HealthTech

Meeting the new CMS obstetric standards – Tips for compliance

Carolyn St.Charles
Chief Clinical Officer, HealthTech

Presenter

Carolyn St. Charles is the Chief Clinical Officer for HealthTech. Carolyn has extensive experience working with rural hospitals to develop and strengthen Swing Bed programs. St. Charles earned a master's degree in Business Administration from the Foster School of Business at the University of Washington and a bachelor's degree in Nursing from Northern Arizona University.

Carolyn St.Charles, MBA, BSN, RN
Chief Clinical Officer
Carolyn.stcharles@health-tech.us
360.584.9868

Jul – Dec 2026 webinars

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Meeting the new CMS obstetric standards – Tips for compliance

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: July 10, 2026 | **Time:** 12pm CST
URL: https://bit.ly/4vwkC5q

Beyond the visit: Chronic Care Management that works

Presenter: Marcella Wright, DNP, MS, RN - Director of Care Coordination and Lean Consulting
Panelists: Cobre Valley Regional Medical Center
Annette Gonzales, Population Health Coordinator/ Clinics Manager
Maricella Pena, RN, Chronic Care Management - Care Coordinator,
Micah Pura, RN
Mia A. Rivera, RN
Frank Stapleton, Chief Clinical Operations Officer

Date: July 24, 2026 | **Time:** 12pm CST
URL: https://bit.ly/4eCH2uI

Swing Bed: A care model redesign

Presenter: Cheri Benander, RN, MSN, CHC, C-NHCE, HACP-CMS – Director of Clinical Services

Panelist: Tommi Cline, DNP, RN, CHC, NE-BC Chief Nursing & Compliance Officer

Date: August 7, 2026 | **Time:** 12pm CST
URL: https://bit.ly/4g5A8ka

Zero Balance Accounts (ZBA)

Presenter: Margaret Bistrovich - VP Revenue Cycle Client Services and Greg Oelerich - VP of Business Development
Date: August 28, 2026 | **Time:** 12pm CST
URL: https://bit.ly/4f0vl2e

Strengthening cybersecurity in healthcare

Presenter: Derek Morkel, CEO – HealthTech
Panelist: Jeremy Masterjohn, IT Director and HIPAA Security Officer, Spooner Health
Date: September 11, 2026 | **Time:** 12pm CST
URL: https://bit.ly/4xSXlMU

Jul – Dec 2026 webinars

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Rural Health Clinic survey readiness simplified: Part 1 – Navigating CMS Appendix G and operational standards

Presenter: Cheri Benander, RN, MSN, CHC, C-NHCE, HACP-CMS – Director of Clinical Services
Date: September 25, 2026 | **Time:** 12pm CST
URL: https://bit.ly/4aisX4h

Rural Health Clinic survey readiness simplified: Part 2 – Meeting CMS requirements and driving performance improvement

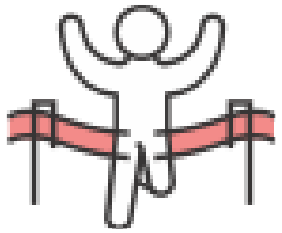
Presenter: Cheri Benander, RN, MSN, CHC, C-NHCE, HACP-CMS – Director of Clinical Services
Date: October 23, 2026 | **Time:** 12pm CST
URL: https://bit.ly/4w9OYuG

Leadership skills for all leaders

Presenter: Greg Oelerich - VP of Business Development
Date: November 6, 2026 | **Time:** 12pm CST
URL: https://bit.ly/4vxMDd3

Frequent survey findings for Critical Access Hospitals – and – strategies for compliance

Presenter: Cheri Benander, RN, MSN, CHC, C-NHCE, HACP-CMS – Director of Clinical Services
Date: December 4, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3QLXCQK



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Carolyn St.Charles, RN, BSN, MBA
Chief Clinical Officer
Carolyn.stcharles@helth-tech.us

Cheri Benander, RN, MSN, CHC, C-NHCE
Director of Clinical Services
Cheri.benander@health-tech.us

Marcella Wright, DNP, MS, RN
Director Care Coordination & Lean Consulting
Marcella.wright@health-tech.us

Leadership Development

$499 - 20 Contact Hours
Leadership Development is a comprehensive course designed to address the critical need for cultivating leadership skills among middle managers who find themselves in leadership roles without formal training and staff members who aspire to grow into management and leadership roles.

Lean Practitioner

$499, 16 Contact Hours
A Lean culture empowers individuals closest to the work to drive meaningful improvements. This Lean course equips frontline staff with the essential tools, resources, and knowledge to master and apply Lean principles effectively.

At its core, Lean focuses on enhancing process efficiency through fundamental concepts and tools. The four key principles for designing, assessing, and refining processes include defining the ideal state, identifying waste (muda), applying the four rules, and harnessing the power of observation. Critical tools such as value stream mapping and A3 problem-solving drive this methodology. While some may view Lean as a fleeting trend, its evidence-based history proves it to be a reliable, results-oriented approach with a proven track record of success. Lean isn't just a set of processes—it's a transformative mindset and methodology that fosters a safe, efficient, and high-quality environment for both patients and healthcare workers.

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Care Coordination

HealthTech acknowledges the crucial role Care Coordination plays in driving success and sustainability within primary care. To empower the growth and sustainability of your programs, we provide arange of self-paced, asynchronous courses designed to enhance and expand services under CMS Care Coordination:

- **Care Coordination Fundamentals** – $299, offering 12 contact hours
- **Behavioral Health Integration** – $219, offering 9 contact hours
- **Transitional Care Management** – $159, offering 8 contact hours
- **Annual Wellness Visits** – $199, offering 7.5 contact hours
- **Advance Care Planning** – $149, offering 6 contact hours

These courses are tailored to support the continued development of your care coordination services, ensuring your team stays at the forefront of primary care excellence. Each course is crafted to equip members of the professional primary care team—including nurses, health educators, health coaches, and other qualified health-care providers—with the essential knowledge, skills, and expertise to conduct comprehensive consultative visits and create personalized preventive care plans. Focusing on a team-based care model, the platform prioritizes coordinated care, harnessing the collective expertise
of diverse team members. This approach enhances care coordination for patients with chronic and behavioral health conditions while reinforcing the integration of health promotion and prevention into everyday practice.

Swing Bed Courses for Critical Access Hospitals

The Swing Bed concept allows a hospital to use its beds interchangeably for either acute care or post-acute care. The reimbursement "swings" from billing for acute care services to billing for post-acute skilled nursing services, even though the patient usually stays in the same bed . Swing Bed allows patients to receive care close to home. The two courses Basics and Beyond Basics provide the fundamentals to care for Swing Bed patients and meet regulatory requirements.

Swing Bed Basics for Critical Access Hospitals
$299 - 9 Contact Hours
The Swing Bed Basics course focuses on the elements of a successful Swing Bed program including understanding and implementing CMS regulatory requirements found in the State Operations Manual Appendix W, State Operations Manual Appendix PP, and the Medicare Benefit Policy Manuals.

Swing Bed Beyond Basics for Critical Access Hospitals
$299 – 9 Contact Hours
The Swing Bed Advanced Course is focused on strategies to grow and strengthen the Swing Bed program including understanding the requirements in Appendix PP that apply to Swing Bed strategies for increasing volume. The course is divided into six modules, with one bonus module discussing the MDS which is required for Swing Beds in a PPS hospital. Each module may take up to two-weeks, but the course is self-paced.

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Description

CMS published new standards for safe obstetric care that were effective July 1, 2025 for emergency departments, and January 1, 2026 and January 1, 2027 for obstetric services.

The presentation will briefly describe the obstetric standards for emergency departments, but will focus on compliance with the standards applicable to an obstetric services. The presentation will cover:

- Organization and Supervision effective 1/1/2026
- Delivery of Care effective 1/1/2026
- Staff Training effective 1/1/2027
- Quality Assurance Performance Improvement effective 1/1/2027

The QAPI standards effective 1/1/2027 include collecting, tracking and analyzing data to improve identified disparities in diverse populations. It also requires at least one measurable performance improvement project focused on improving disparities and outcomes of obstetrical patients. The presentation will provide practical solutions for meeting this standard, including collecting data on social determinants of health and identifying an improvement project that can improve outcomes of your population.

Learning Objectives

Upon completion of the webinar, the participant will be able to:

1) Identify each element of the new Safe Obstetrical Care standards and the dates they must be implemented

2) Outline strategies for collecting data about health disparities

3) Describe how to choose a measurable improvement project

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Obstetric Standards Purpose and Scope

CMS Announces New Policies to Reduce Maternal Mortality, Increase Access to Care, and Advance Health Equity

The Centers for Medicare & Medicaid Services (CMS) announced today new baseline health and safety requirements for hospitals and Critical Access Hospitals (CAHs) providing obstetrical (OB) services to make pregnancy, childbirth, and postpartum care safer.

CMS is also removing barriers to expand access to care for those formerly incarcerated and others in underserved communities.

CMS has finalized new health and safety requirements for hospitals and CAHs providing obstetrical services, which set baseline standards for the organization, staffing, and delivery of care within obstetrical units, update the quality assessment and performance improvement (QAPI) program, and require staff training on evidence-based maternal health practices.

CMS Announces New Policies to Reduce Maternal Mortality, Increase Access to Care, and Advance Health Equity

“These new requirements build on CMS’ maternity care action plan.

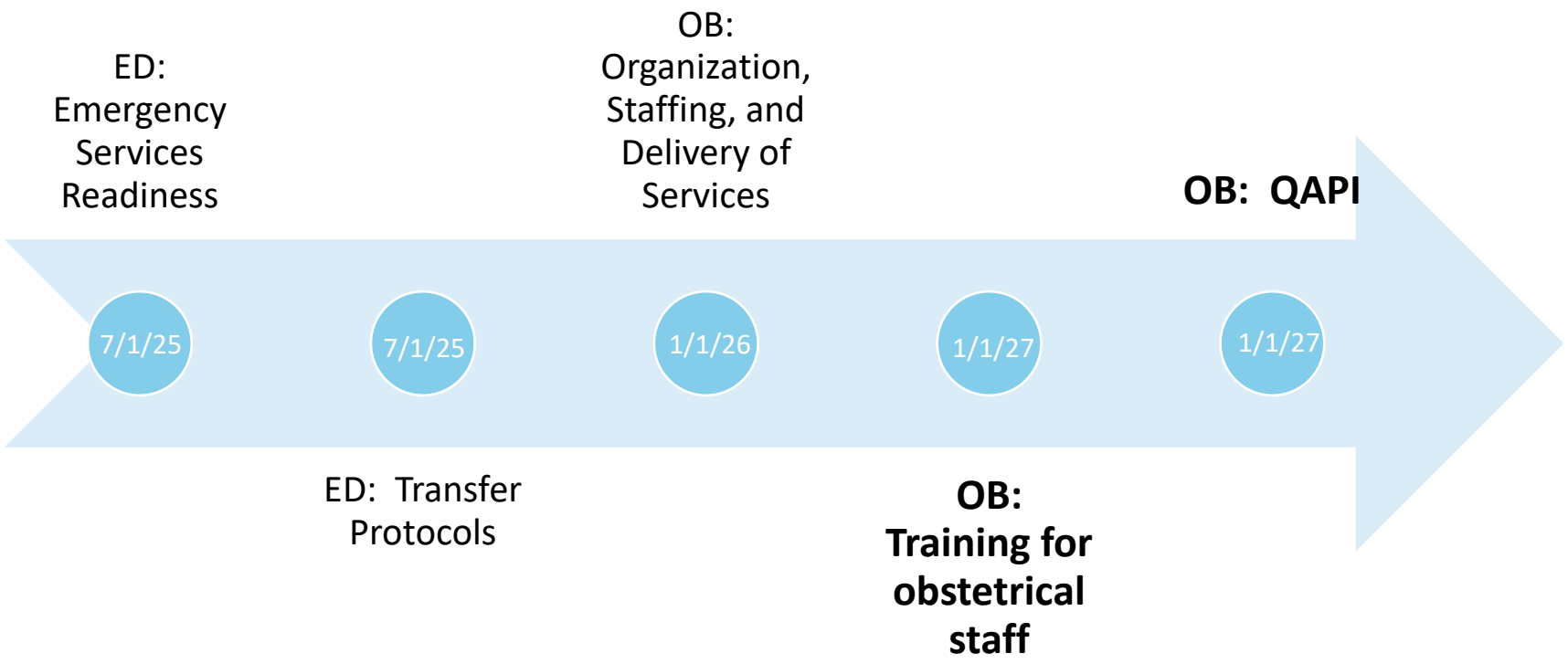
Additionally, CMS has established emergency services readiness and transfer protocol requirements for all patients, which will better prepare hospitals and CAHs to respond to obstetric emergencies.

Of note, CMS is finalizing a phased-in implementation for all of these new requirements in an effort to balance the need for improved maternal health outcomes while addressing potential burden concerns raised in public comments.”

Dr. Dora Hughes, Chief Medical Officer and Director for CMS’ Center for Clinical Standards and Quality.

https://www.cms.gov/newsroom/press-releases/cms-announces-new-policies-reduce-maternal-mortality-increase-access-care-and-advance-health-equity

Timeline


ED: Emergency Services Readiness
7/1/25
ED: Transfer Protocols
7/1/25
OB: Organization, Staffing, and Delivery of Services
1/1/26
OB: Training for obstetrical staff
1/1/27
OB: QAPI
1/1/27

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Emergency Department Effective July 1, 2025

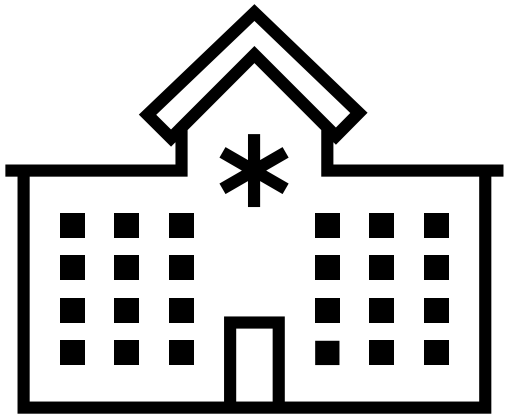
Obstetrical Emergencies – Key Elements

- ❑ Develop Protocols for obstetrical emergencies
- ❑ Availability of equipment, supplies and medications for obstetrical emergencies
- ❑ Availability of drugs, blood, biologicals for treating obstetrical emergencies
- ❑ Availability of equipment including, at a minimum, airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters

Obstetrical Emergencies – Key Elements

- ❑ Staff (includes contract staff, travelers, providers) trained annually on protocols and provisions implemented for emergency obstetrical care
- ❑ Governing board approved which staff must complete training
- ❑ Annual training
- ❑ Documentation of training
- ❑ Demonstrated staff knowledge on obstetrical emergencies (competency)
- ❑ **Utilize QAPI program to identify staff training needs and any additions, revision, or updates on an ongoing basis**

We’ll review briefly since these standards were effective a year ago (7/1/2025)



Meet Emergency Needs of Patients

Hospital §482.55(c)

Effective July 1, 2025, in accordance with the complexity and scope of services offered,

there must be adequate provisions and protocols to meet the emergency needs of patients.

Critical Access Hospital §485.618(e)

Effective July 1, 2025, in accordance with the complexity and scope of services offered,

there must be adequate provisions (as required under (b) and (c) of this section) and protocols to meet the emergency needs of patients.

Protocols

Hospital §482.55 (c)

(1) Protocol must be consistent with nationally recognized and evidence-based guidelines for the care of patients with emergency conditions, including but not limited to patients with obstetrical emergencies, complications, and immediate post-delivery care.

Critical Access Hospital §485.618 (e)

(1) Protocol must be consistent with nationally recognized and evidence-based guidelines for the care of patients with emergency conditions, including but not limited to patients with obstetrical emergencies, complications, and immediate post-delivery care.

Equipment, Supplies, Medication

Hospital §482.55(c)(2)

Provisions include equipment, supplies, and medication used in treating emergency cases.

Such provisions must be kept at the hospital and be readily available for treating emergency cases to meet the needs of patients.

Critical Access Hospital C-0884 §485.618(b) (not new)

Equipment, supplies, and medication used in treating emergency cases are kept at the CAH and are readily available for treating emergency cases. The items available must include the following:

Drugs, Blood and Blood Products, and Biologicals

Hospital §482.55(c)(2)(i)

Drugs, blood and blood products, and biologicals commonly used in life-saving procedures;

(not new)

C-0886 §485.618(b)(1) Drugs and biologicals commonly used in life-saving procedures, including analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions.

C-0890 §485.618(c) Standard: Blood and Blood Products The facility provides, either directly or under arrangements, the following: (1) Services for the procurement, safekeeping, and transfusion of blood, including the availability of blood products needed for emergencies on a 24-hour-a-day basis.

Interpretive Guidelines §485.618(c)(1) This requirement can be met at a CAH by providing blood or blood products on an emergency basis at the CAH, either directly or through arrangement, if that is what the patient's condition requires. **There is no requirement in the regulation for a CAH to store blood on site, although it may choose to do so.**

Equipment and Supplies

Hospital §482.55(c)(2)

Provisions include equipment, supplies, and medication used in treating emergency cases.

Such provisions must be kept at the hospital and be readily available for treating emergency cases to meet the needs of patients.

Critical Access Hospital C-0884 §485.618(b) (not new)

Equipment, supplies, and medication used in treating emergency cases are kept at the CAH and are readily available for treating emergency cases. The items available must include the following:

Equipment and Supplies for Life-Saving Procedures

Hospital §482.55(c)(2)(ii)

Equipment and supplies commonly used in life-saving procedures; and

C-0888 §485.618(b)(2) (not new)

Equipment and supplies commonly used in life-saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.

Call In System – Hospital Only

Hospital §482.55(c)

(2)(iii) Each emergency services treatment area must have a call-in system for each patient.

Staff Training

Hospital §482.55 (c)(3)

Applicable staff, **as identified by the hospital,** must be **trained annually** on the protocols and provisions implemented pursuant to this section.

Critical Access Hospital §485.618 (e)(2)

Applicable staff, **as identified by the CAH**, must be **trained annually** on the protocols and provisions implemented pursuant to this section.

And it's been a year since the regulation was effective

Staff Training

Hospital §482.55 (c)(3)(i)

The governing board must identify and document which staff must complete such training.

Critical Access Hospital §485.618 (e)(2)(i)

The governing board must identify and document which staff must complete such training.

Decision about **WHO** should be trained must be evidence-based.

Recommend

1) Nurses
2) Travelers or contract staff if they work in the ED
3) Respiratory therapists
4) Ultrasound technicians
5) Providers (if they have not had training in Obstetrical Emergencies)
6) **ALL NEW STAFF AT TIME OF HIRE**

Staff Training

Hospital §482.55 (c)(3)(ii)

The hospital must document in the staff personnel records that the training was successfully completed.

Critical Access Hospital §485.618 (e)(2)(ii)

The CAH must document in the staff personnel records that the training was successfully completed.

Staff Training and Competency

Hospital §482.55(c)(3)iii

The hospital must be able to demonstrate **staff knowledge** on the topics implemented pursuant to this section.

Critical Access Hospital §485.618 (e)(2)(iii)

The CAH must be able to demonstrate **staff knowledge** on the topics implemented pursuant to this section

Competency

Competency Means Verified!

Demonstration of competency is not documentation that staff attended a training, listened to a lecture, or watched a video. A staff's ability to use and integrate the knowledge and skills that were the subject of the training, lecture or video must be assessed and evaluated by staff already determined to be competent in these skill areas.

Methods for verifying competency:

- **Observation**
- **Demonstration**
- **Simulation**
- **Verbal (Use selectively!)**
- **Written Test**
- **Documentation Audit**

<u>Competencies must be based on role and responsibilities</u>

Staff Training

Hospital §482.55 (c)(3)(iv)

The hospital must use findings from its QAPI program, as required at 482.21**, to inform staff training needs and any additions, revisions, or updates to training topics on a going basis.**

Critical Access Hospital §485.618 (e)(2)(iv)

The CAH must use findings from its QAPI program, as required at 485.641, **to inform staff training needs and any additions, revisions, or updates to training topics on a going basis.**

QAPI - Metrics

Education and Competency

1. Education modules developed
2. Initial competency completed for all clinical staff and providers who work in the ED
3. Annual competency completed for all clinical staff and providers who work in the ED completed
4. Travelers do not work in the ED without competency, or – are not permitted to care for emergency OB patients
5. All staff and providers who work in the ED have current NRP certification
6. Annual education plan based on outcomes from QAPI program

Protocols

1. Protocols developed and approved by the medical staff
2. Protocols followed (chart audits)

Outcome Measures

1. No birth injury to the mother
2. No birth injury to the infant
3. FHR accurate (as determined by QC)
4. Staff and providers recognize fetal and maternal distress
5. Blood available within 10 minutes for emergency transfusion
6. Time from delivery to transfer (if no OB service)
7. Outcomes of external chart review

QAPI - Case Review

For patients who receive care in the ED for an obstetric emergency -

1) Review 100% of cases with a multi-disciplinary team as soon as possible after the event

2) Include the TEAM…. Not just providers

3) Review specific metrics… for example
   - Time from arrival to physician present
   - Time from arrival to RT present
   - Time from arrival to anesthesia present
   - All equipment available
   - All drugs available
   - Staff knowledgeable
   - Outcome

4) Education / Training immediately after the event

5) Consider an external review

Analyze Data for Improvement and to Develop Educational Programs

Have you implemented all of the ED standards?

- ❑ Develop Protocols for obstetrical emergencies
- ❑ Availability of equipment, supplies and medications for obstetrical emergencies
- ❑ Availability of drugs, blood, biologicals for treating obstetrical emergencies
- ❑ Availability of equipment including, at a minimum, airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters
- ❑ Staff (includes contract staff, travelers, providers) trained annually on protocols and provisions implemented for emergency obstetrical care
- ❑ Governing board approved which staff must complete training
- ❑ Documentation of training
- ❑ Annual training
- ❑ Demonstrated staff knowledge on obstetrical emergencies (competency)
- ❑ Utilize QAPI program to identify staff training needs and any additions, revision, or updates on an ongoing basis

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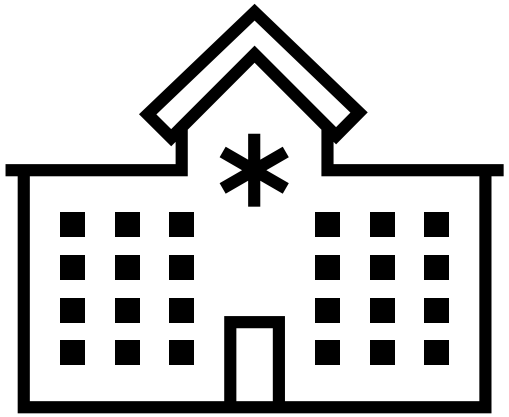
Organization and Supervision of Services Effective January 1, 2026

Scope

Applies to ALL acute care and critical access hospitals that provide **obstetrical services**



Standards of Care

Hospital §482.59

If the hospital offers obstetrical services, the services must be well organized and provided in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services must be consistent in quality with inpatient care in accordance with the complexity of services offered

CAH §485.649

If the CAH offers obstetrical services, the services must be well organized and provided in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, postpartum patients. If outpatient obstetrical services are offered, the services must be consistent in quality with inpatient care in accordance with the complexity of services offered

Organization and Staffing

Hospital §482.59

(a) Effective January 1, 2026, the organization of the obstetrical services must be appropriate to the scope of the services offered. As applicable, the services must be integrated with other departments of the hospital

CAH §485.649

(a) Effective January 1, 2026, the organization of the obstetrical services must be appropriate to the scope of the services offered. As applicable, the services must be integrated with other departments of the CAH

Supervision

CAH §485.649(a)(1)

Labor and delivery rooms/suites (including labor rooms, delivery rooms (including rooms for operative delivery), and post-partum/recovery rooms whether combined or separate) must be supervised by an experienced registered nurse, certified nurse midwife, nurse practitioner, physician assistant, or a doctor of medicine or osteopathy

CAH §485.649 (a)(1)

Labor and delivery rooms/suites (including labor rooms, delivery rooms (including rooms for operative delivery), and post-partum/recovery rooms whether combined or separate) must be supervised by an experienced registered nurse, certified nurse midwife, nurse practitioner, physician assistant, or a Doctor of Medicine or a Doctor of Osteopathy (MD/DO)

Medical Staff Privileges

Hospital §482.59 (a)(2)

Obstetrical privileges must be delineated for all practitioners providing obstetrical care in **accordance with the competencies of each practitioner** in accordance with § 482.22(c).

CAH §485.649 (a)(2)

Obstetrical privileges must be delineated for all practitioners providing obstetrical care in **accordance with the competencies of each practitioner,** and consistent with credentialing agreements established under § 485.616(b).

Policies for Obstetrical Care

Hospital §482.59(b)
Effective January 1, 2026, Obstetrical services must be consistent with needs and resources of the facility.

Policies governing obstetrical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care and safety.

CAH §485.649 (b)

Effective January 1, 2026, obstetrical services must be consistent with needs and resources of the CAH.

Policies governing obstetrical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care and safety.

Equipment

Hospital §482.59(b)(1)

The following equipment must be kept at the hospital and be readily available for treating obstetrical cases to meet the needs of patients in accordance with the scope, volume, and complexity of services offered: **call-in-system, cardiac monitor, and fetal doppler or monitor.**

CAH §485.649 (b)(1)

The following equipment must be kept at the CAH and be readily available for treating obstetrical cases to meet the needs of patients in accordance with the scope, volume, and complexity of services offered: **call-in-system, cardiac monitor, and fetal doppler or monitor.**

Protocols

Hospital §482.59(b)(2)

There must be **adequate provisions and protocols, consistent with nationally recognized and evidence-based guidelines, for obstetrical emergencies, complications, immediate post-delivery care, and other patient health and safety events as identified as part of the QAPI program** (§ 482.21).

Provisions include equipment (in addition to the equipment required under paragraph (b)(1) of this section), supplies, and medication used in treating emergency cases. Such provisions must be kept in the hospital and be readily available for treating emergency cases

CAH §485.649 (b)(2)

There must be **adequate provisions and protocols, consistent with nationally recognized and evidence-based guidelines, for obstetrical emergencies, complications, immediate post-delivery care, and other patient health and safety events as identified as part of the QAPI program** (§ 485.641).

Provisions include equipment (in addition to the equipment required under paragraph (b)(1) of this section), supplies, and medication used in treating emergency cases. Such provisions must be kept in the CAH and be readily available for treating emergency cases.

Training – It's Different!

Hospital § 482.59 (c)

Effective January 1, 2027, the hospital must **develop policies and procedures** to ensure that relevant staff are trained on **select topics for improving the delivery of maternal care.**

Critical Access Hospital §485.649(c)

Effective January 1, 2027, the CAH must **develop policies and procedures** to ensure that relevant staff are trained on **select topics for improving the delivery of maternal care.**

Training

Hospital § 482.59 (c)

(1) Training concepts must reflect the scope and complexity of services offered within the facility, including but not limited to:

(i) Facility-identified evidence-based best practices and protocols to **improve** the delivery of maternal care within the facility; and

(ii) The hospital must use **findings from its QAPI program,** as required at § 482.21, to inform staff training needs and any additions, revisions, or updates to training topics on an ongoing basis.

Critical Access Hospital §485.649 (c)

(1) Training concepts must reflect the scope and complexity of services offered within the facility, including but not limited to:

(i) Facility-identified evidence-based best practices and protocols to i**mprove** the delivery of maternal care within the facility; and

(ii) The CAH must use **findings from its quality assessment and performance improvement (QAPI) program**, as required at § 485.641, to inform staff training needs and any additions, revisions, or updates to training topics on an ongoing basis.

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Obstetric Services Effective January 1, 2027

Training and QAPI

Hospital § 482.59 (c)

(2) The hospital must provide relevant new staff with initial training.

(3) The governing body must identify and document which staff must complete initial training and subsequent biennial training on the topics identified at paragraph (c)(1) of this section.

(4) The hospital must document in the staff personnel records that the training was successfully completed.

(5) The hospital must be able to demonstrate staff knowledge on the topics identified at paragraph (c)(1) of this section

Critical Access Hospital §485.649 (c)

(2) The CAH must provide relevant new staff with initial training.

(3) The governing body must identify and document which staff must complete initial training and subsequent biennial training on the topics identified at paragraph (c)(1) of this section.

(4) The CAH must document in the staff personnel records that the training was successfully completed.

(5) The CAH must be able to demonstrate staff knowledge on the topics identified at paragraph (c)(1) of this section

QAPI

Hospital § 482.21
Effective January 1, 2027, for hospitals that offer obstetrical services, the following additional QAPI requirements apply:

(1)**Obstetrical services leadership must engage in QAPI** as specified in this section for obstetrical services, including but not limited to participating in data collection and monitoring as specified in paragraph (b) of this section.

(2) If a maternal mortality review committee (MMRC) is available at the State, Tribal, or local jurisdiction in which the hospital is located, the facility leadership, obstetrical services leadership, or their designate(s) must further have a process for incorporating publicly available MMRC(s) data and recommendations into the hospital QAPI program as specified in paragraph (b) of this section

Critical Access Hospital § 485.641 (d)(4)

Effective January 1, 2027, for CAHs that offer obstetrical services, the following additional QAPI requirements apply:

(i) **Obstetrical services leadership must engage in QAPI** as specified in this section for obstetrical services, including but not limited to participating in data collection and monitoring as specified in this paragraph (d) and paragraph (e) of this section.

(ii) If a maternal mortality review committee (MMRC) is available at the State, Tribal, or local jurisdiction in which the CAH is located, the facility leadership, obstetrical services leadership, or their designate(s) must further have a process for incorporating publicly available MMRC(s) data and recommendations into the CAH QAPI program as specified in this section

QAPI

Hospital § 482.21 (b) (4)
Effective January 1, 2027, for hospitals that offer obstetrical services, the hospital must utilize its quality assessment and performance improvement (QAPI) program to assess and improve health outcomes and disparities among obstetrical patients on an ongoing basis. At a minimum, the hospital must:

Critical Access Hospital § 485.641 (e)(2)

Effective January 1, 2027, CAHs that offer obstetrical services, the CAH must utilize its QAPI program to assess and improve health outcomes and disparities among obstetrical patients on an ongoing basis. At a minimum, the CAH must:

QAPI

Critical Access Hospital § 485.641 (e)(2)(i)

Hospital § 482.21(b)(4)(i)

Analyze data and quality indicators collected for the QAPI program
by diverse subpopulations
as identified by the CAH among obstetrical patients.

QAPI

Critical Access Hospital § 485.641 (e)(2)(ii)

Hospital § 482.21(b)(4)(ii)

Measure, analyze, and track health equity data, measures, and quality indicators on patient outcomes and disparities in processes of care, services and operations, and outcomes among obstetrical patients.

QAPI

Critical Access Hospital § 485.641 (e)(2)(iii)

Hospital § 482.21(b)(4)(iii)

Analyze and prioritize identified patient health outcomes and disparities,
develop and implement actions to improve patient health outcomes and disparities,
measure results, and track performance
to ensure improvements are sustained when disparities exist among obstetrical patients.

QAPI

Critical Access Hospital § 485.641 (e)(2)(iv)

Hospital § 482.21(b)(4)(iv)

(iv) Conduct at least one measurable performance improvement project focused on improving health outcomes and disparities among the CAH's population(s) of obstetrical patients annually

We are not a 1,000 bed facility.....

We are not a research hospital....

We have limited resources.....

Where do we even start?

Step 1

Critical Access Hospital § 485.641 (e)(2)(i)
Hospital § 482.21(b)(4)(i)

1) Gather and review data and quality indictors by population and subpopulations:

- Identify populations (obstetric and community)
- Identify sub-populations (obstetric and community)
- Collect and analyze outcomes of care / quality indicators

Identify the OB Population(s) You Serve

Ask IT to run a report / query to identify obstetric population (at least two years of data and ideally five so you have a good sample size)

- American Indian of Alaska Native
- Asian – non-Hispanic
- Black or African American – non-Hispanic
- Hispanic
- Native Hawaiian or Other Pacific Islander
- White – non-Hispanic

(Depending on your community the list of ethnicities may need to be expanded)

Identify Community Population

Review community population data

- Hospital CHNA or Public Health CHNA
- United States Census Quick Facts

Is your OB population different than the community? Why or Why Not?

Total Population		53,889	7,171,646
Age	Below 18 years old	**20.1%**	23.3%
	65 years and older	**28.8%**	17.1%
	Median Age	**49.3**	37.7
Sex	Female	**50.6%**	50.3%
	Male	**49.4%**	49.7%
Race/Ethnicity	American Indian or Native Alaskan, non-Hispanic	**17.8%**	5.3%
	Asian, non-Hispanic	**0.9%**	3.5%
	Black, non-Hispanic	**0.8%**	4.3%
	Hispanic	**18.7%**	31.4%
	Native Hawaiian/Other Pacific Islander	**0.2%**	0.3%
	White, non-Hispanic	**62%**	54.9%
	Two or more races, non-Hispanic	**1.7%**	2.19%

Population	
Population estimates, July 1, 2025, (V2025)	53,801
Population estimates base, April 1, 2020, (V2025)	53,268
Population, percent change - April 1, 2020 (estimates base) to July 1, 2025, (V2025)	1.0%
Population, Census, April 1, 2020	53,272
Population, Census, April 1, 2010	53,597
Age and Sex	
Persons under 5 years, percent	4.3%
Persons under 18 years, percent	18.0%
Persons 65 years and over, percent	33.0%
Female persons, percent	50.4%
Race and Hispanic Origin	
White alone, percent	76.0%
Black alone, percent (a)	1.0%
American Indian and Alaska Native alone, percent (a)	18.2%
Asian alone, percent (a)	0.9%
Native Hawaiian and Other Pacific Islander alone, percent (a)	0.2%
Two or More Races, percent	3.7%
Hispanic or Latino, percent (b)	18.9%
White alone, not Hispanic or Latino, percent	60.5%

Population	Percent of Hospital OB Population	Percent of Community Population
American Indian of Alaska Native		17.8%
Asian – non-Hispanic		0.9%
Black or African American – non-Hispanic		0.8%
Hispanic		18.7%
Native Hawaiian or Other Pacific Islander		0.2%
White – non-Hispanic		62%

Identify Sub-Populations

Use expert opinion (OB nurses and providers to identify potential sub-populations) and CHNA or US Census data

- Diabetes
- Drug or alcohol use
- Mental Health diagnosis
- Obesity
- Teen pregnancies

- Religious or other distinct groups
  - Amish
  - Refugees
  - Etc.

Total Population		53,889	7,171,646
Age	Below 18 years old	**20.1%**	23.3%
	65 years and older	**28.8%**	17.1%
	Median Age	**49.3**	37.7
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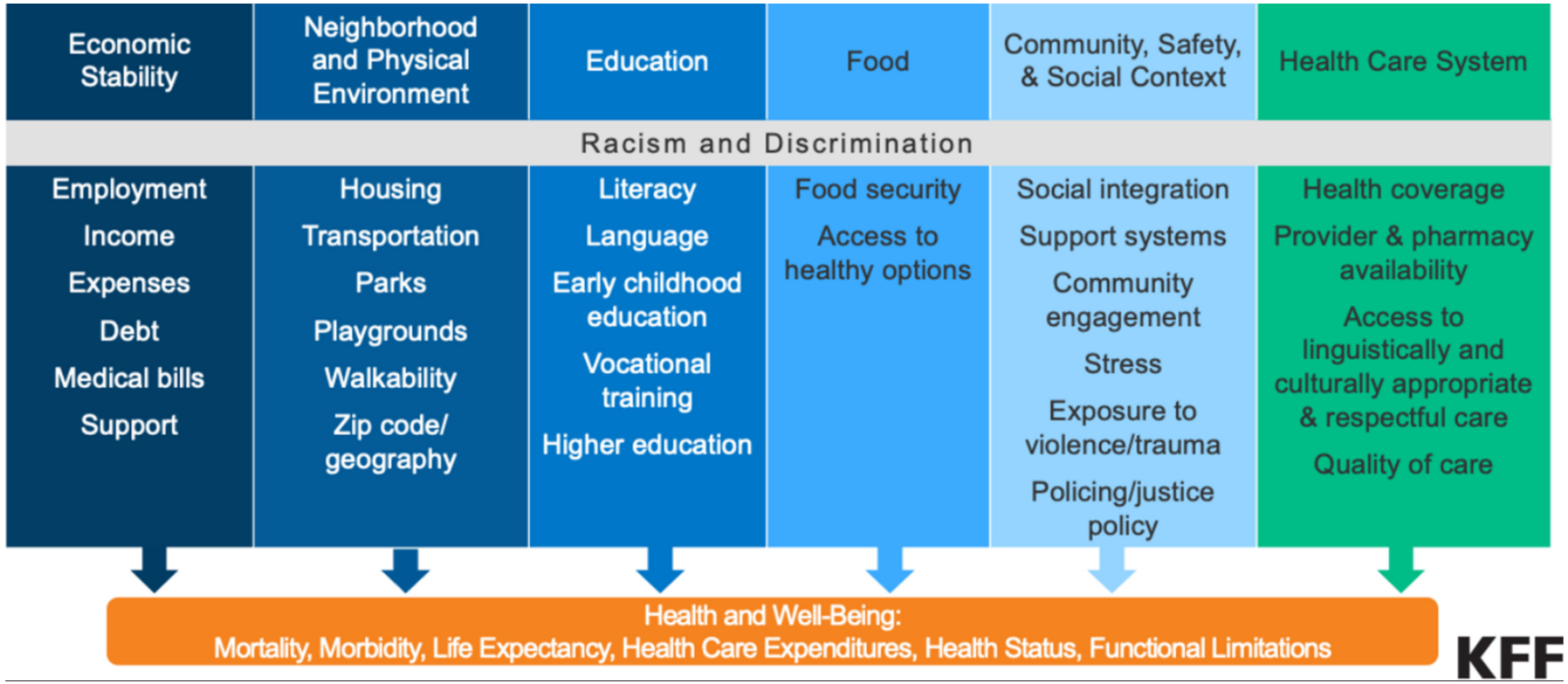
	Hispanic	**18.7%**	31.4%
	Native Hawaiian/Other Pacific Islander	**0.2%**	0.3%
	White, non-Hispanic	**62%**	54.9%
	Two or more races, non-Hispanic	**1.7%**	2.19%
Income and Poverty	Income Inequality (Gini Index)	**0.468**	0.47
	Median household income	**$41,179**	$53,510
	Living below the poverty level	**24.1%**	16.95%
Employment	Unemployed	**6.2%**	5.0%
	Travel time to work (average)	**18.7 min**	25.1 min
Education	Graduation Rate	**75%**	78%
	High school degree or higher (over 25 years old)	**85%**	86.51%
	Bachelor's degree or higher (over 25 years old)	**19%**	28.45%

Ask IT to run a report / query to identify obstetric sub-populations (at least two years of data and ideally five so you have a good sample size)

Sub-Populations	Collate by ethnicity If there is a sufficient amount of data for a reliable sample				
	American Indian	Black	Hispanic	White non-Hispanic	Total
Diabetes					
Drug or alcohol use					
Mental Health diagnosis					
Obesity					
Teen Pregnancy					

Identify Social Determinants of Health

SDOH—defined as the conditions in which people are born, grow, live, work, and age—are significant drivers of disease risk and susceptibility. These determinants include education, income, access to transportation, access to safe and affordable housing, and access to nutritious foods. The differences in social position and power shape identities and access in society, and adverse SDOH disproportionately affect BIPOC individuals.



Social Determinants of Health	Collate by ethnicity / sub-populations If there is a sufficient amount of data for a reliable sample						
Poverty	American Indian	Black	Hispanic	White non-Hispanic	Other Sub-Populations		Total
					Teen mothers		
Housing - homeless							
Transportation							
Literacy							
Food security							
Support systems							
Exposure to violence, trauma							
Policing/justice							
Health coverage							
Provider & pharmacy availability							
Access to linguistically & culturally appropriate & respectful care							
Note: Not all social determinants of health are included							

Identify Outcomes of Care

Use expert opinion (OB nurses and providers) to identify outcomes of care

Ask IT to run a report / query (at least two years of data and ideally five so you have a good sample size). Sort by populations and/or sub-populations if possible.

- Low birth weight
- High birth weight
- C-sections
- Inductions
- Eclampsia
- Post-partum hemorrhage
- Transfers mother or neonate (and reason)
- Minimal or no prenatal care
- Breastfeeding exclusively

Outcomes of Care	Collate by ethnicity / sub-populations If there is a sufficient amount of data for a reliable sample						
	American Indian	Black	Hispanic	White non-Hispanic	Other Sub-Populations		Total
					Teen mothers		
Low birth weight							
High birth weight							
C-Sections (primary)							
Inductions							
Pre-eclampsia							
Post-partum hemorrhage							
Transfers (mother and/or neonate)							
Minimal or no pre-natal care							
Breastfeeding							

Step 2

Critical Access Hospital § 485.641 (e)(2)(ii)
Hospital § 482.21(b)(4)(ii)

Measure, analyze and track health equity data, measures, and quality indicators on patient outcomes and disparities:

- Processes of care
- Services and operations
- Outcomes

Processes of Care Methods and procedures used to deliver healthcare services, focusing on how care is provided	Outcomes / Disparities Include specific issues experienced by at-risk populations
*Pre-natal care	___% all women receive the recommended pre-natal visits ____% of teen mothers receive the recommended number of pre-natal visits
*Prenatal needs assessment including medical, social and structural drivers of health before 10 weeks gestation or when pregnant individual first presents for care	___% of all pregnant women receive a prenatal needs assessment
*Referrals for at-risk or unmet social needs from physician / provider office	___% of patients at-risk identified ___% of patients referred
*Nutritional counseling for healthy eating by dietitian or individual competent in pregnancy related nutrition (referred from physician / provider office	___% of patients identified at nutritional risk ___% of patients referred

*ACOG: Tailored Prenatal Care Delivery for Pregnant Individuals, Clinical Consensus CC, Number 8, May 2025

Processes of Care, cont. Methods and procedures used to deliver healthcare services, focusing on how care is provided	**Outcomes / Disparities** **Include specific issues experienced by at-risk populations**
**Skin-to-skin immediately after birth	___% skin to skin
*No separation before rooming in	___% of all pregnant women receive a prenatal needs assessment
*Assistance / support for breast feeding	
*Discharge criteria includes at least one effective feeding at the breast within 8 hours prior to discharge	
*Breast feeding support post-discharge	
*Rooming in at least 24-hours per day	
*Protocol that requires frequent observation of high-risk mother-infant dyads by nurses to ensure safety of the infant while they are together	
Post-Parum depression screening – ideally before leaving the hospital but if not at first physician / provider visit	
**Comprehensive postpartum visit no later than 12 weeks after birth. This care should be individualized and include assessment of a range of health needs, including mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance	

*CDC: The Maternity Practices in Infant Nutritional and Care (mPINC), May 13, 2026

** ACOG: Tailored Prenatal Care Delivery for Pregnant Individuals, Clinical Consensus CC, Number 8, May 2025

Services and Operations Encompasses the logistical aspects of healthcare delivery, including resource management, staffing, and service availability	**Outcomes / Disparities** **Include specific issues experienced by at-risk populations**
*Continuous observation first 2 hours after birth	____% continuous observation after birth
*Comprehensive Pre-Natal Education	Pre-natal classes available in the community and accessible to all pregnant women including those with transportation or other barriers ___% pregnant women attended at least ___ pre-natal classes
Nursing and Provider education on Social Determinants of Health at hire and annually	___% attended annual education

*CDC: The Maternity Practices in Infant Nutrition and Care (mPINC), May 13, 2026

Outcomes of Care Results of healthcare interventions, measuring the effectiveness of care in terms of patient health and satisfaction	**Outcomes / Disparities** **Include specific issues experienced by at-risk populations**
Birth weight	Birthweight within range
C-Sections (primary)	____% primary c-sections
Inductions	____% inductions
Preeclampsia	____% preeclampsia
Post-partum hemorrhage	____% post-partum hemorrhage
Transfers (mother and/or neonate)	____% transfers to higher level of care
Breastfeeding	____% breastfeeding

Metrics

At a minimum…. Choose one (ideally two) metrics from each category

1) Services and Operations
2) Processes of Care
3) Outcomes of Care

Choose metrics that are both easy to collect AND you can collect data by population or sub-population

Step 3

Critical Access Hospital § 485.641 (e)(2)(iii)
Hospital § 482.21(b)(4)(iii)

1) Analyze and prioritize health outcomes and disparities

2) Develop actions to improve health outcomes and disparities

3) Measure results and track performance to ensure improvements

Prioritize

Health Outcomes & Disparities	Frequency	Populations and Sub Populations Impacted	Mother / Infant Health High Risk - 5 Medium Risk - 3 Low Risk = 1
High Birth Weight Infants	___% of births	Native American	5
Lack of prenatal care	____% of births	• Teen mothers • Mothers living in poverty • Homeless	5

Actions

Health Outcomes & Disparities	Frequency	Populations and Sub Populations Impacted	Mother / Infant Health High Risk - 5 Medium Risk - 3 Low Risk = 1	Interventions
High Birth Weight Infants	___% of births	Native American	5	Work collaboratively with tribal health to improve attendance at pre-natal classes
Lack of prenatal care	____% of births	• Teen mothers • Mothers living in poverty • Homeless	5	1) Identify SDOH at first pre-natal visit 2) Work collaboratively with public health

Measure Interventions AND Outcomes

Health Outcomes & Disparities	Frequency	Populations and Sub Populations Impacted	Mother / Infant Health High Risk - 5 Medium Risk - 3 Low Risk = 1	Interventions
High Birth Weight Infants	___% of births	Native American	5	Work collaboratively with tribal health to improve attendance at pre-natal classes
Lack of prenatal care	____% of births	• Teen mothers • Mothers living in poverty • Homeless	5	1) Identify SDOH at first pre-natal visit 2) Work collaboratively with public health

Step 4

Critical Access Hospital § 485.641 (e)(2)(iii)
Hospital § 482.21(b)(4)(iii)

1) One measurable improvement project focused on health outcomes and disparities annually

Choose One

Health Outcomes & Disparities	Frequency	Populations and Sub Populations Impacted	Mother / Infant Health High Risk - 5 Medium Risk - 3 Low Risk = 1	Interventions
High Birth Weight Infants	___% of births	Native American	5	Work collaboratively with tribal health to improve attendance at pre-natal classes
Lack of prenatal care	____% of births	• Teen mothers • Mothers living in poverty • Homeless	5	1) Identify SDOH at first pre-natal visit 2) Work collaboratively with public health

Considerations

It’s Not an Individual Sport

Involve staff, PHYSICIANS & APPs, public health, community leaders

Don’t Assume

Be strategic about data

Where can we make a difference?

Having one successful project is better than 5 unsuccessful ones!

There are lots of issues… where can you make a difference?

Don’t develop solutions / interventions that are not rational or practical or cannot be implemented

Morality Story

Provider explaining to an over-weight waitress who works 10 – 12 hours a day, has no spouse, and three elementary school age children ---- that she should go to a gym after work to exercise.

Be Flexible

Carolyn St.Charles, MBA, BSN, RN
Chief Clinical Officer
Carolyn.stcharles@health-tech.us
360.584.9868

Resources

Resources

Grobman W, Entringer S, Headen I ...**Social determinants of health and obstetric outcomes: A report and recommendations of the workshop of the Society for Maternal-Fetal Medicine**

American Journal of Obstetrics & Gynecology, 2023; 230, B2-B16

ACOG: Levels of Maternal Care. Obstetric Care Consensus No. 9. American College of Obstetricians and Gynecologists

Obstet Gynecol 2019;134:e41–55

https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2019/08/levels-of-maternal-care

ACOG: Identifying and Managing Obstetric Emergencies in Non-Obstetric Settings

This multiyear initiative seeks to enhance the identification and management of pregnancy-related emergencies in nonobstetric settings.

https://www.acog.org/programs/obstetric-emergencies-in-nonobstetric-settings

Resources

ACOG: Cardiovascular Disease (CVD) in Pregnancy and Postpartum Algorithm (PDF)

https://www.guidelinecentral.com/guideline/3911922/

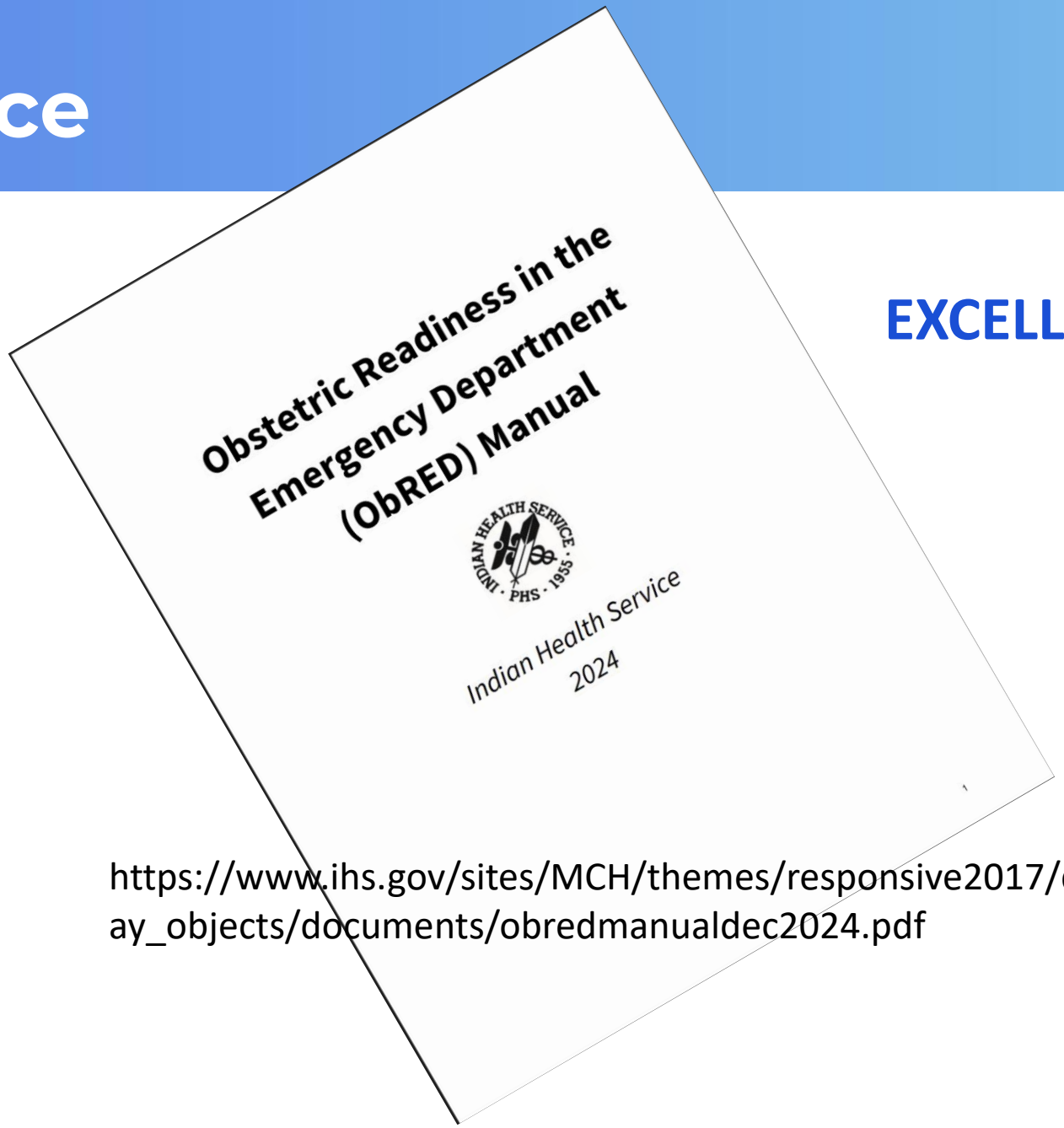
Acute Hypertension in Pregnancy and Postpartum Algorithm (PDF)

https://www.acog.org/community/districts-and-sections/district-ii/programs-and-resources/safe-motherhood-initiative/severe-hypertension

Eclampsia Algorithm (PDF)

https://www.guidelinecentral.com/guideline/3911905/

Resource



EXCELLENT RESOURCE

https://www.ihs.gov/sites/MCH/themes/responsive2017/display_objects/documents/obredmanualdec2024.pdf

ObRED Manual

1. Ob Triage: Pre-Hospital (Field or EMS) or In-Hospital
2. Normal Delivery
3. Abnormal Deliveries
    - Shoulder Dystocia
    - Breech Delivery
4. Hemorrhage
    - Quantitative Blood Loss (QBL) Calculations
    - Example Mockup of PPH Box: Level 1 (Moderate)
    - Example of Hemorrhage Kit: Level 2 (Severe)
6. Hypertension
    - Example of Hypertension Kit
7. Maternal Cardiac Arrest
8. Maternal Sepsis
9. Maternal Substance Use
    - Opioid Use Disorder
    - Opioid Withdrawal:
    - Alcohol Use Disorder
10. Consultation and Transfer Guidelines

https://www.cms.gov/newsroom/press-releases/cms-announces-new-policies-reduce-maternal-mortality-increase-access-care-and-advance-health-equity

AMA – Recommendations for Policy

1. Ensure feasibility and implementation of Core Alliance for Innovation on Maternal Health patient-safety bundles and checklists.
2. Expand evidence-based programs to treat substance use disorder in pregnancy and postpartum (PDF).
3. Address social determinants of health among patients who are pregnant or postpartum by enhancing medical-legal partnerships.
4. Promote telehealth and home monitoring during pregnancy and the postpartum period and address barriers to providing remote patient care.
5. Ensure the acquisition of the right type of data.
6. Address physician workforce needs in maternity care.
7. Use new payment models to prevent maternal death

American Hospital Association

1. Examine quality and outcomes data to guide strategy

Systematically collect data, review metrics and identify disparities to drive strategies for improvement in health outcomes

2. Consider the causes of disparities in health outcome

Investigate how clinical and community-based strategies work toward reducing disparate outcomes.

3. Involve patients and community in their own care

Engage patients, families and community stakeholders to design care that is responsive to their needs and preference

4. Engage the workforce

Deploy interdisciplinary care teams who are trained to provide person-centered care.