Redesigning Prenatal Care:

Making care more effective, efficient, and equitable in pregnancy.

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The American College of Obstetricians and Gynecologists

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Disclosures

Dr. Peahl receives support from:

- the FDA (grant)
- *Michigan Department of Health and Human Services (grant)*
- *Blue Cross Blue Shield of Michigan (QI work)*

It takes a TEAM (Human Centered Design project).

Dr. Martina Caldwell

Henry Ford Health System

Dr. Gwendolyn Daniels

IPH Institute for Population Health

Dr. Michelle Moniz

M

Dr. Ana De Roo

M

Shanayl Bennett

mothering JUSTICE

Dr. Mary Brynes

M

Dr. Vanessa Dalton

M

Dr. Michele Heisler

M

+ University of Michigan Undergraduate Students: Lexy June and Kayla Wilson

It takes a TEAM (Human Centered Design project).

Dr. Gwendolyn Daniels

IPH
Institute for Population Health

It takes a TEAM (Prenatal Care Redesign).

Dr. Gwendolyn Daniels

ACOG:
Dr. Chris Zahn
Lamiya Ahmed
Megan McReynolds
PATH Panel

ACOG Redesigning Prenatal Care Committee
Dr. Mark Turrentine
Dr. Sindhu Srinivas
Dr. Tiffany Moore-Simas

University of Michigan:
IHPI
Department of Ob/Gyn
Prenatal Care Redesign Group
Student workers!

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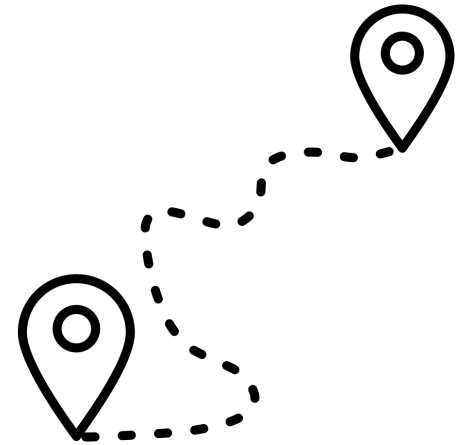
Today's PATH:

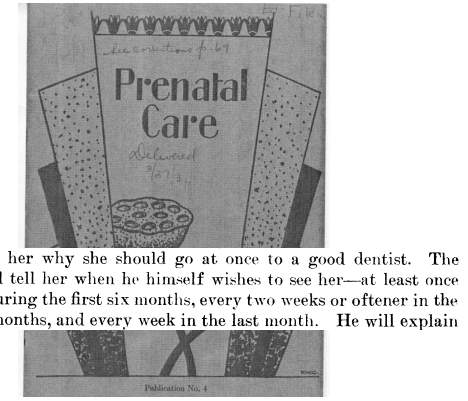
1. Background: Maternity Care Crisis & Prenatal Care
2. Introduce PATH: Plan for Appropriate Tailored Healthcare in pregnancy
3. Redesigned Prenatal Care in Action
4. FAQs



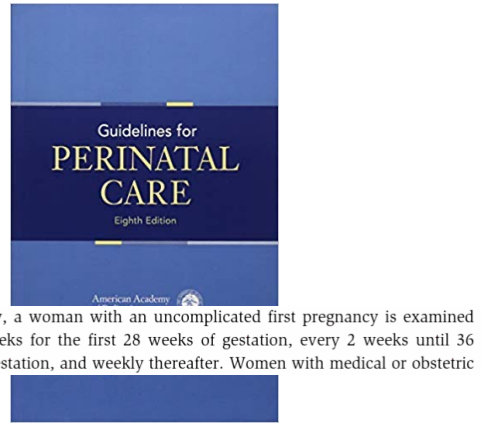
Background

Time travel

1930



2020



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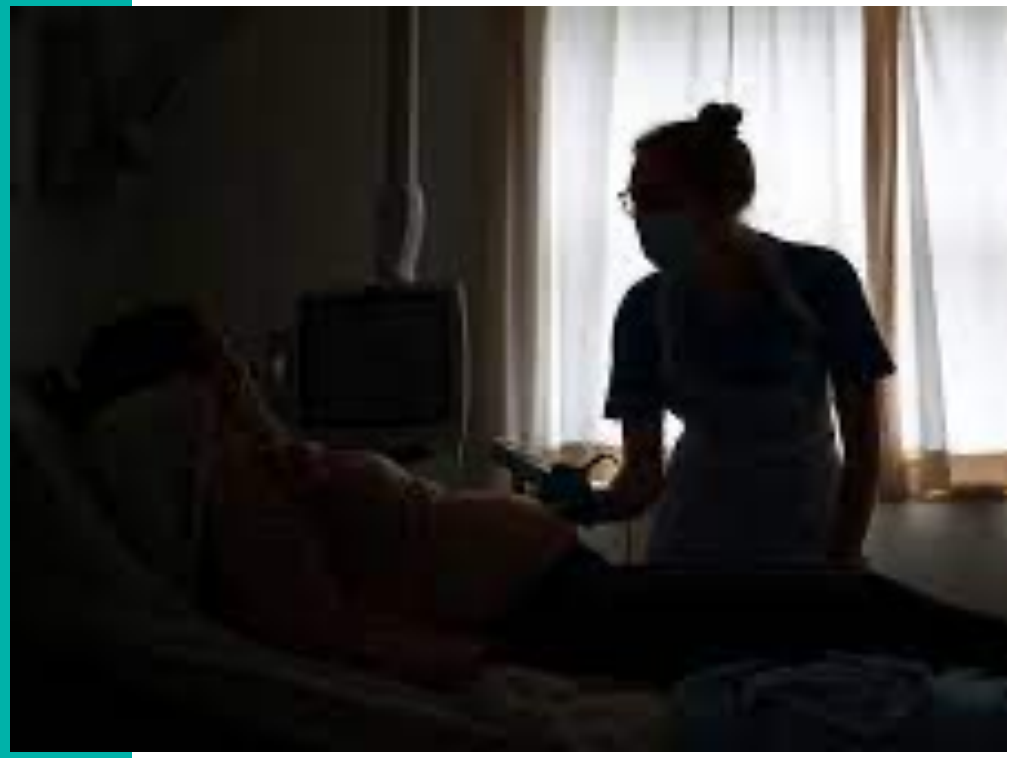
We face a maternal health crisis in the United States.



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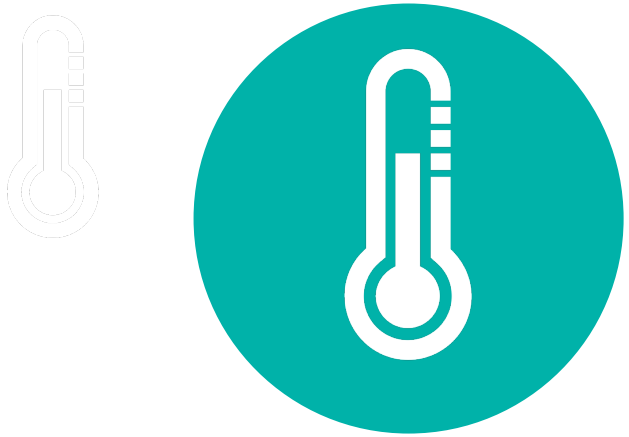
Severe maternal morbidity and morality is often seen as an inpatient issue.

Postpartum Hemorrhage

Difficulty controlling bleeding at the time of delivery results in the need for extra procedures in the operating room and a blood transfusion.

Severe Preeclampsia

A patient is admitted to the hospital with high blood pressures, kidney damage, and difficulty breathing. She is admitted until her preterm birth.



Postpartum infection

A patient returns 3 days after delivery with fever and chills and is found to have a sepsis from a retained placenta.

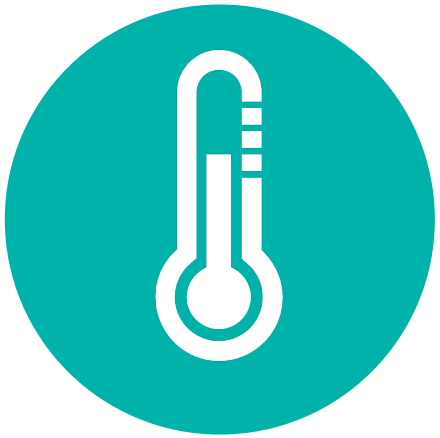
But many adverse maternal events could be prevented or reduced through routine prenatal care.

Postpartum Hemorrhage

This patient had difficulty attending her prenatal appointments. She missed her third trimester labs, and her anemia was not identified or addressed.

Severe Preeclampsia

This patient lost insurance between pregnancies. She did not have good BP control at the beginning of pregnancy. Her provider did not tell her about aspirin to prevent preeclampsia.



Postpartum infection

This patient's prenatal visits were rushed because she needed to return to work. She did not learn warning signs to look out for when she went home in her routine care.

Ideally, prenatal care addresses issues BEFORE they become severe morbidity.

Manage anemia

A patient attends all prenatal visits and screenings. Her anemia is identified in pregnancy. She receives iron and has a normal blood count at the time of delivery.

Control Chronic Conditions

A patient receives weight loss counseling before pregnancy and has good control of her high blood pressure. She takes aspirin in pregnancy and does not develop preeclampsia.

Identify warning signs

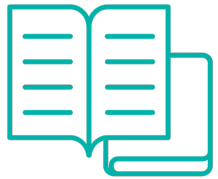
A patient receives excellent prenatal counseling on postpartum warning signs. She notices an odor to her vaginal discharge and gets evaluated before she gets sick.

Redesigning Prenatal Care is the backbone of improving unacceptable, preventable, poor pregnancy outcomes and disparities in the U.S.

What is prenatal care?

One of the **most common preventive care services** in the United States that aims to **improve the health** of 4 million pregnant patients and their children each year through:

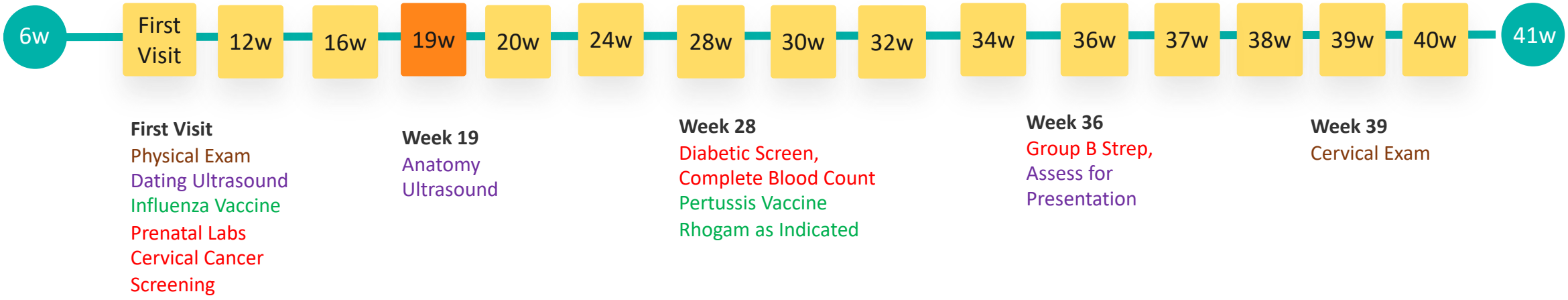
1. Medical screening & treatment



2. Anticipatory guidance

3. Social Support

The traditional prenatal care model requires >40 hours for every pregnant person.



This schedule has remained in place since it was first established in 1930.

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This schedule is too much care for some, not enough for others, and the wrong care for many.

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Data supports the Goldilocks dilemma of prenatal care.

Too much.	Too little.	Not the right care.
Metanalysis data demonstrates the safety of 8-9 vs. 12-14 visits. >10 prenatal visits associated with increased intervention without improved outcomes.	>25% of patients do not access prenatal care until the second trimester. Lower access for marginalized groups, in part driven by capacity.	RCT evidence for telemedicine equivalence. Limited attention to non-medical needs. Poor experience for marginalized patients.

Kilpatrick 2017, Osterman 2022, Scott 2019, Tucker Edmonds 2016, AHRQ

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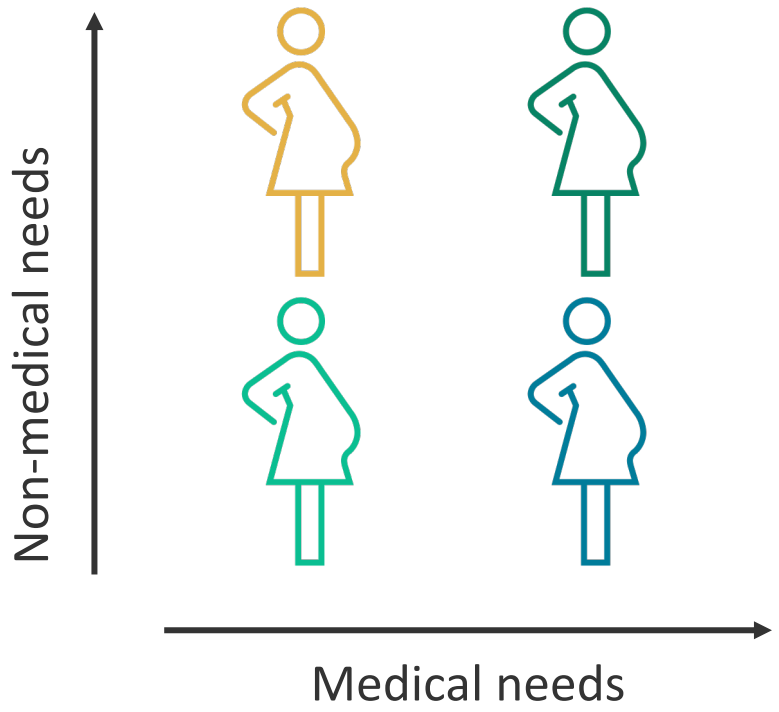
Pregnant people are not one-size-fits all. Their care delivery should not be either.



Every patient, regardless of their individual needs, receives the **same** care.

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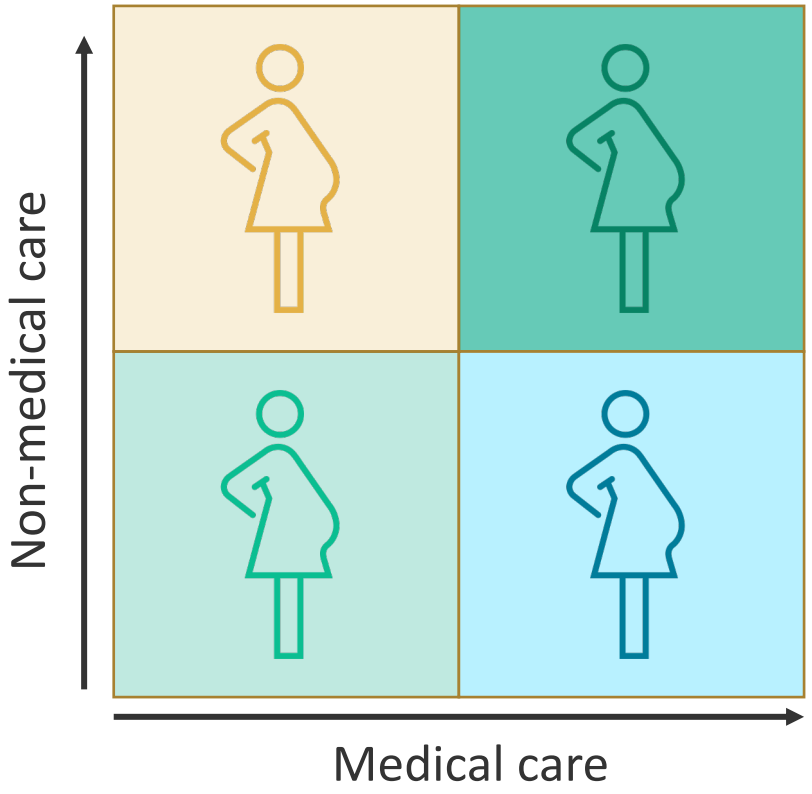
Ideally, prenatal care would be designed to meet patients' individual needs…



…as well as their preferences for care delivery.

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But to date, pregnant people (particularly the most marginalized) have often been left out of the conversation.

Human Centered Design Study

Study Objective:

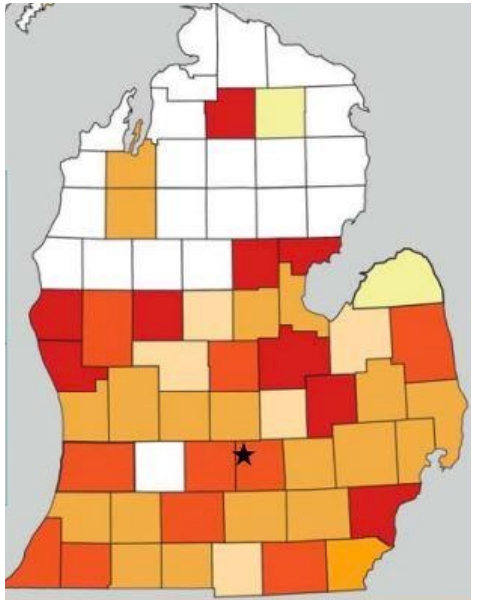
Original Investigation | Obstetrics and Gynecology

Experiences With Prenatal Care Delivery Reported by Black Patients With Low Income and by Health Care Workers in the US

A Qualitative Study

Alex Friedman Peahl, MD, MSc; Michelle H. Moniz, MD, MSc; Michele Heisler, MD, MPA; Aalap Doshi, MS; Gwendolyn Daniels, DNP, MSN; Martina Caldwell, MD, MSc; Vanessa K. Dalton, MD, MPH; Ana De Roo, MD, MSc; Mary Byrnes, PhD

To examine patients' and health care workers' experiences with prenatal care delivery in Detroit, focusing on Black pregnant people living on low incomes, to inform care innovations to improve care coordination, access, quality, and outcomes.



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Human Centered Design centers the patient not the health system.

Human Centered Design:
A social-justice informed strategy leveraging end-users' perspectives to develop creative, patient-centered solutions tailored for specific populations and locations through viewing problems from the user's perspective.

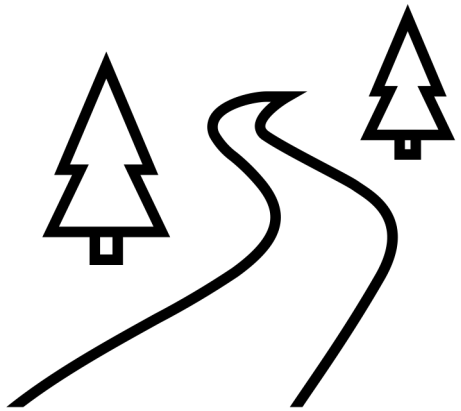
To date, Human Centered Design has been used largely in high income, White populations.

We wanted to center **marginalized pregnant people** to rethink the best approaches to improving prenatal care access, experience and outcomes.

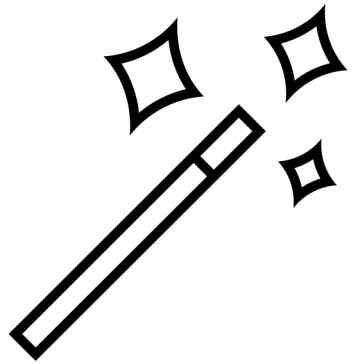
IDEO 2020, Butler-Tobah 2019

Human Centered Design methods allow novel solutions to emerge.

Journey Mapping



“Magic Wand”



IDEO 2020, Butler-Tobah 2019

Human Centered Design: Study Methods

Focus Groups

14 patients/ health care workers

Preliminary insights, acceptability of interview script

Interviews

19 patients (pregnant/PP)
19 health care workers

90 minutes
Conducted in the community

Human Centered Design informed analysis

Inductive coding and matrix analysis

Allowed novel insights and solutions to emerge; Member Checking

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Human Centered Design: Key Results

	Failures of current prenatal care delivery	Ideal future state of prenatal care
Medical care	Unclear benefit, low value appointments	Enter pregnancy healthy, intensity of care matched to patient needs
Anticipatory guidance	Inadequate accessible information, discomfort asking questions	Education integrated into care, safe spaces for questions
Social Support	Insufficient screening for needs, insufficient resources, complex access	Incorporation of basic social needs screening & easily accessible resources
Maternity care professionals	Limited contact focused on medical care does not support trusting relationships	Provider as the caring center of all services, medical and social
Care infrastructure	Poor integration of aspects of care, one-size-fits-all.	Care infrastructure

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Human Centered Design: Key Results

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Maternity care professionals	Provider as the caring center of all services, medical and social
Care infrastructure	Care infrastructure

"If it's not high risk, it shouldn't be treated as high risk. Even the settings of clinics and hospitals is just kind of like counterproductive, in my opinion."
Healthcare Worker 7

"You've got a suicide hotline, why can't you have a pregnancy hotline… Some people aren't able to say what it is that they need, what it is that they want and answers that they want to get."
(patient 3, multiparous, post partum)

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Human Centered Design: Key Results

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"I feel like it [prenatal care] should be everybody should have at least anything, just a safe haven of peace that they can be in when they are pregnant." (Patient 3, multiparous, postpartum)

"More support for mom during these nine, 10 months … that could be housing, that could be transportation, that could be financial support…and just kind of lay off the pressures of the world and really to focus on bringing in a healthy baby." (Healthcare Worker 6)

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Human Centered Design: Key Results

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"It's important for the doctor to care because if the doctor don't care about your body, how are you supposed to know what's going on?" (Patient 12, multiparous, 20 weeks)

"They [providers] have to be all things…Actually addressing all concerns; not just some concerns... And if it's something they cannot address, they need to make sure that they're putting their patient with the appropriate person to be able to address it." (Healthcare Worker 7)

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Human Centered Design: Key Results

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Care infrastructure	Care infrastructure

Care should always be personalized…I think that moms would feel like they are more involved in their care and maybe would be more likely to come to appointments if they feel like, oh, I have set out this path for myself so I will show up. (HCW 2)

It's already in my head: a housing program that you make sure that they are stabilized…then they're attached to other resources like, a one-stop shop. …that person is going to be able to have a chance. (HCW 15)

Late hours, group care, care navigators, telemedicine, and other flexible care models (patients and HCWs)

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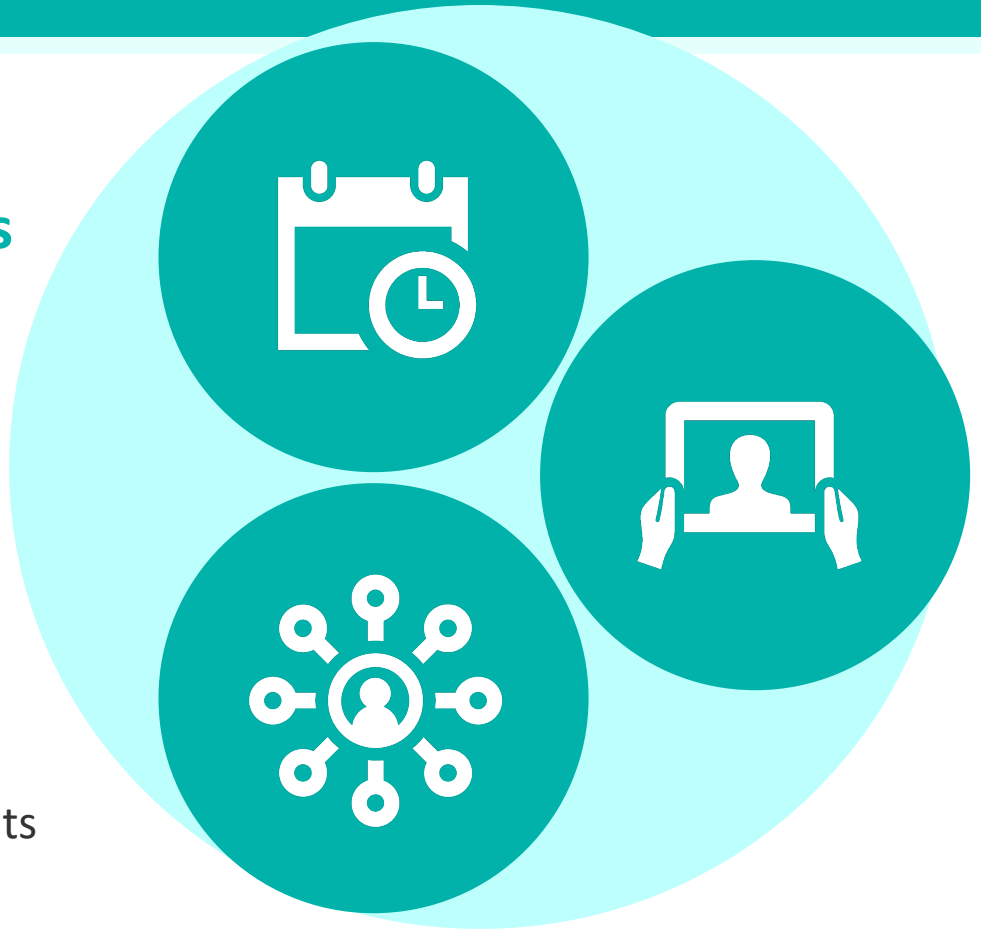
COVID-19 catalyzed changes in prenatal care delivery that facilitated individualized care.

Targeted visit schedules
Focused on needed services



Telemedicine
Video visits and use of home monitoring devices

Awareness of gaps in non-medical services
Poor attention to anticipatory guidance and social determinants

Peahl et al. Am Journal Obstet Gynecol 2021; 223(3): 339-e1

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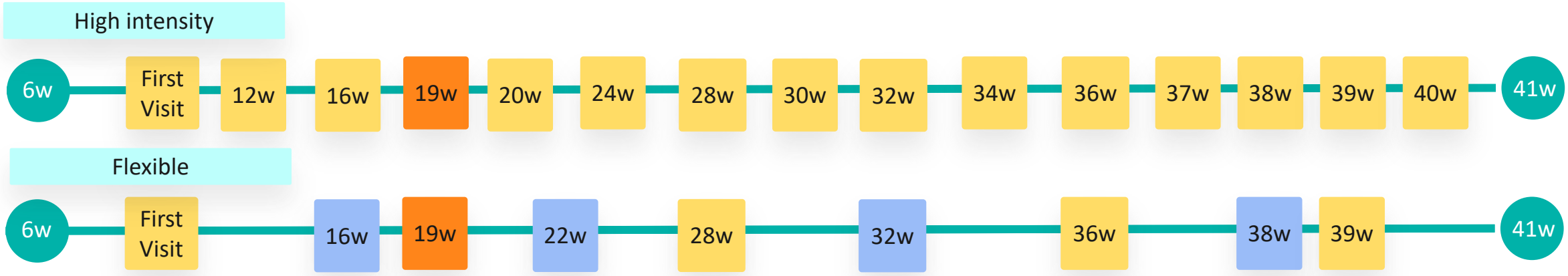
These changes included new visit schedules and use of telemedicine.



First Visit
Physical Exam
Dating Ultrasound
Influenza Vaccine
Prenatal Labs
Cervical Cancer
Mental Health Screen

Week 19
Anatomy Ultrasound

Week 28
Diabetic Screen,
Complete Blood Count
Pertussis Vaccine
Rhogam as Indicated
Mental Health Screen

Week 36
Group B Strep,
Assess for Presentation

Week 39
Cervical Exam

The same services are delivered, just more efficiently.

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The Plan for Appropriate Tailored Healthcare in pregnancy (PATH) was developed by interprofessional experts

Jeffrey Bacon, DO

Tiffani Buck, MPH, MS, ARNP-BC, RN

Yvonne Butler Tobah, MD

Beth Choby, MD

Joia Creer-Perry, MD

Lauren Desmothenes, MD

Christina Han, MD

Susan Hintz, MD, MD, Epi

The panel included 19 experts & public members

Camille Hoffman, MD MSc

Sue Kendig, JD WHNP-BC, FAANP

Tekoa King, CNM MPH

Milton Kotelchuck, PhD MPH

Monica Lutgendorf, MD, CDR, MC, USN

Tiffany Moore Simas, MD, MPH

Sindu Srinivas, MD MSCE

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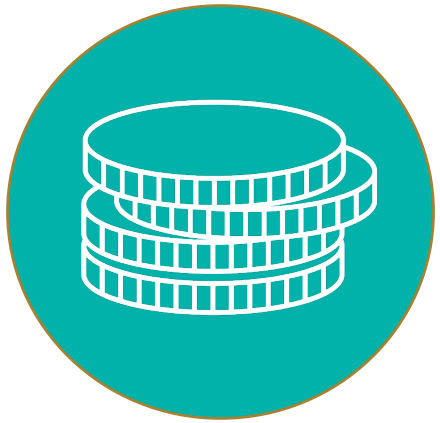
A national listening tour, including 100 participants from >25 organizations, have helped refine recommendations.

Patients and Advocates

Providers and Researchers

Public health leaders

Policymakers



Payers

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PATH recommends a nuanced, tailored approach to prenatal care to meet individuals' needs & preferences

Patient presents for care

Screen for medical & social determinants

Solicit and incorporate patient's preferences

Determine a Tailored Prenatal Care Plan

Visit Frequency & Monitoring Schedule

Determine intensity based on medical & social needs

More frequent contact for patients with pregnancy complications and chronic conditions

Telemedicine & Care Modality

Deliver recommended services through 4 in-person visits (1st visit, 28w, 36w, 39w)

Determine visit modality (in-person vs. telemedicine vs. other) for additional visits with the patient

Most monitoring can be completed remotely

Support for Social & Structural Determinants

Provide additional support based on community/health system resources and patient needs.

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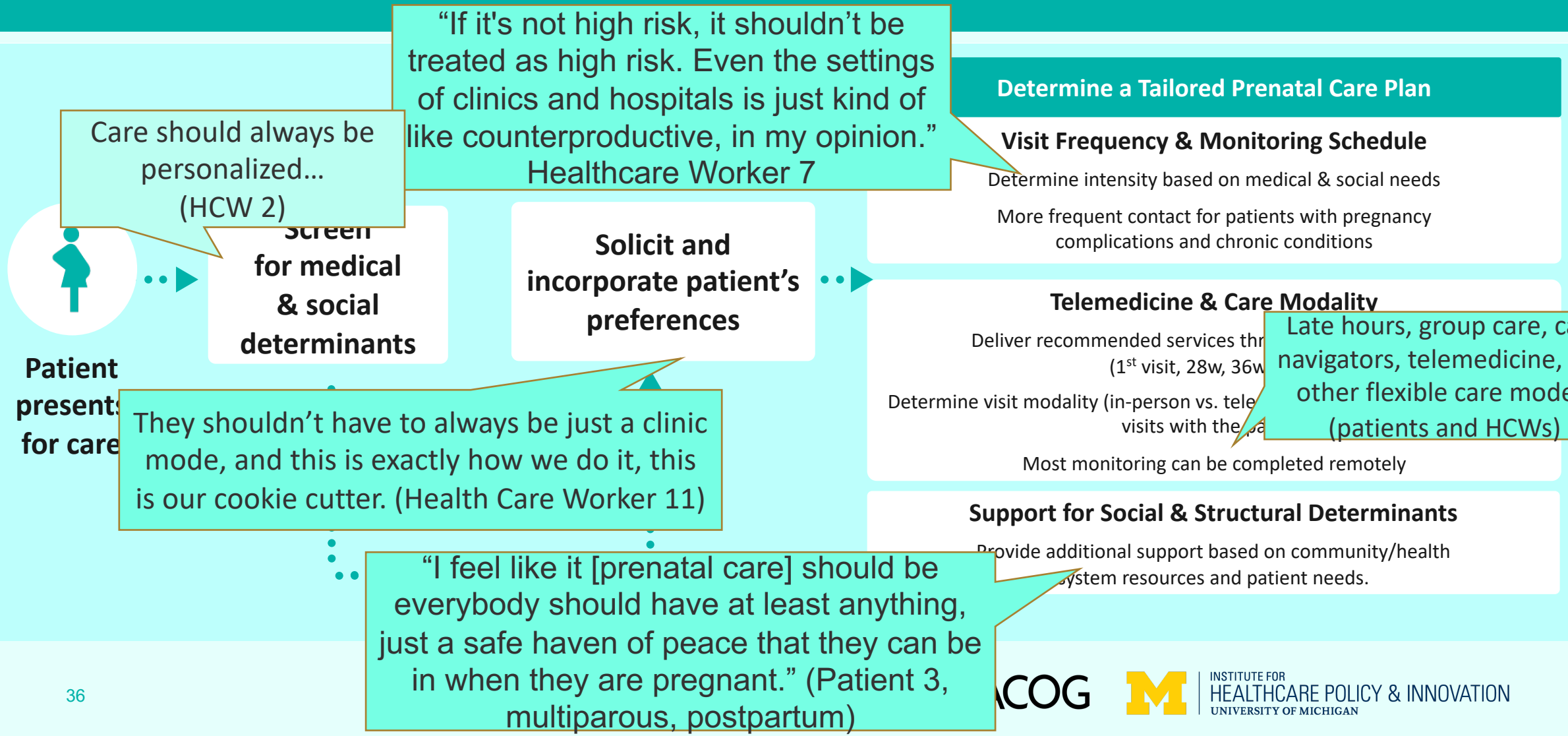
PATH recommendations are directly responsive to Human Centered Design work from Detroit.



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Tailored prenatal care in practice

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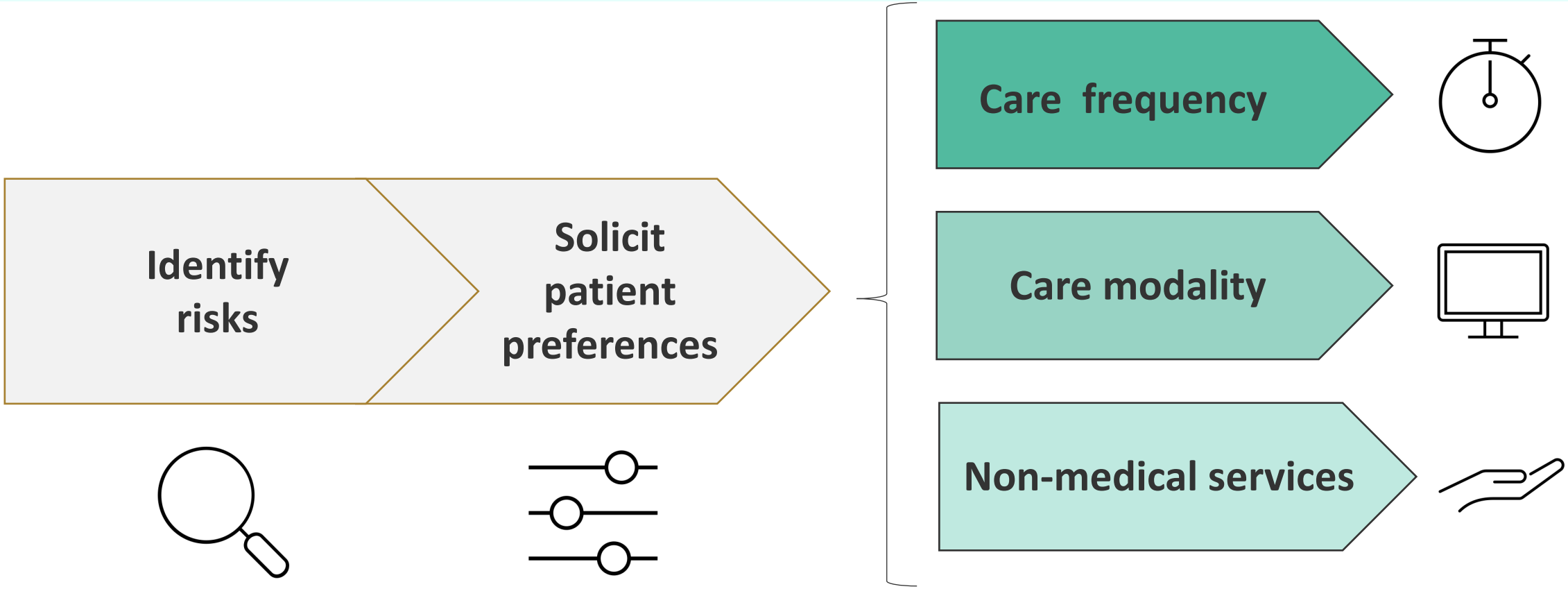
PATH in action at the University of Michigan.



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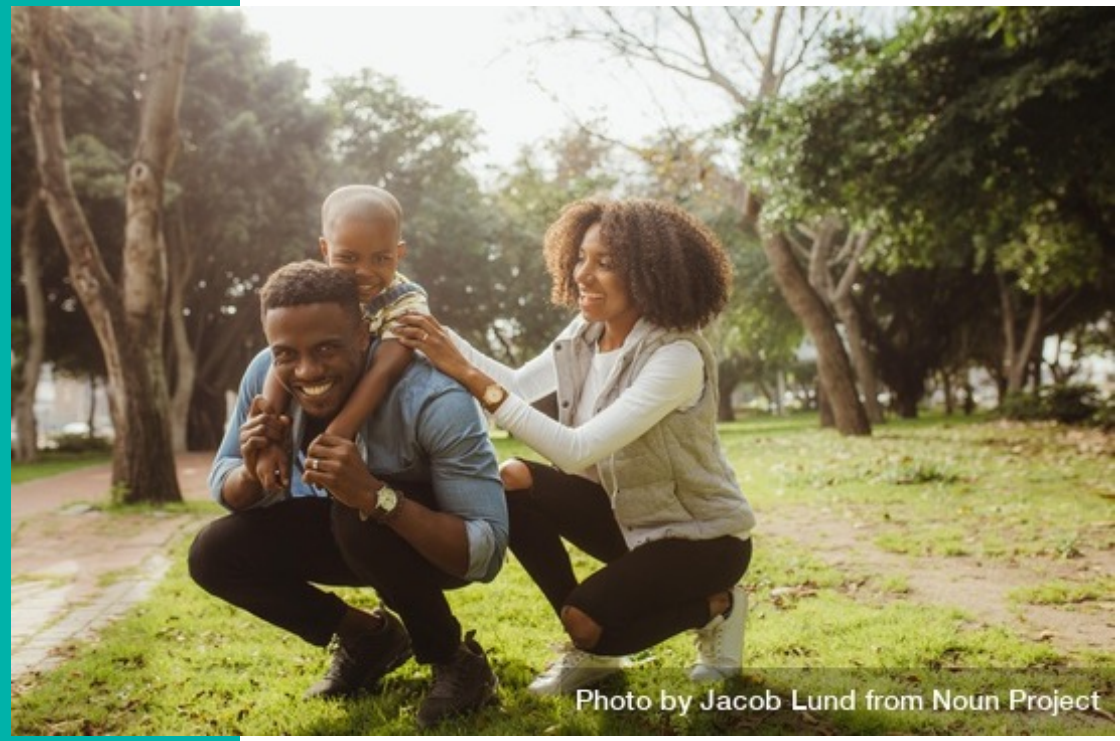
This is Maya.

She is a 31-year-old G2P1 who just took a positive pregnancy test after noticing she was more tired chasing her toddler. She and her husband, Devon, are excited for their son to have a sibling, but they are worried about juggling two kids and their busy work schedules.



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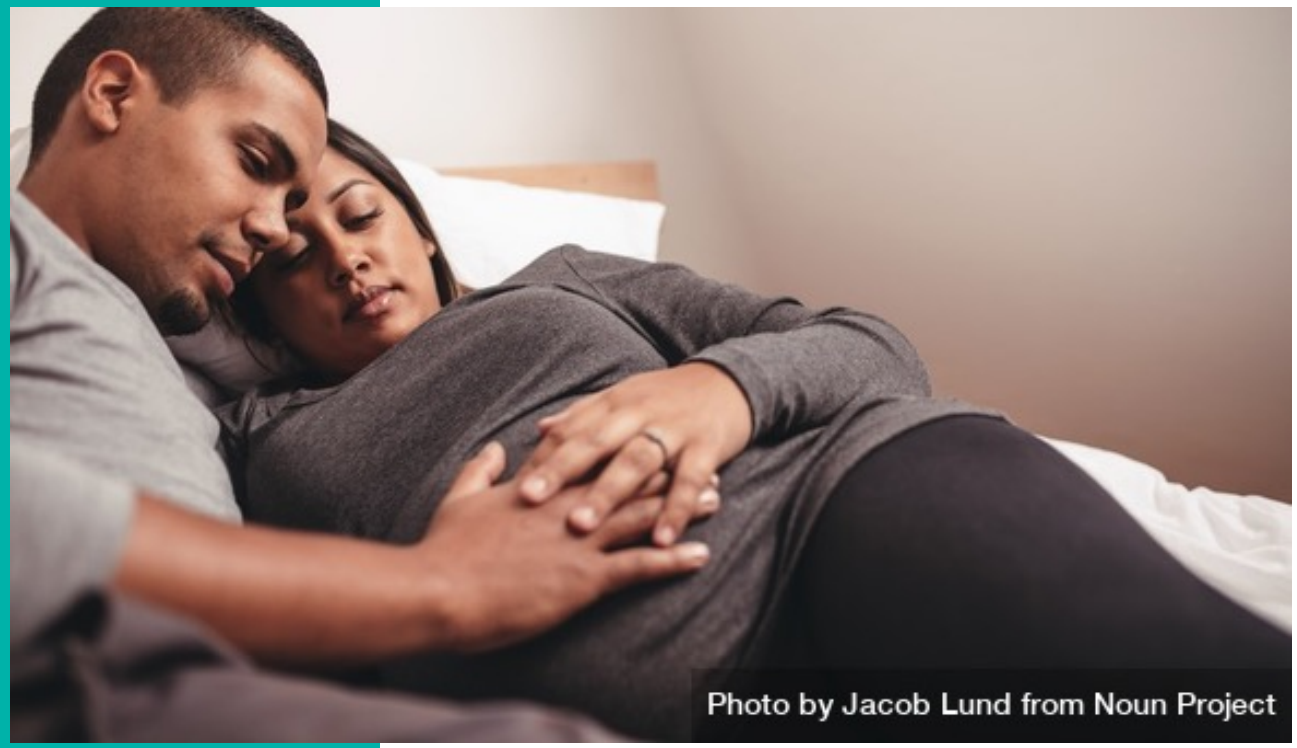
This is Taylor.

She is a 26-year-old G1P0 who just took a positive pregnancy test after her first missed period. She and her boyfriend, Brian, are excited but nervous about their first pregnancy.



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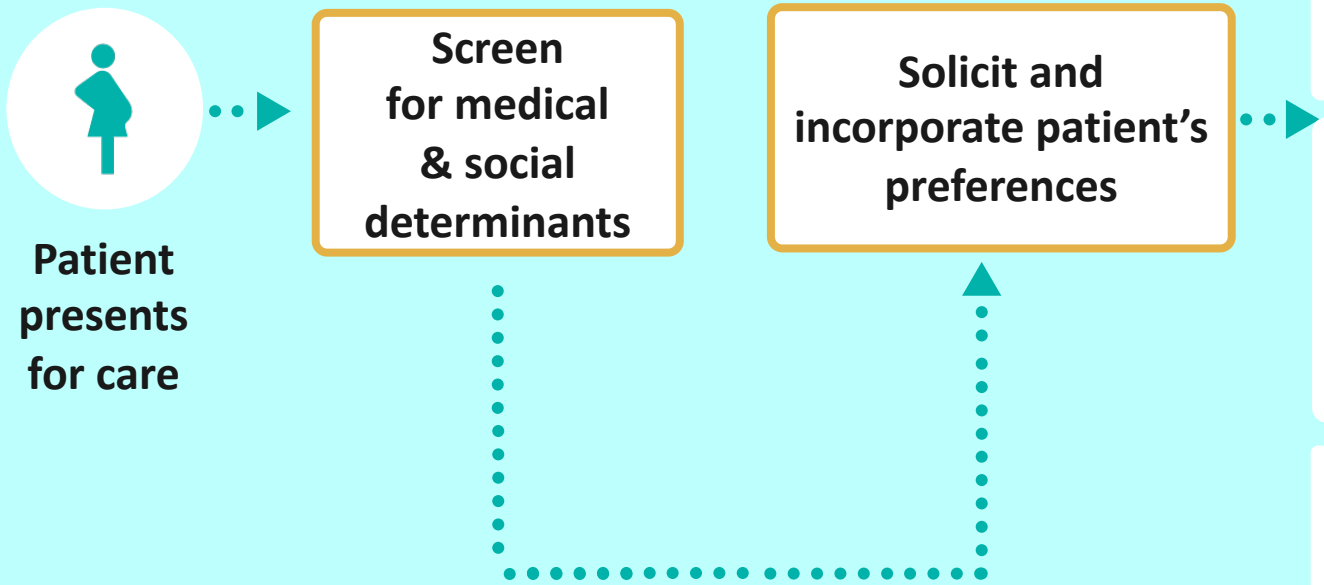
PATH recommends a nuanced, tailored approach to prenatal care to meet individuals' needs & preferences



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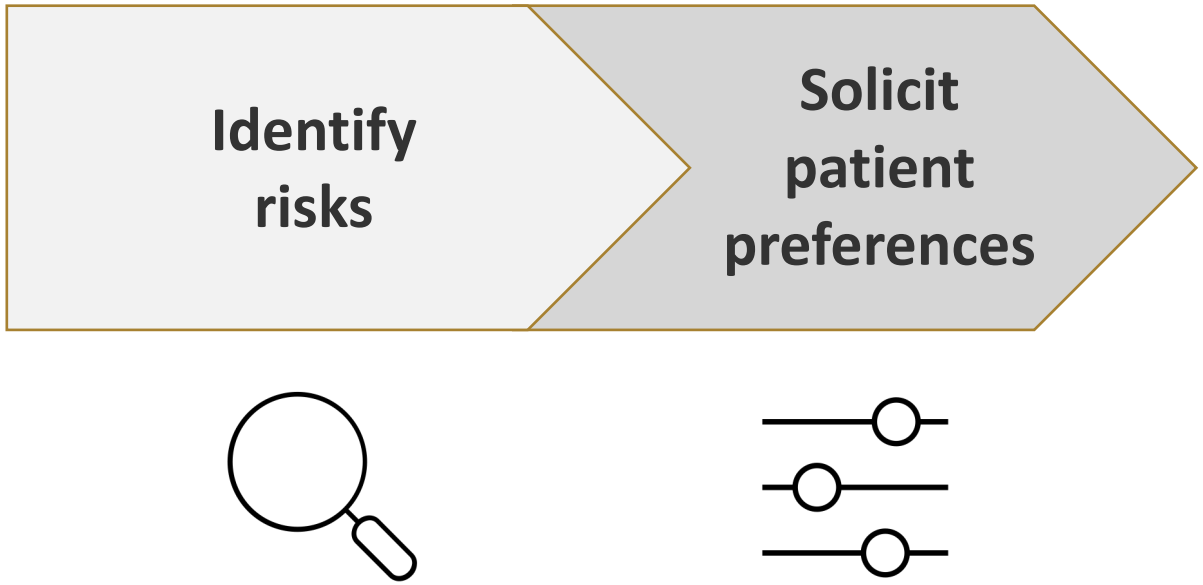
Prenatal care tailoring starts with a robust risk assessment and understanding patients' preferences.



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Prenatal care tailoring starts with a robust risk assessment for medical *and* social risks.

Identify risks

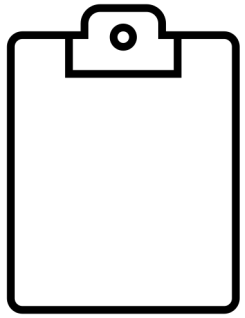
Medical Risks
Phone intake with nurse

If positive:

- Provider message
- Early optimization
- Early counseling/ preparation

Prenatal care tailoring starts with a robust risk assessment for medical *and* social risks.

Identify risks



Social Risks
Phone Intake +
Portal survey

If positive:

- Automatic referral
- EHR alert to care team
- Follow-up and check-ins

Prenatal care tailoring incorporates patients' preferences for selecting key features.

Solicit patient preferences

Decision Support Tools
Help patients to identify preferences

	Hybrid prenatal care	In-person prenatal care	Group prenatal care
What are the potential benefits of this model?	Virtual visits can decrease your travel time and make care more convenient. Some people feel more ownership over their care with home devices.	Some people prefer to come to the clinic for all of their appointments to see their doctor or midwife in person.	Some people like the extra education, peer support, and sense of community with group care.
What are the potential downsides of this model?	Some people, especially first-time moms, may not feel comfortable checking their blood pressure at home.	Some people find traveling to the clinic burdensome and inconvenient.	Some people find the group appointments are too long, and have trouble with set appointment times.
Will I need to have a home blood pressure cuff to participate in this model?	Yes, to complete virtual visits you will need a home blood pressure cuff.	No, for routine care you will not need a blood pressure cuff, unless your doctor or midwife recommends it.	You will discuss this with your Centering doctor or midwife.

Prenatal care tailoring incorporates patients' preferences for selecting key features.

Solicit patient preferences

Decision Support Tools
Help patients to identify preferences

Key points of tailoring:

- Provider type
- Visit modality
- Wraparound services

Prenatal care tailoring incorporates patients' preferences for selecting key features.

VON VOIGTLANDER WOMEN'S HOSPITAL
MICHIGAN MEDICINE

Pregnancy Care Clinicians:
The Michigan Plan for Appropriate and Tailored Healthcare in Pregnancy (MiPATH)

You can use this grid to think about which pregnanc
fit for you for your medical care. You will review yo
during your intake call. If you know you would like
midwife, you can tell the clerk who scheduled your

	Certified Nurse Midwife	General Obstetrician Gynecologist (Ob/Gyn) Docto
What care does this type of clinician provide?	Specialists in normal birth who focus on: • Individualized care • Education • Choices in pregnancy and birth	Doctors with expertise in: • Routine pregnancy • Complicate pregnancy • Gynecologi care after birth
Who can choose this clinician?	Patients without medical or pregnan	

What resources can provide both information and support c
pregnancy?

- Stay Home Stay Connected: This free online support program inc
  - Small groups (8-10 people) with similar due dates who mee
    the first week of each month to discuss pregnancy topics.
    by a pregnancy doctor or midwife.

What resources can provide information about pregnancy?

- Prenatal book: All patients at Michigan Medicine receive "Your Ch
  Experience", a book that reviews what to expect at every stage of
  pregnancy. You will receive this book at your first prenatal visit.
- Prenatal classes: There are a variety of online classes offered thr
  Michigan Medicine, covering topics from preparing for birth to n
  care. You can find links to these classes on our website:
  https://www.umwomenshealth.org/resources/classes-support.
- Education from your doctor or midwife: After each visit, relevant education

MiPATH: Pregnancy and Postpartum Patient Resources

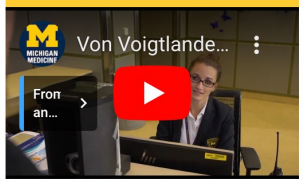
Thank you for choosing University of Michigan Health for your care. We are privileged to partner with you for your pregnancy and postpartum care through our Michigan Plan for Appropriate Tailored Healthcare (MiPATH) plan.

Michigan Plan for Appropriate, Tailored Healthcare (MiPATH)

MiPATH has two phases. The first is a tailored pregnancy care model that provides patients with options for medical care, education, and support during and after pregnancy. With MiPATH, you work together with your doctor or midwife to select the pregnancy care plan that meets your needs, including medical care, education and social support. After pregnancy, the model continues to be tailored to your needs with additional support, education, and medical care determined by your pregnancy, birth and postpartum needs.

- Introduction to Michigan Plan for Appropriate, Tailored Healthcare (MiPATH)
- Choosing Your Prenatal Care Visit Options
- Making Your Virtual Prenatal Care Visits Successful
- Choosing Your Pregnancy Care Clinicians
- Education and Social Support Resources for MiPATH
- Postpartum Period

Virtual Birth Center Tour



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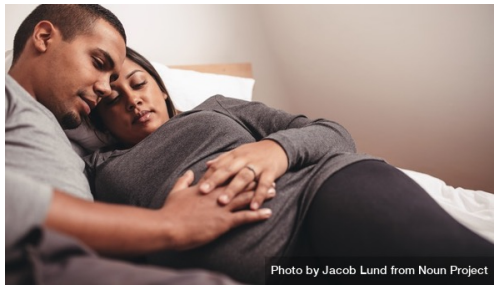
Individualized prenatal care plans

Risk Assessment:	Preference

Maya

Medical : none **Social** : employment	**Provider:** CNM **Modality**: Hybrid?



Taylor

Medical: cHTN **Social**: pregnancy anxiety, isolation	**Provider:** Ob/Gyn **Modality**: In-person?

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PATH recommends a nuanced, tailored approach to prenatal care to meet individuals' needs & preferences

Patient presents for care

Screen for medical & social determinants

Solicit and incorporate patient's preferences

Determine a Tailored Prenatal Care Plan

Visit Frequency & Monitoring Schedule

Determine intensity based on medical & social needs

More frequent contact for patients with pregnancy complications and chronic conditions

Telemedicine Telemedicine & Care Modality

Deliver recommended services through 4 in-person visits (1st visit, 28w, 36w, 39w)

Determine visit modality (in-person vs. telemedicine vs. other) for additional visits with the patient

Most monitoring can be completed remotely

Support for Social & Structural Determinants

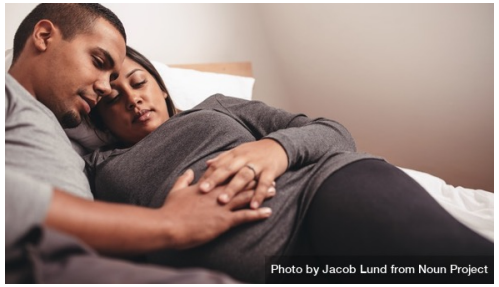
Provide additional support based on community/health system resources and patient needs.

Maya and Taylor discuss their prenatal care plans with their prenatal care plans with their maternity care professional at their first visit.

Individualized prenatal care plans

Risk Assessment:	Preference	Setting the Plan

Medical : none **Social** : none	**Provider:** CNM **Modality**: Hybrid **Wraparound:** None	More flexible care plan



Medical : cHTN **Social**: transportation, isolation	**Provider:** MD **Modality**: in-person, RPM **Wraparound:** Unsure	More intense care plan

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Individualized prenatal care plans: Maya

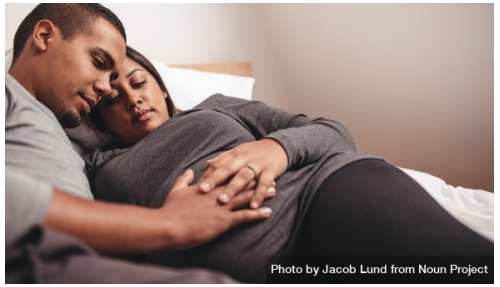
More flexible care:
Maya has few additional needs in pregnancy. Her care plan is minimally burdensome so *she* can focus on work and her family, and her clinic can provide additional capacity for patients with higher needs.

Remote monitoring: Maya has access to a blood pressure monitor at work

Education: After Visit Summaries, App

Wraparound: Maya leans on her family and coworkers

Individualized prenatal care plans: Taylor



More intense care:

Taylor has both medical and social needs. Her care plan is designed to provide increased support through more contact with her maternity care professional and wraparound services for non-medical needs.

6w — First Visit — 12w — 16w — 19w — 20w — 24w — 28w — 30w — 32w — 34w — 36w — 37w — 38w — 39w — 40w — 41w

Remote monitoring: Taylor's clinic helps her to get a blood pressure monitor

Education: After Visit Summaries, Pregnancy Book, App, Online Classes

Wraparound: Online Support Program, Social Work Consult

Individualized prenatal care plans: Stay Home Stay Connected

Grouped by gestational age

Ob/Gyn, Midwifery, Family Medicine

Medicine, Midwifery, Social Work

Monthly Zoom meetings with gestational age specific curriculum

Peer support and connection

Online video series on mental health & wellness

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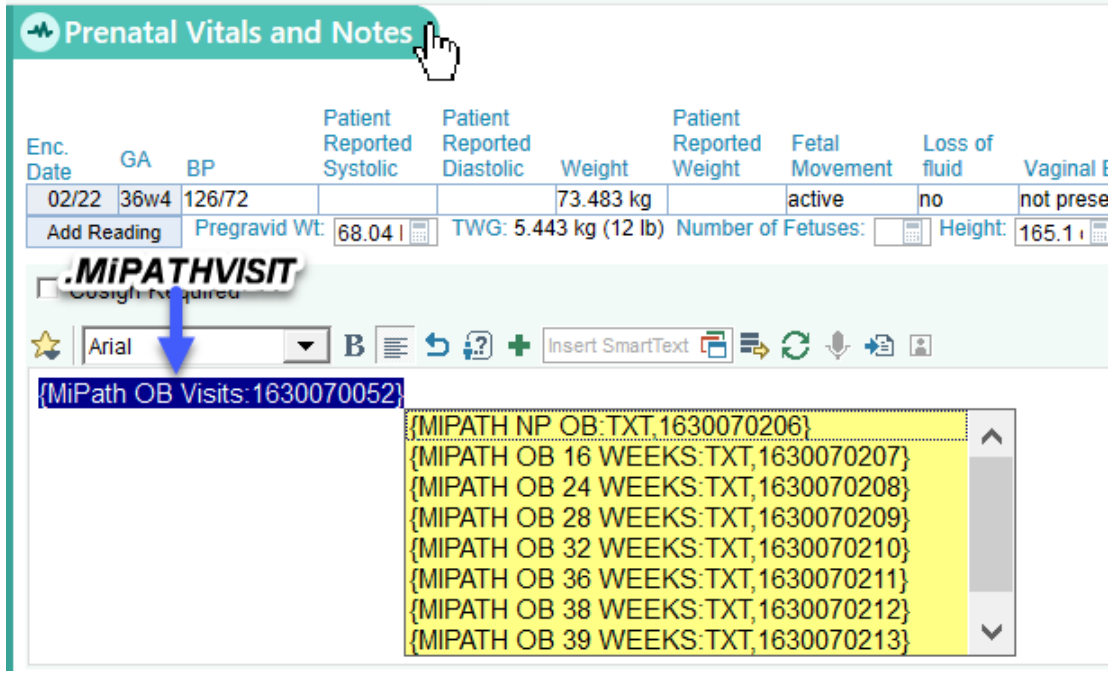
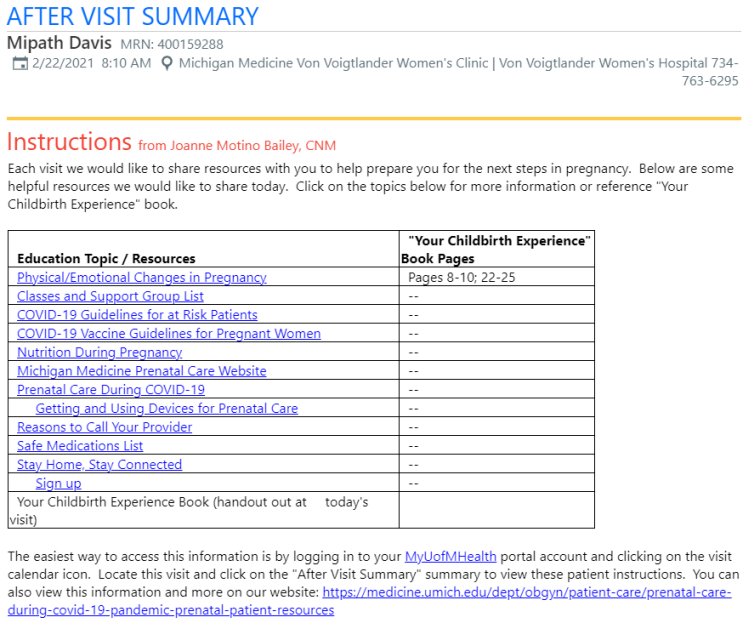
Individualized prenatal care plans: team support





AFTER VISIT SUMMARY

Mipath Davis MRN: 400159288

2/22/2021 8:10 AM Michigan Medicine Von Voigtlander Women's Clinic | Von Voigtlander Women's Hospital 734-763-6295

Instructions from Joanne Motino Bailey, CNM

Each visit we would like to share resources with you to help prepare you for the next steps in pregnancy. Below are some helpful resources we would like to share today. Click on the topics below for more information or reference "Your Childbirth Experience" book.

Education Topic / Resources	"Your Childbirth Experience" Book Pages
Physical/Emotional Changes in Pregnancy	Pages 8-10; 22-25
Classes and Support Group List	--
COVID-19 Guidelines for at Risk Patients	--
COVID-19 Vaccine Guidelines for Pregnant Women	--
Nutrition During Pregnancy	--
Michigan Medicine Prenatal Care Website	--
Prenatal Care During COVID-19	--
Getting and Using Devices for Prenatal Care	--
Reasons to Call Your Provider	--
Safe Medications List	--
Stay Home, Stay Connected	--
Sign up	--
Your Childbirth Experience Book (handout out at today's visit)	

The easiest way to access this information is by logging in to your MyUofMHealth portal account and clicking on the visit calendar icon. Locate this visit and click on the "After Visit Summary" summary to view these patient instructions. You can also view this information and more on our website: https://medicine.umich.edu/dept/obgyn/patient-care/prenatal-care-during-covid-19-pandemic-prenatal-patient-resources

Standardized scripts and EHR text for scheduling, prenatal visits & education ensure patients receive high quality options, individualized to meet their needs.

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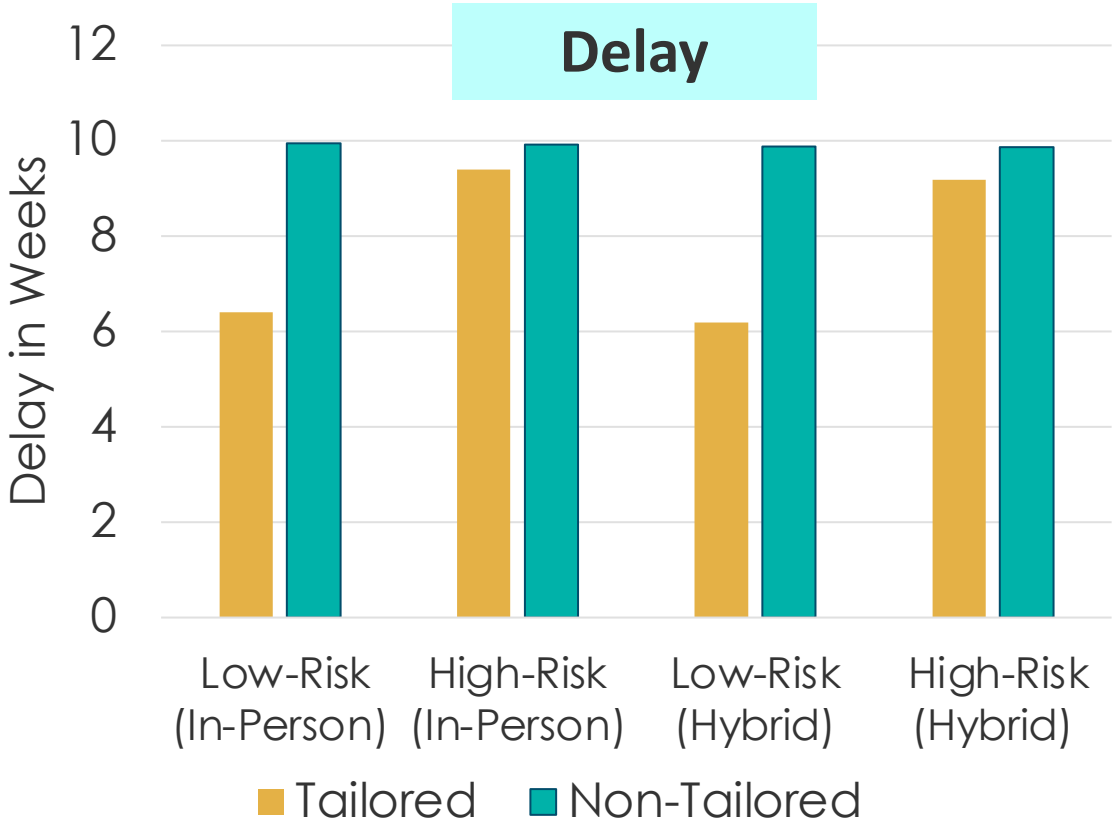
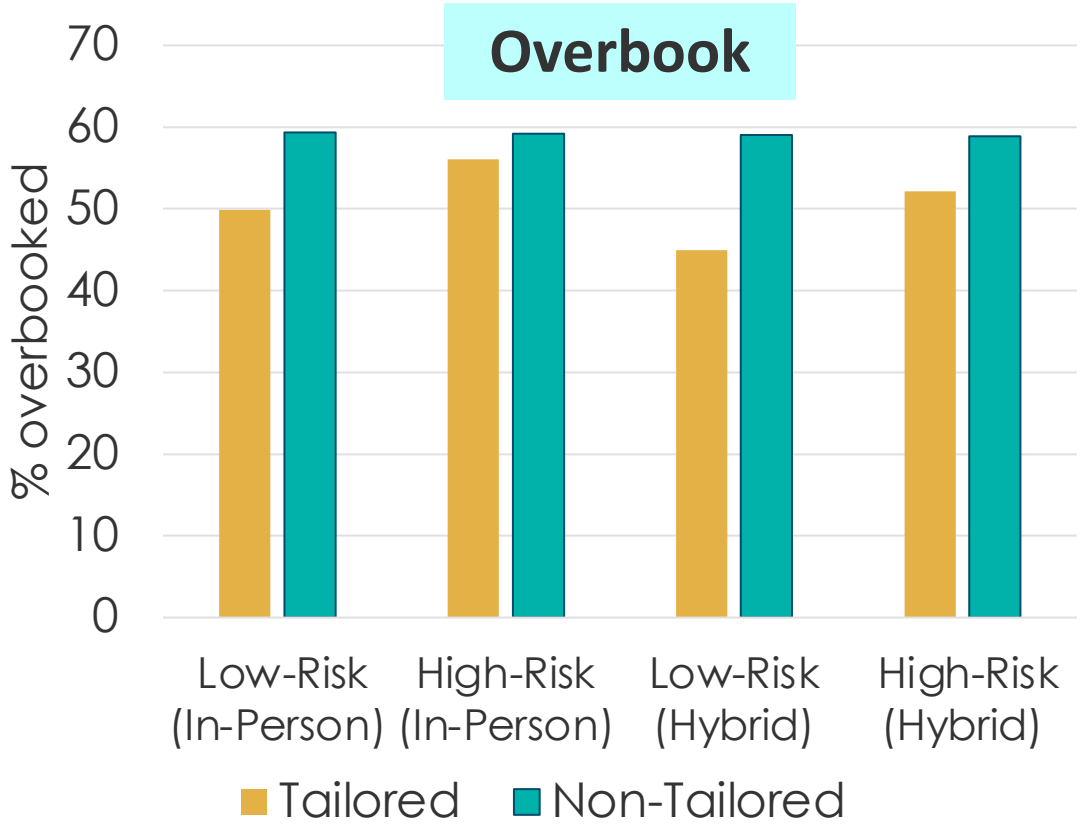
Individualized prenatal care plans improve clinic operations





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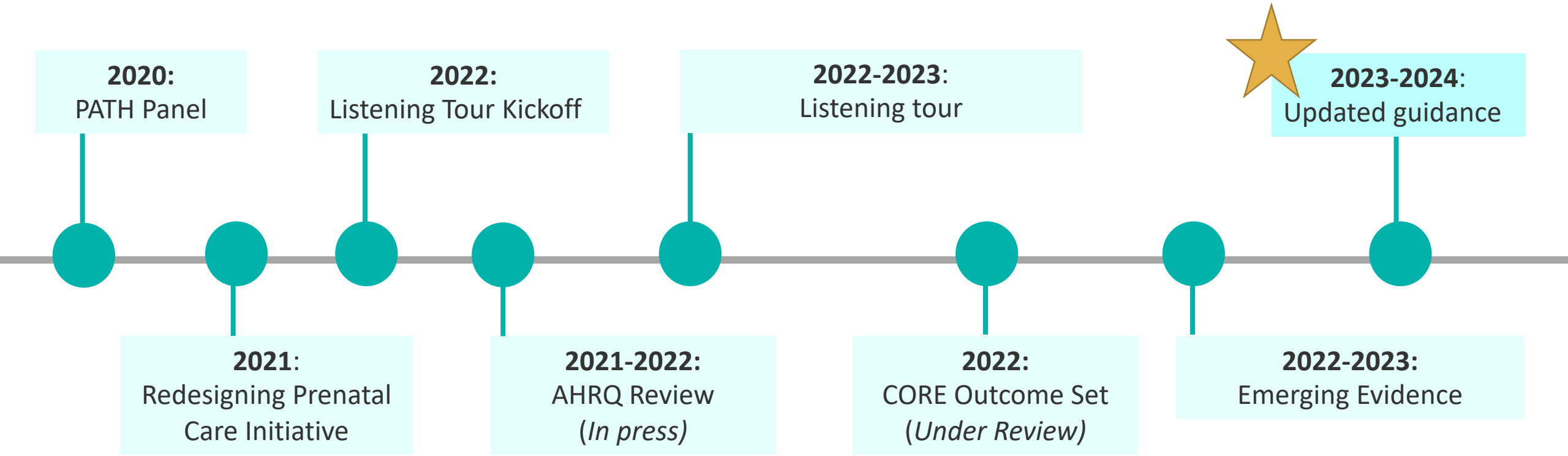
New prenatal care recommendations will be finalized in 2023, with stakeholder input and emerging evidence



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Your Perspective:

What can tailored prenatal care look like across the state of Michigan?

1. How can we better integrate maternity care services across clinical and community partners?

2. How can PATH help to address significant inequities in care delivery, particularly for pregnant people marginalized by racism & socioeconomic status?

3. How can PATH be applied across the many settings where prenatal care is delivered?

> Only a crisis, actual or perceived, produces real change.
>
> -Milton Friedman

I look forward to your questions.

@AFriedmanPeahl alexfrie@med.umich.edu

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Frequently asked questions

FAQ 1: What is an “average-risk” patient?

1

- Who does PATH apply to?
- How can I make sure I am applying new models of care the right way?

Answer 1: What is an “average-risk” patient?

1

Pregnant people without significant medical, pregnancy, or mental health conditions, that can be cared for by general maternity care clinicians (*e.g.*, Obstetrician-Gynecologists, Family Medicine Physicians, Certified Nurse Midwives, and Nurse Practitioners).

Flexible definition due to:

- Limitations in current risk stratification scores which assess childbirth morbidity and mortality risk, not need for increased prenatal care services
- Variation in practice by region, group or clinician
- Goal of inclusivity for patients with common chronic and pregnancy conditions (e.g., cHTN, GDM)

FAQ 2: How can we recommend a targeted (reduced) visit schedule in the midst of the maternal health crisis?

2

- What is the evidence for the traditional model of prenatal care?
- What is the evidence for targeted visit schedules?
- Isn’t more better?

Prenatal care evidence can be divided into two key categories:

2

“WHAT”

Prenatal Care Services

The different elements of care provided to patients including screenings and management

“HOW”

Prenatal Care Delivery

The way prenatal care is administered, including visit frequency and modality

There is strong evidence to support many prenatal care services (WHAT)

2

Gestational Diabetes Screen	Vaccinations	Rhogam Administration	Blood pressure screening
Screen for Anemia	Group B Strep Testing	EPDS Depression Screen	Prenatal Vitamins
ASA for at-risk pregnancies	Dating Ultrasound	Assess for fetal presentation	STI screening

Kilpatrick *Guidelines for Perinatal Care* 2017

Studies demonstrate prenatal care can be delivered with targeted visit schedules and telemedicine

2

Targeted visit schedules	Telemedicine (Virtual visits)	Data limitations
Equivalent maternal and infant outcomes Improve access to care but concerns that this is perceived as “less care”	**Equivalent maternal and infant outcomes** Improve convenience, but concerns about quality without device/broadband access	1. Limited modern studies 2. Data from “real world” settings is limited 3. Lack of diversity in included patients

Evidence from observational studies supports different models of prenatal care visit frequency

2

1. **Peer countries with better maternity care outcomes than the US recommend fewer visits**
   Systematic review of peer countries' guideline

2. **Receipt of guideline-based prenatal services does not increase after 5 prenatal visits**
   Claims analysis of prenatal visits and services

3. **In low-risk patients, >10 visits is associated with greater intervention without benefit**
   EHR analysis of visit number and outcomes

Peahl et al *AJOG* 2020, Gourevitch et al *AJOG* 2021 , Carter et al *J Perinatol* 2016

Evidence for the traditional prenatal care model supports maintaining services, but modifying delivery

2

Traditional

12-14 in-person visits

Developed without evidence

Maintained due to tradition

Flexible

Targeted visits, telemedicine

Limited but reassuring evidence

Based on logic, not history

A new CORE outcome set will standardize how prenatal care innovations are assessed.

2

Frequency Of pRenatal CAre viSiTs (FORCAST)

- Core Outcomes Measures in Effectiveness Trials (COMET) rigorous eDelphi approach
- Built upon existing Systematic Reviews
- Diverse stakeholder perspectives:
  - Patients/Public Members (20)
  - Providers/Researchers (37)
  - Policymakers/public health leaders (14)

A new CORE outcome set will standardize how prenatal care innovations are assessed.

2

Maternal

1. Maternal quality of life
2. Maternal mental health outcomes
3. Maternity care experience
4. Lost time
5. Attendance at recommended visits
6. Unplanned care utilization
7. Completion of ACOG recommended services
8. Diagnosis of obstetric complications (proportion, timing)
9. Disparities in care outcomes
10. Severe maternal morbidity and mortality

Neonatal

1. Gestational age at birth
2. Birth weight
3. Stillbirth/perinatal death
4. NICU admission

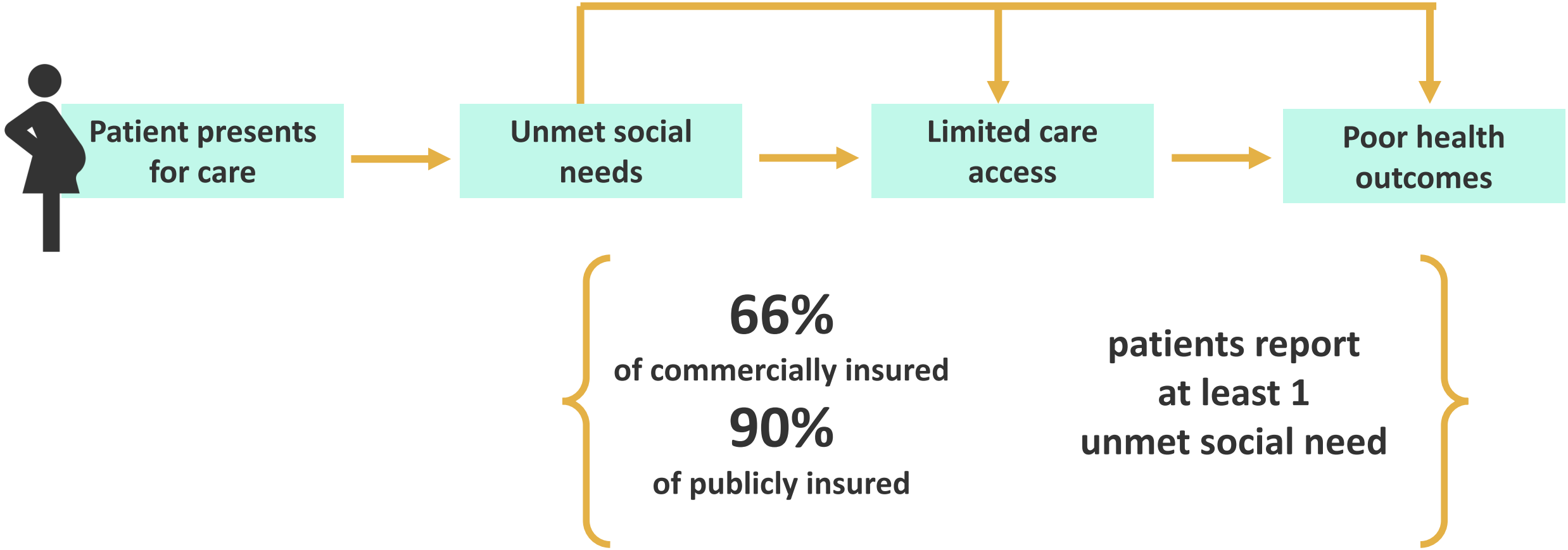
FAQ 3: Can I screen for SSDOH without clear referrals available?

3

- Is it unethical to screen for something I can't treat?
- Social determinants feel out of my lane.

Social determinants of health affect >80% of health outcomes

3



CDC, Peahl 2023

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Even if we don't routinely screen for unmet social needs, we often see their effects.

3

Patient misses multiple scheduled, routine prenatal visits …	Patient on insulin suddenly has low blood sugars…	Patient frequently calls nurse line with questions…

Even if we don't routinely screen for unmet social needs, we often see their effects.

3

Patient misses multiple scheduled, routine prenatal visits …	Patient on insulin suddenly has low blood sugars…	Patient frequently calls nurse line with questions…
…due to unreliable transportation and inability to miss work.	…due to low intake from food insecurity after losing her job.	…because she is feeling socially isolated and needs support.

We currently use “band-aid” approaches address patients’ immediate clinical need.

3

Patient misses multiple scheduled, routine prenatal visits …	Patient on insulin suddenly has low blood sugars…	Patient frequently calls nurse line with questions…
…due to unreliable transportation and inability to miss work.	…due to low intake from food insecurity after losing her job.	…because she is feeling socially isolated and needs support.
Play “catch up,” completing services when possible.	Adjust insulin doses to prevent hypoglycemic episodes.	Add on more visits to provide increased points of contact.

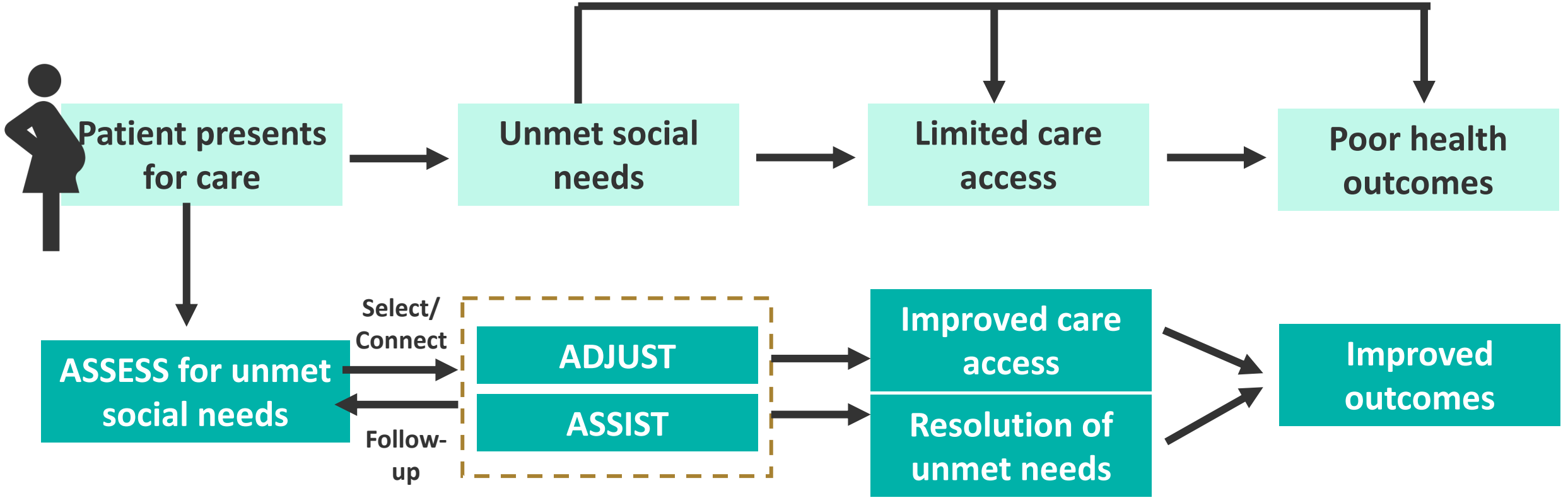
These “band-aid” approaches fail to address patients’ underlying unmet social needs.

3

Patient misses multiple scheduled, routine prenatal visits …	Patient on insulin suddenly has low blood sugars…	Patient frequently calls nurse line with questions…
…due to unreliable transportation and inability to miss work.	…due to low intake from food insecurity after losing her job.	…because she is feeling socially isolated and needs support.
Limited transportation	Food and Employment Insecurity	Low Social Support

The National Academy of Medicine provides a flexible framework for social needs

3



CDC, Peahl 2023

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Integrating social needs screening is limited by real-world challenges…

3

"I'm not trained to manage social problems. I can do medical care but how can I help a person with food insecurity?"

"I don't know the resources available in my community. I would have no idea where to send someone."

"I can't add one more thing to my practice. I already have to cover too much in one visit."

"It's unethical to screen patients if you don't have anything to offer them to help."

…that must be solved with real-world solutions.

3

Training	Maternity care professionals must be prepared for how to adapt care and integrate social needs
Networks	Strong connections between community-based organizations and health systems require investment and upkeep
Teams	Though maternity care professionals may be anchor in prenatal care, teams are best aligned to address complex needs
Adjustments	Care modifications to improve access can be an effective way to address unmet social needs while awaiting assistance.
Empathy	Acknowledgement and empathetic listening can improve patient experience, even in the absence of tangible interventions.

Peahl 2023, Tully 2022, ACOG Listening Tour

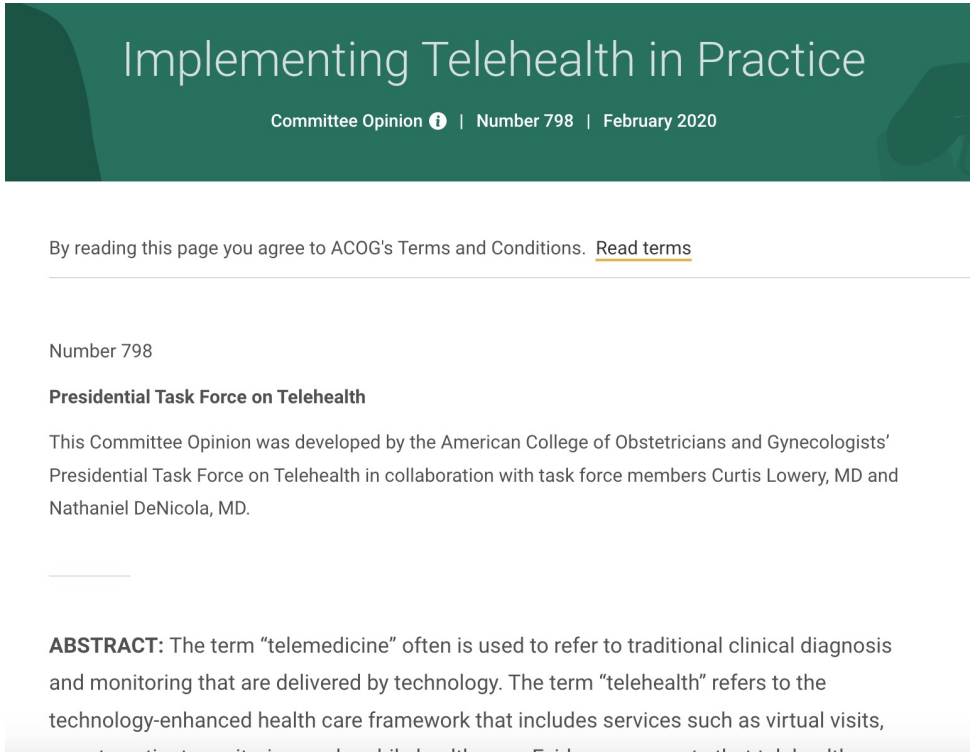
FAQ 4: My clinic does not have telemedicine infrastructure. Can I still offer PATH?

4

- Is PATH all or nothing?
- Are phone visits sufficient for telemedicine?

Answer 4: My clinic does not have telemedicine infrastructure. Can I still offer PATH?

4



Implementing Telehealth in Practice

Committee Opinion | Number 798 | February 2020

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Number 798

Presidential Task Force on Telehealth

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Presidential Task Force on Telehealth in collaboration with task force members Curtis Lowery, MD and Nathaniel DeNicola, MD.

ABSTRACT: The term "telemedicine" often is used to refer to traditional clinical diagnosis and monitoring that are delivered by technology. The term "telehealth" refers to the technology-enhanced health care framework that includes services such as virtual visits,

- Consider regulatory issues
- Implement audio-only
- Ensure access to BP monitors
- Continue care tailoring

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FAQ 5: Is home blood pressure monitoring as reliable as office measures?

5

- Can patients accurately collect blood pressure information?
- Can I make critical decisions about patient care based on a home blood pressure monitor result?

Answer 5: Is home blood pressure monitoring as reliable as office measures?

5

Primary Care ✓	Postpartum Care ✓	Prenatal Care ✓
• Standard of care • Widely accepted for chronic HTN management	• Improves completion of recommended follow-up • Reduces disparities in access	• Well documented feasibility/acceptability • Widely implemented in the COVID-19 pandemic

Answer 5: Is home blood pressure monitoring as reliable as office measures?

5

1. **Ensure blood pressure monitor access**
   Need for advocacy to increase insurance coverage for DME

2. **Check blood pressure cuff fit**
   Ensure cuffs are available in a variety of sizes

3. **Provide proper patient education**
   Confirm patients know proper technique, how to report values, and when to contact their provider for symptoms/elevated BP

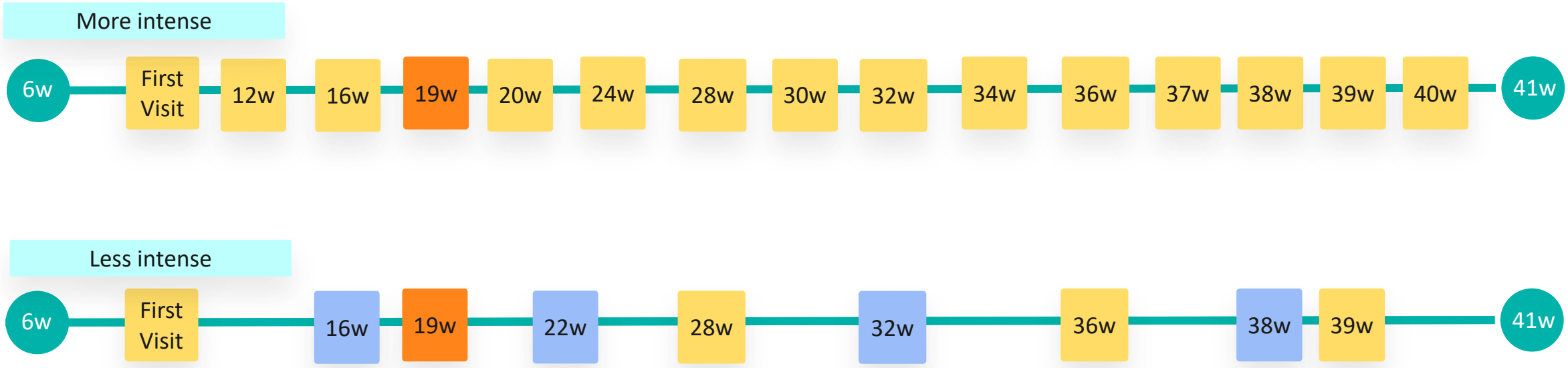
FAQ 6: What happens if my uncomplicated patient develops gestational diabetes or hypertension?

6

- How do I adjust prenatal care plans for evolving risk?

Patients with increasing risk should transition to the more intense prenatal visit schedule.

6



Peahl 2021

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Visit schedules can be adjusted to chronic conditions and evolving pregnancy complications.

6

Condition	≤13'6 weeks	14 0/7 to 27 6/7 weeks	28 0/7 to 35 6/7 weeks	≥36 0/7 weeks
Current Guidelines	4 weeks	4 weeks	2 weeks	1 week
Low-risk	4*-6* weeks (services)	4*-6* weeks (services)	2-4* weeks (services)	1*-2* weeks (services)
Chronic Hypertension	4* weeks	4* weeks	2* weeks	1* weeks
Preexisting Diabetes	4* weeks	4* weeks	2* weeks	1* weeks
Hx Pregnancy Loss (Early)	4* weeks	4* weeks		
Gestational Hypertension			2* weeks	1* week
Gestational Diabetes			2* weeks	1* week

*=some visits appropriate for telemedicine

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FAQ 7: How does group prenatal care, home visiting, and other models of care fit with PATH?

7

- How do I support my patients' individual needs?

PATH recommends a nuanced, tailored approach to prenatal care to meet individuals' needs & preferences

7

Patient presents for care

Screen for medical & social determinants

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Determine a Tailored Prenatal Care Plan

Visit Frequency & Monitoring Schedule

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Telemedicine & Care Modality

Deliver recommended services through 4 in-person visits (1st visit, 28w, 36w, 39w)

Determine visit modality (in-person vs. telemedicine) for additional visits with the patient

Most monitoring can be completed remotely

Support for Social & Structural Determinants

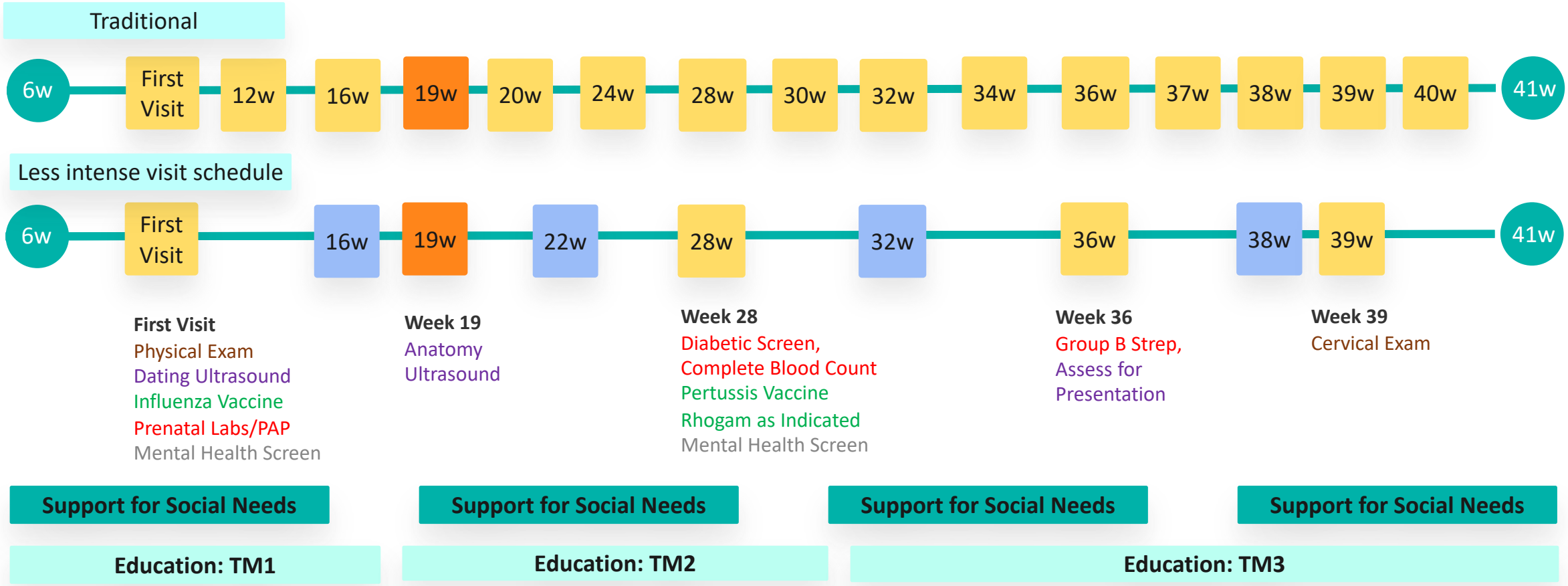
Provide additional support based on community/health system resources and patient needs.

FAQ 8: Will I get paid less for PATH?

8

- How do I keep my doors open?
- How does PATH work with existing global/bundle payments?

PATH is not less care: it is the same services organized in a more patient-centered way.



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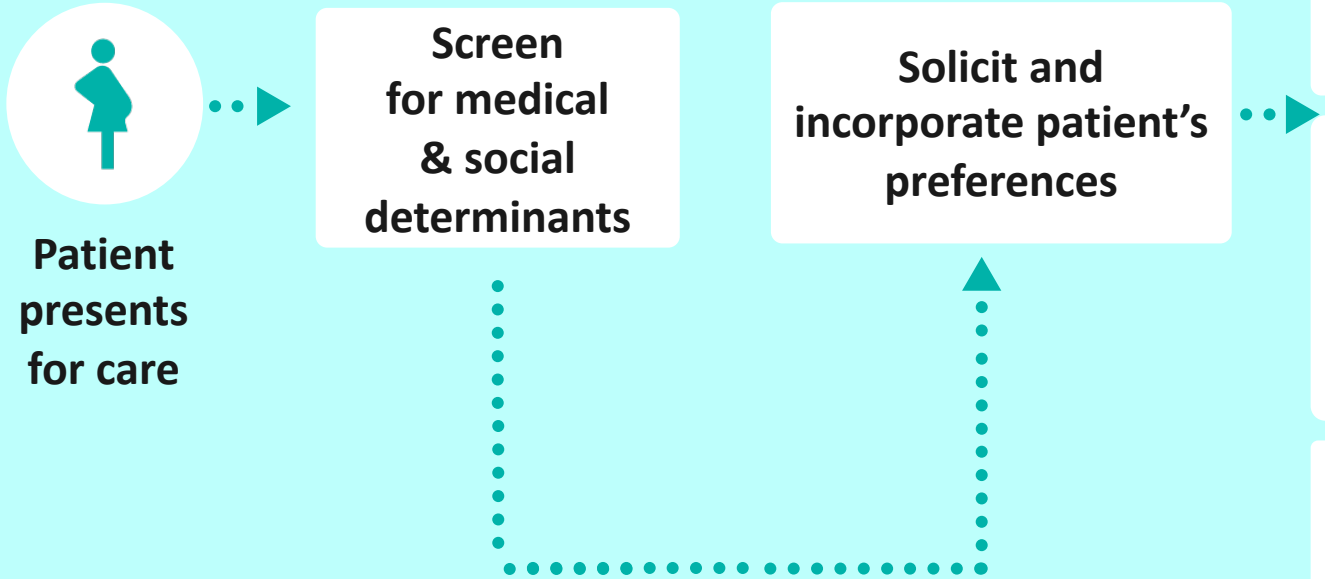
Answer 8: Will I get paid less for PATH?

8

PATH is NOT less.	PATH recommends the same services, just organized differently.
PATH may be more.	PATH incorporates remote monitoring and home devices
PATH may be more.	PATH recommends additional screening and wraparound services
PATH may be more.	Patients receiving hybrid care may utilize more asynchronous services (e.g., portal messages) not captured in traditional billing

PATH recommends a nuanced, tailored approach to prenatal care to meet individuals' needs & preferences



Determine a Tailored Prenatal Care Plan

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We look forward to your questions.

@AFriedmanPeahl alexfrie@med.umich.edu

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