

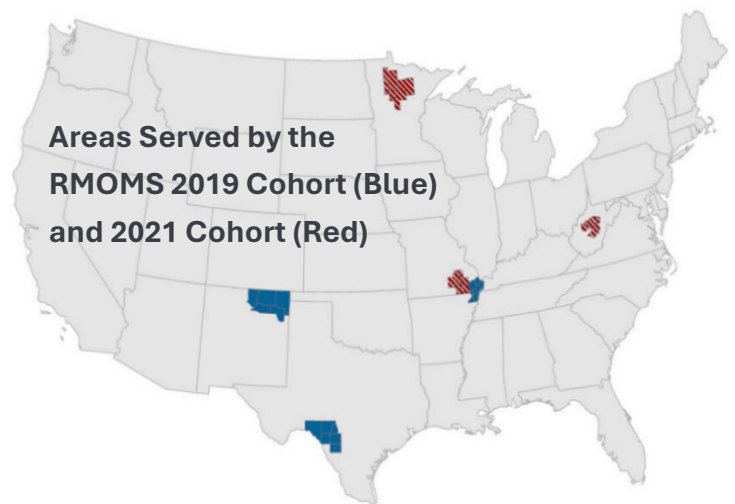


RURAL MATERNITY AND OBSTETRICS MANAGEMENT STRATEGIES (RMOMS) PROGRAM

2021 COHORT FINAL REPORT, 2026

INTRODUCTION

Following the [2019 pilot](#) of the Rural Maternity and Obstetrics Management Strategies (RMOMS) Program, the Health Resources and Services Administration Federal Office of Rural Health Policy (HRSA FORHP) funded three additional awardees in 2021. These 2021 Cohort networks leveraged one planning year and three implementation years (September 1, 2021 through August 31, 2025) to expand access to care and improve outcomes for mothers and infants in rural communities facing provider shortages and other barriers, such as lack of transportation.^{1, 2, 3, 4} The networks included:



Families First: Rural Maternity Health

Collaborative (Minnesota):

Families First, led by Sanford Health, supported more than 2,800 women across six northern Minnesota counties through initiatives ranging from telehealth to obstetric emergency training. Families First drew heavily on collaborations with network partners and tribal health organizations, whose contributions were central to planning and implementing an innovative group prenatal care model.

RMOM-Southeast Missouri Partnership (RMOM-SMP): Serving seven counties in southeastern Missouri, RMOM-SMP built on the work of a neighboring 2019 Cohort network, adopting Maternal-Fetal Medicine (MFM) telehealth, remote patient monitoring (RPM) for hypertension, and patient navigation programs. Led by Missouri Highlands Health Care, a Federally Qualified Health Center (FQHC), the network served more than 3,300 participants.

West Virginia Rural Maternity and Obstetrics Management Strategies

Collaborative (WV-RMOMS): The WV-RMOMS network, which covered eight counties in central West Virginia, expanded rural maternal health capacity by placing new providers in clinics and hospitals, launching a doula program, and expanding wraparound services, such as home visitation and lactation support. Led by the West Virginia Perinatal Partnership (WVPP), it had the largest number of partners, including seven hospitals and four FQHC networks, but the smallest population, serving just under 2,500 women.

All three awardees served relatively small populations across large geographic areas during the RMOMS implementation period, reflecting their role in providing important maternal health services in very rural service areas. In addition, their populations fluctuated over time as women moved into or out of these service areas or chose to see other providers.

This final report outlines the populations served by the networks, highlights networks' innovative strategies and new contributions to the RMOMS program, describes approaches for building network cohesion, and summarizes program impacts.

POPULATIONS SERVED (2019 AND 2021 RMOMS COHORTS)

The networks provided maternal health care to more than 15,000 women. Of these, 12,990 delivered 13,139 infants.

The 2021 Cohort was slightly larger than the 2019 Cohort, serving approximately 1,600 more women (Table 1). Overall, RMOMS participants were generally younger and more likely to be insured through Medicaid compared with women in rural America and the nation overall.

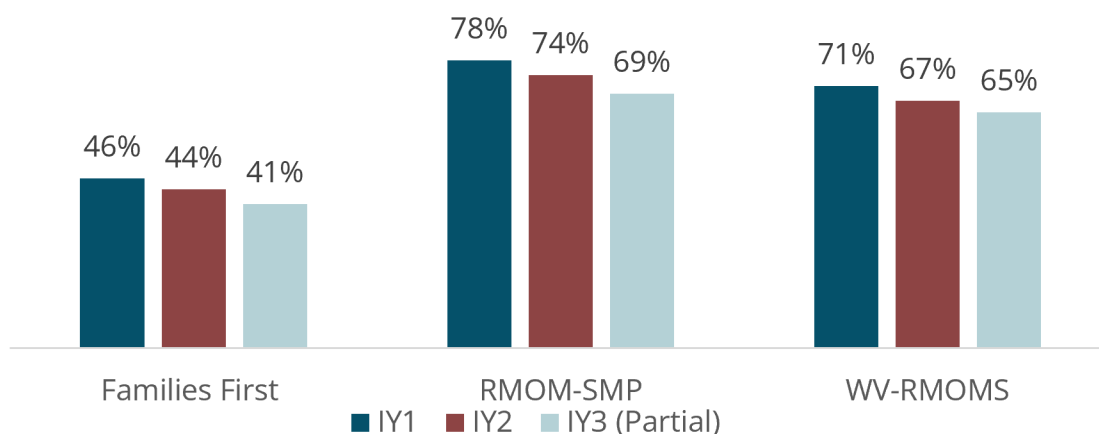
- About 30 percent of participants across both cohorts were age 24 or younger, reflecting the rural national average.
- Medicaid coverage in the RMOMS service areas exceeded coverage rates for rural America overall (55% in the 2019 Cohort and 61% in the 2021 Cohort vs 47% in rural areas nationally).
- In the 2021 Cohort, Medicaid coverage rates varied significantly by network and declined over time (Figure 1), reflecting national trends of Medicaid coverage losses following the end of the COVID-19 Public Health Emergency (PHE).⁵

Table1: RMOMS Participant Characteristics by Cohort

Characteristic	2019 Cohort	2021 Cohort	Both Cohorts	Rural National (NVSS)	National (NVSS)
Total population*	7,062	8,613	15,675	479,785	3,596,017
Women who delivered	5,745	7,245	12,990	--	--
Infants	5,803	7,336	13,139	--	--
Age (years)					
Under 18	2%	1%	1%	3%	1%
18–24	29%	31%	30%	28%	20%
25–29	31%	30%	31%	32%	27%
30–34	23%	22%	23%	24%	31%
35 and older	15%	13%	14%	13%	21%
Missing or unknown	0%	2%	1%	0%	0%
Health insurance status					
Medicaid	55%	61%	58%	47%	41%
Private insurance	28%	33%	30%	43%	51%
Uninsured	3%	2%	2%	6%	4%
Military	3%	1%	2%	2%	3%
Missing or unknown	11%	4%	7%	0%	<1%

Notes: *The total population is deduplicated within each network across the three years to account for RMOMS participants who received services in multiple years or experienced multiple pregnancies. The 2019 Cohort implementation period was September 1, 2020 to August 31, 2023. The 2021 Cohort implementation period was September 1, 2022 to August 31, 2025. For the third implementation year, two awardees (Families First and WV-RMOMS) submitted data for the full year and one awardee (RMOM-SMP) submitted data for the first six months. Source: de-identified patient-level data submitted by the awardees and 2023 National Vital Statistics System (NVSS) data. Rural national and national data are from the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), NVSS, which contains demographic and health information on all U.S. births.

Figure 1: Percent of Medicaid-Insured RMOMS 2021 Cohort Participants by Network



Notes: The 2021 Cohort implementation period was September 1, 2022 to August 31, 2025. For the third implementation year (IY), two awardees (Families First and WV-RMOMS) submitted data for the full year and one awardee (RMOM-SMP) submitted data for the first six months. Source: de-identified patient-level data submitted by the awardees.

NETWORK STRATEGIES

While some 2021 Cohort network strategies mirrored those of the 2019 Cohort, such as MFM telehealth, RPM, and patient navigation, the 2021 Cohort networks also introduced a range of innovations to improve access to and quality of clinical care and help reduce barriers through support services.

Clinical Enhancements

RMOMS helped fill gaps in clinical care in rural areas that often face provider shortages and long patient drive times to more urban centers for both routine and high-risk pregnancy care.

Placement of New Maternal Health Providers in Rural Clinics through WV-RMOMS

WV-RMOMS helped partners hire and onboard key maternal health clinicians, including obstetricians, Certified Nurse Midwives (CNMs), and a women's health nurse practitioner (WHNP) (see textbox). The network also supported the reestablishment of limited women's health services at a rural partner hospital, which had closed its obstetric unit before the RMOMS program. These providers now offer basic services, including prenatal and postpartum care and women's health care (e.g., Pap tests, contraception).

New WV-RMOMS Providers

- Local obstetrician offering prenatal and postpartum care at two FQHC sites
- CNM providing comprehensive women's health care four days a week at two FQHC sites
- CNM from health care system visiting rural hospital-based clinic
- Women's health care (including some maternal health care) from visiting health department clinicians

The network did not use a "one size fits all" model, allowing partners to hire the types of providers and establish part-time patient schedules that best suited their local contexts. WV-RMOMS noted the importance of hiring trusted providers with ties to the area, resulting in two key sustainability benefits: first, that these providers had positive reputations in the community and could attract more patients, and second, that they would commit to living and working in the area for years.

Group Prenatal Care at Families First

To improve patient engagement in care, Families First developed and implemented group prenatal care at two Indian Health Service (IHS) network partner sites in Red Lake and Cass Lake. Key features of the approach included:

- **Opportunity for pregnancy health education:** Group prenatal care allowed more time for maternal education and gave pregnant women a space to make friends and grow their social support networks.
- **Adapted for a rural population:** Families First developed its approach to fit the rural context, where small populations and long travel times make it difficult to form group prenatal care cohorts. To address this, Families First chose to adapt an established curriculum from the March of Dimes because it was less oriented toward “due date groups,” allowing women at different stages of pregnancy to participate together. In addition, one site used rolling enrollment so women could immediately join an existing group instead of waiting for a new cohort to form.
- **Efficient workflows:** Group prenatal care sessions occurred once each month at a regularly scheduled time with approximately five to eight group members, plus the providers. A session visit included an individual clinical check-up with the site’s regular prenatal care providers and an educational or cultural activity from a guest speaker. This structure enabled comprehensive and efficient transmission of information while also including attractive offerings.
- **Involvement of local tribal organizations:** These organizations were crucial to developing a program that met the unique needs of local populations in this tribal region.

80 percent of eligible Families First patients opted into group prenatal care, reflecting positive uptake among both patients and providers.

Obstetric Emergency Training with Mannequins

The RMOMS award allowed Families First, RMOM-SMP, and WV-RMOMS to purchase and conduct clinician training activities with obstetric-specific mannequins, often in partnership with tertiary centers poised to assist rural hospitals that see relatively few births per year. In the Families First network, the mannequin also simulated a twin pregnancy and allowed participants to implement specific tasks, such as starting an IV line, within a wide range of training scenarios for building knowledge and confidence in addressing emergent needs during delivery. For RMOM-SMP, the mannequin supported low-volume delivery hospitals in practicing emergency delivery scenarios, which paired well with the network’s focus on improving care for high-risk pregnancies.

“It was great to be able to walk through procedures with [the ED], to confirm that they were doing it right. And it allowed us some reflection on what we can still be doing better with our OB education simulation training.”
– Families First Clinical Provider

Support Services

Networks also addressed behavioral health and social needs that can influence maternal health outcomes. Highlights from their support services and complementary clinical efforts included:



Support Groups and Substance Use Disorder (SUD) Treatment for Young Mothers in RMOM-SMP

RMOM-SMP strengthened existing programs and referral systems, ensuring that women could access behavioral health treatment, social support from their peers, and educational opportunities. The network funded staff for a new maternity home and enhanced referral pathways with the home’s SUD treatment program to connect women with recovery housing and treatment. While support groups, especially for young mothers, were already established locally, RMOM-SMP formalized partnerships by improving referral coordination and integrating these programs into monthly network meetings. This approach strengthened provider communication and created more consistent pathways to access support.



Doula Care at a WV-RMOMS Partner Hospital

WV-RMOMS built on a Medicaid managed care organization grant to support doula protocol development, training, and placement at network hospitals. The first doula trained and onboarded through the WV-RMOMS network had attended 19 births at her hospital by March 2025. In her dual role as a doula and patient navigator (a role also supported with WV-RMOMS funding), she offered an informational packet when pregnant women arrived for their first prenatal visit. Interested patients were added to the “doula list,” which was shared with the obstetrics department, and then they received visits throughout pregnancy and delivery support. Many clients had experienced challenges or complications in previous deliveries, leading them to desire support for future deliveries. WV-RMOMS reported that the labor and delivery staff at the partnering hospital, which became the first in the state to have a doula-specific written policy, were very supportive and collaborative on all aspects of the new doula initiative.



Van Services: Families First and RMOM-SMP

In rural settings with few and often cumbersome public and Medicaid-supported transportation options, both Families First and RMOM-SMP used funds to help purchase dedicated vans to assist participants with getting to and from their prenatal and postpartum appointments. The Families First van was conspicuously decorated with the network’s logo and a large picture of a mother and baby, making it recognizable in the service area. The vehicle supported by RMOM-SMP was owned and operated by the maternity home that offers SUD treatment and peer support. During the summer of 2025, an average of 44 rides per month were delivered by the Families First van, enabling patients to attend scheduled prenatal and postpartum appointments.

Extending the Legacy of the 2019 Cohort

The 2021 Cohort also adopted many of the approaches first introduced by the 2019 Cohort, including:

- **Patient navigation:** Patient navigators, nurse care managers, and high-risk obstetric coordinators were central to networks’ work to connect women to support services and provide emotional support. RMOM-SMP partners reported that women who engaged with care coordinators were more likely to attend appointments, follow through on referrals, and access needed services. The WV-RMOMS-supported patient navigator at one partner hospital averaged about 22 patients per month in 2025. She reported that her patients especially appreciated being able to text anytime with questions or concerns through the Mood App, a postpartum depression app with two-way texting functionality.
- **Routine prenatal and MFM telehealth:** RMOM-SMP and Families First built virtual connections between rural clinics and MFM providers and obstetricians at tertiary centers to promote access to care for rural mothers, especially those experiencing high-risk conditions, as well as access to expert advice for local rural clinicians.
- **RPM:** All three networks provided women with devices and education to monitor blood pressure and glucose from home. The Families First model also included remote non-stress tests, providing women with a convenient option for monitoring fetal status at home.

KEY TO SUCCESSFUL NETWORK COORDINATION

The 2021 Cohort networks were robust, with partner numbers ranging from 6 (Families First) to 18 (WV-RMOMS). All networks included multiple hospitals, from Critical Access Hospitals (CAHs) to large health care systems. Beyond that, however, the networks differed widely, showing that a range of structures and collaborative approaches can work well in rural areas. For example, each network was led by a different type of organization – a large health care system, an FQHC, and a statewide Perinatal Quality Collaborative (PQC). This section describes some of the characteristics that suggested network cohesion, along with those that facilitated coordination.

Indicators of Network Cohesion

Networks demonstrated their cohesion through the following factors:

- **Stability:** Networks remained stable or grew throughout the three RMOMS implementation years. Families First and WV-RMOMS maintained consistent partnerships, while RMOM-SMP grew by adding a faith-based organization that offered housing, SUD treatment, and group-based parenting and peer support.
- **Data sharing and reporting:** Participation in RMOMS often exposed a lack of data sharing infrastructure to view comprehensive patient records and coordinate care across the pregnancy and postpartum continuum. Using RMOMS funds, awardees established new data processes. Families First created a network-wide REDCap database, RMOM-SMP expanded prenatal care provider access to hospital labor and delivery records, and WV-RMOMS coordinated with the state health information exchange in West Virginia. These efforts reflected partners' willingness to collaborate to understand RMOMS participant care patterns, evaluate program outcomes, and report program and patient-level data to HRSA.
- **Referral patterns:** Network cohesion and collaboration were also demonstrated by the volume of referrals partners made to connect women with clinical and support services. Although networks had difficulty reporting referral data in the first two implementation years, by the third year, they documented more than a thousand referrals each, ranging from 1.0 referrals per participant at RMOM-SMP to 2.2 at Families First.

Facilitators of Success

The 2021 Cohort networks drew on various factors to support cohesion, including strategies for distributing funding and planning activities at each partner location.

- **Role of network lead:** All three network leads had an established presence in their regions, either as service providers or training entities. WV-RMOMS, for instance, was anchored by the WVPP, a long-standing regional consortium and PQC that had strengthened maternal health programs statewide for years. Families First was led by Sanford Health, the region's only major health system and delivery hospital, which eliminated competition for patients among partners. Missouri Highlands Health Care, a local FQHC, was a trusted resource in the community with longstanding collaborative relationships with key partners.
- **Partner engagement in network activities:** While networks took different approaches to distribute funds, they all actively engaged partners in network activities, as opposed to centering work at the network lead site. WV-RMOMS distributed funds directly to partners to meet local needs, allowing for individualized strategies while still bringing network partners together for training and community opportunities. This approach kept partners engaged by ensuring tangible benefits for each organization. In contrast, RMOM-SMP and Families First emphasized cross-partner referrals and joint activities. For example, RMOM-SMP partners collaborated on MFM telehealth, with a hospital partner providing specialists and Missouri Highlands Health Care supplying nurses, sonographers, and equipment.

- **Regular governance council and in-person meetings:** These meetings served as platforms to share ideas and resources, plan for implementation, and troubleshoot issues. Each partner within the Families First network had equal voting rights, regardless of size and service offerings. WV-RMOMS met quarterly, including through two in-person meetings, and conducted site visits. In-person meetings, not available to the 2019 Cohort during its planning year due to the COVID-19 pandemic, strengthened rapport across 2021 Cohort network partners. WV-RMOMS emphasized that in-person site visits deepened the network’s understanding of local needs and challenges, which was especially important since the lead organization was based outside the service area.

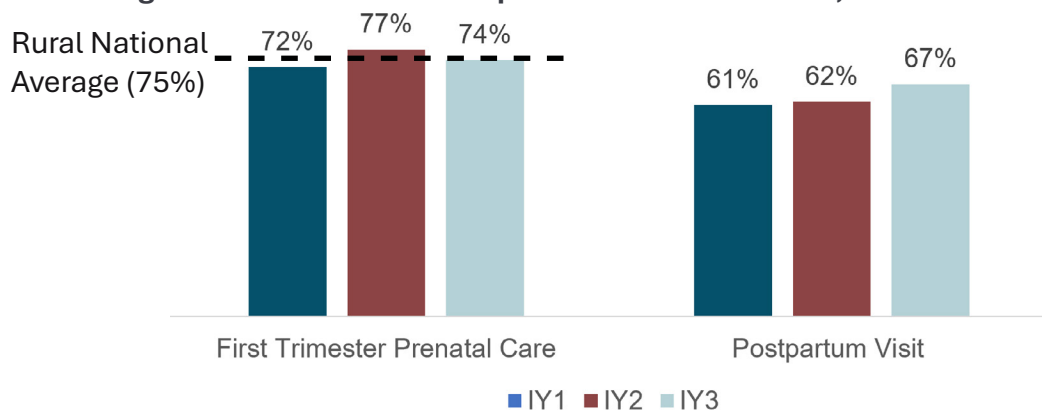
The RMOMS networks created new service lines and programs with lasting effects through increasing access to care, addressing barriers to care, and improving care quality.

MATERNAL HEALTH OUTCOMES

Network strategies focused on improving access to care, leading to increases in prenatal and postpartum care utilization. Ongoing, comprehensive health care engagement during these periods helps identify and address risks early, preventing complications that could endanger maternal and infant health and lead to costly interventions, such as long neonatal intensive care unit (NICU) stays. In addition, the RMOMS networks tailored their offerings to provide crucial support services and new telehealth care options, which may have helped improve the overall prenatal care experience and outcomes for their populations.⁶

Across the three 2021 Cohort networks, both first trimester prenatal care initiation and postpartum care rates increased from the first to the second implementation year (Figure 2). Notably, the share of women receiving a prenatal visit in the first trimester rose from below to above the U.S. rural average of 75 percent by the second implementation year before declining slightly in the third implementation year.⁷ In addition, postpartum visit utilization increased from the first to the third implementation years, from 61 percent to 67 percent. While these findings should be interpreted with caution due to the small sample size for the rural service populations, they suggest that the 2021 Cohort networks may have contributed to improvements in care utilization.

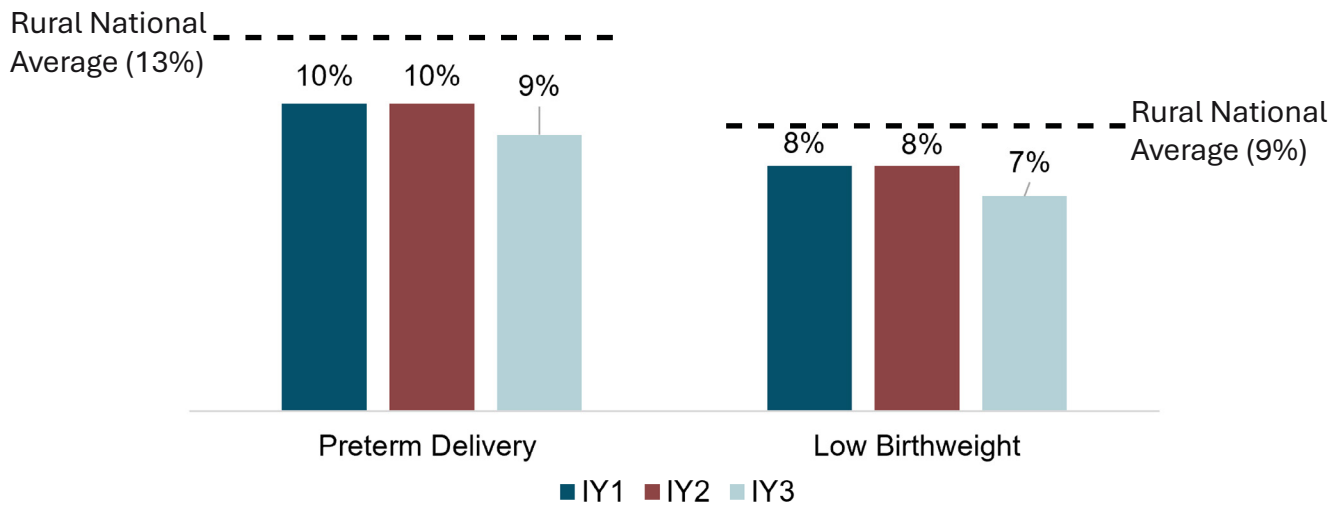
Figure 2: Prenatal and Postpartum Care Utilization, 2021 Cohort



Notes: For the third implementation year, two awardees (Families First and WV-RMOMS) submitted data for the full year and one awardee (RMOM-SMP) submitted data for the first six months. Source: de-identified patient-level data submitted by the awardees and 2023 NVSS Natality Data. The first implementation year was September 1, 2022 to August 31, 2023. The second implementation year was September 1, 2023 to August 31, 2024. The third implementation year was September 1, 2024 to August 31, 2025.

Similarly, poor infant outcomes (preterm birth and low birthweight) either decreased or remained stable across the three years (Figure 3). Trends, however, varied by network. RMOM-SMP saw the largest reduction in preterm births, dropping from 14 percent in the first year to 11 percent in the second, while Families First experienced a slight increase and then a decrease of two percentage points across the second and third years. For both measures, 2021 Cohort rates were at or below the rural national averages (13 percent for preterm birth and 9 percent for low birthweight).⁷

Figure 3: Infant Outcomes, 2021 Cohort



Notes: Preterm birth is before 37 weeks of gestation. Low birthweight is less than 2,500 grams. For the third implementation year, two awardees (Families First and WV-RMOMS) submitted data for the full year and one awardee (RMOM-SMP) submitted data for the first six months. Source: de-identified patient-level data submitted by the awardees and 2023 NVSS Natality Data. The first implementation year was September 1, 2022 to August 31, 2023. The second implementation year was September 1, 2023 to August 31, 2024. The third implementation year was September 1, 2024 to August 31, 2025.

SUSTAINABILITY AND CONCLUSIONS

Although the RMOMS 2021 Cohort implementation period ended in August 2025, the program impacts are far from over. Networks remained strong throughout the initiative – some even adding new partners – and demonstrated a commitment to ongoing coordination. Networks also expressed confidence that most initiatives would continue well beyond the RMOMS funding period, supported through insurance reimbursement or by partner commitment to sustain efforts they viewed as highly valuable and attractive to patients.

Data reported by the 2021 Cohort also showed signs of improving patient access to care. Between the first and second implementation years, the share of women receiving a prenatal visit in the first trimester rose by five percentage points. Postpartum care attendance rose each implementation year, suggesting that the networks' efforts increased care availability and attendance. As networks operate post-RMOMS and the program initiatives strive to leave lasting impacts on their partners, access to essential clinical and support services across the care continuum should continue to expand in rural areas. These improvements may lead to better care options, innovative strategies and technologies, and healthier mothers and infants.^{6, 8, 9}

RMOMS Network Strategies

Activity	Bootheel Perinatal Network (MO)	Rural OB Access and Maternal Services (ROAMS) (NM)	TX-RMOMS (TX)	Families First (MN)	RMOM-SMP	WV-RMOMS
Clinical Interventions						
New clinical providers, models of care		Visiting OB program at rural FQHC		Group prenatal care visits		New maternal health clinicians Visiting OB model for high-risk care
New medical equipment	OB mannequin Sonography equipment	Beds, warmers, and emergency devices Genetic testing kits Sonography equipment		OB mannequin Sonography equipment Telehealth cart	OB mannequin	OB mannequin New sonography staff and equipment at a rural clinic
Telehealth						
Telehealth for routine prenatal care or other services		Virtual visits at a rural clinic with a hospital-based OB		Virtual visits at a CAH with a hospital-based OB	Virtual visits at a rural clinic with a hospital-based OB	
MFM telehealth	Virtual visits at local clinic with out-of-state MFM provider	Virtual visits at rural hospitals with MFM provider	Virtual visits at rural hospital with MFM provider and case reviews	Virtual visits at rural hospital with MFM provider	Virtual visits at FQHC with MFM provider	
Remote patient monitoring	Cuff Kits through AIM partnership	Blood pressure and glucose monitoring		Remote stress tests and blood pressure monitoring	Blood pressure and glucose monitoring	Cuff Kits through AIM partnership
Patient Navigation						
Patient navigators/care coordinators	System Care Coordinators (SCCs) at three locations	Family navigators in three locations	Three perinatal case managers	High-risk OB care coordinators at three locations	Care coordinator at FQHC	Patient navigators at three locations
Protocols and workflows	Automated referral system	Pathways Community Hub Institute protocol		Obstetric emergency protocols	New protocol for maternal health patients	
Support Services						
Maternal health care supports	SCC referrals to home visitation	Lactation consultation	Lactation consultation Infant supplies	Expanded home visitation services Infant supplies	Referrals to home visitation	Doula training and placement Expansion of home visitation Lactation consultation Infant supplies
Addressing health-related social needs	SCC referrals to resources and Medicaid MCO supports	Family navigator screening and referrals	Perinatal case manager screening and referrals	Van to alleviate transportation barriers	Patient navigator screening and referrals	Patient navigator screening and referrals

Activity	Bootheel Perinatal Network (MO)	Rural OB Access and Maternal Services (ROAMS) (NM)	TX-RMOMS (TX)	Families First (MN)	RMOM-SMP	WV-RMOMS
Behavioral health supports	SCC behavioral health screening and referrals	Pre-existing screening and referrals	Mental and behavioral health screening	Pre-existing screening and referrals	Staffing and transportation for SUD treatment center	Drug Free Moms and Babies peer counselors at two FQHCs; referrals; Mood App
Provider and Community Engagement						
Provider training	Virtual and in-person training for emergency services personnel	Grand Rounds Training for ultrasound technicians Community Health Worker certification	Training for ultrasound technicians Education for perinatal case managers	Training with an OB mannequin	Training with an OB mannequin for emergency personnel	OB emergency training sessions and mannequin Funding for lactation consultation certification
Policy work and stakeholder engagement	BPN Connect meetings with major family services agencies in the Bootheel	Policy work with state organizations and Medicaid		Native American Advisory Council Tribal Health/ Family Spirit Program	Coordination with MCOs for reimbursement	Policy work with Medicaid on doula reimbursement Stakeholder meetings
Patient education		Mothers Council Postpartum education series Advertising	Parenting classes marketed through radio spots and social media ads Birthing classes	Parent educational resources	Young Parent Mentoring Program	Parenting education and birthing classes

Notes: The awardees in the first three table columns (in MO, NM, and TX) were part of the RMOMS 2019 Cohort.

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