Strengthening the Perinatal System of Care (PSOC) in Maine

Amy Belisle MD, MBA, MPH

Maine DHHS

January 2022

Agenda

- Review Perinatal System of Care Work over the last 2 years
- Discuss implementation of work: Maternal and Newborn Levels of Care (LOC) work and Quality Improvement related to the Perinatal System
- Discuss potential goals and work for next year and how it aligns with your work

Review of Perinatal System of Care Work: Building Perinatal Systems

Infant Mortality Needs Assessment (2019-20)

Improve Care for Pregnant People with SUD and SEI

- Implement Eat, Sleep, Console at Birth Hospitals
- Plan of Safe Care
- MaineMOM Initiative

Safe Sleep Campaign (2019-present)

Perinatal System of Care Workgroup (2020-present)

- Hospital Maternal and Newborn Levels of Care- LOCATE Subgroup
- Risk Assessment for Preterm Delivery Subgroup
- Maternal Transport Subgroup
- Updated EMS Protocols on Obstetric Emergencies and Newborn Care

Upcoming Work (Present)

- Develop policies for expanded Pregnancy and Post-Partum Coverage
- Join Alliance for Innovation on Maternal Health (AIM) QI Work with the Early Childhood Comprehensive Systems (ECCS) Grant

Review of Perinatal System of Care Work: Overarching Goals and Outcomes

1) Achieve healthy pregnancies & the best possible maternal & birth outcomes in all areas of the state, and across all populations

- Reduce the Infant Mortality Rate to 4 deaths per 1000 live births over the next 5 years in Maine. (Current 5.5 infant deaths per 1000 live births)
- Reduce Maternal Morbidity and Mortality Rates up to 12 months post-partum

2) Ensure all mothers and infants receive the right care in the right place at the right time through perinatal regionalization efforts

- Ensure access to perinatal care for all areas of the state, especially rural, so that all women and infants receive timely and high-quality care
- Assure appropriate transport of women and infants
- Measure: % of VLBW babies (<1500g) are born at Level 3 or higher hospitals, Goal 90% (Healthy People 2010/2020) (Current 85.2% in 2017)

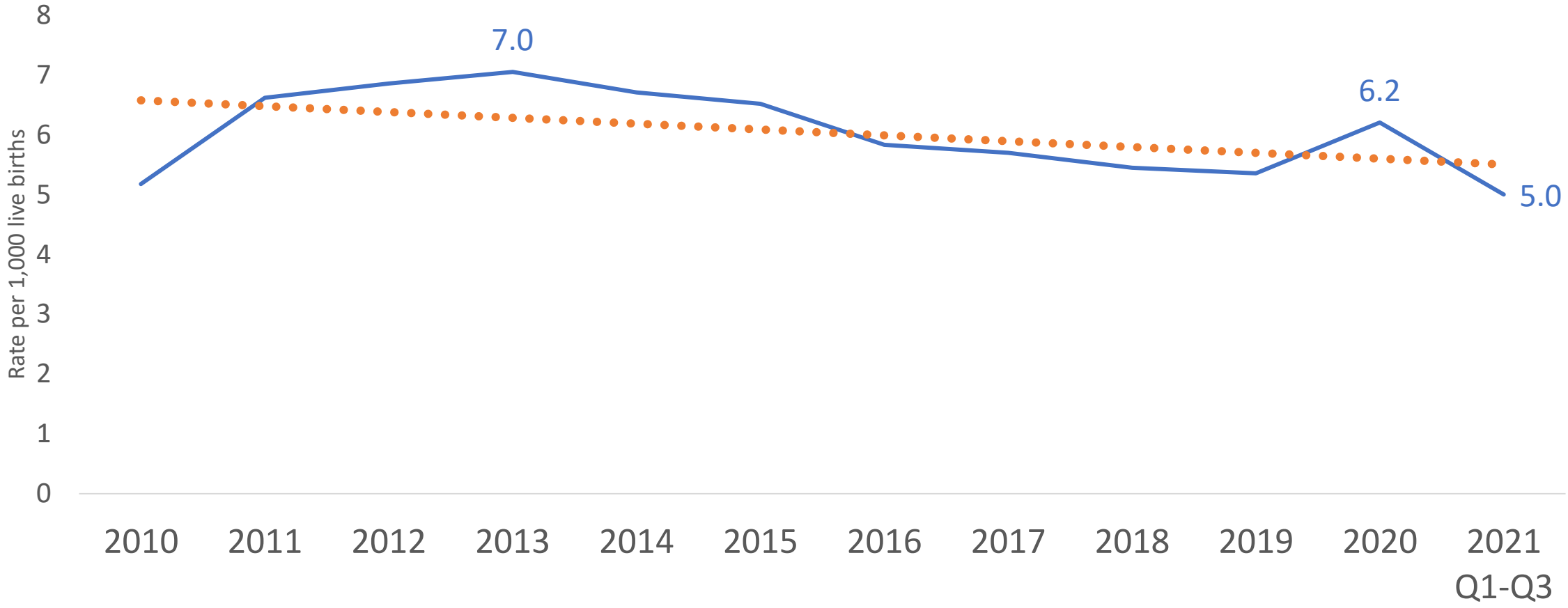
Review of Perinatal System of Care Work: Foundational Work at DHHS

- Identified 4 Priority Areas for Rural Health Transformation after 4 Rural Health Listening Sessions in 2019
    - Engaging Communities
    - Strengthening Statewide Infrastructure
    - Support Regional Models for High-Need Services (including Perinatal)
    - Develop Rural Care Model and Payment Pilots
    - Several groups recommended looking at how EMS/Office of Rural Health set up trauma system for blueprint for perinatal system

Review of Perinatal System of Care Work: Overview of the Maternal and Neonatal Levels of Care (LOC) Process

- Over 40 states have done work on perinatal regionalization and over 20 states have done the LOCATe tool
- Jan-March 2020: Hospitals completed Federal CDC LOCATe tool
- Spring 2020: Initial Data Review: Maine CDC Maternal Child Health Team, MCH Epidemiologists. Perinatal Nurse Outreach Educator; Data sent to Federal CDC for analysis
- Fall 2020: MCDC sent hospitals request for data clarification
- Winter 2020-21: MCH team reviewed how hospitals' self assessed level of care for maternity and newborn LOC vs LOCATe tool analysis
- February-August 2021: MCH team set up 1 hour virtual site visits with 26 birth hospitals and 3 of 7 non-birth hospitals to review findings
- September 2021: Follow-up visits completed with level 2 and 3 birth hospitals
- Winter-Summer 2021: Maine DHHS worked on draft guidance document around LOC with feedback from hospitals and providers
- Fall 2021: Finalized hospital LOCs and guidance document
- 2022: LOC guidance in place; Develop plan to pilot maternal transport data collection tool and risk assessment tool

Review of Perinatal System of Care Work: Provisional Infant Mortality Data



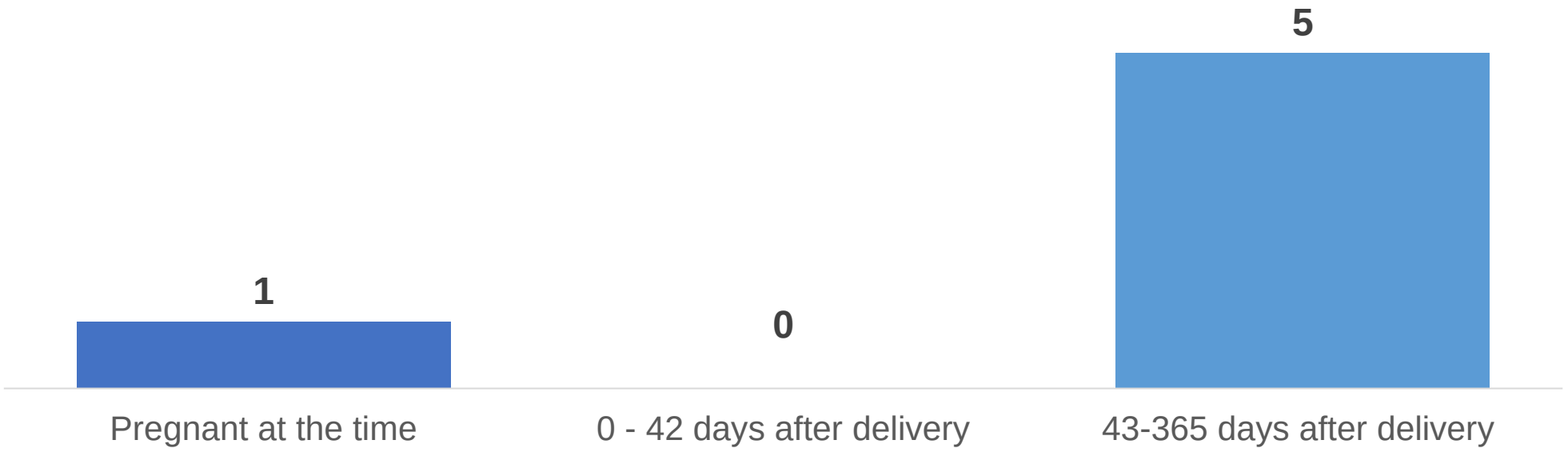
Erika Lichter
Associate Research Professor/MCH Epidemiologist, erika.lichter@maine.gov

Source: Death certificate data, Maine CDC Data, Research and Vital Statistics Program
2020 and 2021 data are provisional and subject to change.

Review of Perinatal System of Care Work: Pregnancy Associated Deaths

There were **6** pregnancy associated deaths in 2020.

5 of 6 occurred **between 43 days and one year** of delivery.



Erika Lichter
Associate Research Professor/MCH Epidemiologist, erika.lichter@maine.gov
Source: Maine DRVS linked death and birth data, 2020 and Maine MFIMR medical abstraction.
Note: These data are provisional and subject to change.

Next Steps on Implementing Perinatal System of Care Work

Level of Care (LOC) Guidance LOC Map

Hospital Notification of Changes in Level of Care

Align work with Federal Government Emphasis on Maternal Health

CMS Guidance: evidence-based best practices for hospitals in managing obstetric emergencies (**HRSA RMOMS Opportunity**

CDC HEAR HER Campaign

Maine QI Projects:

PQC4ME- AIM Bundle- Maternal Hypertension

Risk Assessment Tool for Preterm Labor

Maternal Transport Data

Building Systems Focusing on Maternal-Child and Family Health

Implementation of Work: Level of Care Guidance Final Document

MAINE

Perinatal and Neonatal Level of Care (LOC) 2022 Guidelines

Effective January 2022

Adapted with permission from the Washington State Department of Health (DOH) Perinatal and Neonatal Level of Care 2018 Guidelines

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Introduction

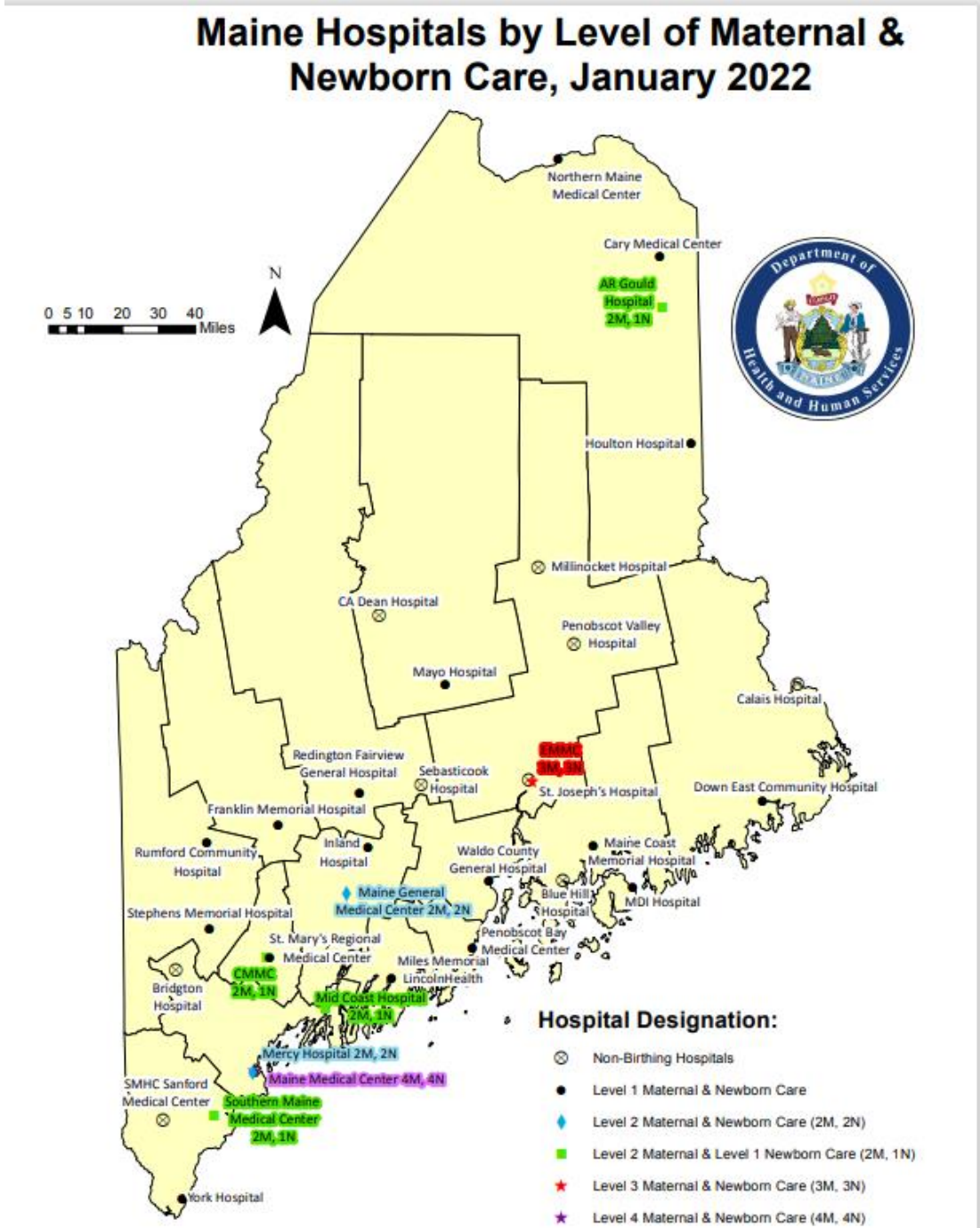
In 2020, Maine Department of Health and Human Services (DHHS) asked all of the hospitals in Maine to complete an assessment from the Federal CDC on maternal and neonatal Levels of Care (LOC) using the LOCATe tool as the state works towards strengthening the perinatal system of care and reducing infant and maternal morbidity and mortality rates. In 2021, DHHS and the Maternal and Child Health Team at the Maine CDC met with each hospital to review their LOCATe tool results and determine the appropriate maternal and newborn LOC. In order to help hospitals assess their facility's capabilities and LOC, Maine DHHS developed this guidance document which is adapted from the Washington State Department of Health's Washington State Perinatal and Neonatal Level of Care 2018 Guidelines. This document follows national guidance, including the American Academy of Pediatrics Levels of Neonatal Care and Guidelines for Perinatal Care recommendations to use uniform, nationally applicable definitions, and consistent standards of service[1,2] to improve neonatal outcomes. The guidance is also consistent with American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine's Obstetric Care Consensus: Levels of Maternal Care that was updated in August 2019.[3] The Guidelines don't require individual hospitals to provide the entire scope of service within a LOC; variation may be needed to meet the Guideline objectives and the unique goals of a hospital or region. This document will be reviewed every 3 years.

It is expected that these guidelines will help:

- improve the outcome of pregnancy,
- increase access to appropriate care for pregnant people and newborns, and
- optimize allocation of resources.

This is not a regulatory document. Maine DHHS uses this document as a reference for hospitals applying for Level I, Level II, Level III, or Level IV designations.

Implementation of Work: LOC MAP



Hospital Name	Icon	Newborn Level of Care	Maternal Level of Care	OB Phone Number	Hospital Phone Number
AR Gould Hospital	■	1	2	207-768-4468	207-768-4000
Cary Medical Center	●	1	1	207-498-1179	207-498-3111
Central Maine Medical Center (CMMC)	■	1	2	207-795-2530	207-795-0111
Down East Community Hospital	●	1	1	207-255-0242	207-255-3356
Eastern Maine Medical Center (EMMC)	★	3	3	207-973-8730	207-973-7000
Franklin Memorial Hospital	●	1	1	207-778-6394	207-778-6031
Houlton Hospital	●	1	1	207-521-2130	207-532-2900
Inland Hospital	●	1	1	207-861-3100	207-861-3000
Maine Coast Memorial Hospital	●	1	1	207-664-5464	207-664-5311
Maine General Medical Center	♦	2	2	207-248-5230	207-626-1000
Maine Medical Center	★	4	4	207-662-2589	207-662-0111
Mayo Hospital	●	1	1	207-564-4293	207-564-8401
Mercy Hospital	♦	2	2	207-553-6300	207-879-3000
Mid Coast Hospital	■	1	2	207-373-6500	207-373-6000
Miles Memorial/LincolnHealth	●	1	1	207-563-4536	207-563-1234
Mount Desert Island (MDI) Hospital	●	1	1	207-288-5082 Ext. 1352	207-288-5081
Northern Maine Medical Center	●	1	1	207-834-1515	207-834-3155
Penobscot Bay Medical Center	●	1	1	207-301-8343	207-301-8000
Redington-Fairview General Hospital	●	1	1	207-858-2405	207-474-5121
Rumford Community Hospital	●	1	1	207-369-1208	207-369-1000
Southern Maine Medical Center	■	1	2	207-283-7350	207-283-7000
St. Mary's Regional Medical Center	●	1	1	207-777-8280	207-777-8100
Stephens Memorial Hospital	●	1	1	207-744-6151	207-743-5933
Waldo County General Hospital	●	1	1	207-505-4140	207-338-2500
York Hospital	●	1	1	207-351-2129	207-363-4321

Non-Birthing Hospitals

- Blue Hill Hospital
- Bridgton Hospital
- SMHC Sanford Medical Center
- Sebasticook Hospital
- CA Dean Hospital
- Penobscot Valley Hospital
- Millinocket Hospital
- Calais Hospital
- St. Joseph's Hospital

Implementation of Work:
Hospital Notice of Maternity and/or Newborn Care Changes

- **<u>Temporary or Permanent Termination of Maternity and/or Newborn Care</u>**
  - Hospitals should provide notice of temporary closure at least 30 days prior to the effective date, and 120 days prior to the effective date, for a permanent termination of service, In cases when such notice cannot be done, the hospital should provide notice soon as reasonably practical for a temporary termination of service, by sending a Change in Service Notification to the Maine Department of Health and Human Services Division of Licensing and Certification (DLC)
- **<u>Change in Level of Care for Maternity and Newborn Services (Level 1, 2, 3, or 4)</u>**
  - Provide notice of at least 30 days and within 120 days notice for a proposed change in LOC to the Maine CDC Maternal and Child Health Program Director who will notify the DHHS Chief Child Health Officer.
  - The hospital and the Maine CDC Maternal Child Health Team will meet to discuss the LOC designation and reach agreement on the level of care.

Implementation of Work: CMS Guidance

- CMS issued guidance on best practices for managing obstetric emergencies in December 2021
- The Condition of Participation for Quality Assessment and Performance Program requires hospitals to develop, implement, and maintain an effective, ongoing, hospital wide, data-driven quality assessment and performance improvement program
- CMS is encouraging hospitals to implement evidence-based best practices for the management of obstetric emergencies, along with interventions to address other key contributors to maternal health disparities
- Highlights Alliance for Innovation on Maternal Health (AIM)/ACOG patient safety bundles
- Adopted annual reporting on new structural quality measure for Hospital Inpatient Quality Reporting (IQR) that asks hospitals to attest whether they participate in a statewide and/or national maternal safety quality collaborative and whether they have implemented safety practices or bundles to improve maternal outcomes
- Aligns with Perinatal Quality Collaborative Work

Implementation of Work:
HRSA RMOMS Funding Opportunity

- Rural Maternity and Obstetrics Management Strategies Program (RMOMS)
  Funding to improve access to, and continuity of, maternal and obstetrics care in rural communities through regional aggregated care, coordination of a continuum of care, use of telehealth, and the implementation of financial sustainability strategies.
  Geographic coverage: Nationwide
  Application Deadline: Apr 5, 2022
  Sponsors: Federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services
- 5 Awards; up to $1,000,000 a year for 4 years
- **Eligibility requirements**
- All domestic public and private entities, including nonprofit organizations, for-profit businesses, faith-based and community-based organizations, tribes, and tribal organizations
- Have demonstrated experience serving, or the capacity to serve, rural underserved populations
- Represent a network composed of participants that include at least 3 healthcare organizations and is inclusive of the 6 required network partner types. 1) at least two rural hospitals or Critical Access Hospitals (CAH); 2) at least one FQHC 3) at least one Medicare certified Rural Health Clinic (RHC), to the extent which these entities are in the network service area and engaged in maternal and obstetrics care 4) at least one Level III and/or Level IV facility 5) regionally and/or locally available social services (home visiting, Head Start) and 6) the state Medicaid agency.
- Has not previously received an award under this program for the same or similar project

Implementation of Work: Quality Improvement/Pilots

- Maine joined the **Alliance for Innovation on Maternal Health (AIM) | ACOG QI work** in October 2021 under The Perinatal Quality Collaborative for ME (PQC4ME) at the Medical Association Center for Quality Improvement (CQI)
- PQC4ME is linked to the Northern New England Perinatal Quality of Care Network (NNEPQIN) based at Dartmouth-Hitchcock.
- Previous PQC4ME projects include the implementation of Eat, Sleep, Console to improve care for Substance Exposed infants, improving Safe Sleep practices. and pilot testing of Maternal Naloxone post-delivery (in process)
- Under the Early Childhood Comprehensive Systems (ECCS) grant, the Maine CDC designated funding to the PQC4ME to help support AIM Bundle implementation and additional projects
- Maternal Hypertension will be the first AIM bundle in Maine. The QI Project kick off will be on January 26, 2022, 12 noon – 1 pm (webinar) and is open to any interested Maine birth hospitals and other clinical teams. Click on this link to **REGISTER**.
- Other Northern New England states are working on AIM bundles: New Hampshire- maternal SUD; Vermont- post-partum hemorrhage

Implementation of Work: PQC4ME will Pilot Algorithm for Preterm Labor Birthing and Non-Birthing Hospitals

For Consultation/Transfer, MFM via ONE CALL: (207) 662 - 6632 or NL-EMMC (207) 973 - 9000

Algorithm for patient presenting with pre-term labor signs/symptoms

PERFORM initial assessment upon admission

- **DETERMINE** presence/frequency of contractions (palpation and external monitor), and other signs/symptoms of PTL (a)
- **DETERMINE** whether there is uterine bleeding (suggesting placental abruption, placenta previa).
- **Check** fetal well-being with electronic fetal monitor.
- **SEND** urine for urinalysis with reflex to urine culture if positive.
- **PERFORM** sterile speculum exam: Visually inspect for PROM, umbilical cord prolapse, or fetal prolapse; if between 24 -34 weeks, *obtain and hold fetal fibronectin* (fFN) (c) and GBS culture before digital exam (if PCN-allergic, request sensitivities at time of culture); assess cervical dilation visually.

if PROM: → See addendum for **PPROM protocol link**

If evident intrauterine infection, placental abruption or fetal compromise: → **DELIVERY** may be warranted, consider **CONSULT** MFM

TVU readily available?

yes → **PERFORM** transvaginal ultrasound (TVU)

- **TRIAGE** based on cervical length (CL).
- **DETERMINE** risk of Preterm Birth (PTB).

Low Risk (CL ≥ 30 mm)	Medium Risk (CL 20 - 29 mm)	High Risk (CL <20 mm)
DISCARD fFN	SEND fFN (c)	DISCARD fFN

negative fFN → DISCARD fFN

positive fFN → **ADMIT** for inpatient management

1. **TRANSFER** to tertiary care center as per leveling criteria and **shared-decision making** with patient/family.
2. **CONSULT/NOTIFY** MFM, neonatology, pediatrics.
3. **GIVE** IVF hydration.
4. **SEND** GBS culture and CBC.

GIVE medications for: see Medications box (d)

- **Fetal benefit** (betamethasone to lower risk of RDS; magnesium sulfate for neuroprotection).
- **Tocolysis** (for short-term pregnancy prolongation).
- **GBS prophylaxis** (per Perinatal GBS algorithm).

PERFORM key tasks at delivery

- **PERFORM** delayed cord clamping (recommended for all vigorous term and preterm infants x 30 - 60 seconds after delivery).
- **OBTAIN** cord gases.

→ **MOVE** infant to Newborn/NICU and **INTIATE** postpartum care for mother

no → **PERFORM** digital exam

- **TRIAGE** based on cervical dilation.

≥ 2 cm or ≥ 80% effaced → DISCARD fFN

< 2cm dilated or <80% effaced → **MONITOR** cervical change, reasses at 2 hours, or PRN → Cervical change?

yes → DISCARD fFN

no → **DISCHARGE** home, and FOLLOW UP for PTL (b)

DISCHARGE home, and **FOLLOW UP** for PTL* (b)

See addendum for notes (a), (b), (c), and (d)

This document is a compilation of Maine Health MFM guidelines and does not substitute for clinical decision making or consult with MFM, OBGYN or Midwifery services. Please refer to guidelines for details and references.

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Links to MFM Obstetric Guidelines and Protocols

- MFM Preterm Labor Guideline
- MFM PPROM Protocol
- MFM Corticosteroid for Fetal Lung Maturity Guideline
- MFM GBS Early Onset Prevention Guideline
- MFM Maternal Fetal Transport Guidelines
- MFM Magnesium Sulfate for Neuroprotection Guideline

All MFM Obstetrical & Perinatal Guidelines https://www.mainehealth.org/Healthcare-Professionals/Clinical-Resources-Guidelines-Protocols/Obstetrical-Perinatal-Guidelines

Maine Perinatal Outreach website: www.mmc.org/perinatal-outreach

(a) Preterm Labor Signs/Symptoms and Diagnosis

- menstrual-like cramping, low back pain
- uterine contractions
- vaginal discharge

The diagnosis of preterm labor is based upon the presence of regular uterine contractions accompanied by a change in cervical dilation, effacement, or both, or initial presentation with regular contractions and cervical dilation of at least 2 cm. (ACOG Practice Bulletin No. 171. Management of preterm labor. October 2016.)

(b) Follow-up after Evaluation for PTL and discharge

- Instruct patient to call with additional signs or symptoms of PTL
- Schedule a Prenatal visit within 1 - 2 weeks
- If started, complete 48-hour steroid window as an outpatient, see Medication box (d)

(c) Fetal Fibronectin Criteria

If the fetal fibronectin enzyme immunoassay kit is to be used the following criteria should be met:

1. Amniotic membranes are intact.
2. Cervical dilation is minimal (< 3 cm).
3. Sampling is performed no earlier than 24 weeks, 0 days and no later than 34 weeks, 6 days of gestation.
   a. The test is not recommended for routine screening of the general obstetric population.
   b. Although a negative test appears to be useful in ruling out preterm delivery that is imminent (ie, within 2 weeks), the clinical implications of a positive result have not been evaluated fully.
4. No bleeding, intercourse, vaginal examinations for **at least 24 hours** prior to sampling.

Fetal Fibronectin Collection

1. Perform sterile speculum exam and rotate the provided Dacron swab across posterior fornix for 10 seconds to absorb cervicovaginal secretions. Subsequent attempts may invalidate the test. (Use only the Hologic Collection kit).
2. Remove swab and immerse Dacron tip into buffer solution. Break shaft at score mark.
3. Align shaft with cap and push down tightly.
4. Label specimen with patient's name, DOB, and collection date and time.
5. If not immediately sent to lab, specimen must be refrigerated after collection. It is ideal to transport the specimens refrigerated, however specimen integrity is maintained at **room temperature for 8 hours.**

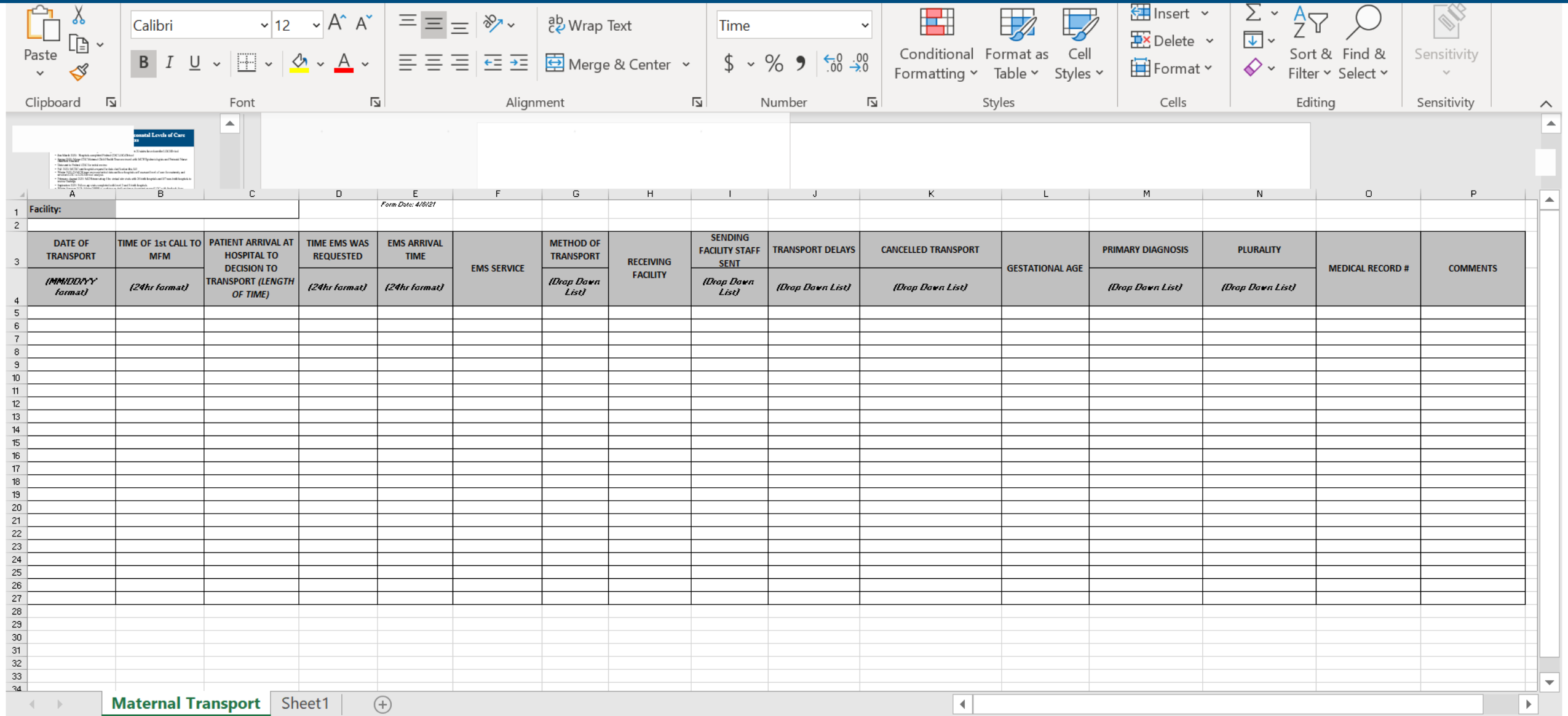
For Consultation/Transfer MFM via ONE CALL: (207) 662 - 6632 or NL-EMMC (207) 973-9000

Medications

(d) Preterm Labor and Preterm Birth (PTB) Medication Considerations

Use in PTL	Recommendations
Fetal Benefit	To lower risk of respiratory distress syndrome, intraventricular hemorrhage, necrotizing enterocolitis, and neonatal death, give a **corticosteroid course** to all patients 24 - 34 weeks gestation: ° Betamethasone: 12mg IM every 24 hours x 2 doses. - if betamethasone unavailable, may use: ° Dexamethasone: 6mg IM every 12 hours x 4 doses. **Note: After MFM/NICU consult, timing of administration at periviability (20+0 - 25+6 wks) should be guided by the family's decision regarding neonatal resuscitation.* (Periviable birth. Obstetric Care Consensus No. 6. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130:e187–99.) **Rescue Corticosteroid Course for Patients < 34 0/7 Weeks:** If a patient has received a previous corticosteroid course > 14 days previously (though can be provided as early as 7 days from prior dose), AND at risk of delivery within the next 7 days AND < 34 0/7 weeks, give corticosteroid course. **Note: Repeat courses or serial courses (more than two) are not recommended. Whether to administer a repeat course of corticosteroids with preterm, premature rupture of membranes is controversial, and there is insufficient evidence to make a recommendation for or against.* **Because corticosteroid treatment for < 24 hours is still associated with reduction in neonatal morbidity and mortality, the first dose of corticosteroids should be administered even if the ability to give the second dose is thought to be unlikely (e.g., PPROM with suspected early labor).* **Patients Between 34 0/7 and 36 6/7 Weeks** Antenatal corticosteroids may be of benefit to infants born in the late preterm period. A steroid course is recommended for patients who are considered at high risk of delivery within 7 days and who **have not received a previous course** of antenatal steroids. **For neuroprotection at < 32 weeks gestation, give:** ° Magnesium sulfate 4 gram bolus, followed by 1 gram/hour for up to 24 hours
Tocolysis Use for short-term pregnancy prolongation (to allow time for patient transfer, medications administration for fetal benefit); give a tocolytic for up to 48 hrs.	**First Line: ≤ 32 weeks, give ONE of the following:** ° Indomethacin: 50-100 mg by mouth loading dose followed by 25-50 mg by mouth every 6-8 hours, not to exceed 48 hours total treatment. ° Nifedipine: 20-30 mg by mouth loading dose, then 10-20 mg by mouth every 6-8 hours **First Line: 32 - 34 weeks, give:** ° Nifedipine: 20-30 mg by mouth loading dose, then 10-20 mg by mouth every 6-8 hours **Note: Tocolysis is contraindicated when risks of use outweigh potential benefits (e.g., in case of nonreassuring fetal status, severe preeclampsia or eclampsia, maternal bleeding with hemodynamic instability, chorioamnionitis, PPROM, or agent-specific maternal contradictions).*
GBS prevention	**Follow MMC GBS Early-Onset Prevention Guideline. For all patients, as needed, give either:** ° Penicillin G: 5 million units IV initial dose; then, 2.5 –3.0 million units every 4 hours until delivery. ° Ampicillin: 2 g IV initial dose; then, 1 g every 4 hours until delivery or the threat of PTB is low. **If penicillin allergy, low risk** (e.g., isolated maculopapular rash without urticaria or pruritus): ° Cefazolin: 2 g IV initial dose; then, 1 g every 8 hours until delivery. **If penicillin allergy, high risk** (e.g., anaphylaxis, angioedema, respiratory distress, urticaria): ° Clindamycin: 900mg IV every 8 hours until delivery. ° If sensitivities unavailable, then give vancomycin (1 gram IV initial dose every 12 hours until delivery). If isolate susceptible to clindamycin and erythromycin, they give clindamycin (900mg IV initial dose every 8 hours until delivery).

Implementation of Work: PQC4ME will Pilot Data Collection Form for Maternal Transports



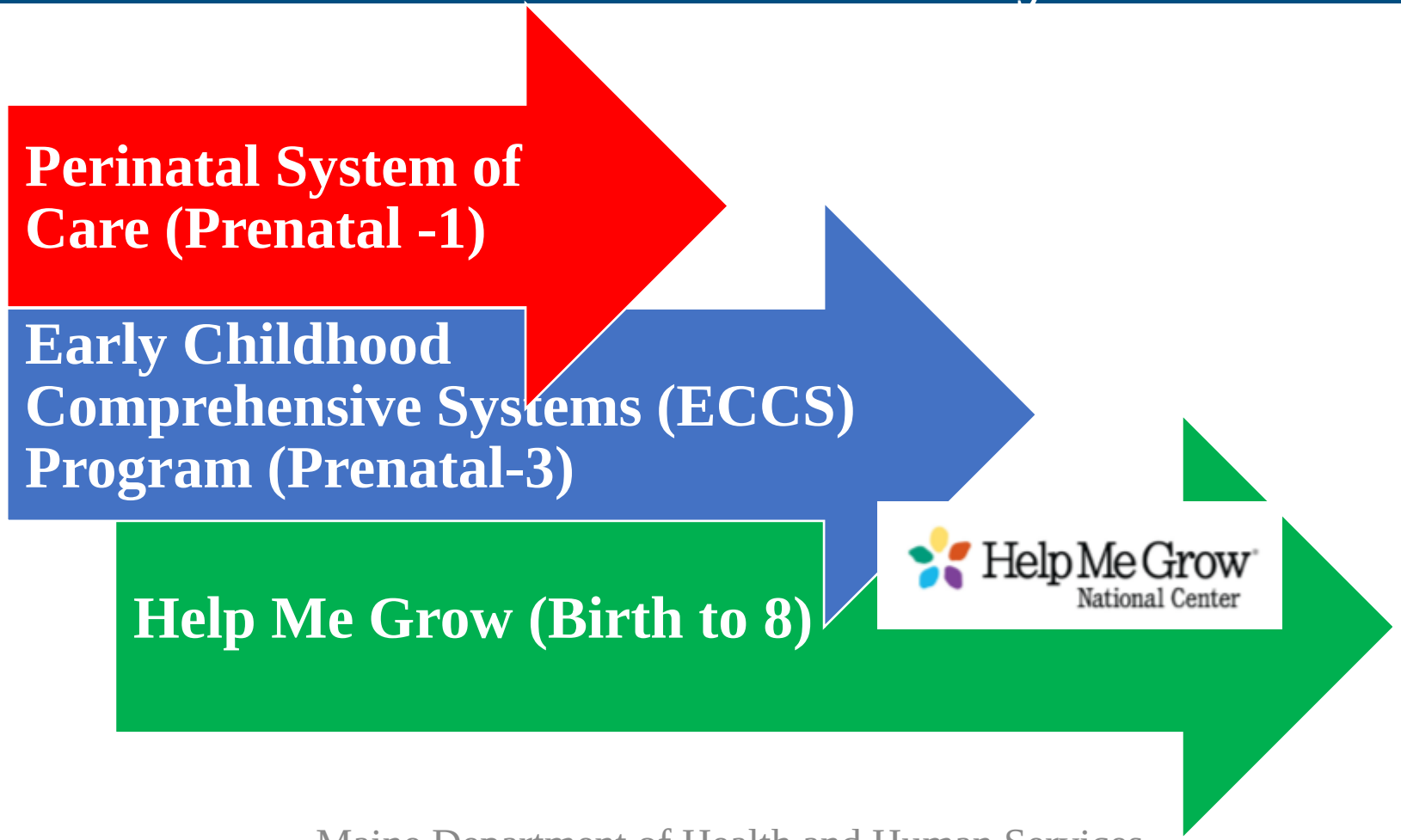
Facility:

Form Date: 4/6/21

DATE OF TRANSPORT (MM/DD/YY format)	TIME OF 1st CALL TO MFM (24hr format)	PATIENT ARRIVAL AT HOSPITAL TO DECISION TO TRANSPORT (LENGTH OF TIME)	TIME EMS WAS REQUESTED (24hr format)	EMS ARRIVAL TIME (24hr format)	EMS SERVICE	METHOD OF TRANSPORT (Drop Down List)	RECEIVING FACILITY	SENDING FACILITY STAFF SENT (Drop Down List)	TRANSPORT DELAYS (Drop Down List)	CANCELLED TRANSPORT (Drop Down List)	GESTATIONAL AGE	PRIMARY DIAGNOSIS (Drop Down List)	PLURALITY (Drop Down List)	MEDICAL RECORD #	COMMENTS

Maternal Transport | Sheet1

Implementation of Work: DHHS is Working to Build Systems Focusing on Maternal-Child and Family Health



Discuss potential goals and work for next year and how it aligns with your work (Will be narrowed to 3-4). These were discussed at the Quarterly Perinatal System of Care Meeting in December 2021

1. Continue to build infrastructure to Strengthen the Perinatal System of Care in Maine
2. Provide hospitals feedback on QI efforts with annual data collected from birth certificates
3. Start implementation of AIM Bundles in Maine as part of ECCS grant
4. Continue to build pathways for maternal transport
5. Gather more information on gaps in the perinatal system around health equity
6. Develop workforce capacity- look at simulation opportunities for delivery rooms, OB emergency training in rural non-birth hospitals for First Responders, ED staff
7. Provide education around preconception health, chronic disease management during pregnancy, and post-partum health
8. Continue work around improving care for pregnant people with SUD/OUD and Substance Exposed Infants

Thank You!

DHHS Commissioner's Office

- **Amy Belisle, MD, MBA**, **MPH,** Chief Child Health Officer, Amy.belisle@maine.gov

Maine CDC

- **Maryann Harakall,** MCH Program Director, Maryann.Harakall@maine.gov
- **Angie Bellefleur,** ECCS Project Director, Angie.Bellefleur@maine.gov
- **Kelley Bowden, MS, RN,** now Retired Perinatal Outreach Nurse Coordinator for the Maine CDC

Consultant

- **Katherine Flaherty, ScD, MA,** Katherine Flaherty Consulting, LLC, ***Katherine.flaherty@kflahertyconsulting.com***, 508-613-5990