Albert Schweitzer Fellowship Final Report: Expanding UMMS Prenatal Partners

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Program: University of Michigan Medical School Prenatal Partners
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1. Background and Project Evolution

Prenatal Partners is a student-led initiative at the University of Michigan Medical School that pairs pregnant patients who do not have strong social support systems with medical student partners. These partners offer emotional support, help patients process pregnancy-related information, and accompany them to appointments when appropriate. The program was originally developed through the University of Michigan Hospital's Maternal Fetal Medicine clinic, where it served patients with high-risk pregnancies. From the beginning, the program was designed to respond to an important gap in care: the reality that pregnancy can be especially isolating for patients who are dealing with limited family support, language barriers, financial strain, or other social stressors.

My original ASF application proposed expanding Prenatal Partners to several community sites in Washtenaw County, including Ypsilanti Family Medical Center, Chelsea Clinic, and Packard Health. That original plan was rooted in the belief that the model could help support pregnant patients more broadly across the county, especially in settings serving marginalized communities. I entered the fellowship with a clear goal of building durable clinic relationships, implementing the program at one or more new sites, and creating a model that could remain in place well beyond the fellowship year.

As the year unfolded, that original plan changed in important ways. It became clear early on that trying to build relationships at multiple sites at once would make it harder to establish any one partnership well. After several initial attempts to connect with Packard Health stalled along with no success in connecting with Chelsea clinic, I shifted the project to focus more intentionally on Ypsilanti Family Medical Center. This change allowed me to build a more stable, thoughtful relationship with the clinic team there rather than stretching my attention across too many places at once. That pivot was not a sign of failure so much as a recognition that implementation work often requires patience, flexibility, and willingness to follow where real momentum exists.

By August 2025, that decision paid off. Ypsilanti Family Medical Center became the main site for implementation, and the program officially launched there on August 22. Instead of integrating into the EHR system, which would have created unnecessary complexity, I worked

with clinic leadership to develop a referral process based on flyers with a QR code linked to my contact information. This approach kept the process simple for staff while allowing patients to choose whether they wanted to engage directly with the program. It also reflected a principle that became increasingly important to me throughout the year: patients should be able to opt into support in a way that preserves their autonomy and dignity.

2. Goals and Accomplishments

My initial goals for the fellowship were to build new clinic partnerships, develop a clear intake workflow, recruit and support medical student partners, and create a sustainable model that could continue after the fellowship ended. I also wanted to ensure that the work remained grounded in the needs of the patient population rather than in the preferences of the organization alone.

In many ways, I achieved the structural goals I set out to complete. I secured a partnership with Ypsilanti Family Medical Center and helped establish a referral workflow there. I recruited new student partners, including first-year students and returning third-year students, to ensure the program would have enough support as older partners moved into clerkships. I also reached my target of 100 service hours through patient interactions, appointment support, and ongoing communication with partners. In addition, I was able to help refine the referral and enrollment process as the program moved from planning into active use.

At the same time, the project also revealed how difficult it can be to translate a good idea into a functioning program. Building relationships with clinic staff took longer than expected. Communication slowed down during some of my busiest clinical rotations. Several referrals did not result in enrollment. These moments were frustrating, but they were also instructive. They clarified where the main barriers were and gave me a better understanding of what it actually takes to create something sustainable in a real clinical environment.

3. Referral and Enrollment Process

Over the course of the fellowship year, the program received five referrals. Of those five, three ultimately dropped off and two became active enrollments. One of the enrolled patients has already been paired with a Spanish-speaking medical student, and the other is actively being paired now. That pattern gave me a clearer picture of where the referral process was working and where it still needed improvement.

The first referral fell through because the patient had a strong existing support system and did not feel the program would add enough value to her experience. She had her mother and fiancé closely involved in her care, and after several conversations it became clear that she did not feel she needed an additional support person. That referral was helpful because it reminded me that a patient being referred does not automatically mean that the program is the right fit for her. The

goal is not simply to enroll as many patients as possible, but to identify the people who would truly benefit from this type of support.

The second referral fell through because the patient decided to move back to Indiana to be closer to her parents. This one was especially meaningful because the clinic had identified her as a strong candidate based on her limited local support in Michigan. We spent time texting and trying to find a phone call time, and she seemed very engaged at first. But ultimately, her decision to move made it impossible for the partnership to move forward. Even though this referral did not become an enrollment, it still showed that clinic staff were beginning to recognize the kinds of patients who might benefit most from Prenatal Partners.

The third referral fell off because we were unable to make contact with the patient despite several attempts through different communication methods. This case highlighted a subtle but important issue: once a patient has been referred, there still needs to be a reliable and recognizable way to reach her. It is not enough for the referral itself to happen. The patient also has to feel confident that the outreach is legitimate and worth responding to.

The two active enrollments gave us the clearest sense of what successful implementation can look like. One of the patients who enrolled speaks Spanish, and we were able to reach her using Michigan Medicine interpreter services. I completed her intake survey by phone, and based on her preferences we matched her with a Spanish-speaking, female-identifying medical student partner. That match reflected the patient-centered nature of the program, since it allowed her to choose the kind of support person she felt most comfortable with. The second enrolled patient was contacted later and is currently being paired with one of the available medical student partners on our side.

4. Process Improvements and Program Structure

As the referral process unfolded, it became clear that communication itself was one of the biggest barriers. In some cases, patients were not recognizing calls or texts from medical students because the numbers did not look familiar. In other cases, patients were busy, overwhelmed, or uncertain about whether the program was meant for them. To address this, I created a Prenatal Partners Google Voice number with an Ann Arbor area code so outreach would look more recognizable and trustworthy. I also began using the patient portal as part of the referral process so patients could at least receive a message letting them know they had been referred, see the flyer, and expect a follow-up call.

This was not a perfect system, but it represented an important step forward. It helped reduce some of the friction that had been keeping patients from connecting with us after referral. It also reinforced a larger lesson about implementation work: many barriers are not dramatic or

structural in the obvious sense. Sometimes they are small, practical obstacles that add up over time and make it hard for a program to function smoothly.

The Ypsilanti Family Medical Center team also made important changes to support implementation from their end. Dr. Llanes began sending regular reminders to the nursing and midwifery staff, and we held an in-person meeting to answer questions and clarify the kinds of patients who were the best fit for the program. That meeting was a meaningful turning point because it moved the program from being an idea in the background to something that staff could actively consider in their intake conversations.

5. Service Hours and Student Involvement

My service hours were earned through a combination of clinic-based and program-based interactions. I remained involved with patients through the University of Michigan's Maternal Fetal Medicine clinic, where I supported three mothers in their third trimester who had recently been diagnosed with preeclampsia. In that role, I focused on health literacy and emotional support, often talking through educational materials and helping patients make sense of new information after difficult diagnoses. Because those pregnancies were in the later stages, our interactions were often weekly or even twice weekly.

One of the most meaningful moments of the year happened while I was on OB triage. A Prenatal Partners patient came in with concern for possible contractions, and I was able to interact with her both as a medical student on service and as her prenatal partner. She later told me how reassuring it felt to have someone familiar on her care team during a stressful moment, especially when she had to stay overnight after her family had already gone home. That experience made the mission of the program feel very concrete. It showed me that the presence of a trusted person can matter just as much as the clinical care itself.

The student side of the program also grew in a way that matters for sustainability. UMMS already has an established Prenatal Partners organization, and that structure has helped keep the program moving forward. Interest from students who want to become partners has remained strong, and several executive board members will continue supporting the project over the next few years. That existing organizational base gives the program a level of continuity that will help it survive beyond my fellowship year.

6. Evaluation and Impact

The impact of the project has been less about dramatic numbers and more about whether the infrastructure is beginning to work. By that measure, I believe the project has had real impact. Referrals are now coming in. Staff understand the program better than they did at the beginning.

Students are actively involved. The clinic has a referral workflow in place. And patients who are enrolled are beginning to receive the kind of support the program was built to provide.

The biggest measurable outcome is that the program moved from planning into practice. Five referrals may not sound like a large number, but each one revealed something important about how patients are identified, how they are contacted, and what makes them decide whether to enroll. Three referrals fell off, but each one gave us useful information. Two enrollments, meanwhile, show that the model can work when the referral and contact process align well.

I also think the project created a foundation for future evaluation. Once there are more enrolled patients, I would like to collect both numerical and qualitative data on patient satisfaction, partner engagement, and program impact. I would also like to explore whether creating a small group for mothers to talk with each other would be useful. That type of peer support could deepen the value of the program and help participants feel less alone in the pregnancy experience. Over time, I hope the program can generate enough data to support research on what kinds of support are most helpful and how the model might be improved.

7. Sustainability and Cost

One of the most important aspects of Prenatal Partners is that it has been a $0 program. No money was used to support medical student partners, and no one received compensation for participating. That made the program especially feasible to maintain, since the primary resources required were time, communication, and coordination rather than a large budget.

At the same time, it would still be possible to add small patient incentives in the future if that became helpful for recruitment or retention. So far, however, referrals have come in without incentives, which suggests that the program can function even in a no-cost model. That is encouraging because it means the core structure is already sustainable in a very basic sense.

Long-term sustainability also depends on the fact that UMMS has an established Prenatal Partners organization with active student interest and executive board support. I will continue in this role until I graduate medical school in May 2028, and I expect that continuity to help the program keep growing. The presence of students who already want to be partners, along with executive board members who will keep supporting the work, makes it much more likely that the program can continue to blossom over the next few years even after my fellowship ends.

8. Reflection on the Fellowship Experience

This fellowship was hard. It was tedious. It required more patience than I expected. A lot of the work happened in the spaces between visible milestones, and a lot of that work was slowed by communication barriers, clinic transitions, and the demands of medical school rotations. There

were months when progress felt almost invisible. There were also times when I worried that the project would stall completely.

What kept me going was resilience and mentorship. My mentors believed in the value of the project even when the process felt slow or frustrating. Their support mattered a great deal, especially during the periods when I was trying to figure out whether to stay with a difficult site or redirect my energy somewhere more promising. They helped me keep the long view in mind and reminded me that meaningful community work often takes time.

This fellowship also helped me think more clearly about the kind of physician I want to be. It reinforced for me that healthcare is not just about clinical facts or procedures. It is also about trust, communication, continuity, and the ability to make patients feel seen. The most meaningful moments of the year were often not the big structural achievements, but the small moments of connection: a reassuring phone call, a patient feeling supported overnight, a staff member recognizing the value of the program, or a student partner stepping into a role with confidence.

I will carry this project forward through the rest of medical school. My hope is that Prenatal Partners will continue to grow over the next few years, with more referrals, more student partners, and eventually more opportunities for mothers to support one another directly. I would also like the program to become a site for research that combines numerical and qualitative data to help us understand what patients actually need and how we can improve the program over time. In that sense, this fellowship has not felt like a finished project so much as the start of something that still has a lot of room to expand.