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Milbank Memorial Fund Proceedings

U.S. Health and Human Services Department Secretary's Postpartum Maternal Health Collaborative Expert Evidence Convening

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EXECUTIVE SUMMARY

With direction from the U.S. Department of Health and Human Services, the Milbank Memorial Fund convened four panels designed to synthesize evidence and opportunities for postpartum mortality reduction to inform the Postpartum Maternal Health Collaborative. These "expert to expert" discussions included state members of the collaborative and additional subject matter experts such as academics, payers, health care providers, and representatives from other states. Panels were convened on the following topics: mental health and substance use disorder (SUD), community and social drivers of health, clinical care, and state-level policy opportunities with a particular lens on addressing persistent and striking disparities in outcomes.

Below are the key themes from the four sessions, and a synopsis of each session, including presentations and group discussion. Sessions were moderated by Drs. Morgan McDonald and Lisa Dulsky Watkins of the Milbank Memorial Fund. The format consisted of brief recommendations from panelists followed by discussion with state teams. (See Appendix A for list of presenters, and Appendix B for list of state participants.)

Key Themes

Panelists and participants identified the following areas for state policy action:

1. **Enable Better Transitions in Care with Technology, Patient-Specific Care Planning, and Outcome-Focused Payment Systems:** Maternal mortality review teams have repeatedly shown care transitions are high risk for patients with complex social needs or diagnoses such as hypertension or substance use disorder (SUD). Integration of wraparound telehealth, virtual patient monitoring, immediate patient communication, and intensive care coordination is an expanding area of innovation that increases patient engagement and care transition quality for patients who are connected to a care team. Payers should develop and test reimbursement models that incentivize and enable patient-need driven transitions without duplicating care coordination services.

2. **Provide Resources First; Then Screen and Refer:** Providing resources to all patients before social risk, SUD, and behavioral health screening increases trust between the patient and provider/health system by demonstrating institutional readiness, normalizing receipt of such services, and alleviating fear of discrimination. Many patients may be reticent to disclose social or behavioral health needs or high-risk behaviors if they do not know that needs will be met, particularly if there is a perceived or real risk of child protective services involvement if they use substances during pregnancy. Thoughtfully involving the other care team members (i.e., community health workers) can identify opportunities to build trust and accurate assessment of needs and resources.

3. **Ensure Cross-Sector Collaboration in Policy and Program Implementation:** State agencies and task forces should coordinate efforts between the public health departments, hospitals, Medicaid, Children's Health Insurance Program (CHIP), managed care organizations (MCOs), doulas, community health workers, social service providers, and behavioral providers to address gaps in

care (particularly behavioral health and substance abuse) and measure progress in maternal health outcomes. Often, social support services already exist and are not at capacity in communities but the connections to them are underutilized. Likewise, policies such as plans of safe care or reporting of substance abuse need to be coordinated among agencies and providers. State experience shows that a coordinating entity needs to understand the landscape of services and priorities and ensure that entities working on the same priorities are coordinating approaches but that there is no one "right" way to form those connections (i.e., approaches in Indiana, Tennessee, and North Carolina differed drastically but worked).

4. **Incorporate Community and Patient Engagement:** States need to be students of implementation science as they create policies and programs to enable patient care. Opportunities such as postpartum insurance coverage extension, inclusion of doulas and other covered services, and enhanced home visiting programs are only effective if patient, provider, and community voices are relied on during the design, implementation, and evaluation of programs and services. Just as initiatives such as the "Hear Her" campaign need to be lifted up to ensure patient voices are heard in clinical care, the patient voice must be represented as changes and improvements are made. States can leverage the variety of existing mechanisms to engage with patients/beneficiaries/consumers.

5. **Support and Expand Quality Improvement Initiatives:** Existing quality improvement initiatives demonstrate positive outcomes. States should support ongoing integration of patient safety bundles and participation in perinatal quality collaboratives with ongoing funding, particularly in low-resource and small-volume/rural clinical settings.

6. **Patient-Centered Care:** States should seek precision in connecting patients with interventions. Addressing the needs of a postpartum mothers in need of treatment for SUD may differ substantially from someone who needs to address cardiac risk, for example.

7. **Data Infrastructure Investment:** Finally, states should prioritize data collection so that existing initiatives and value-based payment initiatives can be evaluated and improved. Likewise, data disaggregation efforts should be incentivized across all sources to assure that no populations are excluded from improvements in postpartum morbidity and mortality.

Mental Health & Substance Use Disorder

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Barriers to Opioid Use Disorder Treatment during Pregnancy

Stephen Patrick, MD, MPH, Professor of Pediatrics, Health Policy & Leadership, Vanderbilt University

Stephen Patrick discussed barriers in access to treatment for opioid use disorder (OUD) during pregnancy. Few treatment providers will see pregnant patients, and even fewer will accept anything but cash payment. There are significant racial and geographic disparities in access to SUD treatment as well, which compound access problems in pregnancy. Patrick highlighted a study showing that state laws prioritizing pregnancy for OUD treatment have been ineffective to date. Patrick recommended that states prioritize access to treatment by pursuing policies that incentivize insurance receipt by treatment providers.

Patrick also commented on the role of child welfare in the postpartum period. He discussed Plans of Safe Care (POSC) as a state strategy but underscored that education and incentives must be provided for social services, protective services, and providers to make POSC a viable upstream and wraparound solution. Patrick also highlighted the importance of using a cross-agency approach that includes data sharing and establishing a task force, as multiple state agencies and clinical partners share responsibility for systems of care for families affected by SUD during pregnancy.

Impact of Punitive Policies on Maternal and Child Health

Mishka Terplan, MD, MPH, Medical Director & Senior Research Scientist, Friends Research Institute

Mishka Terplan discussed the rising number of state policies focused on substances and pregnancy, noting that these policies are increasingly punitive. Punitive policies have failed to improve birth outcomes and are associated with lower birth weight, preterm delivery, and less prenatal care. Terplan highlighted misuse and overuse of drug testing by providers, leading to the removal of children from parental care. Terplan advocated for reform of punitive policies, including the Child Abuse Prevention and Treatment Act and mandatory reporting, which equate substance use with child abuse. These policies have failed to improve maternal-child health outcomes, have decreased patient engagement with health care and willingness to accept screening and treatment for SUD, and compound racial health disparities.

Pennsylvania's Centers of Excellence Program

Elizabeth Krans, MD, MSc, Associate Professor of Obstetrics, Gynecology & Reproductive Medicine, University of Pittsburgh

Elizabeth Krans described Pennsylvania's Centers of Excellence (COE) program, which creates an integrated care model for substance use disorder. The program includes 45 COEs in partnership with Medicaid managed care organizations (MCOs) that incentivize quality-of-care metrics with a $240 per member per month payment. Krans encouraged states to engage multiple stakeholders, including providers, pharmacies, patients, and hospitals, to improve SUD care during pregnancy and postpartum. Pennsylvania saw greater uptake of treatment and provider adherence to guidelines by (1) eliminating buprenorphine prior authorizations and dose limits, and (2) providing clear FAQs for pharmacists, providers, and facilities on alcohol and drug guidelines, appropriate use of buprenorphine, and co-prescription and dispensing of naloxone. Similarly, clear FAQs that help providers navigate substance use and maltreatment reporting guidelines significantly reduced inappropriate reporting to child protective services. Krans also reviewed the COE experience of increasing patient satisfaction and engagement with telemedicine, which decreased stigma associated with SUD, social services, and hepatitis care.

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Addressing Access to Care and Maternal Mortality

Hendree Jones, PhD, LP, Professor of Obstetrics & Gynecology, University of North Carolina at Chapel Hill

Hendree Jones discussed data on maternity care deserts, which affect nearly half a million births in the United States annually. She noted that access to care is further impeded for those in need of SUD care because of parents' fear that their child will be removed from their care. She highlighted frequent postpartum care as a solution, noting that the World Health Organization recommends four contacts in the first six weeks. In the US, there is an average of only one contact in the first six weeks. She also highlighted the importance of focusing on evidence-based, trauma-informed, and culturally appropriate care to properly address stigma associated with seeking SUD care, which she identified as the biggest barrier to access.

Integrative Health Model for Maternal and Child Care

Rebekah Gee, MD, MPH, Founder & Chief Executive Officer, Nest Health

Rebekah Gee discussed her company's innovative approach to behavioral health care through the Nest Health integrated care model, which treats physical and mental health for the whole family. Care includes chronic disease management, substance use treatment, and behavioral health. This approach aims to remove barriers to care, specifically for Medicaid beneficiaries. Drawing on her past experience as a state Health and Human Services Secretary, Gee recommended that states invest in and incentivize integrated care models to address maternal and child health outcomes, including supporting Medicaid MCOs to transition to value-based comprehensive care payment models.

Indiana's Pregnancy Promise Program

Maria Finnell, MD, Chief Medical Officer, Indiana Family & Social Services

Maria Finnell detailed Indiana's Pregnancy Promise Program, which seeks to improve outcomes for Medicaid-eligible pregnant and postpartum individuals affected by OUD. She shared data on the program's success, including a 94% treatment retention rate and positive birth outcomes. The program includes obstetric case management services in partnership with Medicaid managed health plans, addressing of health-related social needs, and ensuring continuity of medication-assisted treatment across pregnancy and the postpartum period. Finnell's presentation highlighted the effectiveness of comprehensive case management in enhancing treatment access and adherence and the necessity of "high touch" care, often 8-12 contacts, to sustain treatment adherence and improve outcomes.

Discussion Themes

The panel discussion with participants led to the identification of the following opportunities:

1. **Implement Non-Punitive Child Welfare Policies:** Provide clear guidance with case examples to providers to implement non-punitive child welfare policies to minimize inappropriate reporting of substance use. Interagency collaboration is necessary to improve implementation of Plans of Safe Care and the alignment of incentives to optimize outcomes for families.
2. **Reimburse Health Care Integration and Telehealth:** Integrated health care services and telehealth can improve access and outcomes. Participants raised the benefits of telehealth and peer recovery programs in providing necessary care, particularly its effectiveness and acceptance among patients.
3. **Address Barriers to SUD Treatment in Pregnancy:** Key issues such as provider bias, lack of treatment providers, geographic disparities, and the effectiveness of state policies prioritizing pregnant women for SUD treatment were emphasized as barriers to care that states should thinking creatively with providers to address.
4. **Prioritize Areas for Improvement:** With so many avenues for improvement, states can benefit from identifying priority areas, including but not limited to funding programs, integrating of agency and clinical approaches, updating payment models and reimbursement, incentivizing quality metrics and coordination, or patient and provider education.
5. **Invest in Training of Clinicians Who Care for Women Affected by Substance Abuse:** Expanding such training will increase the number of obstetric providers who can manage substance abuse, and the number of substance use providers who can see pregnant patients.

Community and Social Drivers of Health

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Screening and Referral for Social Determinants of Health: Maternity Patient and Health Care Team Perspectives

Alison Stuebe, MD, MSc, Professor of Maternal Fetal Medicine, University of North Carolina, Chapel Hill

Alison Stuebe introduced a resource-first approach for screening patients for social determinants of health (SDOH). This method provides resources to all patients before social risk, SUD, and behavioral health screening. Stuebe found this approach increases patient trust by demonstrating institutional readiness and normalizes receiving services without discrimination. Many patients may be reticent to disclose social or behavioral health needs or high-risk behavior if they do not know that needs will be met, particularly if there is a perceived or real risk of child protective services involvement. Stuebe advocated for redefining the role of health services by employing the vital conditions for health and wellbeing framework.

Many patients may be reticent to disclose social or behavioral health needs or high-risk behavior if they do not know that needs will be met, particularly if there is a perceived or real risk of child protective services involvement.

Heart Health Study nuMOM2b

Clyde Yancy, MD, MSc, Professor & Chief of Cardiology, Northwestern University

Clyde Yancy discussed the critical role of SDOH in the context of cardiovascular risks associated with pregnancy. Yancy highlighted findings from the NuMOM2b cohort study that assessed the influence of non-biological factors, such as income, education, and community environment, on health outcomes like metabolic syndrome and cardiovascular health. The study authors observed that social support, health literacy, and adequate insurance are significantly linked to lower risks of developing metabolic syndrome and other cardiovascular diseases.

Addressing Violence and Social Drivers of Maternal Morbidity and Mortality

Maeve Wallace, PhD, Associate Professor, Tulane University

Maeve Wallace discussed integrating health care and social services to improve prenatal and postpartum care. Wallace highlighted successful programs in Louisiana, including the Domestic Abuse Fatality Review Board. The board uses a bi-directional referral system that creates formal partnerships between health care facilities and domestic violence service providers to coordinate care. She also noted the Universal Home Visiting Program in New Orleans, which improves access to health care services, provides access to social services and strives to eliminate transportation and access barriers, thereby decreasing family stress and likelihood of violence.

Social Drivers on the Highway to Health

Jennifer Sullivan, MD, MPH, Senior Vice President, Strategic Operations, Atrium Health

Jennifer Sullivan described the creation of Indiana's Office of Healthy Opportunities, which coordinated efforts across health services, Medicaid, public health, and child services with partnerships across health care systems, philanthropy, and local businesses to decrease infant and maternal mortality. Sullivan discussed leveraging existing state resources like CHIP funding for lead abatement to enhance maternal health during pregnancy and highlighted opportunities for integrating health services like co-enrollment in the Supplemental Nutrition Assistance Program (SNAP) and Medicaid for eligible mothers. She also pointed to the Department of Health's statewide Perinatal Levels of Care initiative, which addressed maternal care desserts by equipping all hospital to stabilize or transfer maternal or neonatal patients to a hospital with the appropriate level of care. Sullivan also highlighted the importance of pivoting programs to fit community and patient needs given limited funding. Having recently served as Indiana's HHS Secretary, Sullivan described her experience implementing key public health initiatives such as postpartum availability of long-acting contraception, intensive mobile clinical emergency simulation for rural facilities, and home visiting into the clinical environment.

Discussion Themes

Three major themes emerged from state participant and panel discussion as concrete approaches for states:

1. **Resource Provision Education Before Screening:** Educate patients about available resources before screening for SDOH to build trust and encourage patients to provide accurate information during screenings.
2. **Cross-Agency Partnerships:** Model statewide initiatives on Indiana's "My Healthy Baby" program, which integrates services across health, human services, Medicaid, and child services, to comprehensively support maternal and child health. Seek out opportunities to co-enroll patients in programs like CHIP and Medicaid when seeking any government or clinical services.
3. **Community-Based Health Initiatives:** Increase investment in community health initiatives such as universal home visiting programs for new parents, which can significantly improve health outcomes by providing support and education and removing barriers to accessing care.

State-Level Policy Opportunities

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Leveraging Medicaid for Postpartum Mortality Reduction in Washington

Beth Tinker, PhD, MPH, MN, RN, Nursing Consultation Advisor, Washington Health Care Authority

Beth Tinker focused on the Washington Health Care Authority's role as the state's largest health care purchaser, detailing its efforts to leverage Medicaid to reduce postpartum mortality. She categorized Medicaid opportunities to improve maternal outcomes into the following categories: data/evidence, benefit designation, quality accountability, care model innovation, payment mechanisms, and maximizing coverage and enrollment. Key successes include extending 12-month postpartum coverage, the upcoming introduction of SDOH screening, and benefits for community health workers and doulas. Quality improvement successes included working with MCOs and statewide mental health support, including the Perinatal Psychiatry Consultation Line and Perinatal Support Washington. She also spoke to challenges to the success of these efforts, including lack of service utilization, insufficient staffing, and persistent racial health disparities.

Strengthening Rural Maternal Health Care

Kristin Dillon, MD, Chief Medical Officer for Federal Office of Rural Health Policy, U.S. Department of Health and Human Services

Kristin Dillon delivered a comprehensive presentation on rural maternal health, covering material from a four-part learning series created with the Rural Health Information Hub. She highlighted the significance of achieving Centers for Medicare & Medicaid Services Birthing Friendly Designation in facilities and collaborating with Perinatal Quality Collaboratives. Dillon emphasized the need for implementing patient safety bundles to improve care processes and outcomes and the additional support low-resource and rural facilities need to participate in these programs. She provided resources for rural communities, such as 3rnet.org, ruralhealthinfo.org and ruralhealthresearch.org.

Expanding Maternal Health Services in North Carolina

Belinda Pettiford, MPH, Section Chief for Women, Infant, and Community Wellness, North Carolina Department of Health and Human Services

Belinda Pettiford described North Carolina's comprehensive strategies to enhance maternal health services through localized health initiatives. With North Carolina's recent Medicaid expansion, the state also extended Medicaid coverage to 12-months postpartum. She also discussed how the state works with local health departments on providing maternal

Dillon emphasized the need for implementing patient safety bundles to improve care processes and outcomes and the additional support low-resource and rural facilities need to participate in these programs.

health services and integrating them into the health care sector, including postpartum, family planning, and reproductive health services. Pettiford's presentation underscored the importance of integrated health services and community involvement in addressing maternal health challenges. Examples of integrated health services included connecting SUD treatment providers with women's health providers, as well as piloting a partnership of community health works and doulas for pregnancy and postpartum care. Pettiford emphasized a "no wrong door" policy, with multiple programs for both mothers and children during pregnancy and up to two years postpartum.

Measuring and Incentivizing Maternal Health Care

Darshak Sanghavi, MD, Program Manager, Advanced Research Projects Agency for Health

Darshak Sanghavi detailed the HEROES initiative now open for state agency or partnering entity application. Applicants commit to address up to two population level health outcomes across a geographic area including heart attack and stroke, alcohol-related health harms, opioid overdoses or maternal health outcomes. Data on these outcomes can be found on the HEROES Toolkit, a national map with county-level data including 60-day postpartum readmission data. Accepted applicants will be paid in six-month intervals for demonstrated improvements in health outcomes. HEROES is a model that states can participate in or replicate to incentivize population health outcomes with full flexibility of partners to design and implement the innovation.

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Discussion Themes

The panel discussion with state participants led to the identification of the following opportunities:

1. **Extended Postpartum Coverage:** Extend health care coverage for mothers beyond the standard postpartum period to ensure they receive necessary medical support for a longer duration.
2. **Doula and Community Health Worker Benefits:** Integrate doulas and community health workers into the health care system to provide essential support, particularly in communities with high needs.
3. **Quality Improvement Initiatives:** Implement and enhance quality improvement programs across health care facilities to improve care at the point of delivery and sustain care through the postpartum period. This should include baseline value-based payment and additional support of perinatal quality collaboratives and ongoing clinical safety bundles.
4. **Bundling Incentives:** Incentivize payers to bundle wraparound services across pregnancy and the postpartum period. By bundling services and payment, providers are incentivized to address the complex needs of mothers during and after pregnancy.
5. **Patient-Informed Programs:** Include patient, provider, and community input in program development, implementation, and evaluation. This feedback should inform how services are offered to ensure high utilization and benefit to patients.
6. **Attention to System Design and Principles of Implementation Science:** This should be a priority from the beginning of policy and program initiation.

Clinical Care

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Rethinking Care Delivery in the Postpartum Period

Veronica Gillispie-Bell, MD, MAS, Medical Director for Pregnancy Associated Mortality Review & PQC, Louisiana Department of Health

Veronica Gillispie-Bell discussed using state specific maternal mortality data to inform quality improvement measures and focus areas in perinatal care. Gillispie-Bell underscored the necessity of partnerships and patient involvement. She described different "sticks and

carrots," such as mandatory hospital participation in the Perinatal Quality Collaborative, and incentives like the Louisiana Birth Ready Designation for hospitals that meet certain criteria. Gillispie-Bell highlighted how innovative strategies like personalized care approaches, i.e., home visits and telehealth, can maintain patient care continuity during the postpartum period. She also stressed the importance of educating all health care providers — including emergency department staff — about specific needs during the postpartum period.

The Case for Hypertension: A Generational Impact

Janet Wright, MD, Director for Heart Disease & Stroke Prevention, Centers for Disease Control & Prevention

Janet Wright discussed the significance of addressing hypertension during pregnancy due to its widespread prevalence and profound impact on both maternal and child health, as well as inequities in related health outcomes for Black Americans. Wright introduced a strategic tool for outpatient clinical teams with over 350 road-tested resources to improve the detection and management of hypertension in pregnancy, including medication safety charts to use during pregnancy and lactation and strategies to identify women with undiagnosed hypertension using electronic health records. Wright also highlighted the Hear Her Campaign, which provides education about urgent maternal warning signs during the pregnancy and postpartum period to pregnant women and health care providers. This campaign is an opportunity for states and health care providers to work together to improve the recognition of urgent symptoms by listening to the patient.

Key Capabilities for Postpartum Care Gap Closure

Isabelle Von Kohorn, MD, PhD, Vice President Medical Affairs, Pomelo Care

Isabelle Von Kohorn shared insights from working at a digital health company that partners with MCOs through value-based payment arrangements designed to integrate and enhance health care. Pomelo Care offers 24/7 comprehensive virtual care, care coordination with in-person services, and innovative patient engagement through phone and chat messaging and remote blood pressure monitoring. Von Kohorn highlighted the opportunity to improve postpartum care through continuous and comprehensive care after the mother leaves the hospital and described how these additional wraparound and telehealth capabilities can be integrated with in-person care teams to overcome geographic and resource barriers to postpartum care.

Discussion Themes

The panel discussion led to the identification of the following opportunities:

1. **Follow-Up Timing:** Appropriate follow-up is critical during transitions, particularly the inpatient to outpatient transition of patients with hypertension. This follow-up can occur any time during the 72-hours after hospital discharge, using usual outpatient care or hospitals' triage or emergency departments. Incentivizing the participation of outpatient primary care clinics in postpartum quality improvement collaboratives provides additional resources for follow-up support.
2. **Reimbursement Policies for Screening and Telehealth:** States can leverage infant health appointments to provide care to new mothers by reimbursing pediatricians for postpartum depression and other maternal screenings and training them on referral resources for mothers. Reimbursing telehealth for certain postpartum care appointments can also improve patient engagement through transitions and improve follow up rates.
3. **Incentivize Hospital Quality Improvement through Designation:** States can create policies that incentivize hospitals to meet quality benchmarks through designations that enhance their reputation and patient trust.
4. **Coordinate Care:** States have an opportunity to incentivize hospitals, MCOs, and health departments to coordinate care efforts, often beginning with creating a shared definition of care coordination and mapping who is providing which types of services to address overlaps and gaps.

THEMES THAT WARRANT FURTHER DISCUSSION

Maternal mortality in the immediate postpartum period is largely driven by cardiovascular and clinical obstetric emergencies. Recommendations to prevent these deaths included enhanced financial support for quality improvement, implementation and exercising of Alliance for Innovation on Maternal Health (AIM) patient bundles, and safer transitions in care settings with technology and enabling reimbursement models. Failures in transitions and care coordination, lack of social services, and inability of health systems, payers, and providers to engage and retain patients in behavioral health and substance use care has largely driven deaths in the late postpartum period. Recommendations in these areas included enhanced state coordination of agencies and facilities and attention to families and providers. These improvements would enable better implementation and evaluation of policies and programs, ranging from postpartum coverage extension to identification and referral for SUD or social needs.

While these panels and discussions highlighted many solutions, there are some outstanding questions that remain. In the course of the yearlong Secretary's collaborative, some issues, as critical as they may be, cannot be addressed in a rapid cycle timeframe. Several themes arose that merit further discussion and revisiting at the conclusion of the collaborative for consideration for next steps and policy directions. These themes are particularly acute in rural and resource limited settings. These included:

- **Gaps in Postpartum Care:** Significant gaps in care exist after the mother leaves the hospital, particularly in terms of consistent and continuous medical monitoring, provision of appropriate behavioral health and SUD treatment, and assurance of family social needs. This is driven both by lack of available care and by lack of utilization of well-intended programs. There is a need for better systems to maintain care continuity in outpatient care settings with obstetric and primary care providers and social services to ensure mothers receive necessary follow-up care and support.

- **Practice Limitations in Clinical Care Settings:** Obstetric practices need additional supports from payers and community models to handle the broader needs of postpartum women, including mental health and social support. Likewise, behavioral health and SUD providers need additional training to build competence in pregnancy and the postpartum period. While telehealth and specific health care innovations are aiming to address these gaps, there are ongoing challenges in ensuring all care providers are equipped to handle these needs comprehensively and payment is aligned to sustainably support innovations that work. There is an existing but unclear gap between the identification of needs through screening and the availability of resources to address those needs effectively.

- **Effective Use of Technology:** While technology, especially telehealth, can address some postpartum care challenges, questions about funding, broadband access, and implementation remain. It is unclear how to equitably implement telehealth solutions given disparities in access to broadband and differing payment models.

- **Cultural and Systemic Barriers:** There is an ongoing need for language interpreters and culturally competent, patient-centered care to effectively engage patients. Many health offices lack bilingual staff and do not use translation services, which can create barriers to access for patients who do not speak English. Lack of racial and ethnic representation in the workforce and biases in clinical decision making and care delivery present additional barriers to highest quality of care for all populations.

APPENDICES

Appendix A: Presenters: HHS Postpartum Presenters.pdf

Appendix B: Participants: HHS Postpartum State Participants.pdf

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