



## Maternal Health Leadership Council Meeting

April 27, 2020

3:30 - 5:00 PM

### Agenda

- 3:30 – 3:40**      **Roll call, introduce new members and approve minutes**
- 3:40 – 4:00**      **Presentation on the Centers for Disease Control's Levels of Care Assessment Tool (CDC LOCATe)**  
*CDC representatives: Alexander Ewing, Health Scientist; David Goodman, Team Lead, Maternal Mortality Prevention Team; Jennifer Wilkers, ORISE Fellow*
- 4:00 – 4:10**      **Q & A Opportunity with Guest Presenter**
- Council discussion and vote to endorse LOCATe Tool implementation in Montana
  - Form subcommittee to guide implementation
- 4:10 – 4:30**      **Maternal health partner presentation – RiverStone Health Family Health Services**  
*Doug Anderson, Program Manager and Shannon Hauck, RN, CLC-Nurse Family Partnership Supervisor*
- 4:30 – 4:40**      **Q & A Opportunity with Guest Presenter**
- 4:40 – 4:45**      **Reports from subcommittees**
- Payer subcommittee
  - Education subcommittee
- 4:45 – 4:50**      **Updates from DPHHS**
- Perinatal Quality Collaborative (PQC)
  - Alliance for Innovation in Maternal Health (AIM)
  - Maternal Mortality Review Committee (MMRC)
  - Public education campaign
- 4:50 – 5:00**      **Public comment/roundtable questions and discussion**

### **Meeting materials**

- Agenda
- March minutes
- CDC slides on LOCATe
- RiverStone slides on Family Health Services
- Final PQC graphics
- List of MMRC members recommended to division leadership to be appointed



## **Maternal Health Leadership Council**

Meeting Minutes:

March 23, 2021:

3:30-5:00 PM:

Location: Zoom only

### **Members Present**

**Chair, Dr. Tersh McCracken**, MOMS Medical Director & Ob-Gyn at Billings Clinic

**Tami Schoen, RN, BAN, WIC/CPA** at Hill County Public Health Department

**Karen Cantrell**, American Indian Health Director at DPHHS

**Janie Quilici, LAC, LCSW**, Perinatal Behavioral Health Counselor at Community Physicians Group

**Olivia Riutta (for Cindy Stergar)**, Outreach & Engagement Manager at Montana Primary Care Association (MPCA)

**Lisa Troyer**, Wellness Consultant at PacificSource

**Mary LeMieux**, Member Health Management Bureau Chief at Medicaid, and Perinatal Behavioral Health/Meadowlark Initiative Project Director

**Vicki Birkeland, MSN, RN, NEA-BC**, Nursing Director, Women's Services at SCL Health-St. Vincent Healthcare and Chair of the Montana Perinatal Quality Collaborative

**Judge Mary Jane Knisely**, 13th District Court Judge, Felony Impaired Driving Court (IDC), CAMO Court (Veterans Treatment Court)

**Brie MacLaurin, RN**, Executive Director of Healthy Mothers, Healthy Babies

**Dr. Christina Marchion**, Family Medicine/OB at Central Montana Medical Center

**Dr. Jean-Pierre Pujol**, Medical Director at Blue Cross Blue Shield of Montana

**Dina Kuchynka, RN, BSN**, Maternal & Newborn Health Manager at SCL Health – Holy Rosary

**Dr. Bardett Fausett**, Maternal Fetal Medicine Specialist and President/Medical Director at Origin Health

**Dr. Malcom Horn**, Director of Mental Health Services at Rimrock

**Dr. Steve Williamson**, Chief Medical Officer, Billings Area Indian Health Service

**Jennifer Wagner**, Rural Hospital Improvement Coordinator at Montana Hospital Association

### **Members Absent**

**Dina Kuchynka, RN, BSN** Maternal & Newborn Health Manager at SCL Health – Holy Rosary

**Vice-Chair, Judge Mary Jane Knisely**, 13th District Court Judge, Felony Impaired Driving Court (IDC), CAMO Court (Veterans Treatment Court)

**Dr. Drew Malany**, Ob-Gyn at Women's Health Care Center, PLLC and Chair of Montana American College of Obstetrics & Gynecology (ACOG)

**Jude McTaggart**, Certified Nurse Midwife at Northeast Montana Health Services

**Ann Buss**, Title V Director/Maternal & Child Health Supervisor at DPHHS

### **Program Staff Present**

**Amanda Eby**, MOMS Program Coordinator at DPHHS

**Brenna Richardson**, Program Assistant at DPHHS

**Stephanie Fitch**, Project Coordinator for MOMS at Billings Clinic

**Dr. Annie Glover**, Lead evaluator and PI for MOMS at University of Montana

### **Public Attendees**

**Dr. Eric Arzubi**, Frontier Psychiatry

**Stacy Anderson**, Montana Primary Care Association

**Kari Tutwiler**, FICMMR Program Coordinator at DPHHS



## **Welcome and introductions**

Dr. Tersh McCracken opened the meeting and lead roll call. Meeting minutes were approved. Dr McCracken announced the vice-chair position is currently open and Amanda will solicit nominations and a vote via email. They announced new members that included Dr. JP Pujol replacing Tim Wetherill of BCBS; Dr. Steve Williamson, Chief Medical Officer of IHS; and Jennifer Wagner, Rural Improvement Coordinator of the Montana Hospital Association (MHA).

## **Maternal health partner initiative presentation Perinatal Behavioral Health Initiative Program (PBHI)– Meadowlark and PRISM for Moms**

Sarabeth Upson, Medicaid Program Officer for the PBHI and Dr. Eric Arzubi of Frontier Psychiatry gave a presentation on the Meadowlark Initiative and “PRISM,” which stands for Psychiatric Referrals, Intervention, and Support in Montana. Sarabeth explained this project is supported by the Health Resources and Services Administration (HRSA) as part of an award totaling \$650,000 annually for five years, which ends in September 2023. Services available include care coordination of perinatal patients (pregnant women and women one to three years postpartum) and screening, brief intervention, referral to treatment and integrated behavioral health. Frontier Psychiatry is a private practice that partners with the state on a teleconsultation line. The PRISM for Moms program offers psychiatric teleconsultation in medication management, treatment plans, follow-up consultation as needed and community resource and referrals for patients organized through Healthy Mothers, Healthy Babies. PRISM for Moms has upcoming educational events such as an ECHO clinic on perinatal mood disorders and mental health issues. For the complete presentation of the Meadowlark and PRISM programs, please click [here](#).

### **Q & A opportunity with guest presenter**

Dr McCracken asked if this service is only available to Meadowlark Hospitals. Dr. Arzubi stated this service is available to any clinician, of any kind that’s wanting support on a perinatal mental health question. Currently, this is not a direct care service, it’s a clinician or healthcare provider service.

## **Legislative/policy update from Montana Primary Care Association (MPCA)**

Stacy Anderson, Policy Director for MPCA, presented on House Bill 632 which implements and appropriates federal stimulus money in the American Rescue Plan Act. One of those pieces having to do with Medicaid is the opportunity for states to expand coverage for pregnant and postpartum women. There is a strong possibility of extending Medicaid postpartum coverage up to a year after delivery, even a in subcommittee format to collect data. Montana Pregnancy Medicaid currently only covers the mother until 48 days past delivery. Stacy explained how council members could provide public comment in the hearing on HB 632. Click [here](#) to view Stacy’s full presentation.

## **Reports from subcommittees**

The payer group met for a second time and the education subcommittee has met just once thus far.

**Payer Subcommittee:** The Payer Group is still learning more about what the payers are doing: what kind of data they collect, how they identify populations. Mary LeMieux reported the meeting covered an overview of the Medicaid targeted case management program and how it works for high-risk pregnancies. Questions came up about what payers would potentially be able to provide in claims data on pregnancy care.

**Education Subcommittee:** This group was initially formed so MOMS could have a more specific strategizing approach on what the program could address from the priority areas the council identified in the December survey and also how to address the specific priorities of health equity/implicit bias and trauma informed care. The challenge of this subcommittee is how to make decisions on education when



there isn't enough data to identify the barriers, challenges, and needs. The education subcommittee is paused for now and while the program staff strategizes how to best organize the group and plan to use them effectively before convening them again.

#### **Discuss and approve application for mini-grant program (council vote needed)**

Amanda explained the background on the mini-grant program that was funded by carryover money from year one that was not spent so DPHHS proposed this program as one of the ways to spend the funds in year two of the grant. This is an opportunity for clinics, hospitals and community partners to implement innovative maternal health interventions at the local level, as long as they are in line with the original MOMS work plan objectives. Preference will be given to Health Professional Shortage Areas with a score greater than 16 and to organizations serving tribal populations. DPHHS and UM will disseminate the grant application April 1 with them being due April 30. Amanda requested volunteers to participate on a selection committee that will review the grant applications and determine the awardees. Vicki Birkeland and Lisa Troyer volunteered, and Amanda asked for others to email her if interested as she would like one more person from the council on the selection committee.

#### **Plan Maternal Mortality Review Committee (MMRC) composition and development**

Tersh provided background on the progress made so far in establishing a Montana MMRC – such as research and a decision brief. He explained that it is owned by the state at DPHHS and should be statewide. Contrary to his prior beliefs that it would be a small clinical committee, he now understood that we need a large multidisciplinary committee. He asked for recommendations from the council on people from across the state from different organizations to serve that DPHHS staff will consider and then make the final decision on who to appoint. Amanda shared a spreadsheet of organizations, core disciplines and specialty disciplines recommended by the CDC to consider including on a MMRC. Amanda and Tersh explained that not all the members would necessarily have to attend all the meetings, but specialties would be called on when the MMRC is reviewing a death related to their specialty. Tersh asked Dr. Steve Williamson about IHS serving on the committee. Staff and members also discussed including representatives from non-IHS facilities that largely serve Native American populations.

#### **Public comment/roundtable questions and discussion**

Brie commented on the importance for the MMRC to have measures in place to prevent secondary trauma in the members from reviewing the deaths and she asked about if the Education Subcommittee would be leading or advising work and if a budget for the education activities could be shared.



# CDC Levels of Care Assessment Tool

# Risk-Appropriate Care (Perinatal Regionalization)

- Strategy promoted in 1976 March of Dimes report\*
- Guidelines set by AAP and ACOG/SMFM
- Simple concept quickly embraced by many states
- Enhanced by public health research



# How Should Risk-Appropriate Care Work?

Shared understanding of facilities' levels of care  
(Level I, Level II, Level III, or Level IV)



Delivery occurs at facilities where the anticipated  
appropriate level of care is available



Level III and IV facilities work to provide support to  
Level I and II facilities when needed

# Levels of Neonatal Care

Facility Level	Definition
<b>Level I</b>	Well born nursery – Provide basic levels of care to neonates who are low risk and have the capability to perform neonatal resuscitation at delivery and provide postnatal care for healthy newborn infants.
<b>Level II</b>	Special care nursery – Provide care to stable or moderately ill newborn infants who are born at or before 32 weeks' gestation or who weigh 1500 g or less at birth with problems that are expected to resolve rapidly, without anticipated need of subspecialty-level services of an urgent basis.
<b>Level III</b>	NICU – Meet level II requirements and have continuously available personnel (neonatologists, neonatal nurses, and respiratory therapists) and equipment to provide life support for as long as necessary. A broad range of pediatric medical and surgical subspecialists should be readily accessible on site or by prearranged consultative agreements.
<b>Level IV</b>	Regional NICU – Meet level III requirements, have considerable experience in the care of the most complex and critically ill newborn infants, and have pediatric medical and surgical consultants available on-site 24 hours a day, with the capability for surgical repair of complex conditions.



# Levels of Maternal Care

Facility Level	Definition
<b>Accredited Birth Center</b>	Care for low-risk pregnant persons with uncomplicated singleton term vertex pregnancies who are expected to have an uncomplicated birth.
<b>Level I</b>	Care for low- to moderate-risk pregnancies with ability to detect, stabilize, and initiate management of unanticipated maternal-fetal or neonatal problems that occur during the antepartum, intrapartum, or postpartum period until the patient can be transferred to a facility at which specialty maternal care is available.
<b>Level II</b>	Level I facility plus care of appropriate moderate- to high-risk antepartum, intrapartum, or postpartum conditions.
<b>Level III</b>	Level II facility plus care of more complex maternal medical conditions, obstetric complications, and fetal conditions.
<b>Level IV</b>	Level III facility plus on-site medical and surgical care of the most complex maternal conditions and critically ill pregnant persons and fetuses throughout antepartum, intrapartum, and postpartum care.

# Discrepancies in Interpretation of Guidelines

Definitions, criteria, compliance mechanisms, and regulatory source of neonatal levels of care vary widely.<sup>1</sup>

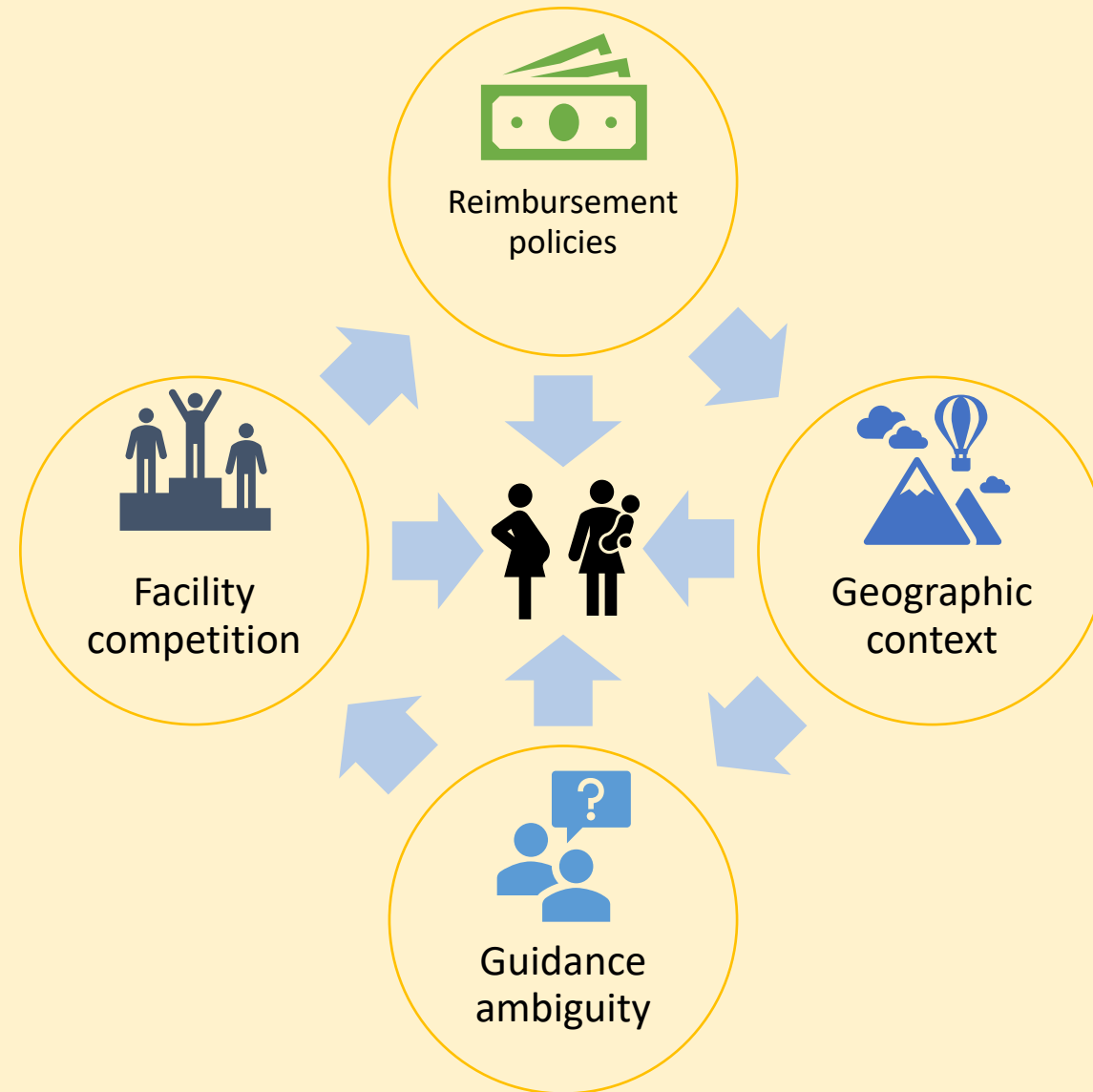
- 31 states had policies for neonatal levels of care (2019).<sup>2</sup>  
22 of these states require ongoing monitoring; 10 require site visits
- 17 states had policies for levels of maternal care (2018).<sup>3</sup>

<sup>1</sup> Blackmon, L., Barfield, W. & Stark, A. Hospital neonatal services in the United States: variation in definitions, criteria, and regulatory status, 2008. *J Perinatol* 29, 788–794 (2009) doi:10.1038/jp.2009.148

<sup>2</sup> Kroelinger CD, Okoroh EM, Goodman DA, Lasswell SM, Barfield WD. Designation of neonatal levels of care: a review of state regulatory and monitoring policies. *J Perinatol* 40, 369–376 (2020) doi: 10.1038/s41372-019-0500-0

<sup>3</sup> Vladutiu CJ, Minnaert JJ, Sosa S, Menard MK. Levels of Maternal Care in the United States: An Assessment of Publicly Available State Guidelines. *J Womens Health* 29, 353–361 (2020) doi: 10.1089/jwh.2019.7743

# Challenges



# What is CDC LOCATe<sup>®</sup>?

## **Produces standardized assessments**

- Based on guidelines by AAP and ACOG/SMFM
- Strengthens evidence for necessity of increased specificity in criteria

## **Facilitates stakeholder conversations**

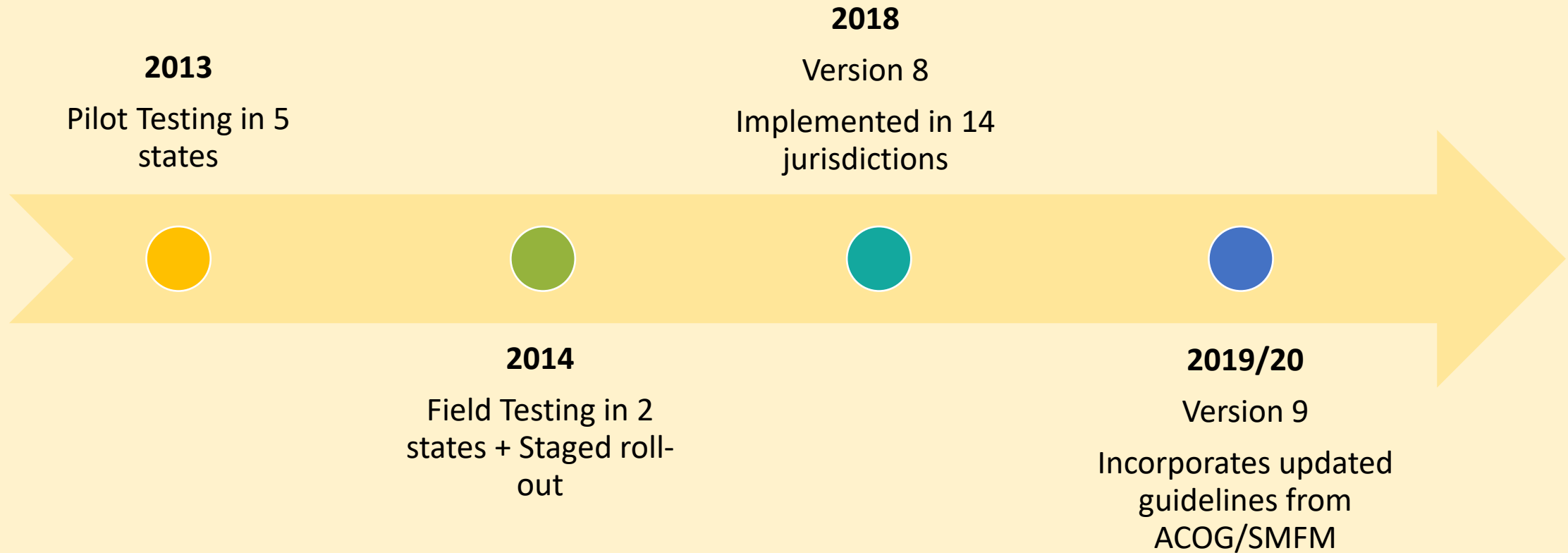
- Increases (common) understanding of risk appropriate care landscape
- Provides data for informed improvements by facilities and systems

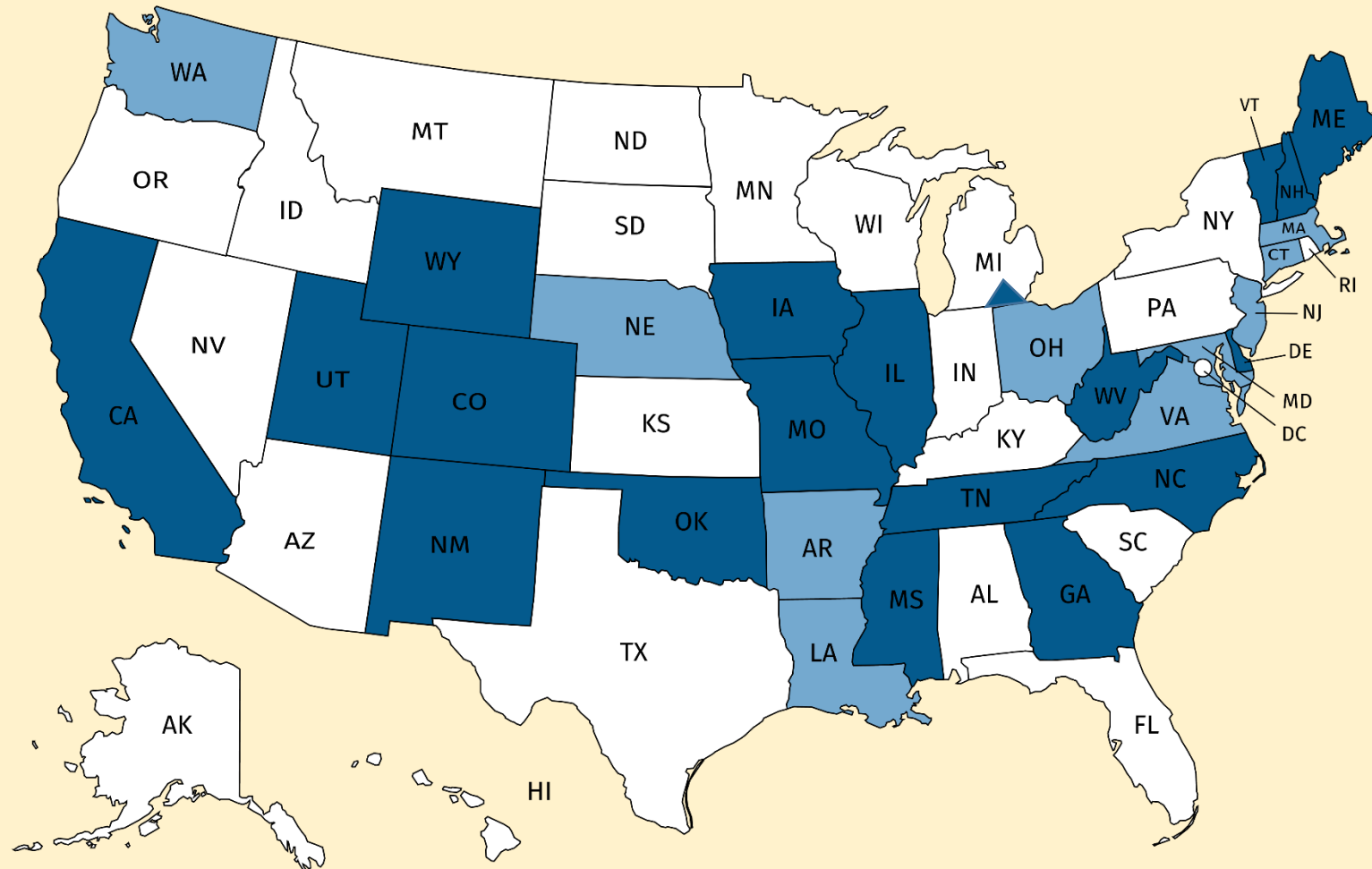
*...while, minimizing burden on respondents*

# What LOCATe® is NOT...

- NOT... A comprehensive assessment of all neonatal and maternal criteria
- NOT... A tool for formal designation of levels of care
- NOT... A tool for health care regulation

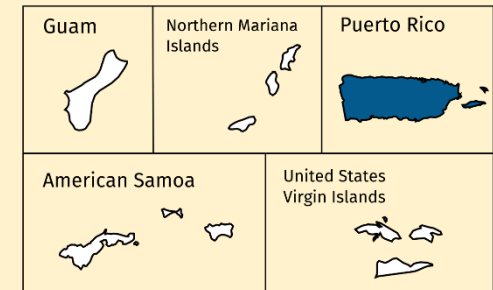
# Development of LOCATe®





### State Implementation Status

- ☐ Not Implemented  
☒ Implemented  
☐ Planning Implementation



# LOCATe Content

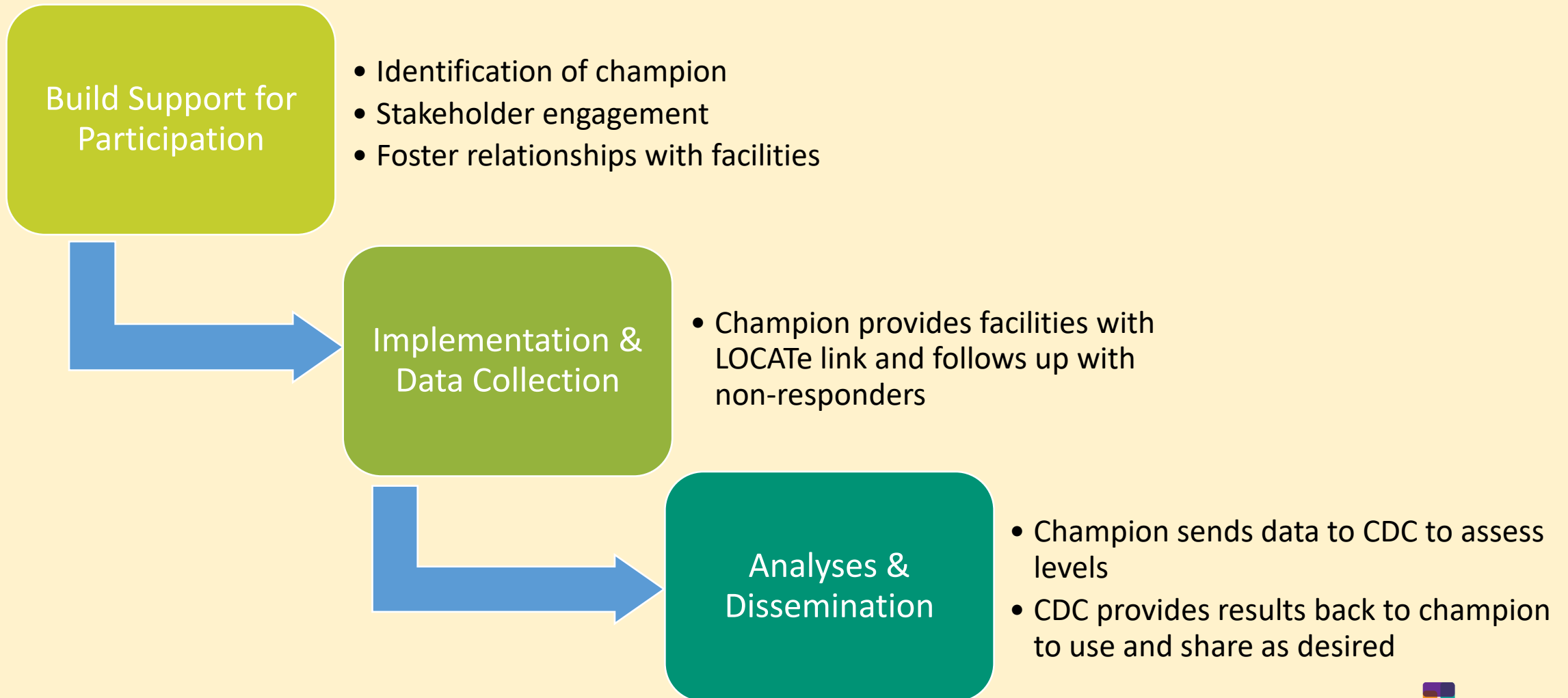
## Assessment includes questions about:

- Facility services & their availability
  - Facility personnel & their availability
- } [Assessing levels of care]
- Self-reported levels of care [Understanding where there may be discrepancies and why]
  - Volume of services [Understanding where/how experience matters]
  - Drills & protocols for maternal emergencies [Helping identify QI opportunities]
  - Transports [Availability for stakeholder conversations]
  - Facility-level statistics [Facilitating rapid development of summary information]

**Web-based platforms: Survey Monkey or REDCap**



# The LOCATe Process



# Neonatal Assessment Discrepancies\*

39% of facilities have discrepancies between self-reported level and LOCATe-assessed level

Based on the **2012 AAP guidelines** for neonatal levels of care, what do you consider your **neonatal level of care** to be?

Facility Level	Self-Reported	LOCATe Assessment
Level I	29%	41%
Level II	32%	41%
Level III	21%	14%
Level IV	6%	3%
Unknown	11%	-

\* Based on data from 767 facilities in 15 jurisdictions

# Maternal Assessment Discrepancies\*

49% of facilities have discrepancies between self-reported level and LOCATe-assessed level

Based on the **2015 ACOG/SMFM guidelines** for maternal levels of care, what do you consider your **maternal level of care** to be?

Facility Level	Self-Reported	LOCATe Assessment
< Level I	3%	13%
Level I	27%	36%
Level II	32%	40%
Level III	19%	8%
Level IV	6%	3%
Unknown	14%	-

\* Based on data from 767 facilities in 15 jurisdictions

# LOCATe results can be used to...

Examine differences in **maternal/neonatal outcomes within and between levels of care** by merging LOCATe results with birth record data.

Identify **priority areas** and leverage perinatal quality collaborative (PQC) for implementation.

Use aggregate findings as talking points to **encourage prioritization of levels of care in the state.**

Use results to **coordinate maternal and neonatal emergency preparedness plans and drills.**

Present results to stakeholders to **increase buy-in and work locally to address challenges.**

Analyze differences in mortality based on specific facility characteristics and **advocate for adoption of new guidelines based on findings.**

# Successes

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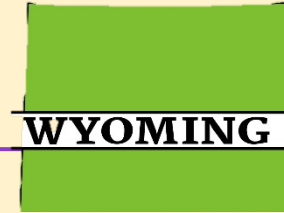
The Illinois Department of Public Health was motivated to use LOCATe to compare their state's perinatal system to the AAP and ACOG guidelines for levels of care. Additionally, staff wanted to use LOCATe results to inform policy decisions to improve care for mothers and infants.

Following completion of LOCATe, a state epidemiologist performed several analyses including describing current hospitals' neonatal and maternal levels of care, the **potential impact of changing levels of care to current national guidelines, as well as neonatal mortality across and within levels of care.**

The findings from these analyses assisted the state of Illinois in the **adoption of the current AAP guidelines for neonatal levels of care.**

# Successes

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Wyoming implemented LOCATe in hopes of capturing responses from facilities in WY as well as those in bordering states who receive high-risk pregnant and postpartum patients from WY. WY attained a 100% response rate and provided individual results to all hospitals.

Following implementation, WY conducted an **analysis of severe maternal morbidity by combining severe maternal morbidity data with LOCATe levels data.**

Results from LOCATe identified that several WY facilities did not have specific maternal care protocols in place. As a result, **WY facilities participated in the Utah Department of Health's Extension for Community Healthcare Outcomes (ECHO) for hypertension in pregnancy.**

# Thank you!

## Questions?

Carla DeSisto  
[wup5@cdc.gov](mailto:wup5@cdc.gov)

**NOTE:** The findings and conclusions in this presentation are those of the presenter and do not necessarily represent the official position of the Centers for Disease Control and Prevention





**Connecting you to a better life**



# Family Health Services

*Maternal Child Health  
Home Visiting*

RiverStone Health  
Connecting you to a better life

# Programs

Nurse-Family Partnership

Parents as Teachers

Maternal Child Health

Healthy Spark

# Key Points

- Prevention focus
- Relationship based
- Resource referrals and partnerships
- Health happens at the speed of trust

# Family Health Home Visiting

## What we do...



- Breastfeeding education by certified lactation counselors
- Case management for pregnant women and their children
- Referrals for healthcare, housing and financial assistance
- Developmental screenings for infants and children
- Nutrition counseling
- Guidance for life changes
- Childhood education
- Education for a healthy pregnancy, healthy infant
- Help with infant and child feeding challenges
- Parenting skills support

# Family Health Home Visiting

## Who we serve...



- Pregnant women
- Families with infants, pre-school aged children and children with special healthcare needs
- Yellowstone County
- Services are at no charge to the clients

# Pregnant moms and addiction

- “We’re not going to arrest our way out of this.”

# A New Approach



# Collaboration



- St. Vincent Health SCL
- Rimrock Foundation
- RiverStone Health



# Program Basics

- St. Vincent Midwifery patients
- Screening and enrollment
- Texts synced to perinatal status
- Texts synced to substance use status
- Care Companion resources and education
- CHAT feature

# Nurse-Family Partnership

## Why Nurses?



- All home visitors are BSN-RN's
- Knowledge, judgment and skills
- High level of trust, low stigma
- Credibility and perceived authority
- Nursing theory and practice at core of original model

# Nurse-Family Partnership

## Who we serve...



- Any pregnant mother
- First time mom's enroll prior to 28 weeks pregnant and previous mom's enroll anytime before delivery
- SNAP/WIC/Medicaid/TANF Qualified
- Voluntary participation and FREE
- Yellowstone County
- Father and family members can participate with mom and baby

# Nurse-Family Partnership

## What we do...



- Evidence based practice
- Weekly to biweekly visits beginning in pregnancy until child's 2<sup>nd</sup> birthday
- Help families:
  - Have a healthy pregnancy and baby
  - To be better parents
  - Build a strong support network
  - Have a safe home and environment
  - Continue education and develop job skills
  - Set goals and find ways to reach them
  - Access to community resources via referrals
- Meet and greet for families in the program



# Parents as Teachers™

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# Parents as Teachers

## What we do...



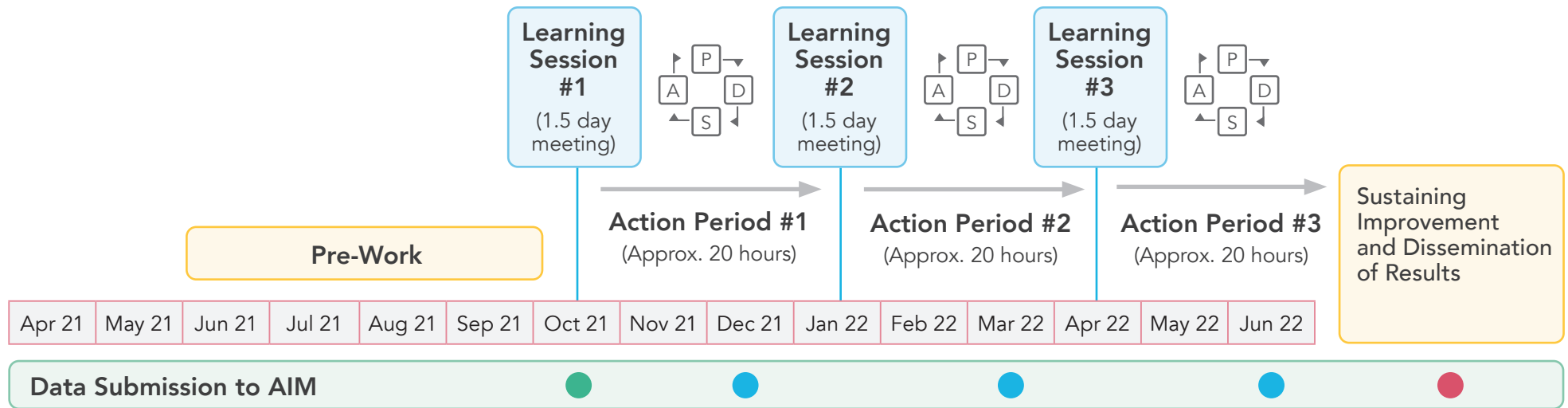
- Evidence based practice
- Every other week visits
- Help family:
  - Look at their child's development and talk about parenting challenges
  - Think about family dynamics and how they impact their child's development and their parenting values and decisions
  - Build strong protective factors for the child and family to be healthy, strong and resilient
- Refer to community resources
- Group connections for families





**Connecting you to a better life**

# MPQC Obstetric Hemorrhage Collaborative Process



## Pre-Work

- Review Packet (2hrs/person)
- Form Team (2hrs/person)
- Orientation Webinar (2hrs/person)
- Readiness Self-Assessment (5hrs/Team)
- Aim Statement (1hr/Team)
- Storyboard Creation (1hr/Team)
- QI Webinar (2hrs /person)
- Data Webinar (2hrs/person)

Approx. 31 hrs/person  
over 4 months

## Learning Sessions

- Learning sessions will be 1.5 days long and will involve sharing with and learning from other members of the AIM cohort who are implementing the bundle.
- These may be online or in-person.

## Action Periods

These are periods of time between each Learning Session when a hospital team works on implementing the AIM bundle change package through PDSA cycles. Additional activities taking place in the Action Periods will include:

- Monthly All Team Calls & Reports
- Data Collection & Reporting
- Site Visits (As Needed)
- One on One Technical Assistance as Necessary (QI, Data, etc.)

Time Requirement: Varies by facility. Minimally, OB leadership/AIM implementation team should plan to attend 2 meetings per month with other cohort members and/or AIM bundle leadership.

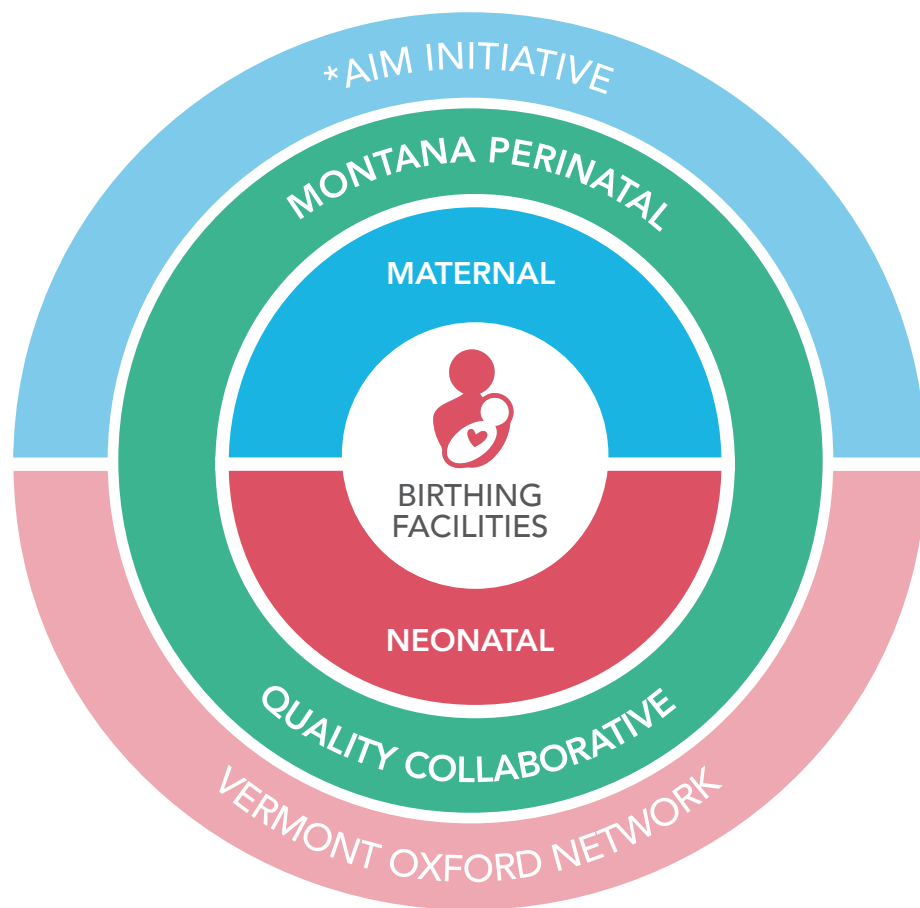
## Data Submission to UM

- Baseline data submitted after enrollment.
- Process and structure measures submitted quarterly.
- Outcome measures submitted at the end of the bundle.

UM will submit all data to AIM.



# Becoming an AIM State



- \* **ACOG** – American College of Obstetricians and Gynecologists, the premier professional membership organization for obstetricians and gynecologists.  
<https://www.acog.org/>
  - \* **AIM** – **Alliance for Innovation on Maternal Health**, a national data-driven maternal safety and quality improvement initiative (funded by HRSA and national ACOG). <https://safehealthcareforeverywoman.org/aim/>
  - \* **MT DPHHS** – **Montana Department of Public Health and Human Services** (Title V/Maternal & Child Health Block Grant Program), coordinating body for the AIM initiative, convening the PQC.  
<https://dphhs.mt.gov/ecfsd/mch>
  - \* **MHA** – **Montana Hospital Association**, partner coordinating body supporting the convening, quality improvement, and education of the PQC.  
<https://mtha.org/>
- PQC** – Learn more about the CDC's guide to perinatal quality collaboratives. <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc-states.html#>
- \* **UM** – **University of Montana Rural Institute For Inclusive Communities**, providing data collection and analysis support to hospitals and submitting data to AIM. <http://ruralinstitute.umt.edu/>
  - \* **VON** – **Vermont Oxford Network** is a nonprofit voluntary collaboration of health care professionals working together to improve neonatal care.  
<https://public.vtoxford.org/>
  - \* **Yarrow** – Contracted by DPHHS to facilitate the PQC AIM Initiative and provide quality improvement technical assistance to hospitals.  
<https://www.yarrowcommunity.org/>

## YOU'RE INVITED TO

Improve health outcomes for mothers and babies by:

- 1 Joining the PQC
- 2 Participating in the AIM Initiative