Welcome to Aim for Safer Birth. I'm your host, Christie Allen, Senior Director of Quality Improvement and Programs at the American College of Obstetricians and Gynecologists, or ACOG. On this podcast, we dive deeper into the rising severe maternal morbidity. And maternal mortality rates in the United States through a data-driven quality improvement lens. So this season, I'm talking about maternal health innovators and how we are charting a course for high-quality maternity care, and I'm excited to talk to Dr. Kristen Dillon. Dr. Dilling currently serves as the chief medical officer at the Federal Office of Rural Health Policy within the U.S. Department of Health and Human Services, or HHS. With a distinguished career focused on rural health care, health policy, and public health, she previously led Oregon Pandemic Response Unit, spearheading COVID-19 vaccination strategies statewide. As a Robert Wood Johnson Foundation Health Policy Fellow in Speaker Pelosi's office, she championed workplace safety policies during the pandemic. And at PacificSource, she directed medical services for Medicaid beneficiaries, pioneering initiatives in rural primary care and behavioral health integration. Dr. Dillon's extensive 20-year clinical career encompasses rural clinics, hospitals, and nursing homes. She's played pivotal roles in quality metrics committees, community health centers, and research networks in the Columbia Gorge region with a commitment to improving healthcare access and outcomes in rural communities. Thanks for joining me, Dr. Dillon.

You bet. It's great to be here.

So as our listeners just heard, you have a really rich depth and breadth of experience in healthcare. Can you tell me a little about yourself and what is not in the bio? Basically what brings you to the work and why we're talking to each other today.

So probably the irony of the history is I grew up in an urban area in the San Francisco Bay Area. But when it came time to leave and go to college, pretty much all I wanted to do was go somewhere small town and rural. And I've never looked back. So I've lived and worked in rural communities for all of my adult life. And my commitment to rural health comes from spending my work days serving the people around me. And now, you know, in the way that careers evolve, serving similar situated communities across the country. So prior to my work now, I was a rural family doc, kind of old-fashioned medicine with definitely the modern side on things. So that included attending probably 500 births as the physician during my career. And I've seen how joyous and health affirming that can be with the family there and in the home community. Many people want their children to be born in their hometown. But I've also been involved in some pretty harrowing, life threatening situations, too. I just was remembering yesterday, one snowy New Year's Eve, sending a sheriff's deputy 65 miles each way to go get blood because we had an evolving situation at the hospital and we knew our supplies were not going to last. The interstate was closed. So experiences like that spur my commitment to ensuring broad access to birth settings that provide the full spectrum of capabilities and really safe, high quality care for the people they serve.

I hear a couple of things as you're talking. One in particular is, you know, some of the stories that we'll talk about with rural healthcare. I also worked in critical access hospitals as a nurse across the country, and the stories almost sound dramatic. You know, standing on a helicopter. Landing pad waiting for blood to drop or sending sheriffs. But the reality is that this is a community, which you stress, which is where folks live and work. There are joyous, happy, affirming situations there. So we're going to cover both a little bit today. So the second thing that I heard while you were talking was you called yourself a family doc. And so I want to acknowledge the fact that I work for ACOG, which is primarily OB/GYNs. And a lot of times the folks I'm talking to are OB/GYNs. I think it's a good lead-in to talking about the different delivery clinicians that are caring for folks in different spaces. So can you talk a little bit for maybe listeners who aren't as familiar with the scope and the practice of family medicine providers?

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Yeah, so when we think about the clinicians who care for people who are pregnant, birthing, postpartum, the core group is obstetrician gynecologists, so physicians who've done a residency in that field, family physicians who are continuing to practice obstetrics. All family medicine physicians receive some training in pregnancy care in our residencies, but now there's a wider range of options. And so many of us continue to sort of go deeper in that area and to continue to provide pregnancy, birth, postpartum services as we go into practice. And then nurse midwives, I think, are the other main clinician that we think of as being primary in birth services. Certainly as we're looking at building out prenatal and postpartum capacity in communities for that outpatient care, we're looking more to nurse practitioners, physician assistants, ensuring that our physicians working in emergency departments have really good maternity care skills. But it's OBGYNs, family docs with OB, nurse midwives that are often the core of the team.

Christie - 00:05:09:

Thank you. That's incredibly helpful. I think I'm going to have the pleasure this season of talking to a variety of providers. So we're going to get the full spectrum, if you will. But it's helpful always to have context. So I think along those lines, you're talking, we are talking about rural maternity care. I don't think we've defined that yet. Can you tell me a little bit, I mean, what I think of as rural, having lived in New York growing up, might be different than what someone else thinks of rural. I've met some folks that are like, I don't live in a rural area. And then they tell you where you live and you're like, really? That that's not. So for the purposes of what we're talking about, and for the federal government as well, kind of where we're working, can you talk to me a little bit about what is rural?

Kristen - 00:05:49:

Yeah, so it's a continuum and it kind of depends where you draw the line. But in general, when we talk about rural communities, we're talking about places in our country geographically where the population per square mile, the population density is significantly lower than it is in the dense cities and suburbs that we typically classify into more urban areas. As a result of having the low population density and being located away from the urban centers, rural communities are often somewhat geographically isolated. They're just far from the cities. Also, in other times, they're isolated by other attributes of geography, like large bodies of water, mountainous areas where there's no roads. So for our office, the Federal Office of Rural Health Policy, we define rural starting with data from the Federal Government's Office of Management and Budget. And then we inform and do some refining of that using information that comes out of USDA, the U.S. Department of Agriculture's rural urban commuting areas, which actually go down to the census tract area. That becomes really important, particularly when we get in some of the western areas of the U.S., because while the counties in many parts of the country are pretty small and a great unit to work with, out here in the western part of the country, some of the counties are gigantic and encompass really large cities. And also areas that are really far outlying from them.

Christie - 00:07:19:

Okay, that's incredibly helpful. I think, you know, it's one of those subjective terms to most of us, but I know that for you all, it's not subjective. Why do you feel like there's a current emphasis on rural maternity care, perinatal care? Um, why are we hearing more about this? I feel like it's sort of a rising topic, if you will.

Kristen - 00:07:41:

Yeah, I mean, certainly in my work, I've seen concerning developments that are really motivating a lot of focus in this area. Just as with health care in general, we're seeing rural communities really struggling with workforce. And when it comes to maternity care, as we discussed, it's kind of a specialized workforce. So here at HRSA, in addition to some of the other things we're looking at really trying to address, especially around access to care and ensuring that folks have care close to where they're living at a reasonable travel distance that they can get to. So at HRSA, we're really focusing on expanding access to maternal care, growing the maternal care workforce, supporting moms experiencing maternal depression and other mental health conditions, and then also providing important social supports that we know are vital for safe pregnancies.

Christie - 00:08:38:

I think it's important for us to acknowledge when we talk in the AIM program and in a lot of maternal health work at the moment, we talk and should be talking and centering the recognition that there are disparities and outcomes. And
I know that those disparities extend past race and ethnicity. Can you talk a little bit about the disparities in locale, if you will?

Kristen - 00:09:02:

Yeah, in our office, as we think about health equity, we do absolutely continue to focus within rural areas on populations that identify as African-American, Latino, Native American, American Indian, Alaska Native immigrant populations, which are more and more coming into our rural communities. But we also recognize the fact that simply looking at rural communities as a whole, there’s significant health disparities between what residents of rural communities experience compared to those who live in urban areas. And we really see those disparities and the differences in outcomes across maternity care, but also rates of chronic disease, premature death, accidental death, just a whole range of issues that impact rural communities. And our work is really focused on doing whatever we can to close those gaps.

Christie - 00:09:59:

Yeah, I think that's important to acknowledge. There's a heavy focus on maternity care around these pieces. And I think that that's incredibly important. And obviously, that's my area and my commitment, as well as AIM, ACOG, HRSA's. But I also think we need to acknowledge that it is a lifespan continuum. And we know that folks want to seek care in their communities. You want to go close to home. Nobody doesn't want their family to be able to visit them. Nobody wants to be driving with a newborn in the back of your car after even the best, most optimal delivery for two or three hours. That's a lot. I worked in NICU for a little while, and I remember packing babies to go home and getting them settled. And a premature infant in a car seat can only be in the car seat for so long. So knowing that those families would have to stop, have to take the baby out, have to feed, clothe, whatever they needed to do. And that’s a stable infant who's had a chance to recover. Can you talk a little bit maybe about the unique impact? You mentioned emergency care providers. Why would it be important for emergency care providers to have some training in this area, especially in rural communities?

Kristen - 00:11:06:

I mean, I think one real piece of it is it's very important to understand that really any of us working in health care need to have the right level of competency for the services we're provided in working with people who are pregnant, potentially in labor or giving birth or postpartum. These folks are often on the younger side, kind of the folks we tend to classify as like, oh, generally healthy. But pregnancy, postpartum are times when some really unexpected things can happen. Person's body is really different during those times. And so setting us all up to realize that. Being pregnant, having recently been pregnant, it's a really important consideration in someone's medical history for getting any kind of care. I think the other piece is more and more we are seeing that rural hospitals are closing their birth units. And when that happens, typically the nurses with expertise in pregnancy and birth may leave the facility. The clinicians who are providing pregnancy-related care may move to another area because they want to continue to practice in the hospital. And so in those cases, the other primary care providers and the folks in the emergency department become the maternity care team at that hospital. And so we're really working on what can we do to train, to help come up with some models for simulations, to help folks know how to staff with equipment, an emergency department or a clinic or another facility that's going to become the maternity care for the community when a birth unit closes.

Christie - 00:12:42:

So I know that's been a focus for AIM as well. And I'm not even sure that it was intended for rural. Folks and access when we started it, but we have the OB Emergency Readiness Resource Kit, which was really made for those facilities. But you highlight an important issue, which is the departure. Of clinicians and or folks with trained expertise. And so I appreciate our emergency medicine colleagues who may have never anticipated seeing themselves as the first line for obstetric care. What unique challenges outside of those, you mentioned quite a few there, but are there any that we haven't gotten to that you think we need to talk about in accessing quality maternity care and maybe some partnerships that could be used to help folks access those?

Kristen - 00:13:28:
Yeah, that's just a, that's a great point. I mean, great healthcare is a team sport. Facilities that are smaller have a typically more limited range of services and are really dependent on the ability, first off, to transfer patients and receive expert consultation from larger centers. Since the pandemic, the rise in telehealth, the opening up of some of the clinician-to-clinician consult codes, a lot of that's become a lot more possible. I think the other thing I'm seeing in some of my travels around the country is also multiple rural facilities cooperating with each other. That can sometimes be a stretch because there may be a history of competition or other sorts of dynamics between those facilities. But in many cases, they're able to come together in the best interests of their broader community and do some deciding about who's going to do what, how are we going to share staff, how are we going to consolidate services so that a larger sort of multi-hospital service area can keep some of these services local instead of having them change or shift and have it all move to a more urban area instead.

Christie - 00:14:35:

That's a great example of patient-centered care in a way that we don't normally think of patient-centered care. We think it's one-to-one, but that really is centering the patient's experience. I really appreciate you highlighting that. You mentioned just now sort of a way to bridge the gap between even some of the rural healthcare resources to ensure more equitable access. Anything that you would want to highlight between urban and rural? I know we placed responsibility on some of our perinatal regional centers to support because those are the hospitals that we recognize are going to receive transports and care for patients. From the community. Any pieces there that you think we could really augment or access in a more effective way?

Kristen - 00:15:17:

I mean, a lot of what we've learned there comes from our Rural Maternity and Obstetrics Management Strategies Program. Which is really all about networking and building continuums of care from rural communities to whatever higher specialty centers patients may need to get the right care. So we funded 12 of those in 11 states. It was about $9 million in 2023 that we put out. And we've learned from them the ways that they've been able to build referral relationships and arrangements, for instance, with obstetricians or maternal-fenile medicine specialists in more populous counties, to allow for transmission and review of ultrasounds that are being obtained in the rural community. So instead of sending the whole patient a couple hours to the city, we send the images across the wires so they can be interpreted and other decisions can be made. Some of the centers have had a really good experience with telehealth expert consultations going the other way, either direct to the patient or to the patient and their local treating clinician, again, to deal with a twin pregnancy or a pregnancy that has something that makes it a little more complicated, but that maybe doesn't necessitate that person moving a couple hours away to be close to care, or, like you said, driving an hour or two each direction to have a clinical visit that maybe could have taken place at least some of the time via telehealth.

Christie - 00:16:47:

Because we should really acknowledge it's not just moving the patient, right? When you have to move somebody to another area for care, even for a visit. There's all these continuum issues, right? You've got limitations around transportation, first of all, just gas money and vehicles if you own one and vehicles. Well-being too. You also have weather conditions, I know, in some of these areas, particularly that we're not used to seeing. I know region by region, some of us experience different emergencies and weather. And there's also the component of child care. Having a partner who's available. I mean, nobody wants to go receive that care alone. So I appreciate the idea of using sort of our technology pieces. I know that HRSA also has a maternal mental health hotline. That's another way that I think really bridges across the spaces to meet people where they're at. Can you tell us a little more about the maternal mental health hotline?

Kristen - 00:17:45:

Thanks for asking about that. That's an important new initiative that HRSA has been anchoring, this Mother's Day, we celebrated the second anniversary of the National Maternal Mental Health Hotline. So that is, again, another way to reach people wherever they are in their communities in a way that's hopefully really low barrier, no cost and confidential, if that's something that's important to the caller. So in its first two years, the hotline has received more than 33,000 calls and texts. And we serve both pregnant and postpartum people. And also their loved ones or family members who may be calling in with concerns or questions.
Christie - 00:18:25:

Wow, that's an incredible reach. And even in the most rural of areas, we generally can figure out some sort of self-service. I say that as somebody who moved from a rural area more to the DC area and do definitely enjoy my change in cell service that I've appreciated. So you mentioned that you yourself had done deliveries and worked in different facilities. Any lessons learned there that you think are incredibly important? I know that sometimes as we talk about this, we sound very removed. I worked in a perinatal regional center after I worked at critical access hospitals, and I remember feeling pretty disconnected. What are some of the things that you keep in mind and that I know that your office works on making sure to recognize, as you've already mentioned, but anything in particular?

Kristen - 00:19:11:

One thing that's come up, just listening to and thinking about the experiences, I really do, from my experience, see birth as a family and a community event, not an individual's health care experience. And I think that's partly what's really driven my commitment to doing everything we can to have high quality birth services really close to where people live and in their community. And even in the situations you're describing where there's complications or maybe an infant who needs hospitalization, that infant needs its parents and the parents need their family and their community supporting them. And the more we can keep those people all close together, the better the outcomes are going to be for everyone involved.

Christie - 00:19:58:

That's an interesting shift. I think sometimes in EAM we talk so often about maternal morbidity and mortality, and it kind of rolls off the tongue as a phrase. And we recognize often as we talk about this that it affects people's lives and whole families with the loss of somebody who's giving birth. But I think we sometimes forget about the folks that fly a little under the radar when we talk about severe maternal morbidity or even something that maybe doesn't rise even up to the level of severe maternal morbidity but could have been without really excellent high-quality care. That leaves a lifetime of memories, sometimes really positive and feeling safe and sometimes really negative. And I don't think from a trauma-informed perspective, you can overstate the importance of having your community around you.

Kristen - 00:20:43:

Yeah, I really agree with that. And I feel like birth can be a very overwhelming experience for the person going through it. And we know that one of the ways we mitigate and heal from that is by having trusted people around us feeling supported. And even as we think about addressing what we're seeing with maternal mental health in our country, certainly anything we can do to mitigate the stress on new parents and have them feel supported, less isolated, less alone, less overwhelmed by the experience, the better we're able to serve them to keep their mental health good.

Christie - 00:21:21:

Yeah, I mean, even when everything goes according to plan, becoming a new parent, taking on that role is incredibly overwhelming, as I recall.

Kristen - 00:21:28:

It's a huge challenge, yeah.

Christie - 00:21:31:

The more you can build community. I know I'm thinking about community. ACOG has recently brought in a new president and has a Dr. Stella Dantas who actually practiced in Oregon and in some of the more Rural areas as I think of them. And she was talking a lot about the community for the provider too. There is something about being able to practice in your own community. Don't you agree?
Kristen - 00:21:54:

Yeah, it's a wonderful role to be able to play in a community, a really wonderful way to serve the community as so many of us do when we live in rural places. It really kind of knits together the work identity, the personal identity, the family life in a way that I found really, really rewarding.

Christie - 00:22:16:

I think that's a good lead-in to asking about workforce development. When we say workforce, it's such a broad term, right? You've already identified the clinicians who do the delivering, the nurses, other folks. Can you talk a little more about the work that HRSA does in particular around some of that development and what's been happening in that space?

Kristen - 00:22:37:

Yeah, thanks for that question. I do. Workforce really has become just a consistent theme, no matter where I am or who we're talking to or what exactly we're asking about, workforce seems to come up. I know it's not a problem that's unique to rural, but it does seem like it may be a little more pronounced. So HRSA's programs include training to grow the workforce in rural and underserved communities, and then mechanisms to support them remaining in those communities after that. So specifically thinking about training, five of our recent nursing awards are specifically benefiting rural populations. And then in the work we do to support rural residency training for physicians, we prioritize family medicine with obstetrics. And also OBGYN programs intended to serve rural. And in that program, we recently made three new awards to organizations that are developing rural family medicine residencies with enhanced obstetric training, including cesarean section and some other more advanced skills, just because that's one of the main strategies that we're seeing across hospitals that are really thriving with being rural and running birth units and maternity care programs that are really sustainable is a key role in most cases for these family medicine docs with enhanced and expanded obstetrical training as part of what they do.

Christie - 00:24:03:

I'm really hearing all hands on deck. Right? And it should be always for the folks we take care of. We'd want it for people we love and we'd want it for the communities we care for. So the all hands on deck can make it complicated. Just acknowledge that. You've got folks coming from different spaces. And I think what I always felt in small community hospitals where I worked are critical access hospitals, which let's pause for a minute. Can you define or talk about what a critical access hospital is? You hear it thrown around a lot, but I'm not sure folks who are listening might know exactly what that defines as.

Kristen - 00:24:38:

Thanks for asking that. So critical access hospitals are a specific type of rural hospital. There are more than half of the rural hospitals in the U.S. now, but it's a special federal designation which limits the bed capacity and the size of the hospital. So it's really the smaller rural hospitals. And in exchange, provides some augmented federal funding to help cover the costs of maintaining those small facilities and keeping them open.

Christie - 00:25:09:

For critical access. That makes perfect sense. Not a misnomer. So back to the question, you know, in some of the smaller hospitals I worked in, some of the best learning and partnership I've had was there with those set teams. I always felt like one of the advantage was, that are one of the advantages of having those set teams was that you weren't rotating folks. When I worked at larger hospitals, you never kind of knew who was going to be in and out, and you have academics with folks training and residencies. So having a set team is really important. How can we best support those teams in their ongoing education when they're at a very small hospital? Without, hopefully, too much turnover and folks are settled in their community? What are the things that folks outside those facilities and inside those facilities can do to really support that work.
One of the key pieces, I think, for really supporting any rural community is understanding if there's what's unique about the context of the population or the community that's being served. So it's things like travel distance, availability of different types of transportation, the capabilities and the scope of the staff who are available, and understanding the community partners. And I guess also then understanding what's the facility level backup in terms of transports and expertise. And are those relationships really being maintained and being strengthened over time? So one of the things I've had really good experience with personally and also seen continuing to grow in popularity across the country is training staff to work as a team and to have the right knowledge to be able to respond to urgent situations and emergencies that may happen fairly uncommonly, but be crucial to handle well when they happen. And then in addition to that teamwork and cognitive skills, it's simulations. And so there's some very high fidelity simulators that allow a team to work as if they were working with and on a patient. And the person running the simulation can create unexpected events that the staff then need to respond to in like a hands on way as if they were working with the patient. That simulation in many cases is being used to sort of supplement the experience working in these facilities where examples like heavy bleeding after birth or serious elevation in blood pressure may not happen commonly enough that the staff is familiar and ready to jump in right away. And so having them practice on that can really help the team be ready when one of these events occurs.

So I'm hearing readiness, right, on multiple levels, but I'm also hearing the different themes of readiness, right, that is internal, external, kind of knowing your resources, having mapped them. And I think that's important anywhere you practice, right, but maybe a little more important. When you might have delays in that access or, or barriers to that.

Yeah, I think you're framing that up in a really interesting way, which is the readiness is, first off, these external connections. You know, who's our backup? Where do we have for transfer? Where do we have, where's the nearest blood bank if we need that? But then also the internal readiness, that's the cognitive, you know, the knowledge and the. Processes and the teamwork internally, opportunities to practice, and then having the right crucial equipment available in the facility to do those first few steps that need to happen right in the moment.

I think the main thing that we hear most consistently from our site visits, from our stakeholders, is that rural communities want and need flexibility. Rural communities have incredible assets in the relationships that people have with each other, their ability to be nimble, their ability to be creative and solve problems with the resources they have at hand rather than doing it the same way it's always done everywhere else. And I think in the work that any of us do trying to support the communities, they really want us to set up our technical assistance, our grant programs, our training programs so that the communities can adjust them to really match perfectly the context that each community is in.

Thanks for tuning in to Aim for Safer Birth. If you like this show, be sure to follow wherever you get your podcasts so you don't miss an episode. To get involved in work related to addressing maternal mortality, be sure to check out the Alliance for Innovation on Maternal Health at saferbirth.org. Together, we can work towards safer births and healthier outcomes for all families. I'm Christie Allen, and I'll talk with you next time on Aim for Safer Birth. This podcast is
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