Postpartum Think Tank Meeting Summary
December 4, 2014

DRAFT

Meeting Goal, Objectives, Participants & Approach
The overarching goal of the meeting was to improve the health and wellness of new mothers and infants through enhanced utilization and quality of postpartum care, with a focus on the postpartum visit. The meeting objectives were to review the current state of research, need for and utilization of postpartum care; develop a systems-based, equity-infused approach to enhanced postpartum care; and apply expertise to develop action steps and recommendations to move this work forward.

The 41 meeting attendees represented four different stakeholder groups: clinicians, public health, consumers and policy and finance, with representatives from business and philanthropy also in attendance. Please see the participant list for a summary of attendees. The meeting was structured based on methodology utilized by the MCH Workforce Development Center to inspire systems-based, integrated thinking, led by Drs. Dorothy Cilenti and Kristen Hassmiller Lich. The meeting was organized by the Association of Maternal and Child Health Programs (AMCHP), with support from the W.K. Kellogg Foundation.

Setting the Stage
Dr. Sarah Verbiest provided an overview of the current state of the postpartum visit and care in the U.S. She highlighted that the current system of care is inadequate to meet the needs of postpartum mothers. It is under-researched, under-funded, and guidelines for comprehensive, quality postpartum care are lacking. She emphasized that this meeting will focus specifically on the fourth trimester of pregnancy (3 months postpartum), recognizing that we first need to do a better job with this sensitive period of time before we can broaden our efforts into interconception care. While the clinical postpartum visit is clearly an important encounter, Dr. Verbiest encouraged the group to think more broadly about work developed by Fahey and Shenassa (2013) that highlights the many tasks new mothers face as they transition from pregnancy to motherhood. In addition to physical recovery, mothers must also care for themselves, the infant, and their family, and also adjust to their new role, whether this is their first or fifth child. The skills that a woman needs to acquire in a short amount of time calls for increased collaboration between public health services, businesses, wrap-around clinical services and women’s advocacy groups to provide the needed external resources for a successful transition. The image below is by Fahey and Shenassa and highlights the complex tasks new mothers must achieve postpartum.
As experts have pointed out, there is a silent epidemic of suffering among new mothers who face fatigue, stress, physical pain, depression, breastfeeding challenges and other challenges, along with efforts to maintain healthy prenatal behaviors, such as tobacco cessation, as well as lose their postpartum weight and avoid rapid repeat pregnancy. Several studies suggest that postpartum women are not adequately prepared for specific postpartum physical and emotional symptoms, and that this affects the quality of their relationship with their health care provider. Further, 20-30% of new mothers do not receive a postpartum visit. There are questions about the timing of this visit, the type of services provided in a postpartum visit, the quality of the services rendered, the length of the average visit, the delivery of health education messages to pregnant and new parents, systems issues with scheduling visits / information sharing, the specific needs of high risk mothers (e.g. mothers who had a complicated pregnancy or labor & deliver, mothers with infants in the NICU), and making sure the highest risk women receive needed care and follow up screening. Dr. Verbiest then shared a series of ideas and strategies for change proposed by other states and leaders. This work was offered to kick start group thinking and idea generation. Please review her power point presentation for additional details.

Dr. Priya Agrawal from Merck for Mothers then spoke, with a charge to participants to reach out to industry and business and better engage them in this work. She noted that there are overlapping interests and opportunities, both for employers and for companies that are reaching this large and important market segment.

**Defining Critical Issues by Stakeholder Group**

Participants were then asked to separate into four different stakeholder groups where they described key drivers within their specific arena and what priority action was needed to create change.

**SYSTEMS/ POLICY**

This group focused on payers, with drivers including:

- Quality outcomes (guidelines and data are required)
- Evidence of interventions and efficacy (evidence informed v. evidence based)
- Internal capacity and values
- Incentives for patients and providers and incentives for payers (business case) and improved capacity to collect data through logical billing structure
- Fragmentation of funding streams and information sharing
- Multiple types of payers, healthcare delivery systems, provider networks, EMRs – limited interaction and fragmentation
- Payers have a different benefit packages, there is still a lot of variation, lack of standardization
- Enrollees & Providers → non reimbursed services → affects quality
- Billing Codes/structure (logical)
- Internal capacity/expertise/vision values
- Regulations / mandates
- Support from advocacy / professional organizations
- Impact of the service on the bottom line – incentives (the business case)
- Policy feeds into payer (influences), mandatory regulations

**Priorities** focused on addressing the following:

- Business case for postpartum care
- Engagement of women in services (by payer and/or provider)
- Gaps in services (i.e. obesity management, LARC)
- Fragmentation of funding stream, delivery systems, information sharing
CONSUMERS
• This group felt there were two perspectives to be considered: the consumer advocacy community and the women themselves.
• Consumer advocacy community
  o Seat at the table to be able to advocate/understand on consumer behalf
  o Defining consumer as woman and family unit
  o We need evidence and data, and lots of different kinds (consumer, clinical), need a greater understanding of the landscape that is evidence-based but dynamic at the same time
  o Need to understand what works and how to help the consumers that we are trying to serve
  o Reinvigorated consumer to drive advocacy and change for women
• Woman
  o One stop for all needs—helping a woman deal with her health holistically (medically, behaviorally, socially)

Priorities combined for both groups include:
• Drive increased levels of consumer engagement – need to create a generation of women who will advocate for themselves
• Drive evidence-based data collection and turn that into something actionable
• Increase capacity of communicating what we know works with consumers to other stakeholders

PUBLIC HEALTH
Instead of focusing on drivers, this group defined key areas of focus and public health practice that include:
• Technology
• Data systems
• Financing
• Workforce development
• Communication channels
• Leadership
• Political will and knowledge about how to influence the system
• Influential champions
• Consumer input and engagement
• Concept of regional postpartum care

The three priority areas identified were
• Leadership – locus of control and ownership
• Influential champions – payers, consumers
• Financing

CLINICIANS
The group identified a list of needs / drivers for clinicians and health systems
• Time
• Guidelines for the clinical content of postpartum care
• Resources
• Money
• Patient engagement
• Communication and care coordination
• Resources (human and financial) – the ability to give contraception
  o Acceptance of contraceptive (stocked, insurance), access to a social worker, nutritionist, etc.
• Communication (between providers, of actual results, with family)/documentation
  o Directly related to resources
  o Electronic medical records
• Reimbursement
• Integration and continuity of care
• Patient expectations and provider expectations (and include family)
• Context and patient access
• Many of these drivers are interrelated

They suggested five priority focuses for postpartum care
• Reproductive life planning and birth spacing
• Self-efficacy and perception of health and wellbeing
• Appropriate use of emergency department visits and hospital readmissions
• Risk factor identification and reduction
• Optimal infant feeding

This group also proposed a set of clinical quality metrics for the postpartum visit including:
• Appropriately spaced pregnancy
• Postpartum hospital readmission
• Contraception
• Emergency visits
• Breastfeeding rates/duration
• Risk factor reduction (and identification)
  o Diabetes
  o Hypertension
  o Tobacco
  o Multivitamins
  o Birth spacing
  o Teratogenic drug use
  o DVT and embolus
  o Substance abuse
  o Postpartum depression
  o Obesity/GDM
  o Intimate partner violence
  o Obstetric complications
  o Folic acid use
  o Chronic disease management
• Patient self-efficacy – perception of her own wellness (measurable in qualitative research) and ability to cope with parenting
• Infant care

Group Discussion about Drivers
• Provider engagement in the importance of postpartum care: Unless they have a sense of its role in women’s health, we won’t be able to impact the delivery of care
• Consumer engagement is essential – both as active participants in their own health care and advocating for what they need, but also platform for engagement at a larger level to influence population change
• We have not done a good job communicating the connection between third trimester of prenatal care, the postpartum period, and the interconception period. We’ve created silos, and our customers get stuck in these silos. We must create a new model of care that integrates or flows. In NY we’ve started to take some of the content in the postpartum visit into the third trimester, so by the time we get to the postpartum period the mom is already prepped and ready.
• It has to be a continuum of care – postpartum doesn’t exist in isolation.
• Reducing fragmentation is one thing but purposeful integration is important
• The challenge starts in the transition gap from pediatric care for young women and then they show up pregnant. Preconception health – we’ve missed that opportunity
• Develop a women’s health strategy that will implement all of those systems
• We completely need to re-conceptualize the relationship between mental health and physical health – you cannot provide good primary care without including mental health.
• The key drivers for poor outcomes more globally (across all the stakeholder groups) are income, racism and social determinants
• We need to break out the data and information systems better. We need clinical evidence, implementation science (what works for improvement), surveys like Listening to Mothers, performance measurement, including the need for something like women-reported outcomes measure/episode of care – this would provide incentives for improvement
• There are many competing messages and priorities (family planning and WIC) during the postpartum period. Who is giving out the information and how can we make it more consistent?
• Preconception care, postpartum visits, etc. we don’t have any expectations on what quality drivers are from businesses, health plans, etc. We need to come up with some measures, drivers, and then hold health plans accountable for paying for them and providers for doing them. Expecting insurance companies to look for outcomes-based measurements is critical.
• “Knowledge brokering” is a Canadian term that refers to translation : Letting policymakers know what women’s experiences are, and sharing this knowledge among key stakeholders
• Peer-to-peer support is important for addressing issues for new moms around isolation
• Health insurance should be included in communication and coordination
• Woman-centered care is important. All new mothers need support, but that may look different based on her health, resources, parity, support systems, etc.

**Systems Mapping**
First, the group discussed in general the goals that they were aiming for in terms of postpartum health and services for mothers. Overall, the key goal was that the well-being of new mothers and young families would be considered to be of value – these young families would matter to a variety of stakeholders from business to policy makers to community leaders.

Other goals for postpartum care and services included:
• Risk factor identification and risk reduction
  o GDM/ Pre-eclampsia (pregnancy as window to future health )
  o Chronic disease
  o OB complications → future OB + Med Health PTB/ IUGR/ Anomalies/ Cesarean, etc.
  o Nutrition/ folic acid / iron deficiency
  o Substance use/ tobacco
  o Depression/ behavioral health/ stress
  o Obesity/ gestational weight loss
• Reproductive life plan and birth spacing
• Self-efficacy and good perception of health and wellness
• Decreased use of the emergency department for postpartum health related problems
• Decreased readmission for postpartum health related problems
• Optimal infant feeding
• Increased maternal satisfaction and happiness
• Decreased maternal morbidity and mortality
• Improved pregnancy outcomes for future pregnancies
• Reduction of interpersonal violence
• Improved women’s health and access to well-woman care
• Stronger relationship with providers
• Optimal infant health – when mother is well the children do well

Then the group looked across the various priorities and came up with the list below. The first four were mentioned the most frequently.
• Reduce fragmentation of funding streams, delivery systems, and information sharing
• Develop a business case for postpartum care
• Close gaps in services (including mental health) through standardization and service integration and enabling services
• Consumer engagement – women advocating for themselves; active participants in their healthcare
• Influencers / leadership across sectors
• Provider engagement
• Better data / information systems
• Qualitative surveys of mother’s experiences
• Clinical evidence for content of postpartum visit and fourth trimester care
• Implementation science – how to provide services in an effective manner
• Performance measurement
• Knowledge brokering (translation of science to general audiences)
• Communication and coordination – among providers, hospitals, community, payers and patients
• Health education and promotion - communication and messaging
• Quality measures and insurance accountability
• One stop for all needs
• Value proposition for integrating prenatal, postpartum and interconception care for continuum of women’s health care
• Mental health and physical health integration
• Income disparities and social determinants

Priorities
The group agreed upon three top priority areas for action. These are a) consumer engagement and demand; b) develop a business case for comprehensive postpartum services; and c) build an integrated and comprehensive system of care for new mothers during the 4th trimester. Please see the systems maps in the attachments to review the interaction and linkages developed by the group and discussed below.

The first map focused on Consumer Engagement and Demand. Key conversation points are captured below:
• Most of the reforms in women’s health care have come because women have demanded it – if women are empowered, then the system would respond. Some historic examples of areas where consumer demand has been successful include: HIV/AIDS, the expansion of WIC, services for Children and Youth with Special Health Care Needs (e.g. Family Voices) and Head Start. This demonstrates that it is possible to focus increased attention in this nation on this vulnerable time for new families.
• Engagement is not the highest level of a market force but demand is, therefore if we can get consumers engaged, then it will lead to demand. Further, engaged consumers may be more likely to
attend their postpartum visits and adopt healthy behaviors, which reflect well on physicians and better inspire them to work harder.

- At the height of this, then consumers form their own organizations to make sure these things are executed and/or consumer advocacy organizations need to have increased resources / reach to serve as a conduit for consumer voices and demands. Organization and structure is going to be very important – need to have leadership emerge.
- Forces that influence consumer engagement include education/awareness of the problem, data to help describe the problems and need for action, and consumer empowerment - opportunities for women’s voices to be heard. If consumer education is raised, this raises consumer engagement as well as increased self-care (potentially).
- In order to get women engaged it will take: Interaction among new mothers and women, caring and persuasive care coordinators, transparency and public reporting and guidance in navigating the healthcare system. We also need indigenous, respected community leaders to engage women locally. Women need to have reason to believe that what they do will make a difference. If they don’t feel valued by the system, then what reason do they have to come together and believe that somebody will take what they say and do something with it?
- There are federal programs such as MIECHV and Healthy Start that are charged to meet the needs of new mothers and infants. How do we make these programs work harder and provide better results for young families?
- Need to hear what women need → inform services → helps improve services

The development of a **business case for preconception health** (including private and public payers) was integrated into the systems map that was started for consumers. Key conversations are captured below:

- There are a number of elements required to make the business case:
  - Data to show improved outcomes for payers, as well as trusted source of data for consumers to use in their decision-making.
  - Clinical evidence and standards (sometimes from professional societies) are essential. If a case is very persuasive with clinical evidence, then providers will do it anyway.
  - A political case for change will also need to be made to convince the powers that be that postpartum care is important and is aligned with demonstrating a value for women in society. For policy change it needs to be locally driven, sustainable solutions, and then it can link back to the bigger, universal approach.
- There is a fundamental problem with relying on a business case because many things take time for the evidence to accrue. At some point there is going to have to be some sort of social contract that highlights our investment in women as a societal belief. Several participants noted that it was essential to move into a broader belief that women matter and are valued – regardless of their reproductive status. So the business case needs to be persuasive in terms of pushing this message of value.

A new systems map was developed for the third priority, which is **integrated and comprehensive services in the fourth trimester** (aka the opposite of fragmentation). Key discussion points are described below:

- Comprehensive, opportunistic, integrated services
- We need to provide our clients with clear information about what to expect when they enter our systems of care – whether at prenatal or postpartum. What ARE the expectations at intake? We need to define them and, at this point, the expectations we meet may be pretty minimal.
  - Where does that first encounter begin? At home, in school?
  - Point of entry – expanded point of entry – no wrong door
  - Notion of transition and hand-off, knowledge and systems of transition - we need to know what is effective transition
• We’re talking about two levels of transformation – how do we make the system we have work? And a differently conceived model of care – when I talk to a young pregnant friend I ask, “where do you get your prenatal care?” I don’t ask someone, “Where do you go for internal medicine?”

• Cooperation between different professional organizations and disciplines – family medicine, pediatrics, OB/GYN, midwives, community health workers, public health aren’t always working as well as they could. These providers represent different points of entry into care and are essential during transitions, as well. If you want to have comprehensive systems, you need to have comprehensive coverage and those providers have to be compensated for those integrations, not just add-ons. Payers should cover all providers that are licensed to provide types of care – eliminate provider discrimination.

• Improved flow of information among public health services, such as WIC, SNAP, Healthy Start – all that information should be carried throughout and connected to these public health systems of care.

• Comprehensive coverage feeds into providers crossing systems – this is about defragmentation. Models like health home or care coordination payment can bring providers together – new payment models can lead to cooperation (i.e. ACO).

Actions
Given the increased focus in the field at the moment on the postpartum period, action steps reflected new ideas at the same time they also highlighted capitalizing on existing opportunities and resources. Of critical importance is a focus on health equity. While all new mothers need support, there are populations of women who are at greater risk for poor health outcomes based on their race/ethnicity, economic status, and risks who require attention as a priority. Additionally, while they highlighted that the three months postpartum are inextricably linked within a woman’s continuum of health and reproductive life planning, participants noted that it is important to take advantage of the current interest in this period of time and capitalize on improving our capacity to care for new mothers during this very sensitive period of time.

CONSUMER ENGAGEMENT
• Partner with consumer advocacy groups and potentially some businesses to conduct a major survey to listen to what new mothers need and want from postpartum care. Their opinions on the timing of the postpartum visit, content of care, need for home visiting, access to nurse hotlines or other clinical support, timing and type of health education, interest in peer support, and suggestions for places where they could receive “opportunistic” services and support could and should drive the rest of the strategies. They can also share strategies for generating consumer demand for postpartum services. It is essential that mothers who are often disenfranchised and at-risk be over sampled. Funding for this work is required. Costs are needed primarily for the design of a quality survey, oversight, and data analysis. Potential partners include Childbirth Connection (e.g. Listening to Mothers Survey), Maternity Neighborhood, Merck for Mothers, Federal Healthy Start Programs, the Black Women’s Health Imperative, Every Woman Southeast Coalition, Birthing Project USA, and others. Timing-wise, the group considered this work a priority – something that should happen first.

• Merck for Mothers together with Wellframe will deliver in the second quarter of 2015 a free, personalized, evidence-based postnatal care app for all (through a smartphone – IOS and Android - application), which will help collect the world’s largest data set of maternal and child health needs in the postpartum period. This information will be available to researchers and others free of charge. This app will educate women in the US about health related matters after childbirth and will empower women to take responsibility for their own care and their newborn’s care in the critical weeks between giving birth and the six-week postpartum visit.
• Develop and distribute information to new mothers that describes all the normal postpartum physical and emotional consequences, with specific information about their impact on daily life and how to effectively manage symptoms (e.g. telling her to get more sleep and manage stress isn’t going to help much). Expand public education on social media to reach new and prospective parents with key information.

**ENGAGING COMMUNITY HEALTH WORKERS**

• Merck for Mothers is exploring potential technologies that will increase community health worker efficiency by facilitating regular communication with clients to ensure adherence to chronic disease management plans. CHWs can use the dashboard to monitor client needs and target follow-up.

• Develop standard service components, guidelines and a model for community health workers (“wise women”) to provide support for new mothers postpartum. This could easily be based on existing programs and formalized to include standard points of services, a curriculum (the Healthy Start Association has a new curriculum on interconception care that could be utilized) and desired outcomes. Reimbursement for these services by Medicaid and private payers could be explored. The model could be piloted within existing programs.

• There are a number of well-funded Federal programs (e.g. Federal Healthy Start and MIECHV) that have required community engagement components. We need to increase expectations for what that engagement looks like and better utilize community leaders to build both formal and informal community support programs. One option for kicking this off would be a national conference that would bring equal numbers of community leaders and front-line staff from federally funded programs together around this topic.

• Review research (published and unpublished) about peer counseling for breastfeeding, mental health (e.g. Postpartum Support International), parenting, and other related topics to review evidence-based methods, potential impact, and strategies. There is work underway in this arena that should be elevated, mined for information, and potentially replicated.

• Review research and information about other programs that provide resources and support to new mothers, such as the March of Dimes and Zeta Phi Beta Stork’s Nest, and support offered by various faith communities. There is work underway in this arena that should be elevated, mined for information, and potentially replicated.

**CLINICAL GUIDELINES AND INDICATORS**

• Develop standards of well-woman care developed and endorsed by professional organizations, including postpartum visit and care. The concept of Bright Futures for Women came up several times. Lead partners include the Patient Safety Council, Preconception Health and Health Care Initiative and Well Woman Task Force. Resources needed include clinical evidence, database of outcomes and risk (Kaiser Permanente) and funding to bring experts together. There was some tension between the need for a larger well-woman approach and the urgency of seizing current opportunities and having a specific focus on care and service components in the three months postpartum. This work is foundational to the capacity to build a business case and address reimbursement issues. Further, the important elements of care are known, and it seems that a focused meeting of clinicians could move this along with relative speed. Once the quality guidelines for postpartum clinical care are developed, they need to be promoted and evaluated to help reduce the current significant variation in care.
The first six weeks following the birth of a child, the postpartum period, is a critical time of health adjustment and recovery in the lives of women. Postpartum discharge instructions for women who are at increased risk for postpartum complications are not standardized and do not always empower women to know when they should seek medical attention for symptoms that could constitute a medical emergency or how to advocate for themselves if they do seek care. In addition, many women are not aware of their health needs after giving birth, particularly how to differentiate normal from abnormal signs and symptoms. Because 98% of women give birth in hospitals and nurses are the primary care takers responsible for providing discharge education, AWHONN is working with Merck for Mothers to solve these problems by launching the project: Empowering Women to Obtain Needed Care. The project work plans includes the following actions:

1) Perform a baseline assessment of the current discharge education materials and processes that are used at select pilot hospitals.
2) Develop and pilot a new standard postpartum planning and training tools for discharge education tools that are focused on reducing maternal morbidity and mortality for hemorrhage, hypertension, and thromboembolism.
3) Identify barriers and facilitators to standardizing and enhancing postpartum discharge planning and education on hemorrhage, hypertension, and thromboembolism.
4) Disseminate AWHONN’s recommendations for improving postpartum discharge education to nurses and other health professionals.
5) Disseminate key information to women through the AWHONN Healthy Mom & Baby consumer multi-media platforms.

FINANCING AND POLICY
- Unbundle postpartum visit from reimbursement for prenatal care – reimburse as a discrete service. Leaders in this arena include CMS and Maternal and Child Health Bureau. Participants suggested that it was important to learn from what is working in other states and develop/promote alternative payment models adopted in demonstration states.

- CMS Postpartum Innovation Project was launched Fall 2014. Details to follow.

DEVELOPMENT OF A BUSINESS CASE
- While clinical guidelines are an essential component of the business case, there is also a good deal of information already available to allow for some initial steps in developing this case. There was interest in pulling together a special task force or group of payers, policy experts, some consumer groups and clinicians in 2015 to write an article to argue this case. AMCHP can provide leadership for this work in 2015.

SERVICE INTEGRATION & LEADERSHIP
- Improve collaboration among national initiatives that are focusing on postpartum care, services and policy initiatives. With a significant interest in this period of time emerging, communication and coordination is important in order to maximize resources, avoid duplication and share learning and best practice. Leadership is needed.

- Conduct landscape analysis of what community based services exist, what populations are served, and how they are paid for, in order to collaborate and integrate. AMCHP could serve as the lead with a deliverable of a compendium or published review article.

- Address barriers to behavioral health care in PP period (coverage, coordination, childcare, transportation, identification of need/ referral for MH services) by reviewing model programs and working with new partners in behavioral health to cross promote their goals and strategies.
Tighten Title V and Title X connection for provision of care in the 4th trimester. Partner with the Office of Population Affairs to include a section on how to provide postpartum contraception in future iterations of the CDC-OPA guidelines *Providing Quality Family Planning Services*. The World Health Organization has published recommendations on this, but there are no current federal recommendations in the US. WHO recommends counseling about contraception during the third trimester of pregnancy, so the woman is ready with a decision/better informed at the postpartum visit (http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/a91272/en/). The guidelines could also discuss immediate insertion of postpartum contraception. Professional medical associations in the US, especially ACOG, address these issues, so it would be important to explore whether Federal Guideline would also be of use.

Allow pediatricians to bill for some postpartum screening and referral services to women (e.g. tobacco screening and cessation counseling, breastfeeding support, contraceptives and depression screening) as studies have shown that mothers are receptive to this screening and support. The IMPLICIT network, a MCH Family Practice QI collaborative, completed a study from 1/12 until 10/14, looking at 8,309 well child visits (WCVs) from 2,631 different babies across 6 sites. They found that mothers took their babies to 8,125 WCVs (97.8%), where they were screened for ICC at 5,058 WCVs (62.3%). While there was a significant variation in the rate of ICC delivery across the sites, of the mothers screened for ICC, 20.7% reported current tobacco use, 8.4% had risk of current maternal depression, 33.7% were not compliant with contraception, and 38.6% were not using a multivitamin. The intervention rates varied from 16.8% to 100.0%. Providing postpartum and interconception care to mothers via well child visit should be reimbursed and further developed as an important opportunistic care opportunity for many new mothers.

Publish a special issue of the Maternal Child Health Journal that will bring together current practice and approaches to postpartum care – from literature reviews by Arden on postpartum visit utilization to articles featuring the role of key federal partners such as WIC and home visiting. This journal could serve as an opportunity to introduce potential clinical guidelines, new funding and policy concepts and prompt greater attention to this work.

**MEASUREMENT**
- Encourage states to include postpartum care in PRAMS survey - Phase 8
- Have postpartum visit completion as a nationally reported, core MCH indicator
- Define comprehensive integrated care component and implement some elements. Examples included: postpartum visit rate as ACO quality measure, postpartum contraception measurement → Medicaid and ACO quality measure, and postpartum visit quality content
- Develop National Benchmarks for adequate postpartum care – including tools and checklists

**MODELS OF CARE**
- A just launched, innovative partnership between the Icahn School of Medicine at Mount Sinai, Healthfirst, and The New York Academy of Medicine aims to improve care for low-income, postpartum patients in New York City by combining a social work-case management intervention with a new payment system designed to incentivize clinicians. This project builds on the strong existing partnership between Healthfirst and Mount Sinai to study the impact of an innovative payment and delivery model that can provide high quality, efficient and equitable health care for members and communities. Also in Ohio, Medicaid initiated a grant-funded postpartum QI pilot project in Cincinnati to improve the occurrence and content of the PPV, focus on reducing disparities in care and ID potential interventions for statewide implementation. Medicaid includes postpartum care as 1 of 22 QI
measures. Several Medicaid managed care plans have implemented incentive programs to reward mothers who complete perinatal and PPV. They also offer a home visit and are working to enhance services such as tobacco cessation and group care. Finally, the Ohio Department of Health supports postpartum visit utilization through local grantees.

- Consider extending Centering Pregnancy groups into 3 months postpartum. Layer in additional information about maternal postpartum health into Centering Parenting Groups. Develop a model for group postpartum care and support for mothers for the first three months postpartum.

- Explore the possibility of supporting early postpartum home nursing visits for ALL new mothers in the US. Review the literature and results of current postpartum home nurse visit programs that are supported across the country. This might be part of a business plan.

- Use 3rd trimester prenatal care visits as an opportunity to provide anticipatory guidance for the postpartum period.
APPENDIX A

Brainstorming Diagrams

Providers

Maternal PP Providers
NP MD PA SNM

- Available in office
- Covered
- Woman acceptace
- Delivering contraceptives
- Resources $ People
- Supportive team (Nutritionist)
- Time
- Reimbursement
- Outcomes based
- Fee for service
- Care where women already go
- Access for patients
- Content
- Capacity of care
- Links with hospital where delivery
- Families
- PT Expectations
- Other providers
- Home health
- SW
- WC

EMR
Results

Communication Documentation

Keep patients out of hospital

Care where women already go

Access for patients

Fee for service

Outcomes based

Reimbursement

Supportive team (Nutritionist)

Resources $ People

Time

Delivering contraceptives

Available in office

Covered

Woman acceptace
APPENDIX B
Full Group Brainstorming Systems Maps

APPENDIX C
Participant List

APPENDIX D
Verbiest Presentation Power Point Slides
Second concept map with comprehensive integrated services in 4th trimester

- Community based care (how peer health works)
  - Empowers women to provide
  - Strengthens services
- New payment models
  - Cooperation (ie Aco)
  - Appropriations of care a woman can get (match to discipline)
- Guidelines
- Transitions Comprehensive Care
- Define SV expectations
- Knowledge about how to support transitions
- System support for transitions
- New systems of care
- Expanded point of entry
- Challenge in cooperation between disciplines + CHNs
- Comp+ integ SVS for women
- Intake
- Intake/ Enrollment easier
- Opportunistic services
- Business case
- Clear care expectations at intake
- Talking data health systems
- Information exchange
- Intake
- Comprehensive coverage care + care coord.
- Optimal infant feeding
- Women’s satisfaction
- Value
- Improved repro. life planning (birth spacing)
- Risk factors ID
- ED visit + pre admission
- Well women care
- Well women
- General mort + morb
- Pregnancies outcomes
- Interpersonal violence
- Community family health
- Comprehensive + integrated services in 4th trimester
- Comprehensive coverage care + care coord.
- Clear care expectations at intake
- Talking data health systems
- Information exchange
- Intake
- Comprehensive + integrated services in 4th trimester
- Optimal infant feeding
- Women’s satisfaction
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