To return to this screen
Click this icon
In your system tray
January Learning Forum

Betsy & Terrah
Creating a Postpartum Care Team
During the presentation, the chat will send questions to Anne Maack.

Click here to open the Chat feature.
The Fourth Trimester Initiative

Through this work we will engage and empower patients, their families and support system, providers, and Kansas communities to intentionally improve maternal health outcomes with our collective, inspired effort.
Welcome!

Introduce yourself on the chat and tell us what PRN is an abbreviation of 😊
Rapid Response

Monthly goal: Hot topics in maternal health

✓ We are a PODCAST!!!!

✓ New Medicaid/KanCare policy for Maternal Depression Screenings!
  ▪ Feb Learning Forum: Mental Health Toolkit for the bedside providers

✓ https://newmomhealth.com/: “Fourth Trimester Project”

✓ Syphilis: KDHE statement 11-30-20

✓ COVID Update
The Kansas Connecting Communities (KCC) team will share information on the Maternal Mental Health landscape in Kansas and resources available through KCC and beyond to support provider capacity for the early identification of and intervention for perinatal mental health and substance use screening, referrals, and treatment support.

Guest Speakers:
Melissa Hoffman, DNP, APRN, PMHNP-BC, KCC Expert Consultant and President of PSI-KS and, Patricia Carrillo, KCC Program Manager
Leaders in Women’s Health Encourage Health Workers to Receive the COVID-19 Vaccine

Vaccination is the Key to Preventing New Infections

January 13, 2021 – During the COVID-19 pandemic, public health measures such as physical distancing, masking, hand hygiene, and appropriate personal protective equipment for healthcare personnel have proven critical in minimizing the spread of existing COVID-19 infection. Vaccination is the key to preventing new infections and is an important next step to combatting the COVID-19 pandemic and saving lives.

“Frontline health workers are encouraged to be vaccinated, to learn the safety profile of approved vaccines, and to inspire vaccine confidence among their communities,” said Judette Louis, MD, MPH, President of the Society for Maternal-Fetal Medicine. “In addition to affording significant individual-level protection, keeping healthcare workers safe protects the workforce so we can continue to provide care to those who are sick with COVID-19 or other illnesses. By preventing the COVID-19 infections, vaccination also helps prevent healthcare workers from spreading COVID-19 infection to patients and other healthcare workers.”

Vaccinations Are Safe and Effective
The vaccines that are currently approved for the prevention of COVID-19 (Pfizer and Moderna) in the United States are mRNA vaccines, which help the body create antibodies to fight future infection. The vaccines do not contain live COVID-19 virus. Data suggest that mRNA is rapidly degraded in the body by normal cellular processes in about 10 to 20 days.

The Pfizer vaccine study included 43,448 people who received two doses of the vaccine 21 days apart. The efficacy of preventing COVID-19 after the second dose was 95%. The Moderna vaccine study included 30,350 people who received two doses of the vaccine 28 days apart. The efficacy of preventing COVID-19 after the second dose was 94.1%. Common side effects of both vaccines include mild to moderate fever, headache, and muscle aches. These side effects suggest that the immune system is working.
COVID-19 Vaccine Update

Is the COVID-19 vaccine safe and recommended for pregnant women?

- The emergency use authorization does not address the safety or effectiveness of the vaccine for pregnant women.
- Currently, CDC and ACOG recommend the vaccine for pregnant women if they are a priority population in the vaccine rollout plan (e.g., health care staff, essential frontline workers).
- It is important for you, as a pregnant woman, to stay informed and talk with your healthcare provider so you can make an informed decision that is best for you and your baby, based on your history, level of risk and likelihood of exposure.
### Kansas Resident Assorted Birth Statistics, 2019

#### Number of Births by Population Group of Mother, Kansas, 2019

- **Hispanic, 6,069**
- **Other/Multi-Race Non-Hispanic, 1,098**
- **Asian/Pacific Islander Non-Hispanic, 1,225**
- **Native American Non-Hispanic, 147**
- **Black Non-Hispanic, 2,419**
- **White Non-Hispanic, 24,400**

#### Pregnancy Outcomes, Kansas, 2019

- **Abortions, 3,543**
- **Stillbirths, 192**
- **Live Births, 35,395**

### Payor Breakdown 2019

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Number</td>
<td>10488</td>
<td>19989</td>
<td>2605</td>
<td>20</td>
<td>1562</td>
<td>245</td>
<td>317</td>
<td>169</td>
<td>35,395</td>
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<tr>
<td>Percent</td>
<td>29.6</td>
<td>56.5</td>
<td>7.4</td>
<td>0.1</td>
<td>4.4</td>
<td>0.7</td>
<td>0.9</td>
<td>0.5</td>
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</tbody>
</table>
Kansas Resident Birth & Death Statistics, 2019

Leading Causes of Death for Women Ages 15-44, Kansas, 2019

Other Birth Statistics, Kansas, 2019

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Births</td>
<td>35,395</td>
</tr>
<tr>
<td>Number of Mothers That Breastfed @ delivery</td>
<td>31,339</td>
</tr>
<tr>
<td>Number of Mothers That Smoked During Pregnancy</td>
<td>3,582</td>
</tr>
<tr>
<td>Number of Maternal Deaths</td>
<td>7</td>
</tr>
<tr>
<td>Stillbirths (&gt;20 weeks)</td>
<td>192</td>
</tr>
</tbody>
</table>

The Kansas 2019 birth rate was 12.1 births per 1,000 population, a 3.2% decrease from 2018 and the lowest birth rate since the state started keeping records in 2011.

REPORT PREPARED DECEMBER 18, 2020  15:53

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT - BUREAU OF EPIDEMIOLOGY AND PUBLIC HEALTH INFORMATICS
Are you tired yet, KANSAS??


- Expert Medical Care (Inpatient PP, Outpt PP, Well Woman)
- Mechanisms to assure timely referral and follow up
- **Postpartum Care Team**
  - Standardized Screening (Medical, social needs, etc)
  - Personalized Patient Plan of Care/Mom Plan
  - Reproductive Health Planning
  - Comprehensive Well Woman Exam attendance
  - Ongoing insurance coverage
Today’s Goal: CIRCLE of Care

NAS to Maternal Health: Building a Postpartum Care Team
Times are CHANGING... finally!

ACOG COMMITTEE OPINION

Number 736 • May 2018

Optimizing Postpartum Care

Recommendations and Conclusions

The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions:

- To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman’s individual needs.
- Anticipatory guidance should begin during pregnancy with development of a postpartum care plan that addresses the transition to parenthood and well-woman care.
- Prenatal discussions should include the woman’s reproductive life plans, including desire for and timing of any future pregnancies. A woman’s future pregnancy intentions provide a context for shared decision-making regarding contraceptive options.
- All women should ideally have contact with a maternal care provider within the first 3 weeks postpartum. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth.
DIAGRAM #1: KPQC Goals & QI Projects (12.20)

Make Kansas the Best Place to Birth & To Raise a Family

- Prevent Perinatal Mortality & Morbidity
- Prevent Infant Morbidity & Mortality
  - Improve Maternal Health
  - Improve Infant Care
  - NAS

Fourth Trimester Initiative
“Mom Plan”

The Postpartum Care Plan

= HEALTHY Moms
The “Mom Plan”

“Fourth Trimester Initiative, a cutting edge approach to study and improve the experience of our mothers and families in Kansas ... to intentionally improve maternal health outcomes with our collective, inspired effort”
# The Postpartum Care Plan

## Table 1. Suggested Components of the Postpartum Care Plan*

<table>
<thead>
<tr>
<th>Element</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care team</td>
<td>Name, phone number, and office or clinic address for each member of care team</td>
</tr>
<tr>
<td>Postpartum visits</td>
<td>Time, date, and location for postpartum visit(s); phone number to call to schedule or reschedule appointments</td>
</tr>
<tr>
<td>Infant feeding plan</td>
<td>Intended method of infant feeding, resources for community support (e.g., WIC, Lactation Warm Lines, Mothers’ groups), return-to-work resources</td>
</tr>
<tr>
<td>Reproductive life plan and commensurate contraception</td>
<td>Desired number of children and timing of next pregnancy&lt;br&gt;Method of contraception, instructions for when to initiate, effectiveness, potential adverse effects, and care team member to contact with questions</td>
</tr>
<tr>
<td>Pregnancy complications</td>
<td>Pregnancy complications and recommended follow-up or test results (e.g., glucose screening for gestational diabetes, blood pressure check for gestational hypertension), as well as risk reduction recommendations for any future pregnancies</td>
</tr>
<tr>
<td>Adverse pregnancy outcomes associated with ASCVD</td>
<td>Adverse pregnancy outcomes associated with ASCVD will need baseline ASCVD risk assessment, as well as discussion of need for ongoing annual assessment and need for ASCVD prevention over lifetime.</td>
</tr>
<tr>
<td>Mental health</td>
<td>Anticipatory guidance regarding signs and symptoms of perinatal depression or anxiety; management recommendations for women with anxiety, depression, or other psychiatric issues identified during pregnancy or in the postpartum period</td>
</tr>
<tr>
<td>Postpartum problems</td>
<td>Recommendations for management of postpartum problems (i.e., pelvic floor exercises for stress urinary incontinence, water-based lubricant for dyspareunia)</td>
</tr>
<tr>
<td>Chronic health conditions</td>
<td>Treatment plan for ongoing physical and mental health conditions and the care team member responsible for follow-up</td>
</tr>
</tbody>
</table>

Abbreviations: ASCVD, atherosclerotic cardiovascular disease; WIC, Special Supplemental Nutrition Program for Women, Infants, and Children.

*Postpartum Care Plan Template is available as part of the ACOG Pregnancy Record.
“New” Model: The Postpartum Care Team

Nurses

Infant Health provider
Specialty Provider
Support persons
OB Navigator
Lactation Support
Home Visitor
### Why does it work? Why does it matter?

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Role</th>
</tr>
</thead>
</table>
| Family and friends                                                         | - Ensures woman has assistance for infant care, breastfeeding support, care of older children  
- Assists with practical needs such as meals, household chores, and transportation  
- Monitors for signs and symptoms of complications, including mental health                                                                 |
| Primary maternal care provider (obstetrician–gynecologist, certified nurse midwife, family physician, women’s health nurse practitioner) | - Ensures patient’s postpartum needs are assessed and met during the postpartum period and that the comprehensive postpartum visit is completed  
- "First call" for acute concerns during postpartum period  
- Also may provide ongoing routine well-woman care after comprehensive postpartum visit                                                                 |
| Infant’s health care provider (pediatrician, family physician, pediatric nurse practitioner) | - Primary care provider for infant after discharge from maternity care                                                                                                                                  |
| Primary care provider (also may be the obstetric care provider)             | - May co-manage chronic conditions (e.g., hypertension, diabetes, depression) during postpartum period  
- Assumes primary responsibility for ongoing health care after comprehensive postpartum visit                                                                 |
| Lactation support (professional IBCLC, certified counselors and educators, peer support) | - Provides anticipatory guidance and support for breastfeeding  
- Co-manages complications with pediatric and maternal care providers                                                                                                                                   |
| Care coordinator or case manager                                           | - Coordinates health and social services among members of postpartum care team                                                                                                                         |
| Home visitor (e.g., Nurse Family Partnership, Health Start)                | - Provides home visit services to meet specific needs of mother–infant dyad after discharge from maternity care                                                                                     |
| Specialty consultants (i.e., maternal–fetal medicine, internal medicine subspecialist, behavioral health care provider) | - Co-manages complex medical problems during postpartum period  
- Provides prepregnancy counseling for future pregnancies                                                                            |

Abbreviation: IBCLC, international board certified lactation consultant.  
*Members of the care team may vary depending on the needs of the mother–infant dyad and locally available resources.*
Best Practice: Maternal Screenings

Prior to & During Pregnancy

Prenatal Care
- Labs, PE, Convo
- Edinburgh
- Healthcare Literacy
- Nicotine Use, SUD
- Obesity
- Abuse, Neglect
- Chronic Disease 
  \( DM, HTN, Asthma \)
- PCP ID
- Nutrition
- Insurance
- Transportation
- Housing
- Sig Other/Support

MOM
- Postpartum Health
  \( Bleeding, Infection, HTN, Immunization \)
- OB F/U
- Patient POC “Mom Plan”
- Family Planning
- Mental Health
- SO/Support

BABY
- Infant Care
- Car Seat
- Safe Sleep
- Shaken Baby Syndrome
- Breastfeeding
- Peds Provider

Delivery / PP

**COVID19?

Postpartum

- Maternal Health
- Mental Health
  Edinburgh
- Weight
- SUD, Nicotine Use
- Abuse/Neglect
  \( Period \text{ of Purple Crying} \)
- Chronic Disease
  \( HTN, Obesity, Anemia, DM \)
- Insurance, Nutrition, Transportation, Housing
- PCP
- Family Planning
  \( One \text{ Key Question, LARC} \)
- SO/Support
KS: Maternal Health Indicators

- Health care access
- Breastfeeding
- Chronic disease (DM, HTN, Asthma)
- Obesity

- Mental health (depression and anxiety)
- Substance use (alcohol, illicit drugs, narcotics, and tobacco)

- Sexual and domestic violence
- Reproductive Life Planning
- Social Determinants of Health:
  - Support, Insurance, Transportation, Housing, Food
- Screening & Referral systems
Postpartum Care Team (ACOG)

**Postpartum Care Team**

- Family/Friend assistance
- Primary Maternal Care Provider
- Infant health care provider
- Primary care provider
- Lactation Support
- Care coordinator/case manager
- Home Visitor
- Specialty provider, if needed (MFM, behavioral health, internal med)

+ **PATIENT!!**
Postpartum Case Study #1

Maternal History

• 33 yo, married, G1, P1001.
• History of opiate addiction, successfully completed buprenorphine program
• Experienced opiate “cravings” during pregnancy. Obtained illicit buprenorphine but did not tell husband.
• Postpartum: mother wrote RN a note about buprenorphine use due to concern for infant.
Infant Care

- **Neonatologist and NNP** helped mother reveal prenatal buprenorphine use with **father** for open discussion on care for infant
  - Discussed opiate addiction as chronic illness
  - Discussed NAS assessment for infant; scoring system, non-pharmacological cares, observation period and potential need of pharmacological tx
Maternal Care

- **Mother** discharged after 48 hours. Remained on border status on Mother/Baby unit in her room to provide 24-hour care for infant
- **Mother linked up to Local Treatment Clinic**, restarted in buprenorphine treatment program
- **Father remained involved**, actively supporting mother and caring for infant
Infant Care

- Infant was monitored for 5 days on mother/baby unit due to long-acting opiate exposure
  - Bedside Finnegan Scoring with parents after each feeding to allow reinforcement of targeted comfort measures.
  - Mother and father providing comfort cares.
  - Mother breastfed (linked into treatment program).
  - Infant’s NAS scoring <8 for 5 days.

- Infant discharged to home
  - Follow up appointment with PCP made within 48 hours.
  - Verbal/phone hand off made to PCP for infant
  - Infant scheduled in Special Care Follow-up Clinic 3 weeks post discharge
  - Visiting Nursing set up 2/wk for 2 weeks
  - Infant Toddler Services referral made
RESOURCES

Maternal

- RADAC (800-281-0029) [https://www.hradac.com](https://www.hradac.com)
- Substance Abuse Center of Kansas (SACK) (316-267-3825) [http://www.sackansas.org](http://www.sackansas.org)
- Local AA or /or NA programs (aa.org/na.org)
- Substance Abuse and Mental Health Services Administration’s (SAMHA’s) National Helpline 800-662-HELP (4357) [https://findtreatment.gov](https://findtreatment.gov)

Provides referrals to local treatment facilities, support groups and community-based organizations

- Becoming a Mom (BAM)
- Johnson/Wyandotte County Specific
  - Children’s Mercy TIES Program (816-960-8400)
  - Connections (Wyandotte)

Infant/Maternal

- WIC
- Healthy Families: Kansas Children’s Service League (pregnancy through 3 to 5 years) [https://www.kcsl.org/HealthyFamilies.aspx](https://www.kcsl.org/HealthyFamilies.aspx)

Infant

- Infant Toddler Services [http://www.ksits.org](http://www.ksits.org)
Important Steps of Postpartum Care Team

Prenatal Care
Screening questions in prenatal care
Referrals
Connections!
TOOLKIT use

L&D
Circle of Care continues
Expert medical care: Mom AND Baby

Postpartum
MOM
Expert Medical Care
Referral to outpatient:
  OB Provider to PCP
  Mental Health
  SUD Resources
  Other specialty

INFANT
NAS Protocol
F/U with Peds, circle of care to OB

Bottom line!
Mom- close follow up with care team, screening and referral of OB Provider to PCP
Postpartum Case Study #2

- Obstetric Hx: G1P0
  Unplanned but happy, FOB involved
  Initiated care 1st trimester
  Met OB Navigator, Nurse, & CNM
- Medical Hx: Depression (no meds)
- Social Hx: recently displaced from family (FOB military), admitted marijuana use

**HPI:** Presented to ED at 18 weeks with c/o UTI.
*ED Providers* noted erratic behavior.

**UDS:** + barbituates
Antepartum Care

- ED Nurse referred Pt to call OB Provider next day. ED Notes completed & faxed to OB Provider. OB Nurse calls pt to make appt same day.
- CNM saw patient 2 days later. Admitted illicit Dilaudid use
- Edinburgh given: 16, neg #10
- OB Navigator in to see Pt- Referral to SUD resources, integrated Mental Health visit in 3 days
- Pt placed on High Risk OB Team list- discussed case 2 months prior to delivery
Pt lost insurance in 3rd trimester, missed several visits
  OB Navigator contact... returned for care
Spontaneous labor @ 37 weeks, NSVD of viable female infant
FOB present, + family involved
High Risk OB Team aware of admit & delivery

Infant Care
  NAS care initiated, 3 day stay (not transferred)

Maternal Care
  OB Nurse, OB Provider, Infant Provider, OB Navigator, Hospital Social Worker, DCF Case Manager involved
  Insurance, F/U appts, Referral back to Mental health
  CNM appt at 2 weeks and 6 weeks
  Breastfeeding clinic with UDS 1 week, continued for 1st month
  LARC at 4 weeks at FQHC
“Mom Plan” + The Postpartum Care Plan = HEALTHY Moms
“New” Model: The Postpartum Care Team

Nurses

Infant Health provider
Specialty Provider
Support persons
OB Navigator
Lactation Support
Home Visitor
Circle of Care

Healthy Mom Circle of Care

- Medical Home
- Positive Pregnancy Test
- Initiate Prenatal Care
- Prenatal Care Mgmt

Healthy Baby Circle of Care

- Pregnancy
- Delivery
- Postpartum Care
- Infant Care

Infant Medical Home

1st Year of Life
Who is YOUR Postpartum Care Team?

Postpartum Care Team

- Family/Friend assistance
- Primary Maternal Care Provider
- Infant health care provider
- Primary care provider
- Lactation Support
- Care coordinator/case manager
- Home Visitor
- Specialty provider, if needed (MFM, behavioral health, internal med)

+ PATIENT!!
Next Learning Forum: Feb 23rd

Maternal Mental Health at the BEDSIDE!
MDS Policy Update:

• The KanCare Maternal Depression Screening policy supports reimbursement for up to 3 screenings during the prenatal period under the mother’s Medicaid ID. The policy also supports reimbursement for up to 5 screenings during the 12-months postpartum period under the child’s Medicaid ID as part of a well-infant/child visit (KAN Be Healthy). This guide is intended for healthcare providers treating pregnant woman and for pediatric providers who conduct well-infant/child visits.

• Optional training will be offered to screeners, including medical providers and their clinical staff, to increase timely detection of maternal depression. Initial trainings are scheduled for:
  • Wednesday, December 2, 2020 from Noon-1:00 CT. Must register to attend:
  • Friday, March 26, 2021 from Noon-1:00 CT. Must register to attend.

• KDHE’s Perinatal Mental Health Integration Toolkit provides guidance on screening practices, templates for local use, and patient and provider resources.

• Perinatal Provider Consultation Line available to providers to access to Psychiatric Consultations and Care Coordination Support as well as support policy and billing questions related to this policy update.
The Provider Consultation Line for Perinatal Behavioral Health


- Consultations available M-F, 8:00 am-5:00 pm
- Call 833-765-2004 or connect online using this [form](https://www.kansasmch.org/connecting-communities.asp)
- Requests responded to within 24 hours or the next business day

More information

- [https://www.kansasmch.org/connecting-communities.asp](https://www.kansasmch.org/connecting-communities.asp)
Save the Date

May 2021: Spring General Meeting