Milbank Memorial Fund Proceedings

U.S. Health and Human Services Department Secretary's Postpartum Maternal Health Collaborative Convening, Part 2

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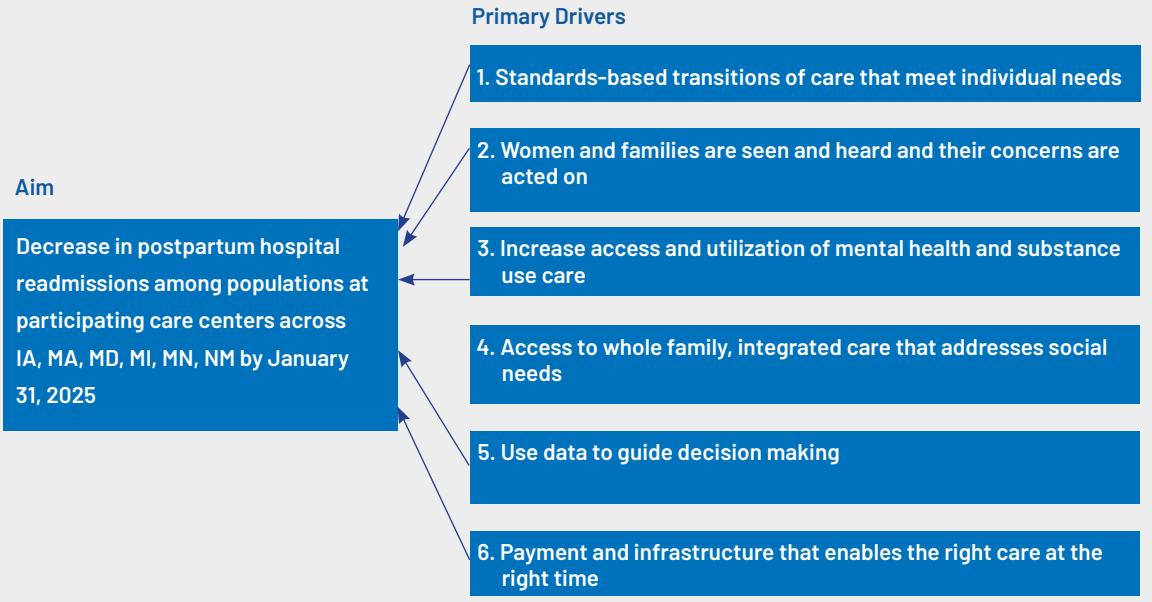
Milbank Memorial Fund

EXECUTIVE SUMMARY

In collaboration with the U.S. Department of Health and Human Services (HHS), the Milbank Memorial Fund convened the second of two virtual meetings in support of the multi-state Secretary's Postpartum Maternal Health Collaborative. The first session, held in April 2024, synthesized evidence and opportunities for postpartum mortality reduction for participant state consideration. The meeting offered key insights from external subject matter experts such as academics, payers, health care providers, and representatives from other states. The second and final session gave states in the collaborative an opportunity to report on their efforts to reduce postpartum morbidity and mortality through rapid Plan-Do-Study-Act (PDSA) cycles over 10 months. Throughout the collaborative, states had opportunities for discussion with each other as they incorporated insights from the subject matter experts and federal agency partners.

State work in the collaborative was guided by a driver diagram developed by HHS with input from all engaged in the process. This framework identifies key contributors to postpartum morbidity and mortality (see Figure 1). Each state used its own data to identify causes of postpartum morbidity and mortality that guided state-level project aims and changes made with providers. Federal technical assistance provided quality improvement, clinical, and policy experts from across HHS. Iowa, New Mexico, and Minnesota pursued projects to address mental health and substance use disorder (SUD) during pregnancy and in the postpartum period. Maryland, Massachusetts, and Michigan focused on addressing cardiovascular conditions. States met as a collaborative monthly to provide peer support and share findings and HHS met with individual states, sometimes several times per week, to keep project momentum.

Figure 1: Key Drivers to Decrease Postpartum Hospital Readmissions



KEY INSIGHTS INTO POSTPARTUM CARE

States tested and implemented evidence-based practices identified during the initial meeting to collaborate with external partners, increase patient engagement, improve care transitions, and enhance data collection in maternal and postpartum health.

Ensure Cross-Sector Collaboration in Policy and Program Implementation

Participating states coordinated efforts between public health agencies, Medicaid, payers, facilities, community-based organizations, and providers. Having a dedicated project lead allowed the states to manage these cross-organization, cross-sector efforts to align resources, communication, and incentives to improve postpartum outcomes.

For example, Massachusetts found that working with a community health center, NeighborHealth, was key to providing comprehensive blood pressure monitoring, behavioral health, and health-related social needs screenings for postpartum patients from Boston Medical Center. Collaboration with NeighborHealth created multidisciplinary teams to manage postpartum care and coordinate primary care with cardiovascular care, behavioral health services, and additional resources. Maryland partnered with Maryland Medicaid and its managed care organizations (MCOs) to expand home health services with blood pressure monitoring to another MCO, so that there is now coverage in all nine MCOs. Maryland also further developed the clinical-public health partnership with perinatal home visiting services with the local health department.

Among the mental health and SUD states, New Mexico worked closely with Medicaid MCOs and a community-based provider on care coordination. With the help of technical assistance from the Substance Abuse and Mental Health Services Administration (SAMHSA), the community-based care coordinator was able to connect more postpartum patients to services. These projects demonstrated that cross-discipline collaboration requires forming relationships that might not already exist (e.g. with child protective services, providers, state departments of health) to align efforts and address misconceptions about SUD.

Standardization and Tailored Engagement Strategies

Many of the state projects established universal standards of care pathways for referral and treatment that could meet individual needs. Michigan standardized scheduling for timely postpartum follow-ups based on evidence-based best practices. Maryland navigated the pregnancy to postpartum care transition by scheduling postpartum follow-ups prior to discharge. Efforts to standardize processes were balanced with more tailored patient engagement strategies to ensure that care delivery met individual needs and transitions of care were successful. Massachusetts shifted its patient communication strategy from weekly portal messages to twice-weekly text reminders based on patient feedback. This led to an increase in the number of patients reporting their weekly blood pressure. In New Mexico, Medicaid MCOs partnered with MECA Therapies, a community-based care coordinator, to screen and refer individuals with substance use disorders.

Support and Expand Quality Improvement Initiatives

Partnering with perinatal quality collaboratives (PQC) was an effective way to enhance maternal health outcomes. Michigan worked with a regional PQC to secure sustainable funding for postpartum cardiovascular screenings, data tracking, and follow-ups in partnership with Sinai Grace and Hutzel Women's Hospitals. Michigan aims to expand these regional PQC collaborations statewide. Similarly, Minnesota is working with the Minnesota Perinatal Quality Collaborative (MNPQC), to implement behavioral health screenings and referrals, ensuring continuity of care through the postpartum period. MNPQC will recruit hospitals and collect data for outcome and process measures. Iowa found that working with facilities with quality improvement experience and a dedication to maternal mental health and SUD were key for the project.

Data Infrastructure Investment

States prioritized data analysis to determine the primary drivers of postpartum morbidity and mortality in their states. They then evaluated and improved initiatives while ensuring equitable access to care. Across projects, states expanded their use of electronic medical records (EMR) and patient data to better track patient outcomes and transitions. For some states, like Iowa and Massachusetts, this included adding screening results to the EMR. Maryland leveraged access to their hospital case-mix data to better understand readmission rates. Minnesota identified challenges accessing individual-level data from Medicaid and known postpartum visits from hospital systems, highlighting an opportunity to enhance data infrastructure to inform decision-making and comprehensive quality improvement.

PROCEEDINGS

Mental Health & Substance Use Disorder

Based on "expert-to-expert" discussions in the first convening, state teams focused on building cross-sector partnerships and training the clinical workforce to address mental health and SUD during pregnancy and the postpartum period. Both Iowa and New Mexico partnered with state Medicaid agencies to increase access to screening, referral, and treatment services. New Mexico Medicaid MCOs worked with a community-based organization to manage care coordination. Minnesota is working with the MNPQC to improve care through the postpartum period by reaching women as they are getting care for their infants.

Iowa leveraged Health Resources and Services Administration (HRSA) grant funding to train providers on care for perinatal mood disorders and psychopharmacology, to help patients manage substance use during pregnancy. And New Mexico received technical assistance from SAMHSA to train existing clinicians to address bias regarding opioid use during pregnancy to increase access and treatment.

Iowa

Marcus Johnson-Miller, CPM, Bureau Chief and Title V MCH Director, Iowa Department of Health and Human Services

The Iowa Department of Health and Human Services (DHHS) focused on increasing mental health and substance use disorder screening during pregnancy for women screened as high risk for behavioral health complications. Iowa DHHS worked with local health care facilities, Title V state program staff, Medicaid, and local providers in two counties to connect postpartum women with services within 14 days of hospital discharge. This included improving transitions of care between hospitals, usual sources of care, and community providers. Implementing these changes required assessing the current screening tools, training staff (RNs and fellows) to use pregnancy-specific screening tools, adjusting data collection methods in EMRs, and coordinating with case managers to ensure new patients are screened. Iowa DHHS found that working with existing partners such as those involved in Alliance for Innovation on Maternal Health (AIM) initiatives, that were passionate about maternal mental health and SUD, were key to success. Hospitals involved with AIM had experience with implementing quality improvement initiatives and established trusted relationships with the DHHS.

To increase the number of clinicians available to provide mental health and substance use disorder care to pregnant persons, 70 providers in Iowa received training about the components of care for perinatal mood disorders and 25 received advanced training in psychopharmacology through an existing HRSA grant. Iowa began planning for the implementation of a Perinatal Psychiatric Access Program, a training and phone consultation line that connects prenatal and postpartum care providers with perinatal psychiatrics professionals.

New Mexico

LeAnn Behrens, Deputy Secretary/Chief Operations Officer, New Mexico Department of Health
Christopher Bartsch, Nurse Auditor/Medicaid Quality Bureau Data lead, New Mexico Health Care Authority

The New Mexico Health Care Authority (HCA) and Department of Health (DOH) focused on enhancing access to medication for opioid use disorder (MOUD) treatment for postpartum Medicaid members diagnosed with opioid use disorder. A state mandate, which became effective on July 1, 2024, resulted in Medicaid MCO Blue Cross Blue Shield New Mexico partnering with MECA Therapies, a community-based organization, for delegated care coordination. Initial quality improvement measures focused on increasing screening for opioid use disorder and improving treatment rates for pregnant and post-partum persons with SUD. Initial results were limited given the short timeline and significant challenges, including a rural region with behavioral health provider shortages, hard-to-reach Medicaid members, and inadequate infrastructure, including limited broadband. Stigma associated with SUD and behavioral health disorders and a lack of trust between patients and providers also contributed to limited screening for SUD and care referrals. The technical assistance from SAMHSA for the MCO and delegate entity to improve the member experience, reduce stigma, and increase receipt of treatment became a significant focus of the project. The Health Care Authority and the Department of Health also worked to ensure respect for the sovereignty of Tribes, Pueblos, and Nations while providing care to individuals as requested.

Minnesota

Abby Alyesh, Department of Health and Human Services, on behalf of the Minnesota Department of Health

The Minnesota Department of Health (MDH) is beginning work with the Minnesota Perinatal Quality Collaborative (MNPQC) to implement screenings and referrals for postpartum women with SUD and perinatal mental health conditions. Minnesota had several project redirections due to timing mismatches with grants and data limitations, illustrating the challenges of aligning state health initiatives with available resources and infrastructure. Minnesota also faced challenges in reporting state-level data, as many states do. Minnesota's hospital discharge data does not identify postpartum women, and MDH does not have access to Medicaid data because those data are housed at a different state agency. The MDH team looks forward to continued collaboration with the MNPQC to create richer data about maternal SUD and mental health. The quality collaborative will recruit hospitals to participate in the project and collect data for outcome and process measures, while the health department creates data linkages between hospital discharge data and birth records.

Despite their data challenges, the Minnesota team was encouraged to see other participating states report on postpartum data. Seeing their approaches will help inform how Minnesota collects and reports data.

Cardiovascular Conditions

Many of the takeaways from the initial "expert-to-expert" meeting on clinical care were incorporated by the states focused on cardiovascular health. The Maryland and Michigan teams addressed timely follow-up by scheduling postpartum follow-ups before or immediately after patient discharge, as well as referring patients to primary care providers. Massachusetts initially sent weekly reminders through the patient portal for their blood pressure monitoring program, which they updated to twice weekly text messages based on patient feedback.

States also established ongoing reimbursement and sustainability for screenings and home visiting. Maryland's MCOs will reimburse for home visiting services delivered through Optum OB Home Care. Michigan leveraged Centers for Disease Control and Prevention (CDC) funding through the Southeast Michigan Perinatal Quality Improvement Coalition to support cardiovascular screenings during pregnancy and postpartum. The importance of coordinated care was highlighted across state models, with each state identifying opportunities for scalability. States learned that overlapping care coordination efforts can also add complexity to the patient experience, presenting an opportunity to develop more efficient and organized approaches to care coordination.

Maryland

Shelly Choo, Bureau Director for Maternal Child Health Bureau and Title V Director, Maryland Department of Health

The Maryland Department of Health aimed to reduce postpartum readmissions for pregnant people with hypertensive conditions at the University of Maryland Capital Region Medical Center (UM Cap), a birthing hospital within the University of Maryland Medical System (UMMS). Their multifocal interventions included a focus on postpartum follow-ups, remote blood pressure monitoring by Optum OB Home Care, and referrals to home visiting services

provided by Prince George's County Health Department's Healthy Beginnings service. Success stemmed from leveraging recent state legislation and coordinating with the Maryland Perinatal Quality Collaborative, MCOs, local health departments, and community-based organizations. The team aimed to schedule postpartum follow-up visits within three days of discharge. Scheduling proved to be challenging, especially surrounding holidays, and weekly meetings were held to troubleshoot and refine workflows, with scheduling responsibility ultimately shifted from nursing staff to social work staff. The team also provided blood pressure cuffs and connected patients to home health monitoring services through the MCOs and perinatal home visiting services offered through the local health department. The project resulted in all nine MCOs offering remote blood pressure monitoring. The potential next steps include expanding the initiative to other hospitals within the state, both within the University of Maryland system and in other healthcare systems, developing an OB Cardio Clinic at UM Cap, and increasing referrals for Optum OB Home Care, which now contracts with all MCOs in Maryland.

Massachusetts

Sue Ghosh, Director of Women's Health Initiatives, NeighborHealth

MassHealth partnered with NeighborHealth, a community health center, and Boston Medical Center (BMC) to build on an existing six-week postpartum blood pressure management program that has served 800 patients annually since May 2022. A pilot group of NeighborHealth patients at BMC are continuing to receive ongoing blood pressure monitoring, as well as behavioral health and health-related social needs screenings and referrals, as the patients transition back to primary care services at NeighborHealth. To encourage compliance with weekly blood pressure monitoring, NeighborHealth reached out to patients weekly via the patient portal. In response to patient feedback, they increased their outreach to twice a week via text, which was more convenient for patients. NeighborHealth also improved their data tracking capabilities by adding screening data to their EMR system. Through the pilot, data tracking and outreach strategies were refined, and future goals include scaling the program and refining workflows. While obstetrics staff scheduling into primary care providers was a success, next steps should include a workflow for no-show appointments to ensure that patients receive follow-ups. Opportunities for the remote blood pressure monitoring program include refining enrollment criteria and timing for enrollment appointments and expanding the model to patients on anti-hypertensive medications.

Michigan

Chris Fussman, Maternal and Child Health Epidemiology Section Manager, Michigan Department of Health and Human Services
Megan Chuy, Nurse Consultant, Division of Maternal and Infant Health, Michigan Department of Health and Human Services

The Michigan Department of Health and Human Services (DHSS) worked with the Detroit Medical Center (DMC) at Sinai Grace and Hutzel Women's Hospitals to address cardiovascular conditions during pregnancy and postpartum. The project focused on early diagnosis of cardiovascular conditions in the perinatal period and aimed to increase the number of follow-up visits within six months postpartum through screening and data-tracking. Efforts also included coordinating care across DMC and creating referral pathways to cardiology, internal medicine, and primary care. The Michigan team partnered with a local organization, Rides for Moms, which provided free transportation to appointments for patients during pregnancy and postpartum.

Challenges included provider buy-in and communication between providers due to potentially incompatible EMRs. As a result, the team chose to focus within a single health system with a compatible EMR. They leveraged funding from a five-year CDC grant provided through the Southeast Michigan Perinatal Quality Improvement Coalition.

LESSONS LEARNED FROM CROSS-STATE COLLABORATIVE PROCESS

The Postpartum Maternal Health Collaborative offered lessons on the benefits of cross-state collaboratives that incorporate support from federal agencies and subject-matter experts. The collaborative helped mobilize state teams and provide a framework for states to share information and learn from each other. The technical assistance from federal partners helped define and achieve outcome and process measures in rapid PDSA cycles. The ongoing exchange between states and the federal resources sustained the projects. In the final meeting, SAMHSA, HRSA, and the CDC highlighted existing and planned federal resources that can further support states' work.

In addition to establishing relationships between federal and state partners, the collaborative connected implementors to experts. Presentations from technical experts on themes related to clinical care, mental health and substance use disorder, community and social drivers of health, and state-level policy opportunities directly informed these state quality improvement projects. Connecting these often-siloed parties resulted in the implementation of evidence-based practices and identified areas for further research.

Finally, the cross-state collaborative process highlighted the impact of small process changes for maternal health outcomes. Given the short timeframe, states could not address payment reform or federal broadband expansion to enable telehealth, and instead focused on facility-level changes that led to improved outcomes. These changes included improvements to data collection and analysis, including adding screening results to EMR. Facility-level staff training included scheduling prompt follow-ups, administering blood pressure and behavioral health screenings, enabling appointment scheduling access across teams, and timely connection with primary care, cardiology, behavioral health, and community resources.

APPENDICES

- Part 1: U.S. Health and Human Services Department Secretary's Postpartum Maternal Health Collaborative Expert Evidence Convening
- Fact Sheet: HHS Secretary Becerra's Postpartum Maternal Health Collaborative Effectively Mobilizes State and Local Partnerships to Improve Outcomes
- State Teams/Collaborators
- National Women's Mental Health and Substance Use Technical Assistance Center: This forthcoming center will focus on perinatal mental health and substance use consultation. You can stay updated on SAMHSA's grants and funding page.

- Community-Based Maternal Behavioral Health Programs: These programs are funded by SAMHSA to improve maternal mental health and reduce substance use. More details can typically be found on SAMHSA's website under their grant announcements.
- State Maternal Health Innovation Program: This program is part of HRSA's efforts to improve maternal health through state-led innovations. More details can be found on HRSA's Maternal Health page.
- Maternal and Child Health Medicaid Partnership Center: This new center will facilitate better integration of MCH needs with Medicaid policy, with a focus on enhancing interagency collaboration. Details about this initiative are likely to be available on the HRSA website soon.
- Hypertension in Pregnancy Action Forum: These quarterly forums focus on improving care for hypertensive disorders in pregnancy. Participation details and registration can be found by contacting your local state health department.

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