Maternal Health Leadership Council Meeting

September 22, 2020

3:30 - 5:30 PM (Please note extended meeting time)

Agenda

3:30 – 3:40 **Roll call, review agenda and approve minutes**

3:40 – 3:45 **Adopt the Terms of Reference**

3:45 – 3:55 **Brief update from the Billings Clinic demonstration project**

3:55 – 4:00 **Brief update from the University of Montana data and evaluation team**

4:00 – 4:20 **Maternal mortality review (MMR) discussion**

- Report from the American College of Obstetricians and Gynecologists (ACOG) District VIII MMR Summit
- Discuss next steps for Montana

4:20 – 4:25 **BREAK**

4:25 – 4:40 **Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis**

- Recap of access to care barrier worksheet to check for additional details

4:40 – 4:55 **TOWS matrix strategy session**

- Barrier #1 – Access to care

4:55 – 5:25 **Driver diagram activity**

- Leslie deRosset, Implementation Specialist at the Maternal Health Learning and Innovation Center at The University of North Carolina

5:25 - 5:30 **Public comment**

Meeting materials

- Agenda
- Minutes
- Terms of Reference
- Notes from ACOG MMR Summit
- SWOT on access to care barrier
- TOWS worksheet
- Driver diagram slides

Maternal Health Leadership Council

Meeting Minutes : August 25, 2020 : 3:30-5:00 PM : Location: Zoom only

Members Present

Chair, Dr. Tersh McCracken, MOMS Medical Director & OB/GYN with Billings Clinic
Vice-Chair, **Judge Mary Jane Knisely,** 13th District Court Judge, Felony Impaired Driving Court (IDC), CAMO Court (Veterans Treatment Court)
Kristen Rogers, Family & Community Health Bureau Chief at DPHHS
Ann Buss, Title V Director/Maternal & Child Health Supervisor at DPHHS
Tami Schoen, WIC, CPA at Hill County Public Health Department
Dr. Tim Wetherill, Medical Director at Blue Cross Blue Shield of Montana
Dr. Drew Malany, OB/GYN at Women's Health Care Center, PLLC and Chair of Montana American College of Obstetrics & Gynecology (ACOG)
Dr. Bardett Fausett, Maternal Fetal Medicine Specialist and President/Medical Director at Origin Health
Lisa Troyer, Wellness Consultant at PacificSource
Mary LeMieux, Member Health Management Bureau Chief at Medicaid and Perinatal Behavioral Health/Meadowlark Initiative Project Director
Janie Quilici, LAC, LSWC, Perinatal Behavioral Health Counselor at Community Physicians Group
Jude McTaggart, Certified Nurse Midwife at Northeast Montana Health Services
Olivia Riutta (for Cindy Stergar), Outreach & Engagement Manager at Montana Primary Care Association
Vicki Birkeland, Nursing Director, Women's Services at SCL Health-St. Vincent Healthcare and Chair of the Montana Perinatal Quality Collaborative
Brie MacLaurin, Executive Director of Healthy Mothers, Healthy Babies
Dr. Christina Marchion, Family Medicine/OB at Central Montana Medical Center
Dina Kuchynka, Maternal & Newborn Health Manager at SCL Health – Holy Rosary

Members Absent

Karen Cantrell, American Indian Health Director at DPHHS
Dr Malcom Horn, Medical Director at Blue Cross Blue Shield of Montana

Program Staff Present

Amanda Eby, MOMS Program Specialist at DPHHS
Brenna Richardson, Program Assistant at DPHHS
Stephanie Fitch, Program Coordinator for MOMS at Billings Clinic
Dianna Linder, Director of Grants and Program Development at Billings Clinic
Annie Glover, Lead Evaluator of MOMS at the University of Montana

Public Attendees

Sandra Lloyd, Public Health Analyst- Maternal and Child Health Bureau

Welcome and introductions

Dr. Tersh McCracken opened the meeting and lead roll call, as well as reviewed the agenda and the prior months minutes were approved, with an amendment to add Tami Schoen to the members who were present.

Review the Terms of Reference

Dr. McCracken explained that there was nothing new on this for the council to review because they were still waiting to hear back from the DPHHS legal staff on the requirements of open meeting laws. This item was tabled until the next meeting.

Overview of the Alliance for Innovation on Maternal Health (AIM)

Dr. Tersh McCracken presented on the Alliance for Innovation on Maternal Health (AIM), which is a national data-driven maternal safety and quality improvement initiative. The goal is to eliminate preventable maternal mortality and severe morbidity across the United States. It is funded by a grant from HRSA and is made up of multiple partnerships including national and federal organizations, professional organizations, perinatal quality collaboratives and physicians. AIM offers multidisciplinary groups to work across national, state and facility levels. National organizations are developing quality improvement tools and are supporting a multi-state data platform as well as coordinating interstate collaboration. State level participation includes Montana Department of Health and Human Services (DPHHS), the MTPQC and this council. It is a goal that every hospital has a quality improvement team and that they start implementing some of the safety bundles from AIM and share best practices across the state, as well as with other states. Dr. McCracken feels Montana could be a leader with AIM amongst states like Wyoming, Idaho and the Dakotas.

AIM has rolled out Maternal Safety Bundles which are based on the most common and severe maternal mortality and morbidity occurrences. Each hospital, physician and midwife should know how to address these. The bundles include maternal venous thromboembolism (VTE), obstetrics care for women with opioid use disorder, severe hypertension in pregnancy, obstetric hemorrhage, postpartum basics (from maternity to well-woman care), safe reduction of primary cesarean birth, postpartum basics (from birth to postpartum visits) and reduction of peripartum racial/ethnic disparities. Every AIM Bundle offers four elements, which are called the four Rs: Readiness, Recognition and Prevention, Response and Reporting/Systems Leaning. Dr. McCracken expressed the value of utilizing these guidelines to learn from mistakes, learn from what went right, and learning from the processes and systems. Over the next few months, through MOMS and the leadership council, awe will educate Montana maternal health providers on the AIM bundles with the goal of selecting one to implement in spring 2021 as it applies to Montana and guided by the PQC. The key to a success is partnership and coordination with AIM, PQC and Maternal Mortality Review Committees (MMRC). Requirements to become an AIM state include a Maternal Mortality Review Committee, the ability to collect data, and have a state-based multidisciplinary coordinating body (PQC).

DPHHS updates on PQC, MMRIA and MMRC

Amanda Eby expressed her enthusiasm for the MOMS program's commitment in supporting the PQC in Montana, which includes administrative support to the PQC which will offer a consistent structure. That is still in development but should be announced in September's meeting and working towards wrapping up the current work the PQC is doing on Safe Sleep certification for hospitals.

Amanda updated the leadership council on Maternal Mortality Review Information Application (MMRIA) and explained in the past all of Montana's maternal mortality data was kept on paper. DPHHS has had a staff epidemiologist and data analyst working to create a database for storing, analyzing and pulling reports on historical data. That database is now live and functioning. The transition to using MMRIA will be slightly more complicated because it requires coordination with local, county and state staff on how

to move forward. The Centers for Disease Control (CDC). prefers a regional approach for states like Montana that have a lower number of deaths. Montana is currently in talks with Utah about joining their Maternal Review Committee (MMRC). Kristen Rogers is leading the discussion with Utah on how the partnership would work. Utah has invited a few members of the council to listen in on a maternal review next month. Kristen also discussed the Montana Code Annotated, that requires county local review to continue in some way. Possibly someone from the local level can participate in a death review and that would suffice the code. This is currently being looked at by a lawyer.

Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis

Amanda explained the plan to conduct a SWOT (Strength, Weaknesses, Opportunities, Threats) analysis in breakout rooms for the top four barriers to best prenatal, labor and delivery and postpartum care that were identified in the needs assessment. The council divided into four groups and each group completed a SWOT worksheet for one of the following barriers:

- In prenatal care in Montana, address the lack of treatment options for substance use disorders and lack of providers or consultation to treat depression/depressive disorders.
- In prenatal care, labor and delivery and postpartum care in Montana, address the lack of patient access to care, distance to care.
- In prenatal care in Montana, address patient domestic situations (homelessness, unsafe housing, domestic violence (social determinants of health [SDOH]).
- In labor and delivery and postpartum care in Montana, address provider skill decay from not
- treating a sufficient volume of pregnant women to maintain skills.

After the breakout discussion, the small groups reported out to the full group on how they completed their worksheet. The council will continue this discussion at the next meeting for a deeper dive analysis of each SWOT.

Review council page on website, process for meetings

Amanda asked the council for feedback on the website and how the process is going so far for communication, information on the program and materials for meetings. After receiving minimal feedback, she asked if they wanted her to add navigation to the council's page on the website from the main page of the website so that it can be accessed by the public. Dr. Malaney opted for the link to be added and Amanda said she would add it.

Schedule for reports from demonstration project to council

Dr. McCracken and Amanda asked the council if there was a preference for the frequency in which the receive written reports from the demonstration project; hearing no feedback, he asserted that Billings Clinic will consider what is reasonable and they will likely be quarterly.

September – finalize strategic plan and training on implementation science

The September meeting will include a guest speaker on implementation science, which will be helpful after identifying strengths and weakness and how to implement changes through evidence-based programs to ensure sustainability.

Public Comment

No public comments were made. Members of the leadership council had additional comments and questions.

Brie MacLaurin provided information that the Healthy Mothers, Healthy Babies conference registration is now open. Brie briefly went over the agenda, which would include some sessions on perinatal mood and anxiety disorders, substances use and pregnancy, as well as a fatherhood specialist. Some council members may have free registrations available to them through their organization's sponsorship. This conference is also approved for the six credits required for the perinatal mental health certificate.

Dr. Drew Malany asked about the upcoming meeting in Salt Lake City for the ACOG District Eight Regional Committee Summit on Maternal Mortality Review and a representative from Montana to provide a two-minute presentation on Montana's MMR work. Dr. Bardett Fausett volunteered to do the two-minute presentation on behalf of Montana.

Review Meeting Process and Next Steps

Dr. Tersh McCracken and Amanda thanked everyone for their attendance and contributions to the committee. The next meeting was confirmed for September 22, 2020, 3:30-5:00.

Meeting adjourned at 4:59pm.

LEADERSHIP COUNCIL TERMS OF REFERENCE
9/18/20

This document sets forth the guiding policies and procedures for which the council will operate.

Membership Term: Two-year term to allow for a check in on commitment approximately halfway through the life of the program, with two possible re-appointments for a maximum term of six years. Appointments will occur bi-annually in June.

Other interested parties: Appointed, voting members will not exceed 19, discussion and comments from the public will be invited at the end of every meeting. Other representatives beyond the 19 council members may serve on subcommittees for specific work.

Chair and Vice-Chair Terms: The chair and vice-chair will serve a two-year term but may seek re-election in June bi-annually. These leadership positions are determined through a roll call vote during the meeting or via email to the DPHHS Program Contact. Montana Department of Public Health and Human Services (MT DPHHS) staff will not serve in leadership positions nor are they allowed to vote.

Chair and Vice-Chair Roles and Responsibilities: The council chair and vice-chair collaborate with program staff leads to develop meeting agendas and materials as well as the overall strategic plans for council initiatives. The chair facilitates council meetings with program staff. The vice-chair supports the chair as needed and serves in his/her absence to facilitate meetings.

Proxies: A proxy with voting privileges must be designated and submitted in writing to the department and council leadership by the council member in advance of sending the proxy in his or her place. Proxy attendance does not count toward the council member's attendance requirement.

Attendance Expectation: Members will be excused from the committee after three consecutive unexcused absences from meetings. Regular meeting attendance is important to understanding MOMS program activities and challenges to implementation to be able to advise and provide helpful input to program staff.

Meeting Schedule: Meetings occur the fourth Tuesday of every month, 3:30-5:00 PM. Program staff will provide at least one-week notice if a meeting will need to be extended to 5:30. Rescheduling meetings due to holidays or conflicts will be determined by council leadership and program staff and they will notify members at least one-week in advance.

Meeting Location: While social distancing requirements are enforced by the State of Montana due to the COVID-19 pandemic, meetings will be held via zoom using the following information:

https://mt-gov.zoom.us/j/91224192994?pwd=d1RTaENYczdLVXMra0FJNGhwM2JPUT09
Meeting ID: 912 2419 2994
Password: 201080
Dial by Telephone
+1 646 558 8656

When in-person meetings are possible, the council will meet in person quarterly. The first meeting in-person meeting will be in the basement conference room of the State of Montana USFG building at 1625 11th Avenue in Helena, Montana. Subsequent in-person meetings can potentially rotate locations between Missoula, Bozeman, Billings or other appropriate cities, as determined by the council.

Voting: All council members can vote except potential ad hoc members such as legislative representatives and DPHHS staff. Voting will be conducted using a verbal roll call vote during the meeting or via email to the DPHHS Contact. Decision-making consensus requires a quorum of at least 50% of the council members.

Frequency of Review of Terms of Reference: This document will be reviewed and approved via council vote bi-annually unless council leadership or program staff determine a need for additional review.

Linking Communication Protocols:

- The council will determine a schedule for reports from Billings Clinic, University of Montana, the DPHHS Meadowlark Initiative, DPHHS – Maternal Mortality Information Application (MMRIA), Maternal Mortality Review Committee (MMRC), Perinatal Quality Collaborative (PQC); and other reports as requested.
- Resources available to the council:
    - Information and updates on MOMS program activities are on the website at www.mtmoms.org.
    - The council's meeting notices, agendas, minutes, materials and other resources can be found here: https://www.mtmoms.org/moms-leadership-council/.
- MOMS program staff at DPHHS will email council members the meeting information and materials the week prior to each meeting.

Purpose of the council: The council serves in an advisory capacity to DPHHS program staff to guide on program implementation.

Deliverables/Outputs:

- Strategic plan based on identified gaps in care in the Title V and MOMS Needs Assessments
- Advice on communications campaign plan
- Feedback on MOMS program activities
- Maintain consistent collaboration among all interrelated entities focused on perinatal and maternal health (MMRIA, MMRC, PQC, HMHB, Safe Sleep, Title V, etc.)
- Other items that may be identified by the Leadership Committee or HRSA required

SENIOR LEADERSHIP SIGNATURE APPROVAL

Printed Name	Signature	Date
Dr. Clayton "Tersh" McCracken		

Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE-MM): MMRIA and DVIII States Update
Meeting Notes 9/10/2020

- Funding and technical assistance
    - 24 awards / 25 states (MT was not awarded)
    - Awards made in Sept 2019
    - Ongoing technical assistance and training to all MMRCs

- 47 existing MMRCs in the U.S. and 44 use MMRIA to guide deliberation
    - Provides data standardization
    - Provides a comprehensive picture across multiple jurisdictions
    - Recipients and CDC analyze date and share findings with stakeholders to inform policy and prevention strategies

- Between 2008-2016, four states (Hawaii, Arizona, Colorado, Utah) provided data on 59 pregnancy related deaths.
    - Data on 59 pregnancy related deaths:
        - 28% died while pregnant
        - 28% died within 42 days
        - 44% died with 43 days- 1 year
    - Leading cause of death pregnancy-related deaths in District VIII:
        - 43% Mental Health Conditions
        - 11% Cardiovascular Conditions (includes cardiomyopathy)
        - 11% Hemorrhage
        - 9% Embolism
    - Utah has established a Pregnancy-relatedness Criteria for Mental Health-related deaths including overdose and suicide:
        - Pregnancy complications
        - Chain of events initiated by pregnancy
        - Aggravation of an unrelated condition by the physiologic effects of pregnancy
    - Causes of pregnancy-related deaths due to mental health conditions in District VIII
        - 52% Suicide
        - 26% Unintentional overdose
        - 22% Missing/unknown
    - MMRIA data, submitted by the four District VIII states show:
        - 80% where preventable (vs 66% national)
        - 18% not preventable (vs 29% national)
- Contributing Factors & Recommendations for Actions:
    - Access to clinical care
        - Expand office hours, increase numbers of providers who accept Medicaid

        - Unstable housing
        - Prioritize pregnant women for temp housing program
    - Inadequate transportation
        - Strengthen systems that link person to affordable transportation
    - Obesity and associated chronic illness
        - Improve access to healthy food options. Improve education of healthy eating.

- State Presentations: Key Points
    - Alaska has been reviewing deaths since the 1990's. They have approximately 8-12 a year.
    - Arizona focuses on socio-economic networks to provide robust recommendations.
    - British Columbia has been reviewing deaths since 1936 and follows the Australian and New Zealand perinatal questionnaire.
    - Colorado has been reviewing deaths since 1950's and public health since 1980. They are currently looking more into systematic racism regarding maternal mortality.
    - Montana is currently implementing the MMRIA system and working with the CDC to move forward. A small number of cases and are working on collaborations with Utah and Wyoming.
    - New Mexico is working with NMDOT and comparing automobile accidents relatable to maternal mortality.
- Areas of concern across the board include confidentiality issues as well as emotional and mental support for committee members.

Worksheet

SWOT Analysis

MOMS
Montana Obstetrics & Maternal Support

In prenatal care, labor and delivery and postpartum care in Montana, address the lack of patient access to care, distance to care.

Strengths What do you do well? What unique resources can you draw on? What do others see as your strengths?	**Weaknesses** What could you improve? Where do you have fewer resources than others? What are others likely to see as weaknesses?
-Riverstone residency program, as well as Western Montana residency program, places family practice providers in Montana, stay local. Many interested in OB. -Strong midwifery programs, both lay and certified. -Most women have access to insurance, including Medicaid, private insurance, or IHS. Most providers take Medicaid patients.	-Distance patients have to travel. -Lack of transportation, cost of transportation. -Counties where the birthrate is the highest are the counties that have the greatest need, economically, medically, etc. Higher need —> less resources. -Loss of OB at Crow hospital (could be opportunity).
Opportunities What opportunities are open to you? What trends could you take advantage of? How can you turn your strengths into opportunities?	**Threats** What threats could harm you? What is your competition doing? What threats do your weaknesses expose you to?
-Leveraging midwife programs. Other countries, such as Canada and Australia, rely heavily on lay midwife model. Look at inviting midwives to the table to discuss access. -Look at safe handoff protocols from other countries, states. -Train indigenous midwives… look at Canada, Australia, Afghanistan models. -Increase confidence and skill level of OB providers and related care, such as urgent care, ED. -Investigate role of EMS services and transfer in terms of rural hospitals -Look at number of births occuring outside of hospitals	-General trend of reduction in OB services in rural communities, including in IHS hospitals.

MindTools
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Worksheet

TOWS Strategic Alternatives Worksheet

- For instructions on TOWS Analysis, visit www.mindtools.com/rs/TOWS.

	External Opportunities (O)	**External Threats (T)**
	1. Leverage midwife programs **2.** Investigate the role of EMS services **3.** # of births outside of hospitals-data **4.**	**1.** Lack of OB services, rural comm. **2.** **3.** **4.**
Internal Strengths (S) **1.** RiverStone Residency **2.** Access to insurance **3.** **4.**	**SO** Maxi-Maxi Strategy	**ST** Maxi-Mini Strategy
Internal Weaknesses (W) **1.** Distance to receive care **2.** Transportation-cost and access **3.** Highest birth rate=highest need **4.**	**WO** Mini-Maxi Strategy	**WT** Mini-Mini Strategy

Tailored Support with MOMS Montana

Leslie deRosset
derosset@email.unc.edu
September 22, 2020

Maternal Health
Learning & Innovation Center™

Overview

SWOT → TOWS

Drivers Assessment

A little about me

- Live in North Carolina
- Implementation Specialist = Support agencies & organizations to help build capacity, create sustainable programs and products
- Have worked in Maternal Child Health > 20 years
- Married with two kids and a dog

What is the TOWS Process?

- TOWS = Threats, Opportunities, Weakness and Strengths

- Helps us look at different strategies for strategic planning around an “issue” that was explored in the SWOT Analysis
  - Internal strengths and weaknesses
  - Competitive advantage and disadvantages
  - External environment opportunities and threats

	External Opportunities (O) 1. 2. 3. 4.	External Threats (T) 1. 2. 3. 4.
Internal Strengths (S) 1. 2. 3. 4.	SO Maxi-Maxi Strategy	ST Maxi-Mini Strategy
Internal Weaknesses (W) 1. 2. 3. 4.	WO Mini-Maxi Strategy	WT Mini-Mini Strategy

https://blog.oxfordcollegeofmarketing.com/2016/06/07/tows-analysis-guide/

What is the TOWS Process?

- SO → Strategies for pursuing opportunities.
- ST → Strategies for using strengths to reduce threats.
- WO → Strategies for overcoming weaknesses.
- WT → Strategies to prevent or reduce weaknesses to external threats

	External Opportunities (O) 1. 2. 3. 4.	External Threats (T) 1. 2. 3. 4.
Internal Strengths (S) 1. 2. 3. 4.	SO Maxi-Maxi Strategy	ST Maxi-Mini Strategy
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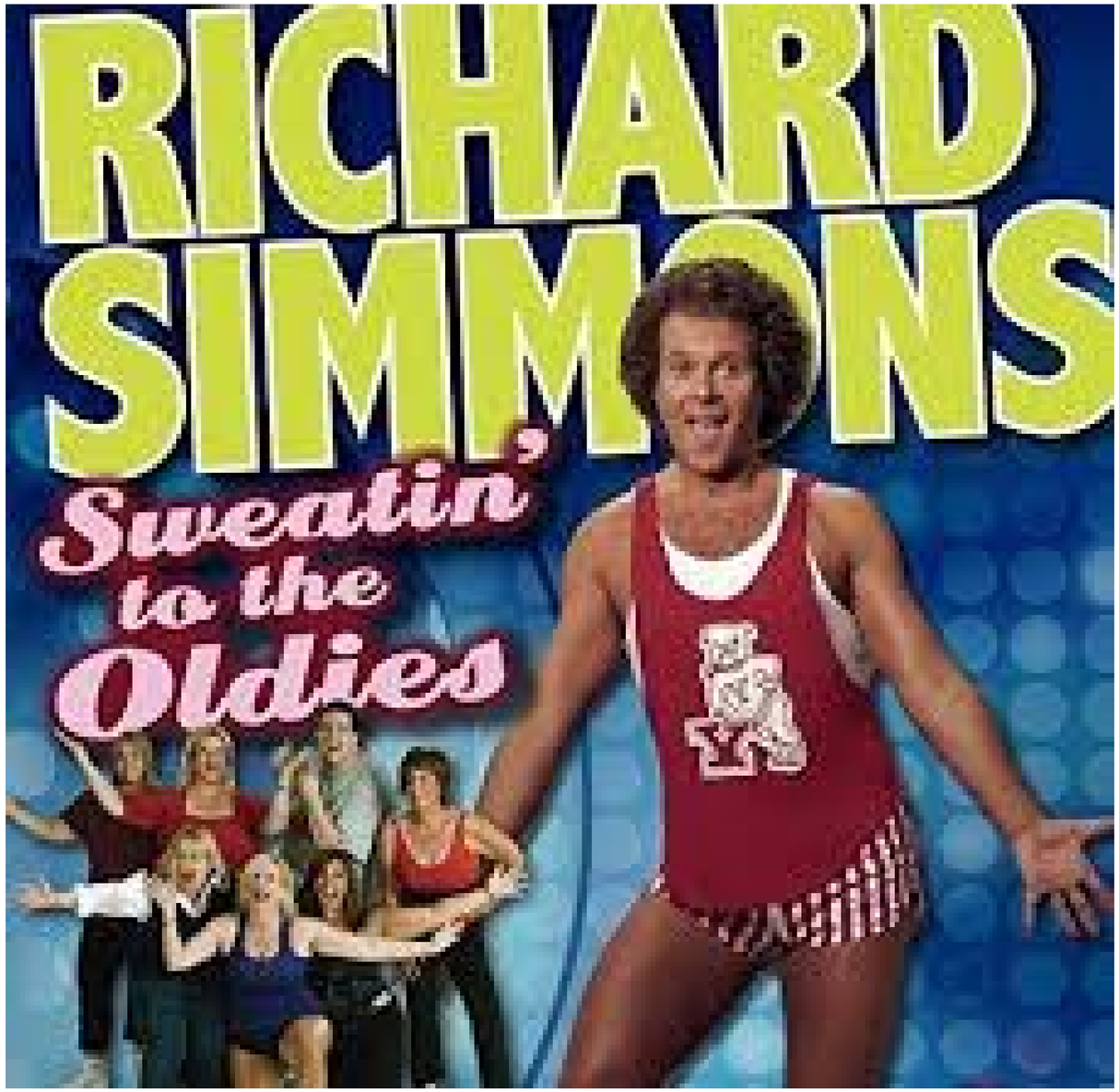
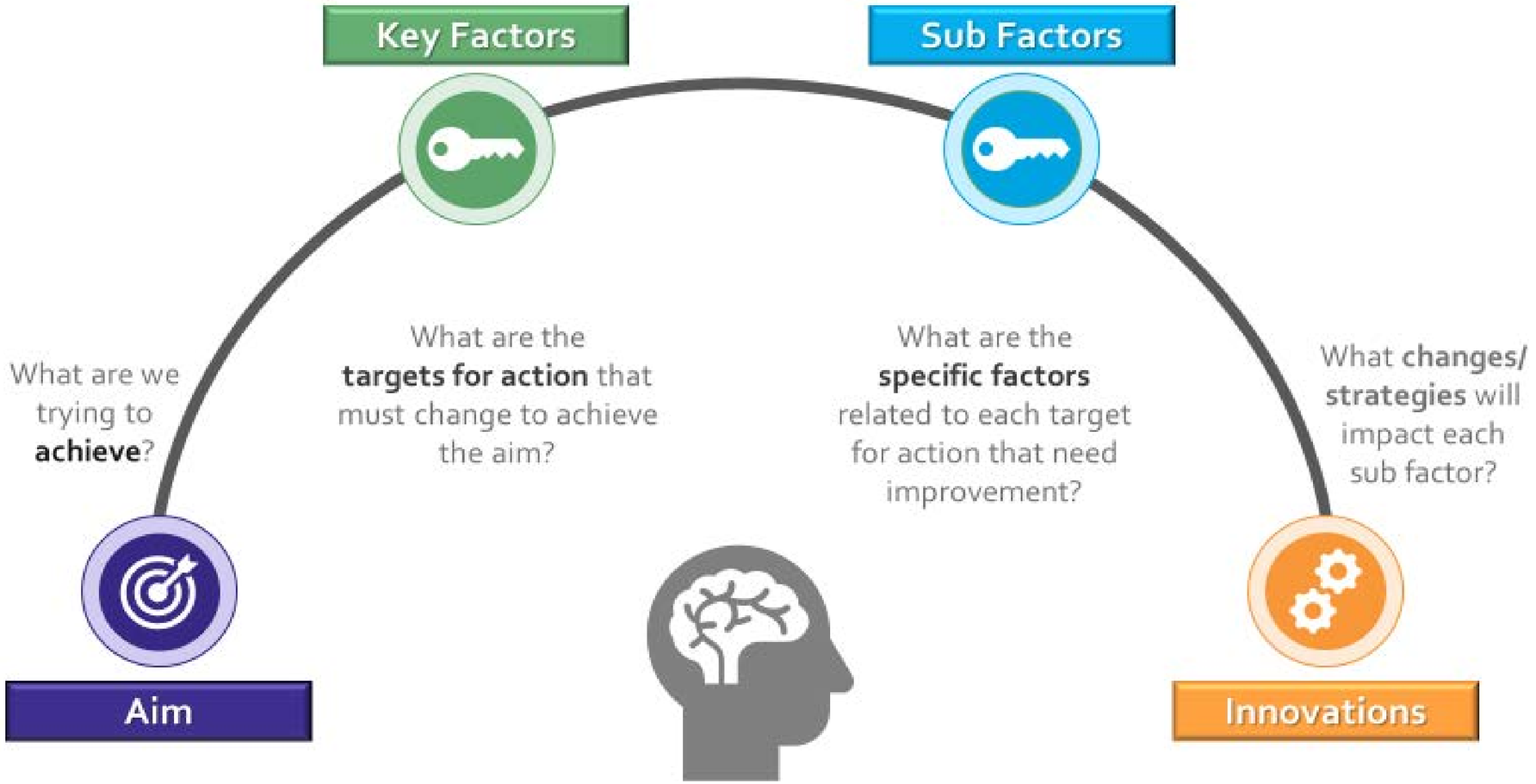


Stretch Break

What is a Drivers Assessment?

- A visual summary of an overall improvement strategy
  - Shows all the possible pathways
  - Helps identify the scope and areas of influence
  - Prioritizes areas of focus
  - Communicates the “big” picture

Why use a Drivers Assessment?

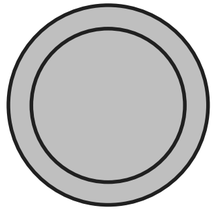


How do a Drivers Assessment & Logic Model Differ?

Key Driver Diagram *(Expanded Focus)*	**Logic Model** *(Zoomed In)*
• Focuses on systems level change • Shows **all the possible** pathways and innovations that can achieve an outcome • Helps stakeholders prioritize innovations	• Focuses on programmatic level detail • Shows pathway and key components **for a specific innovation/program** • May create multiple logic models from a Key Driver Diagram
• Visually links outcomes and activities to explain **HOW and WHY** an expected outcome will take place (causal) • Start with the goal and ask… *If we do **X (innovation) then Y (outcome)** will be achieved **because**…*	• Visually links program components to explain **WHAT** program inputs and activities will achieve the outcome • Start with the goal and asks…*If we want **X(outcome)** then Y **(program activities/inputs)** are needed*

The Process

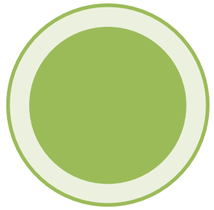
Aim



What are we trying to **achieve**?

We aim to improve…

Primary Drivers



What are the **targets for action** that must change to achieve the aim?

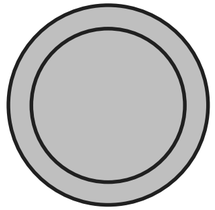
Target for Action #1

Target for Action #2

Target for Action #3

- Catalyze multidisciplinary collaboration in maternal health across the state of Montana
  - Establish the Montana Center for Excellence in Maternal Health to house the **Maternal Health Council** and the Maternal Mortality Review Committee

Aim



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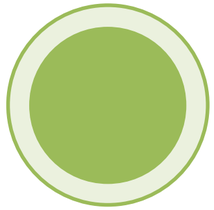

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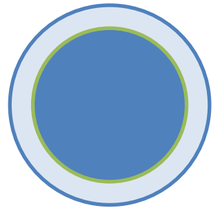
Target for Action #3

Secondary Drviers



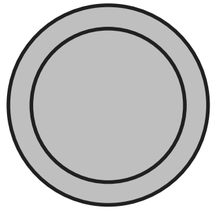
What are the **specific factors** related to each target for action that need improvement?

Sub Factors #1

Sub Factors #2

Sub Factors #3

Aim



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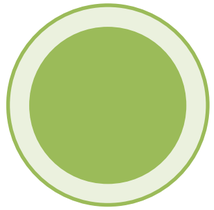
We aim to improve…

Primary Drivers



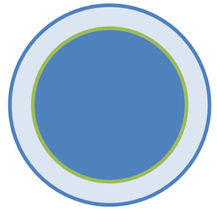
What are the **targets for action** that must change to achieve the aim?

Target for Action #1

Target for Action #2

Target for Action #3

Secondary Drivers



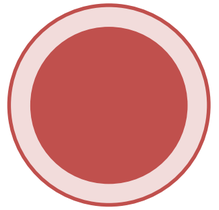
What are the **specific factors** related to each target for action that need improvement?

Sub Factors #1

Sub Factors #2

Sub Factors #3

Change Ideas



What **changes/ strategies** will impact each sub factor?

Innovation #1

Innovation #2

Innovation #3

Innovation #4

Aim

What are we trying to **achieve**?

Key Factors

What are the **targets for action** that must change to achieve the aim?

Sub Factors

What are the **specific factors** related to each target for action that need improvement?

Innovation

What **changes/ strategies** will impact each sub factor?

We aim to improve…

Target for Action	Sub Factors	Innovation
Target for Action #1	**Sub Factors #1**	**Innovation #1**
Target for Action #2	**Sub Factors #2**	**Innovation #2**
Target for Action #3	**Sub Factors #3**	**Innovation #3**
		Innovation #4

Drivers Assessment slide courtesy of MCH WFD. Spring 2020

Aim

Primary Drivers

Secondary Drivers

Change Ideas

Debrief

1. What is the casual pathway?
2. How does knowing this information help our work?
3. What did we see today that maybe we had not seen before?
4. What’s our next step?

What’s Next?

Thank yo

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MaternalHealthLearning.org