Addressing Barriers to Perinatal Care: a Case Study of the Access to Maternity Care Committee in Washington State

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Synopsis

Access to obstetrical services has deteriorated in recent years, as large numbers of physicians have discontinued or restricted obstetrical practice. In Washington State, one response to this access crisis has been the establishment of the Access to Maternity Care Committee (AMCC), an ad hoc group composed primarily of private sector obstetrical providers and representatives of State government responsible for the delivery of health care to women and children.

The major objective of the AMCC is to improve access to obstetrical services for socially vulnerable women, both rural inhabitants and the medically indigent. The committee has been successful in serving as a forum in which to resolve many of the administrative problems that have arisen between private sector obstetrical providers and the State's Medicaid Program, the major source of payment for the one-third of pregnant women who are medically indigent. Building upon the trust that the committee members developed in working together, the AMCC served as a major force in persuading the State legislature to expand substantially its investment in perinatal care by increasing Medicaid eligibility, raising provider reimbursement, and improving social services for pregnant women. Such ad hoc coalitions between the private and public sector may be quite effective in addressing obstetrical access problems in other States.

ONE OF THE MOST FORMIDABLE problems confronting many States is the loss of obstetrical services (*1*). It has always been difficult to ensure adequate perinatal care for low-income residents of inner cities, a problem exacerbated by poverty, drug use, and the absence of social support. In recent years, the problem has spread beyond the cities, particularly as many rural general and family physicians made the decision to selectively discontinue obstetrical care (*2–4*). As a result, a major crisis in the access to obstetrical care has developed in many parts of the United States (*4*).

One major cause of this crisis has been the increasing number and cost of obstetrically related medical malpractice suits (*5–7*). The direct result of the higher rate of suits has been increases in malpractice insurance premiums. As premiums have risen, many physicians have made the decision to stop practicing obstetrics. Even in those areas where physicians have continued to practice obstetrics, many have limited the amount of care they will provide to those considered high risk or to patients lacking insurance coverage. The result has been inadequate prenatal and intrapartum care for that portion of the population with the greatest need (*8*).

Washington State has experienced a deterioration in obstetrical service similar to that reported in other parts of the country. The problem began to manifest itself most noticeably in 1985, a year in which approximately 25 percent of all general and family physicians in the State gave up obstetrical practice (*9*). Because many rural towns had tenuous physician capacity even before this period, the loss of obstetrical providers was most apparent in rural communities.

This rapidly emerging access crisis quickly gained wide notice among public health officials, medical providers, and political representatives. A number of efforts were begun in an attempt to address the obstetrical care crisis. One of the most successful was the establishment of a coalition consisting of private practitioners, public health officials, and representatives of the University of Washington. This paper briefly describes the process through which this coalition was established, the methods it used to define the problem,

Organizations Represented on Washington State Access to Maternity Care Committee

Professional organizations

American College of Obstetricians and Gynecologists—Washington Chapter
Washington State Obstetrical Association (composed of physicians practicing obstetrics in Washington State)
Washington State Medical Association
Washington Academy of Family Physicians
Washington State Hospital Association
American College of Nurse Midwives Region VI, Chapter 3

State government

Washington State Medicaid Program
Bureau of Parent-Child Health Services
Legislative Staff—Washington State Legislature
University of Washington School of Medicine

the legislative efforts catalyzed by this group, and the nature of the resulting legislation that was passed in the 1989 session of the State legislature.

Formation of the Committee

The impetus for the establishment of the committee came from private obstetrical practitioners working in Level II and Level III hospitals in eastern Washington. These hospitals serve as perinatal referral centers for many of the surrounding rural communities. The physicians working in these referral settings noted an abrupt increase in the number of patients with little or no previous prenatal care. These patients often first came to the attention of the medical community when they presented to emergency rooms in labor. When this situation was discussed at meetings of the Washington Chapter of the American College of Obstetricians and Gynecologists (ACOG) and the Washington State Obstetrical Association (WSOA), it was readily apparent that this problem was statewide in scope.

This sudden influx of patients without adequate prenatal care was first recognized in 1985 and 1986. These years were marked by rapid increases in obstetrical malpractice premiums, and the related decision of large numbers of obstetrical practitioners—primarily general and family physicians, but including some obstetricians—to discontinue practicing obstetrics (*10*). When it became apparent that the access problems were accelerating, a proposal was made to the executive committees of the ACOG and the WSOA to form the Access to Maternity Care Committee (AMCC). It was proposed that the AMCC be a multidisciplinary group, whose primary mission was to further define the problem of access to maternity care in Washington State and attempt to find and implement solutions to the problem.

The formal proposal was favorably received by the two associations, and the AMCC was formally established in January of 1988. The budget for the operation of the committee came from the two sponsoring organizations. The administrator of the Inland Empire Perinatal Center in Spokane, WA—the tertiary care center that serves as the hub of one of the four regionalized perinatal care networks in Washington State—was appointed as chair of the committee. The head of the Washington Chapter of the American College of Obstetricans and Gynecologists served as co-chair.

Composition and Goals of the AMCC

The members of the committee were drawn from two basic constituencies—the relevant State professional associations and representatives of State government with responsibility for services to women and children. Although committee membership fluctuated somewhat over time, the major organizations represented are shown in the box.

The committee had one major goal: to improve access to maternity care for pregnant women in Washington State, in particular rural women and medically indigent women. As part of the process of achieving that goal, the committee went through the following distinct steps:

- Step 1: data collection and problem definition,
- Step 2: exploration of alternative solutions,
- Step 3: creating a broad-based coalition for maternity care that bridged the public and private sector,
- Step 4: formulating a legislative agenda—the First Steps Program,
- Step 5: implementation of enhanced maternity care access legislation.

Project Steps: Accomplishing the Goals

Step 1. Data collection and problem definition. The maternity care access crisis was first apparent to the members of communities that were losing their obstetrical services. Although urban areas in Washington State have had a long-standing and chronic problem providing obstetric care to the medically indigent, systems had evolved to cope—albeit inadequately—with the problem. The current maternity access crisis had a much more sudden and dramatic impact on small rural communities because of the all-or-none nature of most rural obstetrics; one day obstetrical care is available to most of the population, and the next day it is unavailable to everybody. In over a dozen rural communities spread

around the State, obstetrical services became virtually unavailable during the period from 1985 to 1987, with the consequence that most residents of these communities were forced to seek obstetrical care in other communities.

With the loss of local obstetrical capacity, private physicians in secondary and tertiary level hospitals adjacent to these rural areas noticed an increased number of patients presenting with little or no obstetrical care. At the same time, the State's Medicaid Program managers were informed by their clients that they were unable to find physicians willing to provide care. Although most rural family physicians accept Medicaid patients, most urban obstetricians—the major source of care once rural generalists left obstetrical practice—do not (*10*).

The committee's first task was to define the extent and the consequences of the shortage of care. Data were provided by the Medicaid Program, which had been tracking the problem; by the State's Prenatal Care Program, which had received a small State appropriation to provide prenatal care in places of need; and by researchers at the University of Washington. An important source of information were periodic surveys of all obstetrical providers in the State conducted at the School of Medicine, with the fiscal support of the State's physician-owned medical malpractice insurer (*9, 10*).

The data demonstrated that the problem was widespread and acute. In many rural counties, more than 25 percent of all women were receiving inadequate prenatal care, and an increasing number of women were receiving no prenatal care whatsoever. In those rural communites without obstetrical services, perinatal outcomes were substantially worse than in comparable rural communties that had retained obstetrical services, and the cost of caring for the damaged infants was much higher (*11*). Overall, previous State improvements in low birth weight and infant mortality had stalled, and in some cases regressed (*12*). The State Medicaid Program reported that the number of providers willing to accept Medicaid patients was declining, while the number of women requiring Medicaid assistance was increasing.

After receiving testimony from a variety of sources, the committee concluded that there were five major causes of the crisis in access to maternity care in Washington State:

- a declining number of physicians practicing obstetrics, largely because of the cost of obstetrical malpractice insurance,
- a declining number of physicians accepting Medicaid patients, because of the perceived high-risk characteristics of these patients, and the low level of reimbursement,
- administrative barriers inherent in the Medicaid Program, which make it difficult for pregnant women to apply for and establish Medicaid eligibility in a timely fashion,
- physicians' difficulty in understanding and complying with the administrative and reimbursement procedures required by the Medicaid Program, and
- an increase in the severity and complexity of social problems confronted by pregnant women.

Step 2. Exploration of alternative solutions. The next challenge was to formulate a strategy to address these fundamental problems. Although there was widespread agreement that the malpractice-related issues were a key cause of the current problem, there was considerable doubt that tort reform was a politically achieveable objective. The State legislature had passed a major tort reform package in 1986, and further legal changes would have been difficult to achieve.

Despite these misgivings, the committee did hold several meetings to discuss the possibility of tort reform. The meetings included the insurance commissioner and his representatives; members of the Washington Trial Lawyers' Association, representing the plaintiff attorneys' bar; members of key legislative staff; and representatives of both the medical association and the physician-sponsored insurance company. A considerable amount of time was spent examining the tort reform solutions adopted by other States, examining the feasibility of implementing alternative dispute resolution mechanisms to lessen the impact of malpractice allegations on physicians, and actually crafting several potential legislative modifications of existing tort law. Ultimately, however, the AMCC made a decision not to pursue further tort reform as an initial response to the access problem.

Once tort reform was set aside as a short-term remedy, the committee focused its efforts on two primary activities:

- improved coordination and communication with the State Medicaid Program, and
- writing and obtaining passage of a bill to enhance perinatal services provided by the State government.

Step 3. Building coalitions: bridging the public and private sectors. One of the major achievements of the AMCC was to reduce the barriers between the private physicians and the State's public sector. Traditionally, there has been a quasi-adversarial relationship between the Medicaid Program and the private practice community. Private practitioners complain that Medicaid

reimbursement rates are inadequate, that the paperwork is burdensome and confusing, that Medicaid decisions are arbitrary and capricious, and that payments are made slowly. Representatives of Medicaid often view the private physicians as excessively demanding, reluctant to care for the medically indigent, and prone to manipulate the existing Medicaid system. The result is poor communication and periodic conflict.

The existence of the committee provided a forum where these issues could be aired and discussed. As these issues were explored, it became apparent to most participants that, in many cases, the problems in the relationship had been exaggerated. The very process of working together towards a common goal through the committee improved relationships among the leaders of the professional societies and the State agencies. The prevailing adversarial relationship was muted.

From a practical standpoint, the AMCC provided a vehicle for Medicaid to establish effective ad hoc groups to improve operating procedures. One committee was created to develop a new way to reimburse physicians for caring for high-risk patients. Another group worked with physicians' office staff to improve billing and payment mechanisms. Over time, trust replaced suspicion as the dominant sentiment binding the two groups and laid the framework for the legislative component of the committee's activities. The working groups created by the AMCC continue to meet.

Step 4. Formulating a legislative agenda: the First Steps Program. Once the decision had been made not to seek further tort reform, it became evident that a significant enhancement of public funding for perinatal services would be needed in order to have an impact on access to perinatal services. Working with State government at many levels—including Medicaid, the Bureau of Parent-Child Health Services, interested legislative staff, and the governor's office—a comprehensive perinatal package was crafted. Named "First Steps," the proposed legislation had three major components:

- increased Medicaid eligibility to 185 percent of the poverty level, thus taking advantage of liberalized Federal program entitlements,
- higher reimbursement to physicians providing obstetrical services to Medicaid patients,
- more funds for social services for at-risk pregnant women, including the establishment of a case management program as well as support services, which includes public health nursing, social service, and nutritional assessments.

As with all legislation, the proposals had a tumultuous course as they progressed through the bicameral Washington legislature. Although there was general support for enhanced perinatal funding, there was considerable disagreement about both the size and the specifics of the proposed project. Additional bills were introduced in both houses of the legislature, and at one time four separate perinatal bills were circulating. To add to the confusion, the whole package became entangled with the abortion issue, which derailed consideration of the various bills for some time.

The underlying strategy adopted by the AMCC was to become part of a very broad-based coalition supporting the First Steps Program. Individual members of the committee—representing the organizations to which they belonged or for which they worked—testified at every possible opportunity before relevant legislative committees. Key senators and representatives were approached individually, and the committee served as a resource that was continuously on-call to the legislature. The Washington State Medical Association provided invaluable assistance by elevating the First Steps Program to the top of its legislative agenda, making available its very adept legislative staff to assist in tracking the progress of the bill and to coordinate testimony and lobbying efforts.

Ultimately the legislation was adopted in its entirety, with only cosmetic differences between the final bill and the proposal that had been endorsed by the AMCC almost a year earlier. The total perinatal enhancement added almost $50 million per year to the amount available for perinatal services in the State. Currently, the new legislation is being implemented.

Step 5. Future activities: implementing First Steps and beyond. The major task of the committee at present is to assist in the implementation of the new legislation. Although the First Steps Program is a major tool in improving access to care, there are some important limitations, especially for rural areas. The major continuing source of diminished access in rural Washington is a lack of capacity—an inadequate number of obstetrically active practitioners and a cadre of faltering rural hospitals. Although improved reimbursement for obstetrical patients may induce some additional physicians to practice obstetrics, changes in financing alone will not modify the fundamental problems inherent in providing rural perinatal care. In particular, the AMCC recognizes that the underlying problem of professional liability has not been addressed.

The committee is currently trying to determine its future course. Clearly, the perinatal access barriers have not been totally eliminated by the new legislation. On the other hand, most members of the committee feel that it is important to concentrate on implementation of the First Steps Program before embarking on a major

new effort. The future direction of the group also depends on the continued support of the organizations that have been providing the financial assistance needed to mount the program. The future of the committee will depend upon consultation with these organizations and discussions among the participants.

Lessons from the AMCC

Certain lessons emerge from our experience with the AMCC. These lessons might well be generalizeable to other States or regions trying to improve perinatal services.

The role of the private sector. The private practice sector has a major role to play in improving health services. In our pluralistic and rather disorderly health care system, most perinatal services are provided by private physicians. This is true even for the medically indigent patients whose major form of insurance is the Medicaid Program. Any solution that ignores or alienates the private sector will probably not work.

This observation is particularly germane to rural areas. Although urban areas have their own set of problems, they are usually blessed with a large array of providers and health care institutions. Most rural communities, by contrast, depend on a relatively small handful of physicians and a single hospital. When private rural physicians opt out of obstetrics—for whatever reason—local access to obstetrical care deteriorates. Only by understanding the problems and perspectives of these rural physicians can any solution work.

The experience of the AMCC demonstrates that a responsible private sector can play a leadership role in stimulating public reforms. Although private physicians will benefit financially as a result of enhanced reimbursement, the major motivation for their participation in the AMCC was social, not economic. It is very distressing for a physician to see large numbers of women without adequate prenatal care, especially if the physician is called upon to try to salvage a healthy baby and healthy mother from the wreck of a neglected pregnancy. It is possible to mobilize these physicians into an effective coalition to work for change.

Public-private coalitions. The relationship between the private sector and the public sector need not be adversarial. The objectives of the two parties are ultimately similar, and it is often a lack of communication rather than contrasting values that generates friction. Most of the administrative problems that aggravated and frustrated physicians dealing with the Medicaid Program proved to have relatively simple solutions. The key is to give physicians a role in articulating concerns, suggesting policy, and monitoring administrative performance. Physicians—on their part—need to be patient with the inevitable constraints of any complex public program, to say nothing of the intricacies of the massive Federal-State partnership that constitutes the Medicaid Program.

Importance and difficulty of involving rural providers. Much of the impetus for the formation of the AMCC was the deteriorating access to obstetrical care in rural areas of the State. Ironically, urban physicians were the first to mobilize an effective coalition to address these problems, even though it was their rural colleagues whose professional lives were most disrupted by changes in the context in which obstetrics is being practiced. A fundamental and continuing problem is that rural providers, by definition, live far from the urban centers where policy is made and implemented. When they do become involved in efforts to modify policy, their heavy workload and the burden of geographic isolation make it difficult for them to participate fully in committee work and lobbying efforts.

The AMCC made a deliberate attempt to involve rural practitioners, and it was successful in getting excellent participation in most of the activities of the larger group. Rural family physicians were particularly effective in the legislative setting, and their vignettes about the problems their patients experienced in getting basic obstetrical care were compelling. It is important to involve the relevant professional associations in selecting effective representation for efforts such as these. It is also vital that these participants be recognized for their participation and that the cost of participation be defrayed to the greatest extent possible.

Importance of good data. One of the key elements of the successful legislative effort was the presence of accurate and convincing data about the scope of the problem. In this area, the university was able to make a unique contribution by tapping existing data sources and providing information in a timely fashion to policy makers. The propitious use of data is also valuable in that it reinforces those health care providers who provide the data by demonstrating that the information can be used to improve their lot and the situation of their patients.

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Changes in Characteristics of Women Who Smoke During Pregnancy: Missouri, 1978–88

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Synopsis

The Missouri birth certificate has had a question, "cigarettes smoked per day?" since 1978; the current data base contains more than 800,000 records. A comparison of the Missouri data for married mothers with the National Natality Survey (NNS) data shows mainly consistent findings between the two data sets. The Missouri data, however, also provided information on the smoking status during pregnancy of unmarried women that is not available from the NNS.

The Missouri data show a substantial difference in the smoking rates of married (23.2 percent) and unmarried (40.9 percent) women. The highest smoking rates during pregnancy are found among unmarried women, ages 20–24, with less than a high-school education, and those with a fourth or higher order child.

There has been a relatively small overall drop in the smoking rate from 1978–80 to 1986–88 (31.1 percent versus 27.5 percent). However, blacks and teenagers have had very substantial drops in smoking rates. There has been only a slight decrease for other high-risk groups such as white unmarried women, women with less than a high-school education, and those having a fourth or higher order birth.

Missouri started using the new national standard birth certificate in 1989 with a differently worded smoking question. The percentage of women smoking and those smoking less than one pack per day in 1989 went down more than would be expected from the trend data. It appears that the new birth certificate question will provide a lower estimate of the percentage of mothers who smoke cigarettes than was acquired from the previous version on the Missouri certificate. The births in Missouri for which mothers' rate of smoking was unknown increased nearly fourfold to 0.9 percent.

THE NEGATIVE relationship between prenatal cigarette smoking and birth weight was documented over 30 years ago by W. J. Simpson (*1*). Other hazards of cigarette smoking during pregnancy have since been documented including spontaneous abortion, growth retardation, perinatal mortality, and certain complications of pregnancy (*2–9*). Because of these risks, different agencies of the Public Health Service have initiated efforts to encourage pregnant women to stop smoking (*10*).

Several studies have reported on the characteristics of women in the United States who smoke during pregnancy (*2, 3, 7, 9, 11–13*). However, most studies are limited to a single year, a small population, or a popu-