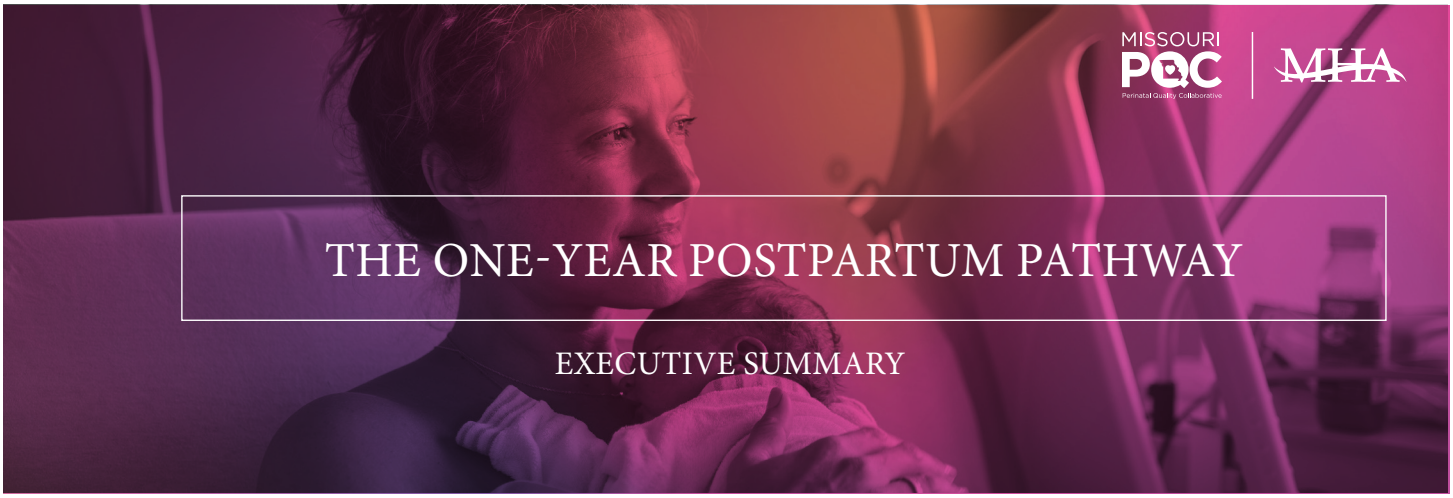

# THE ONE-YEAR POSTPARTUM PATHWAY

EXECUTIVE SUMMARY

## Introduction

In the past four years of evaluating causality of maternal deaths in Missouri, the Missouri Pregnancy-Associated Mortality Review Board found that more maternal deaths occurred between 43 to 365 days postpartum than during pregnancy or the fourth trimester (through 12 weeks postpartum).[1] Given the challenges noted within the current maternal health landscape (Figure 1), the recent extension of Medicaid through 12 months postpartum was an important first step to addressing this statistic; however, further efforts are called for to redefine the spectrum of postpartum care, especially in light of a lack of current professional guidelines and standards of care past the fourth trimester. In partnership with the Missouri Hospital Association and the Missouri Department of Health and Senior Services, the Missouri Perinatal Quality Collaborative developed the Missouri Optimizing Postpartum Care Task Force ("Task Force") with a complex yet direct charge critical to addressing maternal morbidity and mortality and supporting women, infants and families throughout the one-year postpartum period: **to further broaden the definition of the postpartum period and outline the standards for and continuity of postpartum care through the full 12 months post-delivery.**

Through robust engagement of a varied expert Task Force, guidance to outline best practice recommendations for pregnancy, birth discharge, fourth trimester and postpartum care through one year after birth were developed and are discussed in detail as well as visualized in this resource. The Task Force also identified commonly noted barriers to achieving an efficient, coordinated postpartum pathway and establishing effective processes across the health care system and care continuum. These barriers are organized across six major categories and include recommendations for patients and their families; providers; communities; and health, payer and policy systems. Finally, several key topics are covered in further detail with additional guidance, discussion and recommendations to consider as they were deemed essential to achieving improved maternal, infant and family health outcomes.

Figure 1:
**Missouri's Postpartum Landscape**

RANKED 43RD — **Ranks 43rd** in the United States in women's health and reproductive care outcomes[2]

39% — **39% of pregnancy-related maternal deaths** occurred between delivery and 42 days postpartum[3]

43% — **43% of pregnancy-related deaths** occurred between 43 days and one year postpartum[4]

LEADING CAUSES — **Leading causes of postpartum death:** cardiovascular disease, mental health conditions and infections[5]

80% — **80% of pregnancy-related deaths** overall in Missouri are deemed preventable[6]

54% — **Only 54%** of Missouri Medicaid and CHIP participants **attended a postpartum visit**[7]

93% — **93% of counties** are fully designated as primary care professional shortage areas[8]

96% — **96% of counties** are fully designated as mental health professional shortage areas[9]

1 IN 49 — In 2023, Missouri became **one of 49 states** (to date) to extend postpartum Medicaid coverage for one year.[10]

# Summarizing the Postpartum Pathway

After an extensive literature review, the Task Force found limited research currently available regarding best practices for the one-year postpartum period; therefore, recommendations from the Task Force also may inform opportunities for future research and policy change to address these gaps, with the opportunity for future iterations as additional research becomes available.

Highlighted in the pathway and report is the importance of effectively transitioning care across the care continuum, which requires involvement, communication, and coordination among various clinical providers, nonclinical providers, community stakeholders and support staff. While this creates opportunities to better serve every postpartum person, the Task Force recognizes the distinct challenges and barriers to quality care during this period, particularly with regard to health care access, continuity of care and shared awareness of patient progression across providers (Figure 3). The pathway (Figure 4) is summarized in the chart below and is inclusive of both maternal and pediatric visit timing and identified opportunities to deliver best practice care. Additionally, topic-specific best practices and recommendations are detailed in the report (Figure 2).

**Overall, the Task Force recommends a standard of care deployed beginning in pregnancy through one-year postpartum that includes universal screenings, intentional provider handoff communication, patient education, and identification of clinical and nonclinical referral needs. Concurrently, it is recommended that services and supports referenced in the postpartum pathway align with the needs of the individual and efficiently leverage the breadth of providers in maternal-infant care, working across the pregnancy-postpartum continuum through a stronger coordinated system of care.**

To support implementation, the Task Force developed recommendations for a variety of stakeholders, including clinical and nonclinical providers, community-based organizations, and health care and payer systems. These are meant to provide: 1) actionable ways to address barriers and implement identified best practices broadly and consistently and 2) guidance for specific stakeholders for implementation. Actionable payer-related recommendations focus primarily on Medicaid extension; however, the Task Force emphasizes that all payers should implement best practices to support 12 months of quality postpartum care for all Missourians.

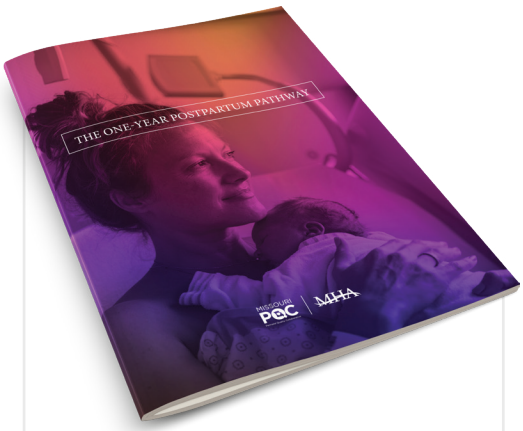


Figure 2:

**Topics addressed and further detailed in the full report**

- » postpartum care of chronic and pregnancy-induced conditions
- » mental health in the first year postpartum
- » addressing social drivers of health (as defined by the Centers for Medicare & Medicaid services), care coordination and patient engagement in postpartum care
- » enhancing the maternal workforce for postpartum care delivery

Figure 3:

**The Task Force addressed barriers and recommendations around several topic areas in the full report**

- » patient disparities and impact of SDOH (as defined by CMS)
- » provider education
- » patient health literacy
- » reimbursement and payment models
- » workforce shortages
- » research and data infrastructure to support extended postpartum care

# EVERY POSTPARTUM PERSON

- Screen all patients for pregnancy within the last 12 months in all care settings, assessing for maternal warning signs
- Health literacy assessment and language competency services Ask Me 5 and related validated screening tools to address mental health, SUD, SDOH, IPV and relevant medical conditions
- Warm handoff among OB and PCP for health concerns Care coordination and warm handoffs between providers and between health services and community services

**Pregnancy**

### Postpartum Planning
- develop a postpartum care plan that addresses the transition to parenthood and well-woman care
- education about urgent maternal warning signs
- provide relevant resources to all patients

**Delivery**

### Delivery Discharge
- provide discharge summary to patient and receiving provider
- lactation consultation and appt. scheduled as needed
- mental health, SUD, IPV, SDOH screening and referral
- referral for relevant medical and chronic conditions
- schedule comprehensive PP visit before delivery or discharge
- GDM: two-hour 75 gram oral GTT

**1 – 7 days PP**

### High-Risk Follow-Up With Maternal Care Provider
- for women at high risk of complications, provide in-person follow-up and/or multiple visits
- severe hypertension: BP check within 72 hours of discharge
- HDP: BP check within 3-10 days of discharge
- consider remote BP monitoring if appropriate
- for SUD, provide support, screening for co-occurring mental health conditions and med titration for MOUD as indicated

**1 – 4 weeks PP**

### Initial Follow-Up With Maternal Care Provider – no later than 3 weeks PP
- address acute postpartum issues
- provide care coordination
- provide alternatives to in-person (e.g., telehealth, home visiting) as needed
- additional PP visits and follow-up as needed based on medical/nonclinical risks

**4 – 12 weeks PP**

### Comprehensive PP Visit With Maternal Care Provider – no later than 12 weeks PP (often 6 weeks)
- mood and emotional well-being
- infant care and feeding
- sexuality, contraception and birth spacing
- sleep and fatigue
- physical recovery from birth
- chronic disease management
- health maintenance
- GDM: two-hour, 75-gram oral GTT (if not completed in hospital)
- identify/confirm PCP, schedule PCP appointment, provide warm handoff

**12 weeks – 12 months PP**

### Annual Well-Woman Visit With PCP (may include OB) – no later than 12 months
- complete medical history, including discharge summary and pregnancy history
- alcohol use screening and counseling
- anxiety screening
- blood pressure
- contraception
- depression screening
- diabetes*
- folic acid supplementation*
- healthy diet and activity counseling*
- intimate partner violence screening
- obesity screening and counseling
- substance use screening and assessment
- tobacco screening and counseling
- urinary incontinence screening

*recommended for select groups

### Pediatric Visit

**1 month:** mental health, SUD screening and referral for treatment for caregiver

**2 months:** mental health, SUD screening and referral for treatment for caregiver

**4 months:** mental health, SUD screening and referral for treatment for caregiver

**6 months:** mental health, SUD screening and referral for treatment for caregiver

- Some elements can be initiated during pregnancy or as early as the patient is receptive (e.g., scheduling postpartum appointments, identification of a PCP and education).
- High-risk postpartum patients, including those with mental health disorders, substance use disorders or relevant medical and chronic conditions, may need additional touchpoints and/or additional services beyond those outlined here.
- Delivery of the services above should vary to address the needs of the individual, particularly for those at low risk or those with barriers to care (e.g., disproportionately impacted populations, people in care deserts or shortage areas). Models such as co-located services, clinical-community partnerships, telehealth and home visiting should be used as needed when available.

# Looking Forward

Transforming postpartum care into an ongoing, structured process that supports transitioning the woman and infant into primary care, subspecialist care as needed, and ongoing social resource support is essential for improving both maternal and infant health outcomes. A comprehensive approach — integrating patient education, provider training, community-based support, and systemic policy and reimbursement changes — is necessary to bridge existing gaps and establish a more effective postpartum care plan.

The Task Force has built a framework that aims to outline a comprehensive approach in the one-year postpartum period. Future dissemination, implementation and evaluation efforts rely on having the trust of the community at the forefront and the ongoing support of Task Force members and broader stakeholders. Methods may include conference presentations, community engagement events, webinars and targeted educational materials, among others, and opportunities to contribute to the body of research for postpartum care.

By implementing these best practices and addressing key barriers, Missouri can build a sustainable, comprehensive postpartum care model and more coordinated system that prioritizes quality maternal-infant health outcomes and improves the overall patient and workforce experience well beyond childbirth.

## The Task Force and the MO PQC call on health care leaders, clinical providers and nonclinical providers to

- share report recommendations with physicians, OB units, primary care services and quality teams
- build robust screening processes and resource and referral networks to identify and address needs in the year following delivery
- consider ways to support ongoing postpartum care and a transition to primary care in their communities, incorporating both clinical and nonclinical roles to address care needs

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