Improving the Content of Care During the Postpartum Period

Recorded February 17, 2021

Derek Mitchell:

Okay, alright. Well, let's go ahead and get started. So, I would like to welcome everyone and thank you for attending today's Improving Postpartum Care Webinar Series. This is the second webinar in the series titled, "Improving the Content of Care During Postpartum Period." My name is Dereck Mitchell. I'm your event producer for today's webinar. Before we begin, we want to cover a few housekeeping items. All participants logged into this webinar currently have their phone lines muted. If you have any technical issues during today's webinar, please send the event producer a message through the Q&A window. The Q&A window can be located on the bottom right corner of your screen. Please select "host" as you send your message. We welcome all audience questions throughout today's webinar. You can submit your questions through the Q&A window. The Q&A window, again, is located on the bottom right corner of your screen, and in the "ask" dropdown list, please select "all panelists" and click "send" to submit your questions or comments. Please note, we will address as many questions as possible during today's discussion. Lastly, we want to let everyone know this meeting is being recorded. With that said, I would like to turn it over to JudyAnn Bigby from Mathematica. Judy, you now have the floor.

Judy Bigby:

Thank you, Derek. Welcome, everyone. As Derek said, this is the second of three webinars on improving postpartum care. Ruth, can you advance the slides? We are excited about the content that we'll be reviewing today. We're focused on how to improve the content of the postpartum care visit. We'll have a welcome from CMCS. We'll then spend just a minute discussing why it's important to improve postpartum care visits to provide more comprehensive women's healthcare and the opportunity for improving postpartum care for Medicaid and CHIP beneficiaries. And we're very fortunate to have Washington State representatives here today to talk about how they're improving the content of care during the postpartum period focused on behavioral health, the use of contraceptives, and their new maternity bundle to provide dyad care. We'll then hear from a managed care organization on how they're improving postpartum care and increasing the postpartum care visit rate. Next. I want to turn it over now to Kristen Zycherman from CMCS.

Kristen Zycherman:

And welcome again to everyone who has given up time in their day to participate on our call. We really appreciate it. We at CMCS have been thrilled to see the participation level and the interest level in the topic, and we've been hearing from states for a long time that they're looking for MIH content, so we're very happy to be working with you all on that. As part of the Maternal Infant Health Initiative, we have a two-pronged goal for postpartum care to not only improve the rate of postpartum care visits, but also to improve the quality of those postpartum care visits. So, we're looking forward to this webinar today to delve a little deeper into what that means and how other states and plans have gone about doing that. So, thank you everyone for joining, and I will hand it back to Judy.

Judy Bigby:

Thanks very much, Kristen. You can advance the slide, Ruth. So, I'm going to spend just a very brief amount of time, because you're going to hear more about why it's important to think about improving the content. The American College of Obstetricians and Gynecologists in 2018 made recommendations about what the postpartum care period should look like. And it was really a call to action to change the postpartum care visit, moving away from one visit to delivering comprehensive care for women after delivery before their next pregnancy or as they move on to primary care. Next. There's a particular need for improving care for Medicaid and CHIP beneficiaries. We've presented this information before, but we know that women in Medicaid have significant comorbidities including being overweight, using tobacco, and having conditions such as diabetes or hypertension, which can negatively impact their pregnancy and the outcomes, for the instance.

We know that there are long-standing disparities in postpartum care follow up for Black women with diabetes or hypertension, and also for women who are Hispanic. About 13% of women experience depression, which is well-known, but it's also much higher for women of color and for low-income women. We also know that we want to see better contraceptive and reproductive counseling after women deliver. The breastfeeding rates also need to improve. Next. So, given those challenges, one of the ways that CMCS is currently tracking the quality of postpartum care is to look at the visit rate. These are the most recent data on women who attend the postpartum care visit on or between 21 and 56 days after delivery reported in Federal Fiscal Year 2019. And you can see that the state median rate is 61%, about. I want to acknowledge that right now, the specification for what counts as a postpartum care visit includes visits that occur on or between seven and 84 days after delivery, so these numbers will definitely change in the future, but what they should is that there is room for improvement.

Next. I'd like to turn now to Beth Tinker and her colleague Judy Zerzan who is joining her from the Washington State Health Care Authority, who will describe the efforts that they are undertaking to improve the content of care during the postpartum period. Beth?

Beth Tinker:

Judy, is my audio okay? I think it is. It's a pleasure to be here with everyone. Thank you for inviting us, and we are looking forward to sharing a bit about the work that we're engaged in Washington, and of course, learning a lot as we are all constantly trying to learn and do better. Next slide please, Ruth. So, a little bit of level setting about who we are. So, the HCA is the Health Care Authority. So, we are Washington State's Medicaid agency, and we are also the largest healthcare purchaser in our state. Our current number of covered persons has increased at quite a faster rate during the pandemic, which I'm sure is true across the country, to more than 2.7 million people. Over two million of those are Apple Health or Medicaid clients, families. And then, we also are somewhat unique, but just to call it out, in Washington State, the Health Care Authority is also the purchaser for public employees and school employees in our state. Next slide please, Ruth.

So, I'll give a bit of information about the population we're talking about. So, again, our state statistics match pretty closely onto national ones in terms of coverage. So, we cover about half the births in Washington. 40,000, again, we've seen a slow decrease on the birthrate over the past few years. We included our federal poverty level just so everyone can see that. We are an active managed care organization state. Because of the MCOs there's over 80% of our population who are enrolled in MCOs. And so, in terms of postpartum care, when we look at data– this data is from our managed care

population, so it doesn't include our fee-for-service population. So, about 70%, again, this was from 2019, had a postpartum care visit. I included the prenatal care. Again, this is first trimester, early prenatal care metric that everyone is really familiar with, just because I think it's interesting to look at those two in context.

We know there's a lot more actually, research and literature on early entry into prenatal care, and kind of what the drivers are for that, or you know, the contributing factors. Interestingly, one of the primary drivers for – you know, underutilization for early prenatal care is lack of awareness of the pregnancy. That's why I bring that up to say you will get these rates that are pretty similar. Now, I would argue that lack of awareness of being postpartum is probably not something that we could argue as contributing to 70% having a postpartum care visit. And I say that to kind of encourage us to think about how we can provide care in that postpartum visit that is really meaningful and valued to patients. I think there are many factors that contribute to 70% of clients – or let's talk about more of what we're concerned about, the 30% of enrollees who don't have a postpartum visit, and there certainly are individual level factors, but I think we talk about those more and I would encourage us to think and talk more about how do we provide the care that people will come for. You know? I do think it's a shared responsibility. There's not a silver bullet and it's complex, but I do think we need to talk more about what that care would look like that would really be meaningful and important to our clients and to our families, since that is what the care is about. I did call out some of the disparities here to acknowledge that there are wide and persistent disparities in Washington as there are across the country. So, when we look at, you know, aggregate numbers, we always need to be pushing, I think, in asking the question. You know, this is the overall, but when we stratify by various factors, what are we looking at, and we need to consider those disparities in all of our initiatives. I think that's good enough. Next slide, please.

So, again, kind of topic of today is improving the content of postpartum care. And when we're looking at how we improve the content of postpartum care, we can just ask ourselves, "Well, how will we know when we've been successful?" How are we going to measure that? What are we setting out to do and then how do we monitor our progress? So, these are not the only metrics that we care about in terms of postpartum care and really measuring our progress throughout our population, but they're important. So, one is access to contraceptive care postpartum. Data is – I just included the data so it's clear to everybody that this first metric is actually from Medicaid claims data.

So, we showed 42% accessed most or moderately effective contraceptives by 60 days. If you remember back to the slide Judy showed, at the national level, it's 39%, so we're a little bit higher than that. That's right at kind of in alignment with that national number. We also are looking at LARC specifically. So, 16% of our population, again this is Medicaid claims data, accessed it– LARC is long-acting reversible contraception defined by implants and IUDs. So, breastfeeding is another metric that we care about in Washington. We're doing well. Again, that was in the details if you just look down, if you stratify, there are certain populations that are not at a consistent level, and so we need to continue to work on that. I believe Healthy People 2020 was 81%, I believe? So, we're doing all of that, but again, when we talk about improving the content of postpartum care, breastfeeding at 6 months of age, you know, dropped precipitously. Again, that's for a number of reasons, but something that we think about is, well, how was our kind of initiative within engagement around improving postpartum care? Can we try to move the needle on more extended breastfeeding? Maternal mortality. Of course, the metric, I'm sure everyone is tracking.

We are lucky in our state to have a maternal mortality review committee, which is where – it's just led by our Department of Health and where this data came from. So, we have a lot about what we see in that

data. This realization, acknowledgement, that a third of pregnancy-related death occurs after what we typically define as the postpartum period in the way that we, I would say, artificially define postpartum recovery as a one-time six-week postpartum visit, which – it's another thing to think about how we ever thought something was such profound physiological, metabolic, psychosocial changes, would be kind of wrapped up nicely and tied with a little bow in that one visit, but I think probably many of us on this call or all of us feel like it's time that we really push on that much back consistently. And we want to keep behavioral health at the forefront. We see on our data that suicide and accidental overdose are the leading causes of death– and again, here, when you look back on population, our American Indian/Alaska Native community are six to seven more times likely to die and our African American and multiracial, more than twice as likely to die. Next slide, please.

So, in terms of our priorities, we have a number of priorities. I've touched on most of these. So, we really do want to improve the quality of care. Again, very much attentive to mental health and behavioral health. And perinatal and postpartum disorder is the most common complication of pregnancy, and we need to structure and deliver our care system in a way that acknowledges that. And treat and respond to mental health needs of families. We want to ensure access to birth control per patient's choice. This is around, you know, informed decision making for the patient and family. We're very engaged in the efforts to extend postpartum coverage. And then, I'm not going to talk much about this, but I felt like it's important and valuable to add that in all of our conversations around increasing in high quality, high value care, and I would summarize that because there are many definitions, the one that I like that I think is digestible is high value care is individual patient outcome per dollar spent. Like, that is really what we are wanting to do.

We are wanting individuals to benefit, and we want that to be in a way that, you know, is cost containing, or you know, perhaps that it reduces costs. And so, when we have those conversations in the perinatal stage, I think you must acknowledge the evidence around midwifery-led care and doula care in really achieving high value care. And so, we are interested and engaged in how we promote both of those models of care in our state.

Next slide, please. So, I'm just going to go through a couple of these one-by-one, and kind of what our specific initiatives are that we are working on. I hope we could give context and interest to the group and generate thinking or conversation. So, in terms of improving the quality of postpartum care, we – probably the kind of driver for this is we have a Bree maternity bundle. So, the Bree maternity bundle came on – comes out of the Bree Collaborative. That is a public-private partnership that's in statute in Washington that was established by the legislature.

The goal is really to increase the value of care, decrease the variation, increase the value of care to patients. And so, the Bree Collaborative works on a host of different kinds of episodes of care or bundles of care, many of which have been orthopedic in nature. But since – let me think, when does this maternity – 2019. The Bree Collaborative decided to focus for a year. So, it was basically the 2019 calendar year, and then we did extend a bit into 2020. But that's – oh, I'm sorry, into 2021. So, most of the work occurred over 2020 and then into 2021. And the purpose of – oh, and then, so what kind of the process is, is Bree Collaborative establishes the bundle, and then it gets sent over to the Health Care Authority. So, this is very current. We just received the approved Bree maternity bundle at the beginning of this month. The goal of the bundle is to promote and incentivize quality care. So, this is kind of the three-legged stool of the bundle, then this would apply to bundles outside of the maternity bundle, but it requires evidence-based clinical component, it requires quality tracking, and then it includes performance metrics that ideally are tied to a special, to an incentive, and/or a penalty. Next slide.

So, a little more about the bundle, you know, probably for something, well, what is different from what you are doing now, so these are kind of the high-level points for us. So, the – this extends postpartum coverage to kind of what we refer to as the 4thtrimester, 60 days to 84 days. The bundle increases the standard of the quantity of care postpartum. Again, I appreciate, and Judy mentioned, it's like do we care about quantity or do we care about quality? And oftentimes, we do care about both. Again, back to my point about the type of care we're providing, I would advocate that we should prioritize the quality care, but as you can see here, part of the Bree is really recognizing that one six-week postpartum visit is really not sufficient. And so, in the Bree maternity bundle, the standard of care is at least two postpartum visits. The Bree maternity bundle absolutely emphasizes the behavioral health screening and intervention, as well as psychosocial functioning and adjustment to parenting. And then, the bundle includes the neonate. So, the current bundle has the care for the neonate, including the first 30 days of life, with again, standard visits for the neonate being a newborn visit at two to five days and the 14th day visit. Next slide, please.

In terms of postpartum, so I think, let me just say really quickly that the process now with the premature bundle is that those of us at the Health Care Authority work on implementation. And frankly, there are a lot of pieces that sort of remain to be seen, including – you know, and they're really difficult decisions like exclusion criteria, risk adjustment criteria, what the actual metrics are, which are – what are just reporting metrics and what are metrics that are actually going to be tied to the thresholds for penalty or incentives, hopefully incentives. Hopefully more incentives. But I just wanted to share with you all again the theme of the talk, postpartum care. These are potentials, because they are yet undecided, but they are metrics that we are talking about and we'll be discussing. I don't mean to imply that all of these will be included, because that would not be reasonable or feasible. But just to give you an idea, we're talking about a list that I probably don't need to read because you've all probably read it by now. Next slide, please.

Okay. So, that was kind of quality of care. So, access to contraceptive care is the next point on an earlier slide. So, what are we doing in Washington? We have robust family planning programs. We have two 1115 waivers and we also have a state-funded program that was just implemented just over a little year ago now. That is for folks who are not federally qualified or the federal waiver programs. The benefits and coverage in those programs are equivalent. We are in – we're just about midpoint in a five-year statewide partnership with UpStream. So, folks unfamiliar with upstream, you can Google them. They're a national non-profit that is committed to increasing access to all contraceptive care for patients' voice and choice. And within that, kind of one of their objectives is same day or one-day access to all birth control methods. So, we're lucky to be in this partnership with them. They do incredible direct training and support. They are a very like, you know, feet on the ground organization. So, anyway, that's an initiative that we have going on in Washington.

We are absolutely committed to provide access to all FDA approved methods. An example of that is we just recently added subcutaneous Depo to our list of methods that clients can access, and we will, you know, continue to move on that. We do have an enhanced payment rate for LARCs that was implemented in 2015. And we also have LARCs carved out of our obstetric global payment. Again, that's – the idea there is to incentivize – particularly post-placental insertion, but there's not a different incentive to wait and do that in additional visit if it were to be included in the global payment. So, these are just some examples of policy – clinical policy changes that we've made to really show our commitment to access the contraceptive care for all of our clients. Next slide, please.

So, then, the next point was mood disorder and dyadic care. So, in terms of the dyad in this context, we are talking about the – just, say, the parent and the infant as the dyad. I think, you know, the science – if

we are to be both data-informed and data-driven organization, we want the best foundation for our population, we must start treating care in a dyadic fashion, recognizing that those lives are reciprocal and inexplicably linked. They are not separate and divergent. And so, how to do that is more difficult, I think, than saying it's the right thing to do, but I love that, you know, that they – we know enough to act. I think that that applies to dyadic care for sure. So, how are we doing this? We've already talked about clinical components of postpartum care. Again, I'm referring back to the bundle. More opportunity. Again, I'm talking about the most – the increased postpartum care visit. So, certainly, with more opportunities for care, face-to-face time with your provider, there's more opportunity to address not only the parent needs and the infant needs, but the critical importance of that relationship, right? That relational health between the parent and infant. We really want to encourage coordination between the obstetric and pediatric providers.

If you recall back on the slide with potential metrics, that was one of them. And then that leaves everyone to say, "Well, what would that actually look like?" And that – I don't think we've quite cracked that nut, although, you know, like a care conference for a certain high-risk client is one idea. So, just to hopefully make this a little more concrete for everybody, we do require in Washington that pediatric providers screen parents, caregivers, loving adults, whoever is coming in with those infants less than 12 months old, they are to be – it's required to have a mood disorder screening for parents. And we are also actively working on implementing DC 0-5, the diagnostic classifications. This is really – not just the age-appropriate assessment classification for infants and children as they age fast, but the developmentally appropriate tool. It has been adopted by many other states. We have current legislations that would implement the DC 0-5 in Washington State. Next slide, please.

Extending postpartum coverage, I think this is on everyone's radar. There's a lot happening on the national level and very thankful to have our Vice President Harris who has been a huge proponent of maternal mental health, particularly of Black and brown women in the Senate, and she continues to be a champion. We also have current legislation in Washington to extend postpartum Medicaid coverage to 12 months. And again, I think I have made those other points, so I will stop there. Next slide, please. Oh, and that was my last slide. So, I hope that was helpful to give a little context to what we're doing in Washington, and we will have time at the end for Q&A or anyone, feel free to contact me. That is completely fine and welcome. Thank you.

Judy Bigby:

Thank you very much, Beth. We actually have a few minutes to take some questions now. So, if people want to submit some questions in the Q&A box, we can take a couple.

Beth Tinker:

Okay.

Judy Bigby:

Beth, we do have a couple of questions already. One question is about can you clarify whether or not in the data that you presented on Medicaid; does it include women who utilize three-day emergency Medicaid to cover childbirth?

Beth Tinker:

Ooh, I actually don't know the answer to that question. I assume that it – yeah, I don't know the answer to the question. I can try to follow up if somehow I can get that person's contact information?

Judy Bigby:

Okay, that would be great. The other question is about your state PQC, perinatal quality collaborative, and whether or not they participate in determining which metrics demonstrate improved care.

Beth Tinker:

Oh, I assume that they're talking about when we're moving to choose metrics for the bundle, and I think yes that will definitely be part of the process.

Judy Bigby:

Okay. Another question comes from someone who says, "Our obstetricians report they have difficulty getting women to come in for their visits. How are you encouraging more follow up visits?"

Beth Tinker:

For attending the postpartum visit?

Jud Bigby:

Yes.

Beth Tinker:

Yeah. I know that that is an issue. It has also been studied in the literature. It seems like one of the major contributing factors in a higher utilization is really antepartum conversation and encouragement by providers for patients to come in for that visit. That seems to be very critical. I mean, I would say the other interesting thing, we looked at data by provider in Washington, and there's just incredible variation where some providers have postpartum attendance rates of more than 95% and others have as low as 30%. Now, of course, we can all – I think – and now, sometimes, their minds go to variation and not – you know, well, what population are they serving? And those are all super valid questions, and I think the reality is that we need to be learning from providers or provider practices that have those very high attendance rates.

You know, I don't pretend to know all the answers, but I think that's very impressive, and there are provider-level factors that can make a difference. There's also clinical flow, you know, like of the practice. Have someone actively reaching out to patients who – no show, those visits. What does that look like? Right? Are there efforts that individual practices can take? As far as our metrics, we really plan – I hope – and this is a metric I feel pretty strongly about is the postpartum visit attendance. I really do want to include postpartum visiting attendance, and I think the clinical practices and clinical care team really need to be our partner in figuring out how to increase those rates.

Judy Bigby:

Okay. I think you're pointing out that you have variation, and you can learn by looking at those differences as one of the approaches that we think is important for quality improvement. There – I'm going to give you one last question. There are two questions that are connected. Someone wanted to know a little bit more about the UpStream collaboration, and then another question wanted to know whether your Title X sites are involved in your effort to improve contraceptive care. For those of you who have other questions in, we'll try to get to them at the end of the webinar.

Beth Tinker:

Sure. I'm – Judy maybe can help me a little bit with the UpStream question, because I wonder if what you're asking is how we came to be in this partnership with them. They have worked with a host of states. I think maybe Washington is the 6th now? I believe the first state was Delaware? So, we – how we were – I don't even know if selected or chosen is the right way to frame that. I don't know the history of that. Judy, do you – it's my sense that that's the person's question.

Judy Zerzan:

Yeah. Yeah, no, I think how we started working with them was we have these Accountable Communities of Health. These regional entities that are sort of the go between the medical side of things and community and social needs and creating those linkages. And I know that it started with a couple of them talking with some of the practices in their region and finding that this was a gap and finding that UpSteam could help train folks on inserting IUDs and answering questions and sort of getting over that first sort of barrier. I think one of the things in getting LARCs into people that want them is that there can be this training barrier if you haven't done it in a while or if you didn't ever learn when you were in your medical training. And they do a really great job of helping do that, and then I know that some of the clinicians that were involved in getting trained early have even gone to train other people and become real advocates for it. So, that's a bit how it's worked here.

Judy Bigby:

Great. I want to thank you Beth and Judy for that presentation. We're going to move on now to our next presenter. I'd like to introduce Cameual Wright who is the Market Chief Medical Officer from CareSource in Indiana. Thank you, Cammie, for joining us.

Cameual Wright:

Thank you so much, Judy. Can everyone hear me okay?

Judy Bigby:

Yes, you're loud and clear.

Cameual Wright:

Okay, thank you again. As Judy mentioned, my name is Cammie Wright, and I am the Chief Medical Officer for CareSource in Indiana. I am extremely pleased to come and speak to you, and I'm thankful for CMCS for the invitation. I think that this is a topic that is very timely and incredibly important, and I

think that the number of individuals who are interested in this topic reflects the importance of it. And so, I'm pleased to be part of this conversation. I work for CareSource, which is one of the four managed care entities here in Indiana. CareSource is a non-profit health plan, and we have been around from the – since the 80s. We are currently in five states and growing every day. We serve about two million members and governmental plans. The largest membership is in Medicaid, but we also serve marketplace and Medicare Advantage members, as well as dual eligibles. Next slide, please. I am obviously here today to talk about postpartum care and what we do as a managed care entity to support postpartum care. And I just want to highlight some of the pillars of that care that have been mentioned earlier by other speakers, but I distilled them down to four main takeaways from the ACOG bulletin around optimizing postpartum care. And one is anticipatory guidance during pregnancy. Viewing postpartum care as an ongoing process. Assessment of the individual from 360 degrees, including their physical, social, and psychological well-being. And then, finally, birth spacing and reproductive planning. What I hope to do today is to show how we support each of these pillars. Next slide, please. The first and I think one of the most important takeaways from ACOG guidance is looking at pregnancy and postpartum care as a continuum and looking at the postpartum period as the 4th trimester of pregnancy. So, I think that there has been a perception that pregnancy is a finite period of time and once the delivery has occurred, we can all breathe a sigh of relief. And what we know is that that is not the case and that many poor outcomes don't manifest themselves or even occur until the postpartum period. And so, we need to look at the whole perioperative pregnancy period as a continuum of care and that the postpartum period should be an ongoing event, as opposed to just one visit. And what we do is we actively engage pregnant women at the time that we recognize their pregnancy.

So, all of our pregnant members are engaged in case management. We at least attempt to engage them. Unfortunately, given the competing priorities of many of our members, that engagement is not always successful, but we do make an active effort to outreach to all of our pregnant members. One important part of that outreach is screening for social determinants of health. So, we use an assessment known as PRAPARE. I'm sure many of you are familiar with this. Then, we use that to better understand the member's social needs. And this is recognizing that it's important not just to address her medical needs, but to make sure that those other related factors are recognized, and barriers are mitigated so that she can have the best outcome possible in pregnancy. And I will speak a little bit to social determinants of health in a few minutes.

We have a Babies First rewards program to incentivize proper behavior in the pregnancy in postpartum period as well as with newborn care. So, we incentivize every prenatal visit. We incentivize the postpartum visit, we incentivize every baby well-child visit, and we incentive lead testing. And that is all to provide just that extra push for our members to receive that all important care. We have close collaboration between our utilization management team and our care management team. And that allows us to quickly recognize when women deliver so that we can outreach to them in a timely fashion. What we really want to do is make sure that we are engaging women early in that postpartum period and recognizing conditions as they occur so that we can support the resolution of those conditions and hopefully prevent exacerbations that might lead to poor outcomes for mom or for baby. And then, finally, what I'd like to get into in greater detail is that we utilize nurse practitioners for telehealth visits during the postpartum period. Next slide, please.

So, we have a relatively new initiative where we have hired our own nurse practitioners and they are performing telehealth visits for our postpartum moms. I think it's important to know that this is not to replace their postpartum visit with their provider. I'm an OB/GYN by training. I recognize the sacredness

of that relationship and the importance of maintaining that obstetrical medical home. This visit is intended to be an adjutant to the care that they're receiving from their provider. So, again, I mentioned that we have close collaboration with our team. We would see notification of a delivery when there is a delivery claim, and the nurse practitioner uses that data to reach out to members who have recently delivered to set up a telehealth appointment. Our goal is to have those appointments within the first three weeks of their postpartum period. This is a time period when frequently, women are not seeing their provider unless they have an acute issue.

So, it is standard for the postpartum visit to occur around six weeks, but based on ACOG's guidelines, we really want to see women have a more than one postpartum visit, and this is our way of encouraging that. We have several goals for this visit. We screen for depression, anxiety, and episodes of mental illness. I think that this is vital, and we know that oftentimes, a decline in mental health is not apparent while the member is in the hospital and it only becomes apparent in the postpartum period. So, we aim to recognize that early and to get that number plugged into essential care, which may involve pharmacological care or psychological care and management. We want to know about tobacco and substance use so that we can do appropriate counseling and referral. We obviously want to assess how the baby is doing, and if the mom has chosen to breastfeed, we want to support her in that effort. We certainly work in collaboration with WIC and with lactation consultants, and we cover those services so we will make appropriate referrals and connections as necessary. We want to assess free patterns of mom and baby, and then we want to also talk about weight management.

I think it is vital that we communicate back to the primary provider, so we have expectations of a letter being sent back to that primary care provider or obstetrician, letting them know that the visit occurred, and any relevant details from that visit. And what's really important is that that nurse practitioner then facilitates scheduling of the follow up visit with their primary medical provider. So, again, we're working in close concert with the obstetrical provider to care for that woman during her postpartum period. Next slide, please. As I mentioned earlier, we have several goals for this postpartum visit. One is early engagement of that member prior to her next visit with her primary provider. Assessment of the maternal and infant well-being, including referral and scheduling for urgent issues. Really patient-centered education on birth spacing and contraceptive options. Wanting to understand that member's plan for future childbearing and making recommendations that are appropriate for her, for her lifestyle, for her cultural and religious context.

We also want to emphasize LARC contraception, long-acting reversible contraception. The data is clear on the benefits of that. And so, one of our goals is if appropriate and of interest to the member, we want to educate and support the usage of that. As I mentioned earlier, we support and refer for breastfeeding care as necessary, and educate on safe sleep, because we know that that is a driver of sudden unexpected infant death. Next slide, please. Before I move on to this, I do want to say that the nurse practitioner engagement is new, and so we do not have outcomes to report as of yet, but we will be looking at key performance indicators including the number of postpartum women who receive care, the number of our members in postpartum period who receive depression screenings, those infants who receive all six visits in the first year, the rate of breastfeeding and LARC usage, and the rate of postpartum readmissions. And we're hoping to note positive trends on that based on this initiative.

We have additional specialized postpartum support as necessary. For those women who have a baby in the NICU, we offer unlimited transportation to and from the NICU. This is a recognized barrier for our members. They may have to visit their baby for a month or two or three in the NICU and getting back and forth can be a hindrance. We support that bonding and that time, and again, offering unlimited benefit for

that. We also have a transition team who initiates discharge planning while that baby's in the NICU so that we can facilitate any post-release needs that the baby may have. We also have an infant scale benefit, and this is something that we created based on feedback that we've gotten from our providers. Many families were bringing their babies back and forth frequently to the office for weight checks when their growth needs to be monitored closely. And the feedback that we got is that if we could provide a reliable accurate infant scale to these families, that the providers to take that objective data, and make recommendations and telehealth visits without the frequency of visits that are typically required. So, we have recently launched that, and the feedback we've gotten has been very positive so far. Next slide, please.

Long-acting reversible contraception, as I mentioned, is incredibly important. Again, based on feedback that we've gotten from the provider community, we pay for LARC use in both the medical and pharmacy benefit, which means that we will pay for it to be provided to – in the office as well as in the hospital, and we will also pay for it if a woman were to go to the pharmacy and pick it up and bring it back. So, we have really tried to reduce barriers to reimbursement. We also are working closely with our perinatal collaborative that we call the Indiana Quality Improvement Collaborative in trying to understand community attitudes around LARC and trying to understand why there has been less than optimal uptake of postpartum LARC, and ways that we can mitigate that. We have supported legislation to remove barriers to contraception including those around LARC, and we have also support legislation to extend the postpartum period of time for Medicaid coverage to one year, so that we can continue to follow and serve these members. Next slide, please.

Social determinants of health we know are incredibly important particularly in the Medicaid population, and these are all of those social needs that either provide distractions or competing priorities to regular healthcare or to directly impact health. And these are things like financial security, housing security, safety, and obviously, food and food insecurity, which are big, big issues here. Next slide. We at CareSource have a program called JobConnect as part of a larger initiative called Life Services that is dedicated to addressing social determinants of health. This is available to all our Medicaid individuals and we specifically encourage it in our postpartum moms. So, all the individuals who are interested, they can be connected with a life coach, and that life coach helps to outline what those social determinants, what those barriers are and really works with the member to bust through those barriers. And this is really important for the new mom who may have lost her job during pregnancy, who may have housing insecurity, who may have intimate partner violence situation where she needs to be rehoused. So, our life coaches work closely with our members to understand what their needs are, to assess their personal situation, and to connect them to internal and external resources that can help mitigate those barriers. We also have a network of over 200 employer partners who are committed to hiring our members. So, we provide job placement assistance, and we connect to these employer partners. So, if that is a need and a want, we make that happen. Next slide, please. And I think that's it, and I am available for questions. I hope that gives you a glimpse of what we as a managed care entity can do to support those postpartum needs.

Judy Bigby:

Cammie, thank you very much. We have a couple of questions for you. The first is what are the incentives that you give for the prenatal postpartum and infant well visits?

Cameual Wright:

Yes.

Judy Bigby:

And how do you know you've seen that they have been improved?

Cameual Wright:

Yes. So, those are financial incentives. So, we provide a dollar amount for each visit in obtaining each of those services. Collectively, it's about $350, so it's pretty substantial dollars on the table for that member. We work with a vendor and the incentives are paid via claim. So, once we receive a claim that that service had been performed, then the vendor helps us administer the benefit to the member via a sellable gift card.

Judy Bigby:

Great. Another question is, is the nurse practitioner model that you're using where they do a telehealth visit in the postpartum period, is that due to the COVID pandemic or is this a model that you decided to implement?

Cameual Wright:

So, it is a pivot of the model. So, initially, the model was designed to be home visits, and we wanted the nurse practitioners to perform home visits so that we could do all of the things that I discussed, as well as assess the home environment. Because of COVID, we decided that it was safe both for the nurses as well as for the members to do this via telehealth. But I also think that an added bonus of telehealth is just increased access and availability, because oftentimes, as we all know, telehealth is more convenient for a variety for reasons. So, even after the pandemic, I think we will probably have a hybrid model of telehealth as well as in-person visits.

Judy Bigby:

Okay. And then one more question for you, Cammie. How long is a life coach available for postpartum mothers and is it available…?

Cameual Wright:

Two years.

Judy Bigby:

Oh, so two years. I think that answers the question.

Cameual Wright:

Two years, and I think it's important to note that even if they come off of Medicaid, so let's say they get a job and they have private insurance, that life coach maintains that relationship for two years to ensure the stability and well-being of that member.

Judy Bigby:

Okay, great. I'm going to go back now. We had a couple of questions for Beth and Judy, but I think we could ask this of you as well, Cammie, and the question was how do informatics help inform your initiatives and what you're doing and how you assess them?

Cameual Wright:

I can start, and then Beth can chime in certainly. So, we believe informatics and analytics are vital. So, the way we use it is first, by recognizing those women who have had deliveries, and even prior to delivery, we mind our data to locate women who may be at higher risk for poor pregnancy outcomes. And using and algorithm, we have different levels of engagement and case management through which we place members based on that data. After the postpartum visit, we expect to engage all of our postpartum women, but again, we have prioritization based on some of the data that we recognize, and some of the risk factors that may or may not be present. Finally, we'll be using informatics and analytics to record data on those KPIs that I outlined.

Judy Bigby:

Great. And you got a comment from someone, Cammie, saying those KPIs were really great. Beth, do you want to answer that question as well?

Cameual Wright:

Thank you.

Beth Tinker:

Sure, I can. And Judy Zerzan can chime in too. I certainly agree. I mean, I think informatics, we – as we have a responsibility to be data-driven. And in terms of in my role, the primary way that I'm looking at the – you know, as a state Medicaid agency, we have access to a ton of data. I think the issue is more making sure we know what we're actually looking at and ascribing meaning to that data, and frankly sharing data responsibly is something I take very seriously, and I think we always need to be careful with about that and what limitations are of data.

Judy Bigby:

Right.

Beth Tinker:

From an agency perspective, I would say from our director down we are very much aligned with data and – especially in terms of disparities in health equity, how we use our data to really drive our equity work I think is incredibly important. And as I mentioned, a lot of that right now is just pushing on stratifying data in every way possible when we can. And frankly, it's not just race and ethnicity and language, right? It's disability, it's gender identity, we need to continue to push on those.

Judy Bigby:

Okay, thank you. I wanted to thank both Beth and Judy from Washington, and Cammie from CareSource for presenting today. We had a lot of great questions. We're going to move right now to Ruth who will tell us what's going to happen next.

Ruth Hsu:

So, our next webinar will be on March 1 at 3 PM Eastern, and this will be an informational webinar about the upcoming Postpartum Care Affinity Group, and then our final webinar on Models of Women-Centered Care will be on March 11, 2:30 PM Eastern. And you can register for these webinars at this link you see here, and we've also put the links in the chat, which you'll see to your right. Then, we also want to encourage you if you're interested in participating in the affinity group to please review the fact sheet, as well as the EOI forms which will be due March 12th at 8 PM Eastern. And again, we just put those links in the chat for you to access. And when you exit the webinar, please take our evaluation survey, and if you have any questions, you can email us at MACQualityImprovement@mathematica-mpr.com. Thank you for participating. We hope to see you next time.