NTTAP National Health Center Training & Technical Assistance Partners Clinical Workforce Development
A PROJECT OF Community Health Center, Inc. and the weitzman institute

Health Outreach Partners
HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

MOSES/WEITZMAN Health System

Addressing Maternal Health Disparities Utilizing an Advanced Team-Based Care Model

Wednesday May 8th, 2024
3:00-4:00pm Eastern | 12:00-1:00pm Pacific

Continuing Education Credits

JOINTLY ACCREDITED PROVIDER™

INTERPROFESSIONAL CONTINUING EDUCATION

In support of improving patient care, Moses/Weitzman Health System and its Weitzman Institute is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Access your certificate right after the webinar by finishing the evaluation, or access the comprehensive certificate in Summer 2024.

Disclosure

- With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between the party listed above (or spouse/partner) and any for-profit company in the past 12 months which would be considered a conflict of interest.
- The views expressed in this presentation are those of the presenters and may not reflect official policy of Community Health Center, Inc. and its Weitzman Institute.
- We are obligated to disclose any products which are off-label, unlabeled, experimental, and/or under investigation (not FDA approved) and any limitations on the information hat we present, such as data that are preliminary or that represent ongoing research, interim analyses, and/or unsupported opinion.
- This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $550,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

At the Weitzman Institute, we value a culture of equity, inclusiveness, diversity, and mutually respectful dialogue. We want to ensure that all feel welcome. If there is anything said in our program that makes you feel uncomfortable, please let us know via email at nca@chc1.com

NTTAP National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A PROJECT OF Community Health Center, Inc. and the weitzman institute

Health Outreach Partners
HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

MOSES/WEITZMAN Health System

Moses Weitzman Health System Affiliates

Where health care is a right, not a privilege, since 1972
Community Health Center, Inc.

the national institute for nimaa
medical assistant advancement

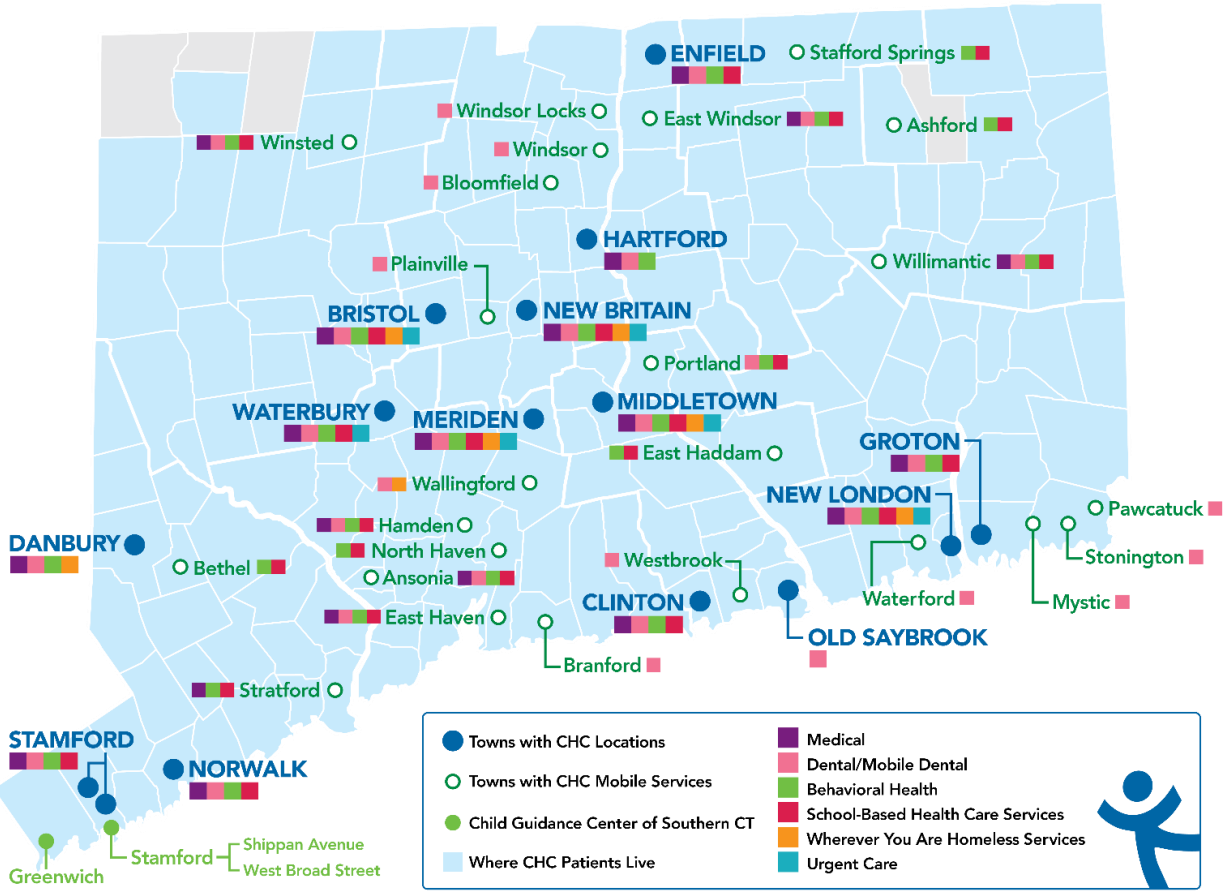
ConferMED™
Connecting Primary Care to the Future

CONSORTIUM
FOR ADVANCED PRACTICE PROVIDERS

MOSES/WEITZMAN Health System

Community Health Center, Inc.

Locations and Service Sites in Connecticut



CHC Profile:

- Founded: May 1, 1972
- Staff: ~1,200
- Total Patients Served: 102,275
- Clinical Sites across CT: 19
- SBHCs across CT: 180+
- Students & Residents/year: 390
- Three Foundational Pillars:
  1. Clinical Excellence
  2. Research & Development
  3. Training the Next Generation

Community Health Center, Inc.

MOSES/WEITZMAN
Health System










NTTAP National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A PROJECT OF Community Health Center, Inc. and the weitzman institute

Health Outreach Partners
HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

MOSES/WEITZMAN Health System

National Training and Technical Assistance Partners

Clinical Workforce Development

Provides free training and technical assistance to health centers across the nation through national webinars, learning collaboratives, activity sessions, trainings, research, publications, etc.

Team-Based Care

- Fundamentals of Comprehensive Care
- Advancing Team-Based Care

Training the Next Generation

- Postgraduate Residency and Fellowship Training
- Health Professions Training

Emerging Issue

- HIV Prevention

Advancing Health Equity

Preparedness for Emergencies and Environmental Impacts on Health

Health Outreach Partners

WWW.OUTREACH-PARTNERS.ORG

WE SUPPORT HEALTH OUTREACH PROGRAMS by providing training, consultation, and timely resources.

OUR MISSION IS TO BUILD STRONG, EFFECTIVE, AND SUSTAINABLE HEALTH OUTREACH MODELS by partnering with local community-based organizations across the country in order to improve the quality of life of low-income, vulnerable and underserved populations.

WE SERVE Community Health Centers, Primary Care Associations, and Safety-net Health Organization

Speakers

- **Mary Blankson, DNP, APRN, FNP-C, FAAN**, Chief Nursing Officer, Community Health Center, Inc.
- **Veena Channamsetty, MD, FAAFP**, Chief Medical Officer, Community Health Center, Inc.
- **Timothy Kearney, PhD**, Chief Behavioral Health Officer, Community Health Center, Inc.
- **Lila Purvis, LMSW,** Behavioral Health Clinician I, Community Health Center, Inc.
- **Meghan Constantino, MSN, CNM,** Certified Nurse Midwife, Community Health Center, Inc.

Objectives

- Discuss research and data around maternal health
- Explore advanced team based care to improve maternal health outcomes
- Outline the roles of the interdisciplinary team

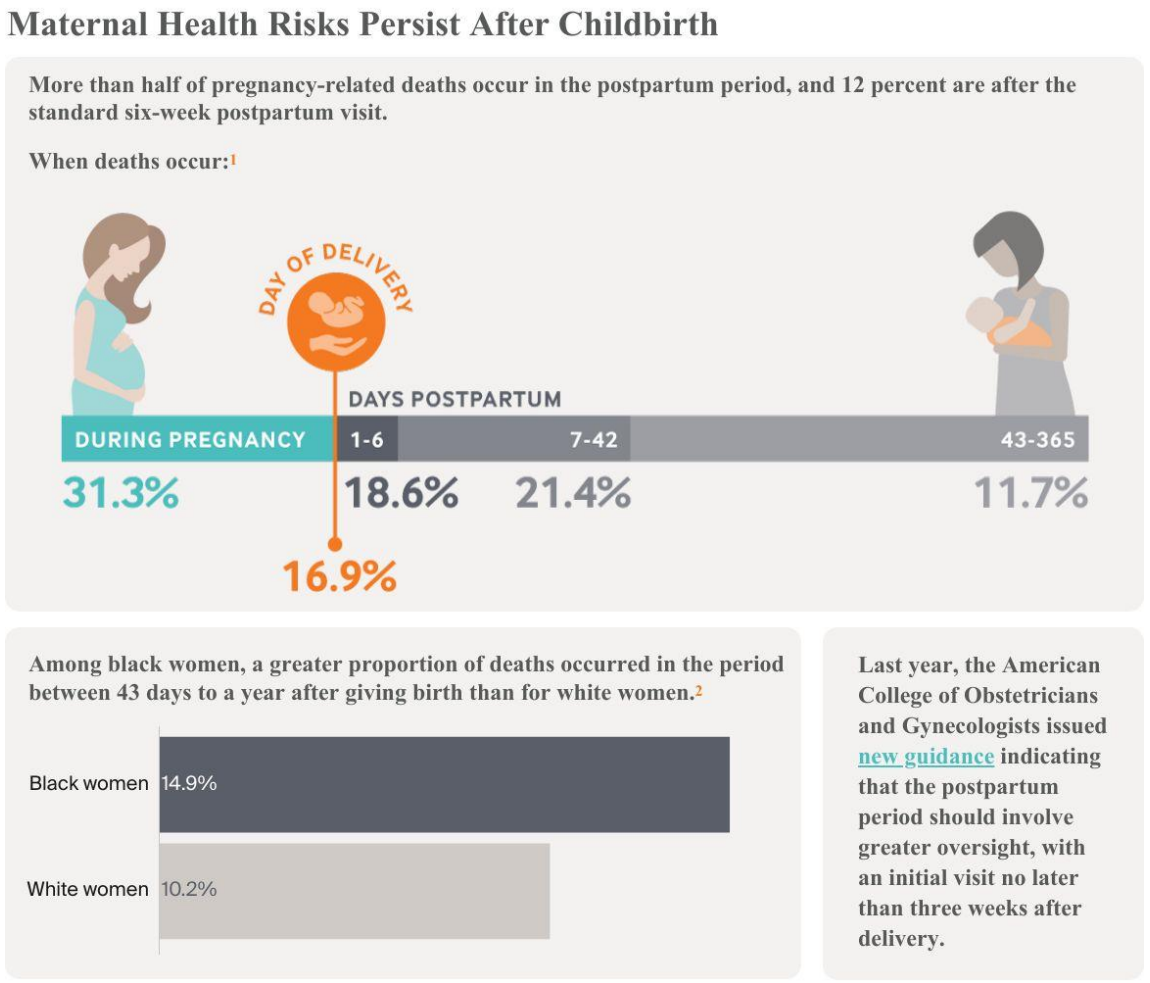
Research and Data

What is Maternal Health?

- Maternal health refers to the health of people before, during, and after pregnancy[1]
- People who get recommended health care services before they get pregnant are more likely to be healthy during pregnancy and to have healthy babies[1]
- People in the United States are more likely to die from childbirth than people living in other developed countries[2]
- 52% of maternal deaths are postpartum[3]

1. U.S. Department of Health and Human Services. (n.d.). *Pregnancy and childbirth. Healthy People 2030*. Retrieved from https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth#cit1
2. GBD 2015 Maternal Mortality Collaborators. (2016). *Global, regional, and national levels of maternal mortality, 1990–2015: A systematic analysis for the Global Burden of Disease Study 2015*. The Lancet, 388(10053), 1775–1812. https://doi.org/10.1016/S0140-6736(16)31470-2
3. The Commonwealth Fund. (2019*). Increasing postpartum Medicaid coverage.* Retrieved from https://www.commonwealthfund.org/blog/2019/increasing-postpartum-medicaid-coverage

Maternal Health Risks Persists After Childbirth



- More than half of maternal deaths occur after birth, yet people in the U.S. typically only have a single office-based visit with their care team within this period, or do not have one at all[4]
- Around one in seven people who have given birth will develop postpartum depression (PPD)[5]
- Only 20% of affected people are detected in the perinatal period and around 10% of those receive adequate treatment and support for PDD[6]

4. The Commonwealth Fund. (2019). *Increasing postpartum Medicaid coverage.* Retrieved from https://www.commonwealthfund.org/blog/2019/increasing-postpartum-medicaid-coverage
5. Mughal S, Azhar Y, Siddiqui W. *Postpartum Depression*. [Updated 2022 Oct 7]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK519070/
6. Haßdenteufel, K., Lingenfelder, K., Schwarze, C. E., Feisst, M., Brusniak, K., Matthies, L. M., Goetz, M., Wallwiener, M., & Wallwiener, S. (2021). *Evaluation of Repeated Web-Based Screening for Predicting Postpartum Depression: Prospective Cohort Study*. JMIR mental health, 8(12), e26665. https://doi.org/10.2196/26665

Maternal Health Disparities: Racial and Social Determinants

- In order to make significant improvements in maternal health, all healthcare organizations need to be aware of the racial and social disparities that exist in maternal health, including health centers[7]
- CDC data show that black people are two to three times more likely to die from pregnancy-related complications than white people, with most of the maternal deaths being preventable[8]
  - African Americans are more than twice as likely as their white peers to have uncontrolled high blood pressure during their childbearing years[9]
  - Social determinants of health such as education, income, food security, homeownership, and access to healthcare significantly impact health outcomes[9]

7. Hoyert DL. *Maternal mortality rates in the United States*, 2021. NCHS Health E-Stats. 2023.DOI: https://dx.doi.org/10.15620/cdc:124678.
8. Centers for Disease Control and Prevention. (2022, September 19). *CDC Newsroom: CDC releases new data on pregnancy-related deaths in the United States*. Retrieved from https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html
9. American Heart Association. (2023, February 27). *Black women in childbearing years face higher blood pressure risks than white peers*. Retrieved from https://www.heart.org/en/news/2023/02/27/black-women-in-childbearing-years-face-higher-blood-pressure-risks-than-white-peers

The Role of the Interdisciplinary Team

What is High-Quality Primary Care?

- High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities. (National Academies of Sciences, Engineering, and Medicine, 2021)
- High-quality primary care is best provided by a team of clinicians and others who are organized, supported, and accountable to meet the needs of the people and the communities they serve. (National Academies of Sciences, Engineering, and Medicine, 2021)

National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

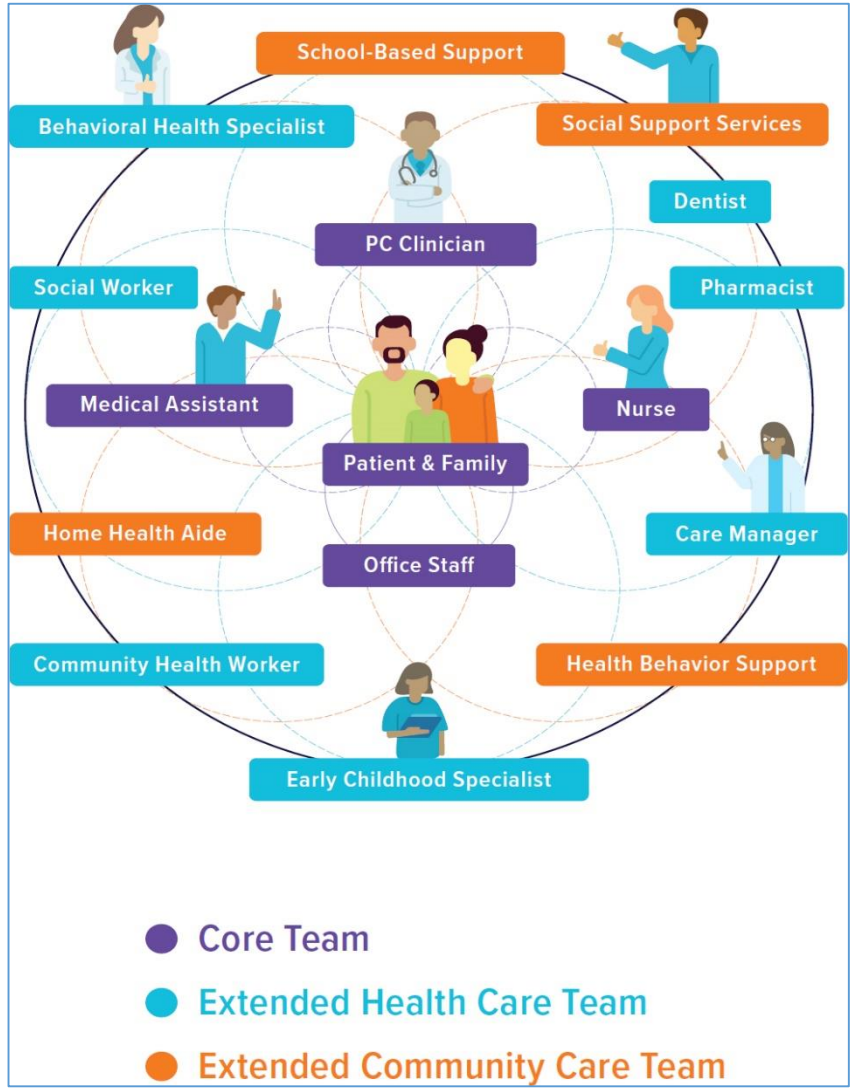
Team-Based Care

- Team-based care is “the provision of health services to individuals, families, [and] their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care. (Mitchell et al., 2012, Okun et al., 2014):
- Advanced models of team-based care provide:
  - Increased access to care and services with a consistent care team
  - Improved quality, safety, and reliability of care
  - Enhanced health and functioning in those who have chronic condition; and
  - More cost-effective care (Hupke, 2014)

Hupke, C. (2014). Team-based care: Optimizing primary care for patients and providers. Institute for Healthcare Improvement.
Okun, S., S. Schoenbaum, D. Andrews, P. Chidambaran, V. Chollette, J. Gruman, S. Leal, B. A. Bown, P. H. Mitchel, C. Parry, W. Prins, R. Ricciardi, M. A. Simon, R. Stock, D. C. Strasser, C. E. Webb, M. K. Wynia, and D. Henderson. 2014. Patients and health care teams forging effective partnerships. NAM Perspectives. Discussion Paper, National Academy of Medicine
Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C. E. Webb, V. Rohrbach, and I. Von Kohorn. 2012. Core principles & values of effective team-based health care. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC

Interprofessional Care Teams

- Facilitators of high-quality primary care include the interprofessional care teams
  - ***Interprofessional care teams*** - Care provided by teams of clinicians and other professionals fit to the needs of communities, working to the top of their skills, and in coordination leads to better health (National Academies of Sciences, Engineering, and Medicine, 2021)
- Figure on the right demonstrates the composition of interprofessional primary care. (National Academies of Sciences, Engineering, and Medicine, 2021)



National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

Team-Based Care in the Maternity Care Setting

- Provision of team-based multidisciplinary care throughout pregnancy and up to 6 to 8 weeks postpartum is associated with high levels of maternal satisfaction in women of low obstetric risk (Perrella et al., 2022)
- Your health care team may consist of a variety of providers: Ob/Gyn, Family Medicine, Certified Nurse Midwives, Nurses (RNs and LPNs), Behavioral Health, Registered Dieticians, Pharmacists, Medical Assistants, Community Health Workers, Doulas, Lactation Consultants, and more. Thanks to advances in telehealth, team members may not always be in your office.
- Ensure you have access to referrals for high risk pregnancies or complications

Perrella, S. L., Miraudo, J., Rea, A., Geddes, D. T., & Prosser, S. A. (2022). Maternal Evaluation of a Team-Based Maternity Care Model for Women of Low Obstetric Risk. *Journal of patient experience*, *9*, 23743735221092606. https://doi.org/10.1177/23743735221092606
UT Southwestern Medical Center. (n.d.). Pregnancy: The power of team-based health care. Retrieved from https://utswmed.org/medblog/pregnancy-team-based-health-care/

Role of Primary Care Provider

Easy access to pregnancy screening	Screening for pregnancy and family planning, including postpartum planning for contraception	Easy access to prenatal care
Coordination with prenatal care providers (internal & external)	Management of chronic health conditions during pregnancy	Support for postpartum visits and needs

Primary Care Nursing During and After Pregnancy

Personalized relationship with patient	Carrying out elements of care plan	Initial history and assessment	Routine prenatal care	Ensuring labs, immunizations and screenings are up to date
Ongoing connections with patients	Follow-up at postpartum visit	Education on contraception	Child birth education	Routine primary care – screening, immunizations, labs, and education

Comprehensive Prenatal Care

Focus on early entry to prenatal care/remove barriers

Comprehensive screening for chronic and urgent issues

Screening for behavioral health concerns during and after pregnancy

Screen for: group education, nutrition, preparation for childbirth

Timely and periodic visit – either individual or group – to assess the patient and provide support

Education and preparation for childbirth

Pre and post coordination with the pediatrician team

Role of Integrated Behavioral Health

Accept referrals, including warm handoffs, from the medical care team based on screenings and assessments

Assessment and treatment of behavioral health, addressing common conditions like depression, anxiety, changes in support systems, and coping skills

Provide individual and group psychoeducation to help patients understand common psychological issues that can arise during and after pregnancy

Ongoing treatment and referral options

Consideration of peer support groups, such as the Centering Pregnancy model

Rising, S. S., Kennedy, H. P., & Klima, C. S. (2004). Redesigning prenatal care through CenteringPregnancy. Journal of Midwifery & Women's Health, 49(5), 398-404.

Other Roles

- Community Health Worker
- Nutritionist/Dietitian
- Lactation consultant
- Childbirth educator
- Chiropractor
- Peer Groups
- Doulas

Case Study Examples

Case Study #1

About the Patient

- 33-year-old pregnant woman initially diagnosed with gestational diabetes and proteinuria

Patient Goals

- Achieve healthy pregnancy and delivery while managing health conditions

Provider Goals

- Accurately diagnose underlying health issues
- Optimize diabetes and kidney health during pregnancy
- Establish ongoing management plan post-delivery

Patient Needs

- Evaluate diabetes and proteinuria by specialists
- Implement lifestyle/diet changes
- Monitor kidney function and glucose levels during pregnancy
- Arrange postpartum pre-diabetes screening

Challenges

- Early gestational diabetes diagnosis raised concerns about pre-existing conditions
- Additional testing revealed early kidney dysfunction
- Uninsured prior to pregnancy

Key Strategies Implemented

- Prenatal care led to gestational diabetes diagnosis.
- Regular visits ensured continuous monitoring.
- Endocrinology managed gestational diabetes with medication.
- Nephrology addressed underlying kidney issue.
- Nutritional counseling provided by WIC.
- Medical specialists accessed via insurance coverage.
- Postpartum follow-up for ongoing health management.

Results

- Gestational diabetes managed with treatment and medication.
- Nephrology monitored kidney issue post-pregnancy.
- Pregnancy had no complications; healthy baby delivered.
- Postpartum glucose testing showed mild abnormalities.
- Positive health outcomes due to comprehensive care coordination.

Case Study #2

About the Patient

- 29 year old pregnant woman presenting with severe nausea/vomiting, history of anxiety/panic attacks, and syncopal episodes

Patient Goals

- She wanted to feel better physically and emotionally during her pregnancy and have a healthy delivery

Provider Goals

- Coordinate mental and physical health care between specialists and primary care
- Determine cause of symptoms and ensure patient's safety during pregnancy
- Support patient's mental health through pregnancy and postpartum

Patient Needs

- Medication management for anxiety and nausea/vomiting
- Specialists evaluations like cardiology for syncopal episodes
- Behavioral health therapy and group support

Challenges

- Differentiating between physical and mental health symptoms
- Patient had some missed appointments which delayed entry into behavioral health treatment
- Very low pre-pregnancy weight and potential effects on the baby

Key Strategies Implemented

- Early prenatal care at 7 weeks for monitoring.
- Frequent visits, including weekly appointments.
- Medication management for nausea, anxiety.
- Referral to behavioral health for therapy.
- Coordinated care among OB, primary care.
- Prescriber involved in mental health management.
- Postpartum referral to home visiting program.

Results

- Physical symptoms treated by medication, specialists.
- Behavioral health therapy supported mental well-being.
- Baby delivered at 37 weeks, healthy.
- Successful postpartum breastfeeding and baby care.
- Baby met milestones and gained weight.
- Coordinated care led to positive outcomes.

Case Study #3

About the Patient

- Poorly controlled type 2 diabetic with known proteinuria.
- Early entry to prenatal care with frequent appointments.
- Outside referrals to nephrology, endocrinology, ophthalmology, maternal fetal medicine.
- Involvement of a community health worker through an IH referral.

Patient Goals

- Improve diabetes management.
- Address proteinuria and kidney health.
- Ensure the well-being of the baby.

Provider Goals

- Control diabetes and manage complications.
- Monitor and address proteinuria and kidney health.
- Ensure the well-being of the baby.

Patient Needs

- Better control of diabetes through improved diet, medication management, and counseling.
- Management of proteinuria and kidney health.

Challenges

- Poor diet adherence despite counseling.
- Premature delivery at 31 weeks due to PPROM and severe pre-eclampsia.
- Postpartum cardiomyopathy and MRSA pneumonia leading to ICU admission.
- Baby requiring intermittent respiratory support in the NICU at 6 weeks.

Key Strategies Implemented

- Early prenatal care, frequent appointments scheduled.
- Referrals to nephrology, endocrinology, ophthalmology made.
- Community health worker involvement through referral.

Results

- Poor diabetes control despite multiple referrals.
- Improved A1c levels during pregnancy observed.
- Preterm delivery at 31 weeks occurred.
- Postpartum complications: cardiomyopathy, MRSA pneumonia.
- Baby required NICU stay for respiratory issues.
- Continued NICU stay at 6 weeks.

How Healthcare Providers can Support Maternal Health

- Patient-centered care leveraging the interdisciplinary team
- Ask questions to better understand their patient and things that may be affecting their lives
- Help patients, and those accompanying them, understand the urgent maternal warning signs and when to seek medical attention right away
- Help patients manage chronic conditions or conditions that may arise during pregnancy like hypertension, diabetes, or depression
- Recognize and work to eliminate unconscious bias in themselves and in their office on an ongoing basis
- Respond to any concerns patients may have
- Provide all patients with respectful quality care

https://www.cdc.gov/healthequity/features/maternal-mortality/index.html

NTTAP National Health Center Training & Technical Assistance Partners Clinical Workforce Development A PROJECT OF Community Health Center, Inc. and the weitzman institute

Health Outreach Partners HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

MOSES/WEITZMAN Health System

Questions?

Wrap-Up

NTTAP National Health Center Training & Technical Assistance Partners Clinical Workforce Development
A PROJECT OF Community Health Center, Inc. and the weitzman institute

Health Outreach Partners
HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

MOSES/WEITZMAN Health System

Next Webinar:

Innovative Practices in Screening for and Addressing Maternal Mental Health

Wednesday, May 22, 2024 1:00pm-2:00pm ET / 10:00am-11:00am PT

By the end of this webinar, participants will be able to:

- Discuss the maternal mental health crisis in the United States, and how maternal mental health disorders are the leading cause of pregnancy-related deaths
- Understand the importance of screening for mental health among new and expecting mothers
- Incorporate innovative whole-child, whole-family approaches to public health interventions and programs to tackle maternal health disparities.

Register Today!

Introducing a New Weitzman ECHO Module on Prenatal & Maternal Health

- Launching **June 6th** at 3pm ET / 12pm PT, with subsequent sessions held **1st and 3rd Thursdays** from 3-4pm ET / 12-1pm PT.
- Topics will include medication management adjustments; mood disorders, such as postpartum depression; transitions of care; and screening for risks and complications.
- Access up to 6, no-cost CME/CEUs
- Visit the link in the chat to **register now!**

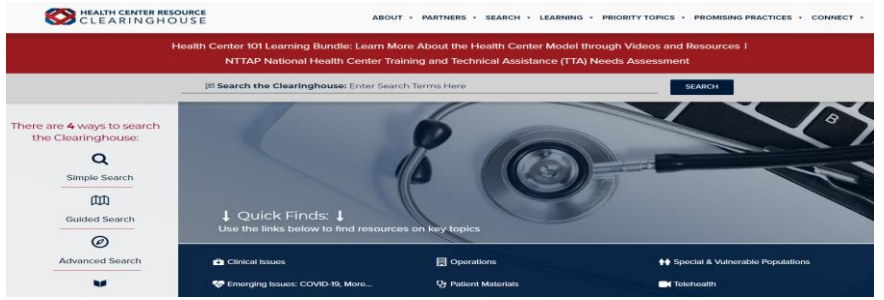
Register Today!

Explore more resources!

National Learning Library:
Resources for Clinical Workforce Development

https://www.weitzmaninstitute.org/ncaresources

Health Center Resource Clearinghouse



https://www.healthcenterinfo.org/

Contact Information

For information on future webinars, activity sessions, and learning collaboratives: please reach out to nca@chc1.com or visit https://www.chc1.com/nca