



Maternal Health Leadership Council Meeting

September 14, 2021

2:30 – 4:30 PM

REVISED Agenda

- 2:30 – 2:40** Roll call, review agenda and approve minutes
- 2:40 – 2:45** Approve final strategic plan – specifically, the council's sections (VOTE NEEDED)
- 2:45 – 3:30** Celebrate council accomplishments and hear updates
- 2:15 – 2:20 Department of Public Health and Human Services (DPHHS)
- Council accomplishments and updates
- 2:20 – 2:40 Dr. George Mulcaire-Jones
- The Obstetric Hemorrhage patient-safety bundle implemented by the Perinatal Quality Collaborative (PQC)
- 2:40 – 3:00 University of Montana (UM)
- Alliance for Innovation on Maternal Health (AIM) and the PQC
 - Levels of Care Assessment Tool (LOCATe)
 - MOMS Rapid Response Mini Grants
 - Leadership Council Interviews
- 3:30 – 3:40** BREAK
- 3:40 – 4:00** Presentation from MOMS mini-grant awardee
Peer Support Perinatal Training Hub
Megkian Doyle and Pam Ponich of Big Horn Valley OneHealth
- 4:00 – 4:10** Questions
- 4:10 – 4:20** Next steps - where we have been and where we are going
- 4:20 – 4:30** Public comment



Maternal Health Leadership Council

Meeting Minutes:

June 22, 2021:

3:30-5:00 PM:

Location: Zoom only

Members Present

Chair, Dr. Tersh McCracken, MOMS Medical Director & Ob-Gyn at Billings Clinic
Dina Kuchynka, Maternal and Newborn Health Manager at SCL Health-Holy Rosary
Mary LeMieux, Member Health Management Bureau Chief at Medicaid, and Perinatal Behavioral
Oliva Riutta, Outreach and Engagement Manager at MPCA
Janie Quilici, Perinatal Behavioral Health Counselor at Community Physicians Group
Tami Schoen, RN at Whole County WIC Department
Brie MacLaurin, Executive Director of Healthy Mothers, Healthy Babies
Lisa Troyer, Wellness Consultant at Pacific Source Health Plans
Jennifer Wagner, Rural Hospital Improvement Coordinator with Montana FLEX Program at Montana Hospital Association

Members Absent

Dr. Christina Marchion, Family Medicine/OB at Central Montana Medical Center
Dr. Bardett Fausett Maternal Fetal Medicine Specialist and President/Medical Director at Origin Health
Dr. Jean-Pierre Pujol, Medical Director at Blue Cross Blue Shield of Montana
Dr. Steve Williamson, Chief Medical Officer, Billings Area Indian Health Service
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
Judge Mary Jane Knisely, 13th District Court Judge, Felony Impaired Driving Court (IDC), CAMO Court (Veterans Treatment Court)
Vicki Birkeland, Nursing Director, Women's Services at St. Vincent's Montana Perinatal Quality Collaborative
Ann Buss, Maternal Child Health Coordinator

Program Staff Present

Amanda Eby, MOMS Program Coordinator at DPHHS
Dr. Annie Glover, Lead evaluator and PI for MOMS at University of Montana
Stephanie Fitch, MOMS Grant Manager at Billings Clinic

Public Attendees

Darci Wiebe, Division Administration for Health Resources Division at DPHHS

Welcome and introductions

Dr. Tersh McCracken opened the meeting and lead roll call. Tami Schoen mentioned that her credentials were wrong. Amanda Eby will make the corrections from the previous meeting. Lisa Troyer said that she should be listed absent from the previous meeting. No additional corrections. Meeting minutes were approved.

Update from Montana Primary Care Association (MPCA)

Olivia Riutta, Outreach and Engagement Manager at MPCA, presented on Outreach, Enrollment, and transitions of coverage during preconception, pregnancy and postpartum. The Montana Primary Care Association (MPCA) works with Community Health Centers and Urban Indian Health Centers. The MPCA is in the process of applying for a federal navigator grant to assist with outreach and enrollment for insurance coverage. The Navigator Grant is three million dollars and it is a cooperative agreement grant (one million each year). Around ten percent of individuals in Montana are uninsured. Riutta said that Affordable Care Act (ACA) and the Medicaid expansion piece has been very effective in dropping the uninsured rate in Montana. Before the ACA twenty percent of Montanans were uninsured. Open enrollment for 2021 is November 1st through December 15th or individuals will need to qualify for a Special Enrollment Period (SEP). Riutta said a question to consider for the council is how do we think about targeting pregnant and perinatal women around coverage and transitions?

Q & A opportunity with presenter

Dr. Tersh McCracken asked how patients would get help? Riutta said that the Billings clinic has two layers. There are folks who do medical enrollment in house and the clinic also has folks who are certified application counselors. If a hospital or clinic doesn't have anybody that does in enrollment, you would then refer right away. The navigator grant would be an additional layer that would provide in person and virtual assistance. McCracken had a follow up question and asked if there would be a special element to address the problem with enrolling indigenous women on Medicaid who are eligible for dual coverage? Riutta said that they are looking to hire a navigator team that understands how to work in indigenous communities. She also said that they will continue to develop outreach and enrollment materials under the Cover Montana brand.

Brie MacLaurin thought that it would be beneficial if the Navigator was able to connect with community health services. Tami Schoen also sees issues with it being solo focused. Schoen said that participants can automatically be eligible for WIC if they have Medicaid. She said that they try and get people enrolled, but participants only have an 800 number that they can call for the Office of Public Assistance. Schoen followed up with a question/suggestion—could there be a connection through the health departments for folks to get assistance? Olivia recommended using Cover Montana.

Janie Quilici asked is there a relationship with the treatment community? Quilici mentioned that she has a patient that just qualified for Medicaid because she is pregnant. The patient is utilizing their medication assisted treatment and is worried that when she goes off Medicaid that she won't be able to afford the prescribed medication. Riutta suggested that someone sit down with the patient and review her employee coverage and look at her out of pocket costs. Riutta thinks that Navigators need to be trained up on this specific issue.

Amanda Eby wanted to confirm if there are only certified application counselors and navigators located in hospitals and Federally Qualified Health Centers (FQHC)? Riutta said that navigators only work for a federal grantee. Montana mostly has certified application counselors and there are virtual navigators serving currently. Any organization can apply to Centers for Medicaid and Medicare (CMS) to have certified application counselors (application window is currently open). Riutta also stated that you don't have to be certified to help someone enroll with Medicaid. Eby asked also asked if she has thought about about strategies or activities related to education to independent OBGYN clinics on connecting women to Cover Montana? Is it possible to have navigators in independent OBGYN Clinics who are not



contractually or financially tied to a hospital system? Riutta said that it most likely isn't happening now due to capacity. But there is potential to make those connections.

Updates on MOMS

No time to cover this topic.

Strategic Plan

Amanda Eby reminded everyone that last summer, the council conducted a strengths-weaknesses-opportunities-threats (SWOT) analysis for maternal health care in Montana. The SWOT informed the MOMS strategic plan, and the draft was submitted to HRSA back in September 2020. The final strategic plan is due to HRSA on September 29, 2021.

Annie Glover encouraged those that have not completed the interview for the needs assessment to schedule the interview with Molly Molloy from the University of Montana. Eby added that the interviews will inform the strategic plan.

The goals for the strategic plan were organized according to the World Health Organization (WHO) Strengthening Health Systems to Improve Health Outcomes Framework – includes six building blocks of a health system:

- **Data**
 - No corrections suggested.
- **Health Care delivery**
 - Eby commented that the program staff does not see this as a final strategic plan for the Perinatal Quality Collaborative (PQC) and Obstetric Hemorrhage patient-safety bundle. This will be continuous, and more goals will be added after the later after they determine a better understanding of the process of the PQC and the first cohort's implementation outcomes.
 - No corrections to be made
- **Financing**
 - Darci Wiebe recommend that they look at why the services are not being billed rather than looking at the rates. It is underutilized. Peer Support and the prep work may have something to do with it.
 - Dr. Tersh McCracken suggested that we change it to say study Medicaid reimbursement and utilization for peer support specialist
 - Eby will speak with program staff about how Hospitals can't bill Medicaid for addiction treatment services unless they are recognized treatment facility and consider adding it as a goal.
- **Workforce**
 - Wiebe wanted clarification on what "engage Indian Health Services (IHS) as hub and spoke participants" means. Eby will change the wording and make it clear that it relates to ECHO.
- **Leadership and Governance**
 - No corrections to be made.
- **Medical Products, vaccines, and technology**
 - McCracken said that we can look at facilitating the use of equipment or figuring out innovative ways to use it, but we shouldn't be using the grant to buy equipment for hospitals. He feels that they should be buying it on their own.

Discuss meeting schedule and plans



Eby said that the committee talked about moving to quarterly meetings. The committee will need to meet in July to get more feedback on other areas of the strategic plan. Would like to use that time and focus on values, key drivers and the plan council activities for next year. In September we will plan on meeting in person. Eby provided two options when the committee could meet. Option one would be to meet on September 14th in Helena from 1PM – 4:00 PM (meet after the ECHO clinic & social afterwards). Option two would be to meet in person in Billings or Helena in conjunction with one of the conferences that is being held the week after September 14th. Eby also proposed the idea of council members taking turns of hosting the meetings.

McCracken agreed with meeting quarterly and meeting in person. He also mentioned that it may be helpful to meet in Helena on September 14th rather than meeting in Billings. He also said that the meeting should start around 1:30 PM.

Eby ended the discussion by saying that an electronic survey will be sent out with questions on the meeting times to confirm. Also, within the survey you can expect to see the same questions that you saw in December.

Public comment/roundtable questions and discussion

No additional comments.



MOMS Maternal Health Leadership Council's Mission, Vision, Values, Key Drivers and Planned Activities

Mission:

MOMS will improve maternal health across Montana through collaboration, data-driven decision making, promoting best practices and innovation, and addressing racial and rural disparities in care.

Vision:

MOMS will improve maternal health to make Montana, the Last Best Place, also the First Best Place to have a baby.

Values:

Equity, Quality, Safety, Evidence-Based, Accessible, Timely, Patient-centered, Data-driven

Key Drivers:

- Attendance and participation at meetings.
- Access to data necessary to decision-making for program guidance.
- Support from organizations members represent to ensure translation of work into local communities and the populations organizations serve.
- Diverse and inclusive membership that represents all relevant interests in maternal health.
- Open pathways of communication to disseminate impactful information that generates discussion and further elevates maternal health as a priority in MT.
- Meeting structure to facilitate efficient and effective council discussion
 - Data
 - Speaker
 - Brainstorming
 - Key driver diagram to identify strategies and action items
- Agendas that clearly specific council expectations regarding need for votes, feedback, input.
- Policy advocacy

Council Planned Activities (2021-2024):

- Ongoing coordination with other maternal health initiatives – PQC, MMRC, Meadowlark
- Sustainability planning
- Policy advocacy planning
- Deep dive investigating and strategizing rural and racial disparities in care
 - Develop action plan

State MHI Program Goals (2019-2024)

Goals were drafted for each of the WHO building blocks of a health service delivery system:

- **Data**
 - Increase collaboration among data and epidemiological staff in Vital Statistics, Office of Science and Epidemiological Support (OESS), Pregnancy Risk Assessment and Monitoring System (PRAMS) and UM.
 - Measure according to executed data use agreements (DUAs) between entities and when 100% of requested data requests are completed in 30-60 days.
 - Establish data extraction and sharing schedule, with consistent format, between Vital Statistics and the Nurse Abstractor/MMRC to ensure reliable data availability for maternal death reviews.
 - Initiate quality improvement plan with birthing facilities, in partnership with the Montana Hospital Association (MHA), to improve their tracking of severe maternal morbidity.
 - Complete the Montana Maternal Health Annual Report on time each year.
- **Health care delivery**
 - Convene and facilitate the Montana Perinatal Quality Collaborative (MPQC) to implement the Alliance for Innovation in Maternal Health (AIM) Obstetric Hemorrhage patient-safety bundle by September 2022. (Subsequent goals related to the PQC and AIM patient-safety bundles will be added later based on the experience of cohort one.)
 - Leverage strengths to promote equitable care across under-served and vulnerable populations.
 - Partner with federally qualified health centers (FQHCs) and Title V Maternal and Child Health Block Grant funded county health departments to increase and improve well-woman visits.
- **Financing**
 - Collaborate with public and private payers to understand their billing practices and utilization of services for maternal health care and identify potential improvements to promote best practices in health care delivery. Identify one initiative with each payer to improve obstetric care.
 - Study Medicaid reimbursement and utilization for peer-support specialists to understand the impact on maternal health patients struggling with substance use disorders (SUD) and/or behavioral health (BH) diagnoses.
- **Workforce**
 - Sustain the twice monthly Project ECHO clinics with at least half of participants clinical at each one.
 - Engage Indian Health Services (IHS) as ECHO hub and spoke participants.
 - Sustain 60% or higher participants who apply learned content from ECHO clinics to their practice.
 - Train 5-10 facilities in obstetric simulations each year (15-30 total sites).
 - Support and increase para-professional perinatal and family support workforce for vulnerable and indigenous populations.
- **Leadership and governance**
 - Enroll MT in AIM September 2021 and maintain membership.

- Engage and support the maternal track of the MPQC, with membership of 100% of facilities that identify as a birthing facility in the state by 2023 participating and actively implementing AIM bundles.
- Convene and facilitate the MOMS Maternal Health Leadership Council to provide program implementation guidance; serve as a hub of information on maternal health; a platform for collaboration and partnership building among various maternal health partners across the state; and a potential avenue for policy changes.
- Staff will become advisors on program and policy regarding rural maternal health at the local, state and national levels as well as empower council members and other stakeholders to lead with them.
- Establish a distribution plan and protocol for the Montana Maternal Health Annual Report and other MOMS reports.
- **Medical products, vaccines, and technology**
 - Administer mini-grant program for equipment at facilities such as fetal dopplers, ultrasound machines, bakri balloons, telemedicine equipment, etc.
 - Support facilities in training and innovative use of birthing equipment.



Celebrating Year One and Looking Ahead

MOMS Council Meeting
September 14, 2021



*Be proud of the power and influence
of your collective voice!*

***Your conversations and collaboration are elevating maternal health as
a priority in Montana and here is the evidence:***

- Decision-making brief to DPHHS Director that established the first state-level, multi-disciplinary **Maternal Mortality Review Committee (MMRC)**
- Recommended members for the MMRC who nearly all enthusiastically accepted their appointment and committed to serve
- Approval vote, review and award of MOMS Rapid Response Mini-Grants that supported **18 local-level projects to improve maternal health**
- Endorsement of the **CDC's Levels of Care Assessment Tool (LOCATe)** to help better understand risk-appropriate care for moms and babies at Montana birthing facilities

Council Accomplishments

The commitment to and collaboration in improving maternal health in Montana has gained momentum and is reaping benefits

- Montana awarded the CDC's **ERASE MM Grant**
- **National, regional and state-level attention** with presentations at
 - National Maternal Health Innovation Symposium
 - National Academy for State Health Policy (NASHP)
 - HRSA Regions 8 and 10 PQC Summit
 - Montana Healthcare Conference
 - Montana Public Health Association
- **Launched the maternal track of the Montana Perinatal Quality Collaborative (PQC)** with 17 actively engaged birthing facilities
- Soon to be **on the map of Alliance for Innovation in Maternal Health (AIM) states!**
- **Superb engagement in LOCATe** with 20 of 26 having completed the assessment by initial deadline

ERASE MM Grant

- Recently awarded Enhancing Review and Surveillance to Eliminate Maternal Mortality (ERASE MM) grant, to begin October 1
 - Intent is to support the pillars of MMR and MMRCs –
 - **Case identification, Abstraction and Analysis**
- Working with CDC to re-configure workplan and budget
- 0.75 FTE Nurse Abstractor and 0.25 epidemiologist
- Recruiting for Nurse Abstractor who will also be the Project Coordinator for the grant
- Training on case identification and the linkage process

MMRC

- Launching this October
- First meeting agenda
 - Presentation on pregnancy-related overdose and suicide deaths
 - CDC orientation/training
 - Overview of Montana Fetal, Infant, Child and Maternal Mortality Review (FICMMR) Law
 - History and analysis of severe maternal morbidity and maternal mortality in Montana
- Meetings to occur quarterly for 3 hours each
- Starting reviews with 2020 deaths at second meeting

Organizations & Disciplines Included

- Obstetrics & Gynecology
- Family Medicine Obstetrics
- Maternal-Fetal Medicine
- Assoc. of Women's Health, Obstetrics & Neonatal Nurses (AWHONN)
- Social Work
- Postpartum Resource Group
- Addiction Counseling
- Perinatal Behavioral Health
- Community Birth Workers – Recovery Doulas
- Ag Worker Health & Services
- Office of Epidemiology & Scientific Support
- DOJ Division of Criminal Investigation Special Services Bureau – Sexual Assault Kit Initiative
- Title V
- Title X
- UM Rural Institute
- MT Coalition Against Domestic & Sexual Violence
- MT Legal Services – Indian Law Attorney
- FQHC
- 5 of MT's 7 Native American tribes

Council Survey Priority Areas

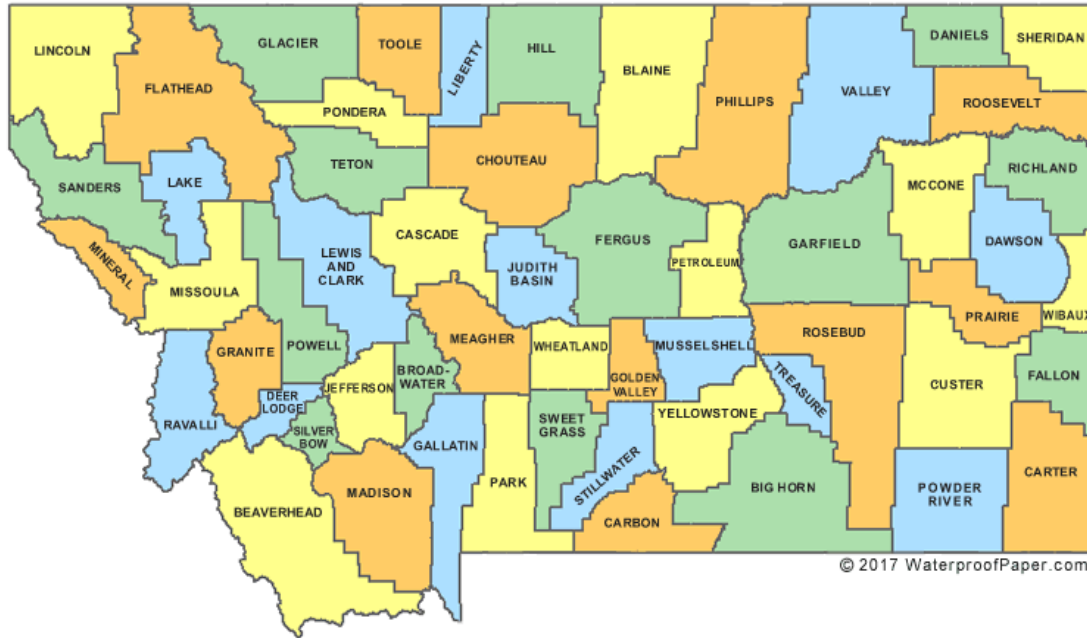
Please rank the following in order of your interest and priority to the program.

1. Rural and racial disparities in care
2. First trimester prenatal care
3. Postpartum care
4. Data collection improvement and alignment to better inform programs, policies, and clinical care.
5. Health equity and implicit bias training
6. Family Planning
7. Adolescent care
8. Preconception Care
9. Trauma-Informed Care Training
10. ACEs Training
11. Reproductive Justice
12. COVID-19

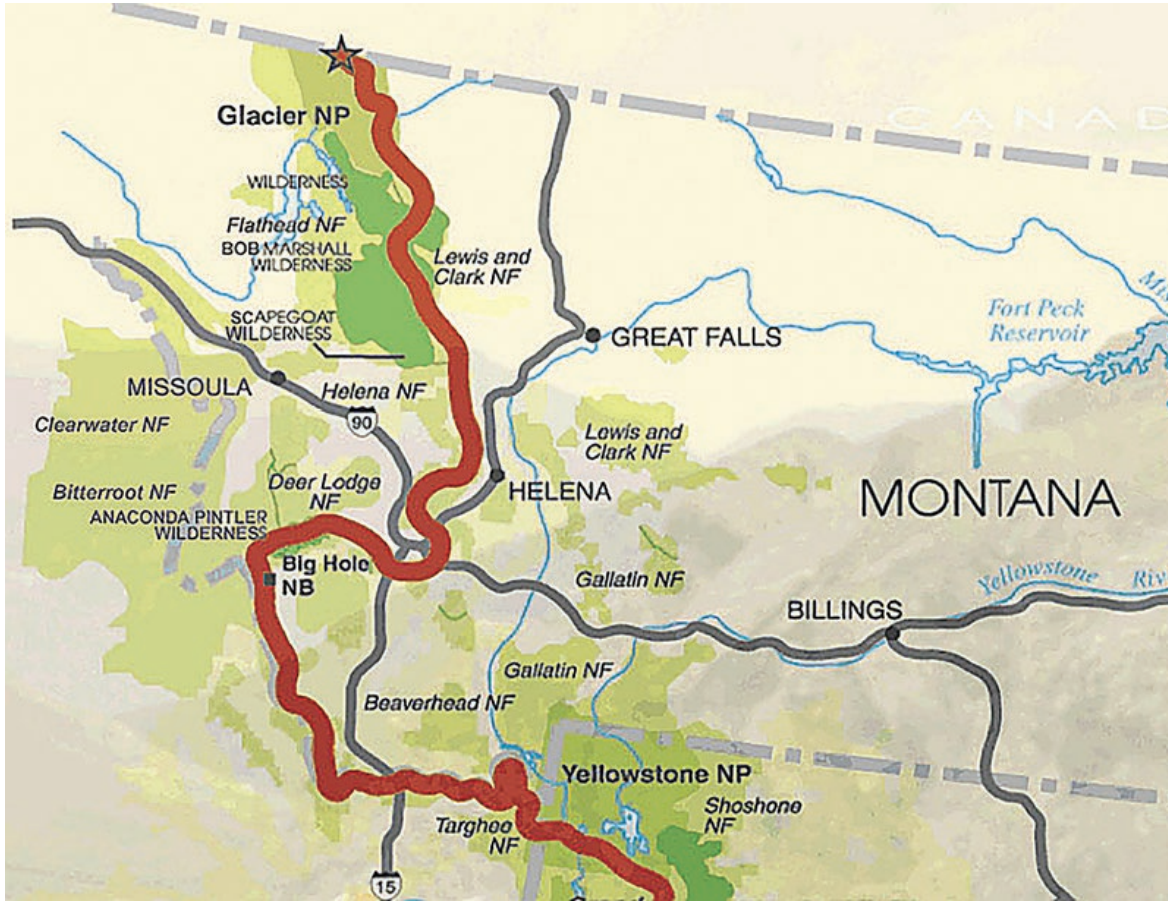
2021-2022 Council Agenda

- Maintain ongoing coordination with related maternal health initiatives – PQC, MMRC, AIM, Meadowlark
- Deep dive investigating and strategizing rural and racial disparities in care
 - Develop an action plan
- Sustainability planning
 - What pieces of MOMS are most critical to continue?
- Policy advocacy planning
 - Infrastructural support for initiatives to continue

OB HEMORRHAGE BUNDLE UPDATE



THREE STATISTICS



- Montana has the 6th highest maternal mortality in US
- The “Great Divide” between rural/urban and Native/non-Natives. *“American Indian/Alaska native women in rural areas had 5.6 times higher mortality than their counterparts in urban (metro) areas.”*
- 60% of Maternal Deaths are preventable



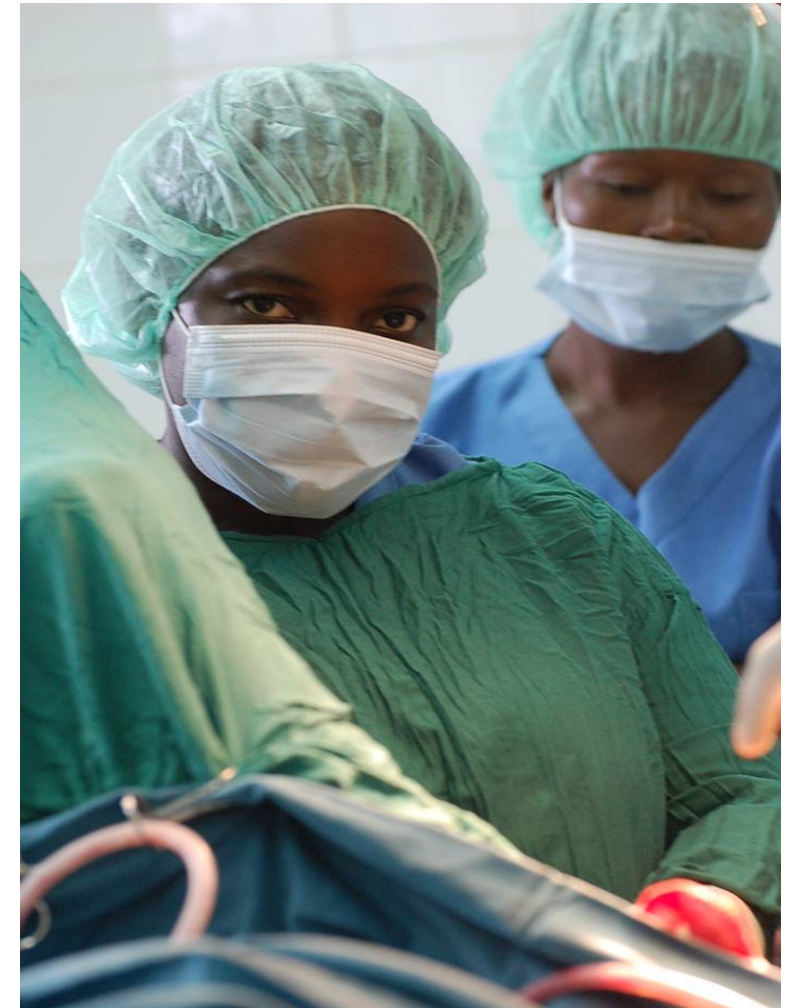
OUR AIM IS TO GET BETTER

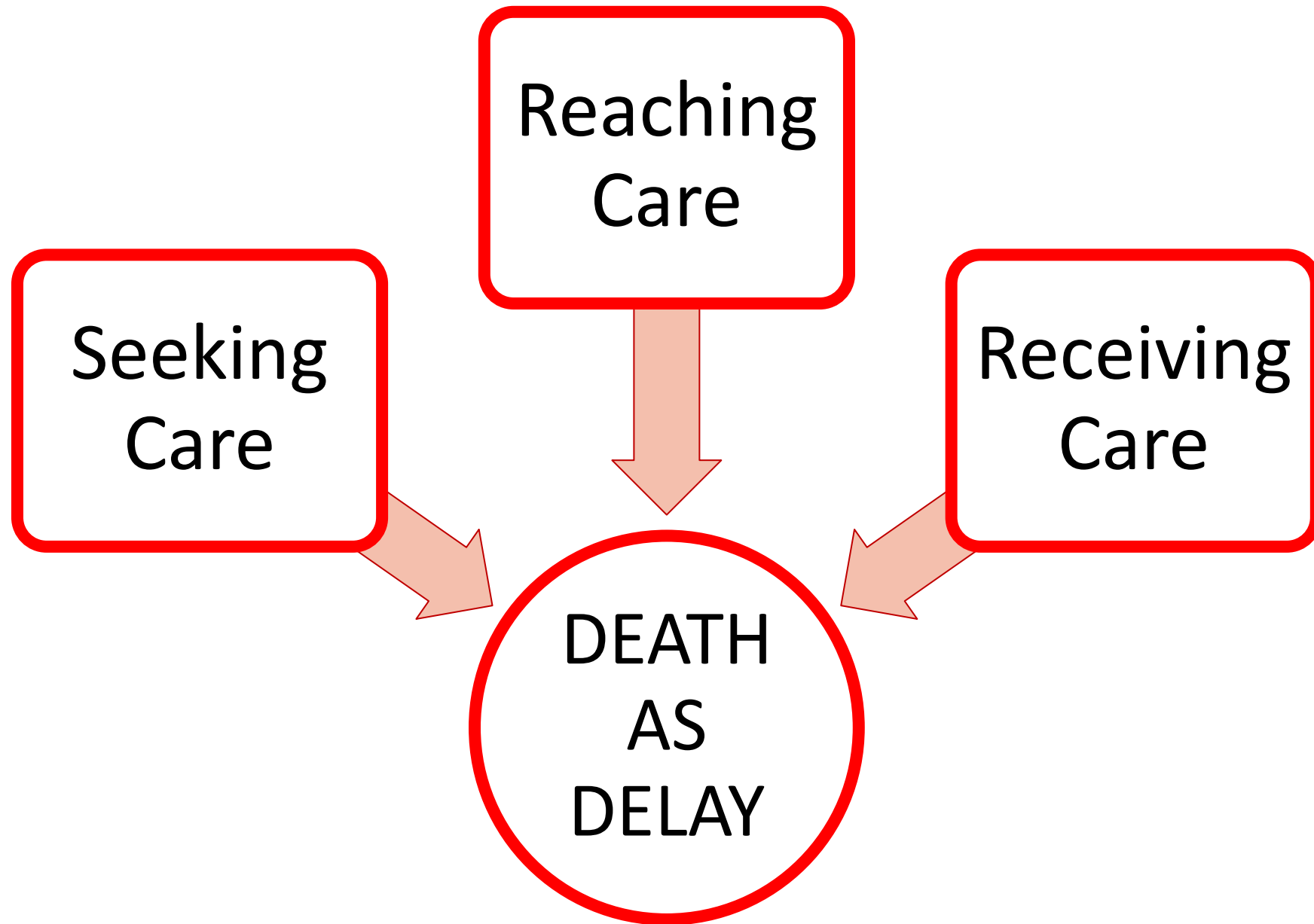
CLINICAL FOCUS on BEST PRACTICES



Obstetrics: “A field of time”

Obstetrical emergencies: “Emergencies of time”

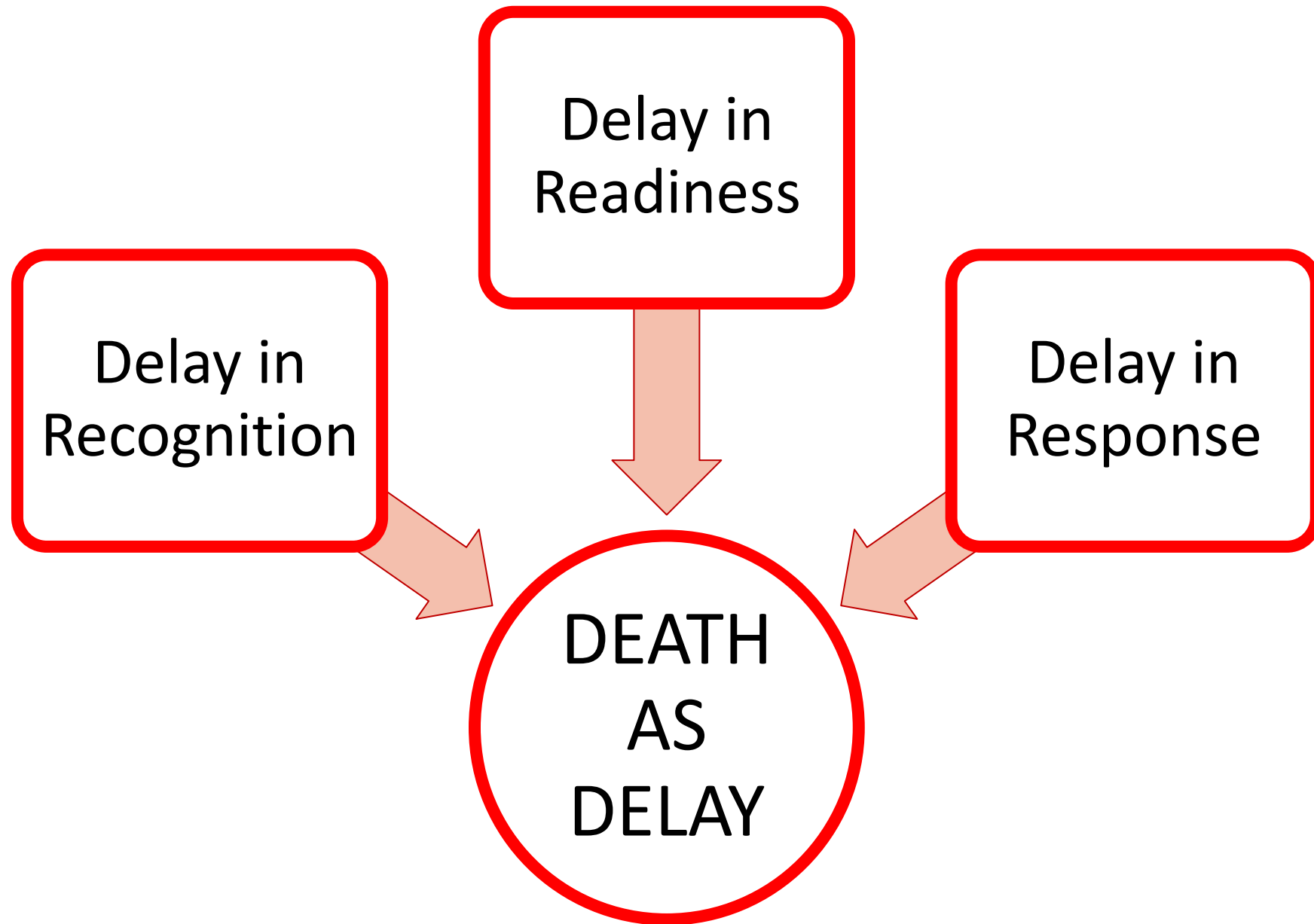






Death as Delay: Rural United States

- Delay in Seeking: *American Indian and Alaska Native women living in rural communities are twice as likely to report receiving late or no prenatal care (13% vs. 6%).*
- Delay in Reaching: *Fewer than 50% of rural women have access to perinatal services within a 30-mile drive from their home and more than 10% of rural women drive 100 miles or more for these services.*
- Delay in Receiving: *Lack of access to appropriate labor and delivery facilities and services for women living in rural areas: Increases in out-of-hospital births, births in hospitals without obstetrics services; and poorer birth outcomes such as preterm births*



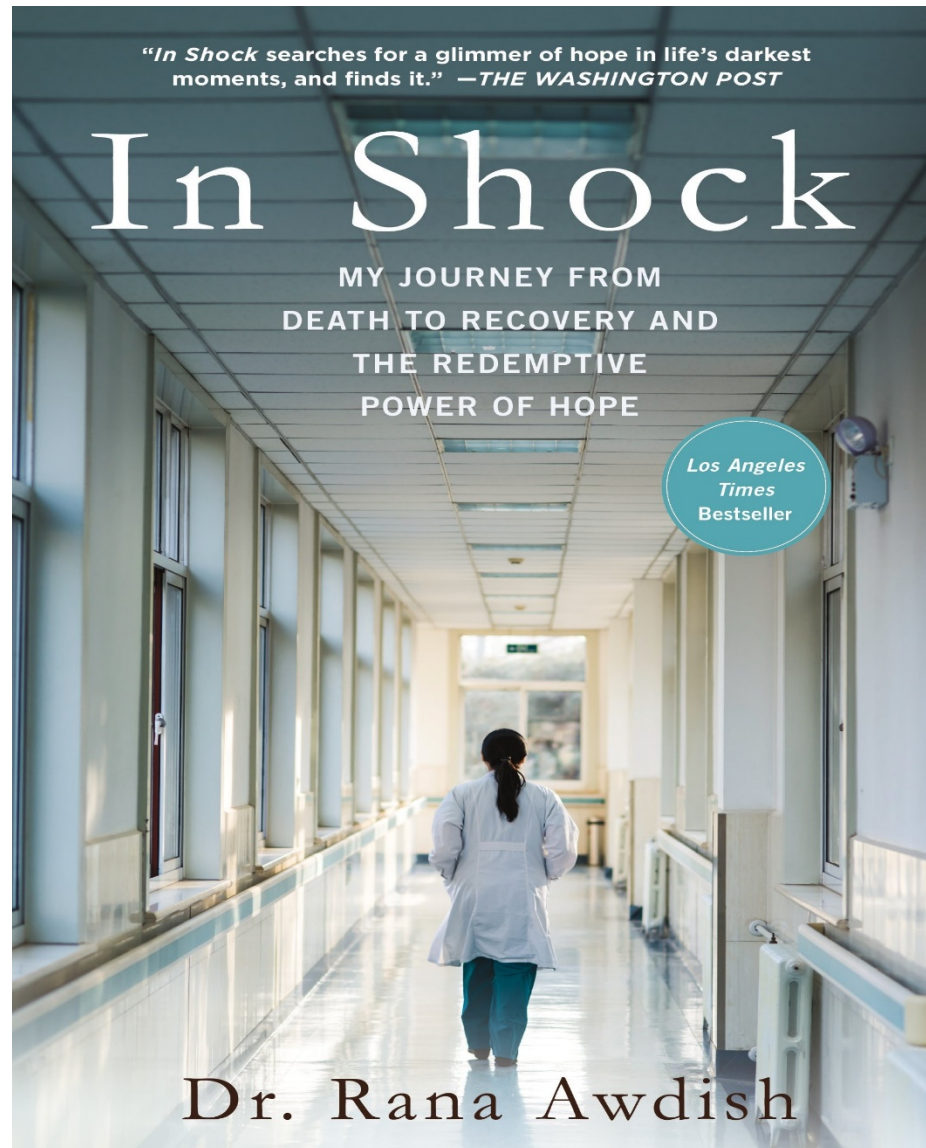
DELAY IN READINESS



DELAY IN RECOGNITION



DELAY IN RESPONSE



“It is easier to stay out of trouble than get out of trouble”

“I had what was referred to in trauma as the “Triad of Death,” the combination of hypothermia, acidosis and coagulopathy. In simple terms the phrase describes a self-perpetuating process in which the blood is too cold and too acidic to allow clotting, which means more bleeding, more transfusions, which results in more hypothermia and acidosis. A sort of unrelenting, suicidal spiral of the blood. They described gallons of blood lost, the gallons frantically replaced, some run through a warmer . . . The moments my kidneys shut down. The rapid accumulation of potassium in my blood stream. The deterioration of my vital signs. The gradual acquiescence of my heart, irritated by the toxic milieu, beating aberrantly, then not all. *Dr. Rana Awdish, “In Shock”*

THE 5 “R’s”



REPORTING

REPORTING/SYSTEMS LEARNING (4 of 4)



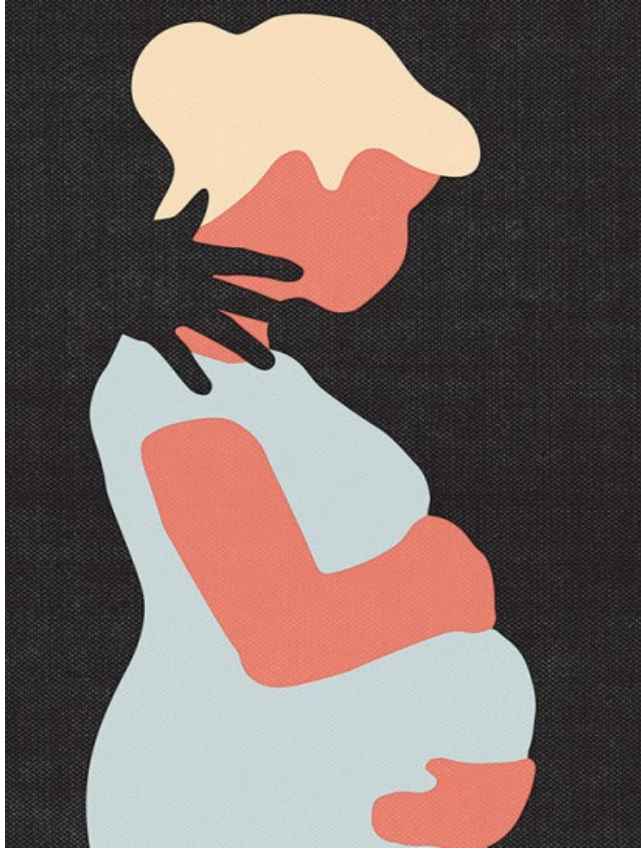
Multidisciplinary review for systems issues

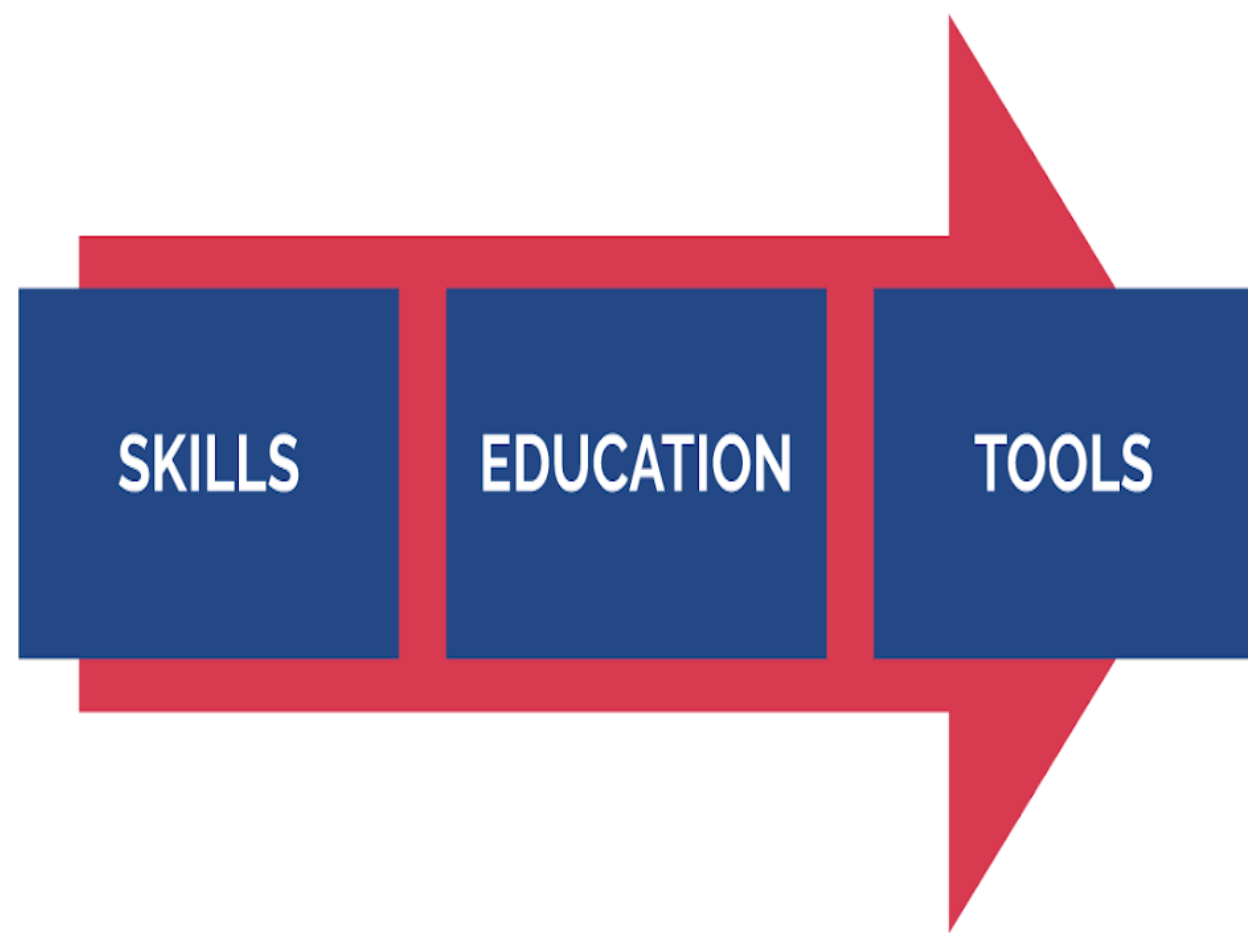
Huddles & debriefs on successes & opportunities

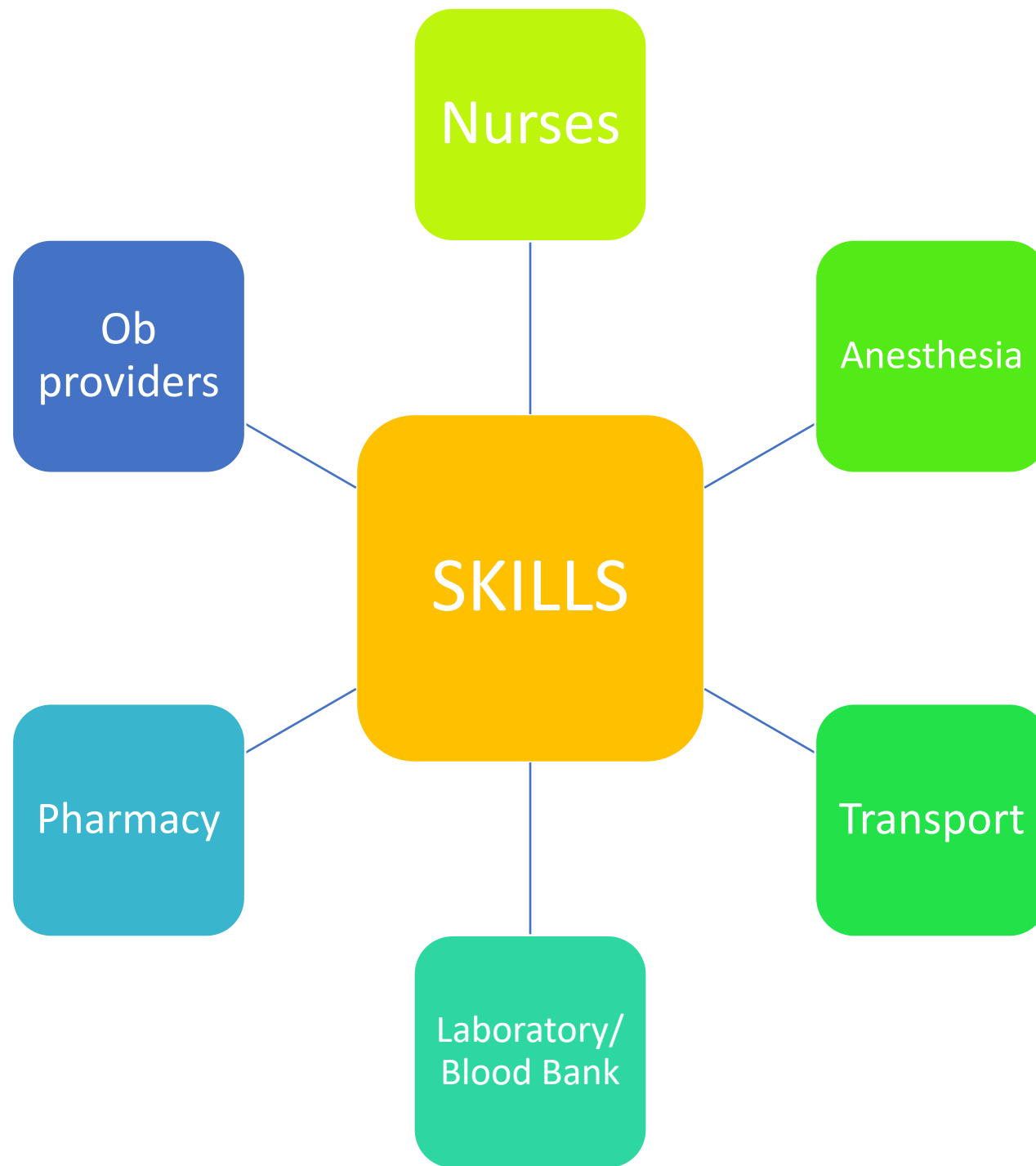


Eliminate preventable maternal mortality
#EveryMomEveryTime

Respect-Based Care: “We are guests in our patient’s lives”







SKILL “ONE”: Ability to Tell Time

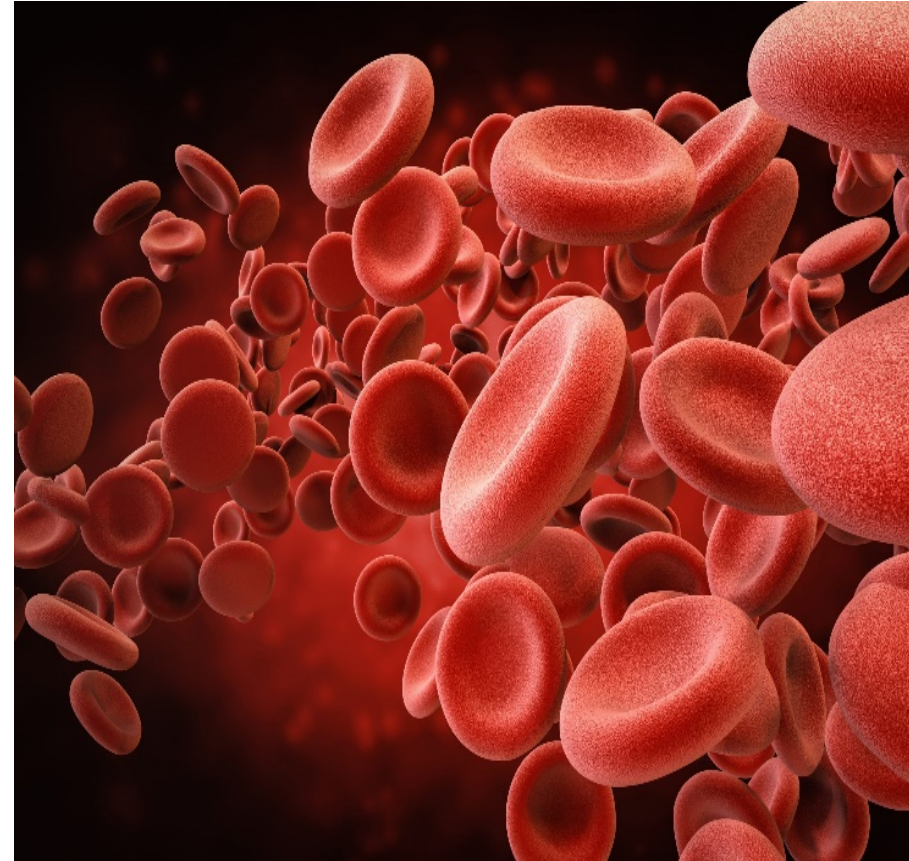


EDUCATION



EDUCATION: BUNDLE COMPONENTS

- Active Management of 3rd Stage
- Clinical Triggers and Quantitative Blood Loss
- Medications and Massage – oxytocin, methergine, hemabate, TXA
- Placental Separation and Delivery
- Hemostatic Resuscitation
- Placenta Accreta Spectrum



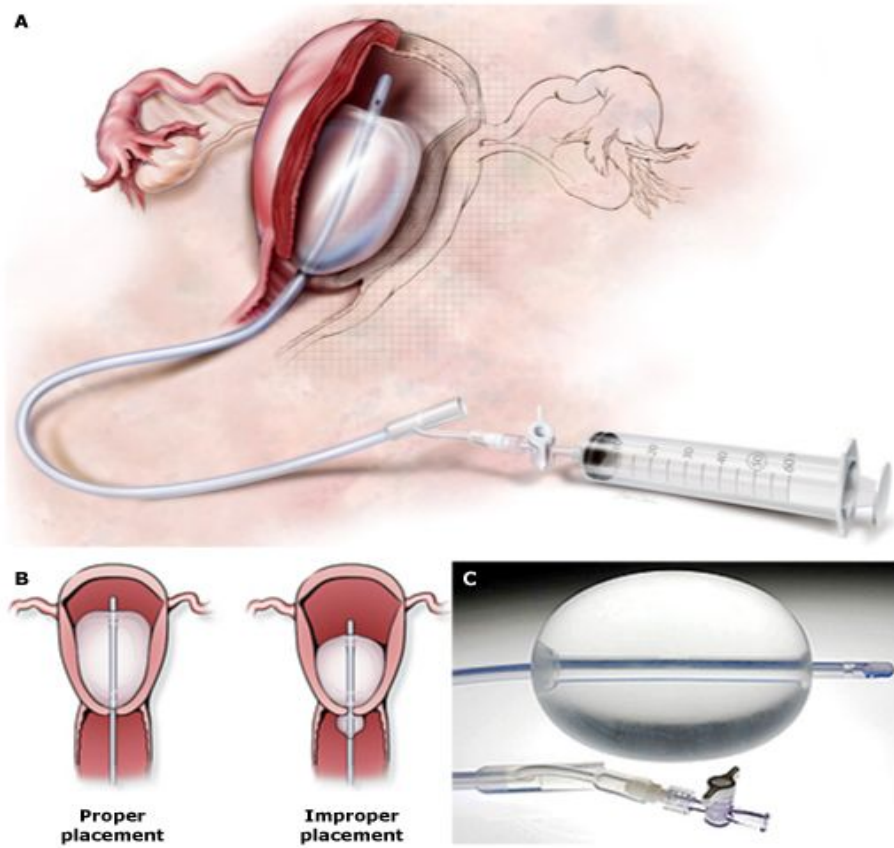
TOOLS: “An instrument or implement used by a craftsman or laborer”

- IV catheter insertion (ultrasound)
- Non-pneumatic Anti-Shock Garment

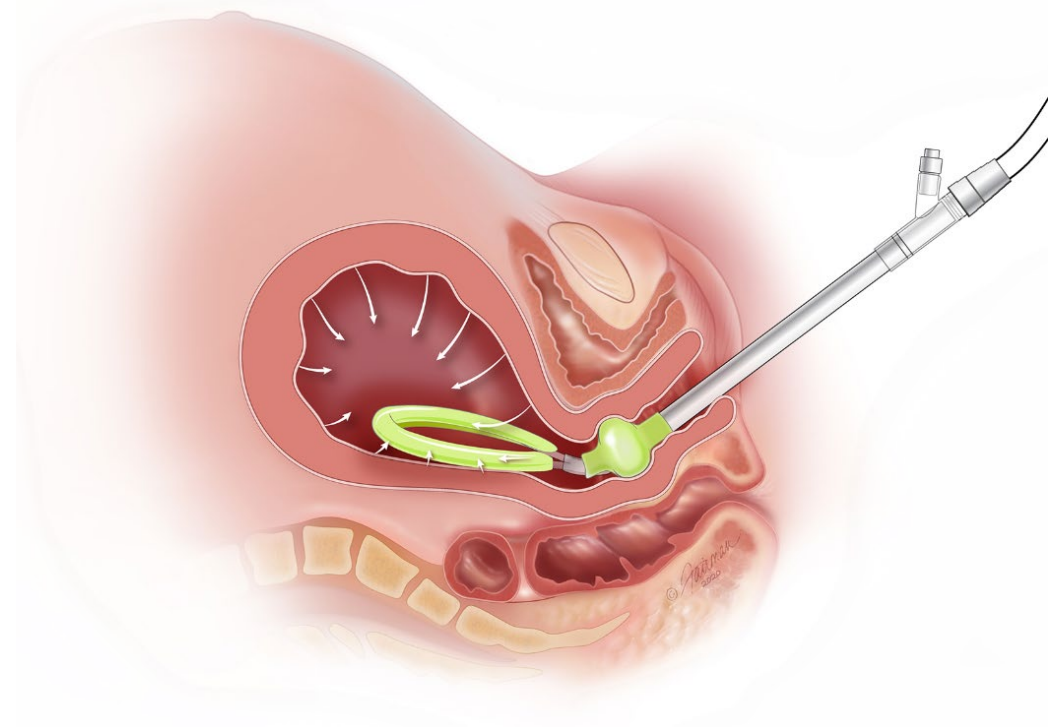


TOOLS:

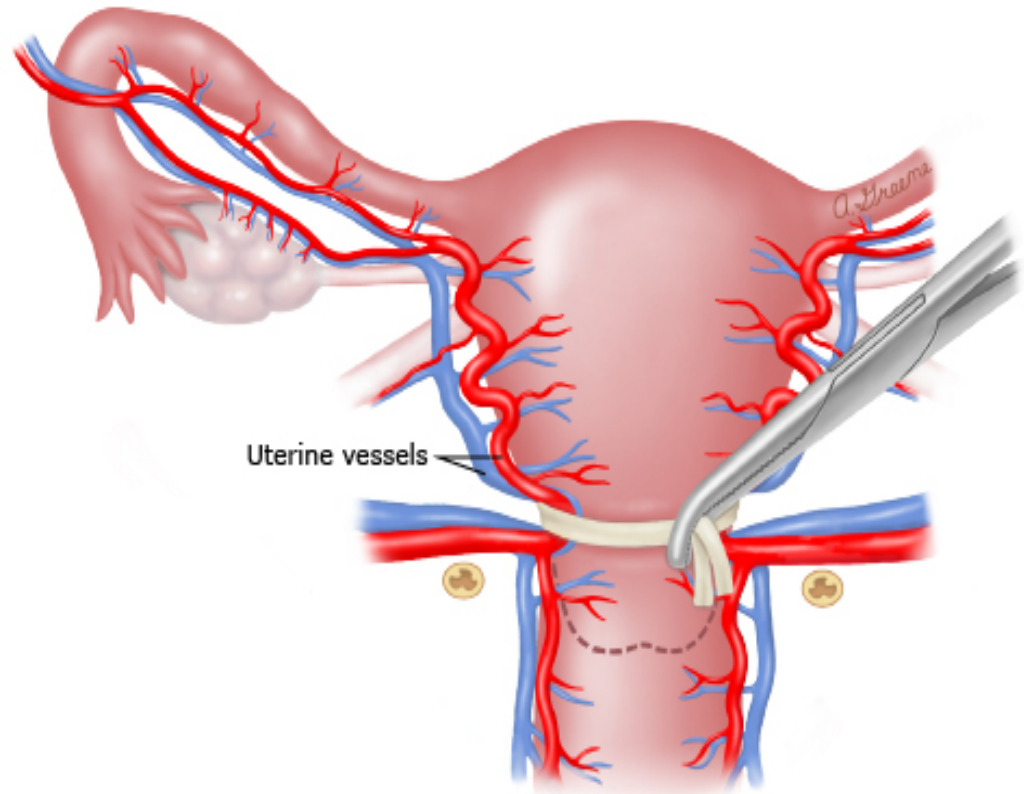
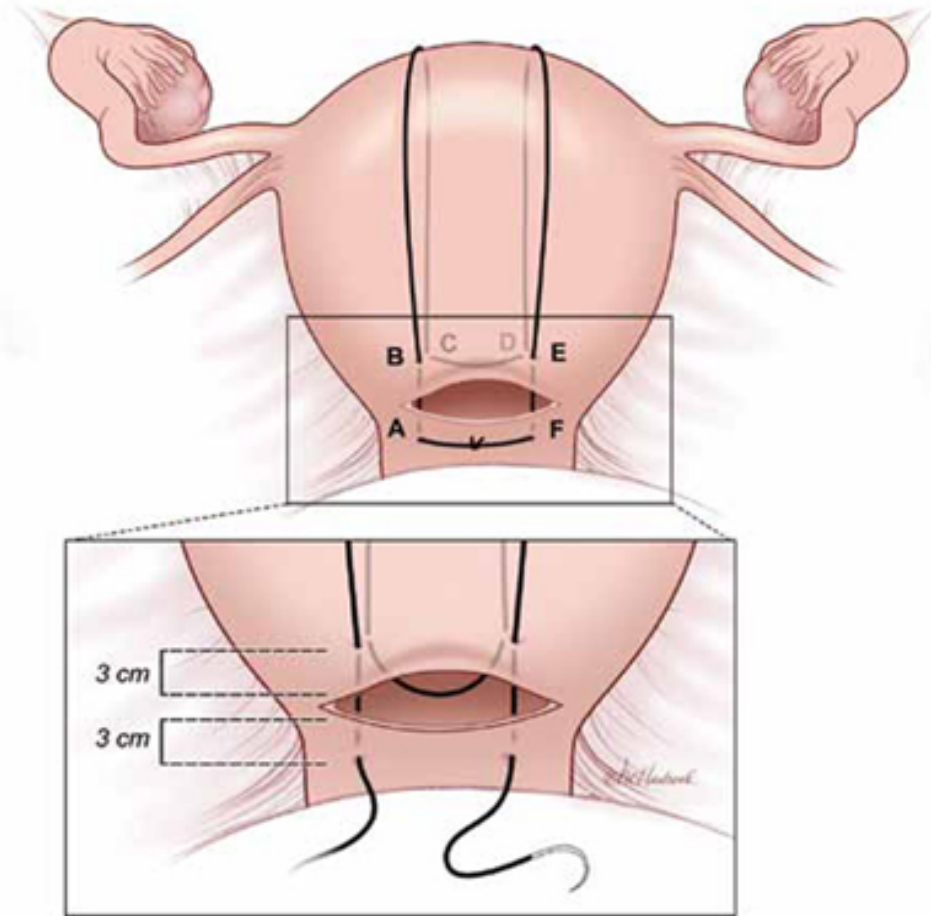
- Intrauterine Balloon Tamponade



- Intrauterine Vacuum Device



TOOLS: Laparotomy



The SIM Difference: Bringing it all together



OB HEMORRHAGE: “The Right Response”

- The rapid, skilled, calm, practiced and respectful response of an obstetrical team
- We come when we are called, recognizing the “field of time” in which obstetrical emergencies unfold.
- We don’t leave to chance what belongs to mindfulness
- We make the “right thing the easy thing”



Montana Perinatal Quality Collaborative



Alliance for Innovation in Maternal Health Initiative (AIM)



Annie Glover, MPA, MPH, PhD, Megan Nelson,
MSW & Carly Holman, MS

MPQC - AIM Initiative

- Montana will be a fully enrolled AIM state as of October 1st in the Fall 2021 cohort.
- UM contracted fiscal partner and responsible for data collection and submission to AIM.
- Yarrow contracted to facilitate the MPQC AIM Initiative.
- MPQC implementing the AIM Obstetric Hemorrhage Patient Safety Bundle.
 - **17** hospitals enrolled

AIM Data Driven Strategy

- Data collection and contributing to the AIM Data Center is a crucial component to participating in AIM.
- AIM Obstetric Hemorrhage Family of Measures
 - Structure Measures (6)
 - Process Measures (5)
 - Outcome Measures (4)
- Hospitals will submit process/structure measure data to UM quarterly.
- UM responsible for outcome measures through DUA with MHA.
- UM will submit all data to the AIM Data Center.

AIM Obstetric Hemorrhage Bundle

Activities

- Orientation webinar held August 3rd
- Data webinar held September 7th
- First learning session scheduled October 5th and 6th
- Facilities engaged in pre-work prior to bundle kickoff in October.
- Baseline data
 - Process/structure measures survey launches in October.
 - SMM snapshot reports prepared for each hospital.

Centers for Disease Control Levels of Care Assessment Tool Montana LOCATe Initiative

Carly Holman, MS, Kaitlin Fertaly, PhD,
Annie Glover, MPA, MPH, PhD, & Amanda Eby, MT DPHHS



Montana LOCATe Initiative

Centers for Disease Control Levels of Care Assessment Tool (LOCATe).

Standardized assessment focused on risk appropriate care.

LOCATe is part of a broader maternal health system needs assessment.

Additional needs assessment module included in the assessment.

Timeline & Recruitment Update

Timeline:

- LOCATe introduction letters sent to hospitals – July 6th
- LOCATE kickoff webinar – July 23rd
- Data collection period – July 23 – August 27 (extended to September 30th)

Recruitment progress:

- **Completed: 20**
 - In-progress: 4
 - Not started: 2
-
- Hospitals *without* a labor and delivery unit are invited to participate in a separate needs assessment survey to gather information on emergency deliveries to understand needs and prioritize resources to support emergency births.

Dissemination Plan

- Facility Snapshot Reports & Webinar with LOCATe champions
- Detailed statewide report for MHA & DPHHS
- Aggregate statewide report
- Topic focused white papers: Transport
- Maternal Health Leadership Council presentation



MOMS Rapid Response Mini Grants

Molly Molloy, MSW, LCSW, Annie Glover, MPA, MPH,
PhD, Amanda Eby, DPHHS, & Stephanie Fitch, Billings
Clinic

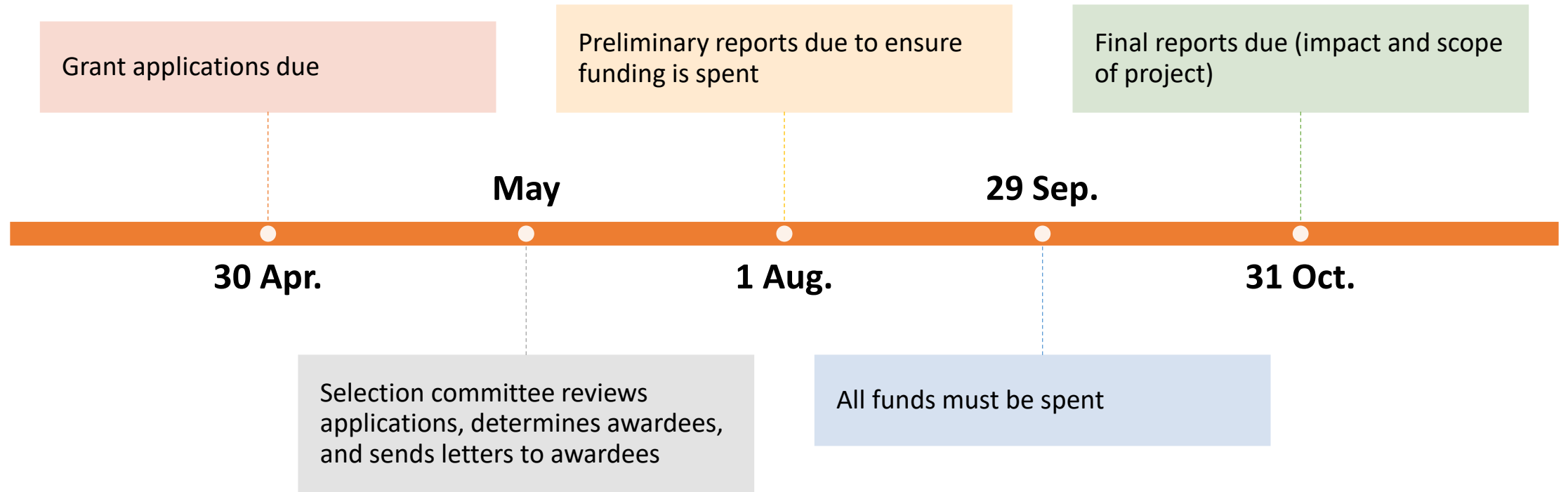
Rapid Response Mini Grant Purpose

Distribute MOMS funds to local hospitals, clinics, health departments, and nonprofits working to achieve MOMS objectives.

Funding to spend on training, equipment, and other innovative responses to improve maternal health and well being

Reward amounts up to \$20,000

Mini Grant Timeline



Rapid Response Mini Grants

\$141,703 Awarded

Communities Served: Anaconda, Billings, Dillon, Fort Belknap, Helena, Hardin, Kalispell, Lewistown, & Missoula

Workforce Development

- Becoming Us Mental Health Intervention Training
- CBT Training
- Certified Lactation Counselor (CLC) Training
- Doula Training
- MMH Certificate Training
- Native American Peer Support Certification
- Peer Support Training
- Perinatal Mental Health Exam Certification
- PSI Trainings
- Recovery Doula Training
- Wellbriety Training

Resources

- Books
- Car seats
- Documentary on Native American women
- Gas vouchers for prenatal/postpartum visits
- Healthy cooking classes for new parents
- Fatherhood and Motherhood is Sacred Training
- Lactation Management Pocket Guide
- Supplies and resources for training moms on baby needs
- Office Supplies

Programming

- Family Connects training and consulting fees
- The Network program startup and administration (certified postpartum doulas servicing mothers in crisis)
- Rural services case management, consultant services

Hospital Equipment

- Hospital Grade Breast Pump
- Infant Scales

Billings Clinic Mini Grants

Communities Served: Big Sky, Hardin, Helena, Kalispell, Lewistown, Ronan, Sidney, and Whitefish.

Trainings

- 100 registrations to AWHONN's Maternal Fetal Triage Index training
- 50 registrations to Neonatal Orientation and Education Program
- 46 registrations to Perinatal Orientation and Education Program
- 30 registrations for Obstetric Triage Orientation Education
- 149 participants registered in Healthstream for NRP, STABLE, or both.

Supplies

- 1 Butterfly portable ultrasound machine
- 1 omni tablet package for simulator
- 1 bedside virtual monitor for simulator
- 1 video camera
- 1 tripod
- 1 Childbirth Model set
- 1 Cervical Dilation set
- 1 Templates for Protocols and Procedures for Maternity Services

Simulators

- 9 Prompt Flex simulators with PPH Module
 - 3 delivered to facilities so far
- 1 newborn PEDI simulator
- 1 premie blue simulator
- 1 Newborn Anne simulator

Leadership Council Interviews

Molly Molloy, MSW, LCSW, Carly Holman, MS, Megan Nelson, MSW, Annie Glover, MPA, MPH, PhD

Montana Maternal Health System Needs Assessment

- Purpose: to gather information on the maternal health system and services in Montana to identify areas of strength and need.
- Utilized the WHO Strengthening Health Systems to Improve Health Outcomes framework.
 - The framework includes six building blocks of a health system:
 - Service Delivery, Health Workforce, Health Information System, Medical Products, Vaccines, and Technologies, Sustainable Financing and Social Protection, and Leadership and Governance.
- 11 interviews were conducted with Leadership Council members.

Emerging Themes from the Interviews

Service Delivery Barriers

- Geographic distance/ access to care in rural communities
- Transportation
- Properly trained professionals

Health Workforce Needs

- Workforce shortages and hiring issues in rural communities (OB nurses, OBGYNs, Psychiatrists, Mental Health Professionals, Social Workers)
- Care coordination and improving the care team
- Education and training needs (behavioral health, referral networks to community resources, consistent training)

Sustainable Financing

- Medicaid expansion has helped increase access to care, but there is still room for improvement

Other

- Need to work more collaboratively (in care coordination, across the state)
- Consider missing populations from out work (fathers and partners, middle class families)
- Other areas of need (interpersonal violence, postpartum work, implicit bias)



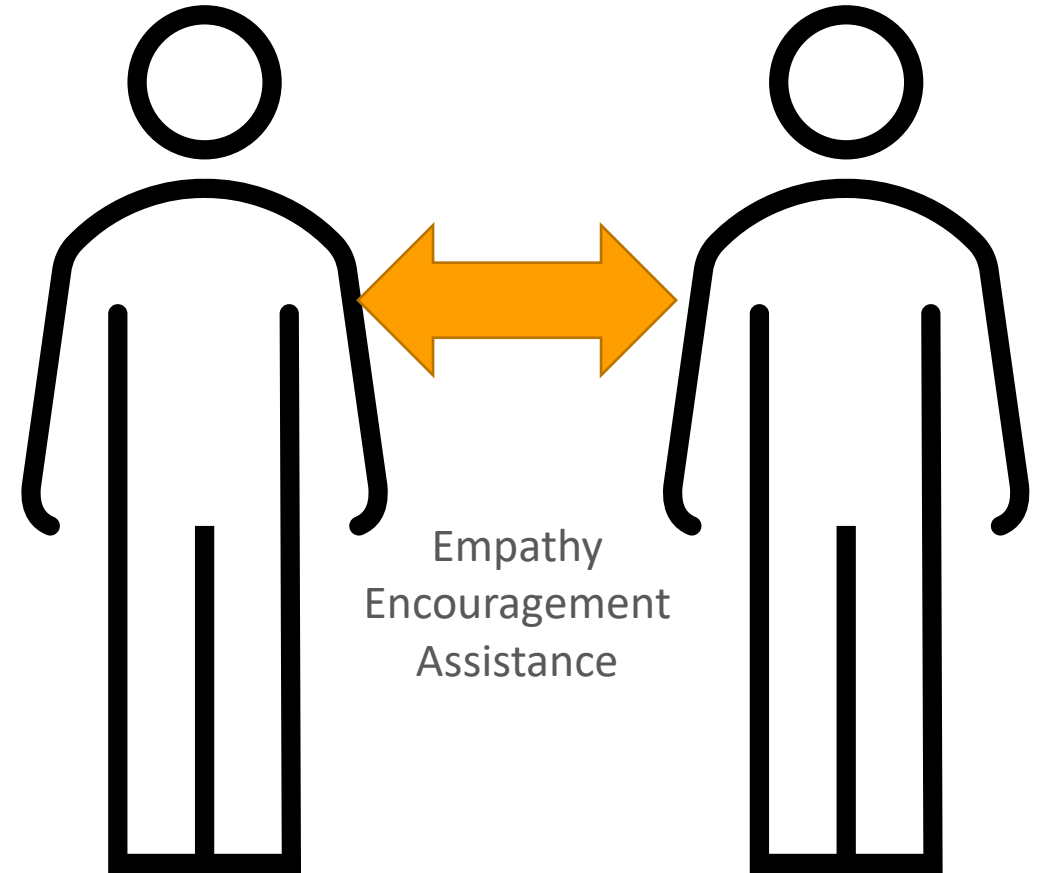
WHAT IS PEER SUPPORT THROUGH ONE HEALTH?

DEFINING THE ROLE

PEER SUPPORT IS

a process through which people who share common experiences or face similar challenges come together as equals to give and receive help based on the knowledge that comes through shared experience (Riessman, 1989).

- A “**peer**” is an equal, someone with whom one shares demographic or social similarities.
- “**Support**” expresses the kind of deeply felt empathy, encouragement, and assistance that people with shared experiences can offer one another within a reciprocal relationship.

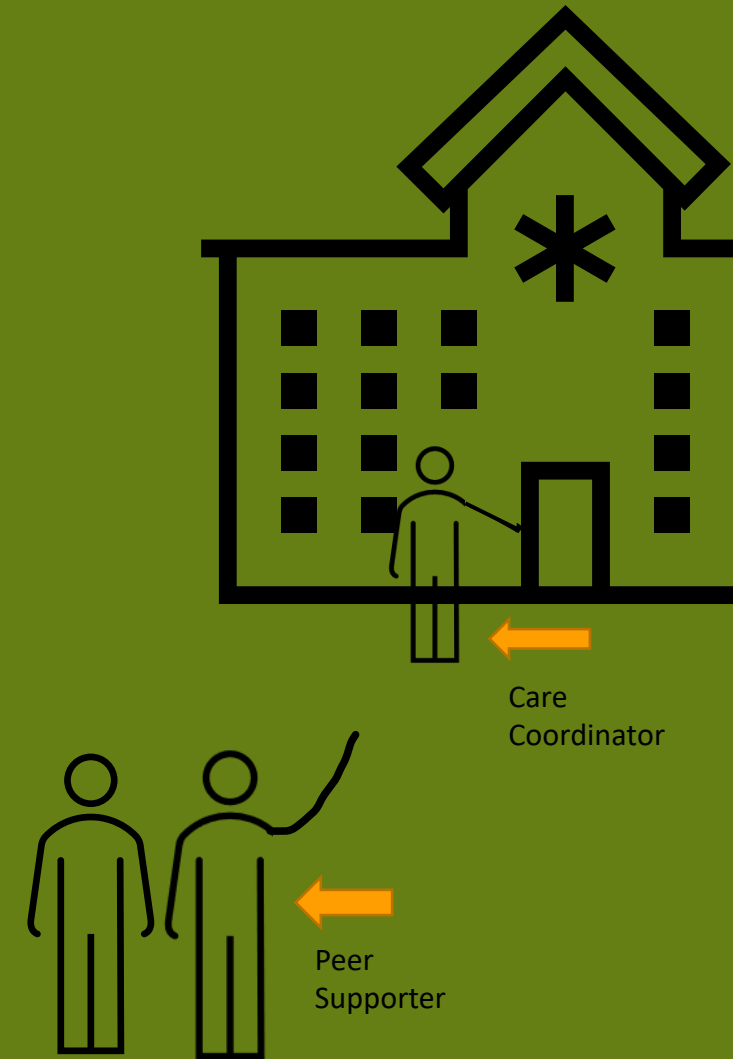


THE PRACTICE OF PEER SUPPORT

- As a practice, peer support is characterized by equitable relationships among people with shared experience, voluntariness, the belief that giving help is also self-healing, empowerment, positive risk-taking, self-awareness, and building a sense of community (Budd, Harp, & Zinman, 1987; Harp & Zinman, 1994; Clay, 2005).
- Peer support, by definition, is “*led by people who are using or have used mental health services*” (Stamou, 2014, p. 167; Faulkner & Kalathil, 2012). No one can function as a peer supporter who does not have documented history of SUD, mental health, or chronic illness diagnosis. Every peer supporter must pass a 40-hour course that includes information on ethics and boundaries, be certified by the state of Montana, and be under supervision by a qualified supervisor.
- When we recognize the **lateral help-seeking** patterns of socially and culturally diverse, marginalized, or stigmatized people and we create paid positions that facilitate the naturally-occurring desire of those in recovery to support others to find recovery, we create systems of Intentional Peer Support – IPS. What we have at One Health is Intentional Peer Support.

PEER SUPPORT AT ONE HEALTH

- Community members voluntarily engage with peer supporters. It is usually through word-of-mouth that people learn of peers in the community who can understand/empathize with them and point the way to help. They also know peers have life-saving Narcan.
- Community members do not need to be patients of One Health to engage with peer support. A peer supporter's door stays open to everyone, regardless of their readiness to receive One Health services.
- Peer supporters facilitate opportunities for support and growth like parenting classes, bible studies, workout groups, book clubs, etc. that everyone benefits from, including the peer supporter.
- The peer supporter has a relationship of respect and trust with One Health integrated care providers that they can share with seekers in the community.
- Peer supporters provide information as equals with experience. We make sure that peer supporters are well-informed lateral points of contact. Peer supporters help the One Health integrated care providers by being rooted in their communities and helping to close the trust gap with key messaging.
- When someone being supported by a peer wants services that One Health offers, peer supporters do a warm handoff into the One Health clinical system through the care coordinator. Peers are part of our community team; they do not cross over into the clinical teams.
- The care coordinator ensures peer supporters know the care plans for One Health patients so that they can provide informational, navigational, and/or emotional support the patient may need to more fully engage in their integrated care.
- Peer Supporters also teach Narcan classes, facilitate recovery and support groups, and participate in community outreach all as peers.



It is vital that we have respectful, trusting, asset-based relationships with our peer supporters because they communicate their trust of us and our system to those who do not yet have a trust relationship with us.

WHAT PEER SUPPORT IS NOT

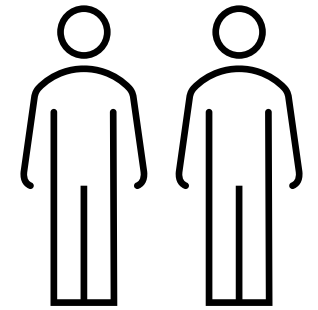
Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain" (Mead, 2003, p. 1).

Peer support is not a clinical intervention. It is non-clinical support whose benefits are primarily intrapersonal and social in nature (Mead & MacNeil, 2005).

Peer support is not hierarchical. It always occurs as horizontal relationships. In working with individuals with psychiatric diagnoses, the goals of IPS are to move from top-down helping to mutual learning, from a focus on the individual as the locus of dysfunction to a focus on relationships as a tool for growth, and from operating from fear to developing hope (Mead, 2014).

Peer support is not peer-delivered services. The development of peer support as horizontal relationships is quite different from using peer staff within a traditional program to perform functions such as traditional case management services or driving people to appointments. Simply hiring people with psychiatric histories to do some of the usual tasks of the traditional mental health system is not practicing peer support (Penney, 2018).

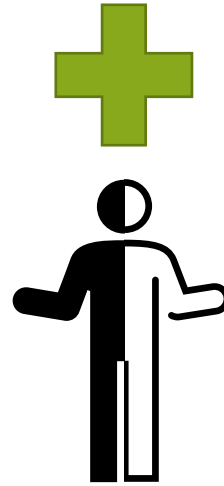
The **utility of peer support cannot be measured in clinical outcomes.** Instead, it needs to assess self-esteem, self-stigma, social connectedness, community integration, community participation, and quality of life (Penney, 2018).



WHAT IS A RECOVERY DOULA?

Peer Support Specialist

people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer supporters help people become and stay engaged in the recovery process and reduce the likelihood of relapse.

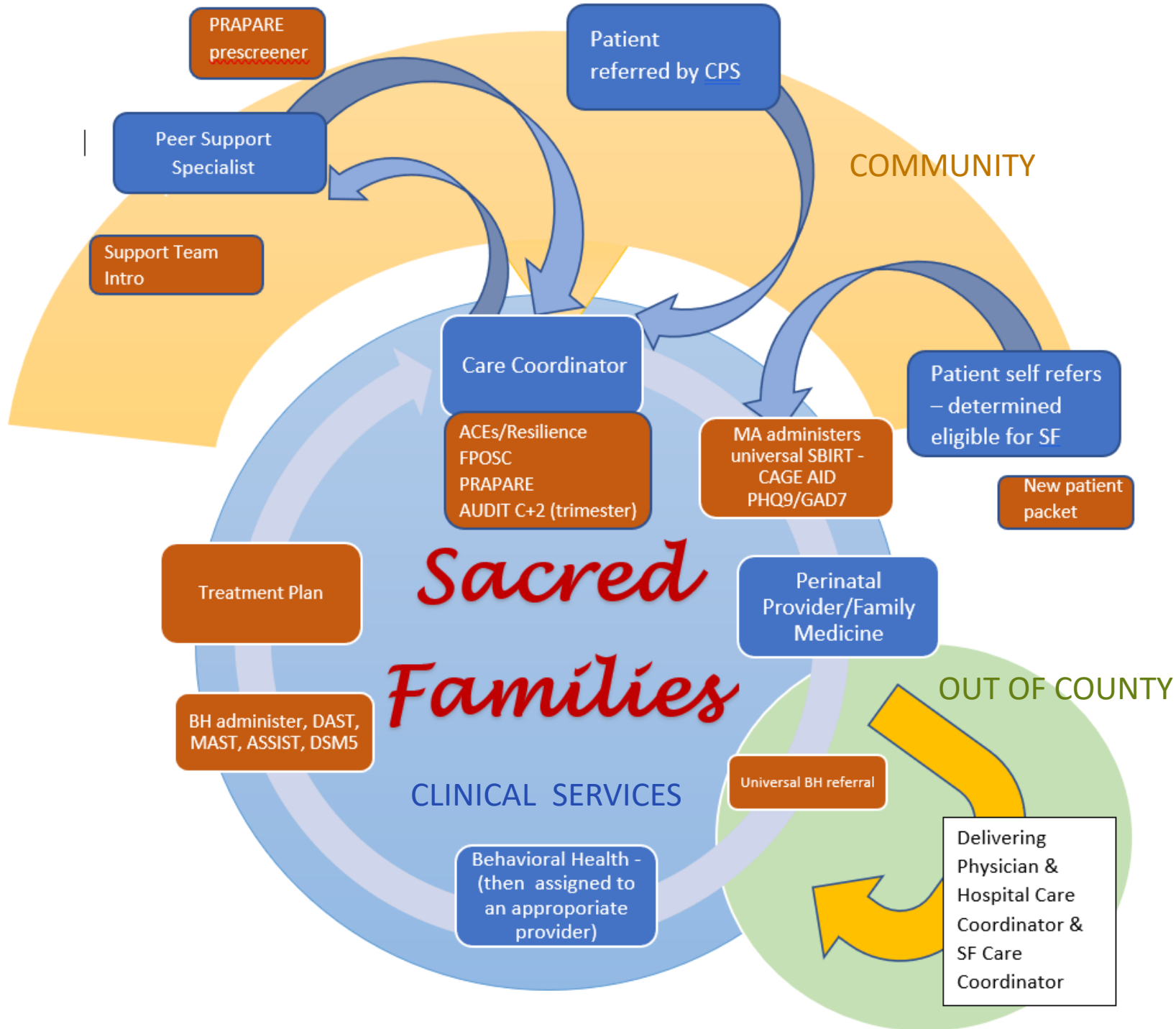


Doula

people who provide social, emotional, informational, and navigational support to a mother or a father before, during and shortly after childbirth to help the family achieve the healthiest, most satisfying experience possible.

WHY?

1. Doula services are not accessible to low-income patients because they are not reimbursable. Peer support is.
2. Many women in our demographic do not have a trusted person who can attend their birth to support them. Peer supporters have trusting relationships, are trauma informed, and as doulas are able to access the hospital.
3. The period directly after birth is the most vulnerable for relapse. Families that have entered recovery to protect their child from shared exposure encounter extreme stress after birth and need perinatal support in addition to recovery support. This is also a period of time that has elevated risk for overdose, depression, and suicide. More frequent monitoring is warranted during this time and recovery doulas have the training and capacity to support perinatal families impacted by substances.
4. Doulas and peer supporters at One Health support moms AND dads/partners, therefore we have male and female recovery doulas. Indigenous patients have unique needs around trauma. We have specifically trained Indigenous recovery doulas.



ONE HEALTH INTEGRATED CARE PATHWAY

Sacred Families refers to our One Health program that is part of the Meadowlark Initiative.

Sacred Families serves all families (mom and dad/partner and other children, sometimes grandparents too) with children in the first 1,000 days (conception through age 2) who are IMPACTED by substance use (*it does not have to be their own*).

PEER SUPPORT PERINATAL TRAINING HUB

Because of lateral help-seeking, we train our peer supporters so that they have all the information we want our community to have, on hand, ready to share in real time.

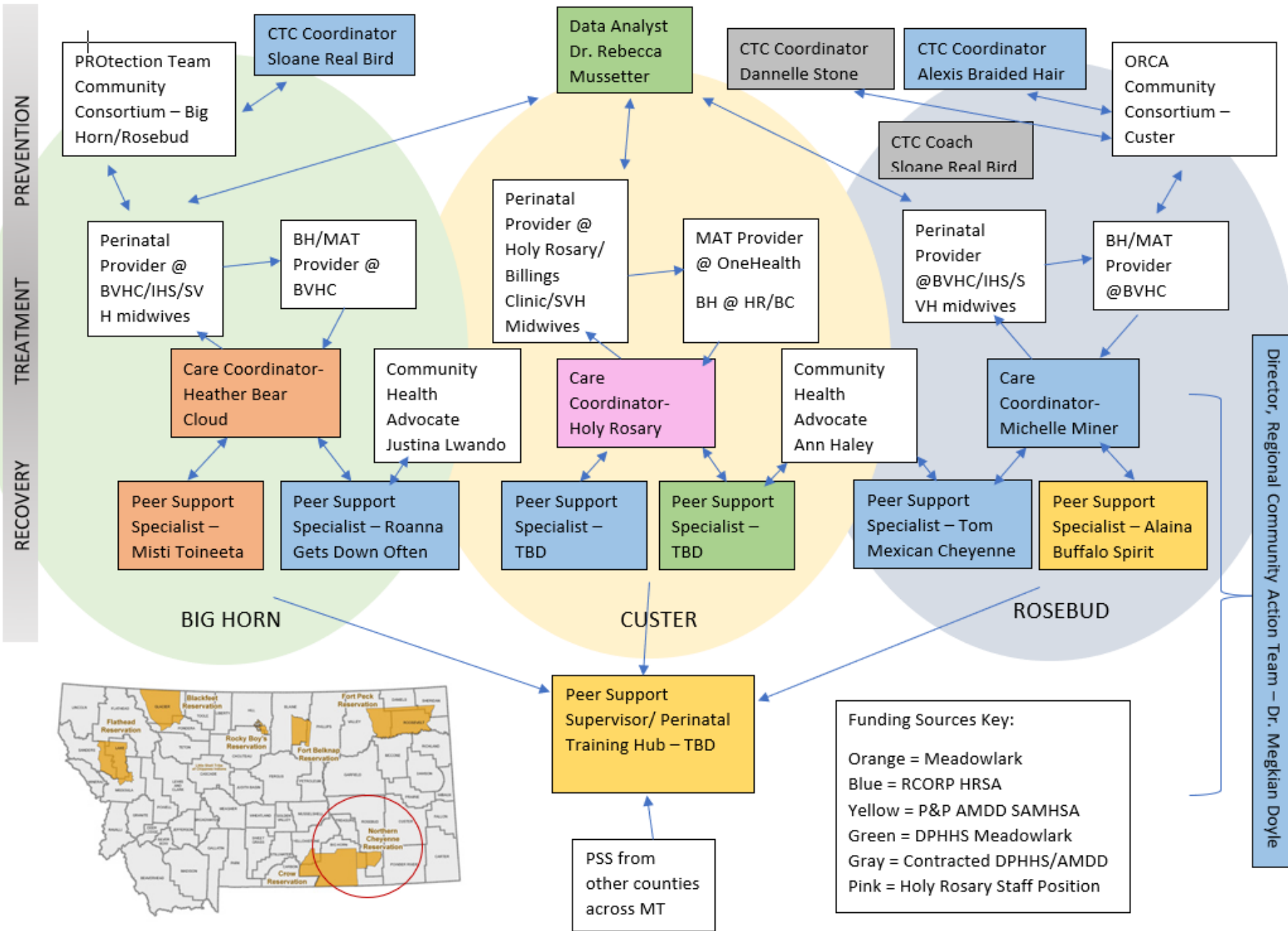
- They are Master Narcan Trainers – they make sure the community has access to Narcan and understands how to administer it. They can tell the difference between opioid overdose and psychostimulant overamping.
- They have a Fatherhood is Sacred/Motherhood is Sacred Certification. Wanting to be a better parent is the #1 motivator for spontaneous recovery.
- They are certified as Doulas or Indigenous Doulas – pregnancy, birth, labor, trauma, depression, etc.
- Of course, they are state-certified peer support specialists.

Some of their coursework topics include:

Communication for children, parents, families, and couples
Family conflict
Trauma informed care
Adverse childhood experiences
Domestic violence and non-violent relationships
Mental health first aid
Eat, sleep, console
De-escalation

Critical incident desensitization
Childhood development
Pediatric overdose
Substance use and addiction studies
Stroke recognition
Community resources for SDoH
Patient-centered medical home and HSP
Motivational/Solutions-based interviewing

REGIONAL COMMUNITY-BASED PERINATAL RESPONSE MODEL



THE BIG PICTURE –

How do all the programs in the regional community action team (RCAT) fit together?

New grant applications will continue to support the development and implementation of evidence based practices for prevention and expand peer support to cover larger target populations.

GOALS:

- Decrease substance use and the number of new people developing SUD.
- Increase the number of community members currently struggling with SUD who are receiving care and/or support.
- Support and educate the community to reduce stigma.
- Effectively work alongside other organizations in our area so that no matter how community members are engaged, we are giving them the best we have – together.

HOW DO FAMILY MEDICINE AND BEHAVIORAL HEALTH PROVIDERS CONNECT PATIENTS WITH PEER SUPPORT

S
B
I
R
T

<input checked="" type="checkbox"/>	POSITIVE
<input type="checkbox"/>	NEGATIVE

Referral to treatment

Behavioral
Health

If the patient refuses a referral to BH, then providers can give the patient contact information for a peer supporter in case they would like to talk to someone at some point.

Meadowlark-eligible patients (men and women) are handed to the Sacred Families Care Coordinator (each has their own PSS).

All other patients are provided information to connect with an appropriate PSS.

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2021-2022 MOMS Maternal Health Leadership Council Meeting Schedule

DATE	TIME	LOCATION	TOPICS
No meetings in July or August			Review/confirm Vision/Values/Key Drivers and plan council activities
September 14, 2021	2:30-4:30 mtg. 4:30-5:30 social	Helena, USFG building TBD	Celebrate council successes, review and confirm complete strategic plan; mini-grant awardees present; ERASEMM grant discussion
3rd Tuesday of the month so not to conflict with ECHO			
January 18, 2022	12:00-2:00	Zoom (in-person option)	Policy advocacy discussion
April 19, 2022	2:30-4:30 4:30-5:30 social	TBD (council member to host in Missoula, Bozeman, Billings, Butte or other) (Zoom option)	Sustainability planning
July 19, 2022	12:00-2:00	Zoom (in-person option)	Racial disparities in care
October 18, 2022	2:30-4:30 4:30-5:30 social	TBD (council member to host in Missoula, Bozeman, Billings, Butte or other) (Zoom option)	Rural disparities in care

2021-2022 Council Agenda

- Ongoing coordination with other maternal health initiatives – PQC, MMRC, Meadowlark
- Sustainability planning
- Policy advocacy planning
- Deep dive investigating and strategizing rural and racial disparities in care
 - Develop action plan