



ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH

Video Transcript: Leveraging System Strengths to Solve Capacity Gaps in Limited-Resource Environments Community of Learning
Session 3: The Power of Connection: Scaling Maternal Care Through Partnerships

Allison Finkenbinder [00:00:00] Thank you everyone and welcome to the third session of this Community of Learning, Leveraging System Strengths to Solve Capacity Gaps in Limited Resource Environments. Today's session focuses on relationships and we'll hear from three panelists who will be sharing how they've used partnerships in their state and region to enhance maternal care. My name is Allison Finkenbinder, excuse me I'm a TA specialist with the AIM TA Center and a women's health nurse practitioner. And we welcome you all here. We do ask if you could please put your name and organization in the chat so we know who is in the room today. Thank you. Great, welcome everyone. I love seeing where people are from.

Allison Finkenbinder [00:00:50] All right, we have a few things we're gonna cover before we get talking with our panelists. First, this community of learning is hosted by the Alliance for Innovation on Maternal Health Center, or on Maternal Health Technical Assistance Center, also known as the AIM TA Center. AIM is a quality improvement initiative to support best practices that make birth safer, improve maternal health outcomes, and save lives. The AIM TA Center is managed by JSI Research and Training Institute, a nonprofit public health consulting organization that works both internationally and across all 50 states. We are dedicated to improving lives through better health and education outcomes for individuals and communities. The AIM TA Center is supported by a cooperative agreement with the Health Resources and Services Administration of the US Department of Health and Human Services. The contents are those of the authors. They may not reflect the policies of HRSA, HHS, or the U.S. Government. And thank you. I love seeing the names, so keep them coming. Please share your name and where you're from in the chat. Welcome. So our goal today is that today's session supports you all and your organization and your work around implementing the AIM patient safety bundles and maternal health initiatives. Our hope is that by the end of the session, you all will be thinking about your own local and regional partners that can support maternal health. And start to anticipate some of those challenges that may come up and identify some mitigation strategies to address those challenges, and that you'll identify ways to engage with and support your local and regional partners in this maternal health space. So with that, oh, I'm not quite done. I have a few things I have to touch on before I introduce our speakers. So a couple of housekeeping items. The webinar today, as you may see, is being recorded. The recording will be available and posted to the website in the next two weeks. We are going to have time for questions and answers at the end, but you don't have to wait to ask your question if you wanna put it in the chat. We have folks monitoring the chat. We're kind of gathering all those questions together so that they don't get lost. And we'll come back to them during the Q&A portion at the end. We really love to see faces. So if you're able, we welcome you to come off camera. And if you have a question and would like to come on mute and ask it, it would be helpful if you use the raise your hand function, which you can

find if you click on the three dots that say more. If you do need any technical support, please use our chat feature to message any of the hosts directly. And lastly, we welcome your feedback. We really take it seriously. We look at each and every comment. So there is a link to the evaluation that was just posted in the chat and we welcome you to fill it out in real time as we go along. And we'll remind you about the evaluation again later.

Allison Finkenbinder [00:03:53] Okay, what I wanted to get to, I'm really excited to. Welcome our panelists for us today. And so first, I'd like to welcome Rebekah Porter, who is a nurse consultant with the Alaska Division of Public Health, section of Women's, Children's, and Family Health. Rebekah serves as a perinatal quality collaborative coordinator for the state of Alaska. And prior to her work with the Alaska PQC, Rebekah worked in the infectious disease program in the section of epidemiology. Rebekah has also had roles working in tribal health and with the Centers for Disease Control and Prevention. And her interests lie in perinatal health, child health, infectious disease, social determinants of health and quality improvement. Welcome, Rebekah. Next, I'd like to welcome Dr. Jimmell Felder who currently resides in Greenwood, South Carolina. She is a double board certified in pediatrics and obesity medicine and also has an MBA. Dr. Felder has been practicing medicine in upstate South Carolina for almost 20 years. She's taken care of children in different settings, but currently works part-time at a pediatric urgent care. Dr. Felder convened and leads the Health Outcomes Task Force, also known as HOT, I love that, for self-regional health care since December, 2022. This physician task force has created initiatives to mitigate disparities in their specialty areas, and one initiative called Guided Beginning has paired perinatal navigators with women in high-risk pregnancies until one year postpartum. Additionally, Dr. Felder is a member of the South Carolina maternal morbidity and mortality review committee. Welcome, Dr Felder.

Jimmell Felder [00:05:30] Thank you for having me.

Allison Finkenbinder [00:05:33] And next, I'd like to welcome Dr. Hannah Dudney, who is the Associate Medical Director of Women's Health for the Tennessee Department of Health Division of Family Health and Wellness. Dr. Dudney received her medical doctorate from the University of Tennessee College of Medicine and completed her residency in obstetrics and gynecology at Vanderbilt University Medical Center. Additionally, she obtained a postgraduate medical ethics certificate from Vanderbilt. And Dr. Dunney is board certified by the American Board of Obstetrics& Gynecology. Prior to joining the Department of Health in 2022, she practices an OB-GYN in Nashville, Tennessee. At the Department Of Health, she co-chairs the Maternal Mortality Review Committee, the Tennessee Perinatal Advisory Committee, and the Doula Services Advisory Committee. She is a 2026 recipient of the CDC Enhancing Reviews and Surveillance to Eliminate Maternal Mortality, also known as a ERASE, Maternal-Mortality Visionary Award. Welcome Dr. Dudney.

Hannah Dudney [00:06:30] Thank you for having me.

Allison Finkenbinder [00:06:32] All right. Well, thank you all for being here. I'm really looking forward to this discussion. As we mentioned, today's session is about engaging partners in our maternal health work. And we know that this work to improve maternal health outcomes cannot exist solely within the walls of a traditional labor and delivery unit, especially as we're seeing services consolidate across rural regions. And so we wanted to start by asking how have you engaged your local or regional core network to bring in a range of partners to support maternal health? And Dr. Dudney, I'm wondering if you could kick us off.

Hannah Dudney [00:07:10] Yeah, absolutely. I know there's a number of people that may not automatically see themselves as a role in the obstetrics care team. But with consolidation of care and increasing OB deserts and the increasing distances that people are having to travel for maternity services. It's no longer an if you will see an OB patient, it's a matter of when and how to have the best outcomes for patients, you need to be prepared in order to have those services and skills to be able to care for these patients. So when, excuse me, So people that may see themselves may not see themselves as a part of the OB care team, but are actually a partner, for example, someone may come and be transported by EMS. And if EMS is not prepared for that transport, they may not have those skills and those procedures and techniques to be able to care for them. OB patients walk into urgent cares, they come into emergency departments, even if that emergency department isn't one that's affiliated with an OB unit. And so those emergency staff need to be prepared to be able to care for those patients. I also see primary care as a part of the OB care team. Prior to becoming pregnant, patients may have chronic medical conditions. And as their primary care makes decisions regarding the management of those chronic conditions. Especially for reproductive age women, you need to keep in mind the impact of that treatment decision. Is this a medication that would be safe in pregnancy if the pregnancy was to occur? What is this patient's family life plan? What are their desires regarding contraception or fertility? And keep that in mind when discussing that treatment plan with the patient. Also, if someone is treating substance use disorder or prescribing MAT, they need to be of the nuanced care for patients that are pregnant in postpartum as opposed to a general population. So at the state level, we're trying to address many of these gaps where people may not necessarily see themselves as a part of that OB care team. And as a part of that, we've developed the Tennessee Maternal Health strategic plan. And if you flip to the back of that strategic plan, we've got six action plans for six different groups that kind of consolidates throughout the plan where someone may see themselves. And I think this was an action that we specifically took because we hear that, that people say, I don't necessarily see myself in this. I'm a policymaker. I work in an academic center mostly doing research. Kind of where's my role in maternal health? So the six different areas in which we have action plans for our healthcare systems and providers, community-based organizations, academic institutions, individuals and families, because they are one of the most and the most important members of that OB plan, policymakers and professional medical organizations. So as we go through the implementation process of our strategic plan, which we are doing as we speak, just had our maternal health summit yesterday, we are helping people see themselves in this plan. We're implementing it through our Maternal Health Task Force with our perinatal educators, through our perinatal regional centers, but also with our PQC partner here in Tennessee, TIPQC, and our hospital association. But as a more granular example that I wanted to give regarding engaging with a partner that may not see themselves traditionally as an OB partner, those are EMS providers. So they were not previously trained in neonatal resuscitation here in Tennessee. They were trained in pediatric resuscitations and adult resuscitations. But as many people know, neonatal resuscitation is quite different than pediatric resuscitation in some of its algorithms and things and may not provide the best care for a newborn when resuscitating at birth. And through our health surveillance system, we were seeing an almost doubling in our out of hospital home unplanned home births here in Tennessee over the last few years. And consequently, EMS was then having to care for these out-of-hospital births. And we wanted them to have the most up-to-date skills to be able to do that. So our perinatal educators at our regional perinatal centers have implemented NRP education for EMS across our state. And as a direct result of this education, we've been hearing stories about how they're using these new skills that they have. We heard a remarkable story recently about a 27 week out of hospital birth with a successful

resuscitation with our EMS. Baby went to the NICU, had a stay in the NICU, has been discharged and is doing very well. And that may not have been that same outcome if that EMS team hadn't had the NRP training. So we're looking to help people see their part in that OB care team and provide those trainings and assistance that they need.

Allison Finkenbinder [00:12:13] That's great, thank you. I think there's a lot of interest in EMS kind of that supporting that community with this work. So I anticipate you may be getting some questions about that. I'd like to ask you, Dr. Felder, when we first met, you spoke about your role as a pediatrician and how you've used that role to partner with and support maternal health. Would you share that story with the audience and how you incorporated an outpatient maternal health component into the care of the newborn?

Jimmell Felder [00:12:45] Absolutely. Yes. And so as Dr. Dudney was talking about not seeing yourself as part of the care team, you know, pediatricians are often the first physician to see a mom after she's had her baby when she comes in for that, you know, weight check or that two-week checkup. And so even though we're not obstetricians, we are part of that maternal health care team. Because we're seeing that mom right after she's had a baby. So most pediatricians now across the country are involved in postpartum depression screening. And so that's how we have incorporated and become a more intricate part of the maternal healthcare team because we actually doing screens on those mothers. And so most use the Edinburgh for postpartum depression, or you can use your typical PHQ-2 or PHQ-9 to screen for maternal depression. And so even though we necessarily are not really taking care of the mom herself, we want a healthy mom because we want her to be healthy enough to take care of this newborn that she's now having to take of. And so, yes, we look at ourselves as part of that care team. Because it's the whole person, whole family. We want to make sure that the whole family is healthy, not just mom, not just baby, but the whole-family unit. And so we have to embrace things that have come along. Since my first time in practice, we were not taking care of mothers. We were not screening mothers. We were, you know. As a byproduct, but now we're focused. We are screening for depression. We are screenings for other things in mother. And then that brings in some interesting caveats of what we can also get into or think about as we partner with the OBs and other primary care providers as mom transitioned from the OB space back to her primary care provider. Or seeing more of the pediatrician as she comes into contact with her baby.

Allison Finkenbinder [00:15:13] Thank you, I love hearing about that, kind of combining in that care for the dyad. Rebekah, I'm wondering if we can hear from you next, especially thinking about the unique kind of rural and remote regions that exist in Alaska. Could you share how the Alaska PQC engages with the local or regional care networks to bring in that range of partners, to really support maternal health in Alaska?

Rebekah Porter [00:15:39] Absolutely, thank you. Our approach to engagement has centered around building relationships across the full continuum of care and creating opportunities for partners to work together. We've connected with our local chapters and affiliates of national organizations such as ACOG, AWOHNN, ACNM, and AAP, while also using, I mean, intentionally reaching out to traditional clinical partners to include birth workers, doulas, home visitors, and community-based partners. We make a deliberate effort to invite these partners to our annual meeting and encourage their participation on committees, including our Maternal Child Death Review Committee, which works closely with our Alaska Perinatal Quality Collaborative. And our Annual Meeting, which is a joint meeting with our Maternal Child Death review program is an open registration, creating opportunities for providers and community partners from across the state to network, share

perspectives, identify gaps, and build relationships that extend beyond the meeting itself. This was actually another opportunity where I was able to engage with a patient with lived experience and recruit them to participate on our patient advisory council. So that was a great opportunity and one of the benefits of having that open registration. Alaska has a strong regionalization of maternal and newborn care, which has been intentionally developed to ensure that women and babies have access to appropriate levels of care when they need it. However, our geography creates unique challenges. And if you wouldn't mind, Allison, bringing up that slide so folks can see just how far some people have to travel for care. Women may travel across very large geographic areas to reach a regional hub or Anchorage for delivery or for higher levels of care. In some communities, women may leave their homes as early as 37 weeks to stay in a maternal home at a regional hub or an Anchorage in preparation for delivery. While this approach is intended to improve outcomes by ensuring access to the right level of care, it can come with significant social and emotional costs, including being separated from partners, children, extended family, and their community during an important time in their lives. These realities make strong communication and collaboration across the care network significant. Engagement with tribal health partners is particularly important as much of the movement across the state is coordinated within the robust tribal health network, which utilizes case managers to assist in care coordination. Additionally, Alaska has one of the highest rates of out-of-hospital births. Most of these births, out-of-hospital births occur along the road system, not necessarily in our remote villages. But we've engaged with partners and efforts like the Alaska Birth Transfer Committee to improve coordination for women and newborns who must transition to, who need to transition to the higher levels of care from the Community Birth Center. And we're now looking to see how we can utilize the work that's been done in this space to improve other statewide transfers like hospital to hospital transfers. Being a small population state can also have its advantages in this work. Relationships are often interconnected and one partner can help us connect with another, making it easier to bring together individuals and organizations that might not otherwise have opportunities to collaborate. And especially important part of this work is understanding and addressing the differences in maternal health outcomes experienced by Alaska native mothers, improving maternal health outcome in Alaska requires meaningful partnerships with our tribal health organizations in understanding unique strengths, needs, and barriers within Alaska Native communities. Our care network, therefore, extends beyond hospitals and clinical providers to include tribal health, public health, birth workers, doulas, home visitors, and community organizations. These partnerships are essential to ensure that efforts to improve maternal outcomes are culturally responsive, geographically appropriate and grounded in the experiences of the families that we serve. Overall, our goal has been to build a broad and connected maternal health network, one that brings together clinical, community, public health, tribal health and quality improvement partners. In a state where geography can create significant barriers to care, these relationships are critical to ensure that women receive the right care at the right time, while also recognizing and addressing the very real challenges that come with accessing that care.

Allison Finkenbinder [00:20:32] Thank you. I think this map does a good job of showing us how geographically huge Alaska is. So just with that, if you could maybe just orient us a little bit. So the red lines, people are basically having to transfer to those kind of clusters where things are clustered. That's how far they're traveling. So that's imposed on the rest, you know, the lower 48.

Rebekah Porter [00:20:57] Yes, so some people have will travel to their local regional hub, which are kind of it's, it's like this spoke model. So you've got the little bit of kind of centralized areas on the like, kind of almost like on the outside of Alaska, but you see kind

of Fairbanks at the in the middle of the state, and then Anchorage is where a lot of that those red lines kind of go to because our Level three NICU is located here in Anchorage. We have four NICUs in the state, three of which are located in Anchorage. So a lot of the care ends up, most of the high-risk pregnancies end up in Anchorage to deliver.

Allison Finkenbinder [00:21:43] Okay, thank you. Well, that's just those partnerships and the coordination to make that happen. Thanks for sharing that map. It's really impactful. I'd like to talk about some of the challenges and barriers that can arise when partnering in this work. And Dr. Felder, I'm wondering if we can start with you. You know, when we spoke, you mentioned some specific challenges for a pediatrician who wants to support the maternal-infant dyad, including some barriers around insurance, billing and payments. Can you share more about that?

Jimmell Felder [00:22:23] Sure. Well, first, I'd like to say that the presenters and everybody involved are obsessed with that Alaska map. So we know that you in the audience love that map too. You know, I look at my tiny state of South Carolina and it's like covered by smaller little islands of Alaska. So it's a very fascinating map. But back to talking about the insurance and billing. So, like I said, now, it's common practice for pediatricians to screen for maternal postpartum depression. And usually those screens are given at the two-week visit all the way up to six months. And so we follow that because we know that postpartum depression may not arise until a little bit later. And so, we continue to screen at every visit we see that mom coming to bring that infant and baby in. However, when we were first... Challenged to do this, there was some pushback from pediatricians because we have 15 minutes to do all of the things that we need to do in a well child visit and now you're gonna ask us to take care of our mom that you know that we're not really her primary care physician. But this all changed in 2017 when the American Academy of Pediatrics rolled and got new billing codes out. That would make sure that pediatricians specifically could get billed and reimbursed for administering a screening for a mother. So that code is 96161, and it's a caregiver-focused health risk assessment. And so now, pediatricians are actually reimbursed for doing that work. So I mean that's a little bit interesting, because now you have someone else in the maternal care team. The reason there was so much pushback though, as you can imagine, if a mom does screen positive, what do you do? We don't wanna screen and then have a, I don't know what to do with this positive screen. And so then you would work with your OBs. I would pick up the phone if someone had a severely high score that I was very concerned about. And made sure that they got in with their OB, not tomorrow, but that same day. And so that would also include partnerships between your local pediatrician OB office or a pediatrician in primary care offices to know that when that pediatrician called and was concerned that that mother was taken right in to be seen that day. So those concerns could be addressed. But you could think about ways and where. You know, on our state-wide level, we had talked about hypertension, and maybe we could do the same thing where the pediatricians, again, as they come in and bring their baby in for the weight check or that two-week checkup, would it be possible for us to just grab a blood pressure on that mother? Well, it would be possible first to grab a pressure, of course, because we do have of pressure cuffs, but we also have to work on the barriers. As far as what's the liability for them? What is the, are we gonna get reimbursed for that? What is follow-up for that. And so I think those things can and will probably be something that we would move towards, but we'd have to work those barriers out just like we did with the postpartum depression screening. We've done it before. We could do it again, right? But we need to work those things out because, you know, as pediatricians our scope of practice ends at 21. And so are we giving medical care if we take a blood pressure that's a little bit different than a piece of paper that we screen, you know that we scan until the baby's chart. That's a little bit difference, right, because we

don't have a chart per se for mother. So those kind of things are some of the barriers as pediatricians who really want to make sure that mom is healthy and would love to get those kind of things when you got them, the one stop shop, but you also have to be cognizant of liability and scope of practice and those types of things.

Hannah Dudney [00:27:02] If I don't mind interjecting as an OB, I would love for you to take a blood pressure because mom is oftentimes seeing you guys soon after birth, sooner than she is in my office to see me. And for you to be able to take a blood pressure and then get that routed to our OB care team. And this brings up a topic that we were just talking about recently here in Tennessee is if there's a way for our moms to be to get their blood pressure checked when they come into the health department for a WIC visit. We know WIC is often an environment where they get a high touch environment where they have a number of touch points in our health departments. And it would be wonderful for them to be able to get a blood-pressure check while they're there. And the exact same barriers that you just brought up are ones that we've been discussing internally of, where is this going to be documented in the chart? What are the logistical challenges to having someone being seen for a non-clinical visit when they are going to do a clinical thing? But I'm all for overcoming barriers. And so any way that we can try to make this work, because if it's right for mom, it's the right thing for us to do. Thanks for sharing.

Allison Finkenbinder [00:28:09] Thanks Dr. Felder. You know, something with you talking about this again, like treating the mom, you know, making sure the mom is okay is going to make sure that infant is okay. It makes me think I've expedited partner therapy and I work more I come from kind of the STD family planning space and you know we treat the partner, but it's as it's really treating the patient to decrease them from re-exposure different. But it's making me think that, right? Kind of by treating the mom, you're treating the baby almost in a sense, so.

Hannah Dudney [00:28:39] Anyways, I am more argument there for treating mom and making sure she's healthy and doing well, so.

Allison Finkenbinder [00:28:46] Yeah. Anyways, I'm curious how, you know, other folks that are on the call, how you are working with pediatricians in your work. I'd love to hear about that in the chat if anyone's willing to share. I do want to continue though on this thread about kind of barriers that we might be coming up against, you really partnerships. I mean, we can have a lot of barriers, right? Whether it might be clinical, it might not be financial. We're hearing about billing and that is a very big barrier we come up against in clinical care. And sometimes it's historical tensions. So Rebecca, I wanted to start with you. If you could just share what's a major tension or maybe it's a systemic barrier or trust issue, that your partnerships have faced as you work on patient safety bundles in your state, and then what kind of things have you done to mitigate that?

Rebekah Porter [00:29:41] Yes, absolutely. One of the major tensions that we have experienced in our work is the issue of trust, especially when our partnership is situated in a state organization. So our PQC is housed within our Alaska Department of Health, so we are state affiliated. With this, while this provides an important infrastructure and resources, we recognize that being a part of a state system can create barriers to participation for some populations and communities who may have concerns about government systems or how the information may be used. This is really important with our relationship with tribal health partners, where past experiences of systems and institutions can make data sharing a significant concern. We have worked to build trust by separating participation and access to resources from the requirements to share data. Where possible, we offer

support, technical assistance and resources to tribal health partners without requiring them to provide data as a condition of participating in an initiative. This allows partners to engage in ways that feel appropriate and safe for their communities while still benefiting from the quality improvement efforts. We also have encountered tension between community birth practitioners and hospital-based providers around transfers for care. These relationships can be complicated by differences in practice settings, perspectives, and past experiences. But rather than allowing those differences to become a barrier to collaboration, we continue to intentionally invite community birth providers and hospital providers to participate together. And look for opportunities to establish common ground. One example of this is our most recent initiative, which was the OB-Hemorrhage Initiative, where we actually had two community birth centers participating alongside our hospital teams. This created a more neutral forum for providers who may have had different perspectives to work together around shared patient safety goals. By focusing on a common clinical concern and giving all providers a meaningful role, we've been able to create opportunities for relationship building and greater understanding across settings. Ultimately, we are working to build trust by meeting partners where they are, recognizing the historical and systemic factors that influence participation and creating multiple pathways for engagement. We don't want data sharing, organizational affiliation, or differences in practice settings to be the barriers in participation for these efforts that are designed to improve safety for mothers and babies. Our approach is to build relationships first, identify shared goals, and create a collaborative environment where partners can contribute in ways that are meaningful and appropriate for their communities.

Allison Finkenbinder [00:32:46] Great, thank you.

Jimmell Felder [00:32:49] Just wanted to jump in, if I could, Allison, talking about building trust. So our initiative from the task force that I lead in the maternal infant health space was exactly to garner trust. So we have a trust issue as well. I live in a rural community. And in South Carolina, black mothers are actually three to four times likely to die during or after childbirth. And so we wanted to try to mitigate some of those statistics that we have in our state. And so what we did was get race concordant perinatal navigators, and actually they're community health workers who are trained and licensed in the perinatal space. And so they are paired with a mother at referral all the way into one year postpartum. And so those community health workers, slash perinatal navigators, we all have different names for them, but they actually are paired with those mothers to help them navigate the system, help to mitigate some of the social determinants of health factors that we know is more about health than what we do in a clinical setting. And so when we can get those. A social food insecurity, housing insecurity, taking care of or manage or mitigate it with our community health worker, then the care team can help the mom, you know, focus on getting her blood pressure down or the things that are coming up there. So I just wanted to throw that in as a way that we've tried to build our trust back in our community as well.

Allison Finkenbinder [00:34:41] That sounds amazing. Thank you for sharing that. Dr. Dudley, kind of getting back to challenges, barriers, tensions. I'm wondering if you wanted to share what's going on in Tennessee.

Hannah Dudley [00:34:55] Yeah, one of the biggest challenges that we have faced is really building that broad recognition for the scope of the maternal health challenge and creating shared ownership for it. From the Department of Health perspective, we really support our perinatal quality collaborative, which is not a part of TDH, but is adjacent and funded by TDH and our Medicaid agency. And so our PQC does a lot of the work of implementing AIM bundles in our hospitals and birth facilities. But one of our roles is to

really think about the larger environment in which this work is happening. Here in Tennessee, our maternal mortality data is truly sobering, and we have significant geographic gaps in obstetrics care, as do so many other states, not like Alaska, but we have different types of gaps. But many people outside of maternal health, including members of our general public, certain organizations and even members in terms of our general assembly don't recognize the problem in the scope of maternal mortality in our state and in the nation at large. It's hard to think of a nation that spends more than any other nation on maternal health care, but we have some of the worst outcomes in the developed world. And those are hard statistics to really take home. And it seems to be a large problem, and it is a large and being able to try to find ways in which we can make meaningful steps in that. And so one of the things that we've been working on is the framing of this messaging and framing it as a nonpartisan issue, a healthy pregnancy, a safe delivery, and then having a healthy mother return home to her family. Is the outcome that we are all looking for and trying to find ways in which we can build collaboration across communities and across perspectives. We try to lead with the data, but then also build connections to what that means for Tennessee families and how we can implement solutions.

Allison Finkenbinder [00:37:04] Thank you.

Allison Finkenbinder [00:37:06] All right, well, we've touched on some challenges, a variety of challenges that can arise when partnering in this maternal health work. And I'd like to ask about supporting our partners in this work around maternal health, and especially in limited resource and geographically vast settings. The success of a partnership can really rely on these bridge rules, the individuals who connect patients to care across different organizations. And so I'm curious how your partnership model really supports or trains or equips these frontline staff to ensure that the patient's care is seamless and culturally safe. And Rebekah, I'm wondering if you could start us off.

Rebekah Porter [00:37:53] Sure. Our partnership model is designed to ensure that frontline staff, including those that work in rural and remote areas, have access to the training resources and connections that they need to provide seamless and culturally safe care. We recognize that Alaska geography can make participation in traditional in-person learning difficult, so we work intentionally to reduce these barriers. We provide funding to support staff from rural facilities to attend our in-person learning sessions in Anchorage, allowing them to participate in the hands-on learning, build relationships with colleagues from across the state, and then they're able to bring that new knowledge and practice back to their communities. At the same time, we utilize virtual modalities for annual meetings and steering committee meetings so that distance and travel requirements do not prevent those frontline providers from participating in statewide conversations and quality improvement work. Our steering committee meetings are all virtual, our in-person, our annual meetings that we have that we do in conjunction with our maternal child death review program are hybrid. So we have an online option as well as participating in person. And we do, in the past couple of years have supported travel assistance in those from, for those rural and remote providers to come into Anchorage for those in-person opportunities. We also create ongoing opportunities for learning and connection through our perinatal lunch and learn series, which provides accessible education on relevant maternal and newborn health topics. Those are virtual. They happen once a month for about nine months out of the year. And looking ahead, we're hoping to expand our focus on respectful maternity care to further equip providers and train teams with appropriate, with approaches that support patient autonomy, communication, dignity, and culturally safe care. We also have our substance exposed newborns initiative program support, which

provides additional resources to help facilities and frontline teams implement and sustain screening for substance use during pregnancy, including trainings for screening, brief intervention and referral to treatment. They don't have to be a SUNNY site to receive that training for the SBIRT. They can just reach out and request it and work with my colleague Jen to get that education. And importantly, we do not approach this work as a one-size-fits-all model. Our initiative selection process incorporates the priorities and needs identified by participating facilities along with the data from our maternal child death review program. This allows us to balance state-wide needs and evidence with the realities and priorities of the people providing care on the ground. Ultimately, we see frontline providers as partners and leaders in this work, rather than simply recipients of training. And so by reducing geographic barriers, providing multiple ways to participate, and creating ongoing learning opportunities, this allows facilities to help shape the initiatives we take. And we aim to equip equip teams with knowledge, relationships, and resources that they may need to provide safe, coordinated, and culturally responsive care to Alaska families.

Allison Finkenbinder [00:41:26] Thank you. A lot of efforts going on there. Dr. Dudney, could you talk to us about how you're supporting partners in Tennessee?

Hannah Dudney [00:41:35] Yeah, an example of how we've been supporting our frontline providers and expanding that maternal safety net is through some of our non-traditional or people that don't necessarily see themselves as a part of the maternal care team. I know I talked about WIC earlier with us talking about potentially having WIC staff taking blood pressures. One of the things we have implemented is training WIC staff and urgent maternal warning signs. Because WIC staff, they have frequent trusted interactions with moms and families across Tennessee on a regular basis. And they are in a perfect position to reinforce that messaging that the patients will be receiving and do receive from their clinical team. And so they're able to understand those urgent maternal warning signs. And we are not asking WIC staff to diagnose conditions or triage patients based upon certain conditions and things because that wouldn't necessarily be within their scope of or appropriate. But we're asking them to reinforce that messaging, help encourage moms to take symptoms seriously. And equip them with some communication strategies on how they can use what they've learned to amplify their message. So when they go into a health care facility, identify themselves as someone who is pregnant or has been pregnant in the last year. Let them know what's being experienced, I am having chest pain, I know this is an urgent maternal warning sign and I'm coming here for help. You know, giving them that messaging so that they feel confident to be able to relay that and so we've provided training for our WIC staff on on urgent maternal warning signs and giving them the tools to be able to kind of take this back into into their practice when they're having their WIC visits. Another part that we have implemented and some training that we've implemented is with our home visitors. So in Tennessee, we've got our CHANT program, which is our Community Health Access and Navigation Program, and it provides linkages and navigation to care. They do some maternal and child screenings, including some depression screening. They provide family supports and they link families to resources in the community. Patients can be referred to CHANT from their clinical team, but there also can be community referrals as well. And so we have educated our CHANT staff about maternal mental health conditions and we've enhanced their maternal protocols, both the pregnancy protocol and postpartum protocol with additional resources and information about mental health condition so that those moms are being screened in that setting as well, and these CHANT home visitors are a trusted messenger. They're able to relay that information in a way, and they really know these families. They are in their home, they're meeting with them virtually, and they really get to know them. And so it's just another way

in which we can have that safe touch point with families. I want to highlight a little bit of work that our PQC, TIPQC has done here in Tennessee working with another group. So, through the implementation of their maternal cardiac bundle. They've been doing some cross-training with doulas, and they are not asking doulas to diagnose cardiac conditions, but to be aware of preeclampsia, be aware of cardiac warning signs, and the larger maternal health warning signs as well, as a way to also amplify that message that people are getting from their clinicians and help them recognize and then advocate when something isn't right. And so the maternal health system is larger than just labor and delivery. It's larger than just the traditional providers that we may think of. And we have found that it is very important to engage different groups, whether that's EMS or WIC or doulas as a way to help surround our moms with that safe care.

Allison Finkenbinder [00:45:35] Thank you. And Dr. Felder, what's happening in South Carolina around supporting partners?

Jimmell Felder [00:45:45] Okay, I was stuck on I couldn't get off mute, but I put in the chat are IMPH Institute of Medicine and Public Health. We had a big task force that I was a part of. And that's the executive summary. I cannot find the link that I gave y'all the last time. But, but anyway, thank you for putting it in there. But So we have worked as a state on this since I think 2023 was when several task force were convened, the IMPH task force, and then there's a maternal health innovation task force through DPH. And so there's lot of synergistic work that is taking place across the state. That particular task force that I was on is for resourcing people in rural areas. And so that was one of the reasons why I hopped on that one because I live in a rural area. And so, that specific, what can we do because as we have more maternal deserts, we have to resource places in rural areas on how to recognize if a woman is in trouble. As far as the urgent maternal warning signs. And so similarly in South Carolina, we have our band project that is coming out where moms are gonna wear a little silicone band on their wrists. We're rolling it out pretty small and as pilots in four rural places and then in four, rural hospital systems. And that way we can kind of get the kinks figured out before we roll it out statewide, but the plan is to roll it out statewide. And basically what it is, is the mom is to wear this band for as long as we can get her to wear it. You know, some people said a year. I was like, I don't think a mom's gonna wear a silicone band for a year, but you know, maybe. But as long as she will wear it, and it has a QR code on it to talk about what the urgent maternal warning signs are, but it also is a visual. Cue to a ER staff person or a primary care provider to know that this mom is postpartum. And so if she comes in and her blood pressure is in the range for postpartum women, not just regular, you know to pay attention to that because she is in a postpartum period. So those are just some of the things that we're working on in South Carolina. Also, training ERs across the state, not just in those four cities or towns, but to have posters and training of the ER too because in rural areas sometimes people do show up to an ER or a freestanding ER that does not have an OB unit attached to it. So to make sure that those staff in those areas are well resourced and knowing the urgent maternal warning signs also key as well. So those are some of the things we're doing in South Carolina.

Allison Finkenbinder [00:48:55] Thank you. All right, there's a lot going on. This is great.

Allison Finkenbinder [00:48:59] Okay, well, those are kind of my questions that I had. We are going to transition into some Q&A from the audience. I do want to remind our audience, please keep putting questions in the chat if you have them. And also please fill out the evaluation in which the link was just reshared in the chat. All right. So, I think this first question is for you, Dr. Dudney, and it goes back to the neonatal resuscitation program

that you have going on, that content that's provided for EMS. And Ashley is wondering if that content, that NRP content, is the same as the standard NRP or if it's a modified version. Can you talk more about that?

Hannah Dudney [00:49:45] Yeah, to the best of my knowledge, I would have to check with our perinatal educators from our regional centers. But to the rest of my knowledge, it is the same NRP that is used in the hospital setting. And they go through the learning and then the hands-on training as well. And then they have the ability to be NRP certified. So they have, the state pays for the books as well as the exam for them to be able to take that. And we have had great feedback from our EMS. We've even had some hospital systems incentivize financially their EMS to become NRP certified, giving them an additional bonus on their hourly wage if they are NRP-certified as a part of their role.

Allison Finkenbinder [00:50:34] Okay, thanks. Great. And then we had another question from Amy. And so Amy, if I'm not getting this right, please come off mute and correct me. But the question is about education on how to take an accurate BP. And so I think it was when you were talking about kind of the pediatric space, Dr. Felder, but this actually really is a question for all of you, I think, how you're supporting your staff around taking an accurate blood pressure. And so Amy's question is, does this mean education on how to take an accurate BP? What's the cut point for severe hypertension and to retake the blood pressure in 15 minutes and then the next steps, if the value is still above the cutpoint? Does that make sense? And Amy, is that right? You were kind of wondering what that looks like in the pediatric space. I don't know if Amy is still on. We're not doing that actually.

Amy Scott [00:51:30] I'm still on. Oh, wait, Amy. Thanks. Hi, hi. Yeah, I just, I recognize that in the pediatric space, this is probably not necessarily their realm to take care of the maternal patient all the time and knowing what is severe, what's not severe, what is the process that we would be following relative to education for providers? So that they understand that they need to link with an OB and what is concerning, what's not concerning, one of the next steps. Who's taking the blood pressure? Is it a provider? Is it a nursing assistant? Is a nurse? I have so many questions in that pediatric setting.

Jimmell Felder [00:52:18] I was just saying on one of these task force that I sit on, that was one of the things that came up that maybe pediatricians could help with, you know, doing that first blood pressure since we do see those mothers at, you, know, sometimes three days after they've had the baby. And so what I said is there are a lot of barriers into rolling that out and some of the thing that you've said. But of course, there would be training, there wouldn't be, you wouldn't expect, Um, you know, we, we see, um. Adults even though we see up to 21 in pediatrics. So our staff have to be well versed in taking blood pressures into teeny tiny babies all the way up to you know adults. So that would not be an issue on whether how to take accurate blood pressure. But what I said about recognizing that postpartum blood pressure the cutoff point is a little bit different than you know regular hypertension. Then that would be something that we would just need to have a little chart, you know, for. And we would manage that. That would be ring, ring, OB, it's your turn.

Amy Scott [00:53:23] Great. I love that. That's essentially what I want to know is like, what is the, what is the care model that would be employed in pulling in the OB aspect of this? Because that's what's needed. You know, ultimately I wouldn't expect a pediatric office to manage mama, but they could be a wonderful place to identify, oh, whoa, we still have issue. And we need we need to address this. I will just add that Yeah, yeah. There's many

other considerations, even mental health. I don't know if you've thought about mental health screening, but there's so many things that the pediatric office can in partnership with the OB office can do to support this dyad. And I think that's ever more important. And I don't know, I'm a fan of the medical home model, which never really got off the ground, but. I think it's a great model of care and it would be lovely to care for moms and babies in the same space and that they both had the providers in that same space. Now, in the space of Alaska, that could be quite the challenge based on that map I just saw, but maybe in other places. So enough of me. I just wanted to share my thoughts.

Jimmell Felder [00:54:42] Let me just say quickly, I mean with the caveat to know that most pediatricians, they now work for large systems, they're not a lot of private pediatricians. They are some, but for the first time now, they are more employed physicians than they are in private practice. So you also have to balance the caveat of a time crunch in 15 minutes and how much you can ask a pediatrician to do in 15 minutes. And so we also had to be very cognizant about that part as well. And so to take away time to do a blood pressure, mental health screening, a postpartum screening in 15 minutes, and do all the things you have to do for the baby, that's quite a lot. So, I mean, I think it should be done, but I think there are more ways that we could partner with our OBs and other primary care physicians to get some of that work done.

Amy Scott [00:55:39] Exactly. Hence my support for the idea of a medical home model and it would be a mother-baby sort of model. I think it would really nice to consider that. It got shelved many decades ago and I don't really see it happening now and it'd be really beneficial. But then there's the whole payer thing. So that's a whole other discussion.

Allison Finkenbinder [00:56:00] Anyway. Thanks. Thank you for addressing, I appreciate it. Thank you, Amy. I think we have time for one more question. I think this may be really for all of you, but I wanted to start with you, Dr. Dudley. Can you say more about the partnership with EMS, knowing how important that is, and really based on the experience you've had so far in Tennessee, what should we, really all of us, because I know a lot of states are interested in this space and engaging with EMS, what are some things we should consider? When trying to get engaged with the EMS across our.

Hannah Dudley [00:56:35] So I would start with talking to your EMS teams. So we worked with the EMS board here in Tennessee to learn more about their education and training requirements. We first wanted to make it a requirement, actually, for their licensure to be NRP. And that didn't launch right away and is still something that there are always barriers when you want to implement something new as a licensure requirement. You don't want to decrease the number of those that are in the profession, but if there's a strong need for it. And so we took a little bit of a different perspective at when we launched this program as we provided the funding for the training and the exams and the educational materials and then worked with facilities that through our perinatal educators through our regionalization program in order to be able to get this out into the communities. They already have established relationships with all of our hospitals across the state where they go to be doing education and training already. And so they reached out to them individually with their EMS teams to see who is interested. And then really it just grew organically. Practices would, they would go in and they would do a seminar and then a practice in a community and then other areas would hear about it. And they would say, hey, we want that. We want our fire department to be certified. We want EMS to be certified. How can we get a part of that? And so then we would refer them to our perinatal regional educators. So I would say start with talking with the EMS teams, talking with EMS board, and then if anyone is interested, I can connect you with those in TDOH that have, and those in

Tennessee that have really done this. We've had an educator here in Tennessee who's championed this work, and she has some great materials.

Rebekah Porter [00:58:25] I would also say that with the rural health transformation program funding that's been coming out, and I know it's being implemented differently in different states, but that might be a good opportunity. I was on a call for our Healthy Beginnings in Alaska, that work group, and connected with a regional EMS coordinator, education coordinator. Who was interested in the birth transfer committee, so was able to connect him with that committee, but also that we're using rural health, our hospital association, which we work really closely with at our PQC, received an award for OB simulation training out in remote rural Alaska. So they're going to set up, a kind of simulation program that has like, train the trainer components and hoping to get simulation products out to kind of those regional hubs so that, and it can kind of be like a simulation in a box, but a really big box, not a little one, but so that we can get more of our remote communities and our remote areas a little bit more. Prepared for obstetric emergencies.

Allison Finkenbinder [00:59:54] Oh, wow. That's great. Thank you.

Allison Finkenbinder [00:59:57] I realize we are at time, so I feel like we could keep going. So much to talk about, but I just wanna wrap up. We have one reminder, we have one more session in this Community of Learning series. So it has been changed, but it is now going to be held on October 22nd at 3 p.m. Eastern, so still a Thursday. It's just one week later than it was originally scheduled. So just please note, check your calendars now that you can join us. That session is gonna be focusing on strategies for data utilization in low volume settings. And then we have just, again, that one last reminder to please complete the short evaluation for today and that concludes our session. Thank you everyone, take care.