Maternal Health Leadership Council Meeting
October 27, 2020
3:30 - 5:00 PM

Agenda
3:30 – 3:40       Roll call, review agenda and approve minutes
3:40 – 4:00       Maternal mortality review (MMR) discussion
4:00 – 4:25       Determine key drivers for workplan objective 1: catalyze multidisciplinary collaboration in maternal health
4:25 – 4:35       Draft Strategic Plan – submitted to HRSA 9/29
4:35 – 4:45       Maternal Health Report preview from University of Montana
4:45 – 4:55       Update from a MOMS partner – Healthy Mothers, Healthy Babies (HMHB)
4:55 – 5:00       Public comment

Materials
Agenda
Draft minutes
MMR flow chart
Driver diagram slides
Draft strategic plan
Maternal Health Report slides
HMHB slides
Maternal Health Leadership Council
Meeting Minutes : September 22, 2020: 3:30-5:30 PM : Location: Zoom only

Members Present
Chair, Dr. Tersh McCracken, MOMS Medical Director & OB/GYN with Billings Clinic
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
Karen Cantrell, American Indian Health Director at DPHHS
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
Vice-Chair, Judge Mary Jane Knisely, 13th District Court Judge, Felony Impaired Driving Court (IDC), CAMO Court (Veterans Treatment Court)
Lisa Troyer, Wellness Consultant at PacificSource
Jude McTaggart, Certified Nurse Midwife at Northeast Montana Health Services
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
Carly Holman, University of Montana

Public Attendees
Leslie deRosset, Implementation Specialist at the Maternal Health Learning and Innovation Center (MHLIC) and the University of North Carolina

Welcome and introductions
Dr. Tersh McCracken opened the meeting and lead roll call. Dr. Christina Marchion motioned to approve the August minutes and the leadership council approved the meeting minutes.
Adopt the Terms of Reference
Dr. McCracken requested to adopt the Terms of Reference. Amanda Eby gave a brief recap that the Terms of Reference was created from a template provided by MHLIC. There was a delay with approving the terms due to legal guidance on requirements for public meetings. Since public funds are used for this program, meetings will always be open to the public and archived on the website. Dr. McCracken requested a motion to approve. Dr. Drew Malany motioned to approve the Terms of Reference and the leadership council approved the terms.

Update from the Billings Clinic demonstration project
Stephanie Fitch provided an update on the Billings Clinic demonstration project. Billings Clinic continues to do Project Extension for Community Healthcare Outcomes (ECHO) clinics the second and fourth Tuesdays each month. They are always looking for case presentations for future ECHO Clinics. Billings Clinic continues to work with Simulation in Motion Montana (SIM-MT) for the mobile simulation training but are hitting some delays because of COVID-19. Trainers for the American College of Obstetricians and Gynecologists Emergencies in Clinical Obstetrics (ACOG ECO) Train-the-trainer program are unable to travel due to COVID-19 restrictions, so ACOG is piloting a virtual option. Nursing certification courses for Neonatal Resuscitation Program (NRP) and Sugar, Temperature, Airway, Blood pressure, Lab work and Emotional support (STABLE) will be offered to nurses in rural Montana for facilities that are non-birthing, primarily. Billings Clinic continues to work out details for the perinatal substance use treatment demonstration project, which will connect women to behavioral health and medication assistance treatment. Virtual patient monitoring is still in the planning stages and could be rolled out early 2021.

Update from the University of Montana data and evaluation team
Carly Holman (filling in for Annie Glover) provided an update on the University of Montana data and evaluation. The Maternal Health in Montana report is almost final with plans to present to the leadership council in October. This report will always be available to the public and is a comprehensive overview of maternal health in the state. The telemedicine obstetrician care delivery and COVID-19 research study is also almost complete, with plans to present the results later this winter. The severe maternal morbidity study has launched and is in partnership with the Montana Hospital Association (MHA). The research focus is to assess patterns and quantify causes of severe maternal morbidity in Montana as well as examine disparities related to geography, race, hospital and maternal characteristics. The University continues to provide ongoing technical assistance and quality improvement support to the state and Billings Clinic.

Maternal mortality review (MMR) discussion
Dr. McCracken provided a summary of the ERASE Maternal Mortality: MMRIA and ACOG DVIII States Update meeting, stating that it was inspiring and invigorating to hear what other states are doing, what they've found, how they're acting on it and what their barriers have been. Dr. Drew Malany also summarized the discussion from the meeting, stating Montana is doing well with hospital inpatient deaths, as far prevention. Most deaths are happening from six weeks to one year in the areas of suicide,
mental health and car accidents. Montana does have Maternal Mortality Review Information Application (MMRIA) now and starting with 2020 deaths, all deaths will be reported through the MMRIA system. Another stand out focus in the meeting was the health coverage need for women, postpartum six weeks to a year. The Montana Medical Association is looking at the effect of Medicaid expansion and what the impact is on patients losing private insurance and still being covered.

Ann Buss provided next steps for a Maternal Mortality Review Committee (MMRC). Montana will be joining a regional committee with Utah and Wyoming. The Montana Code Annotated is written in such a way that the state will be able to do the MMRC at an established county level and then work with the regional committee. The Department of Public Health and Human Services (DPHHS) will need to figure out data use agreements and memorandums across states. Additional steps include working with the Centers for Disease Control (CDC) on training for MMRIA. Montana will develop the MMRC at a state level, utilizing the local FICMRR review committee lead. Further discussion on how many times a death will be reviewed will continue, and finer details will continue to be worked out.

**Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis & TOWS matrix strategy session**

Amanda Eby provided a brief description the SWOT Analysis findings from the August meeting. Leslie deRossett with the MLHIC facilitated a discussion to recap and expand the Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis of the access to care barrier. Then Leslie facilitated the council in completing a Threats, Opportunities, Weaknesses and Strengths (TOWS) Assessment of the access-to-care barrier. Leslie explained having identified threats and weaknesses can help build a better TOWS. Leslie’s presentation can be found here.

**Key comments and concerns from the SWOT Analysis and TOWS Assessment**

- There is a real threat to the health of women with the potential roll back of Medicaid Expansion and Affordable Health Care Act.
- If we don’t work to make changes, we will see an increase in severe morbidity and mortality.
- Increase awareness and access to psychiatric care and social workers.
- Recognizing culturally competent care for Montana’s American Indian community members, both on and off the reservations.
- Understanding cultural differences and multi-generational trauma communities face - especially those communities that are still incarcerating pregnant women that are caught using illegal substances.
- Trying to reduce the stigma and educating healthcare people of trauma that pregnant women may be experiencing.
- It’s important to find opportunities and identify residents that might want to stay in a frontier community because of education on loan repayment programs.
- Finding a way to connect relationships already established with the Indian Health Services and connecting them with midwives.
Finding areas of opportunities to increase training for EMS and paramedics to provide more advanced life-saving skills during transfers. Montana has a lot of volunteers in rural areas and would benefit from grants.

Montana is a very connected state that enjoys working across the board - this opens opportunities

How can Montana’s Home Visiting Program help with the MOMS Program?

One area of opportunity is to get into Montana schools and educate the younger population about Student Loan Repayment Programs.

Another area of opportunity is filling the gap between what’s happening on the ground in communities and counties versus what’s happening at the state level.

After wrapping up the TOWS assessment, Leslie gave a brief introduction to driver diagrams to prepare for the topic at the October meeting.

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 October 27, 2020, 3:30-5:00.

Meeting adjourned at 5:34 pm.
MMRC Proposal for Montana- just a draft
Maternal Death

- ID’d by Dept of Vital Statistics
- Hospitals
- EMR/ Law Enforcement
- Physicians
- Need to have a double check to make sure all are accounted for

Referred to County FCMR Team

- Verifies Maternal Death
- Collects Basic Facts
- Makes local and/or urgent recommendations
Referred to MT MMRC

- Data Extracted by MMRIA Extractor
- MMRIA Database file initiated
- Pertinent information collected for review
- Distributed to MMRC

MMRC

- Composed of Physicians/CNM, Hospital Admin, Social Work/Psych, Legislator, etc.
- 4-year renewable term
- Meets twice a year
MMRC Review

- Determines Preventable/Not Preventable
- Makes Recommendations
  - PQC
  - Health Dept
  - Hospitals
  - MMA/ACOG/etc.
- Writes Cases Summary
- Produces annual report
- Distributed to MMRC

Refers to Regional MMRC

- Case summaries discussed
- Regional Information shared
- Information from regional meeting Taken back to the state
Drivers Discussion Anticipated Outcomes:

- Identify primary drivers that connect the secondary drivers to the aim, and then to the goal.
- Identify change ideas or innovations that will better inform how to carry out the secondary drivers.
Aim: Catalyze multidisciplinary collaboration in maternal health

Goals: Ensure maternal health is a priority issue in Montana

(Key Factors) Primary Drivers:
Create urgency and immediate action around the importance of maternal mortality/morbidity in MT

(Sub Factors) Secondary Drivers:

Change Ideas (Innovation):

MaternalHealthLearning.org
**Aim**
Catalyze multidisciplinary collaboration in maternal health

**Goals:** Ensure maternal health is a priority issue in Montana

**Key Factors (Primary Drivers):**
- Create urgency and immediate action around the importance of maternal mortality/morbidity in MT

**Sub Factors (Secondary Drivers):**
- Support and collaborate with PQC to guide towards AIM enrollment
- Establish Maternal Health Task Force (Council)
- Establish a Maternal Mortality Review Committee
- Develop maternal health strategic plan

**Change Ideas (Innovation):**
Aim

Catalyze multidisciplinary collaboration in maternal health

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(Sub Factors) Secondary Drivers

Support and collaborate with PQC to guide towards AIM enrollment

Establish Maternal Health Task Force (Council)

Establish a Maternal Mortality Review Committee

Develop maternal health strategic plan

Change Ideas (Innovation)
# 2020 DRAFT STRATEGIC PLAN

## 1. Overview of Maternal Health & Wellness

### a. The Montana Obstetrics and Maternal Support (MOMS) program has worked with a task force, the MOMS Maternal Health Leadership Council to identify strengths and challenges related to the top four barriers to the best prenatal, labor and delivery and postpartum care that were identified by a needs assessment. The table below summarizes the strengths and challenges identified for each of the programs areas of work – driven by needs assessment results.

<table>
<thead>
<tr>
<th>Barrier/Focus Area</th>
<th>Strengths</th>
<th>Challenges</th>
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<tbody>
<tr>
<td>Access to care</td>
<td>• Two family medicine residency programs to recruit providers interested in obstetrics to stay in Montana to practice.</td>
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<td>• Strong lay and certified midwifery programs.</td>
<td>• Patients must travel long distances to receive care, which also provides safety challenges in inclement weather.</td>
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<td></td>
<td>• Medicaid expansion program makes most Montanans insured and most providers take Medicaid patients.</td>
<td>• Patients lack reliable and affordable transportation to care.</td>
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<td></td>
<td>• Patients must travel long distances to receive care, which also provides safety challenges in inclement weather.</td>
<td>• Rural hospitals and Indian Health Services (IHS) continually reducing obstetric services.</td>
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<td>• Patients lack reliable and affordable transportation to care.</td>
<td>• Patients lack the necessary technology and/or internet for telehealth.</td>
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<td>Provider skill level</td>
<td>• MOMS Extension for Community Healthcare Outcomes (ECHO) is providing clinical training and patient case review sessions for rural providers.</td>
<td>• ECHO struggles to get patient-case submissions and to get physicians to attend rather than nurses.</td>
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<td>• MOMS Simulation in Motion-Montana (SIM-MT) Training provides mobile high-fidelity medical simulation training to reduce errors, improve outcomes and increase team performance at rural non-birthing hospitals.</td>
<td>• SIM-MT is currently contracted only for trainings in Eastern Montana.</td>
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<td>Social determinants of health (SDOH)</td>
<td>• Some clinics have started screening for SDOH to identify the patient’s situation and provide resources.</td>
<td>• Covid-19 has prevented MOMS from hosting face-to-face trainings.</td>
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<td>• Some facilities have teams meeting to discuss domestic violence.</td>
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<td></td>
<td>• Urban communities have resources that provide resources for women experiencing domestic violence such as housing, help with forensic interviews, legal assistance and referrals to substance use disorder (SUD)/mental health treatment.</td>
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<td></td>
<td>• Training on SDOH is inadequate.</td>
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<td>• Provider caseloads are overwhelmed without enough time to adequately address SDOH.</td>
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<td></td>
<td>• There are not enough resources to refer patients to for SDOH.</td>
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<td></td>
<td>• Many organizations lack social services, case managers and counselors.</td>
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<td></td>
<td>• Rural areas do not have stable domestic violence resources and housing.</td>
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<td>Treatment for substance use and depressive disorders</td>
<td>Funding and workforce training to provide treatment and professional mental health services.</td>
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<tr>
<td></td>
<td>More providers are waivered to give medication assistance treatment (MAT).</td>
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<td>The “Eat. Sleep. Console” program is reducing Children and Family Services interventions and keeping babies out of the neonatal intensive care unit (NICU).</td>
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<td></td>
<td>The Montana Primary Care Association (MPCA) MAT trainings, Quitline program, perinatal mental health conferences, local maternal mental health coalitions and breastfeeding supports are all strengths.</td>
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<td>It is difficult to keep all key players consistently apprised of all the relevant activities.</td>
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<td>There are limited treatment options for prenatal SUD and perinatal mental and anxiety disorders (PMADs).</td>
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<td>The stigma surrounding prenatal SUD patients prevents patients from seeking care and providers from adequately caring for these patients.</td>
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b. MOMS program staff compiled the [Montana Maternal Health Programs and Resources report](#) to identify perinatal resources and serve as the hub of information on existing maternal health initiatives within Montana.

2. Maternal Health Task Force (MOMS Leadership Council)
   a. [Click here to access the Council Charter](#) that contains the council’s aim, mission, goals and roster.

   **MISSION:**
   MOMS will improve maternal health across the state to make the Last Best Place also the First Best Place to have a baby.

   **VISION:**
   - What are we trying to accomplish?
     - Improve maternal mortality and morbidity rates in Montana by increasing access to specialty providers and resources needed for high-risk pregnancies – perinatology, psychiatry, medication assisted treatment (MAT), behavioral health treatment, substance use treatment and community-based resources.
   - Why is it important?
     - Montana has the sixth highest maternal mortality rate nationwide and Montana’s rate of severe maternal morbidity is 35% higher than the national rate. Maternal health is the cornerstone of a community’s health.
   - Who is the target population?
     - Pregnant and postpartum mothers through the first year after delivery.
   - What is the time frame for completing the effort?
     - Five years

   **KEY DRIVERS:**
   The council is working with program staff and support from the Maternal Health Learning and Innovation Center (MHLIC) to develop key drivers. MHLIC
Implementation Specialist, Leslie deRosset gave an overview of a driver diagram at the Council’s September 22, 2020 meeting to introduce the concept prior to facilitating them in the strategy activity at upcoming meetings. Program staff plans to work with the Council to define approximately two to three drivers per program objective (goal), as indicated in the grant’s work plan.

b. Membership by Organization Name & Roles

<table>
<thead>
<tr>
<th>Representing/Role</th>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOMS Medical Director and OB/GYN (Chair)</td>
<td>Dr. Tersh McCracken</td>
<td>Billings Clinic</td>
</tr>
<tr>
<td>State public health/Title V Director</td>
<td>Ann Buss</td>
<td>Montana DPHHS</td>
</tr>
<tr>
<td>Local public health</td>
<td>Tami Schoen</td>
<td>WIC, Hill County Public Health Dept.</td>
</tr>
<tr>
<td>Maternal Morbidity Review Committee</td>
<td>Dr. Drew Malany</td>
<td>Women’s Health Care Center, PLLC</td>
</tr>
<tr>
<td>Maternal Fetal Medicine Specialist</td>
<td>Dr. Bardett Fausett</td>
<td>Origin Health</td>
</tr>
<tr>
<td>Family Practice trained OB in rural area</td>
<td>Dr. Christina Marchion</td>
<td>Central Montana Medical Center</td>
</tr>
<tr>
<td>Rural maternal health nurse</td>
<td>Dina Kuchynka</td>
<td>SCL Health - Holy Rosary</td>
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<td>Perinatal Quality Collaborative</td>
<td>Vicki Birkeland</td>
<td>SCL Health - St. Vincent’s</td>
</tr>
<tr>
<td>Tribes and tribal organizations</td>
<td>Karen Cantrell</td>
<td>American Indian Health Director: DPHHS Director's Office</td>
</tr>
<tr>
<td>Private payer Medical Director</td>
<td>Dr. Tim Wetherill</td>
<td>Blue Cross Blue Shield of Montana</td>
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<td>Lisa Troyer</td>
<td>PacificSource Health Plans</td>
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<td>Mary LeMieux</td>
<td>DPHHS - Medicaid</td>
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<td>Substance use counselor</td>
<td>Janie Quilici, LAC, LSWC</td>
<td>Community Medical Center</td>
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<td>Rural midwife</td>
<td>Jude McTaggart</td>
<td>Northeast Montana Health Services</td>
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<td>Drug court judge</td>
<td>Judge Mary Jane Knisely</td>
<td>13th District Court</td>
</tr>
<tr>
<td>Social worker</td>
<td>Malcolm Horn, Ph.D., LCSW, MAC, SAP</td>
<td>Rimrock Addiction Treatment Services</td>
</tr>
<tr>
<td>Federally Qualified Health Centers</td>
<td>Cindy Stergar</td>
<td>Montana Primary Care Association (MPCA)</td>
</tr>
<tr>
<td>Community organization/nonprofit</td>
<td>Brie MacLaurin</td>
<td>Healthy Mothers, Healthy Babies</td>
</tr>
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c. The MOMS Leadership Council meets monthly for one and half hours, occasionally meeting for two hours.
Planned activities include the following:

- **Click here for an infographic** that visually displays most of the MOMS grant activities that were planned in the project narrative.

- Upcoming Council meetings will include the following activities:
  - TOWS analysis of one of the top barriers to best prenatal/labor and delivery/postpartum care identified by our needs assessment to determine
    - Strategies that use strengths to maximize opportunities and minimize threats; and,
    - Strategies that minimize weaknesses by taking advantage of opportunities and avoiding threats
  - Driver diagram activity for one of the following program goals:
    - Catalyze multidisciplinary collaboration in maternal health
    - Measure maternal health in Montana
    - Promote and execute innovation in maternal health service delivery
  - Tree diagram activity to show how the council’s goals fit within the program goals
  - Update on the maternal health innovation demonstration project
  - Update on data and evaluation projects
  - Update on MMRIA and MMRC
  - Update on PQC and AIM

- The Title V 2020-2025 Maternal and Child Health Needs Assessment results indicate that for the next five years, Montana will focus on activities addressing National Performance Measure 1: Well-Women Visit—Percent of women, ages 18 through 44, with a preventive medical visit in the past year.
  - The MOMS Program Director will serve as a technical assistance resource for the county public health departments that are focusing on NPM 1.
  - The Title V Needs Assessment also affirmed the need to continue with State Performance Measures 1 and 2, both of which will support the MOMS strategic plan to increase the number of women receiving prenatal care services.
    - SPM 1: Access to Public Health Services – Number of clients ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 4,500 or less.
    - SPM 2: Family Support and Health Education – Number of clients ages 0 – 21, and women ages 22 – 44 who are
assessed for social service and health education needs; and then are placed into a referral and follow-up system or provided with health education as needed.

- The MOMS Program’s Educational/Awareness Campaign supports SPM 2

3. **State MHI Program Goals (2019-2024)**
   - a. Catalyze multidisciplinary collaboration in maternal health
   - b. Measure maternal health in Montana
   - c. Promote and execute innovation in maternal health service delivery

**Objective C: Promote and execute innovation in maternal health service delivery**

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Activities</th>
<th>Responsible</th>
<th>Timeframe: Milestones / Deliverables</th>
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</table>
| Provide technical assistance and education to medical and public health providers to improve maternal health interventions | Conduct professional development and maternal health grand rounds through Project ECHO. | Billings Clinic | - Continue Project ECHO clinics twice per month through Y2  
- Continue recruitment efforts to increase physician attendance  
- Y2M1: Submit CME application  
- Y2M1-7: Cover seven AIM patient-safety bundles  
- Host twice yearly curriculum planning meetings with ECHO hub panel and consider evaluation feedback to advice curriculum  
- UM continue to provide quarterly reports for Billings Clinic to review |
| | Disseminate best practices in screening, assessment, clinical care, and community health initiatives in maternal health. | Billings Clinic | - Y2M1-6: Cultural liaison creates and disseminates tribal resource guides  
- Develop clinical care guides and toolkits  
- Collaborate with the Billings Clinic marketing department to create new page on the Billings Clinic website to house the Maternal Resource Center  
- Assess the need and interest in virtual maternal support groups across Montana as well as in-person perinatal mental health retreat for patients  
- Y2M6-12: Tour Motherhood Centers in Seattle and/or Minneapolis  
- Develop plan for Y3 implementation of retreat and other in-person events |
| | Provide nursing certification opportunities for Neonatal Resuscitation Program (NRP), Electronic Fetal Monitoring (EFM), Sugar, Temperature, Airway, Blood pressure, Lab work and Emotional support (STABLE) and Pediatric Advanced Life Support (PALS). | Billings Clinic | - Y2M1-2: Contact sites to recruit nurses  
- Y2M3: Identify trainers at participating sites  
- Y2M4: Create training schedule for the remainder of Y2 and order training materials  
- Y2M6-12: Complete EFM & NRP nursing certification courses at 10 facilities  
- Y2M12: Begin scheduling trainings for STABLE and PALS at facilities in Y3 |
<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsible Institution</th>
<th>Goals</th>
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</table>
| Provide Simulation in Motion-Montana (SIM-MT) mobile, high-fidelity simulations for non-birthing, critical access hospitals. | Billings Clinic and SIM-MT | • Y2M1-12: SIM-MT to complete remaining trainings after delays due to COVID-19  
• Continue consistent communication and evaluation monitoring with SIM-MT |
| Provide American College of Obstetrics and Gynecology (ACOG) Emergencies in Clinical Obstetrics (ECO) training opportunities for all levels of providers in birthing hospitals covering breech vaginal delivery, shoulder dystocia, postpartum hemorrhage, umbilical cord prolapse and teamwork/communication | Billings Clinic | • Planning and timeframe for this activity is uncertain due to challenges with securing ACOG trainers because of COVID-19. |
| Conduct demonstration project to test telehealth interventions in maternal health in rural and American Indian/Alaskan Native (AI/AN) communities | Billings Clinic | • Y2M2: Streamlined access to care for rural and Tribal-based patients for mental health care including substance use disorder (SUD), depression, anxiety and other behavioral health issues.  
• Y2M4: Clinical Coordinator establishes high-risk registry to track co-managed patients.  
• Y3-Y5: Continue expansion of telemedicine-based supports and consultation accessibility, expanding range of specialty consultation |
| Facilitate co-management of high-risk patients with urban-based specialists and rural-based generalists. | Billings Clinic | • Y2M9: Schedule regional outreach visits in rural & Tribal communities  
• Y2M7: Implement expanded virtual care, connecting specialists device-to-device with rural care team and patients  
• Y3-Y5: Continue to expand outreach and virtual support, including care coordination  
• Y4-Y5: Expand program to include resident rural rotations |
| Pilot telemedicine facilitated approaches to perinatal care | Enable telehealth to integrate behavioral health services into prenatal and postpartum care using: mental health screening and treatment; SUD screening and treatment; and medication-assisted treatment (MAT). | Billings Clinic and Rimrock Addiction Treatment Services | Y2: Work with providers to develop and implement integrated care model, with access to behavioral health specialists, care coordinator, and peer supports, using telehealth and locally based resources Y2M1: Identify universal screening tool based on input from providers and research on screening tools covered by Montana Medicaid. Y2M1: Work with MPCA to schedule MAT waiver training to all providers interested in providing MAT services. Y2M1: Design evaluation study, create consent materials and study workflow, submit to IRB Y2M2: MOU agreements between Billings Clinic, University of Montana and Rimrock Foundation executed Y2M2: Hire MAT Project Social Services Care Coordinator Y2M2: Create universal screening and referral workflow Y2M4: Begin universal screening at patient admission → scoring by nurses → results confirmed with patient → providers review positive patients → providers refer patient to MOMS care coordinator to discuss treatment options Y2-5: Implement referral to treatment protocols regionally, tracking outputs and outcomes | Support multidisciplinary networks of providers to expand service accessibility in rural communities by implementing telehealth and outreach clinics for medical and behavioral health services. | Y2M6-12: Develop specific resource and referral lists and protocols for regional behavioral health referrals, support groups, and community resources to address unmet social needs Y2M9-12: Convey resource and referral lists and protocols to other practices in the region |
i) Changes in our activities from our original application are listed below:
   • We are no longer implementing a consultation line because our needs assessment results showed that providers were not very likely to use it and it would be difficult to avoid duplicating this service that the Montana Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program.
   • We are postponing community listening sessions due to COVID-19 and assessing needs through other strategies and means such as facilities assessment.
   • Activities that were not included in original application:
     o ACOG ECO,
     o Nursing certifications,
     o OB Nest remote monitoring
     o Facilitation support for the Perinatal Quality Collaborative.

b) Identify maternal health activities proposed within the most recent Title V Needs Assessment that are being included within the strategic plan.
i) The Title V Needs Assessment has three Evidence Strategy Measure (ESM) recommendations for addressing NPM 1:
   (1) **ESM 1:** Number of participants attending webinars for providers on increasing preventive and prenatal care visits among women in their clinics
   (2) **ESM 2:** Number of marketing public awareness messages (i.e. brochures, TV ads, blogs, Facebook posts, website content, etc.) that promote preventative and prenatal health care for women of reproductive age
   (3) **ESM 3:** Percent of primary providers that have received training and/or consultations for assessing behavioral health needs and providing non-stigmatized care

c) Highlight maternal health innovations that will be implemented by the project by topic:

<table>
<thead>
<tr>
<th>Access to care</th>
<th>Provider skill level</th>
<th>Social determinants of health</th>
<th>Treatment for substance use and depressive disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telemedicine integration of behavioral health and SUD screening and treatment into prenatal and postpartum care</td>
<td>Project ECHO</td>
<td>Integration of care coordinator in perinatal telemedicine workflow process</td>
<td>Telemedicine integration of behavioral health and SUD screening and treatment into prenatal and postpartum care</td>
</tr>
<tr>
<td>Maternal Resource Center</td>
<td></td>
<td></td>
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<tr>
<td>Nursing certification opportunities</td>
<td></td>
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<tr>
<td>SIM-MT</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>ACOG ECO trainings</td>
<td></td>
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</tbody>
</table>
Montana Maternal Health
Key Indicators

Annie Glover, PhD, MPH, MPA
Director of Research
Maternal Mortality

• Pregnancy-related deaths per 100,000 live births
  • United States: 29.6
  • Montana: 40.7
    • National rank: 6th highest rate among 50 states
    • Regional rank: Highest rate in Western states
  • AI/AN population in Montana: 167.2
  • Non-Hispanic white population in Montana: 23.9
  • Healthy People 2020 goal: 11.4

• National maternal mortality has more than doubled since 1987
  • Racial disparities are driving much of the increase

Source: Rate from CDC Wonder, 2019 report of 5-year (2013-17) pregnancy-related death rate estimate; Rankings by America’s Health Rankings, United Health Foundation
Severe Maternal Morbidity

• Qualifying conditions and complications per 10,000 hospital-based deliveries
  • Montana: 194
  • United States: 144

• Most common SMM subtypes in Montana: blood transfusions, sepsis, eclampsia, and hysterectomy.

• National disparities:
  • AI/AN population: 206
  • Non-Hispanic white population: 139

Sources: 2017 Montana Hospital Discharge Data; ACOG SMM Screening and Review
Pregnancy Risk Factors

RACIAL DISPARITIES IN RISK FACTORS (% OF LIVE BIRTHS, 2014-2018, MONTANA VITAL RECORDS)

- Any risk: 33.5% (White), 47.2% (AI/AN)
- Previous Cesarean: 13.1% (White), 18.8% (AI/AN)
- Previous poor outcome: 1.9% (White), 2.3% (AI/AN)
- Previous preterm birth: 3.0% (White), 7.3% (AI/AN)
- Gestational hypertension: 7.0% (White), 8.7% (AI/AN)
- Pre-pregnancy hypertension: 1.0% (White), 1.1% (AI/AN)
- Gestational diabetes: 4.7% (White), 6.3% (AI/AN)
- Pre-pregnancy diabetes: 0.8% (White), 1.8% (AI/AN)
Prenatal Care Utilization

RACIAL DISPARITIES IN MATERNAL HEALTHCARE (% OF LIVE BIRTHS, 2018, MONTANA VITAL STATS)

- **Prenatal Care in 1st Trimester**
  - White: 77.1%
  - AI/AN: 70.7%
  - Other: 73.2%

- **Any Prenatal Care**
  - White: 99.4%
  - AI/AN: 93.1%
  - Other: 97.5%
  - All Montana: 98.6%

- **Cesarean Section**
  - White: 27.7%
  - AI/AN: 31.0%
  - Other: 34.8%
  - All Montana: 28.2%
Maternal Health Report 2020: Additional Topics

• Mental health
• Alcohol & substance Use
• Pregnancy during adolescence
• Family planning & STI
• Rural disparities
• Health insurance coverage
• Primary care
Definitions: Mortality

• **Pregnancy-related death:** Death of a woman while pregnant or within 1 year of the end of a pregnancy—regardless of the outcome, duration, or site of the pregnancy—from any cause related to or aggravated by the pregnancy or its management, excluding accidental or incidental causes.

• **Pregnancy-associated death:** Death of a woman, from any cause, while she is pregnant or within 1 year of termination of pregnancy.

• **Maternal death:** Death of a woman while pregnant or within 42 days of termination of pregnancy, excluding accidental/incidental causes.

Source: Centers for Disease Control & Prevention
Severe maternal morbidity: Unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman’s health.

<table>
<thead>
<tr>
<th>Condition 1</th>
<th>Condition 2</th>
<th>Condition 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>acute myocardial infarction</td>
<td>eclampsia</td>
<td>sickle cell disease with crisis</td>
</tr>
<tr>
<td>aneurysm</td>
<td>heart failure/arrest during surgery or procedure</td>
<td>air and thrombotic embolism</td>
</tr>
<tr>
<td>acute renal failure</td>
<td>puerperal cerebrovascular disorders</td>
<td>blood products transfusion</td>
</tr>
<tr>
<td>adult respiratory distress syndrome</td>
<td>pulmonary edema/acute heart failure</td>
<td>hysterectomy</td>
</tr>
<tr>
<td>severe anesthesia complications</td>
<td>severe anesthesia complications</td>
<td>temporary tracheostomy</td>
</tr>
<tr>
<td>cardiac arrest/ventricular fibrillation</td>
<td>sepsis</td>
<td>blood products transfusion</td>
</tr>
<tr>
<td>conversion of cardiac rhythm</td>
<td>shock</td>
<td>ventilation</td>
</tr>
<tr>
<td>disseminated intravascular coagulation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
References

https://www.americashealthrankings.org/ex-plore/health-of-women-and-
children/measure/maternal_mortality_a

ACOG. Severe maternal morbidity: screening and review. Secondary Severe 
maternal morbidity: screening and review 2016. 
https://www.ajog.org/action/showPdf?pii=S0002-9378%2816%2930523-3

DPHHS. Hospital Discharge Data System Secondary Hospital Discharge Data System 
2017

Creanga AA, Bateman BT, Kuklina EV, Callaghan WM. Racial and ethnic disparities 
Healthy Mothers, Healthy Babies
The Montana Coalition

Brie MacLaurin, RN
Executive Director
MISSION & VISION

Mission: Healthy Mothers, Healthy Babies endeavors to improve the health, safety, and well-being of Montana families by supporting mothers and babies, age zero to three.

Vision: There will be a safe and healthy beginning for all babies in Montana.
HMHB Programs

- Essentials (Essentials for Baby): Crib/Car seat/Care items
- PURPLE (Period of PURPLE Crying Program): Shaken Baby Syndrome Prevention project
- MT-ECC (Montana Early Childhood Coalition): Partnership work
- MMH (Maternal Mental Health): Conference, protocols, resources
Essentials for Baby

- Cribs
- Car seats
- Care items

  - Ordered by home visitors and other family support direct workers
    - Cribs delivered to the home
    - Car seats installed by a technician when possible
    - Care items ordered when HMHB receives a grant for a specific population, i.e. homeless teen parents

- Campaign
Impact of Essentials

- Prevents infant/child deaths
- Child abuse prevention
- Reduces risk of injury by accidents
- Reduces parental stress, which leads to increased positive parenting
Period of PURPLE Crying Program

- Montana's only universal (all babies get it) child abuse prevention program. PURPLE

- Over 90% of parents of newborns learn about PURPLE Crying in the hospital

- Important program for caregivers of babies effected by neonatal abstinence syndrome

- Training available.
Impact of PURPLE

- 100% of Shaken Baby Syndrome/Abusive Head Trauma (SBS/AHT) cases are preventable
- SBS/AHT can cause death or life-long suffering
- Non-related men are most common abuser, provides mother materials (app, booklet, dvd) to educate caregivers

**This work allows HMHB to remain connected to the birthing hospital network. We conduct annual surveys to check in on the program and help work out any challenges they may be facing.**
Montana Early Childhood Coalition (MT-ECC)

- Local coalition work
- Montana Advocates for Children
- Montana Children’s Health Data Partnership Project
- Various taskforces: Community Health Worker Advisory Council, Emergency Services for Children, State Health Improvement Planning, MOMs Leadership team, MT Access to Pediatric Psychiatry Network, MT Perinatal Association
Local Coalitions

The local coalitions are working to increase coordination and advocacy across maternal and child serving systems at the grass roots level in towns, counties, reservations and regions.

Helena, Missoula, Kalispell, Great Falls, Billings, and Polson all have subgroup activity focused on MMH.

***HMHB hosts monthly meetings, agenda driven by ECC leaders***

Agenda items often include: Group sharing, Advocacy, and Special focus

State partners often join for updates.
Montana Advocates for Children (MAC)

MAC Priorities

- Public PreK: mixed delivery model
- Provider Scholarship Rate Increase
- Require Residential Rental Property Insurance and Renters’ Insurance to cover home-based child care
- Align eligibility standards for Early Head Start Child Care Partnership sites with Best Beginnings Child Care Scholarships
- Explore and address identified child care licensing challenges
- Improve mental health and substance use disorder screening and treatment in the perinatal period for mothers, infants, and caregivers
- Align Head Start and STARS Standards

MAC MEMBERS

* Head Start Association
* MT Childcare Association
* MT Assoc. for the Education of Young Children
* HMHB
* MT Childcare Resource and Referral Network
* MT KidsCOUNT
Montana Child Health Data Partnership Project
“Measuring our Collective Impact to improve MCH”

The organizations and early childhood coalition coordinators and members that participated in this planning grant:

- Montana Department of Public Health and Human Services
- The Montana Children’s Trust Fund
- The Montana Early Childhood University Project
- The Montana Office of Public Instruction
- PacificSource
- Montana Hospital Association
- Montana Kids Count
- Blue Cross Blue Shield
- Headwaters Foundation
- BUTTE 4 C’s
- Headwaters Foundation of the Rockies
- St. Vincent Healthcare
- Rocky Mountain Tribal Epidemiology Center
- The Headwaters Foundation
- The Federal Reserve Bank of Minneapolis
- Helena Branch
- SoSo
- ChildWise Institute

ORGANIZATIONS

- Healthy Mothers, Healthy Babies
- The Montana Institute
- The Office of the Governor of the State of Montana
- The Montana Children’s Trust Fund
- The Montana Early Childhood University Project
- The Montana Office of Public Instruction
- PacificSource
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- SoSo
- ChildWise Institute

OUR CRITERIA

Criteria were developed and agreed upon by the stakeholder group through an iterative process.

IMPACT ON CHILDREN
Aligns with purpose of the project; outcome-focused; includes both risk and protective (HOPE) measures; includes domains of family well-being

ACCESSIBLE
Easy to collect; already being collected; able to monitor

ACTIONABLE
Relevant to urban and rural communities; community coalitions can affect

HIGH-QUALITY
Valid sources; can be used to establish baseline; replicable (can follow over time)

CULTURALLY RELEVANT
Definitions and measures are relevant to all populations, particularly American Indian; allow for disaggregation by race where possible
SELECTED SHARED MEASURES

The following are the 10 agreed upon measures. The definitions and data source of each measure still need to be refined and identified in the next phase, but preliminary discussions and research were done to ensure data availability.

- Percentage of women who initiated prenatal care in their first trimester
- Quality well-child check rates
- Percentage of low birth weight babies
- Number of children who attend quality child care and/or early education
- Percentage of women who have a post-partum visit within 60 days
- 3rd grade reading proficiency levels
- Percentage of 2-year-olds who receive immunizations on-time
- Foster care rates for children ages 0 to 5
- Number of children receiving evidence-based home visiting services
- WIC rates for children ages 0 to 5
Maternal Mental Health (MMH)

- Increase screening
- Resource Guide support
- Training
- Conference
- Parent voice
Screening is crucial in the perinatal population

- Only 11% of patients with clinical depression present with depression as a primary complaint (Cerimele, et al., Obstet Gynecol., 2013)

- Approximately 20% of women experience depression during the perinatal period, with rates tripling for higher risk groups such as teens and women with low-income (Lancaster, 2010; Robertson, 2004)

- Universal screening is needed to reduce impact of implicit bias

https://hmhb-mt.org/for-advocates-healthcare-providers/perinatal-mental-health/
Resource Guide Support
Training

- 1-2 hours training on Perinatal Mood and Anxiety Disorders (PMADS)
  - CORE at St. Vincent’s
  - Great Beginnings Great Families Conference
  - MSU Nursing Program
Perinatal Mental Health Conference

SAVE THE DATE
VIRTUAL
PERINATAL MENTAL HEALTH CONFERENCE
NOVEMBER 2-6, 2020

Themes:
- Perinatal SUD
- Fatherhood
- Foundations of PMADs
- OCD, PTSD, and Suicidality
Parent Voice

Mother Love

is a safe space where stories are shared, wisdom is found, and healing happens.

Mother Love Happens with:
- Podcast
- Parent Groups
  ...program in development
- Future vision =
  Resource rich website
- Peer Support Training
- Bright by Text
Impact of MMH

**INDIVIDUAL**
- Most common complication of childbearing and often does not resolve on its own
- Women in childbearing age commit suicide more than any other aged women
- High amounts of shame lead to resistance in seeking treatment

**FAMILY**
- Depressed mothers often use harsher discipline
- Maternal depression is #1 cause of toxic stress (this stress leads to lifelong physical/social/emotional challenges)
- 1 in 10 fathers in relationships with someone with a PMAD will experience one, too
- Less safety precautions taken, so increased risk of injury (improper car seat use, unsafe sleep, not installing safety latches, etc.)
- Children of parents with undiagnosed/untreated mental illness are more at risk of experiencing their own mental health challenges.

**COMMUNITY**
- Over 450 trained in 2019 from over 30 counties
- MMH work groups started in 4 communities
- Protocol printed and distributed to over 225 people
- “Vetted resource lists” projects beginning
- Estimated total societal cost of untreated PMADS in the U.S. is $14.2 billion for all births in 2017 when following the mother-child pair from pregnancy through five years postpartum
Communications

- Quarterly newsletter
- Social media
- “Sharing fairies” at and between meetings = Focus on relationship and trust
- Website
- Blog