Maternal Health Leadership Council Meeting  
April 25, 2023  
12:00 – 3:30 PM  
University of Montana UC Room 330  
https://mtgov.zoom.us/j/81568742180?pwd=cXdBL2tseTN4VGZPMUxrcm5vZmFkQT09  
Meeting ID: 815 6874 2180  
Password: 652538

Agenda

12:00 – 12:15 (Lunch buffet) Introductions and review agenda

12:15 - 12:45 Updates from Healthy Mothers, Healthy Babies (HMHB), including overview of LIFTS  
Stephanie Morton, Director of Programs and Impact for HMHB

12:45 – 1:00 Pregnancy Risk Assessment & Monitoring (PRAMS) overview and dashboard demo  
Kara Hughes, PRAMS Coordinator for DPHHS

1:00 – 1:15 Questions, Discussion

1:15 – 1:45 Patient experiences of respect and autonomy in Montana’s maternal health system  
Carly Holman, University of Montana

1:45 – 1:55 Questions and Discussion

1:55 – 2:10 Break

2:10 – 2:30 Update on maternal health issues in the Montana state legislature  
Jennifer Wagner, Montana Hospital Association (MHA)

2:30 – 2:40 Questions and Discussion

2:40 – 3:10 Simulation Leadership Academy (SLA) Overview and Updates  
Stephanie Fitch, Billings Clinic MOMS Grant Manager

3:10 – 3:20 MOMS, MMRC, and MPQC-AIM updates  
DPHHS

3:20 – 3:25 Q&A discussion, recap, next steps

3:25 – 3:30 Public comment

Next meeting – July 18
Linking Infants and Families to Supports (LIFTS) in Montana

Presented to the MOMS Leadership Council on April 25, 2023 by Stephanie Morton, MSW
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.
Linking Infants & Families to Supports

Link into all that Montana has to offer for growing families.

hmhb-lifts.org
The problems

• Parents & caregivers struggling to find needed resources to support their families
• Family support providers spend too much time seeking needed referral sources for clients and patients
• Many new parents and caregivers, as well as families living in recovery feel isolated
• Seeking help is not a normalized behavior, particularly for new parents and caregivers
The Idea

DEVELOP a statewide online resource guide for expecting and parenting families in MT

HELP family support providers refer to other agencies & communities

EMPOWER families with information when they need it

PARTNER with local community coalitions & organizations

CREATE something beautiful, accessible & easy to use
LIFTS, Built to Assist

• Improves awareness and access to resources
• Lists 2,900+ resources for families from pregnancy through age three
• A helpful tool for providers making referrals
• User friendly for parents & caregivers
• Lists community events where families can connect
How?

• Created in partnership with stakeholders

• Focused on collecting community level data, knowledge
  • In 3\textsuperscript{rd} year of subcontracts to ECCs for collection (data, outreach)
  • LIFTS in Indian Country in summer 2022
  • Targeted outreach through staff work

• Performed system-level outreach collecting data from partners
  • WIC, MIECHV, MT Food Bank Network, etc.

• Contracted with SciGaia for system development
Parents and caregivers

• Find accurate information quickly and easily
• Learn about resources they may have been unaware of
• Find family friendly events to connect
System partners and providers

• Work in partnership, be enhancing instead of duplicative
• Focused on collecting community level data
• Make out-of-area referrals easier
• Promote the solutions and work that is happening/identify gaps
LIFTS, Built to Assist

SERVICES

• Focuses on prenatal to age three

• Searchable by:
  • 56 counties
  • 7 Reservations
  • User location (City, County, Reservation, Zip Code)

• 30 service types
  • Plain language, some overlapping,
LIFTS Service Types

- Attachment and Bonding
- Birthing and Parenting Classes
- Car Seat Installers
- Certified Nurse Midwives
- Child Care Supports
- Child Development Information and Support
- Dental Services (accepting Medicaid)
- Domestic and Interpersonal Violence Resources
- Doulas and Other Birth Professionals
- Family Planning
- Family Practice
- Family Support and Education
- Food and Nutrition Supports
- Housing
- Lactation Support
- Medicaid Enrollment Assistance
- Medication Assistance for Substance Use Disorders
- Mental Health Professionals
- Obstetricians and Gynecologists
- Other, Legal and Social Services
- Pediatricians
- Peer Support Specialists
- Play Spaces
- Psychiatric Services
- Public Benefits Enrollment
- Public Libraries
- School Based Health Centers
- Substance Use Disorder Treatment Providers
- Supplies for Pregnancy, Breastfeeding and Baby Care
- Support Groups
EVENTS

- Family friendly
- Substance free (or limited)
- Free / Low cost
- Social support and community connection
- Added by community organizations
I'm looking for Services in Bozeman, MT
Services

Narrow your search

Select a Service Type

Service Type

Select a County or Reservation

County or Reservation

OR

Select a City

City

Find Help

Frequently Asked Questions

Specialty Guides

List a Service on LIFTS

Services

Statewide Services

Peer Support Specialists

The Circle - Peer Support Meetings

View More Details

Website

Support Groups

The Circle - Peer Support Meetings

View More Details
Services

Narrow your search

Select a Service Type
Food and Nutrition Supports

Select a County or Reservation
County or Reservation

OR

Select a City
Choteau

Clear All Filters

Food And Nutrition Supports

Teton County WIC
Choteau, MT

View More Details

Program:
Teton County WIC

Call Email Directions Website
Contact Information

Program
Teton County WIC

Primary Phone
406-466-2562

Email
mnaylor@tetonmt.org

Address
905 4th St NW
Choteau, MT 59422

County
Teton County

Services Offered

• Food and Nutrition Supports
  Access food banks and financial assistance for groceries

• Family Support and Education
  Programs to build parenting skills, including In-home services

• Lactation Support
  Advice and support for lactating and breastfeeding

Additional Information

WIC is a nutrition program that provides nutrition and health education, breastfeeding support, healthy food and referrals to other services free of charge to Montana families who qualify. WIC Services are available to: pregnant women, moms (up to six months after delivery), breastfeeding moms (up to one year after delivery), infants and children under the age of five. WIC is for all kinds of Montana families: married and single parents, working or not working. If you are a father, mother, grandparent, foster parent, or legal guardian of a child under five years, you can apply for WIC.
Rising Sun Wellness

Contact Information

Program
Camille Deitz

Primary Phone
406-360-5263

Address
172 2nd St E Suite 210
Kalispell, MT 59901

County
Flathead County

Services Offered

- Mental Health Providers
counselors, therapists and other supports for mental wellbeing

Vetted Guide

- Flathead PMAD Resource Guide

Program Contacts

<table>
<thead>
<tr>
<th>Contact</th>
<th>Credentials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Camille Deitz</td>
<td>MA, LCPC, PMH-C</td>
</tr>
</tbody>
</table>

Additional Information
State level outreach to collect data from partners to update and expand information
• Collaboration with early childhood coalitions and other organizations
• Updated FAQs
• Welcoming user feedback
• Online Forms to Submit a Services or Events
Contact

We'd Love to Hear from You!

Do you need help finding a particular service? Our anonymous warmline is designed to help parents with the searching. We'll be answering calls between 9 am to 5 pm, Monday to Friday. If you call after hours, leave a message and we'll return your call within 1 - 2 business days.

Warmline

The LIFTS Warmline does not offer crisis services. If you need immediate assistance, please call 911. You can also call the Montana Suicide Prevention Lifeline at 1-877-273-8255 or reach the Montana Crisis Text Line by texting "MT" to 741-741.

Contact Information

Phone (Warmline)
406-430-9100

Email
hmhb@hmhb-mt.org

Website
https://hmhb-mt.org

Address
318-320 N Last Chance Gulch #2C
Helena, MT 59601
Why a warmline?

- Not finding what you need on LIFTS
- Internet connectivity issues
- Sometimes you know what your problem is, but you may not know what you need to address it or maybe what it is called.
- The best solution is often a person. Connecting people to people where they live.
Our anonymous warmline is designed to help parents, caregivers, and professionals find the resources they need.

This is not a crisis line.

HMHB answers calls between 9 am and 5 pm, Monday - Friday. If you call after hours, leave a message and we'll return your call within 1-2 business days.
The LIFTS Family of Supports

The LIFTS Warmline

Call Us (406) 430-9100

LIFTS Online Resource Guide

LIFTS Magazine
LIFTS Magazine

• Sharing stories about “when help helps” from Montana caregivers

• Normalize accessing supports

• Raise awareness of helpful resources

• Drive readers to LIFTS Online Resource Guide

• Easy to use online version, with magazine feel; also ADA accessible versions as well

https://hmhb-mt.org/magazine/
Primary distribution is through birthing hospitals
  • 2021 was 16,000 copies
  • 2022 was 17,000 copies

Currently producing LIFTS 2023!

https://hmhb-mt.org/magazine/
Thank you for all the good work you do in the lives of families & children.

For questions, please contact me stephanie@hmhb-mt.org

Stephanie Morton
Director of Programs and Impact

www.hmhb-lifts.org
A Health Survey of Montana’s Mothers and Babies
PRAMS Presentation
April 25, 2023

• PRAMS Staff
• What is PRAMS/CDC Objectives
• Methods/Data Collection
• Questionnaire
• Uses
• Analysis Plan
• Dashboard
• Q & A
PRAMS Staff

Vacant
Montana’s Lead MCH Epidemiologist/MCH Epidemiology Section Supervisor

Kara Hughes
PRAMS Coordinator/Epidemiologist Lead

Maren Weber
PRAMS Data Manager

Ellysse Boughey
State of Montana’s MCH Spatial Epidemiologist
What is PRAMS

• Surveillance System of Mothers and Infants
  – “An ongoing, systematic collection, analysis and interpretation of health-related data essential to the planning, implementation, and evaluation of public health practice”

• Survey of postpartum women about their experiences and behaviors before, during, and shortly after pregnancy.

• PRAMS is federally funded by the Centers for Disease Control and Prevention (CDC)

2016-2021 PRAMS Participating Sites

PRAMS represents approximately 81% of all US live births

Note: Map produced by the CDC (Updated with 2021 Grantees)
CDC PRAMS Objectives

• To promote the collection of population-based data of high scientific quality
• To conduct comprehensive analyses
• To translate results into useable information
• To build state capacity for collecting, analyzing, and translating data
Methods

• Random Sample
  – Of all live births to Montana residents born in Montana
  – Designed to be representative of Montana population

• Oversample
  – Groups of moms that would otherwise be too small to calculate reliable estimates
Questionnaire

Main Survey:
• Core Questions (required)
• Standard Questions (optionally utilized)

Optional Additions:
• State Added Questions
• Supplements
Questionnaire Topic Areas

- Attitudes and feelings about the most recent pregnancy
- Preconception care
- Content of prenatal care
- Medicaid and WIC participation
- Breastfeeding
- Cigarette smoking and alcohol use
- Health insurance coverage
- Physical abuse
- Infant health care
- Contraceptive use
Uses

What PRAMS is Good For

• Population estimates of pre-pregnancy, prenatal, and post-partum behaviors and attitudes.

• Some subpopulation group estimates
  – Large subpopulations

• Associations of behaviors and attitudes (risk/protective factors).

• Needs assessments

• Some program evaluation
  – Large programs
  – Population-based initiatives (public health campaigns)

What PRAMS is Not-So-Good For

• County Level Estimates

• Some subpopulation group estimates
  – Subpopulations not well represented in Montana

• Some program evaluation
  – Implementation evaluation
  – Outcome evaluation of small/targeted programs
PRAMS Data in Action

Has been Used For:

• Title V MCH Block Grant: needs assessment and national performance measures
• State Health Improvement Plan: baseline and trend measures
• Rocky Mountain Tribal Epidemiology Center: program planning
• MOMS Program: *Maternal Health Report* & Presentation to Maternal Health Task Force
• Data Briefs
Analysis Plan

• Maternal Oral Health Care in Montana, 2017-2019
• Maternal Disability in Montana, 2018-2020
• Maternal Tobacco Use in Montana 2017-2020
• Maternal Mental Health in Montana 2017-2020
Analysis Plan

• Labor and Delivery Trends in Montana, 2017-2020
• Maternal COVID-19 Vaccination in Montana, 2021
• Prenatal and Postpartum Care Visits 2017-2020
• Maternal and Infant Vaccination in Montana, 2017-2021
• Prenatal and Postpartum Care Visits 2017-2021
• Maternal and Infant Vaccination in Montana, 2017-2022
• Maternal Morbidity 2017-2022
• Breastfeeding 2017-2022
PRAMS Dashboard

https://dphhs.mt.gov/InteractiveDashboards/PRAMSDashboard
More Information

CONTACT US

Kara Hughes–PRAMS Coordinator
khughes3@mt.gov | 406.444.1627

Maren Weber–Data Manager
Maren.weber@mt.gov | 406.444.3009

VISIT OUR WEBSITE:
www.dphhs.mt.gov/prams

CHECK OUT THE PRAMS DASHBOARD:
www.cdc.gov/prams
Patient Experiences of Maternal Healthcare in Montana: A Mixed Methods Study

Carly Holman, MS., Annie Glover, PhD, MPH, MPA., Jessica Liddell, PhD, MSW, MPH., Al Garnsey, Emma Piskolich, Megan Nelson, MSW.
Funding Disclaimer

This project is supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) as part of an award totaling $9.6 million designed to improve maternal health outcomes with 0% financed with non-governmental sources. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by DPHHS, HRSA, HHS, or the US Government.
Outline

• Background
• MOMS Maternal Health System Needs Assessment
• Methodology
• Results (Survey and Interviews)
• Discussion & Conclusions
• Next Steps
Background

• The United States has an urgent call to address the high rates of maternal morbidity and mortality and eliminate the persisting disparities.¹

• The Institute of Medicine includes patient-centered care as a core domain of healthcare quality.²
  • “Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.”
• Patient-provider interactions significantly impact pregnancy and childbirth experiences.³

• Negative experiences can influence future health-seeking behaviors and have long-term adverse impacts.⁴

• Research has demonstrated that shared decision-making,⁵ informed consent,³ and communication about care, contribute to positive experiences and improved health outcomes.³,⁵

• Gathering information on patient experiences can drive quality improvement initiatives aimed at respectful patient-provider interactions and broader health-system reform.⁵,⁶
MOMS Maternal Health System Needs Assessment

• The MOMS needs assessment activities initially focused on the healthcare delivery system, emphasizing obstetric care.
  • CDC Levels of Care Assessment Tool (LOCAtE)
  • Emergency Obstetric Services Survey
  • Provision of Postpartum Contraception

• The purpose of the maternal healthcare experiences study was to examine patient experiences of *respectful care* and *autonomy in decision-making* in Montana’s maternal health system.

• Little information exists on patient maternal healthcare experiences in Montana.
Methods

- **Mixed-Methods Study:** An online survey and semi-structured interviews.
- **Study Population:** People that had experienced pregnancy in Montana in the last five years.
- **Data Collection:** Occurred from July 26, 2022 – October 15, 2022.
- The University of Montana Institutional Review Board approved the study (120-22).
Methods – Survey

Instrument

• Mothers on Respect Index (MORi).\textsuperscript{6}
• Mothers Autonomy in Decision-Making Scale (MADM).\textsuperscript{5}
• Health Leads Social Screening Tool.\textsuperscript{7}

Recruitment

• Social media campaign through Facebook and Instagram.
• Postcard invite sent to Montana Women, Infants, and Children (WIC) participants.

Data Analysis

• Descriptive statistics and group comparison based on sociodemographic attributes.
# MORi & MADM

## Birth Place Lab
University of British Columbia

[Birthplacelab.org](http://birthplacelab.org)

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### Section A: Overall while making decisions about my pregnancy or birth care:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt comfortable asking questions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I felt comfortable declining care that was offered</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I felt comfortable accepting the options for care that my doctor or midwife recommended</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I felt pushed into accepting the options my doctor or midwife suggested</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>I chose the care options that I received</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My personal preferences were respected</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My cultural preferences were respected</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

**Section A Total Score: [Sum of all circled items]**

### Section B: During my pregnancy I felt that I was treated poorly by my doctor or midwife because:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My race, ethnicity, cultural background or language*</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>My sexual orientation and/or gender identity*</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>My type of health insurance or lack of insurance*</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>A difference of opinion with my caregivers about the right care for myself or my baby*</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

**Section B Total Score: [Sum of all circled items]**

### Section C: During my pregnancy I held back from asking questions or discussing my concerns because:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My doctor or midwife seemed rushed*</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>I wanted maternity care that differed from what my doctor or midwife recommended*</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>I thought my doctor or midwife might think I was being difficult*</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

**Section C Total Score: [Sum of all circled items]**

### Please describe your experiences with decision making during your pregnancy, labour and/or birth:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Completely Disagree</th>
<th>Strongly Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My doctor or midwife asked me how involved in decision making I wanted to be.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My doctor or midwife told me that there are different options for my maternity care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My doctor or midwife explained the advantages/disadvantages of the maternity care options.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My doctor or midwife helped me understand all the information.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I was given enough time to thoroughly consider the different care options.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I was able to choose what I considered to be the best care options.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>My doctor or midwife respected my choices.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

**SUM of all circled items = total score**
Differences from PRAMS Survey

PRAMS
- Focuses on access to services and health behaviors.
- Probability sampling methodology ensures data are representative of Montanans.
- Data are used to track trends, set targets, and identify risk and protective factors for health outcomes.

Maternal Healthcare Experiences Survey
- Focuses on experiences of care and how participants felt about their care.
- Non-probability convenience sampling, not representative of the population.
- Not intended to assess population gaps, oriented toward quality improvement.
Data Quality Monitoring

Survey data quality monitoring involved regularly reviewing responses submitted and taking specific measures to ensure data quality:

1. Removed information on incentives from all recruitment materials to minimize “bot” responses.
3. Tossed responses with –
   • Out-of-state or out-of-country zip code.
   • Irrelevant information or random text entries e.g., “adadjkk” in open-ended questions.
   • Batches submitted in a large set.
Methods – Interviews

Interview Guide
- The interviews followed a moderator’s guide based on MORi and MADM scales.5,6

Recruitment
- We recruited participants through the Maternal Healthcare Experiences Survey.

Data Analysis
- All interviews were conducted virtually and recorded, transcribed verbatim, and analyzed using thematic analysis in MAXQDAn.
- We conducted a hybrid inductive/deductive process for coding and theme development.
Results

*Preliminary results analyses in-progress
Participant Characteristics

- 427 participants
- Respondents were from 40 (71.4%) of Montana’s 56 counties, with 58.6% living in rural areas and 41.5% in urban areas.
- Most participants (76.6%) received perinatal care from a physician, 16.2% from a Certified Nurse Midwife (CNM), and 7.3% from another provider type (most commonly a Direct Entry Midwife).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age in years</strong></td>
<td></td>
</tr>
<tr>
<td>18-29</td>
<td>132 (30.9)</td>
</tr>
<tr>
<td>30-39</td>
<td>254 (59.5)</td>
</tr>
<tr>
<td>40-49</td>
<td>41 (9.4)</td>
</tr>
<tr>
<td>50-59</td>
<td>1 (0.2)</td>
</tr>
<tr>
<td><strong>Race and/or ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>385 (90.2)</td>
</tr>
<tr>
<td>American Indian, Native American, Alaska Native</td>
<td>40 (9.4)</td>
</tr>
<tr>
<td>Hispanic/Latinx</td>
<td>22 (5.2)</td>
</tr>
<tr>
<td>Asian or Asian American</td>
<td>5 (1.2)</td>
</tr>
<tr>
<td>African, African American, or Black</td>
<td>4 (0.9)</td>
</tr>
<tr>
<td>Native Hawaiian or Pacific Islander</td>
<td>2 (0.5)</td>
</tr>
<tr>
<td>Middle Eastern or North African</td>
<td>2 (0.5)</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>10 (2.3)</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
</tr>
<tr>
<td>$0-24,999</td>
<td>60 (14.1)</td>
</tr>
<tr>
<td>$25,000-49,999</td>
<td>104 (24.4)</td>
</tr>
<tr>
<td>$50,000-74,999</td>
<td>85 (20.0)</td>
</tr>
<tr>
<td>$75,000-99,999</td>
<td>62 (14.6)</td>
</tr>
<tr>
<td>&gt;$100,000</td>
<td>115 (27.0)</td>
</tr>
<tr>
<td><strong>Social-Risk</strong></td>
<td></td>
</tr>
<tr>
<td>Experience social risk indicators</td>
<td>279 (65.3)</td>
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<td>Do not experience social risk indicators</td>
<td>148 (34.7)</td>
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<tr>
<td><strong>Education level</strong></td>
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<tr>
<td>Post secondary education</td>
<td>356 (83.4)</td>
</tr>
<tr>
<td>No post secondary education</td>
<td>71 (16.6)</td>
</tr>
</tbody>
</table>
Participants with **social risk indicators** experienced lower levels of respectful care.

Patient Experiences of Respectful Care by Social Determinant of Health (SDH) Indicators (N=427)

Maternal Health Care Experiences Survey conducted July 26, 2022 – October 15, 2022
Results – Experiences of Autonomy in Decision-Making

Participant Experiences of Autonomy in Decision-Making (N=427)

Participants with **social risk indicators** experienced lower levels of patient autonomy.

Patient Experiences of Autonomy in Decision-Making by Social Determinant of Health (SDH) Indicator (N=427)

Maternal Health Care Experiences Survey conducted July 26, 2022 – October 15, 2022
Participants working with a Certified Nurse Midwife (CNM) experienced higher levels of **respectful care**.

*Patient Experiences of Respectful Care by Provider Type (N=396)*

Participants working with a Certified Nurse Midwife (CNM) experienced higher levels of **patient autonomy**.

*Patient Experiences of Autonomy by Provider Type (N=396)*

Maternal Health Care Experiences Survey conducted July 26, 2022 – October 15, 2022
Interviews

*Preliminary results analysis in progress. Highlighting themes related to respectful care and autonomy in decision-making.
Results – Interviews

Participant Characteristics

- 39 interview participants.
- Average length 49 minutes.
- Participants were from a mix of rural and urban communities.
- Most (87.1%) had completed post-secondary education.
- Over half (57.9%) of participants had an annual household income over $75,000, with a quarter (23.7%) reporting a household income of less than $50,000.

Table 1. Participant Characteristics (N=39)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age in years</strong></td>
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</tr>
<tr>
<td>18-29</td>
<td>9 (23.1)</td>
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<tr>
<td>30-39</td>
<td>26 (66.7)</td>
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<tr>
<td>40-49</td>
<td>4 (10.3)</td>
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<tr>
<td><strong>Race and/or ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>35 (89.7)</td>
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<tr>
<td>American Indian, Native American, Alaska Native</td>
<td>6 (15.4)</td>
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<tr>
<td>Hispanic/Latinx</td>
<td>2 (5.1)</td>
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<tr>
<td>Asian or Asian American</td>
<td>1 (2.6)</td>
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<tr>
<td><strong>Income</strong></td>
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<tr>
<td>$0-24,999</td>
<td>5 (13.2)</td>
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<tr>
<td>$25,000-49.999</td>
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<tr>
<td>$50,000-74,999</td>
<td>7 (18.4)</td>
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<tr>
<td>$75,000-99,999</td>
<td>7 (18.4)</td>
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<tr>
<td>&gt;$100,000</td>
<td>15 (39.5)</td>
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<td><strong>Geographic Location</strong></td>
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<td>Micropolitan</td>
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<td>Small Metro</td>
<td>21 (53.8)</td>
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<tr>
<td><strong>Education</strong></td>
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<tr>
<td>High school</td>
<td>1 (2.6)</td>
</tr>
<tr>
<td>Some college</td>
<td>4 (10.3)</td>
</tr>
<tr>
<td>Post-secondary</td>
<td>34 (87.1)</td>
</tr>
</tbody>
</table>
Preliminary Themes

1. Mutual respect/dignity

2. Autonomy/shared-decision making

3. Information sharing

4. Provider type/care models
Theme: Mutual respect/dignity

Positive experience

“And I think the first day I went home, I was all panicked. I think he's breathing too fast and I think he's spitting up too much. And I was just anxious and I called him [Pediatrician] and I called him and I called him and he explained it to me happily….They were communicative. They answered questions and they answered them in a way that didn't make me feel judged or less than. And they didn't seem rushed and would really make it a point to ask us if we understood and answer our questions.”
Theme: Mutual respect/dignity

Negative experience – [discharge post delivery]

“After the specialist had just said to me, you can leave. This is a plan. It makes sense. This doctor comes in…He said, okay, well it looks like you're leaving even though you have really high blood pressure and he says to me…when you either have a seizure or stroke out, quote, I guess we'll see you back here in a few days. I could not believe he said that. I was so pissed off at this point. And I said, I just had a discussion with the specialist. He seemed fine with it.”
Theme: Autonomy/shared-decision making

Positive experience

“Then initially, when they came in to break my water, I wasn't quite ready…We said, "We're not ready to do that now." They said, "Great, we'll come back in a couple hours and kind of revisit what that looks like." Then the second time we really talked about what are the benefits of this, what's the pros, what's the cons. Really, I think from that conversation with them, decided that was kind of our best option. We didn't feel rushed and I think just felt really empowered to make those decisions that were best for us, but also felt like we trusted our care team.”
Theme: Autonomy/shared-decision making

Negative experience

“I wish that the provider, the one that made the call to have me induced...would've talked me through a little bit more as to why they were doing that...I assumed that something was wrong...and that's why they were inducing me... I didn't even really get more information until the six-week post visit where I asked “did I have preeclampsia? Is that why?” And then I got a more thorough explanation as to why they made the decision that they did...but I feel like I didn't have a very good sense as to why they had made that decision to induce me, so I was pretty panicked initially that they had seen something or that something came up that was of high concern.”
Theme: Information sharing

Positive experience

“They had put me on Pitocin…They had explained to me why they chose Pitocin…But they kept monitoring me, and they kept telling me things were progressing. At one point, the monitor moved, so the nurses came to check up on me. They explained that they were just concerned for a second because they couldn't hear the heartbeat, but their heartbeat was still there. Everything at every point was explained to me. I got an epidural with this one. The morning nurse that I had, just talked me through the whole thing. Yeah. I felt like I was in control the whole time, which was nice.”
Theme: Information sharing

Negative experience

“The morning after I gave birth, I mean, I gave birth early in the morning, but the day shift nurse was just checking in with me and I just asked her, I said, something seemed weird after I gave birth. I said this to her and I said, did something happen? And she just looked at me kind of quizzically and goes, you didn't know that you hemorrhaged? And I said, what? I had absolutely no idea. And then she looked back on my chart and read a few notes to me. I'm like, are you kidding? I had absolutely no clue... And that was my chief complaint was that I think I should have been told that before.”
Theme: Provider Type

Midwife Care Model

“I've had an OB and my midwife, so I've had three pregnancies. And the midwife ... I think just the way that their appointments are structured. I just got to spend more time with her. And not that ... thankfully, all my providers seemed to legitimately care, but it was a little more personable. Definitely got to know me more, so it was like my mini-therapy appointment every month or whenever I'd go and see her. I appreciated that. They're not as rushed.”
Discussion

• Overall, patient experiences of autonomy and respect were high.
• However, reduced levels were associated with social-risk factors and the type of provider.
  • Socially marginalized populations face discrimination and bias in healthcare settings, negatively impacting the quality of care.¹
  • The midwife care model allows more time with patients than physician models and is associated with greater patient satisfaction.⁸
Putting it all together – preliminary takeaways

What matters to patients during pregnancy and childbirth?

• Participants’ relationships and interactions with their care team shaped their overall birth experience much more than their delivery going to plan.

• Even in emergent events, many patients reflected positively on their birth experience when they were treated with *dignity* and had *autonomy* in their care.

• To improve the quality of care during the perinatal period, more must be done to adapt systems around the needs of patients, prepare providers to offer care in a patient-centered way, protect patient autonomy, and ensure respectful care.
**Next Steps**

- Complete survey and interview data analysis.
- Disseminate findings in Montana and at national conferences.
- Develop a set of recommended practice improvements for MOMS and the MPQC to implement quality improvement initiatives focused on patient-centered care practices.
References


Disclaimer

I am presenting today on behalf of the MHA Advocacy Team. This information is educational in purpose and is not a call to action or lobbying effort.

The following bills are followed by the MHA Advocacy Team and have been identified by MHA to have potential impact to maternal and newborn health, as well to the overall care of our communities.
The Montana Hospital Association (MHA) is a nonprofit organization with more than eighty members that provide the full spectrum of healthcare services, including hospital inpatient and outpatient services, skilled nursing facilities, home health, hospice, physician services, assisted living, senior housing and insurance services.
Through advocacy, MHA represents the interests of our members in the legislative and executive branches of federal and state governments.

MHA staff and consultants collaborate with the American Hospital Association on federal advocacy initiatives and engage with the Montana’s lawmakers and elected officials on state legislative issues.

MHA’s governmental relations staff also interact with federal and state officials to shape the regulatory activities of many federal and state agencies. This involves analyzing rules and regulations proposed by federal and state agencies, and providing comments where appropriate.

To help serve the varying needs of our member hospitals and healthcare providers, MHA has created advisory groups to help staff in advocating health policies. In sharing their expertise with MHA, these groups are helping to direct and inform public policy for the greater healthcare community in Montana.
HB 2: The Budget!

In HB 2, Section B, Mary Caferro (Democrat HD 82) proposed that Medicaid allows for post partum coverage to be extended from one full month after birth to 12 months after birth.

HB 2 passed out of the Senate Finance and Claims Committee with no changes to the Medicaid rates and contains the extension for post partum coverage proposed by Representative Caferro. HB 2 is scheduled for a second reading on 4/24/2023.

Other healthcare focused notes about HB 2:

- Implemented a 4% provider rate increase for all Medicaid providers not included in the rate study.
- CAHs will still be paid at 101% of costs.
- Physicians will continue to receive the Medical Consumer Price Index inflation rate, which is projected to be 4.2% in State Fiscal Year (SFY) 2024.
- Nursing Homes: With the additional increases to provider rates, the SFY 2024 rate is projected to be in the $258 range and the SFY 2025 rate in the $270 range.
**HB 645: Prohibit donations of certain blood and blood products**

Revise laws related to the donation of blood and blood tissue.

- Prohibits certain donations of blood and tissues (see below)
- Provides a penalty (misdemeanor - fine up to $500)
- Revises immunity provisions related to blood and tissue banks
- Creates an exemption from the prohibition on discrimination based on vaccine status for the screening and testing of blood and tissues.

Prohibited: whole blood, plasma, blood products, blood derivatives, human tissue, organs, or bones

That contain: gene-altering proteins, nanoparticles, high-count spike proteins from long covid-19, or other mRNA or DNA vaccines, chemotherapies, or other pharmaceutical biotechnologies.

**Sponsor:** Greg Kmetz (R) HD 38

**MHA Position:** Oppose

**Amends MCA Sections:**
- 49-2-312
- 50-33-104
HB 568: Establish safe nursing standards for hospitals

Enact a new law to:

• Establish required nurse to patient ratios.
• Annual nurse staffing plan submitted to DPHHS
• Nurse staffing committee
• Record keeping for deviations from submitted plan.
• Mandatory overtime not allowed - with exceptions
• Nurse rights regarding safe nursing standards

Establish penalties such of not meeting ratios:
• Failure to submit the staffing plan by the appropriate deadline will result in a violation and a civil penalty of $25,000.
• If a hospital fails to submit or follow a corrective plan of action, the department may impose a civil penalty of $5,000 a day for each day that the hospital fails to submit the corrective plan of action.

Sponsor: Mary Caferro (D) HD 82

MHA Position: Oppose
HB 873: *Provide for the disposition of fetal remains*

Provides for the dignified treatment and disposition of fetal remains following a spontaneous miscarriage or abortion.

Healthcare provider shall:
1) disclose to the parent or parents of the fetus, both orally and in writing, the right of the parent or parents to determine the final disposition of the fetal remains
2) provide written information concerning options, rights, and procedures

Following a spontaneous miscarriage or abortion, the health care provider shall:
1) ensure that the fetal remains are retained until final disposition is arranged. If the remains are stored by the health care provider, the remains must be stored: in the same manner as human remains and not as pathological waste; and at no cost to the parent or parents.
2) provide for the final disposition of the fetal remains by releasing fetal remains to the parent or parents immediately on request; cremating or interring the fetal remains.

**Sponsor:** Lola Sheldon-Galloway (R) HD 22

**MHA Position:** Oppose

Amends MCA Sections:
- 37-19-101
- 50-20-105
HB 873: *Provide for the disposition of fetal remains*

Documentation:
- a) age of the parent or parents of the fetal remains
- b) a designation of the final disposition of the fetal remains
- c) any other information required by the department, including but not limited to: (i) the gestational age of the fetus, (ii) the sex of the fetus, (iii) whether the fetus was part of a multiple birth or multiple fetus pregnancy, and (iv) any other information that could aid in developing an understanding of the causes of spontaneous miscarriage

MHA Testimony in Opposition:
Not only is it difficult to identify fetal remains in early spontaneous miscarriages or abortions, but the operational burden of space, time, and staff resources are a barrier to many facilities.

*Probably Dead*
SB 516: *Provide for the Preserving Fertility Act*

**Sponsor:** Jen Gross (D) SD 25

**MHA Position:** Support

Amends MCA Sections:
- 2-18-704
- 33-31-111
- 33-35-306
- 53-6-101
- 61-3-303

Revise laws related to fertility preservation services for people diagnosed with cancer.

Requires insurance coverage of fertility preservation services and creates a voluntary assessment for cancer screening efforts.

Context: Image a patient in their 20's or 30s that has been diagnosed with cancer. The standard of care is to offer fertility preservation in advance of cancer treatment since treatment can impact fertility. The patient has days to decide to have eggs retrieved or sperm preserved. Then most often insurance declines and patients have to cover the costs out of pocket.
HB 590: *Revise labor laws relating to violence against healthcare workers*

Returned to House with Amendments on 4/17/2023

**Sponsor:** Edward Buttrey (R) HD 21

**MHA Position:** Support

Amends MCA Sections:
- 50-16-805

Revise laws related to violence against health care workers and workers employed by health care providers.

This bill provides employers to report violence against healthcare workers and employees of health care providers and report that to the Department of Justice (DOJ).

The Department of Justice will be responsible to compile an annual report on workplace violence in healthcare and publish to the DOJ website each year.

Sunset on June 30, 2025.
HB 200: *Revise the Montana Safe Haven Newborn Protection Act*

**Passed**

**Sponsor:** Sherry Essmann (R) HD 52

**MHA Position:** Support

This bill revises the Montana Safe Haven Newborn Protection Act to clarify that a newborn may be surrendered via Newborn Safety Device.

A newborn may be placed in the Newborn Safety Device by the surrendering parent at a hospital, fire department or police department.

When the device enters the building, an alarm sounds to signal a child has been surrendered.

The facility, police department, or fire department can leave information and resources in the drawer for the surrendering parent; ensuring anonymity.

Amends MCA Sections:
- 40-6-402
- 40-6-405
HB 303: Implement Medical Ethics and Diversity Act

Protect medical practitioner, health care institution, and health care payer actions based on conscience. Provides protections on free speech and whistleblower, as well as provides immunity and limits governmental liability.

A healthcare institution or healthcare payer may not be required to participate in or pay for a healthcare service that violates the institution's or payer’s conscience.

- Payers must list what they won't cover
- Does not exclude emergent care
- Does not include facilities that are owned/operated by the state.
- Includes anyone who provides care; so it could also include environmental services, dietary, etc.

Sponsor: Amy Regier (R) HD 6
MHA Position: Oppose

Amends MCA Sections:
- 37-1-308
- 50-20-111
HB 392: *Generally revise midwifery laws*

Passed

**Sponsor:** Jodee Etchart (R) HD 48

**MHA Position:** Neutral

Amends MCA Sections:
- 37-27-302

Revises current midwifery laws for licensed direct-entry midwives that:

a) expand ability for midwives to obtain and administer certain prescription drugs
b) require certain education prior to the ability for midwives to administer drugs
c) establish protocols for drug procurement, storage, administration and disposal.

Prescription drugs included are oxygen, postpartum anti-hemorrhagic agents, injectable local anesthetics, antibiotics for group b strep, epinephrine, IV fluids, Rho(d) immune globulin, newborn vitamin K
HB 417: Require consent for sensitive health exams

Require informed consent for sensitive medical examinations and provide exemptions and penalties.

Licensed healthcare providers may not knowingly perform or supervise the performance of a breast, pelvic, urogenital, prostate, or rectal examination on a patient who is anesthetized or unconscious.

Exemptions include:
 a) the patient or a person authorized to make health care decisions for the patient has provided specific informed consent to the examination
 b) the examination is within the scope of care for a procedure or diagnostic examination scheduled to be performed on the patient;
 c) an emergency exists, it is impracticable to obtain consent, and the examination is necessary for diagnostic or treatment purposes.

New act codified within MCA Title 37 - Chapter 2 - Part 3 - General Provisions relating to healthcare practitioners.

Sponsor: Jill Cohenour (D) HD 84
MHA Position: Support
Licensure Compacts

Licensing compacts are one way that state regulatory oversight of health care can offer a faster pathway to interstate licensure practice. Compacts are created when a certain number of states agree upon a uniform standard of care and enact a state law to support that standard.

SB 155: Create occupational therapy licensure compact | Passed
SB 214: Enact Audio and Speech-Language Pathology Interstate Compact | Passed
HB 777: Adopt the interstate counseling compact | Passed
Connect:

MHA Advocacy: https://mtha.org/advocacy/

Montana Legislature: https://leg.mt.gov/session/
MOMS presents the

SIMULATION LEADERSHIP ACADEMY:

A Rural Train-the-Trainer Obstetric Simulation Program

Prepared for MOMS Leadership Council – April 2023
DISCLAIMER

- The Simulation Leadership Academy (SLA) is funded by the Montana Obstetrics and Maternal Support (MOMS) grant. MOMS is funded in whole or in part under a contract with the Montana Department of Public Health and Human Services. The statements herein do not necessarily reflect the opinion of the Department.
- The Academy’s speakers report no relevant disclosures or conflicts of interest.
MOMS SIMULATION HISTORY

Simulation in Motion – Montana (SIM-MT)

American College of Obstetricians and Gynecologists (ACOG) Emergencies in Clinical Obstetrics (ECO) Simulation Training Program

MOMS Simulation Leadership Academy (SLA)
SLA FACULTY

Mary Robertson
RN, BSEd, BSN, CHSE
MOMS Nurse Clinician
Billings Clinic

Stephanie Fitch
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MOMS Grant Manager
Billings Clinic

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MOMS Medical Director
Billings Clinic

George Mulcaire-Jones
MD
Family Medicine w/Ob
Independent Contractor
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Annie Glover  
PhD, MPH, MPA  
Senior Research Scientist  
Rural Institute for Inclusive Communities

Kimber McKay  
PhD, MPH  
Former MOMS Evaluator  
University of Montana

Dr. McKay is not currently working with the MOMS program. She is listed in recognition of her contributions during the initial development of the SLA.
STRATEGIC PLANNING

- May 2021: Discussions on SLA begin
- June 2021: Initial outline created
- October 2021: Strategic planning
- February 2022: Curriculum finalized
- April 2022: Course launched
- September 2022: Course concluded; consultants hired
- November 2022: Outside consultants review, curriculum revamp begins
"Tell me and I forget, teach me and I may remember, involve me and I learn."

Benjamin Franklin
Our Initial Thoughts

Purpose and Types of Simulation

Skills and maneuvers
- Hemorrhage
- Cord prolapse
- Breech deliveries
- Shoulder dystocia
- Crash c-section
- Cardiac arrest

We provide manikins. Participants to conduct a SIM event and report back to group.

1. Standards of best practice
2. SIM design and implementation
3. How to write learning objectives

How do we evaluate learners?
How do we evaluate this program?

Needs to align with MPQC and AIM
INTENDED AUDIENCE

• The SLA is designed for:
  ◦ health care administrators
  ◦ physician champions
  ◦ nurse midwives and other advanced practitioners with obstetric responsibilities
  ◦ nurse leaders and nurse educators at rural health centers.

• Strongly encourage participation from at least:
  ◦ one senior physician/certified nurse midwife leader (or physician assistant/family nurse practitioner with emergency delivery care responsibilities)
  ◦ one administrator (manager level and above)

• We encourage facilities training medical and nursing students to include them in the SLA as available and appropriate.
MISSION
Inspire, educate, and equip all Montana hospitals to implement competent maternal health simulation programming into routine practice.

VISION
The MOMS Simulation Leadership Academy will be a Center of Excellence for Montana hospitals, providing training, resources, technical assistance, and clinical support for those practicing maternal healthcare simulation.
COURSE AIMS

**Rational**
- Retain program autonomy while aligning with local and national maternal safety initiatives.
- Participants learn how to assess their staff’s retention of trained skills.
- Localize Montana geography and site-specific factors into this program.
- Incorporate team, role, and individual competency into training plans.

**Emotional**
- Participants will not be afraid to fail and will recognize that mistakes are opportunities to learn.
- Participants will feel excited, confident, and ready to jump in and try new ideas.
- Create an environment of team cohesiveness and collaboration.
- Facilitate effective communication skills among team members.
At the completion of the SLA, participants will be able to:

- Demonstrate manikin use and maintenance.
- Assess unique training needs and objectives, facility resources, and audience in order to make appropriate selection of simulation modalities and processes.
- Recognize possibilities for expanding simulation training as a learning tool for care of patients with non-emergent physical and mental health conditions.
At the completion of the SLA, participants will be able to:

- Integrate evidence-based materials into simulation practice.
- Describe processes for implementing simulation as part of quality improvement activities and efforts. Example PQC.
- Develop and execute assessment strategy for simulation participants.
- Plan, develop and execute a simulation event for your facility.
COURSE STRUCTURE

- Hybrid training course, composed of:
  - 6 virtual training sessions hosted via Zoom; will be held on the 1st Tuesday of the month
  - On-site simulation assistance (by request)
  - Ongoing consultation and coaching sessions as needed.
- Homework customized to meet individual sites’ needs.
ALIGNMENT WITH STATE & FEDERAL INITIATIVES

- Montana Perinatal Quality Collaborative (MPQC)
- Alliance for Innovation on Maternal Health (AIM) Patient Safety Bundles
- International Nursing Association for Clinical Simulation Learning (INACSL)
COHORT 1 EVALUATION

Pre and Post survey conducted via REDCap

<table>
<thead>
<tr>
<th>Simulation Leadership Academy Participation by Session.</th>
<th>Participants (n)</th>
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<td>Virtual Training Session I – April</td>
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<tr>
<td>Virtual Training Session II – May</td>
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<tr>
<td>Virtual Training Session III – June</td>
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<td>Virtual Training Session IV – July</td>
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<td>Virtual Training Session V – August</td>
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<td>Virtual Training Session VI – September</td>
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<th>Simulation Leadership Academy</th>
<th>Pre (N=18)</th>
<th>Post (N=7)</th>
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<tr>
<td>I understand the purpose and science of simulation.</td>
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<td>5.0</td>
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<tr>
<td>I understand how to do a needs assessment prior to</td>
<td>3.8</td>
<td>4.6</td>
</tr>
<tr>
<td>beginning a simulation exercise.</td>
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<td></td>
</tr>
<tr>
<td>I understand how to develop simulation objectives.</td>
<td>3.8</td>
<td>5.0</td>
</tr>
<tr>
<td>I understand how to select a simulation modality.</td>
<td>3.3</td>
<td>5.0</td>
</tr>
<tr>
<td>I understand how simulation can be a learning tool to</td>
<td>4.6</td>
<td>4.6</td>
</tr>
<tr>
<td>improve care for non-emergent physical and mental</td>
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<td></td>
</tr>
<tr>
<td>health conditions.</td>
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<td></td>
</tr>
<tr>
<td>I understand how to execute a simulation training.</td>
<td>3.7</td>
<td>4.7</td>
</tr>
<tr>
<td>I understand how to use and maintain a manikin.</td>
<td>3.7</td>
<td>4.9</td>
</tr>
<tr>
<td>I am confident I can develop a new clinical scenario</td>
<td>4.1</td>
<td>4.3</td>
</tr>
<tr>
<td>for simulation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am confident I can conduct effective simulation</td>
<td>3.8</td>
<td>4.6</td>
</tr>
<tr>
<td>trainings for obstetric emergencies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am confident I can correctly use medium-fidelity</td>
<td>3.8</td>
<td>4.9</td>
</tr>
<tr>
<td>birthing simulators.</td>
<td></td>
<td></td>
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<tr>
<td>I am confident I can identify key components of an</td>
<td>4.1</td>
<td>4.6</td>
</tr>
<tr>
<td>effective debriefing.</td>
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<td></td>
</tr>
<tr>
<td>I am confident I can evaluate the effectiveness of</td>
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<td>4.7</td>
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<tr>
<td>simulation trainings.</td>
<td></td>
<td></td>
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<tr>
<td>I am confident I can facilitate team communication.</td>
<td>4.4</td>
<td>4.9</td>
</tr>
<tr>
<td>I am confident I can utilize simulation in healthcare.</td>
<td>4.5</td>
<td>5.0</td>
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</tbody>
</table>
"I feel so much more confident with giving simulations and education to the staff. I have been doing them on our unit but didn't have any education on giving them. I now feel I have the tools I need to continue the simulations and education. And I will be more confident in them as well."

In the week following course six – the session dedicated specifically to coaching obstetric emergencies – one of the participating sites experienced a breech delivery and reached out to thank the SLA team for "the timely coaching that prepped [their] team to manage this emergent situation comfortably and safely."
EXTERNAL CONSULTANTS

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## Updated Curriculum

<table>
<thead>
<tr>
<th>Session</th>
<th>Core Content</th>
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</thead>
<tbody>
<tr>
<td>Virtual Training Session I</td>
<td>Introductions, purpose and science of simulation, and simulator demonstration and care recommendations.</td>
</tr>
<tr>
<td>Virtual Training Session II</td>
<td>Simulation best practice, needs assessment, and creating learning objectives.</td>
</tr>
<tr>
<td>Virtual Training Session III</td>
<td>Types of simulation, scenario design, and expected interventions and clinical checkpoints.</td>
</tr>
<tr>
<td>Virtual Training Session IV</td>
<td>Facilitating a useful debrief, review of AIM-related SIM, and assessment of learning. Assign implementation and filming of medical SIM.</td>
</tr>
<tr>
<td>Virtual Training Session V</td>
<td>Use of SIM for non-emergent, communication, and behavioral health issues; behavioral health SIM review; Assign implementation and filming of behavioral health SIM.</td>
</tr>
<tr>
<td>Virtual Training Session VI</td>
<td>Performance of selected OB maneuvers, simulation design principles for deliberate skills practice, wrap up with post-test and evaluation survey.</td>
</tr>
</tbody>
</table>
QUESTIONS?
REFERENCES