Improving Postpartum Care_MIECHV Opportunities_4_0

Hello, and welcome to HV-ImpACT's webinar on improving postpartum care-- MIECHV opportunities. We're really pleased to have you here today. Just want to give you a short introduction to the webinar room. You'll see a chat box over to the left where we welcome everyone to join in and share where they're from, their program, and any other information you'd like to have as you join this webinar, so please do introduce yourself over in the chat to the left.

You'll see beneath that there's a web links block where you'll have an evaluation survey. If you happen to leave early, you'll be able to click on that as you're leaving so that you'll have an evaluation to complete. We'll talk more about that. If you're having any kind of issues with audio-- we are asking you to listen through your computer speakers for this call, and we have not provided a phone number. If you're having issues with your computer and you do need that, please go into the technical support box and type that you would like to have the phone number sent to you.

Otherwise, we'll be listening to a video, and we're going to be using computer speakers for the most part today. There's a file share pod beneath the slide deck that you'll see, an infographic that one of our presenters will be sharing today that you'll be able to download at any point during this, and also after the webinar there will be a little time to download as well.

So with that, we're going to get started. I'm Karen Cairone. I'm the technical assistant manager for HV-ImpACT, and I'm very pleased that you've joined us today for this one hour on postpartum care for MIECHV opportunities. Again, we're joining by computer whenever possible, and you'll need to mute your [AUDIO OUT] otherwise you can leave your computer speakers open as we will be showing video.

Use the technical support box for any kind of issues you have during this call, whether you're having a hard time hearing presenters or something happens with your file screen download. So please do use that technical support. Again, use the chat throughout for all kinds of questions that you might have as well as to be able to respond to others that post questions in the chat. And I just want to note that we are recording this today. We'll make this file available-- the transcript and the slides will be available about a month from this call, so you can expect to have that information soon on HRSA's website. So with that, we're going to get started.

At the end of this webinar, you'll be asked to complete evaluations, and I just want to let you know how much we do value your feedback, that you take the time to tell us how we can improve our webinars and make them better in the future. Based on some feedback that you've provided over the past year or two with our webinars we have made some revisions already. We've included more awardees from different regions so that we have a broader representation of MIECHV awardees on these calls. We've shortened our webinars from 90 minutes to one hour. And we've also increased our focus on performance measures throughout. So we wanted to just let you know we really do value the time you take to fill in our evaluation. And you'll see that pop up right at the end of the webinar today.

Our presenters for today are Doctors Sarah Verbiest and Jennifer Medley. And I just want to share with you a little of information about our presenters before they get started. Dr. Sarah Verbiest is the executive director for the Center for Maternal and Infant Health and the director of the Jordan Institute for Families at the University of North Carolina at Chapel Hill.

Dr. Verbiest is the senior advisor to the national pre-conception health and health care initiative. She's a principal investigator on two research projects focusing on postpartum health and wellness and the creator of Birth Control After Baby and Taking Care of You postpartum care booklets. She leads several statewide infant mortality prevention campaigns.

She is also the principal investigator for a new cooperative agreement with the federal government focusing on integrating pre-conception care into the well-woman visit. Dr. Verbiest recently edited a book that was published in April of 2018 with the APHA Press called Making Change Happen-- Moving Life Course Theory into Action. Women's health is Dr. Verbiest's passion-- elevating the importance of centering the woman in her care and well-being across her life to come.

Jennifer Medley is our other presenter, and she is the senior chief advisor for the Home Visiting Program in Arkansas for the Department of Health. Jennifer joined the department's family health branch in 2014, and she currently oversees the maternal, infant, and early childhood home visiting grant. She also manages the development of the annual Title V Maternal and Child Health Grant Plan and Update. We are so excited to have Dr. Verbiest and Jennifer Medley here today to present on this webinar.

So with that, I want to share the objectives that we plan to get through. Throughout the course of this hour, we hope that awardees listening to this call will be able to describe the importance of increased attention to postpartum wellness and the unique needs of women after giving birth, we want to be able to have awardees describe strategies for home visiting programs to better support women and families during the postpartum period, including increasing their postpartum visits, and finally, we'd like you to learn about Arkansas MIECHV efforts around performance measurement related to moms and babies. So those will be the three objectives that we'll cover during this time. With that, I'm going to turn it over to our first presenter, Dr. Sarah Verbiest.

Thank you. Thank you for the opportunity to talk about one of my favorite topics, which is post-partum health and wellness. And I know that this is something that really matters to all of the MIECHV, as your performance measure number five focuses specifically on post-partum care. And I think you have a great goal of focusing on the percent of mothers enrolled in home visiting prenatally or within 30 days after delivery. You receive a postpartum visit with a health care provider within eight weeks of delivery. It's a really important measure, and I'm excited to talk with you more about that today. There we go.

So there are many reasons why the postpartum visit and, more importantly, postpartum care is very important. I think for many years, this was a topic that didn't get very much attention and really has been a neglected time in a woman's life in recovery. However, more recently in the US, as you can see by the slide, we have begun to see an increase in maternal mortality. And if

you look at the other industrialized countries that are listed there, you can see that their rates have been going down while ours in the US have been increasing.

And what's particularly important about the increase is that we see significant disparities in terms of maternal mortality for women of color as compared to white women. And when we think about mortality, just like, as you know, with infants, infant mortality is the tip of the iceberg. And so we're also seeing increases in maternal morbidity as well, and there are also disparities in that arena. So this has really, I think, begun to prompt more attention to this really important period of time, which I think it's unfortunate that it's taken a crisis to get our attention, but I do think that it provides a really significant opportunity.

And so along those lines, I wanted to make sure, if you heard nothing else from the webinar today, that I shared with you some information from the Association of Women's Health Obstetric and Neonatal Nurses-- AWHONN. If you want to find out more information about this, you can look at AWHONN and type in "post-birth." But this is information that they are working to make sure that women have and the people who love them have before they leave the hospital after having their babies. And I think that these are signs that all home visitors who are visiting new moms should know.

And so the items that are in red-- POST-- pain in chest, obstructed breathing or shortness of breath, seizures, or thoughts of hurting yourself or baby-- those signal a need for immediate and urgent attention. So if you're visiting a new mom and she sharing any of this with you, you really need to focus on getting her attention immediately.

If she is sharing other symptoms with you that you see for the birth, around bleeding, her incision not healing, red or swollen legs that are painful to the touch, a high fever and a headache that doesn't get better with medication, and if she has vision problems, those are also important to really work with her to get those attended to by a health care provider. And we list these because these are some of the symptoms that we are seeing identified with women that end up not surviving.

And I think another really critical role in terms of not only understanding the symptoms and helping women understand the importance of getting attention, but we know that it's really important that home visitors and others are an advocate for these moms, particularly for women of color, women who may not speak English, and women who may not communicate well. It's easy for providers in some ways to attribute these to just regular postpartum discomforts when these are serious and require attention. So something for you to think about, and AWHONN has really great material on their website and additional information that may be of use.

So taking a step back from that really important infomercial about post-birth, I wanted to zoom back out and think about how do we look at and approach the postpartum period in general. And so I think we could probably generally agree that there's a general public expectation that mom and the new couple should be really happy and that there's going to be a quick recovery. I think this is reinforced consistently by media, by movies, and I think in some way it's how people present themselves to the world, so happy with a quick recovery.

I think this is similar in a workforce where there is an expectation that she's going to come back productive with a quick recovery because after all, she just had a really nice 6 to 12-week vacation from work, which we know is not true but we have to admit that that's an expectation that coworkers are going to have, who are going to be really anxious to shift back the burden of work that they've taken on. And then, especially for first time parents and their partners, there is an expectation that labor and delivery is going to be safe, that recovery will be painless-- once you get through labor and delivery everything will be fine-- there will be a quick recovery, and again, everyone will be happy.

And I think that in many cases, there are families that are happy all the time and have quick recovery, but I think that these expectations can set people up to try to hold themselves to standards that aren't really realistic and force people to try to present themselves in ways that aren't true. And so it's not particularly helpful if we get a mom paid post-partum visit, and so culturally, when she's asked how she's doing and she says, I'm fine, that doesn't really provide information to the health care provider.

At the same time, when providers and others are expecting her to say that she's fine, that also may not make them probe for other issues. And so I think being mindful of the use of the word "I'm fine," and giving people space to talk about how hard it can be through postpartum is something that I think is important. We have a picture of a candy wrapper on this slide because my colleagues and I often think about postpartum as the idea that once the candy, a.k.a. the baby, is out of the wrapper, we tend to throw the wrapper away. And so we think that taking care of the wrapper is also important.

So, I like to share some of the work from Fahey and Shenassa. They have this really great perinatal maternal health model that I think really encapsulates a lot of what home visitors should be thinking about when they're working with new families and new moms. And so in the center is the focus on maternal health and thinking about some of the key tasks that the woman has to sort out in those first months and first year after having a baby.

And so the first area is physical recovery, and we're going to talk a little bit about that. So there's a lot that can happen, and it can be different from pregnancy to pregnancy. So, how to actually recover from this huge physical experience of becoming pregnant, carrying a pregnancy, having a baby, and recovering from that. Women also have to figure out who they are in the context of having this child, and it can be particularly challenging for first mom, but every time a family changes and grows, there's a new shifting of "who am I" in the context of my family and my life.

And then there's also the complexity of taking care of herself. Infants, newborns, as we all know, are high-need little beings, and also the family. So these are all the things that the moms are trying to figure out when you're visiting them in the postpartum period. So how do we as health care providers, as home visitors and others, support that?

And so there are some four areas that we can think about as you're providing services to new families. So one is how do we help her effectively mobilize social support? So how do we create and communicate concrete plans for postpartum support? So one thing about Americans-- and this is a huge generalization, I admit-- but we aren't always the best at asking for help. And I

think helping moms understand that it's OK to ask for help, and that when you ask for help it does open opportunities for others to be a part of their experience, is something that we can talk about. And so thinking about helping her understand what would be helpful for her and how to ask for it is really important.

We also need to think about self-efficacy. So we have to help support her capacity to meet all of these different parenting demands. I think what can be really challenging is when someone leaves the hospital and she has a long list of all the things that she needs to be worrying about-- back to sleep, purple period of crying, infant car seat safety, how to feed this child, cord care. There's a lot. And so helping to support her ability to care for this new complex being, who may be different if she's had more than one child from the last infant that she had, is another thing that home visitors can do.

There's also, as we've learned-- and we'll talk about a little bit later from our research-- that moms are very vulnerable because they're trying to figure out who they are as new moms, and they recognize the weight and responsibility of caring for this baby and their family. And so it's very easy for them to interpret messages as being critical, and so very sensitive. And so focusing on positive coping, so instead of talking about what she's maybe going back to that's not good, focusing on what she's doing to take care of herself that is strength-based is another really excellent approach to working with new moms.

And then finally, helping to really set realistic expectations to really lift up that this is a big biological, psychological, and social transition for her and her family, and that it takes time to adapt to a new normal are some other messages that it's great for home visitors to communicate. So there's a lot in this model, and we're going to break it down a little bit with the rest of our time.

Something else that we've heard, so there's a lot of things when we're rethinking about physical recovery in some ways when we think about all of these different issues that women are thinking about. So we know we think and are concerned about perinatal depression and well-being. I already talked about all the complexities of infant care.

Oftentimes, we're very quick to want to start to talk to them about what contraception they're going to use, and do they want to have any more children, which can sometimes feel like an overwhelming conversation if they're already having concerns just about intimacy with their partner. There's sleep and fatigue, there's just the physical recovery. And then thinking about what medications they might take, and what exposures they might have, and how that might, for example, interfere with breastfeeding and breast milk.

So there's a lot. And what we found is, a lot of times different providers will focus on each of these different bubbles and forget that they all are linked together. And so I think the message here is that we really don't want to just talk about one particular thing like emotional well-being without asking her about what's her pain level as she's recovering from a c-section, and asking about her sleep, and maybe her relationships. Because these are all intermingled and difficult to separate, and we need to just accept, again, the complexity of what she's experiencing postpartum.

And this is just a quick snapshot. I really like the listening to mothers surveys. And this is just an example of some of the physical symptoms and issues that new moms are dealing with. And so if you'll see the lighter color to the left are women that report this as major, meaning that it significantly disrupts and impacts their ability to function, and then minor being something that they notice and absolutely pay attention to but not as much as major.

And so if we look at this, there are things that we don't often think to advise about or talk about, such as hemorrhoids, such as backaches, such as concerns about weight, feeling stress, and then certainly sleep loss is a very common issue. And I think being mindful of some of these symptoms-- headaches that she might be dealing with and thinking about. It you're noticing that there are certain issues she's experiencing, thinking about some of the physical recovery and talking about that can be useful.

And so one really great way to be able to address some of the physical symptoms is to meet your performance measure and help make sure that women are getting postpartum visit after they have their baby. And so this is an example of generally how we're doing. The data is a bit old but it hasn't changed a whole lot in terms of women receiving services.

So even women that have commercial private insurance, we're still seeing that just over 75% are getting a post-partum visit, meaning about a quarter of women with that coverage are not receiving any care after this significant event of having a baby. And then we look at different populations-- Medicaid and then some of different payers-- we see some varying trends. But we can also see that, particularly for moms that have Medicaid, it's in some cases just about 60% are receiving care. So it's a good number of women that aren't receiving care, so it's a really important measure that you're aiming to.

And that's really important because we have some missed opportunities if women aren't getting the care that they need. We have pretty good breastfeeding initiation in our country. But the continuation to the recommended six months is low and even lower for women that may want to breastfeed for a year. We know that postpartum depression is a significant issue, that almost one in five moms address and have to deal with.

We know that as much as we work hard in helping women stop smoking when they're pregnant, we still see up to 70% returning to tobacco use postpartum, which makes sense if you're trying to cope with a lot of stress and lack of sleep. And then we also know that really short birth intervals between pregnancies, particularly less than six months, can be a risk. So when we don't provide great services to women, we are missing opportunities to help them in the future for themselves and any future children.

And so there are reasons why women aren't getting in for a postpartum visit. And if we were sitting in a room and could have a conversation, I feel like you all would be able to very well articulate some of these as well. We know that some of the predictors of not attending a postpartum visit can include substance use-- alcohol or drug use-- a mental health disorder other than depression, and then also living in high-risk neighborhoods, which is, I think, a proxy for living in poverty, and in some cases lower education. So we know that those are some women who are generally at risk of not getting a post-partum visit.

But we know that other barriers can include women that need to return to work early. We know that one in four women are needing to go back to work within ten days of having a baby. These are often women that are working in professions such as fast food workers, housekeepers, others where there's very limited access to leave policy, and so they may already be back at work.

Other things that we know are challenges for prenatal care as well are lack of transportation. Sometimes it can be very difficult to get a postpartum appointment. Also, there are more significant issues around lack of trust in a provider. So some women will put up with a provider when they're pregnant for the sake of their baby, but once the baby's not in play they may not feel like they want to go back to that provider.

For some women, the value of what they get out of a postpartum visit really isn't worth the investment in getting there, and I'm going to talk a little bit about what some of the OBGYN's-- particularly ACOG-- is doing to really enhance the value of that visit. And we know that it's difficult to access providers in rural and frontier communities. So some of the same things that you face in prenatal care as well. And so it is definitely an important role for home visitors to think about ways that you can plan in advance with your clients and the women that you serve to help them troubleshoot what it would take to make sure that they're getting in for care.

And so there's a post-partum infographic, if we could pull that up real quick, that came out of some work that we did with the Association of Maternal and Child Health Programs. We had a national postpartum think tank group, and they looked at different research, and we just identified a number of ways in which our current system is broken in terms of how we're going to support new motherhood. And so there's lots of reasons why moms say that they forgo the care that they need. And if you look at this, you'll see a number of different reasons, some of which I discussed and some of which I haven't.

And we've offered some solutions that we think would make it easier, such as integrated services, and easier care transitions for women from pre-conception through post-partum and well-baby care. We also know that sometimes women have a lot of help in the first few weeks, but when all their helpers leave, it can become really complicated to figure out how to get out of the door with a newborn. There's lots of feelings of isolation.

And also, not everyone has health care coverage in our country, so if women aren't getting in on time or if they may have immigrant status, and many states they may not have even access to coverage for that visit. And we often know that there can be difficulties with rescheduling, with language issues, some women are afraid because they don't really-- particularly women that may have had some chronic conditions emerge during pregnancy, such as gestational diabetes or hypertension-- some of them are afraid in terms of what does that mean for their future. And some, as I mentioned, are really unhappy with how their birth went, and that may really have disrupted their relationship with their health care provider.

So again, it's a great performance measure to take on, and hopefully this also elevates what you already probably see in practice. But there's a lot of reasons why women aren't getting back in for care. Thank you. So if we could go back to the next slide. And this is available for download if you wanted to continue to have access to that.

So here's something that's really exciting that I want to make sure that you all know. This just came out in April of this year, and these are new guidelines from the American College of OBGYNs. And if you look at this, you'll see that they have really opened up and moved away from just this particular six-week visit to really opening up to make sure that women are getting services when they need them.

And so what they recommend is that all women have contact with their health care providers within three weeks of having a baby. This might be by phone, by text, or it may be going in because they need care. And for women that had high-risk pregnancies or high-risk conditions, they're really wanting to see them get their blood pressure checked within three to ten days postpartum, and they also want to make sure that they're seen for follow-up within one to three weeks postpartum. So this is new, this idea of getting women contact with health care providers much earlier in the postpartum period is new and very important if we're particularly thinking about issues around breastfeeding for example, infection, or those potentially really concerning signs.

And then they also expand to say it may not just be the six-week visit. So they say, I'm going to follow up as needed between 3 to 12 weeks. And so some women may get in at two weeks, have their needs met, and they're fine, and then they're fine. So I think that would meet your metric but also meet her needs. Likewise, some women may need to come in several times. One visit may not be enough. And so what ACOG is trying to do is to really have the care and the quantity of care be responsive to the needs that women have. So I think this is really exciting.

And, of course, it will take a while for this to trickle into practice but I do think it's a great start. They've also done a really nice job in this committee opinion, which is available for free access on their website. They've also done a really nice job of better defining what kinds of services women should be receiving during postpartum care, which I think will enhance the value of the visit for women, which may make it more likely that they will attend that visit. And additionally, they've highlighted the importance of following up women who may have had a stillbirth, who have had an infant death, who have an infant in the NICU, and or who've had chronic conditions.

So, I think that covers-- so that's thinking about that physical recovery. For the last few slides, I'm going to focus on Fahey and Shenassa's focus on the woman's need to learn how to care for herself, infant, and family, and her own role at [INAUDIBLE]. So what I'm going to talk about came from two years of a project working with a group of new moms. And I want to lift up, in all of the work that you do, whenever you have an opportunity, you want to look at how your services are being received. Are you thinking about providing new services? It's awesome to bring moms and their babies together and spend some time talking with them to see what they think would be important.

So we did this. I have to say, these are the best meetings ever. And having babies to pass around laps and to play with really created just a really great environment and I think really helped us have more honest conversations and come up with better solutions to the work that we were doing. So one thing that we heard from moms time and time again, which I think is important for home visitors, is that it's really important to engage partners. That these are the folks generally that know mom the best. They can understand what's normal for her, what's not normal for her.

They themselves may be feeling exhausted, overwhelmed, figuring out who they are in the context of their family, and they're often overlooked by home visitors, even though they have a really critical role. We had some moms talk about how great their partners were in the first weeks in terms of helping them to remember when to take Advil and when to take Tylenol, or helping them remember some really critical tasks because they were a little foggy headed and a little overwhelmed. So thinking about how we can really engage partners so that all of that work of adaptation doesn't fall only on her shoulders, that it becomes a family affair.

We've also seen that material support matters. And so we, in our country, have about a quarter of family support diaper insufficiency, meaning that they really are struggling to have enough diapers to properly care for their baby. And so of those, you can see, well how did they get their diapers? In some cases they stretch their diapers, in some cases they may borrow diapers or money, and in some cases they can get them from outside agencies.

But we found that by providing low income families with free diapers, that it can improve their emotional well-being, child health, and other opportunities for child care work and school attendance. So this is just an example of, again, not forgetting that financial issues can be really pressing for families. We know that 25% of all poverty spells in the United States are the result of a family having a new baby, and we often know that we have very limited parental paid leave which, again, can cause people to be very worried and stressed out if they're unable to work and they aren't sure how they're going to be able to make ends meet. So I think it's always important to not forget about that.

Home visitors, as they're engaging with new families, moms and families say it's really important to build trust and mutual respect, and women said that sometimes they can feel like they're made to be dishonest. So for example, questions about where does your baby sleep, we all understand the importance of safe sleep environments but sometimes, how that approached may lead a family to not feel that they can be completely honest about where the baby sleeps at all times. And so it's not a great way to start a relationship, is feeling like someone needs to not be honest about certain things that they are or aren't doing. So taking the time to think about what one might say that might be perceived as judgemental and really think about how to build that real trust and mutual respect in that relationship.

Also, family guidance really needs to be realistic in terms of the context of their lives. And this is, again, where home visitors have an amazing opportunity because you can see the context of their lives and help come up with perhaps innovative strategies to help them achieve their goals within the constraints of their lives. This pairs really well with this idea of shared decision making, which is recognizing that a parent is an expert in her experiences and what matters to her, and that you bring some of your experience, and how together can we bring and honor both of the sets of knowledge to achieve goals of safety, health, and wellness. And some moms really emphasized that it was really impressive that this has just come out in so many, so many different ways, that how a mom purchased parenting needs to be respected and that focusing really on the strength is really critical.

We also heard from moms that it's really important that someone normalizes sensitive issues. So issues around incontinence are really embarrassing, and women are not even admitting it to their

health care provider sometimes. And so, again, talking about some of the things that women may not talk about that we know do occur can open up the door for her to feel like it's not just her, and it's OK to talk about it.

We also heard that women have a lot of fears, and this is certainly not new information. We had a little bit of our breath taken away by how pervasive this fear was among women of all different backgrounds and educational levels about, if I score too high on the depression screen, will they send me away? Will they take my baby away? And we do a lot of keeping our eye on social media, and all it takes is one incident where this happens, where a provider mishandles something, and it's shared widely. And there's a lot of fear about this.

And so there may be fear about mood, having her baby taken away, fear that I'm a bad mom, fear that I'm going to hurt my baby. There's a lot of fear. And so, again, thinking about being reassuring and also recognizing that fear is really important for home visitors.

And that's a strategy that ACOG has recommended in their Postpartum Care Guidelines, is thinking about creating a postpartum care plan and a postpartum care team for the mom. And for those of you that are working with families and women prenatally, this is a great opportunity. And some of you may already be doing it, and I wish that if we were again in a space we could talk, I could hear about how some of you may be working on postpartum care plans. I know that we women spend so much time planning that labor and delivery and don't even give two thoughts about what happens afterwards. I know that I did not bring clothing that was going to fit particularly well on the way home because I didn't even think about it.

So thinking about some simple guidance on what to expect after birth, particularly for first time moms, helping them think about who they might call if certain issues come up for them. And so this may be working with your health care provider or others to think about, if she needs help for breastfeeding, who would she call? Is that person in network if she has health insurance? How would she call them? Thinking about who she might call if she's experiencing depression and other issues so that people don't have to spend time trying to find who to call, they just know who they need to call.

It's also important to keep an eye as your screening and see, are there going to be any unmet needs that you might foresee for that family and gently and carefully help them think about how they might plan for that. And also, ask mom what they prioritize. So for some women, it may be that they're most worried about sleep. Some people, that's me. I don't do well without sleep. I fall apart. And so prioritizing support so that they may get a certain amount of sleep would be important.

Other women may prioritize different things in their lives. So again, really thinking about planning it out for that period of time. How are they going to eat? Who's going to be there to take care of them? And also in some cases, how to keep certain people from being there. Not everyone's mom are positive influences, or mothers-in-law are positive influences, and so there's also some advance planning in terms of how to manage complex family situations in the postpartum period as well.

I think as you continue to do your work, really thinking about the systems of care that your clients are trying to interact with. So often, as I mentioned before, we look at each of those different bubbles separately. If someone's going to take care of her pelvic floor issues over here, and this person's in contraception there, and this is lactation person that you call over here, and then there's that pediatrician over there. And so it can be a lot of different systems that aren't always working very well in synchronicity. We know that mom and baby medical records are often separated. And in that very first few months, particularly the first 6 to 12 weeks, mom and baby are pretty symbiotic. And I think we often forget what a very closely connected unit the two of them are. So thinking about these bigger systems of care as you're doing some of your planning and strategy over time is really important.

And then finally, I think this is a great opportunity for home visitors, and something we heard time and time and time again is about the importance of building community support and social capital. So you are able to be in the home for certain periods of time. But if you're able to work on connecting new moms with each other so that they can be providing support to each other when you're not there is a really great strategy. Looking at your community and figuring out where are family-friendly places where new parents can connect, and get resources, and meet each other, and commiserate, and complain, and share tips are really important ways to help people stay connected and to really extend your reach to them.

Thinking about breast feeding-friendly community groups, talking with moms if they're getting support online, which is where a lot of women turn online to get support, talking with them perhaps about how to assess if where they're getting support and what that online support, whether that's helpful and accurate. And I think also, home visitors have an opportunity to really think about some problem solving around sleep work and balancing family needs both within the family but also in thinking about how to access potentially other services and support during that time.

And so in summary, the fourth trimester is a really critical transition period for the woman, for her infant, and for the family. And I love that home visiting programs are supporting new moms. We absolutely heard from the women that we work with that they thought the best thing in the world would be if every new mom had a chance to have someone visit her in her home. So I think that you're meeting a need that we've heard women say is important, and you're honoring and can be with families during a period of time that's very unique and very important.

We know that post-partum health care, and education, and services really needs to be tailored to women experiences, and preferences, and constraints. It can be really frustrating perhaps to be told, well, your neck would feel better if you could go and get a massage, when there's no way that she's going to be able to afford to get a massage. And so there may be some other creative ways and strategies that are low cost to help her look at easing neck pain, for example. So being really mindful about the advice that we're giving.

We also know that information that's provided through the health care provider and through home visiting care needs to be consistent. And so if you're finding that you may be giving advice one way and women say they're hearing it another way, you may want to make sure that as

you're connected with her medical home or obstetric providers, and make sure that this advice that you're giving is consistent. It can be very confusing when it's not.

We know that communication really needs to be compassionate and culturally sensitive. And that, I think when we look at the disparities in maternal mortality and morbidity, we look at disparities in who's getting postpartum care, we look at disparities in terms of who receives paid parental leave, that I think we also need to be really mindful of looking at patient, provider, and peer biases so that we can examine our own practice and that we can really work to build trust and mutual respect.

And with that, I think I've reached my time. And that's just a picture of some of the moms that were part of our postpartum care work. And I also want to recognize Dr. Alison [? Stevie ?] and Dr. Kristen Tully, who are my partners and friends and colleagues in this work and could not be in the space without them. Thanks.

Thank you so much, Dr. Verbiest, for all of that wonderful information. Folks, if you have questions, please go to the chat pod. You can ask them now, or you can wait and ask them at the end of the presentation. There will be some time for Q&A at the end.

So I do have one here coming in right now in the chat pod. We're struggling with reduction of our program due to lack of funding, especially being able to offer home community visits. Any strategies to be able to bill or get funding for visiting? We have not qualified for anything thus far. Any [? IBCLCs ?] that bill for home visiting or other ideas for funding support?

That's a great question. I'm not sure that I can answer that right off of the cuff in terms of how different folks are doing it. It may be that in some states, in North Carolina, for example, we have a pregnancy care management program. And we do know that our nurses and social workers are able to bill for providing care in homes for higher risk women. So I think it may be worth looking at your Medicaid program, for example, to see if there's any funding for a home visit.

And the same might be to look at, again, who will be the payers for her prenatal care. And I think I would explore the possibility of looking at least to those folks for some reimbursement at least for a visit because honestly, if there's a problem that isn't caught, they're going to be responsible for providing resources to address those problems. So they may be, in particular, a good place to explore would be my suggestion. And perhaps others have other suggestions or could type their suggestions in.

I do think that it's a really critical issue. And certainly as we look at expanding, for example, the number of visits that she might have, we know that for some services there, what we call bundled. So a provider can be paid after they deliver a baby. And so in some cases, there's honestly not a lot of financial incentives for clinics and others to provide quality postpartum care. But I do think that some of that is changing, and I think that's also an issue that you all might want to think about in your own practice is looking at thinking about policies around funding and supporting quality postpartum care.

Thank you again, Dr. Verbiest. We do have another question that we're going to visit in our Q&A period at the end. So we'll hold that one for now and come back to that just so that we can turn this over to Jennifer [? Medley ?] and hear about Arkansas' MIECHV program efforts. Jennifer?

Yes. Thank you, Karen. All right. Good afternoon, everyone. I'm excited to be here today to talk with you about two of the MIECHV-funded programs we have here in Arkansas. And those are Nurse Family Partnership and a promising approach called Following Baby Back Home. And Following Baby Back Home is currently in the process of seeking evidence-based status, so we're excited about that here in the state and crossing our fingers for late August when those results come out.

So I know that different states implement different models, so I want to give you a quick recap of each of these models in case you're not really familiar, especially with Nurse Family Partnership. They enroll low income, first-time mothers before their 28th week of pregnancy, and the families are seen by a nurse home visitor. And Following Baby Back Home enrolls families with medically fragile children coming out of the NICU. And these families have a team that comes to see them. They are seen by a nurse and a social worker.

And these programs do operate differently, that they both work to ensure that at-risk families have social support, have connection to health care and resources, and that they have ongoing health developmental parenting and safety education. So the map here is a little bit complex with all the colors. But essentially, Nurse Family Partnership, we support them with MIECHV funds in 13 counties in the delta region of the state. So you'll see the dots and the triangles in light blue along the eastern border of the state coming down there. The delta region is one of the poorest areas in Arkansas, and certainly across the country as well, so the families are really high need in those counties, and that's why the Nurse Family Partnership program was chosen to be implemented there.

And then Following Baby Back Home, all of the red dots and maybe some triangles, they're in the central and southern part of the state with MIECHV funds. That program is also supported by Medicaid, and they're in essentially every county in the state if you include the MIECHV funding. But for the purposes of today, we'll just talk about the MIECHV funded counties.

So within that Following Baby Back Home, 70% of the families that they serve live in poverty. And I think we all realize that poverty leads to stressful living conditions and poor socioeconomic conditions which can impact pregnancy and can contribute to pre-term birth in some instances. I'm trying to advance the slides but I can't make them go. There they go.

OK. So we'll get into the two MIECHV performance measures that are related to the presentation today. And the first one is the pre-term birth measure. So the percent of infants among mothers who enrolled in home visiting prenatally before 37 weeks, who were born pre-term following program enrollment. And so these members refer to the Nurse Family Partnership program specifically.

So in that program, in fiscal year 2017, 12% of the births were pre-term. And of those, 43% received a referral for smoking cessation, which also takes us back to the tobacco cessation referral performance measure. And then 100% of those families were educated about proper nutrition for mom and for baby, so prenatally and post-partum they receive that education. And then 100% of the Nurse Family Partnership moms also receive postpartum care.

And what our nurses reported to me when I was talking with this about them before this session today is that fluid overload is really the most common finding that they have to address with the clients that they see. And so it's really important that the nurse home visitor is able to serve as an advocate for the family and can talk with a physician or other health care provider when these concerns come up. And so that's really a big part of what they do, especially in the delta region of the state, is get those families in contact with their providers and make sure that they have the care that they need when they come home from the hospital.

So I wanted to talk next about our promising approach called Following Baby Back Home. And to get started, we're going to just watch a short three-minute video. So before the video comes on, if you all can mute your phone's speakers and then unmute your computer speakers, you should be able to hear the video. If we want to go ahead and play that, please.

Good job.

A lot of times we see fear.

My daughter Clara was a high-risk newborn. She was born 6.5 weeks early.

Noah was in the ICU because he was born with a genetic defect.

This is the first time they've had to care for their baby by themselves.

She was born positive to four different substances. It's scary with all of her medical issues, and she had a lot of needs. And we've had to adjust our lifestyle.

Without the Following Baby Back Home program, these children would be at a disadvantage.

Having children that are sick is hard, and you don't-- especially when you're in rural communities-- we don't have the access to the level of medical care that always is needed, and so it's nice to have an RN that's trained in children and then a social worker that understands proper growth and development.

It all goes back to just being the all-around support system that the family needs when they're coming home from the NICU.

They're very nice from the very beginning. It made me feel like I wasn't alone anymore. They are always there-- always. For whatever. If something personal, it's like having a friend.

Our typical visit is, we pretty much come in the home and we do weights and measurements on the child. We do some sort of education. We do developmental screenings periodically. Many times, infants that were born premature, sometimes they're a little bit behind. We can intervene by referring to an early intervention program, also providing the parents different activities they can do here in the home.

They offer such great services and such great screenings and information that anyone in the community would be silly not to accept that tool and that information to help their child succeed.

They've learned that they can trust us and that we're there to support them, so they know they can reach out to us in between visits if they need us, if they have questions.

Learning that there is a program like Following Baby Back Home, that sends someone to the safety of your home, and makes sure that they're growing properly, that you're doing the best that you can do is a great resource.

Our goals are to keep the children as healthy as they can be.

It is not just medical and developmental. They're always help with the whole family to have the resources that we need, to make Noah's life easier.

When you realize that you're going to have a medically fragile or a high-risk newborn, you tend to go into panic mode. But we would not trade it for anything. She is our princess, and she runs this house.

[MUSIC PLAYING]

Thank you. So you can see that Following Baby Back Home is a really important program, especially for these families who have such fragile infants coming home with them after a long stay in the NICU. I want to talk about some of our evaluation results for that program. But really quickly, I want to say, part of the reason that we support Following Baby Back Home with MIECHV funds, and also that Medicaid supports them, is that even though the program is quite expensive because we do use a nurse and a social worker, so the cost per family is pretty high.

And it won't necessarily save Medicaid money but what it does is it helps them not waste money. So if we think about all of the money that is spent to keep a baby in the NICU, you don't want to lose all of that when they go home. And so it's really important that these infants and their families have the care and resources they need to stay healthy once they do go home.

So from 2011 to 2014, I did an evaluation of the program and we got some really interesting results-- and great results-- related to the infant mortality rates and the immunization rates for the program. So you'll see here that the infant mortality rate for infants that were born low birth weight was 9.2 per 1,000 live births for the program, compared to 50.4 per 1,000 nationally and 51.7 per 1,000 in Arkansas. So that's a significant, significant finding.

And what we attribute these results to is the fact that the families-- I mentioned that the cost for care goes up-- but what the nurse and the social worker are able to do is to make sure that if the infant needs to go to the doctor, if they need to go to the emergency room, that those things are done quickly so that the child can get the care they need. So that means maybe the cost of care is higher on the front end but long term, their health is going to be a lot better across the life course.

And then what we found is, for infants who are born pre-term, at less than 37-weeks gestation, and another 9.2 per 1,000-- that was the infant mortality rate-- compared to 34.5 and 33.6. So again, a significant finding that shows that this program really does work in terms of lowering morbidity and mortality rates in these fragile infants.

So our immunization rate for the Following Baby Back Home program are almost at 100% for all of the cohorts. So you'll see here that the rate is greater than 96% for infants from birth to 12 months, and then it's 92.2% from birth to 18 months, and almost 90%, so 87%, for the older toddlers. So again, that's the influence of this nurse and social worker coming in and saying, these infants are really susceptible to a host of illnesses by virtue of the fact that they were born pre-term, so we need to make sure that they're immunized on time and according to the proper schedule for them. So that's what we're doing here. And they have seen great success with that.

Then quickly, we'll do the lessons learned. I know it's about time. So, from Nurse Family Partnership, one of the lessons that they talk about a lot is the need to just persist with these families. So these families are challenged in a number of different ways, as you all are familiar with, and they need to know that someone is there and committed to helping them. And so just be with them when these challenges take them out of pocket or make them unavailable for a while.

Nursing Family Partnership also thinks-- and we see this across other models too-- that we really need some more education about breastfeeding and birth spacing in the hospital. And they are really good at advocating for their clients, as are the nurse home visitors and social workers with Following Baby Back Home. So they think that's an important piece of what they do to ensure these families get the care they need.

And with Following Baby Back Home, as I mentioned, we're going to see increased medical expenses on the front end but long term, over the life course of that child, their health is going to be a lot better. And that we really need a continued investment in these infants. We need to ensure continuity of quality care once they go home. And we need to make sure that our home visitors really understand the family. We do this a few different ways with different assessments. But anyway, they get to know them very well and make sure that they have specific needs addressed while they're in the program.

So thank you, Jennifer, for your presentation. We have an additional questions that has come in, and then I've also asked if you have more questions. We have a couple of minutes left. You can post them over in the chat pod. So the first one coming in is actually for you, Jennifer. How do families qualify for the Following Baby Back Home program?

So essentially, what we do is look at families who are coming out of the neonatal intensive care unit-- they do have to come from a neonatal unit in the state-- and then a lot of the referrals come from the doctors there and the families need to be low income and higher risk families. So I can get the specifics on the enrollment criteria but essentially, those are what qualify a family for the program.

OK. Excellent. There's another question for you, Jennifer. How long do the services last in the Baby Back Home program? Do the nurse and social worker visit the family together?

Yes. So they visit the family up until age 3. And yes, the nurse and the social worker do go together. I think that at a certain point, as the child ages and gets closer to that third birthday, if there's not really a need for referral to resources or things like that anymore, they don't necessarily have to go when it gets getting time for them to graduate for the program. But initially, yes, they are there together and addressing those needs at the same time.

Great. We have a question for you, Dr. Verbiest. Are there other considerations when working with moms and families in different settings, beyond on the over-arching need to be culturally responsive, like in rural vs urban, moms that are incarcerated, age, immigration status, et cetera?

Yes, absolutely. And I think that there are many unique situations that different families might be in. And so I think it's really important to start where the family is and where mom is. For example, we know that sometimes older moms have a little bit harder time with that maternal role attainment. They've been used to having different types of autonomy in their life, and so it can be really challenging for them, for example. And we know that some teens may be very isolated or may have a lot of family support.

In terms of issues around immigration status, I think there's some really important work that needs to happen prenatally so that people are thinking forward. How is the birth certificate is completed is really important, thinking about the how there will be follow-up link to services, so I really think that pre-planning, whenever possible, during pregnancy is very important.

In rural areas, we know that social support structures may look different from in urban areas. And so there may be an interest in looking at more text support, or online support, or telephonic support, for example, that you might want to incorporate into your program. And we could spend an entire webinar talking about moms who are incarcerated, and the many complex issues they face due to baby separation. So I think the final summary is that some visitors, as you approach each family, thinking about their unique situation and their unique needs and really working in partnership with that mom and family to identify what's most important to them.

Great. Well, thank you both, Dr. Verbiest and Jennifer, for being our presenters today. Our next webinar will be September 18. It will be supporting your local implementing agencies and their workforce growth and well-being. And we do actually have a newsletter follow-up coming out on postpartum care and pre-term birth that will be due out in September, that will dive deeper into some of the things we talked about today. We hope you'll take the time to finish the evaluation survey and provide feedback on this webinar, and we hope you have a wonderful rest of your day. Thank you for joining us today.