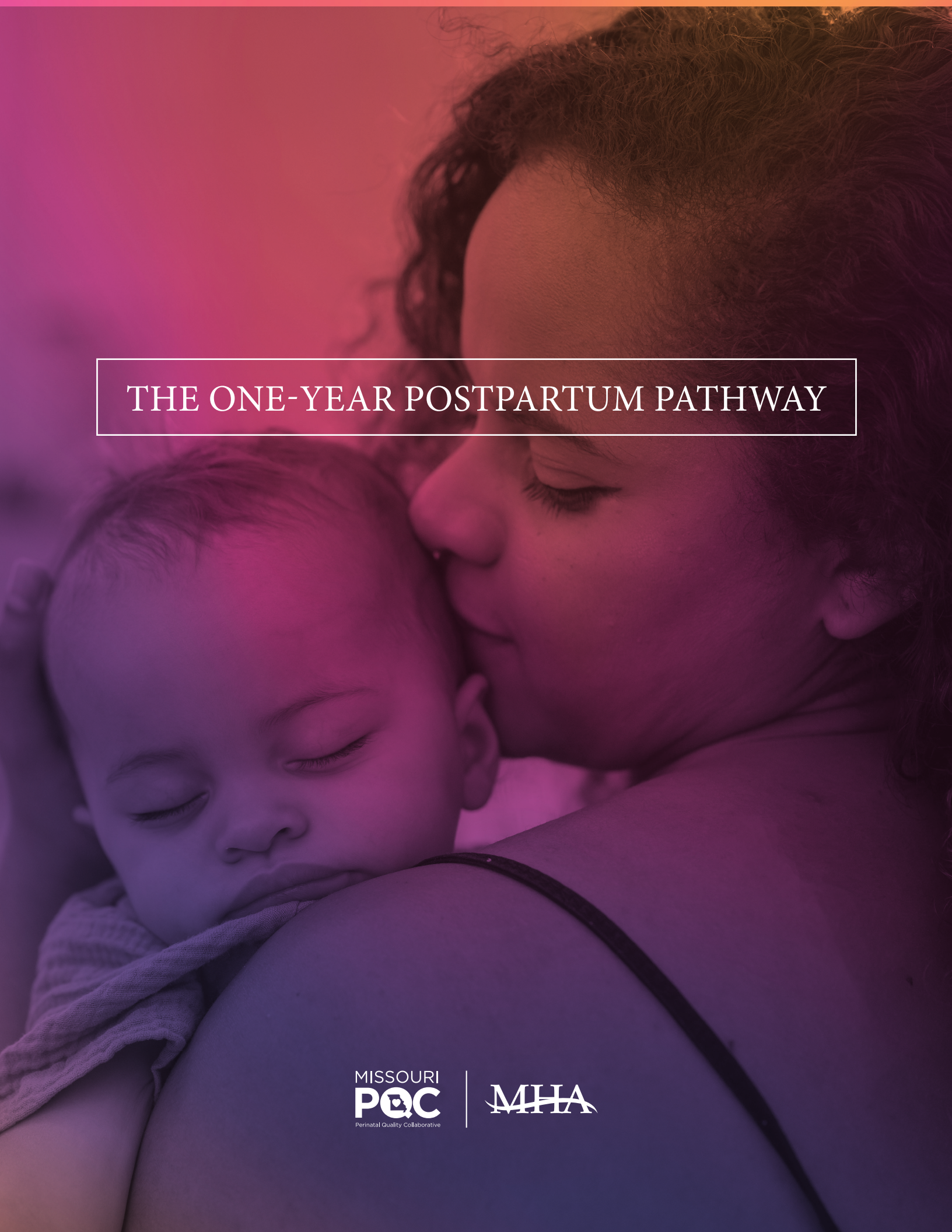

THE ONE-YEAR POSTPARTUM PATHWAY

MISSOURI PQC Perinatal Quality Collaborative | MHA

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Acknowledgements

Improving the health outcomes of maternal and infant populations is a critical priority in Missouri. The Missouri Perinatal Quality Collaborative, in partnership with the Missouri Hospital Association, serves as a statewide convener, resource and change agent. We're working to improve access to high-quality maternal and neonatal care by providing access to perinatal resources for both health care providers and expectant or new parents. Through these efforts, the MO PQC is ensuring better, healthier outcomes for the communities we live in and increased workforce capacity to serve. Optimizing and sustaining implementation of evidence-based practices, supporting the study of evidence-informed strategies and new innovations and encouraging clinical-community integration efforts — noted gaps in achieving fair, just and improved health — are central to the work of the MO PQC.

These efforts would not be possible without the collective vision and collaboration of the Missouri Department of Health and Senior Services, MHA and members of the Missouri Optimizing Postpartum Care Task Force, as well as the collaborative partnerships, programmatic alignment and passionate engagement from stakeholders throughout Missouri who are firmly committed to improving the health outcomes of mothers and infants.

To convene a task force that was broad and varied in both subject matter expertise and geographic representation, stakeholders from across the state were identified and invited to join this effort by MO PQC leadership.

The Task Force includes representation from clinical backgrounds, professional associations, government agencies, community-based organizations and community representatives with unique perspectives (Table 1). We gratefully acknowledge these subject matter experts and appreciate their strong engagement in researching, developing and co-authoring this guidance. We acknowledge the time and expertise given by the project consultant, Simply Strategy, to ensure the Task Force's time, expertise, and summation was optimized, and their facilitation efforts to support the production of the pathway and accompanying guidance.

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Table 1: Missouri Optimizing Postpartum Care Task Force Members

Missouri Optimizing Postpartum Care Task Force Members	Organization/Affiliation	Perspective
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Mary Conley	MHA/MO PQC	Staff
Kimberly Costello, CNL, PCHW	The Doula Foundation	Nonclinical Provider - Community-Based Care
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Introduction

Broadening and redefining the postpartum pathway is critical to addressing maternal and infant morbidity and mortality and supporting women, infants and families throughout the one-year postpartum period. This is especially urgent in Missouri, ranked 43rd in the United States in women's health and reproductive care outcomes[1] and fourth highest for maternal care deserts — a county with no obstetric services — in the U.S.[2]

According to the most recent Missouri Pregnancy-Associated Mortality Review report, 82% of pregnancy-related deaths were between delivery and one year postpartum, and 80% of pregnancy-related deaths are deemed preventable. For Black women in Missouri, the ratio of pregnancy-related deaths was 2.5 times higher than white women.[3]

In 2018, acknowledging the need for postpartum care to be an ongoing process after birth, the American College of Obstetricians and Gynecologists signaled a shift in the delivery of postpartum care from a single comprehensive postpartum visit to a continuum of care through 12 weeks after delivery.[4] After the COVID-19 pandemic and the option to expand Medicaid coverage and services, most states elected to extend postpartum Medicaid coverage to 12 months.[5] In 2022, Missouri followed suit, and legislation was passed to extend Medicaid benefits through 12 months post-delivery rather than the 60 days previously covered. Extension was broadly advocated for and supported as Medicaid covered 40% of all Missouri births in 2023 and provides coverage to some of the highest risk populations for medical and social vulnerabilities.[6] Medicaid extension has therefore provided a pivotal opportunity to improve maternal and infant health outcomes by developing a one-year continuum of care for pregnant and postpartum Missourians that is supported through reimbursement of services.

Methods

Throughout the past four years of maternal death case reviews in Missouri, more maternal deaths have occurred between 43 to 365 days postpartum than during pregnancy or the fourth trimester.[7] The extension of Medicaid through 12 months postpartum coupled with this statistic called for redefining the spectrum of postpartum care, especially in light of a lack of current professional guidelines and standards of care past the fourth trimester. To make an impact on preventable deaths occurring in the postpartum period, the Missouri Optimizing Postpartum Care Task Force ("Task Force") was developed. In partnership with the Missouri Hospital Association and the Missouri Department of Health and Senior Services, the Missouri Perinatal Quality Collaborative assembled the Task Force and assigned them 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 standard of postpartum care and continuity of care through the full 12 months post-delivery.**

The MO PQC strategically convened leaders in maternal-infant health who represented the state in terms of expertise, geographic regions and various backgrounds (see Table 1 for the list and description of Task Force members). Intentional consideration was given to include a broad spectrum of the maternal-infant health workforce, such as clinical and nonclinical providers, mental/behavioral health professionals, including those with expertise in treating substance use disorders during the perinatal period, specialized providers experienced in identifying and managing chronic health conditions, community-based providers and representatives, and doulas. Several Task Force members also contributed insight from their lived experience — three Task Force members welcomed their own babies over the course of developing the recommendations and pathway.

Over the course of more than a year (Figure 1), the Task Force identified topic areas related to the postpartum period and worked across subgroups to identify evidence-based practices. Subgroup recommendations were then shared back with the entire Task Force membership, discussed and prioritized for inclusion in the postpartum pathway. Existing clinical and nonclinical recommendations and evidence-based practices were identified that have not yet been broadly implemented, showing promise to improve outcomes with further spread and scale; however, few, high-quality research studies were identified for postpartum care beyond the fourth trimester. Therefore, recommendations from the Task Force may inform opportunities for future research and policy change to address these gaps, with the opportunity for future iterations as additional research for the one-year postpartum period becomes available. The Task Force subgroups were as follows.

- care coordination
- infant care
- mental health
- chronic conditions
- patient education
- social drivers of health (as defined by the Centers for Medicare & Medicaid Services)
- fourth trimester
- transition to primary care

CMS DEFINITIONS

Social drivers of health (SDOH): The conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH refers to community-level factors. They are sometimes called "social determinants of health." (Adapted from CDC Healthy People 2030)

Health-related social needs (HRSN): Social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They put individuals at risk for worse health outcomes and increased health care use. HRSN refers to individual-level factors such as financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care, and lack of access to transportation. (Adapted from HHS)

Recognizing the importance of addressing racial/ethnic disparities found in the PAMR dataset, the Task Force and MO PQC completed a separate literature review to identify evidence-based and/or promising practices to address population-specific risks and needs. For the purposes of the review, the Task Force agreed to utilize the term Black, Indigenous and People of Color in the search to describe historically marginalized and racialized groups who may experience systemic, socially constructed barriers to fair and just health care. While recommendations in the report apply to all populations, BIPOC populations may face additional barriers, resulting in more adverse outcomes. Focused strategies and interventions for BIPOC populations hold the potential to significantly reduce maternal and infant morbidity and mortality. Throughout this report, **the icon** here references interventions and recommendations noted through the literature review to have the potential to reduce racial disparities and improve outcomes. A central point made by the Task Force was that while these interventions may be population specific for BIPOC, they also hold promise to improve care for all populations.

January 2024

Task Force candidates identified and invited to participate

February 2024

Established meeting cadence, locations, key topic areas, and research and writing process

February 2024 – May 2024

- development of the Postpartum Universal Screening Brief, highlighting best practices for early postpartum care around mental health/SUD screening and referrals
- discussion of priorities, continuum of care components and postpartum EBP through 12 months
- research and development of the MO Postpartum BIPOC Literature Review

June 2024 – November 2024

- finalize one-year postpartum content areas and priority health topics
- establish eight subcommittees, each charged with a different topic area

December 2024 – May 2025

- writing and revision of report
- presentation of the Task Force process at the 2025 Statewide Maternal-Infant Health Convening in St. Louis
- development of dissemination plan for the report

June 2025 – September 2025:

- final draft reviews completed
- design and layout process
- dissemination planning

October – December 2025:

- report published: December 2025
- presentation at MO PQC Maternal & Infant Symposium in Blue Springs, Mo.
- dissemination of report to various provider networks and platforms

Figure 1: The Task Force Process

Led by MO PQC staff and consultants, Task Force meetings were held monthly between February 2024 and April 2025, with a mix of virtual and in-person meetings. The meetings included facilitated exercises to achieve the objectives of the Postpartum Pathways Report: 1) identification of evidence-based practices for postpartum care, 2) creation of a postpartum plan of care template and 3) development of recommendations to optimize postpartum care. Presentations from members of the Task Force on specific content areas, as well as from outside subject matter experts, were prioritized at each meeting to enhance broader knowledge and encourage critical review of findings. Task Force communication and collaborative work outside of meetings was organized by a team comprised of MO PQC staff and external consultants with deep facilitation and maternal-infant health experience.

Summarizing the Postpartum Pathway

The postpartum period is a time of many transitions in care, involving various clinical providers, nonclinical providers and supports, potentially across a variety of settings that create touchpoints and opportunities to better serve across the continuum. Existing evidence-based practices, evidence-informed practices and clinical recommendations identified by the Task Force were compiled to develop a one-year postpartum pathway that prioritizes critical care interventions, screenings and treatment plans. The pathway (Figure 3) includes the following three phases as essential frequencies of encounters with patients in the year after delivery.

- preparing for the one-year postpartum period during pregnancy and confirming this plan at delivery discharge
- addressing acute postpartum issues and stabilizing chronic or pregnancy-induced conditions immediately after delivery through the fourth trimester
- actively transitioning to primary care after the comprehensive postpartum care visit to include specific ongoing screenings significant to postpartum health outcomes

For each phase, the Task Force included patient-provider encounter-specific clinical and nonclinical recommendations that have yet to be broadly implemented and that show promise to improve outcomes with further spread and scale. The pathway also includes recommendations that should recur throughout the postpartum continuum, such as screenings and care coordination best practices.

Figure 2: Terminology

The Task Force has adopted the following terminology for the purposes of this report.

Immediate Postpartum: 0-7 days after delivery	**Fourth Trimester:** 0-12 weeks after delivery	**Extended Postpartum Period:** 12 weeks to 12 months after delivery	**One-year postpartum:** 0-12 months after delivery	**Delivery:** childbirth, to be inclusive of pregnancy loss at any gestation

The postpartum care team may include nonclinical providers such as doulas, community health workers, peer support specialists and other roles to most effectively and efficiently deliver comprehensive postpartum care as outlined in the pathway (Table 2). Additionally, pediatric providers and emergency services teams have a role in the postpartum pathway, as they regularly engage with postpartum women and can address noted opportunities and close care gaps.
To address the distinct challenges and barriers of postpartum care transitions and their impact on quality care and outcomes, particularly with regard to achieving the goals of continuity of care, provider shared awareness, and patient understanding and navigation of the system, the pathway emphasizes maintaining efficiency of workflow and coordination within the pathway and the provider team with recognition for different models of care. Modes of care delivery, the necessary frequency of patient/provider visits, the provider type and the specific elements of care needed during the extended postpartum period may be affected by factors such as the following.

- chronic conditions existing before pregnancy, such as cardiac disease, diabetes and autoimmune disorders, among others
- conditions diagnosed during pregnancy, such as gestational diabetes, obstetric hemorrhage and preeclampsia
- nonclinical factors that can affect an individual's health, such as access to transportation, food security and intimate partner violence
- previous or current pregnancy loss, pregnancy or birth trauma, medical complexities with their baby, or previous or current involvement of child protective services

Therefore, this 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 leverage the breadth of providers in maternal-infant care, working across the pregnancy-postpartum continuum through a stronger coordinated system of care.

Figure 3: Best Practice Recommendations for One-year Postpartum Care

EVERY POSTPARTUM PERSON

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

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

- 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

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

- 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.

Table 2: Care Providers Involved in Postpartum Care

Postpartum Care Providers[8]					
	Primary Maternal Care Provider	**Infants' Health Care Provider**	**Primary Care Provider**	**Mental Health Professionals**	**Home Visitors**
Provides	prenatal, postpartum and/or labor and delivery care	primary care provider for infants after discharge from maternity care	comprehensive care and act as an entry point for care needs	services to improve mental health or treat mental health conditions and disorders	one-on-one clinical, psychological and/or social support to families during pregnancy through early childhood *Models vary*
May include	○ obstetricians ○ family medicine physicians ○ midwives ○ nurse practitioners ○ physician assistants	○ pediatricians ○ family medicine physicians ○ nurse practitioners ○ physician assistants	○ physicians ○ nurse practitioners ○ physician assistants	○ psychologists ○ counselors ○ clinicians ○ therapists ○ psychiatric nurse practitioners ○ psychiatric pharmacists ○ psychiatrists ○ clinical social workers	○ nurse home visitors
Services provided for postpartum individuals include	○ comprehensive postpartum visit ○ specialty and subspecialty care as indicated ○ address acute postpartum and surgical concerns ○ physical exams ○ contraceptives ○ sexual health ○ PMHC screening ○ SDOH screening ○ lactation support ○ family planning ○ management of relevant medical and chronic conditions	○ PMHC screening ○ SDOH screening ○ parent education ○ feeding assessment and education	○ ongoing health care before pregnancy and after postpartum visit ○ co-manage chronic conditions with OB provider ○ parent education	○ institutional and intensive services ○ outpatient services ○ substance use disorder treatment ○ crisis services ○ support groups ○ PMHC screening	○ clinical and risk assessments (nurse home visitors) ○ breastfeeding support ○ support parent-child dyad ○ mental health and IPV support and resources

Modified from: ACOG. (2018) ACOG committee opinion number 736: Optimizing postpartum care. *Obstetrics & Gynecology, 131*(5), e140-e150. Retrieved July 11, 2024, from https://doi.org/10.1097/AOG.0000000000002633; and Missouri Department of Health and Senior Services. (2024). 2024 Missouri State Health Assessment [PDF]. https://health.mo.gov/healthplans/pdf/state-health-assessment.pdf.

Lactation Consultants	Birth Support Workers (Doulas)	Social Workers/ Case Managers	Community Health Workers	Personal Social Support
prenatal and postpartum breastfeeding education and support	emotional and physical support during pregnancy, birth and postpartum *Models vary*	support, counseling, case management, advocacy, guidance and resources	peer support for navigation between health social services and the community	emotional, physical and practical support during pregnancy, birth and postpartum
○ certified lactation counselors ○ international Board Certified Lactation Consultants ○ peer support groups ○ doulas ○ WIC staff	○ community-based doulas engage in overlapping work with community health workers, social workers and case managers	○ trained professionals in a variety of settings, both clinical and community	○ care coordinator ○ peer educators ○ patient navigators ○ outreach/ enrollment agents ○ community health educators ○ nurse navigator	○ family ○ friends ○ community
○ lactation education ○ training on milk supply, latching, pumping and milk storage ○ emotional support and resources	○ information and support on infant feeding ○ emotional and physical recovery from childbirth ○ coping skills for new parents ○ screening	○ long-term supportive services ○ parent-child relationships ○ advocate for parent-child dyad ○ coordinate care ○ help with psychosocial challenges	○ health promotion and education ○ assistance in accessing medical and nonmedical services ○ care coordination ○ social support	○ social support ○ coping skills for new parents and children ○ practical needs (e.g., infant care, meals, household tasks, transportation, care of children) ○ may attend appointments ○ monitor for signs and symptoms of complications, including mental health

Best Practices During the One-year Postpartum Continuum: Pregnancy, Discharge, Fourth Trimester and Beyond

Background

To shift the view of postpartum care from a short-term, medical-only postpartum encounter to an ongoing, structured process that is responsive to individual patient and family needs, supports ongoing clinical *and* social care, and includes effective transitions among the care team and settings, a system must be developed to support a one-year postpartum pathway. Critical patient care gaps exist in the transitions from birth to the initial postpartum visit to long-term health care follow-up.[9] In fact, the decrease from high health system engagement during pregnancy to limited or no engagement postpartum has been coined the postpartum cliff,"[10] with only 54% of Missouri Medicaid and Children's Health Insurance Program participants attending a postpartum visit, leaving many without necessary follow-up for medical care, social support and health education.[11,12]

Mothers often face sleep deprivation, frequent nighttime wakings, learning to breastfeed and managing medical appointments for both them and their baby. Many parents and caregivers underestimate the impact of newborn care and their own postpartum recovery on mental health. Additionally, they may struggle with building a health care support system, lack access to health and social care, and have difficulty understanding when and how to access their providers, and identifying available community resources. Postpartum care varies based on individual circumstances and experiences, such as traumatic birth experiences, infant loss, having a baby in the neonatal intensive care unit, caring for a medically fragile child, involvement with child protective services, or ongoing maternal health-related conditions such as mental health and cardiac. By providing comprehensive support, health care providers can help mothers and families navigate the postpartum period more effectively, supporting both maternal and infant well-being. Research has highlighted the key role that social support plays in maintaining prenatal and postpartum mental well-being, mitigating perinatal mood disorders, and benefitting overall wellness, including postpartum physical and emotional recovery.[13,14,15,16,17] However, many report that they do not receive the psychological or practical support they want and need during this critical time.[18]

The absence of an evidence-based, individualized postpartum care pathway and lapses in health care services correlates with high rates of mortality in Missouri and across the U.S. Addressing the physical, emotional, mental, social and educational needs of postpartum individuals throughout the critical first year with transition to primary care serves as a foundation for lifelong improved health outcomes and reduction of maternal and infant morbidity and mortality.

Best Practices During Pregnancy and at Birth Discharge

Postpartum planning starts during pregnancy. Proactive communication and planning with the patient are required and includes developing personalized postpartum care plans that address maternal recovery, emotional well-being, chronic disease management, the transition to well-woman care and parenthood, and identifying primary care and specialty health care providers with the patient who will best support the patient's health and social needs.

- **Care teams should provide recurring postpartum-related education beginning during pregnancy** on the importance of urgent maternal warning signs awareness, particularly those occurring mid- to late postpartum, from resources such as the CDC Hear Her campaign and MO PQC Ask Me 5 campaign and who to contact for urgent issues.
- **During pregnancy, providers should utilize risk stratification, including the Missouri Notification of Pregnancy and Screening Process for Medicaid, to systematically use patient risk levels to make care management decisions,** such as providing greater access and resources to patients in higher risk levels. The NOP was recently updated to include risk stratification based on the seriousness of risk factors and modifiability through early case management and should be completed by the provider during an encounter where a pregnancy is diagnosed or confirmed.
- **Clinical providers and teams should establish a system for scheduling the postpartum care visit and immediate specialty care or follow-up visit needs (virtual or in-person) before discharge or within 24 hours of discharge.**[19] This supports health system navigation for the patient and offers an opportunity to discuss the importance of follow-up care and relevant medical conditions that need specific focus.
- **Discuss and develop a care plan with the patient, including how and where to receive health care and support** (see Resources: Checklists and Templates for examples). Providers should emphasize the importance of ongoing postpartum health monitoring, the transition to and continued engagement with primary care, the importance of physical and mental health care, and the nonclinical factors that may contribute to engagement. Education should include culturally tailored materials to enhance patient understanding and engagement.
- **Clinical providers and teams should implement timely, automated sharing of a postpartum discharge summary (Figure 4) to postpartum care providers to support continuity of care.**[20]

Figure 4: Suggested elements of a postpartum discharge summary

name and age	positive screening for medical risk factors, mental health and substance use with current treatment plan or recommendations
support person's contact information	medications and supplements
primary care provider (if known), ideally seek to confirm this before postpartum discharge	positive screening for SDOH (as defined by CMS) and current or suggested community services and supports
gravida/para status	need for specific postpartum testing, such as glucose testing or complete blood count
date and type of birth, gestational age at birth, relevant conditions and complications	recommendation for follow-up plan (e.g., three days for BP check)
name, contact information and appointments for relevant providers, including OB-GYN specialists, mental health providers, etc.	

Best Practices for Fourth Trimester

In 2018, the American College of Obstetricians and Gynecologists revised postpartum fourth trimester recommendations.[22] Adherence to established clinical guidelines ensures postpartum care is timely and effective, as standardized visit schedules help detect complications early, providing opportunities for intervention before issues become severe.[23]

- **Providers and care teams should ensure all postpartum women are assessed by a maternal care provider within the first three weeks postpartum and have access to a comprehensive postpartum visit with recommended elements of care no later than 12 weeks after birth (Figure 5).**

Figure 5: ACOG Committee Opinion: Optimizing Postpartum Care

All women should have the following.

- contact with a maternal care provider within the first three weeks postpartum
- ongoing care as needed
- a comprehensive postpartum visit no later than 12 weeks after birth, including a full assessment of physical, social and psychological well-being
  - » 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

- **Providers should utilize repeat condition-specific screenings, to include mental health, SUD, and SDOH (as defined by CMS) screenings, to identify ongoing care needs and risk stratification to establish a medical and social care-appropriate cadence of encounters.** Rescreening using the NOP assessment is recommended and reimbursable during the postpartum period, which can be leveraged to identify patient needs and connect them with the most effective care modalities. Care modalities involving nonclinical and community-based providers, including Managed Care Organization case management, home visiting services, postpartum doulas, and mobile integrated health offer increased and effective touchpoints, often outside of the clinical setting for higher risk patients. Home visits from CHWs and nurses can further support high-risk mothers and infants. Research has shown that interventions such as lactation consultation and peer support groups lead to higher breastfeeding rates at six months postpartum and improved maternal health overall.[25,26]
- **Providers should incorporate or provide pathways to specialized programs for conditions such as cardiometabolic diseases, mental health concerns and substance use disorders, as well as expand their use of remote monitoring programs,** such as home blood pressure tracking for hypertensive disorders, which allow for better management without requiring frequent in-person visits.[27] These programs should follow a life-course model that ensures continuity of care well beyond the immediate postpartum period.[28,29]

- **Care teams should encourage expanded maternal health and family support** by educating mothers on how to advocate for their health care needs during postpartum visits and discuss maternal health warning signs. Increase family resiliency and support through identification of support persons or helpers for the parents to call on, day or night. These may be in the form of friends, family, medical providers or community resources. Emphasize the importance of parents' needs, such as sleep, adequate nutrition and general self-care.
- **Provide support to navigate the postpartum care plan based on the patient's situation and needs.** For example, patients with mental health diagnoses may struggle to complete health-related tasks, and patients with housing insecurity may have limited resources to ensure access to care.
- **Care teams should ensure that parents have access to adequate material support,** such as diapers, by providing information and linkage to needed community resources.
- **Before the completion of the comprehensive postpartum visit, maternal care providers and care teams should help patients schedule with a primary care provider** to support the transition to primary care. New patient appointments may require several months' notice, and patients should have adequate time and information provided to them to make an informed decision on their next care provider.
- **Pediatric providers should provide routine mental health screening at well-infant visits occurring at one, two, four, and six months and facilitate follow-up and referral to treatment, including collaboration with the maternal care provider.** Pediatric visits also provide an opportunity to help ensure continuity of care for the infant and lessens the burden on newly postpartum parents.[30] Dyadic care, an emerging model of care also known as the two-generation approach to postpartum care,[31] allows for mothers and infants to have scheduled appointments together at the same location. This is a comprehensive approach to care with a focus on the health of the family, care coordination, assistance with resources and referrals, and the implementation of standardized mental health screenings for all postpartum and pediatric visits, which can significantly improve maternal and infant outcomes.[32]

Best Practices Beyond the Fourth Trimester Through One Year Postpartum

Despite current national guidelines emphasizing a transition to primary medical care after the comprehensive postpartum visit,[33] this transition continues to be a significant challenge. One analysis of electronic health record data found that just 17.3% of 7,926 postpartum patients who received care at federally qualified health centers completed a primary care visit within six months of delivery.[34] Medical home modes show promise to best support complex, broad health care needs (Figure 6).

Figure 6: The Agency for Healthcare Research and Quality defines the primary care medical home, also referred to as the patient centered medical home, advanced primary care and the health care home, as a model for transforming the organization and delivery of primary care through five functions and attributes:[35]

- **Maternal care providers and care teams should implement timely, automated, warm handoff processes to primary care providers to support continuity of care.** Warm handoffs are defined by AHRQ as a patient-centered transfer involving direct communication between providers and active patient engagement.[36] At a minimum, this should include providing the primary care provider with in-hospital documentation (e.g., delivery report, discharge summary and postpartum notes) and explanation of high-risk conditions, risk factors and current treatment and social support service engagement, as applicable.
- **Providers should educate patients on the value of transition to and engagement with primary care to support optimizing health, continued management of chronic conditions, and referrals to necessary services, as well as the differentiations in primary care practices.** When transitioning to primary care, it is important to note that a substantial portion of reproductive-age women receive preventive care directly from their obstetric and women's health care provider, who serve as their PCP. While the recommended preventive services are the same across providers, well-woman visits with OB-GYNs typically occur annually and are more reproductive system focused with limited coverage of general and/or chronic condition health services.[37]
- **All postpartum patients should transition to primary care and receive at least one preventive care visit each year, ideally within six months of delivery,** encompassing the general health care services topics in Figure 7 with a postpartum care plan and appropriate pregnancy/delivery documentation shared between providers.[38] This visit is a key opportunity to support postpartum patients by identifying, addressing and coordinating needs. While this is an annual recommendation, recent research focuses on evaluating transitions to primary care within four or six months postpartum.[39,40]
- **All postpartum patients should see their OB-GYN or PCP as many times as needed during the one-year postpartum period.** Those with chronic conditions, including perinatal mental health conditions, may require more planned health care interactions for ongoing screenings, therapy and medication titration. This variability and individualization in the frequency of health care encounters is further supported through extended Medicaid coverage based on medical necessity and represents a significant shift from the defined standard of one comprehensive postpartum visit. Screening and risk stratification models are one option to support identifying which patients require more health care oversight and interventions and helps quantify their medical and social complexity.
- **Increase provider and patient knowledge of insurance benefits and maximize utilization in the one-year postpartum period to optimize health.** All payers can encourage engagement in postpartum and primary care after a pregnancy through strategic education, referral efforts and reimbursement approach. MCOs can further support these efforts by clearly communicating extended Medicaid benefits through 12 months to patients, providers and the community, including curating collateral materials to educate patients before delivery and at postpartum visits about postpartum benefits and relevant services, and facilitating engagement with primary care providers. Value-based payment models, based on quality of care and outcomes, should be the standard and include billing codes for screening and patient education.

Figure 7: Well-Woman Preventive Health[41] Care Service Topics: General Health

- alcohol use screening and counseling
- anxiety screening
- blood pressure screening
- contraception and contraceptive care
- depression screening
- diabetes screening
- fall prevention
- folic acid supplementation
- healthy diet and activity counseling
- interpersonal and domestic violence screening
- lipid screening
- obesity prevention
- obesity screening and counseling
- osteoporosis screening
- statin use to prevent cardiovascular disease
- substance use screening and assessment
- tobacco screening and counseling
- urinary incontinence screening

Best Practices That Cross the Care Continuum and Should Be Continuously Reviewed and Discussed With Patients From Pregnancy Through One Year Postpartum

- **All pregnant and postpartum patients should have an initial SDOH (as defined by CMS) screening completed during pregnancy, repeated once per trimester and at all postpartum visits to best support patient social needs and mitigate the nonclinical factors related to poor health outcomes.** Identifying barriers such as financial instability, lack of transportation and limited child care throughout pregnancy and after birth can help identify patients at risk of missing essential postpartum care and connect them to appropriate support services.
- **Providers, care teams and systems should implement timely, automated referral pathways and warm handoff processes between both clinical and nonclinical providers to support continuity of care.** Warm handoffs — deemed an essential workflow to improve patient outcomes — should be used to help patients transition between services and providers, creating mechanisms to refer back to the OB, midwife or PCP, as appropriate.[42]
- **PCPs and specialty care providers should request in-hospital documentation (if not provided) from OB providers (e.g., delivery report, discharge summary and postpartum notes), explanation of high-risk conditions and prescribed treatments and current or recommended social services,** as applicable. Additionally, a comprehensive history, specifically obtaining detailed information on symptoms and past medical and gynecologic history, is one of the most important aspects of a well-woman visit.[43]
- **Care teams should regularly evaluate local and regional clinical-community care options** to support effective linkages for the delivery of preventive services.[44] Maternal care, primary care, specialty care and communities are interrelated systems, and patients may interact with a wide variety of providers and services in the year after delivery, including mental health providers, postpartum doulas, CHWs, emergency or urgent care, specialty care and more.
- **Maternal care providers should complete recommended mental health, SUD and trauma screenings universally** at recommended frequencies and with any recognized concerns. Screening all patients regardless of presentation minimizes bias, increases surveillance and offers early intervention options.
- **All providers in all care settings where pregnant and postpartum patients may present should consistently identify pregnant and postpartum patients and urgent maternal warning signs.** Assess for recent or current pregnancy by asking all patients, "Are you pregnant or have you been in the past 12 months?" and considering symptoms and diagnostic criteria relevant to this information.

Figure 8:

Group models of care, such as CenteringPregnancy®, have been shown to be particularly effective for BIPOC patients, resulting in reduced preterm birth, increased postpartum visit attendance and satisfaction, improved mental health, increased rates of breastfeeding initiation and longer breastfeeding duration, and more.

Figure 9:

MISSOURI MODELS

The **University Health Maternal Transitions** program focuses on transitions to primary care after pregnancy for high-risk individuals. Participants are provided remote blood pressure monitoring devices and care management through four months postpartum and counseled on the importance of primary care. Initial primary care appointments are scheduled to establish care while the patient is still pregnant. Dedicated appointment slots are maintained to ensure that participants receive at least two primary care appointments within four to 12 weeks postpartum.

Barriers and Recommendations to Support Implementation of a One-year Postpartum Care Pathway in Missouri

Throughout the Task Force work, multifactorial barriers were consistently identified that exist across the care continuum and prevent patients from having optimal postpartum experiences and outcomes. In the table below (Table 3), these specific barriers, along with recommendations on how to mitigate them, are described across several overarching themes.

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

Figure 10: BIPOC populations often experience additional barriers, or similar barriers at an amplified level, compared to their white counterparts. For example, experiencing discrimination during the delivery hospitalization predicts fewer postpartum visits and being less likely to discuss relevant topics when they do attend.

Recommendations for each barrier theme are organized across four levels: patients and their families; providers; communities; and systems. **While barriers may occur at one level, the recommendations are targeted at the stakeholders in positions to best address them.** For example, while a lack of trust and comfort with the health care landscape may be a patient-level barrier, those best positioned to address this barrier are providers, communities and systems. Addressing these barriers and acting on recommendations is key to supporting implementation of the postpartum care pathway. Payer-related recommendations focus primarily on the opportunities available through 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.

Barriers, resources and recommendations are subject to the current and ever-changing political, policy reimbursement and environmental landscape, and related efforts may be affected by existing structures. While the included barriers and recommendations are extensive, **additional, significant and overarching barriers exist that impede the achievement of optimal postpartum outcomes that lie beyond the scope of this report,** primarily due to an inability to act currently. Examples include the following.

- a lack of support for family-friendly policies, such as paid maternity and family leave[45]
- the dearth of available, affordable, quality child care, especially for infants, in many areas across the state
- significant lag time in payment processing by payers to providers due to lengthy preauthorization and appeals processes, especially for Medicaid providers

The Task Force recommends the continuation of the convening of maternal health stakeholders statewide to encourage adoption of policies that address these significant and overarching barriers and advocate for continued investment in maternal-infant health care improvement.

Table 3: Barriers and Recommendations to Support One-year Postpartum Care

Patient Disparities and Impact of Social and/or Structural Drivers of Health (as defined by CMS)	
Barriers	**Recommendations**
» lack of basic resources, which may include transportation and access to care (clinical, behavioral, therapy, etc.); child care, time constraints and reliable employment; access to technology and broadband (e.g., internet, smartphone services or access to technological innovations like wearable blood pressure/glucose monitors) » underutilization of or lack of awareness of community-centered resources and care models focusing on postpartum health that leverage community health workers, doulas and nonclinical providers for postpartum care » lack of comfort and trust levels of patients and families in the health care system and potential reliance on information sources such as social media » cultural and societal factors, such as stigma, bias and language barriers; stigma related to seeking health care/ asking for help; lack of culturally congruent care and implicit provider bias; lack of support systems for parents » lack of cohesiveness in the community among community-based organizations and providers, potentially due to competition with other CBOs over available funding and lack of funding/ reimbursement for CBOs in general » cost of health care and gaps in insurance coverage	**Recommendations: Provider** » Implement appointment scheduling before delivery for the transition to primary care, if possible, to ensure patient needs are planned for and prioritized. » Incorporate conversations with patients about priority maternal health topics, such as high blood pressure and mental health, utilizing frameworks such as the Ask Me 5 campaign. » Standardize SDOH, mental health and SUD screenings across all maternal care settings to identify and address needs more effectively. » Develop structured processes for SDOH screening and referrals by utilizing clinical and nonclinical perinatal care team members, such as CHWs, nurse navigators and doulas, to increase screening opportunities, warm handoffs and closed-loop referrals. » Increase provider training on cultural congruence, implicit bias and trauma-informed care to include role-play and simulation experiences as well as learning directly from patients. » Provide care that seeks to increase comfort and trust for patients, including collaborative, jargon-free language in a variety of formats (verbal, written, visual, etc.). » Offer alternative formats/services for patient education, such as communication tools like translators and educational materials that are culturally congruent and available in multiple languages.
	Recommendations: Community » Reduce silos and encourage collaboration between different CBOs through increased funding opportunities including payer reimbursement. » Create and disseminate specific postpartum-focused resources by leveraging CHWs, doulas, lactation specialists and nonclinical providers. » Pursue a centralized resource hub for community resources that is frequently updated, widely disseminated and user-friendly. » Increase collaboration with providers, especially between similar organizations such as the Maternal Health Access Project, the Uplift Connection, Postpartum Support International coordinators, peer recovery coaches, lactation support groups, etc.
	Recommendations: System » Expand telehealth services and accessibility for postpartum care to help bridge care gaps for rural and underserved populations. » Emphasize SDOH-related education at various levels within the health system, including an understanding of systems and processes in place for addressing SDOH-related barriers to care. » Pilot value-based payment models, based on quality of care and outcomes, to encourage SDOH screenings/referral processes. » Policymakers should prioritize reducing the stigma associated with Medicaid and other assistance programs by implementing enhanced reimbursement models that emphasize preventive care and promote dignity in access to services. » Provide support for infrastructure development that will increase coordination between health care providers, systems and resources, such as social service platforms and EMRs. » Address SDOH and systemic inequities in statewide plans focused on improving maternal health.

Provider Education and Awareness

Barriers

- provider knowledge base limitations regarding maternal/postpartum care, especially for emergency department providers, family medicine providers and physician assistants/nurse practitioners not specifically trained in women's health; scope of practice limitations on advanced practice providers due to state requirements
- lack of knowledge of the impact and/or management of mental health conditions/SUD
- lack of knowledge of the impact and/or management of acute or chronic conditions during pregnancy on long-term health outcomes for both mom and baby and optimizing health during interconception
- lack of knowledge of community-based resources/referrals

Recommendations

Recommendations: Provider

- Increase knowledge of educational and peer referral resources for providers, such as MHAP and the PSI Perinatal Psychiatric Consult Line.
- Increase effective utilization of closed-loop referrals and warm handoffs between obstetric and primary/specialty care through implementation and streamlined processes.
- Increase awareness of available referral resources by topics/need through provider training opportunities and informational materials/sessions, with an emphasis on mental health, SUD, cardiovascular disease and SDOH needs.
- Create community partnerships and demonstrate transparency in operations within BIPOC communities.
- Increase the use of OB nurse navigators in provider offices.
- Provide ongoing education for all clinicians who encounter perinatal patients, including family medicine and emergency department, regarding risk-appropriate care for this population.
- Improve frequency, quality and content of provider education on implicit bias and its impact on maternal care.

Recommendations: Community

- CBOs/nonprofits/federally qualified health centers disseminate materials for campaigns such as Ask Me 5 in doctors' offices and other provider locations.

Recommendations: System

- Increase awareness of available educational options through provider training opportunities and informational materials/sessions.
- Provide reimbursement and system support for OB nurse navigators.
- Increase reimbursement and support for SDOH and mental health screenings and referrals for both clinical and nonclinical providers.

Patient Health Literacy

Barriers	Recommendations
» limited maternal and postpartum health literacy, including postpartum care, perinatal warning signs, risk factors for morbidity and mortality, and disease prevention and management » lack of knowledge/awareness toward navigating the health system, including: • their multiprovider health care team • the insurance system • administrative burden of scheduling appointments, seeking information, etc. • identifying and accessing referral resources within their insurance program[49] » lack of knowledge of signs/symptoms of perinatal mental health conditions » lack of culturally congruent communication materials and translation services » misinformation through social media, inconsistent messaging, sensationalized headlines and weak community-clinical linkages affects the ability to effectively educate patients	**Recommendations: Provider** » Encourage utilization of insurance benefits throughout the postpartum period by educating patients before delivery and providing nurse navigation/care coordination services that patients can contact. » Support and empower patients to become their own health advocates through education on postpartum health needs, the connection between SDOH and maternal outcomes, and by connecting them to available services. **Recommendations: Community** » Publicize community resources that may be better situated to address patient health literacy gaps and root causes, such as doulas, support groups, social services, etc. **Recommendations: System** » Create reimbursement and support for enhanced patient education with clear, health literacy-appropriate materials that empower individuals to recognize warning signs of disease progression and understand when to seek urgent medical care.

Reimbursement/Payment Model

Barriers	Recommendations
» lack of payment model structure that is supportive of care coordination and innovation, such as nurse navigators, telehealth, remote monitoring, etc. » lack of provider understanding of reimbursement rates and/or network participation when making referrals » reimbursement rates for Medicaid are far below commercial insurance rates, particularly for mental health services » inability for nontraditional providers to bill for all services; example: community-based organizations that provide navigation services such as mental health or SDOH screening » complex reimbursement challenges can lead to some providers, such as those in mental health, being unable to accept insurance » lack of sustainable funding resources and overreliance on competitive and time-sensitive grants and contracts to support services creates siloed efforts and instability in services	**Recommendations: Provider** » provider and billing team education on evolving/new billing codes or reimbursement models **Recommendations: Community** » Continue to engage in developing innovation in payment models, i.e., Medicaid Transformation. **Recommendations: System** » Develop value-based reimbursement models that allow for nonclinical postpartum care providers to bill for services. » Increase reimbursement rates for Medicaid services. » Increase reimbursement and support for SDOH screenings and referrals for both clinical and nonclinical providers.

Workforce Shortages

Barriers	Recommendations
» geographic limitations, with fewer providers in rural areas as well as fewer hospitals with OB services and women's health providers for postpartum care » low number of providers of color affects the ability to provide patient/provider concordance » significant shortage of primary care providers in Missouri makes transition from OB care to primary care difficult » Missouri has witnessed a severe shortage of OB-GYN physicians for years, and approximately 51.6% of Missouri counties are classified as OB-GYN deserts[50] » significant shortage of psychiatrists trained in maternal mental health care, with fewer than 500 in the U.S. to the 800,000 women who experience maternal mental health complications annually[51]	**Recommendations: Provider** » Leverage all types of clinicians to the highest extent of their scope of work and licensure whose education and licensure includes prenatal, postpartum and women's health care. » Incentivize preceptors in rural areas to educate clinicians. » Incorporate rural care into vacancy programs. **Recommendations: Community** » Provide reimbursement for patient care, engagement, education and referral efforts by community-based organizations that may already be providing related services. **Recommendations: System** » Encourage and invest in capability to host clinicals to take place in rural areas and incorporate rural care into training programs. » Expand the scope of practice for APRNs and encourage practice to the top of license.

Research and Data Infrastructure to Support Extended Postpartum Care

Barriers	Recommendations
» lack of statewide infrastructure support for a comprehensive, updated and accurate data system » isolated data systems and disparate collection prevent cohesive care delivery and result in duplicate screenings and lack of successful referrals » lack of EMR utilization and/or standardized data entry processes for SDOH/care coordination capabilities » dearth of quality research efforts funded by universities and statewide organizations » lack of evidence-based studies being conducted regarding postpartum care beyond the fourth trimester to inform a well-defined postpartum care pathway	**Recommendations: Provider** » Develop and utilize efficient referral networks with local organizations for integration with SDOH screening. » Implement digitized, closed-loop resource and referral systems with population-appropriate resources. » Utilize third-party referral support and follow-up (e.g., PSI support coordinators and associated tracking). **Recommendations: Community** » Community-based organizations are often key to bridging and connecting resources where they are needed; encourage relationship building and CBO participation in developing referral networks. » Develop funding and payment mechanisms to support needed CBO services. **Recommendations: System** » Establish a universal closed-loop referral platform that integrates maternal services from CBOs, health care providers and MCOs. » Increase funding dedicated to postpartum research. » Center people with lived experience in the design, collection and analysis evaluation of assessment. » Obtain funding for improved and sustainable data infrastructure. » Integration of SDOH screening into EMRs, with support for health system implementation and provider training. » Establish mechanisms to link maternal and infant data at the clinical level to promote continuity of care, and at the state level to support data collection that represents the full impact of interventions on the dyadic unit.

Topic-specific Best Practice Recommendations

Recognizing that a variety of physical, social and emotional issues are at the forefront during the postpartum period, the Task Force addressed topic-specific best practices and specific recommendations for the following areas of postpartum care.

- postpartum care of chronic and pregnancy-induced conditions
- mental health in the first year postpartum
- addressing SDOH (as defined by CMS) care coordination and patient engagement in postpartum care
- enhancing the maternal workforce for postpartum care delivery

Postpartum Care of Chronic Conditions and Pregnancy-induced Conditions

Women with chronic health conditions or pregnancy-induced conditions can and do have healthy pregnancies, but quality postpartum care also must account for these conditions. Chronic diseases such as hypertension and diabetes are rising among reproductive-age individuals by 67% and 37% respectively. Conditions like obesity, cardiovascular disease, renal and thyroid disorders, mental health issues, and substance use significantly increase risks of adverse maternal (e.g., preeclampsia, hemorrhage) and fetal outcomes (e.g., growth restriction, stillbirth). Pregnancy also may worsen preexisting conditions due to its physiological and psychological demands, while some conditions may actually improve. Additionally, pregnancy-induced conditions, or health conditions associated with the physiological changes of pregnancy, can lead to long-term health impacts (see Table 4).

Table 4: Variability of Chronic Conditions During Pregnancy

Conditions That May Worsen	Conditions That Vary	Conditions That May Improve
chronic hypertensive disorders of pregnancy (preeclampsia, gHTN, HELLP, etc.)	migraines	rheumatoid arthritis
cardiovascular disease	systemic lupus erythematosus	autoimmune conditions
pregestational diabetes (T1DM, T2DM)	asthma	
gestational diabetes		
Crohn's disease		
maternal cardiac conditions		
seizures		
renal disease		
retinopathy		

While numerous chronic conditions can affect pregnancy, this section focuses on chronic disease management of gestational diabetes mellitus and cardiovascular disease during the extended postpartum period[89] — two leading contributors to maternal morbidity and mortality. Unlike less-studied conditions, GDM and CVD have well-established postpartum care protocols and evidence-based recommendations. Task Force recommendations aim to guide future research and inform policy to address existing gaps in postpartum care practices.

Best Practices for Managing Chronic Conditions in the Postpartum Period

Key strategies such as care coordination, patient education and social support are particularly critical for postpartum individuals managing chronic conditions. These patients often require additional resources, multidisciplinary support and structured follow-up to achieve optimal health outcomes in the postpartum period.[55] The following strategies support improved health outcomes for patients with co-occurring chronic conditions.

- **Providers and care teams should utilize care coordination and interdisciplinary support, such as integrated care teams** — including nurse navigators, doulas, social workers and CHWs — to support personalized care, facilitate access to services and improve communication across obstetric, primary and specialty care providers. These roles often have additional time to work directly with patients and their families to identify needs and resources, discuss patient education and support navigation through the health care system.
- **Providers and care teams should support tailoring long-term lifestyle modifications** — such as nutritional counseling, physical activity recommendations and weight management strategies — to mitigate cardiovascular and metabolic risks. However, interventions must consider barriers such as socioeconomic status, food insecurity and limited access to safe exercise environments. Patient-centered goals tailored to cultural and financial contexts can enhance adherence and promote sustainable health improvements.[57] Understanding these contexts supports recognition of resource needs and referrals — such as prescriptions to fresh food programs and free memberships to local community centers.
- **Providers and care teams should recognize the importance of maternal-related interventions to long-term health outcomes and facilitate ongoing follow-up.** Ongoing care should include individualized risk assessments, coordination with primary care and lifestyle counseling on the positive impact of effective management of blood pressure and blood sugar levels, supporting nutrition, and breastfeeding. Ensuring that receiving care providers have a global context and understanding of patient risk factors, recent screening results, current treatment plan and response, and the overall care plan is critical to closing gaps in care, supporting patient navigation of the health care system, reducing redundancy and engaging patients in their plan of care.
- **Health systems should develop condition-specific education materials, incorporating digital platforms, group visits and peer support networks to enhance engagement.** Patient education should focus on culturally tailored, clear, health literacy-appropriate materials that empower individuals to recognize warning signs of disease progression and understand when to seek urgent medical care.[58]
- **Systems should increase telemedicine accessibility for management of chronic and pregnancy-induced conditions to bridge care gaps for rural and underserved populations.** There are opportunities both at the state and regional system structure levels and by individual organizations and providers to better leverage telehealth in support of increasing access and improving health outcomes.

Cardiovascular Disease Management in Pregnancy and the Postpartum Period

Women with CVD require individualized risk stratification using tools such as the modified World Health Organization classification of maternal cardiovascular risk and the American College of Cardiology/American Heart Association guidelines.[59,60] High-risk patients, including those with congenital heart disease, aortic pathology, severe valvular disease or heart failure, should receive preconception counseling and collaborative management involving cardiologists, maternal-fetal medicine specialists and anesthesiologists to optimize maternal and fetal outcomes. During pregnancy, close surveillance of blood pressure, heart function and signs of decompensation are critical. Women with chronic hypertension and those at risk of superimposed preeclampsia should undergo frequent blood pressure monitoring and early postpartum care management as hypertensive disorders can manifest or worsen in the postpartum period.[61,62] Medication management should be tailored to both maternal hemodynamic stability and fetal safety.[63] Home blood pressure monitoring and early postpartum visits (within three days of discharge for mothers with severe features of preeclampsia, within seven to 10 days for hypertensive disorders and within seven to 14 days for those with heart disease) are recommended to detect worsening conditions.[64] The Task Force recommends increasing the use of affordable, accessible technology to support BP monitoring through home devices. Long-term follow-up should include a comprehensive cardiovascular risk assessment at three months postpartum, particularly for those with chronic hypertension, hypertensive disorders of pregnancy, GDM, fetal growth restriction or placental abruption, as these individuals face an increased lifetime risk of cardiovascular disease.

Diabetes Management in the Postpartum Period

Condition management is critical for individuals with both gestational diabetes mellitus and pregestational diabetes (Type 1 and Type 2 diabetes mellitus). Women with a history of GDM are at an increased risk of developing recurrent GDM in future pregnancies, as well as progressing to prediabetes or Type 2 diabetes within five years postpartum.[65,66] These risks are particularly high in individuals with both GDM and hypertensive disorders of pregnancy, further increasing the long-term risk of cardiovascular disease. Unmanaged pregestational diabetes also poses significant risk for the health and viability of a pregnancy, as uncontrolled glucose increases the risk for fetal congenital abnormalities, specifically related to the neural tube and heart.

For individuals with a history of GDM, postpartum glucose screening is recommended at four to 12 weeks postpartum using a two-hour 75-gram oral glucose tolerance test, per the American Diabetes Association and ACOG guidelines. If results are normal, screening should continue at least every three years to monitor for diabetes development.[67] Those with prediabetes should undergo annual screenings, with targeted interventions including weight management, physical activity and dietary counseling to reduce progression to T2DM. Lactation should be encouraged and lactation support provided, as breastfeeding is associated with improved maternal glucose metabolism and a reduced risk of T2DM.[68,69]

For individuals with pregestational diabetes (Type 1 or Type 2 diabetes), postpartum management should focus on tight glycemic control, medication adjustments and ongoing specialist care. Insulin sensitivity fluctuates postpartum, particularly in breastfeeding individuals, necessitating frequent glucose monitoring and insulin titration. Coordination with endocrinologists, PCPs and diabetes educators is essential to ensure seamless postpartum care. Medication safety should be considered, particularly for breastfeeding individuals, ensuring that prescribed antihyperglycemic agents are safe during lactation.[70]

At the system level, the Task Force recommends **improving access to appropriate technology and medications.** Providing access to affordable or insurance-covered glucometers, continuous glucose monitors and essential diabetes medications can enhance postpartum diabetes control and increase adherence to guidelines for glucose targets, such as A1C, to reduce the risk of end-organ damage. Increasing the use of remote monitoring technologies, such as CGMs for those with diabetes, can facilitate real-time disease management while reducing hospital readmissions and emergency care visits.

Figure 11:

MISSOURI MODELS

The **FIT (Fourth Trimester Integrative Transition) Center at SSM Health St. Mary's Hospital – St. Louis** provides postpartum patients with early and late structured support to transition from obstetric care to primary and/or specialty care. Prompt and potentially extended post-pregnancy, primary and specialty care for high-risk patients support the long-term goal of decreasing patients' risk during future pregnancies and lifetime risk of cardiovascular disease and other medical comorbidities. Care includes the following.

- early postpartum care within 72 hours to two weeks postpartum for specific high-risk groups
- continuity of care with regular visits for three to 12 months and/or successful transition to primary care
- appropriate testing at the recommended intervals
- specific cardiovascular risk assessment at minimum of 12 weeks
- access and referrals to ancillary services such as CHWs, social workers and diabetes educators

The **WISH (Women and Infant Substance Help) Center at SSM Health St. Mary's Hospital – St. Louis** provides comprehensive, high-risk maternity care for pregnant individuals affected by substance use disorders utilizing Medication Assisted Treatment therapy. Care encompasses a full range of co-located services, providing nonclinical and clinical services during pregnancy, birthing through the hospitals and an AfterCare program for patients for as many as two years after childbirth, when risk of relapse is greatest. This includes partnerships with outside organizations for such things as job skills, housing, life skills and parenting to help moms maintain their sobriety.

Mental Health in the One-year Postpartum Period

Mental health conditions, including substance use disorders, are a leading cause of preventable pregnancy-related death in Missouri, as highlighted by the 2025 Missouri PAMR report.[71] Despite the existence of national guidelines for mental health screening and treatment,[72] Missouri has yet to universally implement systematic and coordinated evidence-based guidelines. Early identification and intervention during the perinatal period are critical in improving outcomes for both birthing individuals and their children.[73] Because mental health has been identified as the leading cause of maternal mortality in Missouri, this Task Force took on the development of a Postpartum Universal Screening Brief as its first task.

Best Practices for Mental Health Conditions

- **Providers should strive to provide individualized, patient-centered care** based on case-by-case identified need through trauma-informed and culturally competent care, while also providing universal distribution of resources to all pregnant and postpartum individuals, regardless of screening outcomes.
- **Providers, including OBs and PCPs, should receive ongoing education for effective mental health and substance use treatment options** such as those available through Postpartum Support International. Expanded training programs for providers — offered in various formats — can improve competency across various settings. Providers need to self-assess and consider system-level stigma and bias as well as patient-level resistance associated with asking for and receiving help with mental health and SUDs. OBs and PCPs frequently serve as the initial point of contact for mental health concerns for pregnant and postpartum women. However, systemic limitations in access to specialized perinatal mental health services — driven by geographic inequities, resource coverage gaps and racial disparities, inadequate payment models and a lack of cross-trained providers — leave many patients underserved and unaware of existing resources.[74] Due to workforce shortages for OB, primary care and psychiatric providers, the Task Force urges all providers caring for pregnant and postpartum women to further educate themselves on evidence-based mental health care and treatments specific to this population. Addressing these gaps is essential to enhancing the well-being of families and communities. Additionally, incentivizing providers to pursue certifications in perinatal mental health can enhance the quality of care.
- **Early and ongoing universal screening, brief intervention (e.g., short conversation, feedback and advice), and referral for treatment improve both maternal and infant outcomes (Table 5).** Screening should be completed using evidence-based written and verbal screening tools that are validated for use with the population being screened. Update policies that deprioritize urine or blood toxicology testing and suspend use of biased risk assessment checklists and tools. Please refer to the Task Force's Postpartum Universal Screening Brief for further detail on implementing universal screening.[75]

Figure 12: BIPOC birthing people are even less likely to receive mental health screenings as a part of a standard postpartum visit[76] and are more likely to have unmet mental health treatment needs compared to their white counterparts.[77] Providers should meet or exceed required mental health screening guidelines to provide expanded opportunities for conversations and support.

TABLE 5

MENTAL HEALTH AND SUD SCREENING FRAMEWORK		
CLINICAL CARE PROVIDERS	Pregnancy	At initiation of prenatal care (whenever it occurs) and at least once during each trimester
	Delivery	Prior to discharge from the hospital or birthing center (or prior to release from the care of a home birth professional), with a special emphasis on educating pregnant and postpartum individuals and their support person(s) about warning signs
	Postpartum	Within the first three weeks postpartum and at the comprehensive postpartum visit (no later than 12 weeks after birth)[2]
	Nonobstetric	Throughout the first full year following pregnancy, including annually at preventive care visits[11] and at one-, two-, four- and six-month pediatric visits[10] (Note: Some patients may consider obstetric providers to be their primary care provider.)
COMMUNITY- BASED PROVIDERS	At least once during the care relationship and/or per agency guidelines (this may be a home visitor, doulas, CHWs or other community-based providers)	

Table 5: Adapted from the Maternal Mental Health Leadership Alliance Framework

- **Invest in and engage the community workforce to enhance the perinatal mental health landscape.** Given the varied touchpoints that occur throughout the year after delivery, nonclinical providers, including doulas and CHWs, play a significant role in ensuring that mental health and substance use are identified through screening and patients are referred for treatment. Strengthening collaboration between CBOs, the community health workforce and clinical providers is crucial to fostering unified efforts in supporting families. Dyadic care models also ensure both infants and caregivers are adequately screened and treated, reducing health care disparities.[78] Warm handoffs and closed-loop referrals across clinical-community linkages are essential for ensuring patients transition successfully to appropriate care, with proper follow-up to minimize attrition.
- **Providers should be aware of effective treatment options to improve maternal mental health.** Therapeutic support, including cognitive behavioral therapy, eye movement desensitization and reprocessing, dialectical behavior therapy and other modalities, are effective treatment options to improve maternal mental health outcomes. In-person and/or virtual support groups are evidence-based and address perinatal isolation.[79] Depending on severity of symptoms, medication and intensive inpatient and outpatient programs should be evaluated and considered.
- **Provide treatment and referral to recovery services for patients with SUD.** To treat opioid use, medication for opioid use disorder is the standard instead of supervised withdrawal, and buprenorphine or methadone are the recommended therapies. MOUD should be continued postpartum indefinitely, and while most pregnant women will experience dosage increases during pregnancy, dosage reduction might be necessary postpartum and should be titrated to signs and symptoms of sedation, particularly at the peak of the dose (two to six hours).[80] Working closely with the patient to understand symptoms and medication tolerance is critical to supporting sustained recovery. Specific attention should be paid to postpartum individuals who have a history of mood dysregulation or SUDs, as the postpartum period is a particularly stressful period and can lead to exacerbation of symptoms, including relapse in the case of SUD.[81] Screening for postpartum depression should be routine, and assessing for other co-occurring mental health conditions also should be considered if there is a prior history or if concern exists. Screening should continue at frequent intervals throughout 12 months postpartum and be assimilated into well-woman care. Additionally, incentivizing physicians to provide medications for opioid use disorder, particularly in areas where it is currently unavailable may enhance access to care.

Figure 13:

MISSOURI MODELS

The **Stage Care Program by Korédé House** provides pregnant and postpartum women access to doula care, mental health care and group care in the St. Louis area to navigate maternal life stages. Personalized support, peer connections, relevant, targeted content and education, guided meditations, and appointment scheduling are all available through the Stage Care app.

Rooted in storytelling, community and restorative care, Korédé House provides an extension of the Stage Care community through a physical "third space" for mothering and ambitious women. The same support and community are provided to doulas working with Korédé House.

- **Utilize comprehensive treatment frameworks, such as the Lifeline for Moms Perinatal Mental Health Toolkit,[82] Massachusetts Child Psychiatry Access Program for Moms Toolkit for Substance Use Disorder,[83] ACOG,[84] or Alliance for Innovation on Maternal Health and Alliance for Innovation on Maternal Health — Community Care Initiative resource[85] to strengthen the integration of mental health care into OB practices.** Collaborative models that co-locate or link primary care, obstetrics and CBOs, and the variety of provider types/roles that comprise these entities, ensure continuity of care. These models incorporate peer support and the integration of SUD treatment throughout the first postpartum year,[86] fostering a supportive and holistic approach to care coordination.

Figure 14:

MISSOURI MODELS

The **Maternal Health Access Project** is designed to increase the capacity of perinatal care providers throughout Missouri to diagnose and treat their pregnant and postpartum patients' mild to moderate mental and behavioral health conditions. MHAP helps to bridge the gap in mental health providers by equipping more perinatal care providers with the knowledge and resources they need to meet their patients' needs in-house.

MHAP offers same-day provider-to-provider consultations with a team of perinatal psychiatrists; care coordination support for patients; and education and training materials on a wide range of topics related to perinatal mental and behavioral health. All MHAP services are provided at no cost to providers or their patients. Registration is free and open to any professional in the state of Missouri serving perinatal individuals.

- **Educational initiatives should prioritize patient and family engagement through increased awareness of perinatal mood disorders, SUD and intimate partner violence.** These efforts also must include expanding knowledge of postpartum Medicaid eligibility, with corresponding care coordination to help families navigate benefits and access resources. MCOs and insurance providers can encourage these efforts by providing reimbursement for patient engagement, education and referral efforts by care coordinators and CBOs in addition to traditional health system providers.
- **Systemic reforms must enhance and standardize reimbursement processes.** Medicaid and private insurer reimbursement models for mental health and medical care should support sustainability and promote value-based care models incentivizing quality outcomes. Payment models must include reimbursement for community-based referrals and workforce services, increase rate or offer fee-for-service for mental and behavioral health screening and treatment, and support access to timely, collaborative mental and physical health.

Addressing Social Drivers of Health, Care Coordination and Patient Engagement in Postpartum Care

Parents and caregivers in the postpartum period may be balancing competing priorities as the family caregiver, concerns about changes in personal family dynamics that may be different than expected norms, financial constraints, health/healing and unexpected complex medical problems, all of which may affect a patient's ability to engage with the health care team. Often, delivery of a child is the first time a patient may be experiencing hospitalization or surgery, making it difficult to anticipate challenges and advocate for their needs. Further, stigma related to needing additional physical or mental health care and the impact of societal norms and social media trends can create unattainable expectations for new and new-again parents. Addressing SDOH (as defined by CMS), patient education and care coordination provide additional opportunities to support increased and more effective engagement, particularly for the most in-need moms and families.

CMS defines social drivers of health, also referred to as social determinants of health, as "the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." SDOH refers to community-level factors. CMS' definition is adapted from CDC Healthy People 2030. In addition, CMS defines health-related social needs as "social and economic needs that individuals experience that affect their ability to maintain their health and well-being." These needs put individuals at risk for worse health outcomes and increased health care use. HRSN refers to individual-level factors such as financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care, and lack of access to transportation. This definition is adapted from the U.S. Department of Health and Human Services.

These drivers extend beyond individual health behaviors and medical care, encompassing factors such as housing stability, access to clean water and nutritious food, child care, employment, education, built environment, transportation and language accessibility.[87,88] In the postpartum period, SDOH can significantly affect maternal and infant health outcomes, creating challenges for postpartum individuals seeking necessary care. Exposure to discriminatory practices and lower socioeconomic status are key drivers affecting many nonclinical issues and can lead to worse maternal and infant health outcomes in affected populations.[89,90] Most pregnancy-related injury deaths occurring in Missouri had a documented history of intimate partner violence and all were the result of homicide.[91] Addressing these nonclinical factors through approaches such as patient education and care coordination is critical to ensuring fair access to maternal health care and improving outcomes for women and infants.

Effective care coordination fosters system-level changes by addressing root problems, increasing patient advocacy and encouraging more effective communication between traditionally siloed organizations.[92] Although there is not a standard definition of care coordination, the goal of care coordination is to streamline the organization of a patient's care across multiple environments.[93] This process is particularly vital for postpartum patients who often have many care providers, as it helps them manage referrals, visits, lab results, provider recommendations, insurance coverage, out-of-pocket costs, medication regimens, and access to social and material supports.

It consists of several elements, including navigation and advocacy within complex health systems; effective referrals and handoffs; and the continual updating of resource guides and technology for both patients and health care teams. Care coordination can significantly affect health and lead to improved physical and mental health outcomes and patient satisfaction while lowering costs for insurers, as well as increasing time with patients, leading to increased patient engagement and more respectful care. Holistic care coordination efforts recognize the value of CBOs and other community partners, increasing community-clinical integration efforts.

Care coordination and the role of CBOs are vital in BIPOC patient advocacy. CBOs can improve communication among a patient's care providers, amplify the voices of BIPOC patients, address misinformation and tailor messaging to best meet patients where they are.[94]

Related, the goal of patient education is to provide an understanding of a health condition and all available treatment options to achieve the desired health outcome and improve the patient's quality of life.[95] Health literacy — shaped by education, culture, language and care settings — involves both personal and organizational stakeholders, such as providers, payers, communities and health systems.[96] Personal health literacy refers to an individual's ability to find, understand and use information for health decisions, while organizational health literacy entails the systems' ability to provide fair and just access to understandable health services.[97] Patient education is most effective when it fosters shared understanding, aligns with patient values and supports navigation of the health care system, ultimately enhancing outcomes and resource utilization. With 88% of adults in the U.S. demonstrating limited health literacy[98] and an increasing number of residents from different backgrounds, the need for effective patient education and engagement strategies that consider various cultures is urgent.[99]

Figure 15:

MISSOURI MODELS

The Doula Foundation is dedicated to improving maternal health outcomes and mental well-being in southwest Missouri by reducing barriers to health care and community resources. Through a network of community-based doulas and perinatal community health workers, the Foundation provides birth and postpartum support, in-home visits, care coordination and community navigation services. These comprehensive, culturally responsive services help connect families to vital resources, improve access to care and promote healthier outcomes during the postpartum period.

Experiencing stigma and bias during health care encounters can be highly detrimental to patient engagement.[101] Providing culturally congruent information, both verbally and in print, that is written in plain language and designed with the experience of BIPOC patients in mind, can result in greater engagement throughout the prenatal and postpartum periods.

Best Practices to Address SDOH During Postpartum

- **Standardize SDOH (as defined by CMS) screening (including IPV), across maternal care settings,** including outpatient, inpatient, emergency department and community-based organizations — from pregnancy through 12 months postpartum. Screening should be done using validated screening tools (Table 6) at least once per trimester, and at all postpartum visits, including those with pediatrics and family medicine providers. Providers should receive education on integrating SDOH (as defined by CMS) screening and discussions into clinical care as part of ongoing professional development and maintenance of certification requirements. Universal screening should be implemented for all patients, regardless of insurance status, to ensure fairness in accessibility and outcomes. Additionally, normalizing and destigmatizing the use of public health resources, such as food assistance (WIC, SNAP), housing and transportation support, is essential. Insurance-related barriers that limit individuals' eligibility for SDOH (as defined by CMS) assistance should be examined and eliminated.

- **Expand models that mitigate the impact of SDOH (as defined by CMS) and increase available resources through these models.** Developing prenatal and parenting education programs like Group Prenatal Care that highlight the importance of addressing nonclinical factors in postpartum care is crucial. Community-driven initiatives like community baby showers can help foster social support networks and resource connections. Co-locating services, such as WIC offices within doctor's offices, can increase access and opportunity for patients to utilize these services.
- **Screening should be expanded beyond traditional health care settings to include emergency department visits, outpatient care, pediatric visits, WIC appointments and community-based settings.**[100] The obstetrical provider (i.e., obstetrician, family medicine physician, midwife, doula) must ensure a warm handoff and clear communication for optimal care.

Table 6: Examples of Commonly Used SDOH (as defined by CMS) Screening Tools

Tool Name	Overview	Topics Addressed
The PRAPARE® Tool[102]	17 core questions + 5 supplemental questions	• socio-demographic • food insecurity • housing instability • utility needs • transportation • financial resource strain • employment • family and community support • education • social and emotional health • safety and exposure to violence • incarceration
The Hunger Vital Sign™[103]	2 questions	food insecurity
The Health Leads Screening Toolkit[104]	10 questions	• socio-demographic • food insecurity • housing instability • utility needs • financial resource strain • transportation • exposure to violence • optional: child care, education, employment, health behaviors, social isolation and support, mental health
Accountable Health Communities Health-related Social Needs Screening Tool[105]	35 questions	• food insecurity • housing instability • utility needs • financial resource strain • employment • family and community support • education • transportation • safety • physical activity • substance use • mental health • disabilities

- **Emerging models of care that include the addition of support providers and services to the postpartum person should be supported as sustainable models.** The integration of perinatal doula care as a standard part of the maternal care team has been demonstrated to improve maternal health outcomes, particularly in communities that experience more significant health disparities and worse outcomes.[106] To ensure long-term maternal and infant health support, sustainable reimbursement models should be established for community-based home visiting programs, such as Healthy Start and Nurse-Family Partnership. Additionally, embedding care navigation services into routine prenatal and postpartum care and providing sustainable reimbursement can systematically address SDOH (as defined by CMS) barriers.[107]

Best Practices to Address Care Coordination During Postpartum

Health systems, outpatient clinical providers and community health centers, and CBOs play a critical role in providing maternal health care coordination, but challenges exist around limited communication between clinical providers, CBOs and other relevant stakeholders such as MCOs, local and state health departments, integrated technology systems and more. A robust referral and record-keeping system is vital to effective care coordination.

- **Care teams and systems should leverage a broad and varied health care workforce to support postpartum care.** Promoting the use of care coordinators/navigators and translators, when available, and engagement in learning opportunities will further empower individuals. Systems and communities also must reinforce organized partnerships that support care transitions. A workforce that is more representative of the patient population can improve care experience measures, as research has shown that greater representation of physicians of color, especially in the primary care physician field, is associated with better population health.[109]
- **Employ staff accountable for care coordination in each office setting.** Each practice should include designated personnel, such as a nurse coordinator, to provide care coordination responsibilities. These processes should include integrating different provider roles in the clinical workflow, such as doulas, home visitors and CHWs who can best serve patients within their homes and communities. Emerging models of care suggest the effectiveness of more comprehensive maternal health teams, including clinical providers, care coordinators, CHWs trained in Medicaid and SNAP applications, doulas, social workers, counselors or peer support specialists. Further, a variety of home visiting models, such as Nurse-Family Partnership, Maternal and Infant Early Childhood Home Visiting and community-based Healthy Start programs, enhance clinical maternal health teams by providing community-based and home visiting resources to support care coordination activities.[110] These teams can enhance maternal outcomes by extending their reach to patients before pregnancy and maintaining continuity of care through the postpartum period.
- **Cultivate strong working relationships and communication pathways among members of the postpartum individual's care team.** The Task Force asserts that tools such as referral platforms are only effective if staff are trained and dedicated to care coordination and making the additional connection patients need to support utilization, navigation and evaluation of impact.
- **Payers should reimburse care coordination services.** Training in motivational interviewing,[111] cultural humility[112] and trauma-informed care[113] should be encouraged and supported by employers and the payer system.

- **A statewide, centralized resource mapping initiative should be implemented and publicly available.** These efforts should include patient-friendly, easy-to-follow utilization processes for accessing the listed resources specific to perinatal resources. Reducing administrative barriers that make it difficult for individuals to access social support programs also is essential. To maximize their impact on maternal outcomes, organizations and payers should ensure available benefits, such as transportation and remote blood pressure monitors, are easily accessible for patients and providers through simple processes.
- **Invest in clinical-community integration models and technology resources to increase referral coordination and efficiency.** Technology platforms should integrate all CBOs, health care providers and organizations, and MCOs, and resources specific to the needs of pregnant and postpartum families; thus, enabling seamless communication and coordination across clinical and community providers. The platform should include standardized patient screening tools, adopted by each organization, to minimize redundancy and decrease burden on patients created by repetitive screens or procedures. Additionally, the platform should include services specific to the needs of the prenatal and postpartum population. Accessible medical records and training for patients to use systems and messaging, such as MyChart and other patient portal models, make communication and follow-up straightforward and efficient.
- **Invest in comprehensive, unified EMR systems and EMR interoperability.** Transitioning to a single EMR system with accessible maternal and postpartum resources across the state would streamline record-keeping and referrals (both for health indicators and nonclinical indicators), reduce administrative burden and improve care continuity. Further, mother and infant charts should be linked to facilitate care across the maternal newborn dyad.

Figure 17:

MISSOURI MODELS

The **Bootheel Perinatal Network** strives to ensure every family in southeast Missouri receives the blessing of access to comprehensive, coordinated care before, during and after pregnancy through their Clinical Community Integrated Care Coordination model. Through the Bootheel Resource Network, they are addressing social needs by connecting local health care and community providers through closed-loop referrals via the UniteUs technology platform through one year postpartum.

Best Practices to Address Patient Engagement During Postpartum

Effective patient education and engagement hinges on practices that ensure comprehension, foster trust and support health for all. Emerging models of care emphasize assessing both personal and organizational health literacy to best provide appropriate resources and services.[114,115] Leveraging social platforms and technology to disseminate accurate information, providing training to incorporate cultural humility, and employing motivational interviewing and reflective listening techniques are all strategies that enhance communication and trust.[116] Utilizing scribes and note-taking technology allows clinicians to focus fully on the patient rather than on taking notes.

- **As a minimum standard of care, providers should assess the patient's understanding of the health information being shared** by using techniques like the teach-back method, speaking in plain language, and minimizing distractions such as note-typing or documenting while completing patient care and conversations. For non-English speaking patients, availability of translation services and translated materials are critical. Patience is at the forefront of effective provider-patient interactions. Education should be accessible, personalized and inclusive of multiple learning methods, accommodating various literacy levels and cultural backgrounds. Building time into visits for questions and co-developing treatment plans based on patient values promote deeper engagement.
- **Providers and care teams should facilitate and encourage preparation for visits for patients and families,** such as bringing questions and seeking trustworthy information, to enhance understanding. Offering educational materials in multiple formats such as print, video and in-person instruction, and delivered through a variety of platforms, such as text messaging, online and in-person, can help overcome health literacy barriers. Campaigns that disseminate positive, accurate messaging and connect patients to resources can counter misinformation and provide needed resources.
- **Providers should adopt a humanistic approach, practicing cultural and academic humility, and being mindful of implicit biases.** Using collaborative, jargon-free language in a variety of formats (verbal, written, visual, etc.) and offering alternative times or formats for education can help meet patients where they are. Providers should strive to become a trusted and primary source of education and create a welcoming environment, disseminating positive messaging and directing patients to reliable sources of information and support services. Asking questions such as "What can I explain better?" or "What could I do differently?" can help foster choice and increase patients' self-efficacy. The AHRQ's guide on patient education and engagement offers several examples of evidence-based best practices, including the Teach-Back strategy, the SHARE Approach (Seek, Help, Assess, Reach, Evaluate) and more.[117]

Figure 18:
MISSOURI MODELS

Obstetric care, primary care and emergency care providers notify the MO HealthNet Division and the MCOs of a participant's pregnancy through the **Notification of Pregnancy and Risk Screening** process. This process, recently changed, now includes questions intended to notify MHD and the appropriate managed care plan for the participant's demographic information, clinical risks and nonclinical factors to ensure support and resources can be provided as early as possible. Two screenings are reimbursable per pregnancy — one prenatal and one postpartum.

Figure 19:
MISSOURI MODELS

The **Ask Me 5 Campaign** is a statewide initiative from the MO PQC designed to improve maternal health outcomes through five essential health questions that build trust, open dialogue and address critical health concerns.

- **H**igh blood pressure
- **E**motional and mental health
- **A**ccess to care
- **R**ecognizing substance use
- **T**rauma, abuse and safety

Rooted in evidence-based practices, this campaign empowers

- providers with tools to enhance patient interactions, deliver compassionate care and improve health outcomes.
- patients to advocate for their own health, creating confidence and trust during their pregnancy and postpartum journey.

Enhancing the Maternal Workforce for Postpartum Care Delivery

Maternal health deserts and shortages of PCPs, mental health professionals, psychiatrists trained in maternal mental health and providers of color in Missouri significantly make an impact on the ability to deliver quality, comprehensive postpartum care. In the effort to effectively leverage a broad and varied health care workforce, support access to care and implement 12 months of postpartum care, workforce gaps must be addressed.

Best Practices for Improving the Maternal Health Workforce for Postpartum Care Delivery

- **The Task Force asserts that all types of clinicians should be leveraged to the highest extent of their scope of work and licensure whose education and licensure includes prenatal, postpartum and women's health care.** Given workforce shortages noted across several primary and subspecialist service providers, (e.g., OB, psychiatric, addiction medicine, social work), identifying and clarifying roles and responsibilities for licensed clinicians is critical to addressing barriers and implementing the postpartum care pathway recommendations. Collaborative practice agreements between medical and advanced practice licensed providers should be standardized, based on practice within the fullest extent of the licensure, and consider a pathway to independent practice (similar to a residency/fellowship model) to increase the capacity and capability of this critical workforce, especially in underserved communities.
- **Invest in and engage the community-based workforce by providing reimbursement for patient care, engagement, education and referral efforts by community-based organizations.** Strengthening collaboration between CBOs, the community health workforce and clinical providers is crucial to fostering unified efforts in supporting families. Warm handoffs and closed-loop referrals across clinical-community linkages are essential for ensuring patients transition successfully to appropriate care, with proper follow-up to minimize attrition.
- **Educators and policymakers should facilitate workforce recruitment and development for underserved areas and populations** and implement strategies to attract and retain OB-GYNs to rural and underserved areas, including incentivizing preceptors in rural areas to educate clinicians, incorporating rural care into vacancy programs, investing in the capability of host clinicals to take place in rural areas and incorporate rural care into training programs, and increasing medical school matriculation for BIPOC students and students from low-income or under-resourced communities.
- **Doulas and community-based midwives should be engaged as part of the maternal care workforce by implementing training pathways and sustainable reimbursement models.** The Task Force recommends pathways to training and certification for both doulas and non-nurse midwives, and increasing the number of midwives and doulas, particularly in underserved and under-resourced areas. Policymakers and payers should improve coverage of, and payment at livable wages for, services by midwives and doulas, and invest in freestanding birth centers and home-based birth. Further, education should be provided to medical and social teams to expand knowledge and understanding of the role differentiation of doulas and community-based midwives, and all parties should make efforts to increase communication and care coordination to support improved outcomes.
- **A wider range of perinatal mental health providers should be recruited and reimbursed at a livable wage rate,** including PMH-Cs, certified peer support specialists and doulas.

Conclusions and Looking Ahead

Transforming postpartum care into an ongoing, structured process that extends through 12 months post-birth and transitions to well-woman care is essential for improving both maternal and infant health outcomes. A comprehensive approach — integrating patient education, provider training, community-based support and systemic policy changes — is necessary to bridge existing gaps and establish a more effective postpartum care system.

The Task Force has taken the first step of building a framework that aims to outline a comprehensive, evidence-supported approach in the one-year postpartum period; however, they recognize that the best report only affects communities if it is disseminated and implemented with the trust and engagement of the community at the forefront. To achieve the outlined best practices and recommendations will require the concentrated and visible commitment of all stakeholders in maternal-infant health and a willingness to think and vision creatively in a landscape with limited resources.

Recognizing the provider audience is both broad and varied in role, the Task Force initially aims for wide dissemination to those who encounter pregnant and postpartum women at any point up to one year postpartum. This includes, but is not limited to, FQHCs, OB-GYN offices, PCP and family practice offices, hospital systems, payers/insurers including Medicaid and commercial, policymakers at various levels (health systems, regional, statewide), decision-makers in the corporate sector, emergency departments, local public health agencies (especially WIC offices), home visitation programs, and professional organizations such as ACOG, American Academy of Pediatrics, PSI, and the Academy of Family Physicians, among others.

The next steps after dissemination will be supporting the implementation of recommendations through various stakeholders, either already invested in this work or well-positioned to support action, including the patient voice. Aligning recommendations in this report with the developing state maternal health plan and leaning in to support pilots that further study and evaluate the impact of Task Force recommendations is underway. Considering how to intentionally solicit feedback and provide ongoing evaluation of the utility and relevance of the content also is a planned next step. Evaluation efforts planned include collaborating with key partners to develop a statewide, key performance metrics dashboard to track progress on use of the pathway and implementation. These dissemination, implementation and evaluation efforts will rely on the ongoing support of Task Force members and the broader community. Methods may include conference presentations, community engagement events, webinars and targeted educational materials, among others.

By implementing these best practices at the patient service level and addressing key barriers to the patient, provider, community and system levels, Missouri can build a sustainable, all-encompassing postpartum care model that prioritizes maternal, infant and family health well beyond childbirth.

Resources

General

MO PQC: Postpartum Discharge Transition Workbook
MO PQC: Perinatal Mental Health Conditions Workbook
MO PQC: Evidence-Based Care for Maternal-Infant Dyads Affected by Substance Use Disorder Workbook
MO PQC: Preconception and Interconception Care Workbook
MO PQC: Cardiac Conditions in Obstetric Care Workbook

AIM: Patient Safety Bundles

ACOG: Optimizing Postpartum Care
ACOG: ACOG Postpartum Toolkit for Health Care Providers
Alliance for Innovation of Maternal Health Community Care Initiative: Community Care for Postpartum Safety and Wellness
American Academy of Family Physicians: Postpartum Care: An Approach to the Fourth Trimester
MO PQC: Integrating Doula Care Into Clinical Settings
MoMMAs Voices: Training for People With Lived Experience

Checklists and Templates

4th Trimester Project: Postpartum Care Plan Template
4th Trimester Project: Postpartum Support Plan for New Parents
4th Trimester Project: Postpartum Visit Checklist
PSI: Your Postpartum Plan
Postpartum Support Virginia: Postpartum Plan for Parents and Families
ACOG: Postpartum Care Checklist
Society for Maternal-Fetal Medicine Special Statement: Postpartum visit checklists for normal pregnancy and complicated pregnancy
SMFM Special Statement: Checklist for postpartum discharge of women with hypertensive disorders
Women's Preventive Services Initiative: Recommendations for Well-Woman Care

Mental Health Resources

MO PQC: Postpartum Universal Screening Brief
MHAP: Missouri Maternal Health Access Project
Health Resources and Services Administration: National Maternal Mental Health Hotline
Federal Communications Commission: 988 Suicide and Crisis Lifeline
Postpartum Support International: HelpLine
The Uplift Connection: Missouri Perinatal SUD Resources

PSI: Mental Health Trainings

PSI: Certification in Perinatal Mental Health
National Alliance on Mental Illness: Mental Health for New Parents

Risk Assessment and Screening Tools

MCPAP for Moms: Key Clinical Considerations When Assessing the Mental Health of Pregnant and Postpartum Women
MCPAP for Moms: Screening and Brief Intervention for Substance Use in Pregnancy
MCPAP for Moms: Depression Screening Algorithm for Obstetric Providers
MCPAP for Moms: Bipolar Disorder Screen
Health Leads: Social Needs Screening Toolkit
PRAPARE®: Implementation and Action Toolkit
CMS: A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights
Heart: Pregnancy in Congenital Heart Disease: Risk Prediction and Counselling
European Heart Journal: 2018 ESC Guidelines for the Management of Cardiovascular Diseases During Pregnancy
Circulation: Prospective Multicenter Study of Pregnancy Outcomes in Women With Heart Disease
Heart: Prospective Validation and Assessment of Cardiovascular and Offspring Risk Models for Pregnant Women With Congenital Heart Disease

Patient Resources

Missouri Department of Elementary and Secondary Education: Missouri Family Resources
Missouri State Agencies: Healthy Moms, Healthy Babies
MO DHSS: Missouri WIC
Missouri Safe Sleep Coalition: Resources
Healthy Children: Your Child's Checkups
MO DESE: First Steps

Education

Health Care Professional-facing Materials

4th Trimester Project: Postpartum in Practice: Practice Guidelines and Billing
4th Trimester Project: Clinical Tools for Care Teams
CDC: "Hear Her" Campaign
Reproductive Health National Training Center: Urgent Postpartum Warning Signs
MO PQC: Ask Me 5
Children's Trust Fund: CRIS Link: Missouri Home Visiting Referral System
MHA: Moving Beyond the S of "SBIRT" — Part 1
MHA: Moving Beyond the S of "SBIRT" — Part 2
Florida Perinatal Quality Collaborative: SBIRT Example Video
Kansas Maternal and Child Health: Additional Example Videos

Patient-facing Materials

CDC: "Hear Her" Campaign (also available in various languages)
AIM: Urgent Maternal Warning Signs
ACOG: Pregnancy Status Signs in English and Spanish
MO PQC: Ask Me 5

Respectful, Fair, Just and Supportive Care

ACOG: Communication Strategies for Patient Handoffs
AHRQ: Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families
March of Dimes: Beyond Labels: Do Your Part to Reduce Stigma
ACOG: Respectful Care eModules
Institute for Healthcare Advancement: 10 Elements of Competence for Using Teach-Back Effectively
IHA: Always Use Teach-Back! Training Toolkit
IHA: Teach-Back Quick Guide
Ottawa Hospital Research Institute: Patient Decision Aids: Implementation Toolkit
AHRQ: SHARE Approach Curriculum Tools
CMS: Providing Language Services to Diverse Populations: Lessons From the Field
Rural Health Information Hub: Enhancing Services for Deaf, Hard of Hearing, and Deafblind Patients in Rural America

Trauma-informed Care

SAMHSA: Practical Guide for Implementing a Trauma-Informed Approach
Trauma-Informed Care Implementation Resource Center: All Resources
Journal of Obstetric, Gynecologic, & Neonatal Nursing: National Partnership for Maternal Safety: Consensus Bundle on Support After a Severe Maternal Event
AIM: Patient Support After a Severe Event: The Importance of Providing Trauma-Informed Care
AIM: Implementing a Clinician and Staff Peer Support Program
Crisis Prevention Institute: 3 Keys to Help Staff Cope With Secondary Trauma

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