



Eight Postpartum Support Programs in Rural Communities Across the United States

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Key Findings

- Information provided by eight organizations in unique rural communities indicates that access to mental health services, appropriate clinical care, emotional and logistical support, and social services during the postpartum period is critical for the mental and physical health of rural parents and families, and is essential for efforts to reduce maternal mortality.
- Despite challenges related to transportation, stigma, isolation, and affordability, the organizations profiled here innovate, including in their program offerings and finance models, and collaborate with local and national partners to provide a variety of critical resources to postpartum families in their rural communities.
- Each organization expressed the importance of stable, secure funding for their work.

Purpose

The purpose of this case study series is to highlight locally focused organizations working to improve postpartum health for rural residents across the United States. We conducted interviews with eight unique organizations working in their local rural communities to support postpartum health. These include programs serving rural communities in Colorado, Maine, Minnesota, Montana, Oregon, South Carolina, and Washington. A high-level overview of the organizations themselves and the services they offer can be found on page 2. These may serve as examples to others considering this work.

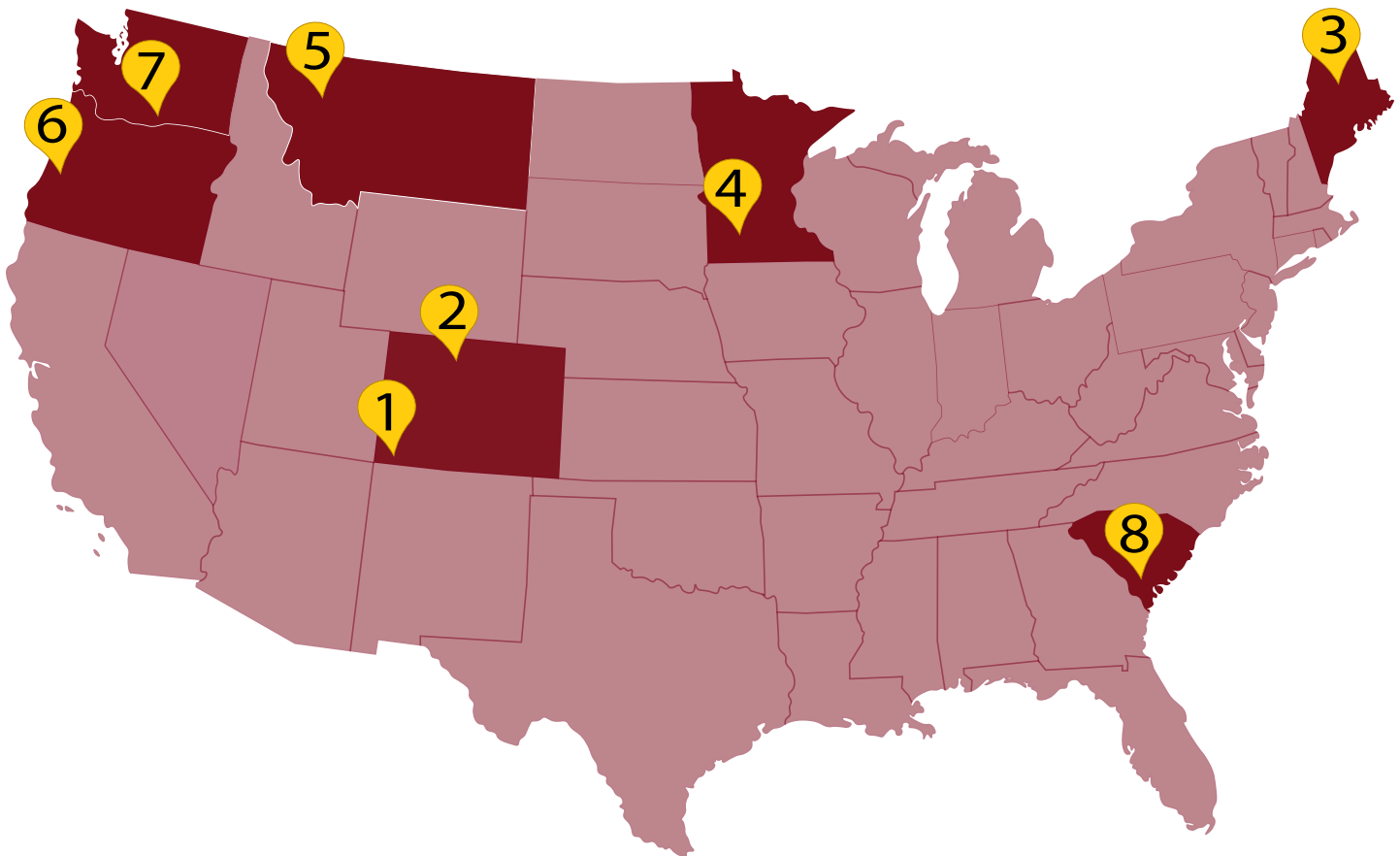
Background and Policy Context

In 2021, nearly 500,000 births occurred in rural communities in the United States.¹ The postpartum period that follows childbirth involves many physical, mental, and emotional changes, and can pose challenges to health and well-being. These challenges may be more complicated to address in rural areas, where access to healthcare services is limited.²

On the extreme end, difficulties in the postpartum period can lead to maternal deaths. Maternal deaths in the United States have increased by 40% in the last decade, and half of all maternal mortality occurs in the year following childbirth.³ Approximately 60% of these deaths are considered preventable.⁴ Nearly 60% of maternal deaths are due to obstetric-related causes, while more than one in five deaths are drug-related or due to suicide or homicide.⁵ Differences in the rate of maternal death and the causes of death exist by rurality.^{6,7} Limited access to care in the postpartum period is frequently cited as a contributor to maternal deaths and other mental and physical health complications that occur in the year after childbirth.⁸

Even when the result is not death or serious illness, many common postpartum challenges are not addressed by standard postpartum care protocols.⁹ Improving the postpartum experience in rural communities goes beyond preventing maternal death or serious illness. The well-known financial and workforce challenges that hinder access to obstetric care also affect postpartum rural residents. As such, improving postpartum health requires financing sustained access to care after childbirth, and expanding access to a range of mental and physical perinatal health services, in order to improve health and

Figure 1: Eight Examples of Postpartum Support Programs in Rural Communities Across the United States



1. Piñon Project Family Resource Center <i>Cortez, Colorado</i> Community-serving non-profit Parent support, education groups, home visiting Since 1994	5. Postpartum Resource Group <i>Flathead County, Montana</i> Community-serving nonprofit Postpartum doula home visits, peer group support Since 2016
2. Alma <i>Glenwood Springs, Colorado</i> Community-serving non-profit Peer-to-peer mental health support specialists Since 2018	6. Family Connects <i>Lincoln County, Oregon</i> County public health Postpartum health assessment, referrals, home visiting services Since 2015
3. Tree of HOPE <i>Waterville, Maine</i> Hospital-affiliated program Perinatal mental health support groups Since 2018	7. Perinatal Mental Health Initiative <i>Columbia River Gorge, Washington</i> Regional initiative Perinatal mental health response training, peer support group Since 2016
4. The Nurturey <i>Marshall, Minnesota</i> Community-serving non-profit Lactation consultant home visits, peer support group Since 2021	8. Family Solutions (SCORH) <i>Lexington, South Carolina</i> State Office of Rural Health Home visiting services, post-pregnancy centering groups Since 1997

well-being for postpartum parents and families in rural communities.¹⁰

Residents of rural U.S. communities already experience access to care challenges during pregnancy, birth, and the postpartum period. As of 2018, only 40% of rural counties have hospital-based obstetric units.¹¹ As a result, rural pregnant patients have to travel farther for care, have less frequent prenatal care prior to delivery, and have reduced access to care after childbirth.¹² These challenges are especially pronounced for low-income individuals and families.¹² Beyond health care, rural residents also face unique challenges in the postpartum period related to transportation, limited access to childcare, and reduced access to paid leave.^{13–15} Understanding the health needs and access challenges that rural postpartum patients face is essential for improving postpartum health and for reducing postpartum morbidity and mortality in rural communities. In addition, it is important to understand and describe the existing supports available to rural postpartum parents and families in their communities.

The purpose of this case study series is to highlight local organizations working to improve postpartum health in rural communities across the United States. These may serve as examples to others considering this work.

Approach

We conducted an environmental scan of existing programs online for parents and families in the postpartum period in rural communities. Using search terms “postpartum support + rural + [state name]” for each of the 50 states, we identified 48 programs across 34 states. We categorized identified programs by the description of services provided, including the scope of services and innovative methods used to address postpartum concerns, as well as characteristics of the surrounding community. We contacted the 18 most comprehensive programs by email, and nine responded. To ensure we included a range of rural communities in our study, we reviewed the geographic locations and characteristics of rural counties and contacted county public health or healthcare organizations to inquire about programs available locally. This process resulted in one additional case study, for a total of 10. Eight case studies describe local-level programs (presented here) and two were nationally focused programs (presented in a companion policy brief).

Primary data were collected through key informant

interviews conducted via Zoom between October 2022 and February 2023. Interviews lasted approximately 35 minutes, and were structured based on a survey instrument of 10 questions, developed collaboratively by the research team. Two members of the research team conducted these interviews. We analyzed each case study individually in order to identify key themes, including challenges and opportunities related to improving access to postpartum support for rural parents.

Case #1: Piñon Project Family Resource Center – Cortez, CO

Rural community context

Cortez is the county seat of Montezuma County in southwestern Colorado, near the Four Corners region (where Colorado, Utah, Arizona, and New Mexico borders meet).¹⁶ Cortez is an archeology and outdoor hub in Mesa Verde Country, and has an industry driven by tourism.¹⁷ Approximately 8,800 Coloradans are Cortez residents.¹⁸ A majority (72.3%) of its residents identify as non-Hispanic white, but a sizeable portion of the population identifies as Hispanic (12.7%) or Indigenous (14%), specifically the Ute Mountain Ute, and Southern Ute tribes.^{18,19} When it comes to health, Montezuma is ranked among the least healthy counties in Colorado (#51 of 64) with higher rates of premature death, smoking and obesity, and teen births, compared with other counties.¹⁸ In addition, residents are more likely to face difficulties accessing medical care, as Montezuma County is classified as a medically underserved area and as a health professional shortage area for primary care, mental health services, and dental care.²⁰ There is one Critical Access Hospital (Southwest Memorial Hospital) in Cortez, but its services do not include labor and birth.²¹

We spoke with Holly Lewis, Early Childhood Programs Coordinator for Piñon Project Family Resource Center.

Organizational overview

Piñon Project Family Resource Center is a nonprofit organization serving families in Montezuma and Dolores Counties in southwestern Colorado. Established in 1994, Piñon uses a two-generation (2Gen)* approach to serve over 1,000 families each year.²² As a nonprofit organization, Piñon has an annual operating budget between \$2.7–3.2 million. Of this, 55% comes from government grants and contracts, 17% from foundation contributions, 6% from individual contributions, 21%

*2Gen is a framework that centers the entire family as the priority, simultaneously focusing on both children and the adults in their lives. For more information, see the [Aspen Institute webpage](#) on the subject.

from program fees and earned income (via their Early Learning Center), less than 1% from in-kind contributions. Lewis described the overarching goal of the organization as strengthening the community by providing comprehensive services for local children and families. The Piñon Project provides an array of services with three focus areas: Early Childhood Programs (including maternal health), Youth Programs, and Family Services. The design is to provide services to all families through robust programming and the ability to wrap families in support. The Early Childhood Programs are focused on broadly improving maternal and infant health and preventing child abuse and neglect. Each of the Early Childhood Programs offered through Piñon Project have their own distinct goals, from providing education on infant feeding and care to promoting school readiness for older children to offering emotional and mental health support for new parents.

Four of their program offerings relate in some way to the postpartum period: Roots (peer support), Incredible Years (evidence-based parent education), SafeCare Colorado (evidence-based home visiting focused on the home environment, physical health of the infant and attachment), and Parents as Teachers (evidence-based home visiting geared toward education and meeting developmental milestones).

Key features

Roots is an ongoing weekly parenting group that includes postpartum and pregnant participants but extends up to parents of kids ages five and younger. In addition to serving as a source of peer support to bolster new parents, Roots incentivizes infant and maternal health by giving \$25-50 gift cards to participants for each prenatal visit or well-child appointment they attend. Roots is especially designed for participants who do not have a strong support network around them. Lewis emphasized that a key feature of the group is facilitating connections between new parents.

“Being a parent under any circumstance can be tough, but especially for those who, for example, are single parents, are new in town, or speak limited English. Roots helps create a support system for people who otherwise wouldn’t have it.”

a weekly basis for eight to fourteen weeks and encompasses parents of children age zero to eight years. Once a year, however, Piñon hosts a group specific to the postpartum parents of infants. Incredible Years is a course-based program with educational material delivered in a format where parents can ask questions and receive support.

SafeCare Colorado involves trained home visitors (Parent Support Providers) meeting new parents at their home to cover topics that include safety, medical needs, and attachment and bonding. Participants might receive cabinet locks, for example, alongside a pediatrician-developed health manual to help parents make health-related decisions for their child. Like Roots, SafeCare is available to families with children age zero to five. Lewis noted that especially for participants in challenging circumstances (teenaged, living in poverty, without supportive family, etc.), SafeCare can be an easy way to get practical assistance in their home during the postpartum period.

Parents as Teachers (PAT) is a home visiting program designed to educate expectant parents or parents of children age zero to kindergarten enrollment, and promote early child development and school readiness. It is an ongoing program in which parents can enroll in at any time, including throughout pregnancy and postpartum; PAT participants are typically looking for a more education-based source of support. Rather than curriculum in a group setting like Incredible Years, PAT is a coaching experience, custom tailored to the specific milestones of each infant or child. In addition, infants and children receive milestone check-ups, and participants are screened for postpartum depression and anxiety and referred to local physicians, counselors, and other mental health care providers as needed.

Challenges and opportunities

Transportation is the biggest challenge faced by Piñon Project clients, and thus, it becomes an issue for staff, too. Lewis emphasized how geographically spread out their local community is, with some families living very far from town. She noted that, while a Medicaid-funded local ride program is an option for some, the hours during which rides are offered are limited and rides need to be scheduled in advance, which can end up being its own barrier for use by postpartum participants. Piñon attempts to help their clients navigate the challenges of transportation by offering gas cards, direct cash assistance, or rides to appointments, depending on client circumstance.

Another challenge is that seeking the services Piñon

Incredible Years is a parenting group that meets on

Project offers can sometimes come with stigma.

"We are fighting against a local culture of 'pull-yourself-up-by-your-bootstraps' mentality. It doesn't apply to everyone, but some people can feel really ashamed about needing help, enough to where they don't seek it."

She hopes to continue to destigmatize help for local families, especially new parents. In addition, Lewis believes their organization is being underutilized by local providers. Piñon Project hopes to see agencies like Child Protective Services and other social service programs refer clients to them in the name of prevention via supporting the family and offering resources, rather than addressing child abuse or neglect after it occurs.

Still, Lewis highlighted the existing relationships in the community that she is heartened to see growing and deepening. Piñon gets regular referrals from the sole pediatrician in town, their local health department and their local Nurse-Family Partnership.

Among the most encouraging aspects of the previous year was the advent of Roots, which was an offshoot of the success of other peer support groups (e.g. for fathers, for parents of children with special health needs, etc.) at Piñon. Piñon staff noticed that in their community, peer-led initiatives often have higher turnout and offer a more authentic source of support for families, and hoped to establish this especially for new parents. Beyond the witnessing of new parents making connections with one another, Piñon received a generous grant through the Alva Goldbug Education Foundation that enabled them to make cash assistance (via gift cards) part of the support group experience. For Lewis, this has been especially meaningful.

"Being able to offer cash assistance has meant we've seen moms taking their little ones to the doctor who otherwise wouldn't have been able to. In turn, we are seeing diagnoses that otherwise would not have been caught, for moms and kids. The ripple effect of helping families is hard to quantify but very clear."

This has prompted discussion of expanding other areas of need. For example, Piñon currently works with

the Montelores Emergency Assistance Council to help their clients receive rental assistance. Piñon Project Family Resource Center will continue to assess opportunities to meet the needs of southwestern Coloradans.

Case #2: Case #2: Alma – Glenwood Springs, CO

Rural community context

Glenwood Springs is a resort town in the Colorado Rocky Mountains situated at the convergence of the Roaring Fork and Colorado Rivers in the Roaring Fork Valley.²³ Glenwood Springs is a year-round tourist hub, drawing visitors to its natural hot springs, and a wide range of outdoor adventure opportunities like skiing, biking, and rafting.²⁴ Home to approximately 10,000 Coloradans, Glenwood Springs is also the county seat of Garfield County.²³ Garfield ranks among the healthiest (#15 of Colorado's 64 counties), with below state averages for health metrics like children in poverty, excessive drinking, and sexually transmitted infections, but a higher rate of teen births and substantially higher rate of uninsurance (16% vs. 9% statewide).²⁵ In terms of its demographic makeup, Garfield County is younger than the rest of the state; one quarter of its population is under 18 years of age.²⁵ A majority (67%) of its residents identify as non-Hispanic white, but a sizeable portion of the population (29%) identify as Hispanic. More than 6% of its population is not proficient in English.²⁵ In 2019, 744 births occurred in Garfield County.²⁶ Valley View Hospital, which has a family birth center, is located in Garfield County.²⁷

We spoke with Kenia Pinela, Director of Programs and Innovation for Valley Settlement, and leader of the Alma program.

Organizational overview

Valley Settlement is a nonprofit organization that uses a two-generation (2Gen) approach to serve Latina immigrant families in Glenwood Springs and the surrounding rural Roaring Fork Valley, Colorado.²⁸ Many of the families they work with are from Mexico, El Salvador, and Guatemala, and there is a large population of Latina immigrant families in the region, although their programming is open to anyone who would like to participate. Valley Settlement was born out of community listening sessions in 2011, when community organizers spoke directly with immigrant families and also with community-serving organizations to better understand the needs of the local community and how to meet them.²⁸ Pinela noted that, while their program offerings

stemmed from the initial listening sessions over a decade ago, they check in periodically with the community to understand emerging challenges and evaluate programs to address them. On an annual basis, they connect with the families in their programs to understand the challenges they are facing and better adapt their programming. In addition, they do door knocking in neighborhoods to meet new families, build relationships, and stay connected to the needs of the broader community. Valley Settlement is funded through a combination of foundation, nonprofit, government and business support, as well as individual donations.²⁹

Alma is a specific program at Valley Settlement focused on the needs of postpartum patients.³⁰ Valley Settlement had identified mental health and access to mental health care, specifically during the postpartum period, as a key community need. Focus groups revealed the extent of this need; Pinela described some patients sharing their experiences with untreated postpartum depression or anxiety. She added that those individuals were never able to get the opportunity to process their feelings, or if they did, it was not in their language.

Health care facilities in the area did not have any bilingual mental health staff at the time. Some did offer translators, but Pinela stressed the importance of processing a tremendously challenging time with someone who shares your native language.³¹

In 2017, Valley Settlement was connected with a researcher at the University of Colorado Boulder, who had implemented a peer-to-peer postpartum support program in the Denver area and was seeing its success. The researcher wanted to expand the program to rural areas, and wondered if Valley Settlement would be interested in partnering with them on this endeavor. Pinela noted how beautifully things seemed to come together, pointing out that this allowed them to meet a previously identified need of postpartum mental health services in their community. The Alma program began as a research study in 2018, and transitioned to ongoing programming in 2021.

Key features

Alma is an eight-week home visiting mental health support program for Latina immigrants who are newly postpartum. It features trained, paid mentors, “compañeras,” who have faced depression or mental health challenges themselves and want to help others in their postpartum journey. All of the compañeras are fluent in Spanish, which eliminates the language barrier previously experienced by moms looking for postpartum mental

health support in the Roaring Fork Valley. Alma leverages the concept of behavioral activation, a component of cognitive behavioral therapy, to support postpartum participants. Pinela described the goal as “feeling better from the outside in,” noting that,

“...one of the biggest things you work on is understanding how your actions make you feel. Alma brings awareness about how the body and mind are linked, and helps moms recognize their own individual values and live their lives according to them.”

Pinela noted the culturally relevant content of the program, focused on shared cultural values among participants.

“Sometimes you have women...in this really fast-paced, unfamiliar culture where they don't speak the language and are just trying to keep up. Self-actualization can also be part of Alma: supporting moms to better know who they are, where they want to go, and recognizing that what they do has a really big impact on how they feel, and controlling what they can.”

Alongside the compañera, Alma brings a babysitter to the home visit, so that the mother can be fully present and concentrate on herself when in this program. This helps address the barrier of lack of childcare for accessing mental health services in rural areas.¹⁵

Pinela described seeing reductions in depression symptoms, anxiety symptoms, and stress among participants. Still, she emphasized, Alma will not provide sufficient support for every participant – those with severe postpartum depression or anxiety need additional help through therapy and/or medication. Alma staff also work in collaboration with participants in the program to identify additional needs beyond peer-to-peer mentoring. For example, Pinela said, they had a mom who joined the program for postpartum depression symptoms, but upon getting to know them and hearing their story, it became clear that they were reliving past trauma or showing post-traumatic stress disorder (PTSD) symptoms. In this case, they treated Alma like the first stepping-stone on this mom's mental health journey, completing the program and connecting them with a

therapist or other provider for further care. Pinela noted the many local options available with which to connect participants, from therapists to behavioral health and substance use disorder treatment centers, all of which have increased their number of bilingual staff in recent years.

The stream of referrals flows both ways: participants are often referred to the Alma program by local health care providers,³² as well as from county Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) programs. Providers identify patients whose circumstances make them a good fit for the Alma program and make the connection.

Challenges and opportunities

Staffing the Alma program is an ongoing challenge for Valley Settlement, specifically the hiring of *compañeras*. Alma currently employs one *compañera*, but Pinela hopes to grow to three to five, to better serve the need in the community. Pinela pointed out that she has had a *compañera* job open for a year and has been unable to find the right fit.

"It is a unique skill set, and can be hard to interview for. People need to not only have lived experience, but also be empathetic, nonjudgmental, and have the capacity to help participants normalize their feelings."

Pinela hopes to find more mentors like this, as well as be able to have people who went through Alma be *compañeras* in the future.

Another challenge Alma staff face is ensuring participants with varying levels of family and friend support get the help they need. In many households, partners and other family members are bought into the ideas of behavioral activation, and can help speed up the journey for mental health improvements. However, noted Pinela,

"When you have a mom trying so hard to feel better, but then she has an environment at home that is not at all conducive to this, or partner who is not at all supportive of her, this can be extremely difficult."

Despite these challenges, Alma staff see many reasons to be hopeful, not the least of which is feedback from Alma participants themselves. Participants receive a pre-

check, complete the eight-week program, and do a post-check at six months after the completion of Alma. From their first evaluation of Alma, said Pinela,

"it became very clear that this program works...it is especially gratifying to see those six month post-check numbers and know that our moms are doing well."

She also emphasized the joy in witnessing healthy, trained peer support at work – seeing *compañeras* with lived experience validating and honoring the participants, and helping them on their journeys. Having local health care providers also recognize the complementary role of peer mentors alongside clinicians in supporting patients through the postpartum period has also been an encouragement.

More broadly, Pinela believes this program has helped with normalizing discussion of depression, anxiety, and mental health challenges in the Latina community for postpartum individuals and their families.

"We've seen a domino effect of how a mom views mental health after Alma, and when there is a supportive family structure in place, this also translates into being able to normalize mental health challenges throughout the community."

Case #3: Tree of HOPE – Waterville, Maine

Rural community context

Waterville is a town of nearly 16,000 residents, located along the Kennebec River in Kennebec County, central Maine.³³ Home to two colleges (Colby and Thomas, which have about 2,000 undergraduate students each), Waterville is also known for its historic downtown area as well as its thriving art and film scene.³⁴ County Health Rankings puts Kennebec among the middle of Maine's sixteen counties, with some measures of health better than state average being offset by others below average.³⁵ For example, Kennebec County has a lower excessive drinking rate, but a higher rate of physical inactivity than Maine overall. Demographically, Waterville is primarily non-Hispanic white (94.2%), slightly higher than the state average of 92.7%.³⁵ Tourism and retail business are primary industries, as well as arts and cultural entertainment.³³ Kennebec County is home to one hospital (Northern Light Inland Hospital),³⁶ which has a family birth center. According to March of Dimes,

there were 1,060 births in the county in 2020.²⁶ Kennebec County is also home to a range of other health care clinics, including a large outpatient medical center owned by MaineGeneral.³⁷

We spoke with Amanda Brown, a birthing nurse at Northern Light Inland Hospital who founded and facilitates the Tree of HOPE.

Organizational overview

Tree of HOPE is a perinatal mental health support group run by Northern Light Inland Hospital in Waterville, Maine. The group is geared toward parents who may be experiencing depression, anxiety, and/or any perinatal mood disorder within pregnancy or in the postpartum period.³⁸ The COVID-19 pandemic pushed them to transition from in-person gatherings at Inland Hospital, to virtual weekly Zoom meetings (a format the group still maintains). Tree of HOPE welcomes all those experiencing perinatal mental health challenges in rural Maine to join their group – they are not required to receive prenatal care or give birth at Inland Hospital. In addition, participation can come from any parent (not just the parent who gave birth); partners can choose to join as either support for their birthing partners or for their own mental health needs.

The group began when Amanda Brown, a local labor and delivery nurse, recognized the need for more postpartum support in her rural community. This recognition was personal: after giving birth to her daughter in 2014, Ms. Brown immediately knew something felt “off.” She had been eagerly anticipating this baby, and had cared for other expectant parents throughout the perinatal period, but nothing about her motherhood experience felt like she thought it would. Brown knew about postpartum mental health issues, but had never known anyone who experienced them personally, and did not have a history of mental health issues. Not feeling how she expected to feel was tremendously challenging, Brown said.

“I was taken aback by the lack of connection I had and how overwhelmed I was with intrusive thoughts sucking the joy out of motherhood.”

For Brown, bottling up these thoughts and feelings without intervention snowballed into postpartum psychosis and admission into a mental health facility. After a short inpatient stay, and with the ongoing support of her family and friends, Brown’s experience improved.

When she returned to work, she knew she needed to do something to ensure that other postpartum people did not have to suffer as she did. Brown expressed her frustration at the lack of support for postpartum patients to her boss, who, at the time managed the birthing center at Inland Hospital.

“We have to be talking about the challenges some of our patients are experiencing. We have to help them.”

Her boss agreed, and Tree of HOPE was born.

Key features

Tree of HOPE has been offering support to postpartum parents since 2016. While annual reach ebbs and flows, the group has served up to 200 patients per year. Brown, certified through Postpartum Support International on Perinatal Mood Disorders,³⁹ is currently the only facilitator of the group; she is compensated for her work by the hospital. She is motivated by a desire to support patients and families through their perinatal journey. Her goal is to reach patients and their families to educate them about perinatal mood disorders so that they are empowered to recognize when something is not “right.” For some, all they need is a support group where they can, as Brown describes,

“...share the good, the bad, and the ugly with other moms, and help normalize their feelings and experience of motherhood.”

Others may benefit from additional help, through prescription medication and/or therapy, available at the hospital. Tree of HOPE shares resources and helps those who seek additional support connect to mental health providers or social workers within the Northern Light system. In addition, Brown is the Postpartum Support International (PSI) coordinator for the state of Maine. PSI is a worldwide organization dedicated to families suffering from postpartum depression, anxiety, or distress; they have offices in each of the 50 U.S. states, and provide virtual support groups and service recommendations.⁴⁰ Whether or not they attend Tree of HOPE meetings, or are patients at Northern Light, postpartum patients can connect with Brown through her role with Maine PSI and access resources, such as one-to-one virtual peer support, therapists who specialize in maternal mental health, specific support networks (e.g. for infant loss), and more.⁴¹

Brown is also passionate about educating the clinicians who care for perinatal patients about how to respond to patients struggling with their mental health, and raising awareness of Tree of HOPE as a resource. To do this, she maintains a growing list of clinician contacts, and has spoken to several clinics and hospitals both in the Waterville area and throughout rural Maine. Brown described the importance of nonclinical frontline staff, too. She noted, for example, that if a patient or their family member calls in describing intrusive thoughts, or suicidal ideation, they should be helped immediately, rather than having to wait for a call back.

Challenges and opportunities

Inconsistent group attendance can be a challenge. Even a small handful of patients in attendance can offer opportunities for great connection and resource sharing, but if only one patient shows up, it is difficult to facilitate conversation. Transportation has also been a struggle for patients, although transportation to group meetings is no longer an issue since transitioning to a virtual format. For patients who need care beyond peer support, finding therapists covered by their insurance company can be a hindrance to getting care. If a therapist does not take their insurance, or any insurance, patients might be asked to pay out-of-pocket, which Brown notes can be cost-prohibitive:

"What person in rural Maine can afford a \$200 therapy appointment, especially when they just had a baby?"

In addition, while many local health care providers refer to Tree of HOPE as a resource, there is still lack of knowledge or support from other clinicians. For instance, Brown discussed a patient who shared that she filled out a questionnaire about their depressive symptoms, but nobody followed up about what it meant, or shared existing resources, such as Tree of HOPE. While she eventually made her way to support, the connection to care could have been more direct. More area clinicians are prescribing medications to treat perinatal depression in their patients, which Brown sees as a positive step, but that there are other useful resources like peer support or one-on-one support that can be key in a patient's postpartum journey to improve their mental health. She hopes to continue to spread the word about Tree of HOPE, so that any provider who sees a patient struggling has it as a resource.

Despite these ongoing challenges, Brown remains

passionate, driven by the patients and families who count on Tree of HOPE.

"Postpartum mood disorders are 100% treatable with help. I wish I could scream that off the rooftops. There is hope!"

Brown notes a growing social media influence, and looks forward to a growing number of educational and awareness opportunities this year. She eagerly anticipates their annual Climb Out of the Darkness event, which raises funds and support and reduces stigma around perinatal mood disorders.⁴² Increasing attendance at the event, she hopes, will also connect patients around postpartum health, and raise awareness about Tree of HOPE.

Case #4: The Nurturey – Marshall, MN

Rural community context

Marshall is a Midwestern farm town in Lyon County, Minnesota, about 150 miles southwest of the Twin Cities. Marshall is a college town home to Southwest Minnesota State University (SMSU), which enrolls 6,700 students each year.⁴³ Marshall's medical facilities include the Avera Marshall Regional Medical Center, which has a family birth center. Marshall is home to Schwann's frozen food company, a regional retail company Running's Farm and Fleet, and a corn wet-milling facility. Demographically, Marshall is primarily non-Hispanic White (76%), with 9.2% Hispanic/Latino, Asian (6.3%), Black or African American (5.1%), and multicultural populations.⁴⁴

Lyon County health rankings place the population at the higher middle range of counties in Minnesota, with a few exceptions. The county has higher than Minnesota average rates of smoking, obesity, and alcohol-impaired driving deaths. Teen birth rate is slightly higher than the state average. The rate of low birthweight among newborns is lower than Minnesota on average (5%). There were 338 births in Lyon County in 2019.²⁶

We spoke with The Nurturey founders, Jenna Erickson (RN, IBCLC) and Jess Dressen (LPN, IBCLC).

Organizational overview

As a labor and delivery nurse, Jenna Erickson was familiar with maternal health experiences in the community when she became pregnant. After the birth of her first child in 2019, she struggled to identify resources and thought the community needed more support



for the transition to parenthood in her area, especially for support services. Erickson became an Internationally Board Certified Lactation Consultant (IBCLC) and postpartum doula, and began doing home visits part-time with local community members in January 2020. After connecting with fellow postpartum parent, Jess Dressen, the two teamed up to begin a postpartum breastfeeding support group during and after their second pregnancies. Initially meeting with other new parents at a chiropractic office, then a church, the two eventually began doing lactation consulting home visits together. As they started to see more families throughout a 60-mile radius, they realized the scope of need for education and early support. The duo has branched out to include pregnancy and postpartum doula services to support families throughout the region. They receive private pay, Medicaid, and commercially insured clients.

The Nurturey, based downtown Marshall, MN, opened its doors in August 2021 to provide a community space for residents of the region to access lactation and postpartum support services. It is a non-hospital affiliated small business. The Nurturey evolved out of the founders' own experiences with lactation and postpartum care during their own pregnancies and postpartum experiences.

Key features

With a physical office space in Marshall, MN, The Nurturey started to offer group visits and drop-in hours in August 2021. During drop-in hours (Mondays 3-6 pm), clients can connect with other parents, speak with lactation consultants to receive advice around lactation concerns, and get other postpartum questions answered. The center also offers childbirth and feeding classes, as well as an "all-purpose" postpartum free support group, which meets twice a month, the 2nd Wednesday and the last Saturday, from 10am-12pm.

The Nurturey continues to offer lactation home visits, which they consider their most popular service. Erickson and Dressen are both trained to offer birth and postpartum doula support services, which they incorporate into all program areas. During a lactation appointment, Erickson noted,

"...we're with the mom for a long time. We have time to ask 'How are you doing?' and 'What else can I help you with?' which opens the door to other ways of supporting the family. We're trying to build community. With the office, we've been able to do more

group activities, and helped moms connect with one another."

As a start-up operation, The Nurturey is funded primarily through private insurance reimbursement for lactation consulting services, but recognizes that this creates a barrier for some community members, which prompted the Nurturey to offer drop-in hours as a no-cost/donation basis and created a sliding scale fee for Medicaid recipients to receive 40% off the standard rate for services. About 20% of the Nurturey's clients are on Medicaid. The Nurturey receives a flat-rate fee for up to six home visits on average, through a partnership with The Lactation Network, a Chicago-based firm that coordinates the insurance billing process for The Nurturey clients. This service model covers services for 40-50% of their clients. The remaining 50-60% of families pay out of pocket.

Challenges and opportunities

A key challenge in the community is identifying resources. While there are programs in the county that work to support families (including the WIC office, county public health home visiting program, and hospital prenatal care), it can be isolating for postpartum people to find supportive resources in the community. Erickson shared during our conversation in November 2022 that some of their clients come from more than an hour's drive away. It can be isolating to experience lactation challenges.

"Sometimes by the time people get to us they have already struggled so much. If we were in a bigger area, would that have been the case?"

The Nurturey values their role in fostering community, and partners with other agencies to grow the visibility of the network surrounding postpartum services, and the transition to parenthood, in the region.

Another key barrier is insurance coverage. The Nurturey is able to bill a few insurances through their connection to Lactation Network, but for families whose insurance falls out of the participating providers, the services may be unmanageable for those who pay out of pocket. An initial visit is \$150 and a home visit is \$200, while follow-up appointments are \$90 in office, or \$140 at home. Their classes range from \$50-250. If the Nurturey was able to take and bill for all insurances

and get reimbursed from insurance carriers at a decent rate, that would open up services to a lot more to people who need it. The administrative infrastructure required for health insurance reimbursement is financially and logistically burdensome to small organizations.

Lactation services are frequently the entry point for clients from community, but the Nurturey's postpartum involvement does not end there. Erickson and Dressen want to be accessible resources to families in the area.

"We say after a visit you have unlimited email and phone support for two weeks. It's a much more comprehensive service than what is typical from a medical office."

The Nurturey values their role in creating community connections and a network of individuals who have given birth in the area. While no longer breastfeeding/body feeding, one group of participants continues to connect through a knitting group at the Nurturey.

The founders recognize that the success of the Nurturey is a result of their educational backgrounds and strong family support systems. Their funding mechanism for lactation services relies primarily on private insurance, and their business model would not likely be sustainable without the substantial privilege the founders have leveraged. Erickson shared,

"If I were in a position where I needed to bring in a fulltime income, this wouldn't cut it, but in our area, there aren't a lot of other options for getting lactation and postpartum support."

The value of community-based spaces to discuss postpartum care continues to drive their commitment. Rural providers are referring clients to the Nurturey, and their childbirth classes have full attendance. One thing that encourages Erickson, in her own words, is "Our name is out there." She has seen growth in community awareness around postpartum concerns, including isolation, through social media and growth in program participation. Each of these factors motivates Erickson and Dressen to continue to advocate and provide services for postpartum individuals in Lyon County.

Flathead County, MT

Rural community context

Whitefish, Montana is a mountainous community located near Glacier National Park in northwest Montana. The town is one of only three in the entire county of Flathead, which occupies 5,098 square miles and is home to about 108,000 people.^{45,46} The U.S. Census Bureau describes the county as 92% non-Hispanic White.⁴⁶ Flathead County has a higher unemployment rate than state average, with the main industries being tourism and recreation.^{45,47} Overall, Flathead County ranks high in terms of overall health, as seventh of 56 counties in Montana. The county has higher particulate matter causing air pollution than the state on average, but is otherwise on-par with state rates of health behaviors and outcomes.⁴⁷ In 2020, Flathead County saw 1,068 births.⁴⁸ The county houses a regional hospital (Logan Health Medical Center), which has an obstetrics unit, a midwifery family healthcare practice, and several clinics.

We spoke with Brooke Jaszczak, the Network Director of Postpartum Resource Group.

Organizational overview

The Postpartum Resource Group is a non-hospital-affiliated, community-based postpartum mental health support group that was founded in 2016 by a midwife who created a support group with her patients. She recognized the need for such support based on both professional and personal experience, as she was also experiencing postpartum mental health challenges at the time. As the group supported one another through the transition to parenting, the program grew. The group eventually transitioned to a board leadership structure, and incorporated as a 501(c)(3) charitable organization in 2019. The organization receives local and federal grants, and two local, annual fundraising events. The group continues to run monthly gatherings/support groups in four locations across the Flathead Valley.

Key features

The Postpartum Resource Group's main goal is to build community support around postpartum individuals with perinatal mental health conditions. Their mission is two-fold: to provide support, education, and resources for mothers and their families who are experiencing postpartum mood disorders, and to educate and inform the community and providers about postpartum mood disorders.⁴⁹ Through referrals from mental health providers and physicians in the area, the Postpartum

Resource Group provides postpartum doula home visits and care network services to clients throughout the Flathead Valley free of charge to participants. They also provide peer support groups with trained facilitators, which they refer to as “Circles.” These circles are peer-led by participants who have lived experience with postpartum mood disorders. These free groups are currently offered at four different locations: The Circle-Kalispell at a local primary care clinic, The Circle-Whitefish at a yoga studio, and The Circle-Columbia Falls at a wellness studio. One group in Kalispell focuses specifically on perinatal loss and grief. The group supports parents generally up to one year postpartum, who are at risk of, or have, a postpartum diagnosis.

Challenges and opportunities

In the Flathead Valley, many local residents struggle to afford basics like housing, food, childcare, and health care due to rising costs. Located near Glacier National Park, the region experienced a population increase during the COVID-19 pandemic, as people moved there to work remotely. The service industry workers were priced out of housing and health care, and a rationing of care and preventive services resulted due to their limited resources. Furthermore, the population is very spread out. Between winter weather and poor driving conditions through the mountain passes, it can be difficult to access areas of the community, its resources, and clinicians.

Due to this remote isolation, the region has inconsistent mental health crisis management protocols for responding to mental health concerns. If a Postpartum Resource Group doula goes into a home and there are wellbeing concerns, there are not clear steps for accessing higher acuity services or supports. A common concern among Postpartum Resource Group doulas is assessing how to support families in accessing resources on their own. Doulas are trained, but have other jobs, their own families, and they cannot regularly spend 12 hours a day with each client.

Postpartum Resource Group has seen a wide range of postpartum experiences and views their role as contributing toward reducing stigma around mental health services. Clinicians, grant-making organizations, and local community partners now have greater awareness of maternal mental health challenges because of the Postpartum Resource Group awareness raising efforts within the Flathead Valley to reduce stigma around mood disorders. Representatives from Postpartum Resource Group present to local labor and delivery staff (including obstetricians, midwives, and Labor and De-

livery nurses), social services, and local high school social workers and nursing staff. The educational efforts of board members and former participants around doula services and perinatal mood disorders in Flathead Valley has brought attention and resources that have supported the receipt of grant funding.

Case #6: Family Connects – Lincoln County Public Health, OR

Rural community context

Lincoln County is a coastal county in Oregon, and home to 44,500 residents.⁵⁰ The county is a popular tourist destination for its scenic views and resorts, and is known as “the whale watching capital of the world.”⁵⁰ Newport, the county seat, is known as an oceanography research center.⁵⁰ The vision of Lincoln County Public Health is to have “A thriving community of active, healthy people of all ages, abilities and cultures who are living, learning, working and playing together in a safe environment.”⁵¹ Yet County Health Rankings place Lincoln County in the bottom 25% of Oregon on overall health and quality of life.⁵² The county has a higher-than-state-average teen birth rate (even higher among Hispanic population at 30 per 1000 births). In addition, the primary care physician to resident ratio is one per 1,850 individuals in Lincoln County, Oregon (state average is one per 1060). Child poverty is higher than state average at 20%. The county is home to a notable Hispanic/Latino immigrant population, and the county demographics feature 81% Non-Hispanic White, 2% American Indian & Alaska Native (non-Hispanic), 5% multicultural, and 9.4% Hispanic population, including Indigenous Guatemalan population in the area.⁵³

Two hospitals in the county serve the population: Samaritan North Lincoln Hospital, an accredited critical access hospital with a family birthing center, and Samaritan Pacific Communities Hospital. The county is considered to have full access to maternity care by March of Dimes maternity care deserts Dashboard, and in 2019 saw 370 births.²⁶

We spoke with Breeze Powell, Maternal Child and Family Health Program Manager with Lincoln County Public Health.

Organizational overview

The Maternal Child and Family Health program within Lincoln County Public Health offers five different home visiting opportunities for families during pregnancy and postpartum in addition to the Special Supplemental Nutrition Program for Women, Infants,

and Children (WIC). These programs include Parents as Teachers, CaCoon (in partnership with Oregon Health and Science University-OHSU), Babies First Home Visits, Nurse Family Partnership, and Family Connects. Each program provides visits for parents and families to support healthy child and family outcomes, dependent on state-defined criteria. While many of these focus on strength factors and healthy child development, the Family Connects program is a postpartum home visiting program that emphasizes assessment on maternal and child health outcomes and referrals. In 2017, the county began implementing The Family Connects Home Visiting model. When the Oregon Legislature passed a law in June 2019 mandating the launch of a statewide home visiting program for families with infants, Lincoln County became part of the statewide early adopter sites in 2020 for universal home visiting programs along with Benton and Linn Counties.⁵⁴

Key features

In 2017, Lincoln County Public Health was Oregon's first implementing partner of Family Connects, a home visiting model focused on postpartum assessments for parents and newborns in the first few months of life. The successful implementation of Family Connects in Lincoln County in its early years gained statewide attention, and contributed toward state legislature approval for ongoing funding to implement a universally-offered home visiting program using The Family Connects model. During a home visit appointment, a nurse home visitor meets with the postpartum parent to conduct a comprehensive questionnaire that identifies priority areas for additional supports. Questions pertain to parent and infant health, including family physical and mental health needs, and assesses the family's social determinants of health. The survey aids the nurse home visitor in identifying opportunities for social service supports and other community-based resources for the family. One to three visits typically occur between 3-12 weeks postpartum.

After assessing needs across key determinants of health, families are connected with community-based referrals, and later receive a follow-up call to check in on additional referral needs. Many of the families that start in Family Connects, opt to continue into one of Lincoln County's longer-term home visiting programs, which use the Parents as Teachers, Babies First and CaCoon models to provide ongoing family enrichment. Powell shared,

"Many families don't learn about our oth-

er programs during pregnancy, so Family Connects is an opportunity to share about these other programs and assess eligibility."

Because Family Connects is universal and can be offered to everyone regardless of risk factors and income, it serves a unique role in the community.

"Not everyone needs a long-term program so for some families the short-term support that Family Connects offers is perfect."

Different from other home visiting programs, Family Connects uses a standardized community alignment approach to identify community resources and supports, beyond the individual family, to address gaps in services more broadly. The insights from these questionnaires are used to pragmatically address community needs through an engaged Community Advisory Board (CAB), which consists of community partners and former home visiting clients.

Lincoln County sees many non-English speakers in the home visiting caseload, including Indigenous Guatemalan families. With the support of an interpreter in 2022, Lincoln County completed 607 home visits. To support the needs of this community, Lincoln County employs a community health worker who is bilingual English/Spanish and a staff interpreter who speaks Mam (a dialect of the Guatemalan Indigenous community).

Challenges and opportunities

The cost of living for county residents can be a challenge. The region serves as a tourist and retirement destination. Differences in access to healthcare and affordable housing for immigrant populations and the tourism workforce compared to wealthier tourist populations increase challenges for less-resourced subsets of the population. Outside of the Newport Township, transportation access poses another challenge. Lincoln County is approximately 1,000 square miles. There is one county transit system and hours are not very flexible. Many families do not have vehicles and this makes accessing healthcare services very challenging. The county covers a vast geographic area and is considered rural. Due to this, primary, prenatal, vision, and dental providers are scarce due to small township sizes and population fluctuations

as a tourist destination. Many of the specialty care providers are anywhere from 1.5-3 hours away from Lincoln County. Breeze Powell, the Maternal Child Health Program Manager of Lincoln County Public Health, shared,

“Despite the challenges, we still have a lot to offer. We are one of the biggest home visiting programs in the state,”

in terms of variety of home visiting models provided to residents in the area. Lincoln County Public Health has a robust and engaged network of community-based resources throughout the county. Through quarterly community advisory committee meetings, the group members verify operations and build relationships with existing community resources, and collaborates to identify additional resources as they become known. Strong partnerships with specialized community resources further promote community wellbeing. Related to prenatal and postpartum-based resources, the county collaborates with Nurture Oregon, which offers wraparound care for pregnant and postpartum people in substance-use disorder treatment/recovery, and the nearby tribal home visiting program. Providers and community agencies outside of public health are highly supportive of home visiting and postpartum care and health. Community Advisory Board consists of 30 active members representing local medical providers, early intervention specialists, WIC staff, Early Learning HUB staff, Housing Authority, local school districts, and others.

Powell attributes the strength of this network to staff continuity in the home visiting program and supportive state and local leaders in public health. Home visiting staff have deep knowledge of the Family Connects model, experience, and connections with community that builds trust with families and encourages program retention. Specifically, the Family Connects program has strong relationships with the two local hospitals, which allow bedside recruitment of Family Connects nurses and program support staff to meet consenting clients postpartum for program enrollment. This key moment of connection greatly increases the rates of family engagement in the Family Connects program.

As the Maternal and Child Health section of the Oregon Health Authority works to proactively support preventive visits through a universal screening and referral model, Lincoln County Public Health has experienced reimbursement delays. The local health department has worked closely with the state to set equitable reimbursement rates for intensive home visits and is actively sup-

porting negotiations with Medicaid and commercial payers (under a unique state pilot program)⁵⁴ to reimburse for these visits. The demonstrated results from an evidence-based program show the strength of the model and recognizes the window of opportunity for connecting clients to services.

Case #7: Family Solutions (South Carolina Office of Rural Health) – Lexington, SC

Rural community context

This project supports families in five rural counties in South Carolina: Allendale, Bamberg, Orangeburg, Hampton, and Barnwell, all of which border Georgia in the southwestern part of South Carolina. Allendale ranks 45th of 46 counties in South Carolina in health, with high rates of adult smoking (25%), adult obesity (46%), and teen births (39 per 10,000 female population ages 15-19).⁵⁵ Social and economic contributing factors include 45% children in poverty (compared to 19% state average), and twice the state rate of children in single-parent households (66% compared to 31%). The other counties similarly rank in the bottom 14 across these social factors.⁵⁶ County Health Rankings describes these counties' variable clinical care access as contributors to the poor health rankings. Among Orangeburg, Bamberg, Barnwell, and Hampton counties, the primary care physician to patient ratios are 1:2,200 or greater (1:5,200 in Barnwell). This extends to dental care and mental health, as well as obstetrics. Across the state, only 55% of rural counties had hospital Obstetric services in 2014.⁵⁷ More recently, despite a population of more than 16,000 women between ages 16-49, only one hospital with obstetric services exists within these five counties, only 1,537 total births occurred in 2019.²⁶

The residents of these counties are predominantly Black or African American. Allendale has seven times more Black residents than any other race or ethnicity (85%), and 12% non-Hispanic white.⁵⁸ The Public Use Microdata Area (which includes Allendale, Bamberg, Orangeburg, Hampton, Barnwell, and one additional county) five largest demographic groups are Black or African American (Non-Hispanic) (54.3%), White (Non-Hispanic) (40.2%), Two+ (Non-Hispanic) (1.5%), White (Hispanic) (1.2%), and Other (Hispanic) (1.13%).⁵⁹

We spoke with Lamikka Samuel, LMSW, Director of Family Solutions, and certified CHW, and Tracy Golden, Senior Program Manager and certified CHW.

Organizational overview

The South Carolina Office of Rural Health (SCORH), in 1997, acquired funding from Health Resources and Service Administration (HRSA), to implement a Healthy Start initiative to address high rates of infant mortality in this rural region compared to the national average. SCORH is a federally designated non-profit organization charged with addressing health needs in rural communities. SCORH provides technical assistance to healthcare providers, advocates for rural-friendly policy, and offers a variety of health and education programs to support the local health and wellbeing of South Carolina's rural communities.

Family Solutions began as an initiative to implement the federally funded Healthy Start program, and has successfully maintained funding for 25 years, serving families from pregnancy through 18 months postpartum. Family Solutions expanded over time to also run a Nurse-Family Partnership program (through MIECHV) and a locally funded Healthy Steps clinical education program, which monitors developmental milestones for children zero to three years and is housed with a specialist at a rural health pediatrician's office.

In 2021, the Family Solutions team piloted a Post-Pregnancy Centering Group to address postpartum health topics in cohorts of rural residents with births around the same time. This program focuses on participants' physical and mental health during the first twelve-months postpartum. During monthly meetings, participants talk about their mental health and receive lessons on various postpartum health topics.

Together, these programs make up Family Solutions and collectively aim to reduce infant mortality and eliminate disparities in perinatal health. In 2021, Family Solutions served approximately 520 families.

Key features

Family Solutions features an intentional collection of programs that provide targeted infant mortality prevention activities. The organization's staffing includes nurse practitioners, social workers, lactation consultants, childbirth educators, reproductive life specialists, community health workers, doulas, and infant health specialists. This robust staffing allows for an internal referral system that easily responds to clients' needs.

Family Solutions targets families deemed at highest risk for infant mortality. They review a number of factors in determining program eligibility, including ZIP code and whether someone is a first-time parent. Referrals are received from local obstetric providers, Medicaid managed care organizations, the local health departments, schools, community organizations and

also self-referrals. Participants are considered if they live within the service area counties of Allendale, Bamberg, Barnwell, Hampton, and Orangeburg. Participants are enrolled in the Nurse-Family Partnership if they have not yet reached 28 weeks gestation and their first viable pregnancy. Participants receive nurse home visiting through 18 months postpartum. Participants enroll in Healthy Start regardless of gestational age and pregnancy history. Healthy Start serves all five counties of the service area. These services are free to all participants, and insurance is not a factor. These are voluntary programs so participants can decide to enroll or terminate services at any time.

Family Solutions' post-pregnancy Centering program (group postpartum care) is a supplement to other programming, run by a nurse practitioner to bring added value to mothers in the Nurse-Family Partnership and Healthy Start programs. During these group meetings, facilitated by a nurse practitioner, the group discusses general postpartum self-care, hypertension, and other topics related to postpartum health. It is important to the Family Solutions program to provide a space for participants to discuss what their bodies are going through and learn about different health topics.

An important topic of these groups is healthy fatherhood, and partner involvement in parenting. It is not uncommon in the region for young mothers to parent on their own. This program recognizes the role of male partners, and supports fathers with parenting skills and interpersonal skills to cultivate strong relationships with their infant and their infant's mother.

Challenges and opportunities

Over its 25-year program history, the Family Solutions team notes that local infant mortality rates have declined. In 1991, rates of infant mortality were between 1.5 and 2.5 deaths per 10,000 births in the counties involved, and there has been just one infant death in the past five years in the region. According to the interviewees, the longevity of this program is due to the strong track record of partnering closely with the state and human services department, local community, and involvement in other initiatives related to perinatal health.

Each year, the Family Solutions program hosts an infant mortality awareness and scholarship luncheon. The purpose of this event is to raise awareness in the community about women's health and pregnancy, and to have a public dialogue about infant mortality. Family Solutions also awards scholarships to participants of the program who wish to continue their education. In Sep-

tember 2022, the program celebrated the success of one family that participated in the program 20 years ago, by offering a scholarship to one of their infant participants who is now a student at South Carolina State University.

Case #8: Perinatal Mental Health Initiative—Columbia River Gorge, WA

Rural community context

The Columbia Gorge region spans both sides of the Columbia River: Washington's Skamania and Klickitat Counties along the northern border, and to the south: Hood River and Wasco Counties in Oregon. The region is known for its dramatic landscape of beautiful canyons and lush forests. Even with Portland's relative proximity, life feels remote in the Gorge. Skamania and Klickitat counties face rates of physician and mental health provider shortages, adult smoking (17%) and obesity (1 in 3), and other poor health outcomes higher than the state average for Washington.^{60,61} Skamania County is considered a maternity care desert, with no access to a hospital with obstetric care or any obstetric care providers within the county.²⁶ Klickitat County has better access to maternity care, yet the county hospitals do not offer obstetric services within the county. In 2019, there were 300 births between the two counties. Maternity care services are more accessible in Hood River and Wasco Counties in Oregon (one hospital provides obstetric services in each; 500 births in 2019),²⁶ but traveling across the river poses unique transportation challenges for some.

Skamania County residents are majority non-Hispanic White (87%), with smaller proportion of multiracial (2.4%) and American Indian and Alaska Native (1.8%) residents. Approximately 7% of the people in Skamania County are Hispanic. Klickitat County has similar demographics, with 12% Hispanic residents, and 82% white (non-Hispanic) residents.⁶²

We spoke with Anna Coughlin and Chelsea Ruder, the Program Coordinators of Perinatal Mental Health Initiative.

Organizational overview

The Perinatal Mental Health Initiative was started by the Program Coordinators after a community needs assessment recognized a gap in screening for postpartum depression in the Columbia Gorge region, and after funding became available through Perinatal Support Washington. Prior to the Initiative, the rural community only had one specialist trained to treat perinatal mood disorders. In 2021, the Perinatal Mental Health Initiative began to develop concrete supports for pro-

viders and clinicians with training around postpartum screenings to refer parents to. These support groups are facilitated by community members trained as peer support specialists and have lived experience with perinatal mental health to address local gaps in perinatal mental health care.

The Perinatal Mental Health Initiative is funded by the Department of Children Youth and Families (DCYF) in Washington State.⁶³ This rural-focused recipient of perinatal mental health services in the state of Washington, but they also serve segments of the northern Oregon Columbia Gorge region. The program also receives funding from a local coordinated care organization to support the leaders on the Oregon side. The organization is seeking greater sustainability to expand their efforts beyond the DCYF grant duration, and has received additional funding from local sources including the Maternal Child health Project through the Columbia Gorge Council and Klickitat Community Link Project. Community Enrichment of Klickitat and Skamania County (CEKSC) serves as a fiscal sponsor.

The Perinatal Mental Health Initiative is managed by two community-based maternal health advocates. Coughlin is a certified lactation consultant (IBCLC) and works for the Klickitat County Health Department for the WIC and Maternity Support Services. Ruder is a public health employee with Oregon Health and Sciences University. When asked about how their initiative got started, Coughlin and Ruder shared that their individual perspectives working in maternal health allowed them to see the scope of the gap in perinatal mental health in their broader community.

Key features

The Perinatal Mental Health Initiative supports individuals from pregnancy through their infant's second birthday. The program focuses on families and provides mental health support and lactation consulting through weekly perinatal mental health support groups. The program quickly grew in its first twelve months to offer three support groups in the area that offer in-person space to discuss their experiences with perinatal mental health, in Stevenson, WA, Bingen, WA, and The Dalles, OR. There is strong community buy-in and interest from a variety of professions that serve families in the region.

The Perinatal Mental Health Initiative also engages with providers through clinical support efforts via a task force. Ruder shared,

"Providers and clinicians in the region are severely overburdened, and we want to make sure that they have the proper training and tools to adequately screen and refer birthing patients"

In 2022, the program hosted a training with community partners, including clinicians and social service agencies, Community Health Workers, and others, about perinatal mood disorders, the importance of screening, and flagging key groups to refer patients in an effort to facilitate greater collaboration across the community. The training was successful at educating and increasing confidence of eighteen providers in the community about perinatal mood and anxiety disorder screening, and they intend to host a similar session again in 2023. In this program year, they are also starting a bilingual Spanish/English support group, which will be run by a trained bicultural parent, and a one-to-one peer support program to offer individualized support to folks who either cannot get to a support group or prefer this structure better than a group setting.

Challenges and opportunities

As a newly started initiative, the Perinatal Health Initiative and its founders are motivated by community buy-in to develop a more robust collaboration across community partners for perinatal services. A wide variety of service providers are committed to addressing perinatal mood disorders. Key challenges for community members to participate in the Perinatal Mental Health support groups are stigma related to mental health and transportation barriers across the region. This project utilizes local connections and social media presence to promote support groups and referral services on a peer level. Shared Ruder,

"We're starting to get traction and be recognized in this work, and the support groups have been encouraging as they move forward. So many things can contribute to the issues of maternal mental health."

Ruder told us that she and Coughlin are motivated by the flexibility of their program model to adapt to the specific needs of the participants to help make connections to other resources in the community.

"A lot of people likely feel that they are alone with their intrusive thoughts, but building a community and realizing you aren't alone in those feelings...a lot of families have been able to support one another while discussing the needs they identify in the support groups"

Conclusion

In order to improve postpartum health in rural communities, it is important to understand and describe the existing local supports available, and the health needs and access challenges for parents and families during an important life transition. This case series highlights eight distinct examples of rural organizations working to support postpartum parents and families in their local communities.

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