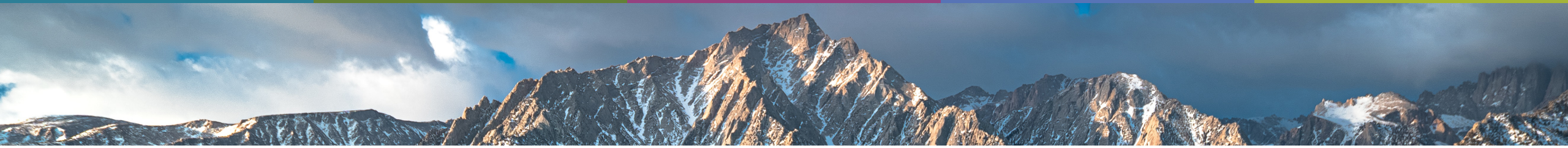
PHM INITIATIVE

EXECUTIVE SUMMARY:

Pregnant People Guide

Population Health Management Initiative (PHMI), a California collaboration of the Department of Health Care Services, Kaiser Permanente, and Community Health Centers.



Populations of Focus Guide Series

This guide is part of a series focused on improving quality of care and equitable outcomes for five high-priority populations:

- Children
- Pregnant People
- Adults with Preventive Care Needs
- Adults Living with Chronic Conditions
- People with Behavioral Health Conditions

This guide provides step-by-step guidance for improving population-based care for **pregnant people**, with the goal of supporting substantive cultural, technological and process changes. In particular, it focuses on **prenatal and postpartum care, and prenatal and postpartum depression screening and follow-up.**

Population Health Management Initiative (PHMI) Overview

These guides were produced by PHMI, a **California collaboration of the Department of Health Care Services (DHCS), Kaiser Permanente and Community Health Centers (CHCs)**.

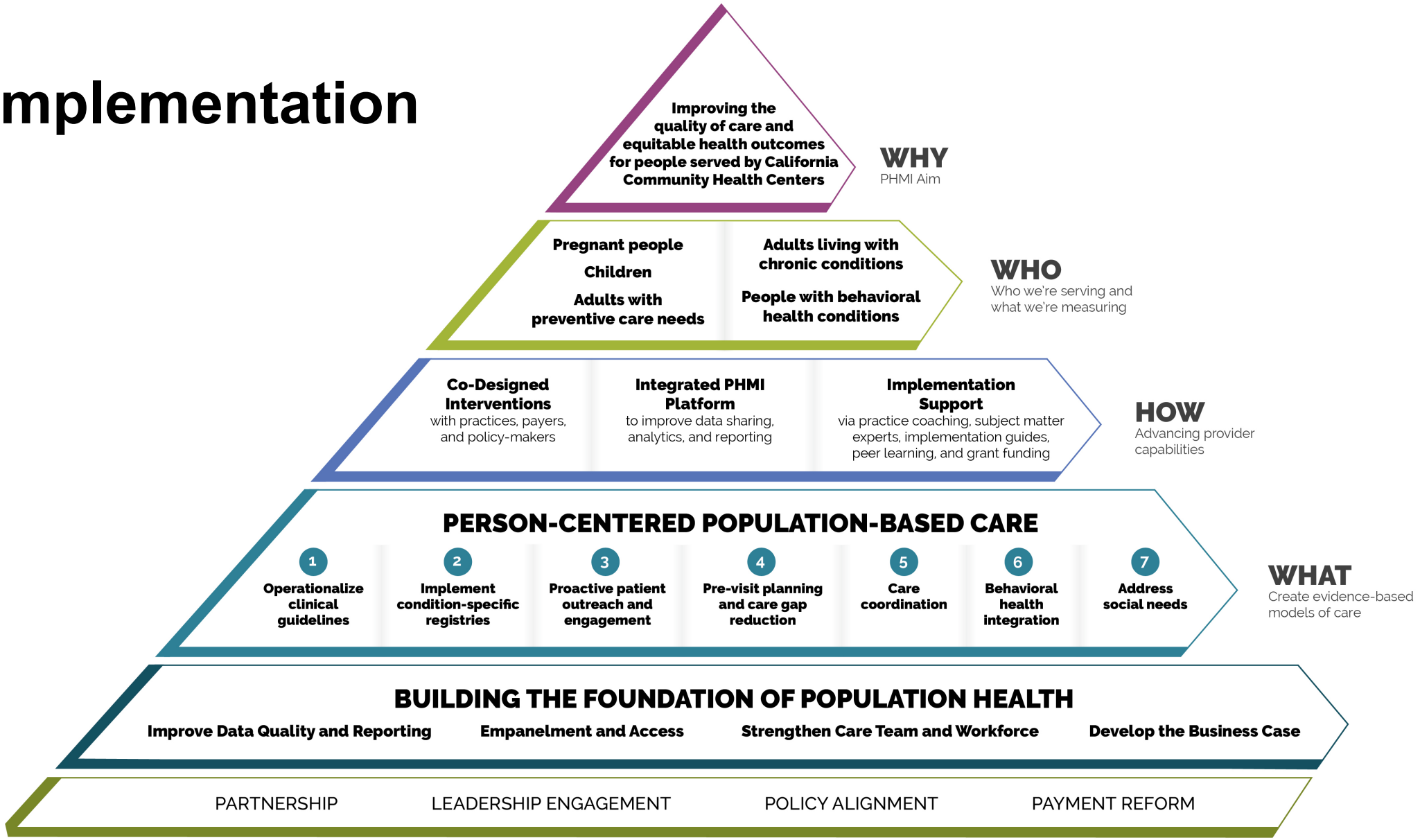
We're building on existing capacity of CHCs to employ **evidence-based models of care to improve quality of care and equitable health outcomes** for key populations of focus: children, pregnant people, adults with preventive care needs and adults living with chronic conditions, and people with behavioral health conditions.

Together, we are **empowering CHCs to successfully transition to the structural transformation** brought about by California Advancing and Innovating Medi-Cal (CalAIM) and new payment models through Alternative Payment Methodology (APM) 2.0.

As part of the capacity-building process, **CHCs can assess their existing population health management capacity** with the Population Health Management Capabilities Assessment Tool (PhmCAT). This self-administered tool can help organizations identify strengths and opportunities for improvement.

For more information about PHMI, visit www.phminitiative.com.

PHMI Implementation Model



Why This is Important

Timely and adequate prenatal care (during pregnancy) and postpartum care (12 months after giving birth) can prevent more than 80% of all pregnancy-related deaths. It can also reduce the risks of complications, infections and low birth weight.

These adverse health outcomes are largely preventable, and are exacerbated by:

- Variation in quality healthcare.
- Underlying chronic conditions.
- Structural racism.
- Implicit bias.

Racial and ethnic disparities in maternal health outcomes persist and increase as women age. As of 2021:

- Black pregnant people were almost three times as likely to die due to pregnancy-related causes than non-Hispanic White pregnant people.
- Provider-dependent factors (e.g. delayed response to clinical warning signs) were the most common contributor to maternal deaths.

By ensuring that people have access to equitable prenatal and postpartum care, we can improve the health outcomes and quality of life for pregnant people and infants.

How This Guide Is Organized

The guide uses existing evidence and bright spot examples from the field to offer practical guidance on improving care.

The key activities are organized into three categories, and we recommend that practices consider planning and attempting to implement the activities in the same order:

1. **Foundational activities:** Activities that all practices should implement.
2. **Going deeper activities:** More advanced activities that build off the foundational activities and help ensure your practice can achieve equitable improvement.
3. **On the horizon activities:** Additional activities, including “ideas worthy of testing” that include the latest ideas and thinking.

For each activity, we provide:

- **Guidance** on how to plan, test and implement the activity.
- **Links** to other resources, technology considerations and examples.
- **Tips** for periodically reviewing and making improvements to key workflows.

This guide also includes sections on measurement, equity, social health and behavioral health integration.

How To Use This Guide

The guide is designed to be part of an organized quality improvement strategy, with the goal of supporting substantive cultural, technological and process changes.

- **Sequencing activities:** We recommend implementing the activities in the sequence provided in this guide, but recognize that different practices may prioritize differently.
- **Testing and implementing:** Consider testing different versions of the action steps and roles on a small scale before scaling throughout your practice.
- **Maintaining the progress:** Ongoing review and continual improvement is important for your practice to maintain your progress and adapt to changes in patient demographics, clinical best practices, payment policies and workforce.

Foundational Competencies

If you implement the activities in this guide, you should be able to perform these foundational competencies:

1. Engage patients served by your practice to validate any of your proposed process improvements and to propose alternative methods to improve quality in your focus area.
2. Analyze core and supplemental quality measures to identify improvement opportunities for achieving timely access to prenatal and postpartum care for attributed patients. Ensure that any analyses of your quality measures are stratified by key patient demographic characteristics to identify disparities in quality performance for specific attention.
3. Use care gap reports or registries to identify all prenatal and postpartum patients due for care.
4. Develop a process for screening pregnant and postpartum people for depression using evidence-based tools.
5. Integrate behavioral health follow-up services as needed (e.g., for positive depression screens).
6. Create an outreach protocol to reach and engage all attributed patients due for care.
7. Create a health-related social needs screening process that informs patient treatment plans.
8. Assess current capabilities and develop a plan for ongoing improvement in data utilization, care team workflows and efficiency that includes sustainable health information technology (HIT) strategies and continuous staff training on technology.

Who Should Use This Guide

Improving the health of a population impacts everyone in a practice. Critical roles needed to engage in the work outlined in this guide and support practice change include:

- Quality improvement leadership, like a director of quality improvement (QI), to support cultural changes.
- Coaches or practice facilitators who are partnered with teams to help identify areas for improvement and support change through change management strategies.

Advancing Equity and Social Health

Many key activities in this guide include considerations for:

- Using the intervention to improve equitable health outcomes and reduce the effects of racism, bias and discrimination.
- Social needs at the individual or population level, such as expanding referral networks.

The following activities dive into these more deeply:

- Key Activity #4. Use a Systematic Approach to Decrease Inequities within the Population of Focus
- Key Activity #7. Use Social Needs Screening to Inform Patient Treatment Plans
- Key Activity #20. Strengthen a Culture of Equity

For a more in-depth understanding of these topics, please see:

- PHMI Equity Framework & Approach
- PHMI Social Health Framework & Approach

Supported Quality Measures

This guide provides detailed guidance to improve your practice's results on the below HEDIS quality measures. These measures were chosen by PHMI to help CHCs improve their population health management capabilities and prepare for APM and CalAIM.

Pregnant People HEDIS Measures for PHMI	
Core Measures	**Prenatal and Postpartum Care** Percentage of people with a postpartum visit within seven to 84 days after delivery
Supplemental Measures	**Prenatal and Postpartum Care (Timeliness of Prenatal Care)** Percentage of deliveries in which people had a prenatal care visit in the first trimester. **Prenatal Depression Screening and Follow-Up** Percentage of deliveries in which people were screened for clinical depression while pregnant and, if screened positive, received follow-up care. **Postpartum Depression Screening and Follow-Up** Percentage of deliveries in which people were screened for clinical depression during the postpartum period and, if screened positive, received follow-up care.

Key Activity Summaries

Overview of Key Activities

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Foundational Activities

1. Convene a Multidisciplinary Implementation Team Focused on Pregnant and Postpartum People
2. Review Perinatal Care Clinical Guidelines Including Specialty Referral
3. Use Care Gap Reports or Registries to Identify All Patients Eligible and Due for Care
4. Use a Systematic Approach to Decrease Inequities within the Population of Focus
5. Develop and Implement Standing Orders
6. Develop or Refine and Implement a Pre-Visit Planning Process
7. Use Social Needs Screening to Inform Patient Treatment Plans
8. Provide Prepregnancy Healthcare
9. Conduct Postpartum Planning and Care
10. Support Patient Self-Care
11. Behavioral Health Screening, Including Postpartum Depression
12. Proactively Reach Out to Patients Due for Care
13. Coordinate Care

Going Deeper Activities

14. Group Prenatal Care, Including Centering Pregnancy
15. Doula Programs
16. Vaccines
17. Continue to Develop Referral Relationships and Pathways
18. Strengthen Community Partnerships
19. Provide Care Management
20. Strengthen a Culture of Equity

On the Horizon Activities

21. Telehealth in Perinatal Care
22. Group Postpartum (New Parent) Care

Foundational Activities

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1. **Convene a Multidisciplinary Implementation Team Focused on Pregnant and Postpartum People**
   Find guidance for developing, launching and sustaining a multidisciplinary team or task force within your practice that will be responsible for the planning and implementation of all of the foundational key activities in this guide and overseeing related quality improvement and equity efforts.

2. **Review Perinatal Care Clinical Guidelines Including Specialty Referral**
   Clinical care guidelines for pregnant people are evidence-based recommendations that help healthcare providers and pregnant people make informed decisions about the optimal care during pregnancy and childbirth. This activity provides guidance on selecting or developing relevant and reliable guidelines.

3. **Use Care Gap Reports or Registries to Identify All Patients Eligible and Due for Care**
   Find detailed guidance on how to reliably and efficiently develop and use a list of all pregnant patients eligible for recommended care (i.e., cervical cancer screening and immunization needs) through a care gap report or registry.

4. **Use a Systematic Approach to Decrease Inequities within the Population of Focus**
   This activity provides guidance for a systematic, evidence-based approach for identifying and then reducing inequities for pregnant people.

Foundational Activities

5. **Develop and Implement Standing Orders**
   This activity outlines the actions required to create a standing order, or a pre-approved provider order, to perform a specific intervention during standard workflows for any patients who meets the criteria. Standing orders, in concert with other key activities, allow care team members to work to the full scope of their license and provide scaffolding to support care team members as they work to greater autonomy.

6. **Develop or Refine and Implement a Pre-Visit Planning Process**
   Effectively and efficiently implement a pre-visit planning process (PVP) for better team-based coordination of care. Pre-visit planning works towards optimizing a team-based approach so patients receive comprehensive care in alignment with the latest clinical guidelines and their own needs and preferences.

7. **Use Social Needs Screening to Inform Patient Treatment Plans**
   Data from screening patients for health-related social needs can be used to inform patient treatment plans, including referrals to community-based services. Social needs are defined as individual material resources and psychosocial circumstances required for long-term physical and mental well-being, such as housing, food, water, air, sanitation and social support.

Foundational Activities

8. **Provide Prepregnancy Healthcare**
   Prepregnancy health services aim to identify and modify biomedical, behavioral, and social risks to an individual's health or future pregnancy outcomes through prevention and management.

9. **Conduct Postpartum Planning and Care**
   Care during the postpartum period should include other preventive health screenings and services a patient might be due for, such as depression screening, substance use screenings, cancer screenings, immunizations, and other elements.

10. **Support Patient Self-Care**
    The term "self-care" refers to patients' engagement in the activities and decisions that improve their health and well-being. Supporting self-care involves activities that enhance the capacity of individuals to engage in their care.

11. **Behavioral Health Screening, Including Postpartum Depression**
    This key activity provides guidance on behavioral health screening during pregnancy and postpartum.

12. **Proactively Reach Out to Patients Due for Care**
    Proactive outreach focuses on identifying sub-populations among patients that may benefit from additional outreach and implementing more personalized reminders and “touches” for them to engage in care.

13. **Coordinate Care**
    When care is coordinated well, the patient and their core and extended care team members know who is responsible for different parts of the patient’s care and everyone has the information they need. Care coordination is central to population health management and works to achieve safer processes and more effective outcomes.

Going Deeper Activities

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14. **Group Prenatal Care, Including Centering Pregnancy**
    Group care models are particularly well-suited to prenatal patients given their focus on anticipatory guidance and creating spaces for peer support. Bringing patients with similar needs together for healthcare encounters increases the time available for the educational component, improves efficiency and reduces repetition.

15. **Doula Programs**
    Doulas support pregnant individuals and their families with education and advocacy. When welcomed into your practice, doulas can be a valuable part of the patient's care team.

16. **Vaccines**
    This activity focuses on two key vaccines of importance during pregnancy: influenza ("flu") and tetanus-diphtheria-pertussis ("Tdap").

17. **Continue to Develop Referral Relationships and Pathways**
    Your practice can take steps to optimize both the referral pathways to providers and receipt of a referral outcome, regardless of referral source. This activity builds on an inventory of existing referral services outside the clinic and identifies steps to support the systematic management of the referral process.

Going Deeper Activities

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18. **Strengthen Community Partnerships**
    Establishing partnerships in the community can help address the most pressing social needs and leverage essential resources that support or assist patients. Deep engagement in this work can require significant resources from your practice.

19. **Provide Care Management**
    Led by a care manager (a licensed clinician or a non-licensed trained individual), care management is an intervention intended to support the highest-need individuals within your practice.

20. **Strengthen a Culture of Equity**
    Find strategies and resources to create a culture of equity in your practice. That means a transformational shift at the organizational level that is necessary for long term and sustainable improvement to health and racial equity.

On the Horizon Activities

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21. **Telehealth in Perinatal Care**
    This activity provides considerations for leveraging telehealth in perinatal care.

22. **Group Postpartum (New Parent) Care**
    Group postpartum care represents an opportunity to expand care and relationships established during the prenatal period. Providing postpartum and well-child care in group settings has the potential to improve the provision of care by enhancing patient-provider relationships, as well as peer relationships, in the postpartum period.

Thank you!