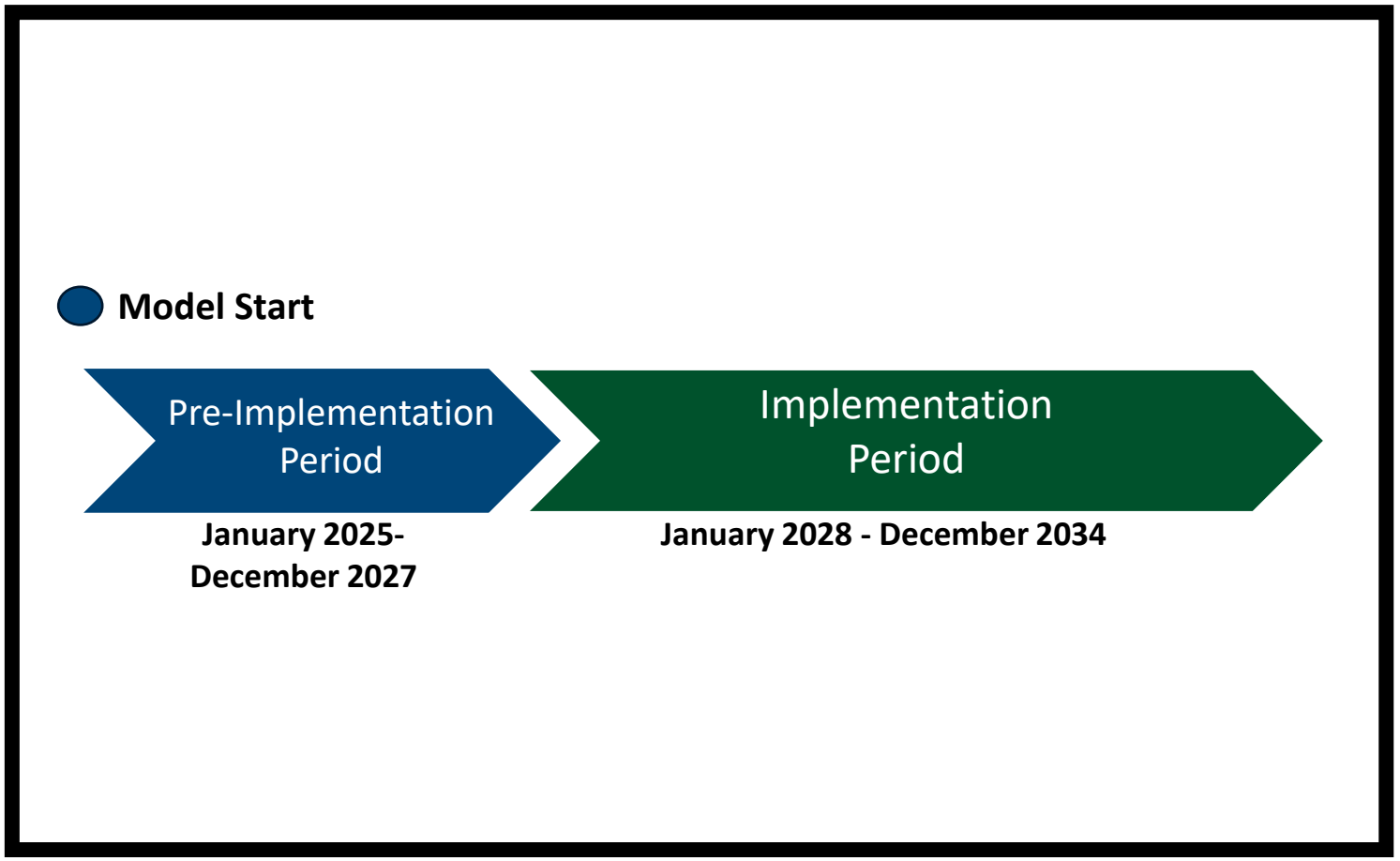
Agenda

- Introductions
- Transforming Maternal Health (TMaH) Overview – *Maggie Jansson*
- Review of Maternal and Child Data by District – *Kelley Bowden*
- Discussion
- Next steps

The Transforming Maternal Health (TMaH) Model

- Designed to **improve maternal health care** for women enrolled in Medicaid (MaineCare) and the Children's Health Insurance Program (CHIP)
  - Led by the **Office of MaineCare Services**
  - DHHS to receive up to $17 million in funding over 10 years.
  - **Invests in infrastructure, planning, and services.**
  - Expands MaineCare coverage for perinatal supports and services.
  - Model Timeline: **January 2025 – December 2034**
    - 3-year pre-implementation planning period
    - 7-year implementation period



From the TMaH Notice of Funding Opportunity:

"Pre-Implementation Period funding and technical assistance will help the Recipient *build critical skills and capacity* to successfully launch a … model that supports delivery of whole-person care during the seven-year Implementation Period."

TMaH will focus on three main areas:

Access to care, infrastructure, and workforce capacity

Quality improvement and safety

Whole-person care delivery

13 Elements of Maine's TMaH Model:

Federally Required

1. Increase access to certified midwifery workforce.
2. Increase access to (licensed) birth centers.
3. Cover doula services.
4. Improve data infrastructure.
5. Develop value-based maternity services payment model.
6. Support implementation of quality improvement initiatives.
7. Support CMS "Birthing Friendly" hospital designation.
8. Increase screening, risk assessments, referrals and follow-ups for perinatal depression, anxiety, tobacco use, substance use disorder, and health related social needs.
9. Increase home monitoring of diabetes and hypertension.

Maine - Specific Selections

1. Increase use of home visits, mobile clinics, or telehealth.
2. Cover perinatal community health worker services.
3. Expand group prenatal care utilization and coverage.
4. Create regional partnerships in rural areas.

Maine's TMaH Model

Increase Access to Certified Nurse Midwives

- Review and promote MaineCare coverage options for interprofessional consultations between midwives and other providers.
- Assess coverage options for certified *professional* midwives.

Increase Access to (Licensed) Birth Centers

- Research other states' licensing and reimbursement practices for birth centers.
- Invest in perinatal transition improvements for planned out-of-hospital births.

Cover Doula Services Under MaineCare

- Establish a Statewide Doula Advisory Council.
- Develop policy and reimbursement for doula services.
- Support doula service implementation.

What is a Doula?

- **A non-clinical professional** who provide **physical, emotional, and educational support** throughout the **entire perinatal period**.
- Sometimes referred to as a **“birth worker”.**
- Build close, trusting relationships
- An evidence-based way to improve perinatal outcomes.
- **Traditional and cultural doulas** play an important role in honoring community practices and supporting maternal health outcomes.
- Can provide affirming cultural care and/or a sense of safety for populations who are experiencing discrimination, bias or language barriers.

[1](EBB 2024)

Doula Implementation – Timeline

2025 Contract with doulas to inform MaineCare's work and support the Statewide Doula Council.

Convene the Statewide Doula Council to advise on design and implementation of MaineCare coverage of doula services.

2026 Conduct a rate determination for doula services.

2027 Seek federal approval for doula coverage and initiate state level rulemaking. Seek state appropriations for SFY 28.

★ We are here

2028 Adopt MaineCare rules covering doula services.

Ongoing Support implementation and outreach regarding doula service coverage.

Maine's TMaH Model

Improve Data Infrastructure

- Complete data needs assessment and workplan.
- Improve the maternal health record within Maine's Health Information Exchange.
- Strengthen DHHS maternal/child data matching & stratification between DHHS programs.

Implement Value-based Maternity Services Payment Model

- Engage FQHCs in maternal health service planning.
- Disperse provider infrastructure payments to support care delivery.
- Develop and implement payment model, including quality incentive payments.

Maine's TMaH Model

Support Implementation of Quality Improvement Initiatives

- Support the continued successful implementation of Alliance in Innovation in Maternal Health (AIM) patient safety bundles currently being done by the Maine Perinatal Quality Collaborative (PQC4ME).

Support CMS "Birthing Friendly" Hospital Designation

- Continuously review CMS "Birthing Friendly" hospital requirements and support providers in status maintenance.
- Identify "Birthing Friendly" status in the MaineCare provider directory.

Maine's TMaH Model

Increase Screenings, Risk Assessments & Follow-Up

- Engage community and clinical partners in care journey mapping.
- Improve and standardize, when appropriate, screening and referrals for behavioral health and health-related social needs.
- Support community and clinical implementation needs.

Increase Use of Home Monitoring Services

- Develop policy and reimbursement for remote monitoring of diabetes and hypertension for pregnant/postpartum MaineCare members.
- Invest in technology, training, and other supports for implementation.

Maine's TMaH Model: Maine Specific Elements

Cover Perinatal Community Health Workers (CHWs)

- Support Perinatal CHWs and their employers to participate in TMaH activities across relevant areas.

Expand Group Prenatal Care

- Explore MaineCare changes to better support group prenatal care.
- Support learning collaborative/curriculum design for group perinatal care models.

Maine's TMaH Model: Maine Specific Elements

Increase Use of Telehealth/Mobile Clinics

- Support virtual behavioral health care to expand access to behavioral health services for patients of obstetric and family practices.

Rural Regional Planning

- Support rural regions to do regional planning for maternal health.
- Release Request for Funding Application (RFA) to enable individuals or organizations within designated rural regions to apply for funding .

Medicaid (payor of covered services & lever for policy change)

+

TMaH (planning, capacity building, & resources)

=

Improved Access & Outcomes in Maternal Health for Women on MaineCare

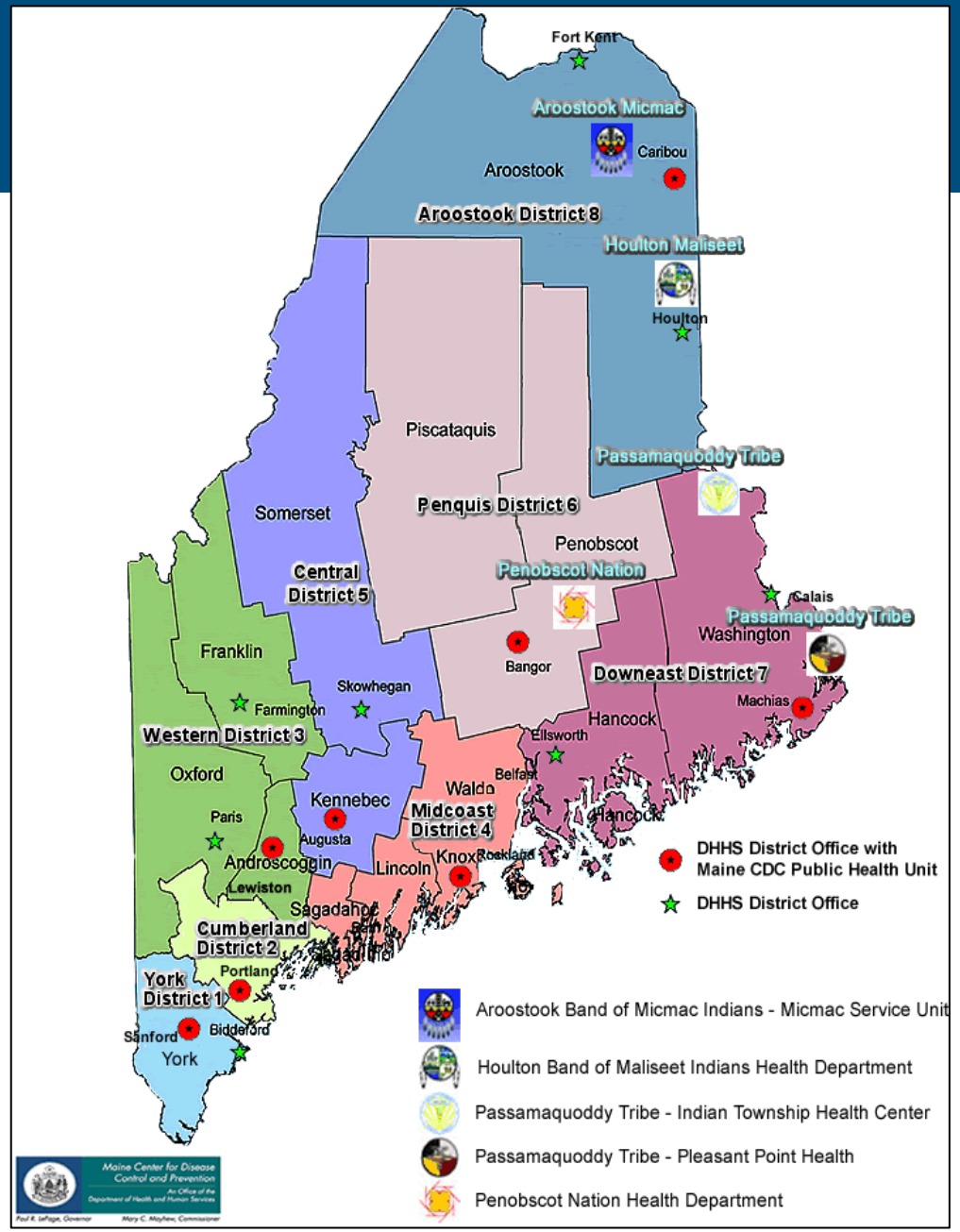
What is Rural Regional Planning?

Rural regional planning can be an effective strategy in health care reform **because it aligns resources, infrastructure, and services around the specific needs of rural populations**, rather than applying a one-size-fits-all approach designed for urban areas.

1. Addresses unique rural health challenges	**2. Builds economies of scale**	**3. Improves care coordination**
4. Maximizes funding and infrastructure investments	**5. Strengthens workforce recruitment and retention**	**6. Supports community-driven solutions**

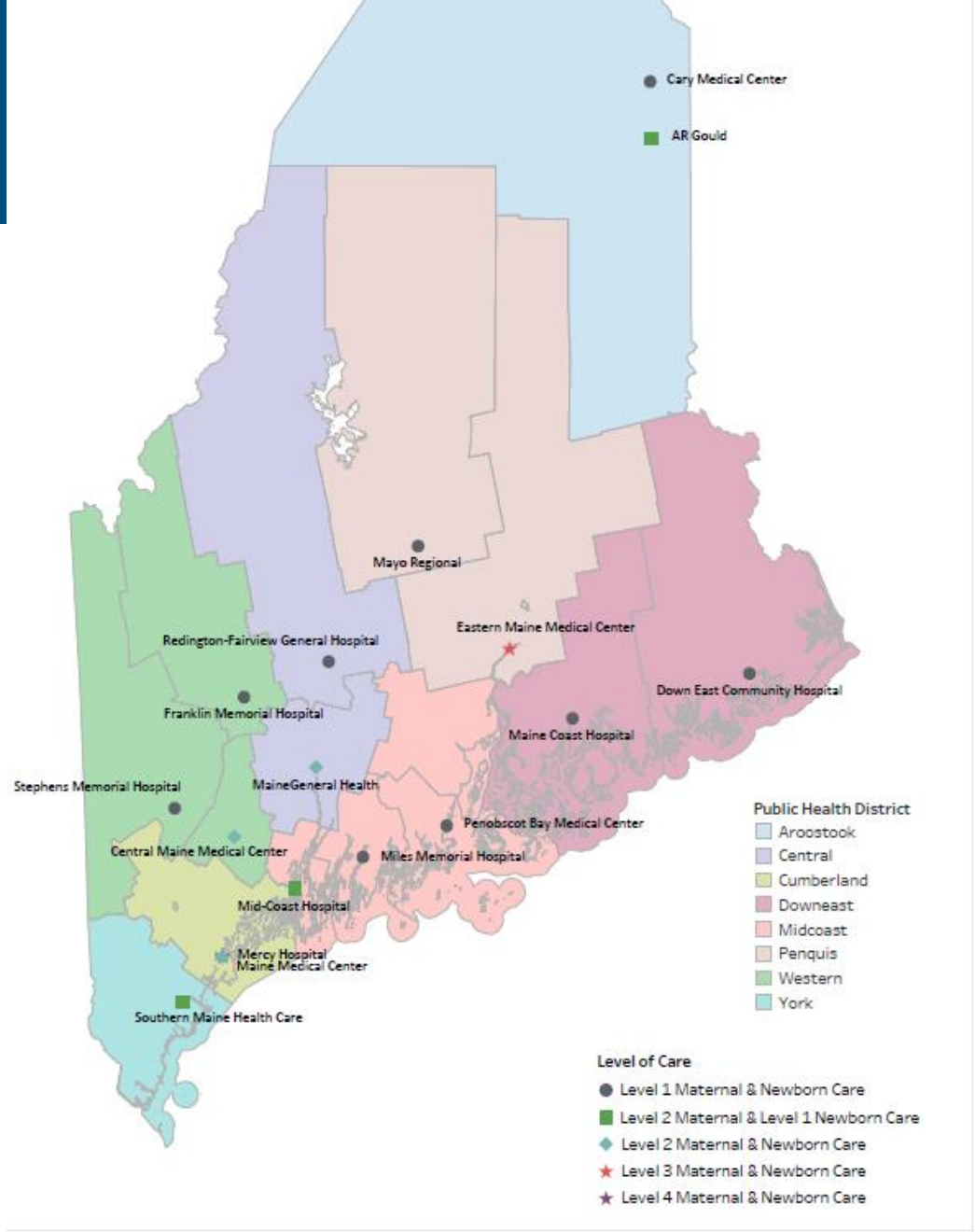
Public Health Districts

District	Corresponding Counties
Aroostook – District 8	Aroostook
Central – District 5	Somerset, Kennebec
Downeast – District 7	Washington, Hancock
Midcoast – District 4	Waldo, Lincoln, Knox, Sagadahoc
Penquis – District 6	Penobscot, Piscataquis
Western – District 3	Androscoggin, Franklin, Oxford
York – District 1	York



Birthing Hospitals by Public Health Districts

District	Corresponding Counties
Aroostook – District 8	Aroostook
Central – District 5	Somerset, Kennebec
Downeast – District 7	Washington, Hancock
Midcoast – District 4	Waldo, Lincoln, Knox, Sagadahoc
Penquis – District 6	Penobscot, Piscataquis
Western – District 3	Androscoggin, Franklin, Oxford
York – District 1	York



Update and Next Steps: Perinatal Rural Regional Planning

Summary of work-to-date:

- May 7th webinar & June 12th in-person meeting
- Regional district meetings
- Weekly office hours
- Upcoming:
  - RFA to be released in September (approx.)
  - One award per public health district

Next step for applicants:

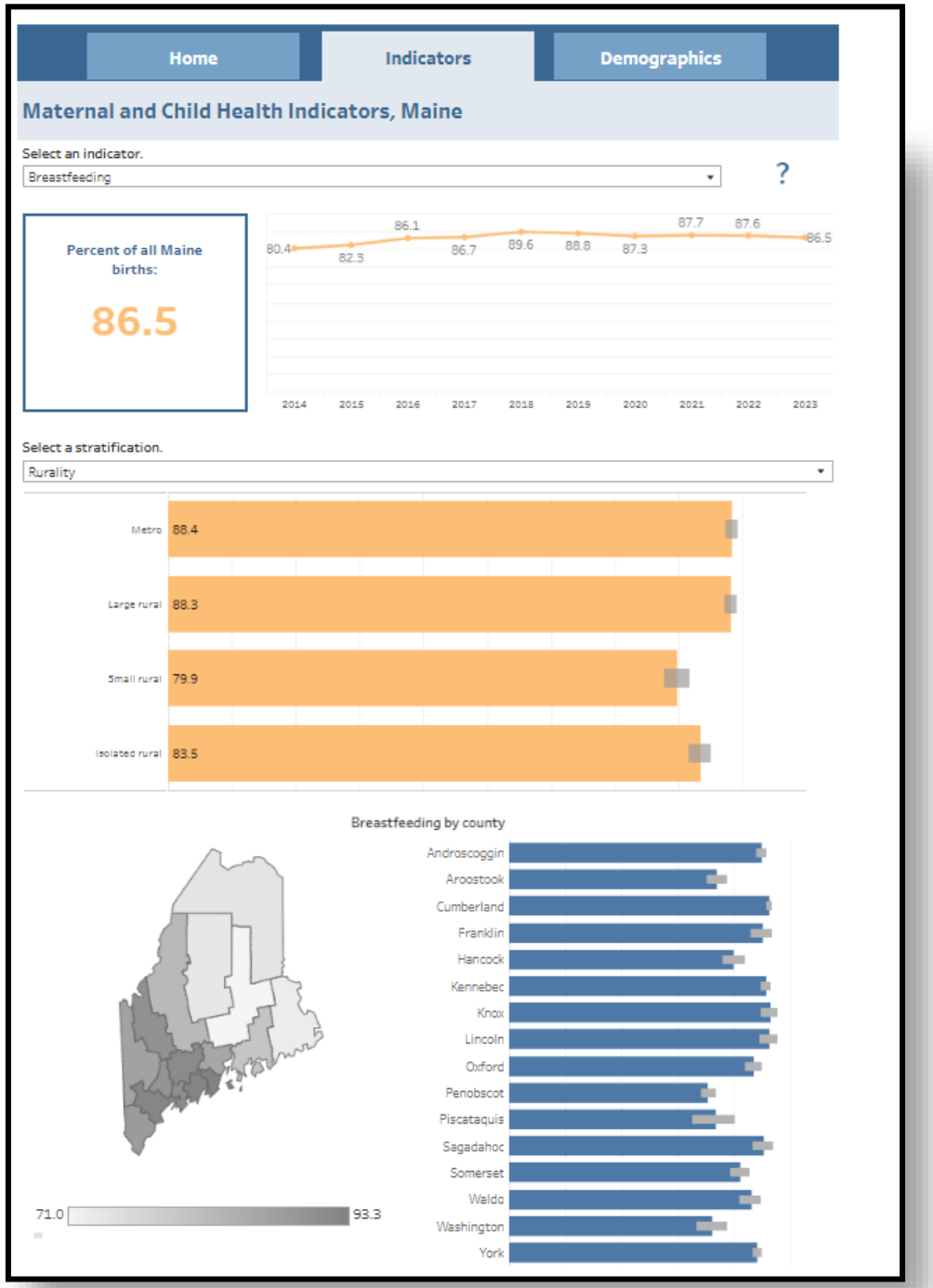
- Convene interested parties from community and hospital(s)
- Review data in your region
- Review TMAH Pillars and Elements
- Discuss priorities and strategies for response to RFA
- Identify any missing partners to engage

Maternal Resources Inventory by Region

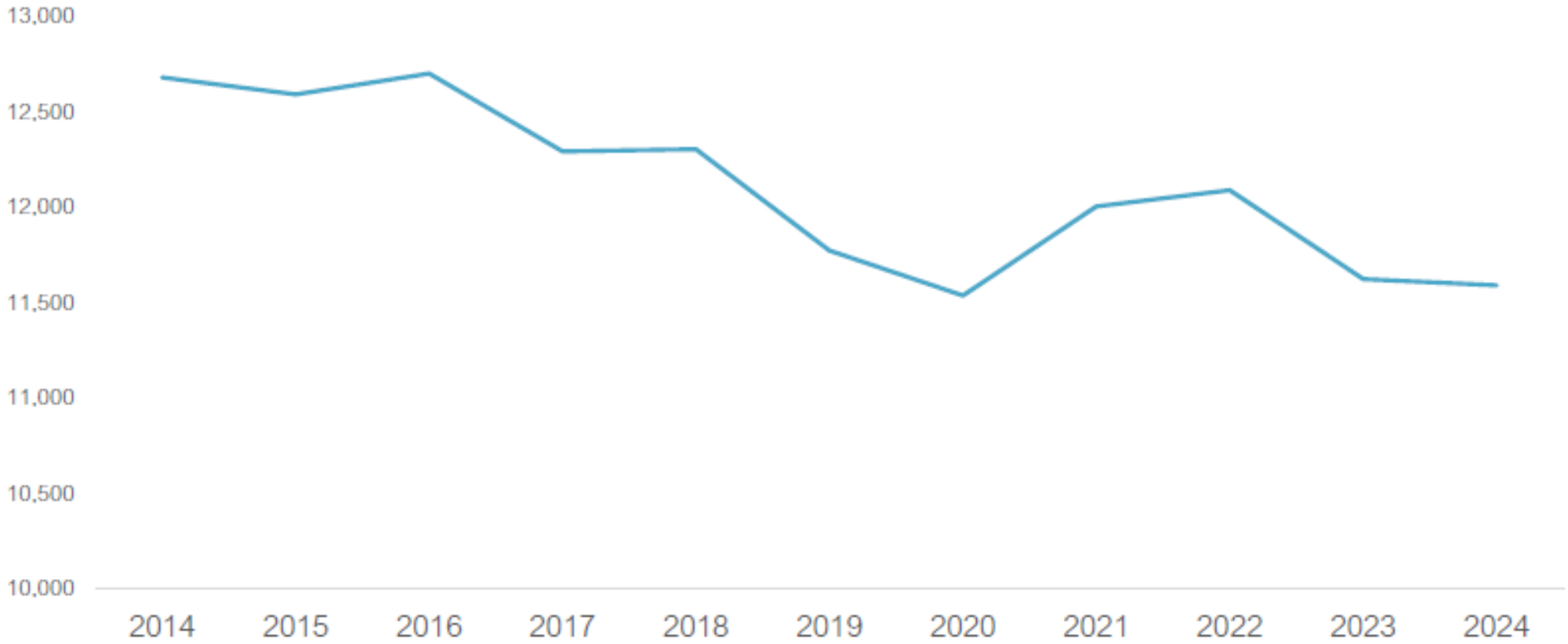
Organization	County	Contact Last Name	Contact First Name	Title	Email
Birthing Hospital(s)					
Non-Birthing Hospital(s)					
OB-Gyn's / Midwives					
FQHCs / Physician Practices					
Tribal Health Centers / Contacts					
EMS Contacts					
Lactation Consultants					
Doulas					
WIC Providers					
Community Org's/ Others					

Data with thanks to Fleur Hopper

[Maine MCH data dashboard]



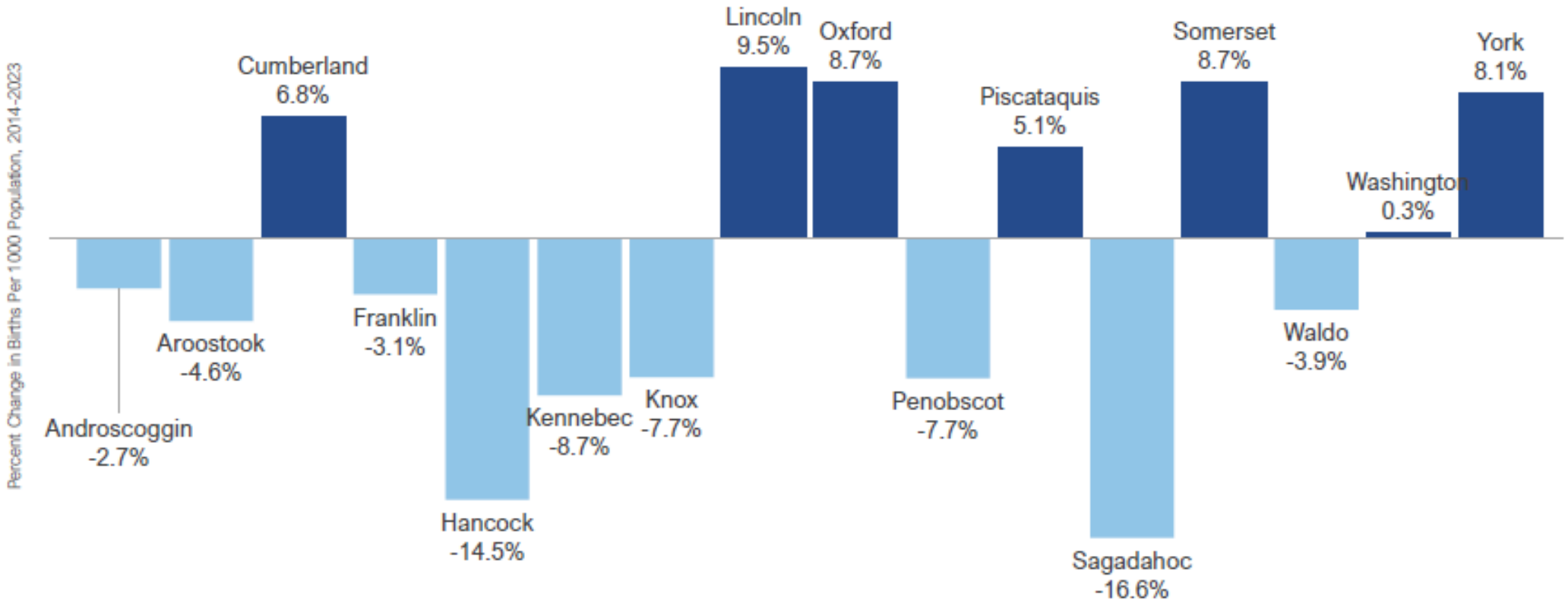
In 2024, **11,588** infants were born to Maine resident birthing parents.



Source: MECDC DRVS, Birth certificates, 2014-2023

Between 2014 and 2023, birth rates declined in nine of Maine's 16 counties.

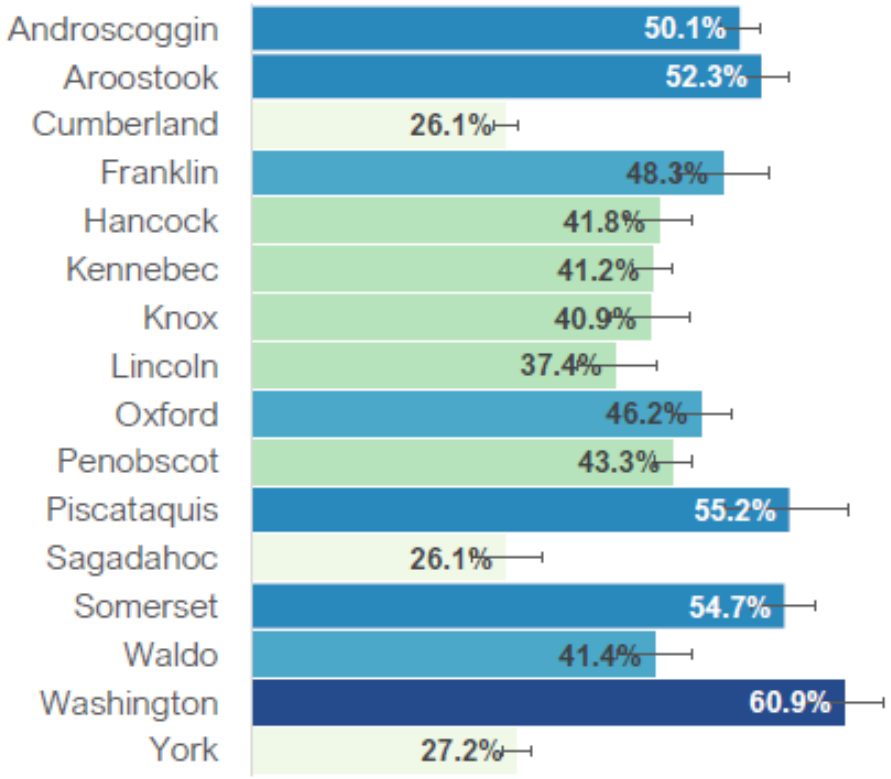
Some counties in Western and Southern Maine saw increases.



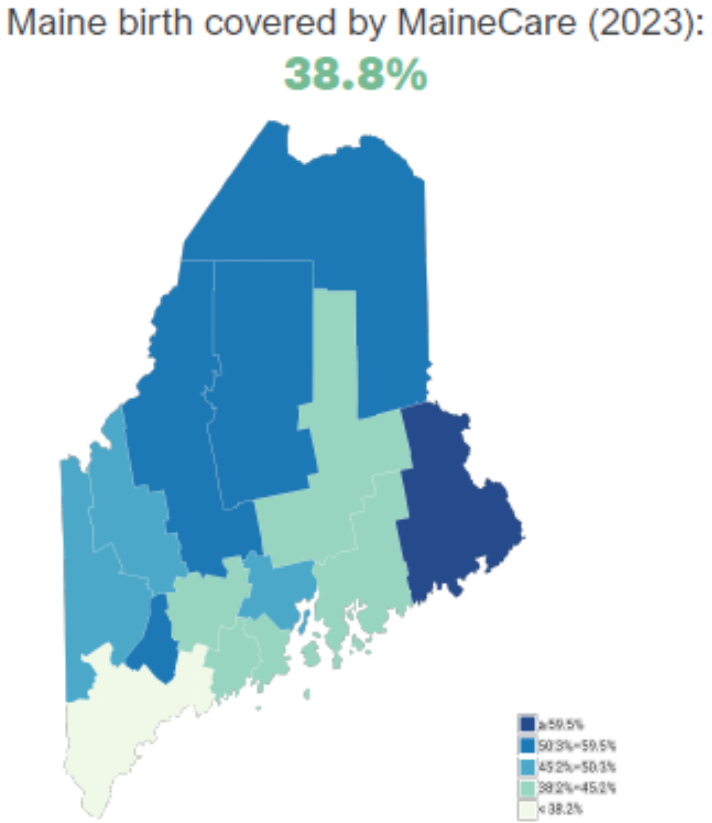
Source: Births: MECDC DRVS, Birth certificates, 2014-2023; Population: US Census, Population Division, Annual Estimates of the Resident Population for Counties in Maine

Maine Center for Disease Control and Prevention

Percent of births covered by **MaineCare** varies significantly by **county** of residence.

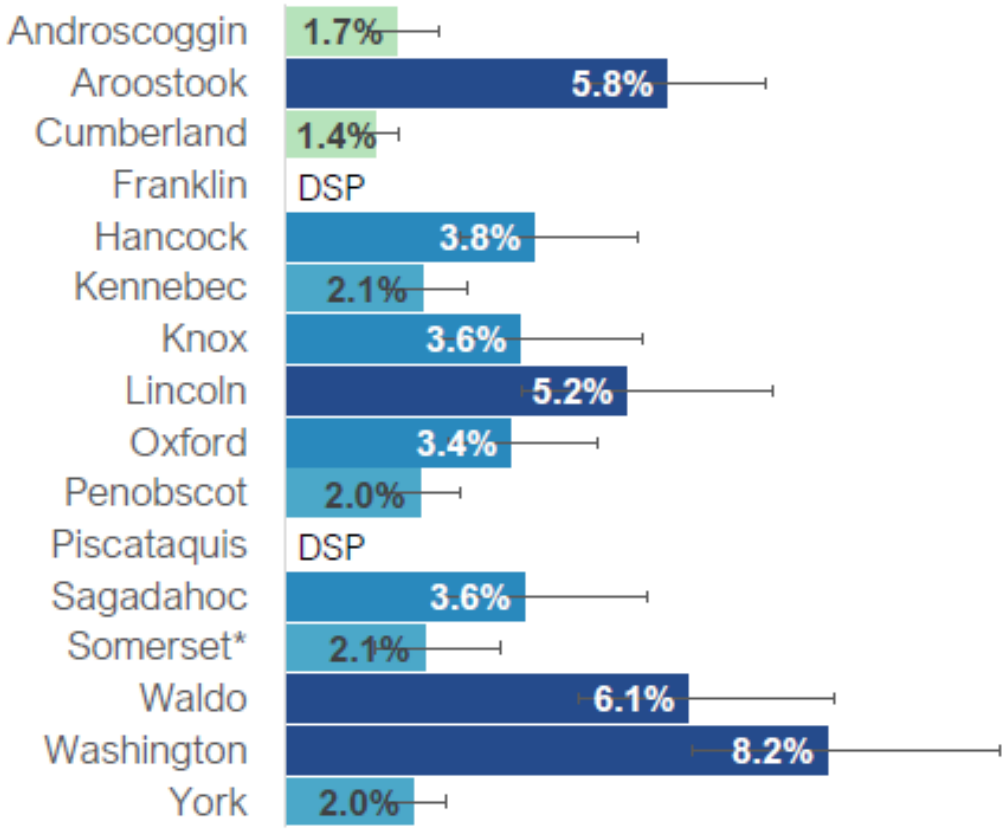


Source: MECDC DRVS, Birth certificates, 2022-2023



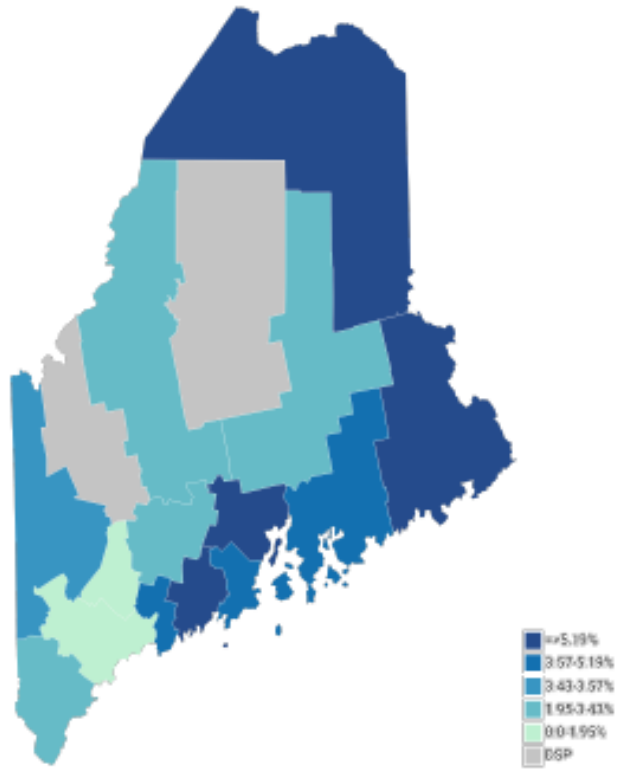
Maine Center for Disease Control and Prevention

Aroostook, Lincoln, Waldo, and **Washington Counties** had significantly higher rates of home birth than the state average in 2022-2023.



Source: MECDC DRVS, Birth certificates, 2022-2023
*Rates are calculated with fewer than 20 in the numerator. Interpret with caution.

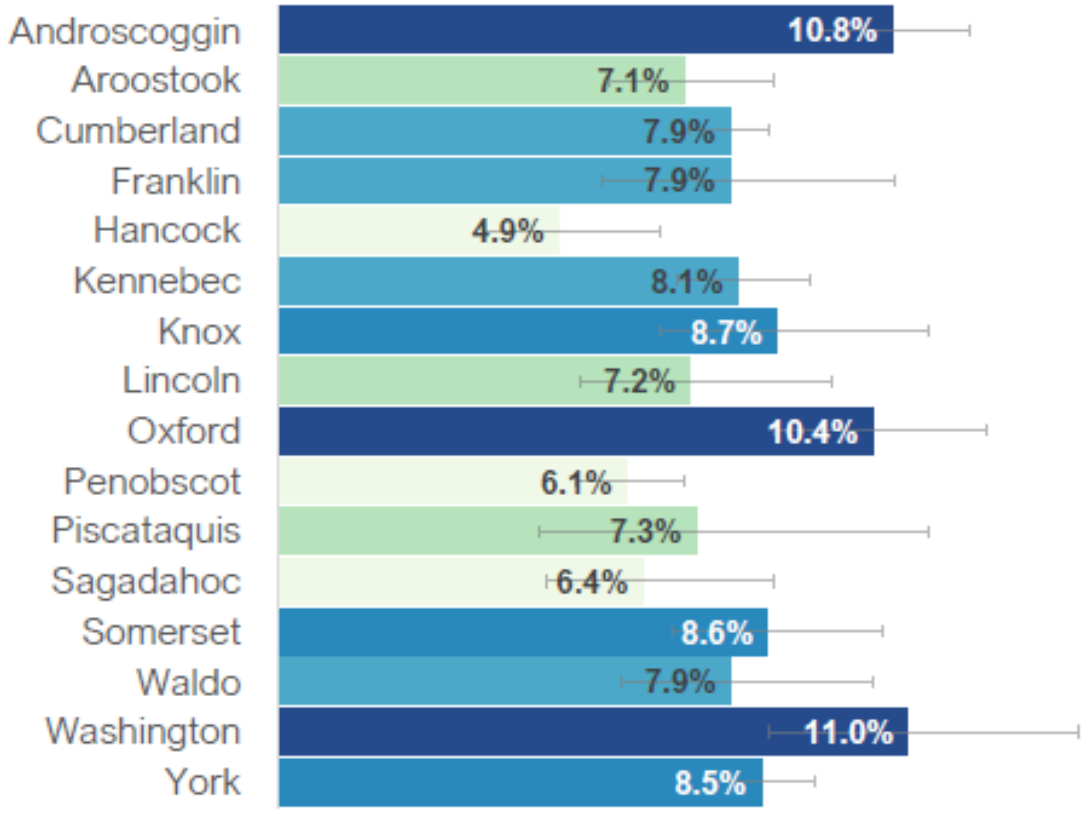
Planned Home Births (2022-2023):
2.6%



Maine Center for Disease Control and Prevention

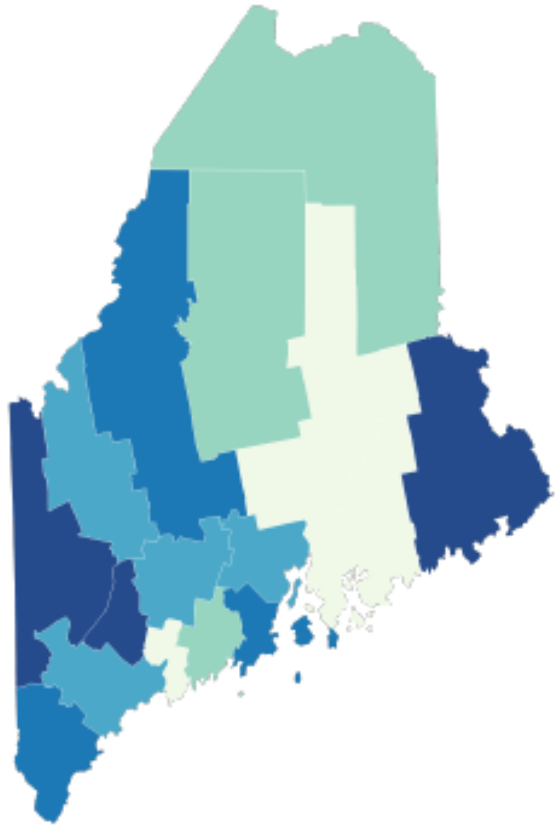
In 2022-2023, about **1 in 10** Androscoggin, Oxford, and Washington County infants were born **low birthweight** (<2500g / 5.5 lbs.).

These counties had a significantly higher rate than the state average of 8.0%.



Source: MECDC DRVS, Birth certificates, 2022-2023

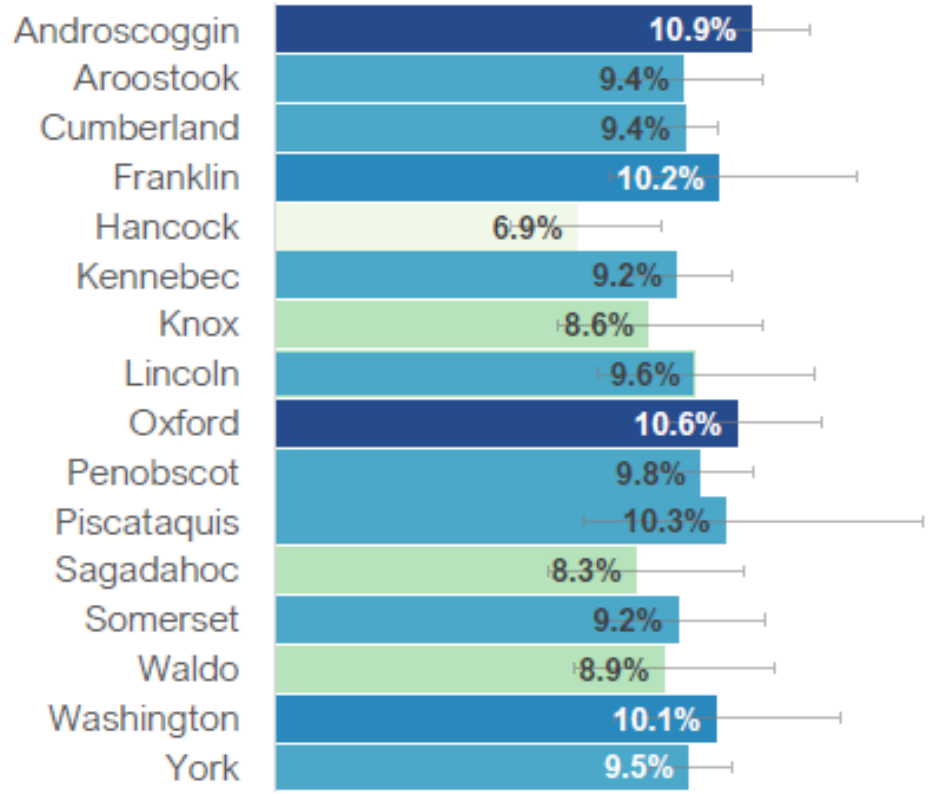
Maine 2023 LBW rate: **8.0%**



Maine Center for Disease Control and Prevention

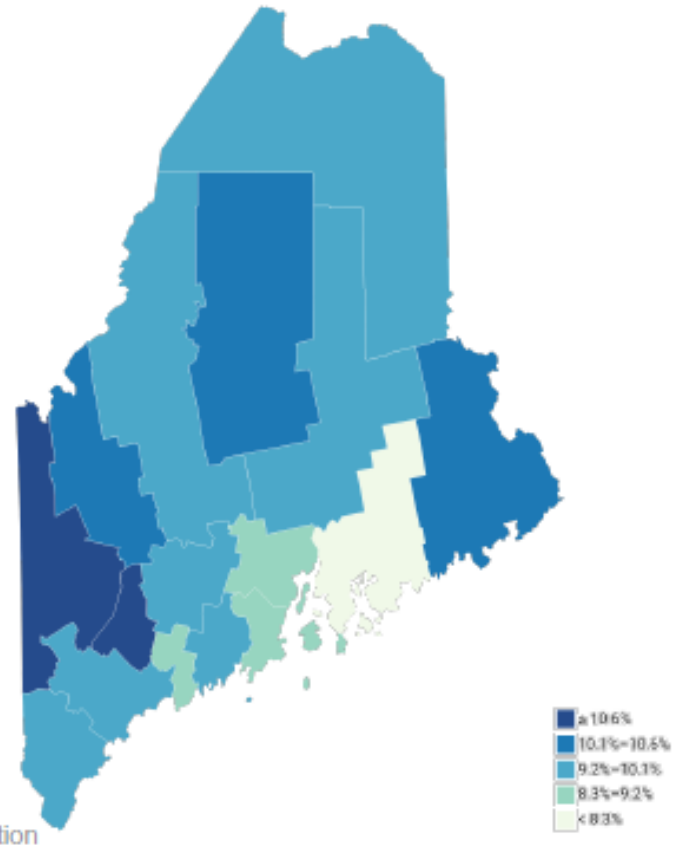
In 2022-2023, **Androscoggin's** rate of preterm birth (<37 weeks) was **significantly higher** than the state average of 9.6%.

Hancock's rate was significantly lower than the state rate.



Source: MECDC DRVS, Birth certificates, 2022-2023

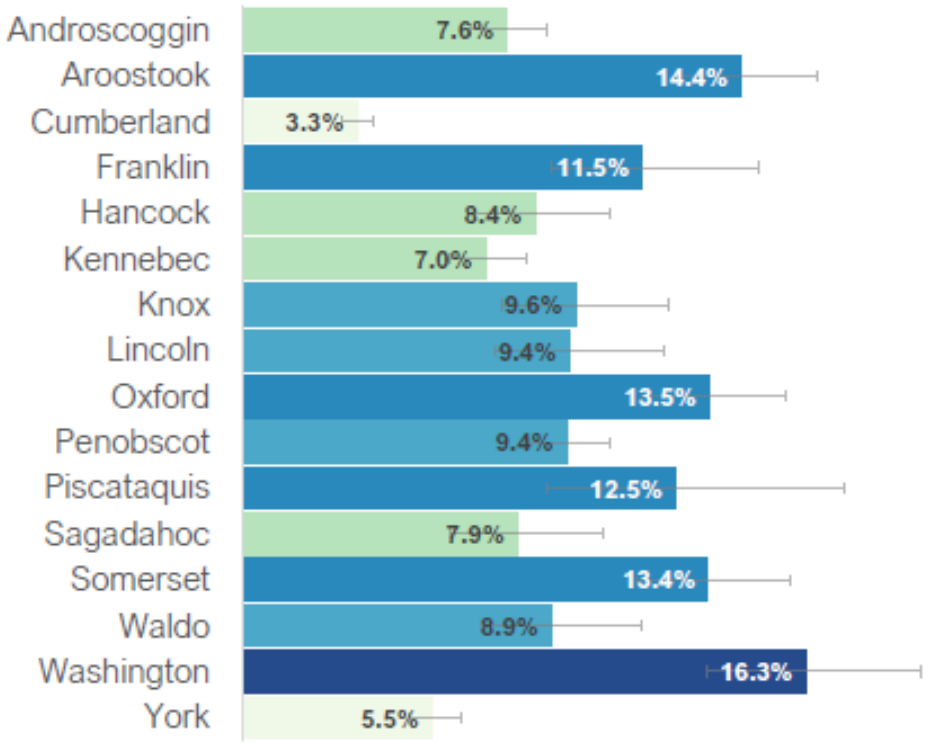
Maine 2023 PTB rate: **9.6%**



Maine Center for Disease Control and Prevention

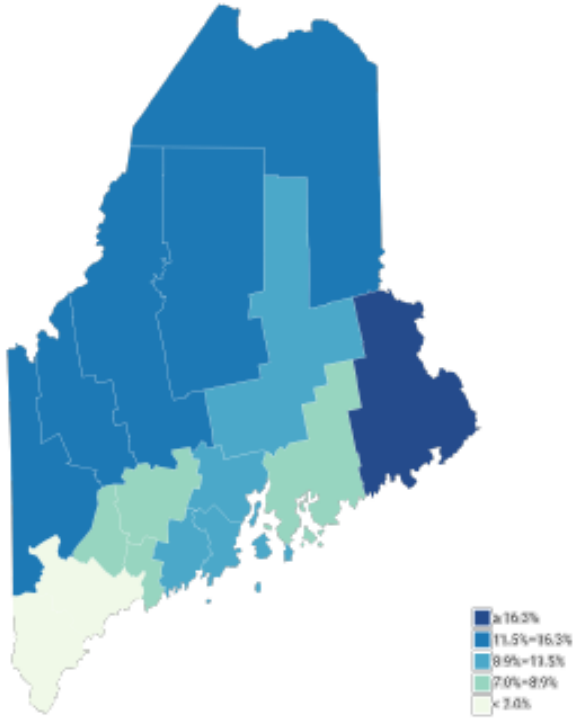
Smoking during pregnancy follows a strong regional pattern in Maine, with highest rates in the north, west, and Downeast.

Close to 1 in 6 Washington County birthing people smoked during pregnancy in 2022-2023.



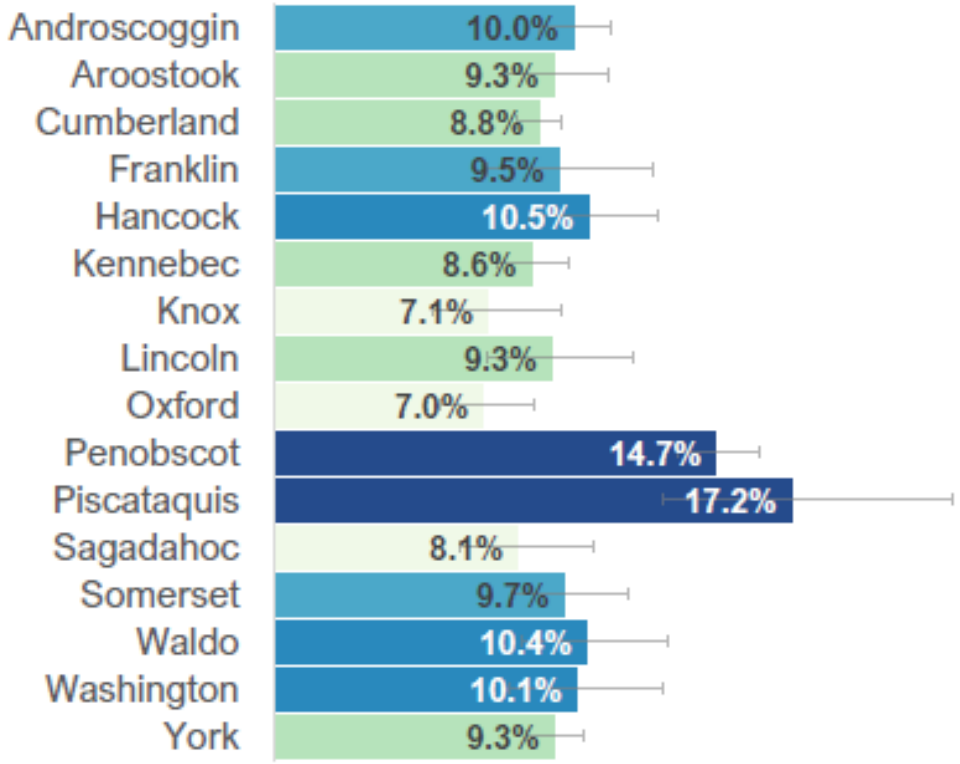
Source: MECDC DRVS, Birth certificates, 2022-2023

Maine 2022-2023 rate: **7.2%**

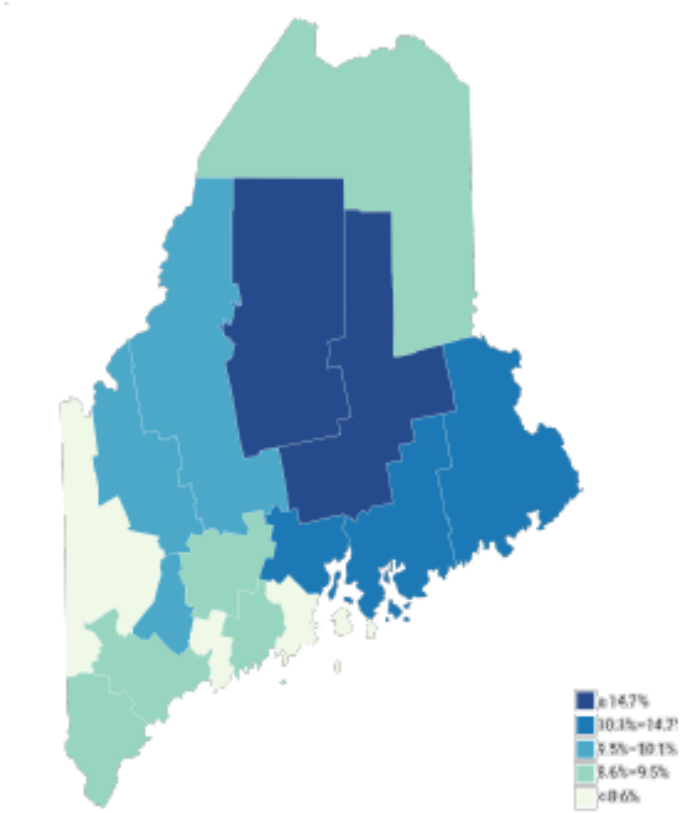


Maine Center for Disease Control and Prevention

In 2022-2023, **Penobscot and Piscataquis County** birthing people experienced **gestational diabetes*** at a significantly **higher rate** than the state rate of 9.8%.



Maine 2022-2023 rate: **9.8%**

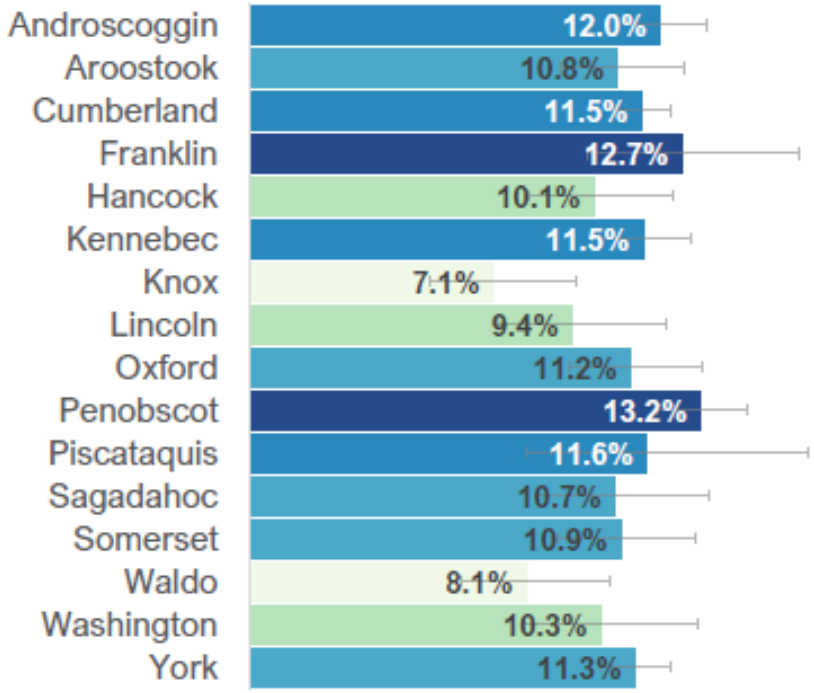


Source: MECDC DRVS, Birth certificates, 2022-2023

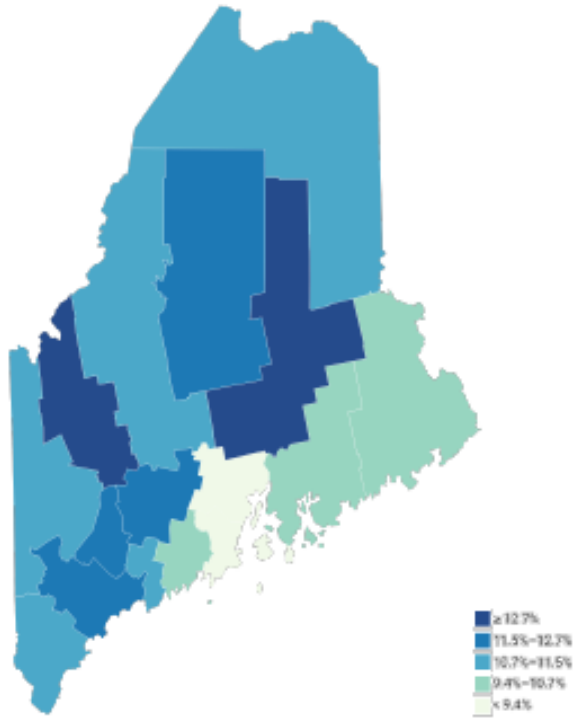
*Defined by US CDC NCHS, *Guide to Completing the Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death*, as diabetes "diagnosis in this pregnancy."

Maine Center for Disease Control and Prevention

In 2022-2023, over 13% of **Penobscot County** birthing people experienced **gestational hypertension,*** significantly higher than the state rate of 11.3%.



Maine 2022-2023 rate: **11.3%**



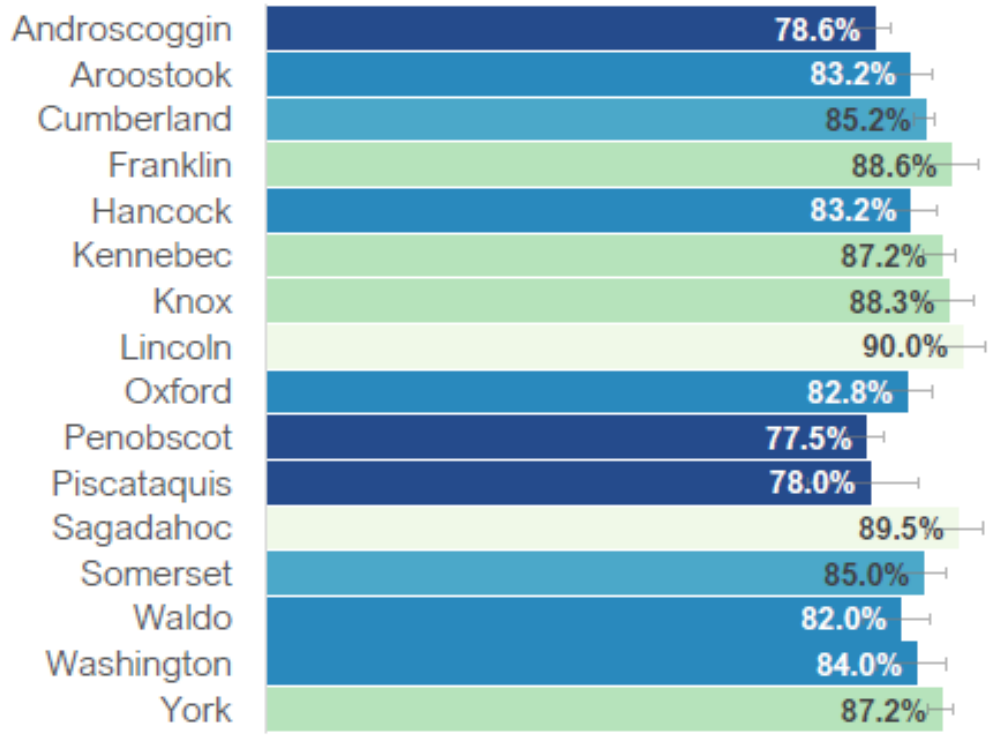
Source: MECDC DRVS, Birth certificates, 2022-2023

*Defined by US CDC NCHS, *Guide to Completing the Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death*, as hypertension "diagnosis in this pregnancy (Pregnancy-Induced hypertension or preeclampsia). "

Maine Center for Disease Control and Prevention

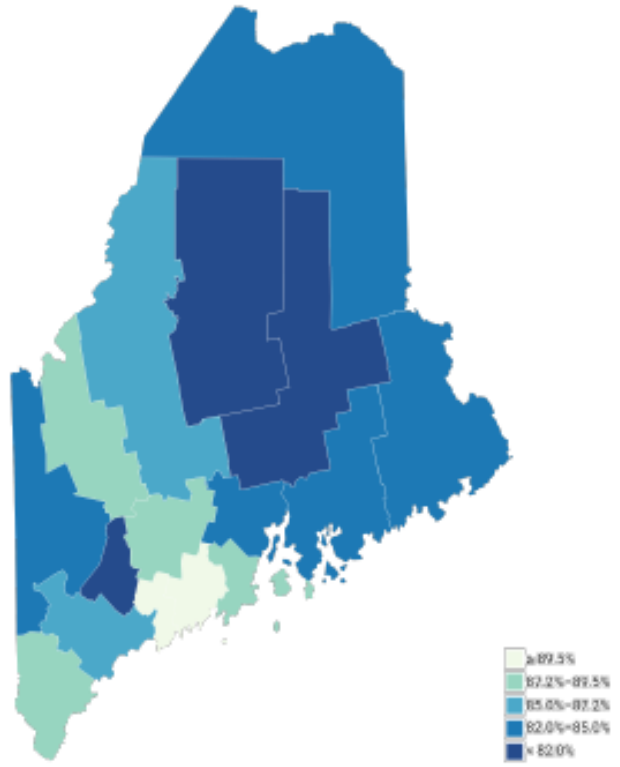
In 2023, **1 in 5** birthing people in Androscoggin, Penobscot and Piscataquis **did not receive adequate prenatal care.**

Androscoggin and Penobscot's adequate PNC rate was significantly lower than the state.



Source: MECDC DRVS, Birth certificates, 2022-2023

Maine 2023 APNCU rate: **84.1%**



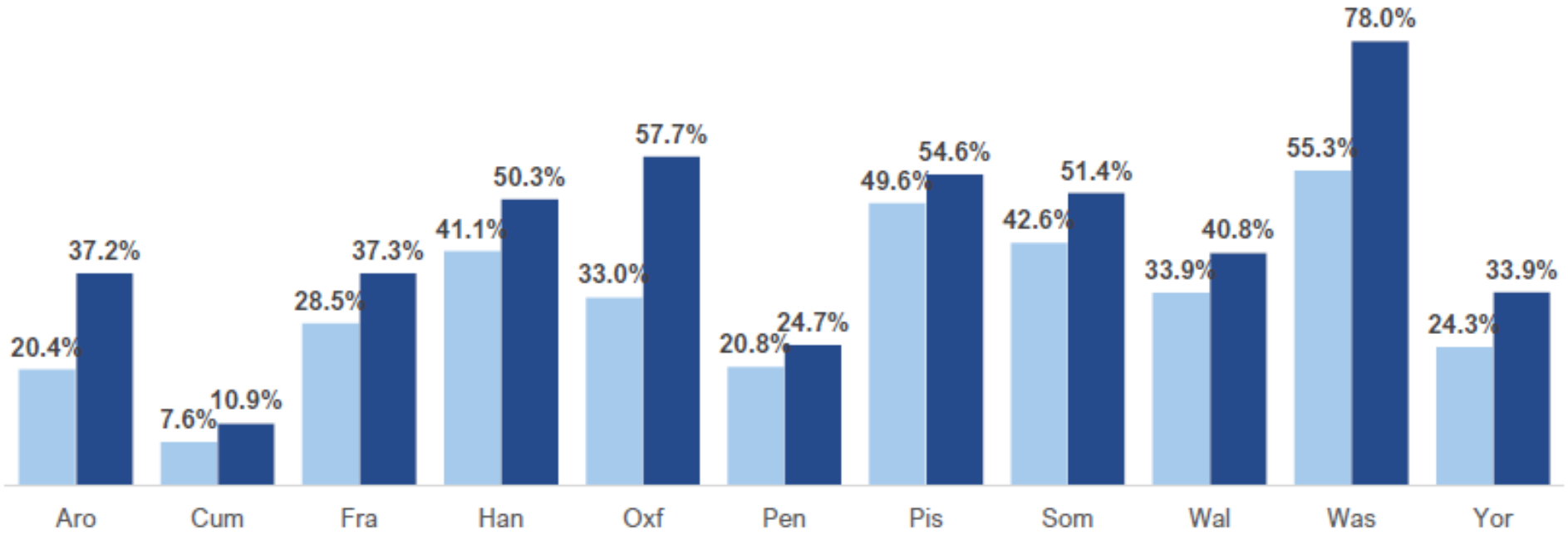
Maine Center for Disease Control and Prevention

In all Maine counties, a greater percentage of births occurred at hospitals **25+ miles away** in 2023 vs. 2014.

The highest percent was among **Washington County** births.

Percent (%) of births occurring at facilities 25+ miles from parent's residential zip code

2014 vs. **2023**



Data Source: Birth Certificates, MECDC DRVS

Maine Center for Disease Control and Prevention

A Walk in Her Shoes: "Penny"
An Illustrative Pregnancy-Related Mortality Journey Map

This journey map is inspired by events in the lives of those with a pregnancy-associated death in Maine. The journey below draws on events from MFIMR case reviews and and was developed in consultation with clinicians and community members to provide a representative and clinically accurate scenario. Details have been changed to protect privacy. In sharing this "journey," we honor the lives of those who have died by giving voice to complex factors that impacted their pregnancy and postpartum experiences.

Penny was a 31-year-old single mother to a three-year-old daughter who lived alone at the time of this unintended pregnancy. Penny's mother lived nearby and cared for her granddaughter when available. Penny's waitressing job did not provide insurance, so she applied for MaineCare during pregnancy. She struggled with PTSD, anxiety, and depression since her prior traumatic birth, which she managed with medication.

1. Prior Birth Trauma
Penny had PTSD following the difficult birth of her first child **three years prior,** which was complicated by pre-eclampsia (preE).

2. Stopped Antidepressants
At 6 weeks, Penny tested positive on a home pregnancy test. She stopped taking antidepressants for fear of them harming her baby.

3. Restarted Antidepressants
At 10 weeks Penny had her first prenatal appointment. Her screening results indicated high anxiety, PTSD, and moderate depression. She also reported a history of intimate partner violence. Penny's physician counseled her on the importance of continuing medication and prescribed new antidepressants known to be safe during pregnancy.

Penny's doctor also suggested she begin mental health counseling due to her prior birth trauma.

4. Challenges Seeking Counseling
Penny called nine providers before finding a therapist that would accept MaineCare. They could not see her for four months.

5. Managing PreE Risk
At a 12-week prenatal checkup, Penny was counseled by her doctor regarding her previous history of preE and discussed what gestational hypertension symptoms to call about. She was prescribed a baby aspirin to decrease risk of preE recurrence.

6. Positive Therapy Experience
Penny was finally able to see a mental health counselor **at 28 weeks.** Her therapist listened to her worries and helped her manage her anxiety about her upcoming birth.

7. Gestational Hypertension Diagnosis
At her 32-week OB visit, Penny had mildly elevated blood pressure (BP) readings and normal labs. She was diagnosed with gestational hypertension. Penny was counseled that she would need to be seen twice weekly until delivery.

Penny was scared that she would have another traumatic birth.

Gestational hypertension is defined as systolic blood pressure (BP) of 140 or higher and/or diastolic BP of 90 or higher at or beyond 20 weeks' gestation among pregnant individuals with a previously normal BP. According to data from Maine birth certificates, 10.6% of resident births in 2022 occurred to a birthing person with gestational hypertension. Gestational hypertension can advance to Pre-eclampsia (preE).

A Walk in Her Shoes
An Illustrative Pregnancy-Related Mortality Journey Map, *continued*

8. PreE with Severe Features Diagnosis
While at her **34 week appointment,** Penny was sent to the hospital for persistent severe range blood pressures. She was diagnosed with preE with severe features, and transferred to a hospital with a higher level of care 100 miles from home.

9. Premature Delivery
Penny delivered a preterm baby, who was admitted to the NICU.

On discharge, Penny screened high for postpartum depression and received a new prescription for antidepressants.

10. Temporary Housing
After her discharge, Penny wanted to stay close to her newborn while he was in the NICU. A social worker identified temporary housing for her.

11. Lack of Support Systems
Penny's mom was able to watch her 3-year-old **while she was in temporary housing.** Penny felt sadness and guilt being away from her daughter, stress about the loss of income, and loneliness from being away from her support systems at home.

12. CradleMe Referral
Penny was referred to CradleME to access Maine's free home visiting programs. They called Penny to follow up but were unable to connect. They also sent a letter to her home, which she didn't receive.

13. Missed Opportunities for Care
While juggling care for her newborn in the NICU, Penny missed her hypertension follow-up appointment **4 days after the delivery,** and a previously scheduled appointment with her mental health counselor.

She was also unable to get to a new pharmacy to pick up her updated antidepressant prescription.

14. Post Birth Warning Signs
While her baby was in the NICU, Penny struggled with persistent headaches and anxiety. She assumed her headaches were because she was tired and stressed. Because of her focus on her baby's health and lack of local support systems, Penny didn't seek treatment for herself.

15. Postpartum PreE Event
At 4 weeks postpartum, while still living in temporary housing, Penny called her mom to complain about a painful headache. Penny became non-coherent over the phone. Her mom called 911.

16. Death
When EMTs arrived, they found Penny dead. Official cause of death was cerebral hemorrhage as a consequence of severe postpartum preE.

Pre-eclampsia (PreE) is a life-threatening condition that develops in pregnant and postpartum people. Pregnant people who experience PreE have elevated BPs and many have protein in their urine. Other symptoms include headaches, swelling of the extremities, and/or blurred vision. PreE can lead to organ damage, seizures, and stroke, as well as preterm birth and placental abruption.

Maine Center for Disease Control and Prevention

PRENATAL

Jaya meets with a **midwife** who learns about her **health, wellbeing and social needs**.

Jaya is then connected with a care team that includes: :

- **Doctor** who collaborates with the **midwife** to manage her type 2 diabetes and support her pregnancy.
- **Doula** who provides information and encouragement throughout pregnancy and helps her prepare for birth.
- **Social Worker** who helps Jaya move to a secure home and enroll in a healthy food program.

Jaya works with her care team to create a birth plan that feels right for her.

Jaya feels safe and supported, and controls her diabetes with a healthy diet throughout her pregnancy.

BIRTH

Jaya and her care team discuss where she will give birth and Jaya decides on a hospital. They work together to follow through on Jaya's birth plan.

Jaya's **midwife and doula** are with her at every step in the birth process. After birth, her doula helps Jaya to feel comfortable caring for her new baby.

Jaya's **social worker** visits her at the hospital to help with the childcare plan and make sure Jaya's housing is secure.

Jaya and her baby are scheduled for follow up medical appointments with her **midwife** before they leave the hospital. Jaya's **doula** has already helped her prepare her home for the baby's arrival.

Jaya feels supported by her care team and prepared to go home. She and her baby are doing well because of the person-centered, team-based care she has received.

POSTPARTUM

Jaya has 12 months of Medicaid coverage including access to her doctor, midwife, and doula. Jaya and her baby receive regular postpartum care and monitoring of her diabetes via telehealth and office visits throughout the year.

Jaya's **doula** visits her and the baby several times at their home. The doula answers questions, checks on their wellbeing, and helps Jaya know the signs of postpartum depression.

Jaya's **social worker** connects her to virtual group parenting classes and ensures that she continues to have healthy food and a stable home.

One year later, Jaya and her baby are thriving, eating well, and live at home. Jaya successfully cares for her baby and herself, thanks to the ongoing support she received from her care team.

Potential Planning Support

(Request For Application)

- Data
- Technical assistance
- Costs for meeting spaces and materials
- Staffing/Administrative support for regional lead
- Stipends to support regional meeting attendance

Next steps

1) Identify a regional lead organization/person

- To support regions with coordinating communication, managing funding, and conducting admin activities

2) Local stakeholder convening

- Continue to build regional inventories of maternal providers and resources

3) Begin thinking about Request for Application (RFA)

- Start drafting ideas for regional focus, priority populations, and early planning needs
- Identify what supports (i.e., data or Technical Assistance) is needed from Kelley

Discussion

Public Informational Webinar

MaineCare invites you to an informational session on Maine's Transforming Maternal Health (TMaH) initiative. This session will provide updates on the progress of TMaH, highlight key activities from 2025, and share what lies ahead as we continue this important work to improve maternal health outcomes across the state.

Maine's Transforming Maternal Health (TMaH) Initiative Public Informational Webinar
Date: Thursday, September 25th
Time: 12:00 – 1:00pm
Registration: https://mainestate.zoom.us/meeting/register/jP22JM2YSAapckWZMmlUnQ

This will be an opportunity to learn more about TMaH, understand how you and your organization can be involved, and ask questions.

We hope you can join us. Thank you for your continued support and work to improve health outcomes for women and families in Maine.

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Thank you!