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Megan: Hello everyone and welcome to this "Ask the Expert" webinar on the Fourth Trimester and New Paradigm for Preventing Maternal Mortality. I'm Megan Hiltner with Healthy Start EPIC Center. We have approximately 60 minutes set aside for this webinar. It's being recorded and the recording along with the transcript and slides will be posted to the Epic Center's website following the webinar. We want your participation at any point during the webinar. If you have questions or comments, please chat them into the chat box in the lower left corner of your screen and we will be responding to them as soon as our presenter is done with his presentation. We also want your feedback after this event. So at the end of the webinar, please take a moment and complete the survey that will pop up on your screen right after the event.

So given the urgent need to reduce maternal mortality and morbidity, the American College of Obstetrics and Gynecology, ACOG, released a revised committee opinion to reinforce the importance of the fourth trimester and to propose a new paradigm for postpartum care. Redefining postpartum care is an initiative set forth by ACOG's immediate past president, Dr. Haywood Brown, and he will be sharing more about this paradigm, the Fourth Trimester Paradigm, in the context of Healthy Start during this "Ask the Expert" webinar. But I'm now going to turn it over to Ms. Kimberly Sherman. She's the women's health specialists with the division of Healthy Start and Perinatal Services for a welcome and an intro of Dr. Brown. Kimberly.

Kimberly: Thank you, Megan, and hello everyone. Thank you for stepping away from your work today to join us for this Webinar and to hear from Dr. Brown. I would like to take a moment just to introduce our presenter today. Dr. Brown has had an exceptional career in both clinical and the academic area and it's filled with many, many accomplishments. His steadfast commitment to improving NCH outcomes across the US and particularly for women is remarkable. In addition to his role as a professor in the Department of Obstetrics and Gynecology at Duke University, Dr Brown has served as chair of the council of Resident Education and obstetrics and gynecology, and he was on the board of directors for the Society for maternal-fetal medicine. He's also past president of the society for maternal-fetal medicine and of the American Gynecological and Obstetrical Society, as well as past chair of the Ob/Gyn section of the NMA. He's served as the director for the American board of inspectors and gynecology. And Dr. Brown as Megan said, is the immediate past president of ACOG.

He has spent his career advocating for women's health with a focus on perinatal health disparities and maternal mortality. And he was a true friend and champion of the Healthy Start community. He has brought to light many of the challenges in providing care that lay before as we move forward in making sure

that every woman has a healthy postpartum period. And we're going to hear more about the paradigm shift in his presentation today. He believed that, you know, postpartum care is really the key to lifelong health and we want to carry that message forward in Healthy Start. So now we're going to just take a moment for a pretest before we hand over the mic to Dr. Brown. Our first question. Almost 25% of maternal deaths are due to the unmet need for contraception. Is that true or false? Feel free to put your answer in now and we'll move onto our second question.

Megan: And I see a lot of folks are figuring out how to do that. You just click the radio button on your screen.

Kimberly: All right. Here are the result. Fifty-two percent of the participants believe that yes, the statement is true. And our second question, the ramifications of the lack of postpartum care include that it contributes to health disparities, that it may impact pregnancy spacing, that there may be undiagnosed postpartum depression and anxiety disorders. All of the above. And again, just click that radio button and hit submit.

Okay. And with that, I will turn it over to our presenter, Dr. Brown. The floor is all yours.

Dr. Brown: Thank you very much for this warm introduction. You know, Healthy Start has had a special place in my heart with my work with the Indianapolis Healthy Start program. So why don't you go ahead to the next slide. And I'm mentioning that I have no disclosures except for the fact that I just realized that I write to up-to-date chapter four maternal mortality, but that's something that's a learning tool.

Next slide. So our objectives are to identify the racial and ethnic disparities in maternal mortality, in fact, as related to mortality. But mostly we're going to talk about disparities in breastfeeding, which is something that Healthy Start certainly plays a role in and how it impacts long-term health for adults and children and next generations, but also explaining how the postpartum follow-up can impact maternal morbidity and mortality and long-term health. Next slide.

So, you know, I really believe there are a number of people who are saying they can't hear, I don't know what the issues are.

Kimberly: Yeah, I'll chat in, folks, if you're listening in from your computer, you can check and see if your computer speakers are muted. You probably can't

hear me say this, but I'll chat into the chat box. Oh, there we go. We've got the phone line there, chatted in, so.

Dr. Brown: So the problem is fairly, as you know, is complex, is multifactorial, perinatal health disparities will document it. This is why we do the work that we do with Healthy Start, but the bottom line is we're talking about opportunities for improvement and how we can do that. And we really believe that the postpartum period and the late period appear as an aspect of education that we need to take better advantage of. Next slide.

So I think that you are all familiar with this factor with a race of maternal disparity and maternal mortality. You know, black women in particular have a significantly higher risk and this is the reason that we have been on Capitol Hill talking about disparity, maternal mortality and the need for maternal mortality review. The other thing that I think we need to keep in mind is that Native Americans have the second highest maternal mortality in this country. Many of them have been isolated to the Indian Health Service sites, but it's also important to recognize that access to care, access to follow-up care, and access to a collaborative care is a big challenge, particularly for these individuals who live in these remote areas. And this is very prevalent in Alaska.

Then of course, we know that fight maternal mortality is actually not going down, but maybe going up. And so the catching up that we're doing is actually by decreasing race and other races, but not necessarily a decrease in rates and whites because of we really believe the comorbidities and also the access to care issues. Next slide.

So this is just a graphic presentation of that. And as you can see that I mentioned, when you talk about American Indians, the second graph there, you can see how that numbers continue to increase just like African American numbers. If you look at all racist of that is also a quite significant and leading into the disparity. Well, you do notice is that women of Hispanic origin have a tendency to have a steady rate of maternal mortality, which is good, but also any maternal death is really a death that we can't tolerate. Next slide.

So these are the things that we have been focusing on and these are the reasons that we have been on the Hill. We're primarily talking about direct maternal deaths, things that we can really impact, you know, Hemorrhage Thromboembolism, amniotic fluid embolize, and then you can see that as we began to kind of show the numbers changed between 87 and 90 and 98 and 90, 95, some of the things remain a toxin and that is hemorrhage, but you can see that cardiovascular conditions in later years have really begun to show a

significant contribution. And that's one of the things that we're going to talk about in a new postpartum paradigm. Next slide.

And this is just a similar way of showing this by years. I won't really belabor that it's hard to see, but as you can see in the blue bars, the later blue bars and the purple bars are cardiovascular disease and cardiovascular conditions have continue to permeate. But we still have to pay attention to the realities of hemorrhage hypertension, and thromboembolic disease because those things are very important in the postpartum follow-up period as we begin to kind of evaluate patients and so forth. Next slide.

The things that I think that is most concerning is that this really talks about preventability. And years ago, we did a paper from North Carolina and looking at all of our maternal deaths and talking about preventability. And we really believe that, I sincerely believe that very few hemorrhages deaths that should not be preventable. Maybe those from amniotic fluid embolize you can see down below. But the bottom line is when we talk about preventability, that is the whole issue with the alliance on innovation and maternal health and the postpartum follow-up period that really contributes to that. We know a significant, a number of preeclamptic deaths, in fact, occur at postpartum. And a specific number of venous thromboembolic deaths occur postpartum. And so challenging the paradigm of when patients ought to be seen is what we try to do in our work. Next slide.

The other thing that we have to think about and all of this is vulnerable populations. And we talked a bit about rural access to care, which you'll see on the next slide. And this says, and this is where our question come from, the US could avoid about 40% of maternal deaths if all women had access to quality care. And I think you all recognize the fact that we live in a state and a country where there's a lot of rural America. We talk about level one and level two hospitals. We talk about transportation areas issues. We talk about the social determinants of health. And when you begin to think about postpartum care and important for us to emphasize to the patient why it's important to follow up, but also to the providers that's why it's important to follow up. And we're going to talk about how we can do that better as we go forward in trying to improve the quality of healthcare for women. We're going to talk about how we might be able to use telemedicine in our public health clinics, in our federal qualified health center clinics along with partners to improve the overall health of our patients are in the setting which they live. Next slide.

So just give you an example. You know, if you look at this map and you may not be able to see it well, one of the things that I'm always concerned about is if you've been looking at how many counties that are considered rule. I mean,

look at that map here and look at maternal deaths are mapped in that. And then if you look at incarceration, these are the states that have specific incarceration is shackling laws. And so imagine if you're trying to have a baby how demoralizing it is for you to have to do it in shackles. This is almost half of all states. And there are people who are working with those types of things. These are the population of women that we have to be concerned about as well because they do indeed pose higher risk. And in many of these facilities, the chances of having a postpartum visit, in fact, is profoundly affected. And so we have to come up with innovative programs even in that area so that we can be able to do postpartum care and we can do that in the public health prisons and the prisons with advanced practice nurses and through telemedicine. Next slide.

So this is where this comes from. This is actually an international slide and it really talks about the challenges that we're facing right now, barriers with family planning services. I think I'm going to talk a bit about that for patients who, even when we talk about immediate postpartum LARC, facility in government institutions for sterilization resistance, the introduction of newer contraceptive methods such as postpartum IUDs. And you can see that nationally and internationally, there are factors that play a role in that, particularly if you don't have a coverage. And it's significant challenges we're now having with just renewing Title X funding is a real significant concern for us for women who live in various communities and so forth and so on who may not have access to contraception. Next slide.

So the big picture, the big picture of disparity and maternal mortality really comes down to a lot of different issues. And I had this conversation today, you know, whether you're talking about institutional biases that impact, keep in mind that, you know, there are some famous people who were near-miss mortalities, we haven't introduced that term yet, but you think about a very wealthy superior woman athlete who nearly came to maternal death from a thromboembolic event. Why? Maybe because institutions did not have the protocols and guidelines in place, maybe she was not supposed to be one who should get sick, etc. etc. So you see that the problem was not literacy or language, it wasn't even maybe fragmentation of care. It may be that she did have a comorbidity that puts her at high risk and recognizing that was very important to her overall outcome. But when these things are not challenged and they're not challenged in a way that they should, it leads to morbidity, it leads to mortality, it leads to post-traumatic stress. And there's new data coming out now on post-traumatic stress from people who've had a near event, for instance, another reason why seeing that patient and follow-up and asking her the right questions is very, very important to her overall long-term health. Next Slide.

These are the disparity bundles that we put in place in hospitals. But not all hospitals have taken advantage of them. And so this is part of the aim program, the national initiative to reduce maternal morbidity and mortality. As I said, every hospital, regardless of its size, ought to have a hemorrhage bundle. And this is the work that we've been doing in states like South Dakota where rural access to care is a real issue. We were trying to get patients transported to the appropriate facility. This is why we have hypertension in pregnancy protocol so that patients who have severe preeclampsia are seen back within 72 hours, particularly if they're on medication. So imagine telling that patients should come back in six weeks or better yet not recognizing the fact that she is at risk for pulmonary edema, she is at risk for stroke and hypertension. And this is the reason that the follow-up period and when it's defined for certain types of patients is critical to the overall care because, needless to say, readmissions are reduced if the patient is seen appropriate.

Safe reduction of primary cesareans. Again, making sure that we follow proper protocols for admissions to labor and delivery, and then, and having follow-up for those patients who've had some cesareans and discussing with them their options for vaginal birth after cesarean. And then overall, we added a disparity bundle to all of these bundles. But you can see the major bundles here really permeate around the direct costs of maternal mortality. And again, now, you know, most patients who have a deep vein thrombosis actually have it in the first three, two days to two weeks after having a delivery. Next slide.

So this mentions one of the initiatives that we have with the level of care and the objective there is to make sure we recognize like we did with the infant, the neonatal levels of care that has certain women who would be better off in a different type of facility. And I'll give you two examples of that. If the patient has a placenta previa and she's at a rural access hospital, it's not that the doctor doesn't have the capability of doing a cesarean and later a placenta previa, but does he have any more than 10 units of blood to deal with the consequences of it if she starts to bleed? That's the reason that for that transfer. And the patient with preeclampsia, with severe features at 27 weeks is transferred for the mother. If she's transferred the babies for sure, but she's also transferred for the...insure the health of the mother and then the follow-up. And this is where that follow-up may need to be coordinated in her community when she's discharged from the hospital. So what I'm saying now is the prenatal components, the intrapartum components and the postpartum components are extremely important. Next slide.

So morbidity, so let's think about it from this perspective. For every woman who dies about 50 more suffer severe complication or a near-miss. And when you begin to think about maternal mortality, preventable maternal deaths and

severe maternal morbidity are absolutely late. So patient who's discharged from the ICU after having a severe hemorrhage is vulnerable to that next postpartum hemorrhage. And therefore, that's where the counselor needs to begin. So the prevalence of delivery hospitals in which women suffer a similar mobility increases by 67% to affect some 34,000 women in the United States each year, 6.4 per thousands deliver hospitalizations in '98 and '99, now to 8.1 in 2004 to 2005.

Again, subsequent pregnancies to counseling. When is the counseling most fresh? The counseling is most fresh within the first two to three weeks postpartum. When is the patient more vulnerable for post-traumatic stress, within the 6 to 12 weeks of and beyond a postpartum. So this is the reason that we've advocated that second visit that should occur sometime before 12 weeks before the patient goes back to work. You know, sometime after you've done the postpartum depression screening, but yet when you're discussing other issues of world women's care, you're going to uncover certain types of things if you're astutely aware of the complications your patient have had. Next slide.

So we previously recommended that all women should attend a postpartum visit four to six weeks following the birth. And keep in mind, we've had that for a while. So why don't we still constantly tell patients to come back in six weeks. I know many of you in the clinical setting. I was just in a place this past week giving this talk and I was with some postpartum nurses. And I said, "Why do you still tell patients to come back in six weeks?" "Well, because that's what we were taught." And so we have to break the paradigm of the six weeks. There's nothing magic about it at all. It started in about the 1950s, but many people thought it really started even before then because it was tied to the post-op visit women had who had hysterectomies and things of that nature. This is when she's most likely going to return to work. And so we recognize the fact that we have to do better because the longer we push it out, you know, the more vulnerable women won't follow up. So 40% of women do not have a postpartum visit and maybe the better their socioeconomic status, the more likely they are. But it really is tied directly to the providers. And whether you're in a public health clinic in your community, or you're in a private physician's office, you'd have to give the patient a reason to come back and she has to recognize the value of that visit and we do as well.

Keep in mind, one of the challenges we've had is that with global building, the postpartum visit is included as part of a visit. So there's no additional funding appropriated by many insurance companies or Medicaid for their postpartum visit unless you create a certain types of programs and incentive programs like we have in the state of North Carolina where if you document certain types of things, like you've done a postpartum depression screen, like you talk to the

patient about breastfeeding, like you talk to her about contraception and follow-up, all the things that we ought to do anyway, we do get an extra piece of dollars for that, for the patients. So it gives people, the patient and the providers, incentive to make sure it happens. And that's important. Next slide.

So these are the ramifications though. And this was one of the things that you saw. It contributes to health disparities no question. So think about your own world that you live in. One of the issues that we have in Healthy Start is infant mortality and prematurity prevention, etc. So imagine the patient who has just delivered a 29 to 30-week baby and she's told to come back in 6 weeks. She's not given any contraceptive method. She's going back and forth to the hospital. She's trying her best to prop her breasts to do breastfeeding, but it's not going well. So she's really beginning to supplement the baby in the nursery. What happens? She may get pregnant, she may not follow-up, she maybe have come from a community where she was transferred and has no way of follow-up. And the bottom line is that she has a 30% chance of having another preterm baby.

Also, pregnancy spacing. When you appropriate counsel cases like this, that the appropriate spacing is 18 to 24 months for having, you know, a better outcome. And patients who get pregnant within 12 months of a cesarean have a higher risk that their uterus may open up. That's important. Early breastfeeding continuation. We live in a world where, you know, 80, I was at a hospital where 90% of the patients sign onto the bottom line that I'm going to breastfeed when I get home. But the issue is how many of them are doing breastfeeding at the end of two weeks. And we know that the long-term health benefits for women who breastfeed for at least four weeks for the mother and the child is quite significant. So she's already discontinued the breastfeeding because it's not easy and then everybody's left at home except for her, it becomes easier to quit.

And really the undiagnosed postpartum depression. If you begin to see patients at six weeks and you don't see them at all. And we know that women who are from vulnerable populations even have a higher risk. Imagine what's happening with them and what they're going through and what if they don't feel comfortable with coming back or even identifying what their challenges might be in the care of themselves and the care of their infant. Next slide.

So this is the fourth trimester. I have never… You know, we talk to our patients about this all the time. Rapid hormonal changes. You released the placenta, the estrogen to progesterone are gone. The breastfeeding is going on, there's vaginal dryness there. There is hot flashes. You have physical changes, you have social changes, and psychological changes. Now in many cultures around the world, there are caregivers that the mother has with her, whether it be her mother, whether it be her aunt and so forth and so on. So she has a lot of health

and many of you may have seen the article that was in the paper this past weekend that even talked about postpartum doulas after everybody leaves the mum at home. The challenge is the fatigue, the challenges of trying to breastfeed, the challenges of feeling guilty sometime was not going well, trying to learn to care for a newborn. And imagine if you have gestational diabetes, so diabetes or she had a hemorrhage and preeclampsia and so forth and so on, and they send you home with a hemoglobin of 8, 7 because you haven't been transfused and you expect to navigate stairs, navigate care of a baby and you had a cesarean. So navigating those types of things are the challenges that we, you know, we have to deal with and this is the reason why follow-up is so important and early follow-up is important. Next slide.

Now, I suspect that many of you have worked in hospitals in the past and you know that you round on the patient that someone rounds on them at 8:00 in the morning or 9:00 in the morning who comes back to talk to them at 10:00 or 11:00 when they arrive ready to go home. We used to have a wonderful care coordination program that was, you know, with home visits and so forth and healthcare navigators that we can help our patients with. Many of those things are hampered by funding, particularly for patients who enrolled in Healthy Start who are underserved and who had Medicaid or have no insurance at all. And keep in mind that many of our immigrant patients lose that initial coverage very early after they have a delivery.

So we are talking about not doing home visits, but I can tell you we can do a lot of home phone calls. If we were to carry it out well and we could talk to the patient, if we could face time the patient, everybody has a phone, and these are the new paradigms we're going to talk about for postpartum care, that's critically important for hypertension, diabetes and yes, substance abuse and other medical complications that we'll talk about. Next slide.

So, discussion considerations for contraception are important. You know, women with hypertensive disease and diabetes and obesity, adolescence, it's important to talk to them about pregnancy spacing, recognize those patients who may have a contrary indication to estrogen and so forth. And talk about alternative contraceptive methods. Next slide.

So next slide please. So we've been talking a lot in the various communities about the importance of postpartum LARC, particularly postpartum IUD, especially for populations of women who want these forms of contraception, but really live in remote areas maybe where I live in hospitals where they don't necessarily, you know, they can learn to do it but they don't necessarily do it and so forth and so on. But education on that is very important. Now, this is not meant to target patients as well. One of the things that we have to be careful

about is saying that, you need immediate postpartum LARC or whether than you want immediate postpartum LARC. And then choosing the appropriate patient for the expulsion rate is a little higher, but again, what we do in our patients, if they have a postpartum IUD and we're doing this at the time with cesarean and repeat cesarean and so forth, that patient comes back in two to three weeks and we can see if it has been as false. We can check the string and so forth, but certainly, we want to see her before four weeks. And if it really is not there, then we can choose another contraceptive method because later on, it decreases to about 4.4%. And so also teaching because the immediately postpartum after insertion less than 10 minutes after the placenta is delivered. This [inaudible 00:29:38] is really quite lower, and it declines specifically after about four weeks. Next slide.

And this one, of course, is pretty easy because it's just a Nexplanon, which is a one-shot item in the arm that almost anyone can do that can be done at the hospital. We actually did a study at Duke where we did immediate versus six weeks delayed study and that study is still ongoing. One of the things that I found by doing this is that you avoid a lot of the irregular bleeding that the patient might complain of, you know, after she gets an IUD or after she gets a Nexplanon. And so, those are the types of things you do with that you get from immediate postpartum assertions of IUDs and also Nexplanons. Next slide.

But this is the most important thing that I think we can do, is screen for depression. I've already talked about the vulnerability that patients have. And you know, there's a period called the postpartum blues and so forth. But you know, at the end of two weeks if that patient is still having signs and symptoms, she may very well, you know, have true postpartum depression. And it's important for you to ask these two questions that come from a, o-depression survey, it's a self-care screening survey, a little interest in place of doing things, feeling down, depressed and hopeless. If the patient answers either one of those questions, and a better yet, imagine if you're asking those questions while you're talking on the phone or you facetime, and you can see her expressions. The psychiatrist have been doing a lot of care for adolescent psychiatry for years to telemedicine and through facetime and through Skype, they actually do this. And so we can do this as well and improve the care of our patient in their own setting and make them feel more comfortable with talking to us about their concerns. Next slide.

Then of course, you and I both know, next slide please, that depression is associated with, you know other adverse outcomes. So we need a system recommendation to ensure that all pregnant and postpartum women are screened at least once. We got to optimize the detection rate, we've got to do the appropriate referrals. We also have to be prepared to do treatment. It always

bothers me a little bit when, you know, women have been on a medication for the anxiety and depression. They're told to stop it because they're breastfeeding, and which is kind of crazy. And then at the same time, we don't want to put them back on it when they have an anxiety disorder because we're just women's health care providers. And it really doesn't make a whole lot of sense to me, but we certainly need to be able to get that patient evaluated and treated.

And I've always recognized that in any setting, you know, we have a tendency to advocate towards certain patients. And in the public health setup which I came up in, you know, we had nurses with different levels of skills and expertise, whether it was in diabetes or whether it was anxiety, whether it was in substance abuse and we work as a team to help our patient. But one of the keys is educating providers on risk factors and screening tools. Postpartum toolkit has just been released to go along with the document on optimized and postpartum care that was released in May. And that toolkit will allow the providers of care to really be able to have almost a step-wise approach to what to do about various types of things. It also allows us to be able to do intussusception discussions on the impact of pregnancy for those with preexisting mental health disorders and add to this substance abuse. Next slide.

So keep in mind that also depression is associated with bad habits, cigarette smoking, substance use, concurrent medication use. And of course, one of the things that we're very concerned about now we're rewriting definitions about maternal mortality is a whole issue of suicide, particularly as it relates to substance abuse and postpartum depression and all these relevant cases that we have to keep in mind. So depression, poor prenatal care, self-neglect and yes, suicide, especially important when patients are codependent on depression and also drug-related potential deaths. Next slide.

So now I don't have to tell you all that opiate addiction has become a problem around the world, but mostly in the United States, because we prescribe most of the opiates in the world, over 90%. And it's also as much of an issue in the postpartum patient. And what we've done now is that we have a tendency to prescribe a lot of opiates after the cesarean, but also prescribe method vaginal deliveries, which almost never happened when I was a trainee and so forth. And so for aiding in early days of practice, I'm not quite sure how we got there. But it does pose significant challenges in medical behavior care and in follow-up. So patients who are either on maintenance therapy because of narcotic addiction or patients who are difficult to manage because of that pain postpartum need early follow-up, need early follow-up. Because they are likely to get addicted to the medication that they're on.

The neonatal abstinence syndrome is now leading cause of admissions to the neonatal ICU. And what I found is that there's a profound amount of guilt that these patients have when they're dealing with their patients and their children. And many times, the children are still in the nurseries, so it's very important to follow them up early, talk to them, begin to kind of help them to come to grips with the situation, especially if they are visiting the baby in the nursery. And in many instances, they may lose that child to Child Protective Services, even if it's illegal drugs that they're dealing with. And those are the challenges they have. And without a method of contraception that's discussed with them, what do you find that many of them, if they don't follow up when they come back with an early pregnancy.

So early postpartum follow-up and long-term follow-up is critical to the prevention of maternal mortality in this group of individuals. And I will call out a program in Tennessee that really does do about a year of follow-up for these patients, run by my colleague out of Knoxville, Craig Tower, a very, very solid and very strong program for patients who have, you know, narcotic addiction. Next slide.

So we have seen a decline in deaths from suicide following the introduction of national guidelines for making recommendations for treatment. And of course, it's always the big issue. Almost, I lost my computer. I'm again. Okay, I'm back on. So you can see how the suicide deaths per 100,000 live births having indeed going down. And that's because we are doing a better job and hopefully can even do a better, better job with early detection of depression and early detection of associations between substance abuse and so forth and the impact on the suicide rates. Next slide.

Now I want to turn our attention to something that you all know at Healthy Start and that's breastfeeding. Because you can see what the breastfeeding rates are by race and by age, and you can see younger women have a lower rate of initiation and continuation of breastfeeding. Non-Hispanic whites, Hispanic, non-Hispanic blacks have the lowest rates. And then you talk about Latina women having some of the higher rates, but again, you get the mixed messages there because it's breast and bottle feeding. And in many instances, we have to begin to kind of do a better job of education, and particularly for women who are African-American who have the highest risk. And this is where early postpartum follow-up and really support for breastfeeding continuation are so important. Next slide.

So rates of exclusive breastfeeding between three and six months' time, the lowest among black women and their infants who are young, unmarried, had lower incomes that were less educated or living in rural areas. So I think you're

getting it. If we can have ways of connecting with those women earlier, we have a better chance of even convincing those women that yes, they can still pump their breast, save their milk, feed their baby, as we do with men and women who are nurses and colleagues of mine who are back at work. And of course, we now have lactation rooms, all of our facilities are for those women so that they could do that and improve their, you know, to help with their children long term.

Next slide. Breastfeeding infants self-regulate. They have early program and a separate regulation. They have less adult adolescent weight gain and less obesity long-term. Next slide.

The issue of the longer you lactate, the lower your risk of cardiovascular disease in postmenopausal women is illustrated in this slide right here where you can see that for women who have breastfed for over 24 months, there's a significant relative risk for them having a lower rate of cardiovascular disease compared to women who have never breastfed. And so those are very important issues, especially if you have hypertension, diabetes, and hyperlipidemia. Next slide.

So women with a history of preeclampsia, did you know they have a four-fold higher risk of the incidence of hypertension later in life, a two-fold elevated risk of heart disease, stroke, and venous thromboembolism. So counseling for those patients in the early postpartum period not to scare them, but to talk to them a little bit about follow-up and how important yearly follow-up is. Because if they present, you know, four or five years later and their blood pressure are elevated, it's real, it's not preeclampsia comeback, it's real. And getting that patient on an appropriate plan where she's actually medicated probably early based on the new hypertensive guidelines, even if she's not planning to have another pregnancy is very important. Next slide.

So these are the ACOG hypertension in pregnancy with recurrent preeclampsia, preterm birth and fetal growth restriction. All the things that we're concerned about, the cardiovascular risk later in life is comparable to obesity and smoking. So ACOG clearly recommends and you should follow up your patients that you've seen in Healthy Start. They need to have an annual blood pressure. They need to have a fat and glucose and lipid and BMI checks almost yearly so that they can make sure that they make the lifestyle changes. And one of the things that you and I both know, we've talked to our patients about achieving a healthier weight between pregnancies. Now how are you gonna do that if they don't come in for their postpartum visit and their postpartum follow-up. And you know that 60% of the patients that you all see and I see are either

overweight or obese. And so counseling the most achieving a healthy weight really improves their overall health and their overall outcome. Next slide.

So talk about pregnancy and future health. Gestational weight gain is associated with obesity and this slide is off a little bit. And gestational diabetes is associated with type-2 diabetes and adverse pregnancy outcome. Next slide.

So it's interesting the more weight you gain, the more you retain. And again, this is why we talk about trying to achieve a healthy weight between pregnancy. If you look at this slide, again, women who are underweight, women who are overweight already, where you see in the darker bar, those women 20 years later, 3 years later, 1 year later, 15 years later, continue to be overweight. And I think again, counseling women on how to do that is very important.

And when I was running my postpartum clinic, I think our discomfort with talking to patients about them being overweight and making recommendations sometimes gets in the way of us really doing the right thing. And the idea is we are assuming, again, one of those biases that the patient wants to be that heavy. And I've tried myself to appropriately refer patients with bariatric care who really have extreme BMIs and I've never had one yet to turn me down. And that's amazing because I said, "You know, you had some serious complication with your pregnancy, cesarean, you know, wound separation, would you like to, I know you tried to lose weight." I'm just going to assume those things when I'm talking to her. And her comfort was saying to me, "well, I've tried to get referred but Medicaid doesn't pay for it." But lo and behold, Medicaid does pay for it in most states with a comorbidity and I explained to them and have one and we can get them to referral. And that makes all the difference in the world.

So you have to ask. And part of our hope postpartum tear off sheet is for the patient to be able to do checks to see what are the things that are most concerning to me today when I come in for my postpartum visit, and then she does that herself. You and I both know that so much care is fragmented, who delivered the patient and don't like to see them postpartum. In the reference system, you may have a better shot that the same person is following up, but we live in the world of group practices. And so your comfort level with your patients has become challenged over the years, which is one of the things that I really have been very, very concerned about. In a public health clinic facility, it seems that the providers are more consistent and that's where I think we have more opportunities. Next slide.

Weight gain is associated with increase of cancer and the mitral cancer, you know, breast cancer, all those types of things are very important. And again, it's also associated with the cycle of obesity in children. And so if you'd give the

patient the breastfeeding insurance policy, where it decreases their risk of neonatal infections, but also there are lower risk for hypertension and diabetes later in life, it can even overcome some of the environmental things that you're dealing with, such as the McDonald's and so forth and so on. But if it becomes a family issue, eating healthier, it becomes much better. Next slide.

So 30% reduction in incidence of type-1 diabetes, a 40% reduction in the incidence of type-2 diabetes with breastfeeding. I think you're getting it again when we're talking about early follow-up and encouragement about continuation of breastfeed. Next slide.

The type-2 diabetes does occur in about 70% of women with gestational diabetes. It may be influenced by race and ethnicity. We know that Latino women have a tendency to develop gestational diabetes a lot earlier, maybe five years after the index pregnancy. So while we're not following them up, that's the challenge. See the next slide.

This is what we recommend that screening for gestational diabetes, and I think we remember again, the reason we screened for diabetes is to predict the long-term risks of diabetes, not whether you're going to have a big baby or not. And patients who are not aware of that really, our physicians, our providers are not aware of that, do us all a disservice. So we recommended that we do the follow-up screen between 4 and 12 weeks, but look at the next two references, 500,000 women in 50 states, 7.2% had gestational diabetes and 75% had no follow-up within a year. And that's not good, that's not good. So we need to make sure we screen our patients in the windows that we talked about. Next slide.

Get to the end so we can get to questions. So risk factors for cardiovascular disease, you see them there, age, weight, smoking, fetal growth and preeclampsia. Next slide.

And then preterm birth is associated with increased risk of cardiovascular disease as you can see. Next slide.

So the components of the postpartum plan to visit, time and end date and location, first follow-up visit between two and four weeks. Now I believe that we need to make the postpartum visit at the time of the last prenatal visit. So if we put it within a window of the planned delivery, the chances are pretty good it's going to fall off in the right time. But if we discharge the patient, tell her to make a phone call to follow up, maybe she doesn't have a phone, maybe she lives in a remote area. Maybe she can't get through to the line. You and I both know how hard it is to get into the appointment line to do different types of things. I even hated myself. What's going to give her a reason to do nothing but

hang up? We need to give her that appointment certainly and then emphasize that appointment at the time she's discharged from the hospital. An infant feed plan or reproductive life plan, pregnancy complications discussions, natal health and substance abuse, postpartum problems she may encounter, chronic health conditions and achieving a healthy weight. Those are the components of a postpartum plan. Next slide.

Innovation in healthcare delivery through telemedicine, teleconsultations for inpatient and outpatient management. And the obstacles we have some time to implementation. We've just published our telemedicine taskforce guideline and you can see that it really will help us to be able to take better care of our patients. We have to overcome some of the cost and reimbursement issues they would need to deal with. Next slide.

So candidates for early postpartum follow-up again, we know we ought to be seeing the hypertensive patients. We know we ought to be seeing the patient with the risk of postpartum depression. We want to be seeing those patients who've had a cesarean, those with like patient challenges. Those with perennial injuries and those with chronic conditions who have various medications. And I would say those with the near-miss event, such as a hemorrhagic event. Next slide.

We have to begin to think about health policies covers beyond six weeks for the women who I want to come back for another visit at three months, which is a time for that well-woman says it, that seamless handover of care from prenatal to a hospital to the postpartum follow-up providers. We've got to talk to educational providers, the public and the payers who got to monitor, incentivize compliance and we've got to fund research to improve lifelong health in women. And so that really it is the objective of us improving postpartum care, improving long-term care, but improving the links between maternal morbidity and mortality. Next slide.

Redesigned the visit. Look At the six-month visit for all women with complications, videos, telephone, health promotion. Talk about the guidelines. Go from there and recreate the guidelines for our colleagues. And include the pregnancy risk factors on the medical history. Next slide. Thank you. So with that, I'll turn it over to your facilitators if there are questions.

Megan: Yeah. Thank you so much, Dr. Brown, for that presentation. So informative. Group, if you have any questions, chat them into the chat box now. We have about close to 10 minutes left for some Q&A. Feedback about being a great presentation.

Dr. Brown: Well, thank you, Kathrine, for saying this is a super presentation.

Megan: Well. And another person echoed that

Dr. Brown: I just want you all to get out there and spread the word because you will see, you in the Healthy Start world have been our best friends with regard to these types of things. We can do so much for our patients even if we do them just with the patients that we see. And then telling the patients that you say, you know, you really need to have an early postpartum visit. That patient goes in and tells their provider, they told me I needed to come back and see them in two weeks, not six weeks. Bam, what do you do? You have educated the patient and you also educated why she should come in.

Megan: Well, and you know, I really appreciated how you actually demonstrated how you counsel a patient regarding weight gain and how you framed that. I think that was very meaningful. Here's the question, from Maxine Reed-Vance. Postpartum visit in conjunction with infant immunization visits. Well, it's a statement, I don't know if you want to share any insights on that as being an important…

Dr. Brown: Absolutely. And I will tell you that that's the public health facilities, so they're experimenting with that now where it's harder to do it in a private physician's office unless you have this whole setup where you have a, you know, a group. But yes, coordinating these visits now with the Well-Baby Visit is helpful. If you can do that and you have a team-based care approach to it, child's come in with immunizations, you should schedule them at the same time, you can almost do one-stop shopping, you know. Patients get these mixed messages about the fact that the baby's not getting enough milk and so forth and so on. Between the pediatricians and the obstetricians, there ought to be someone who has some expertise in lactation.

And I tell people all the time, one of my nurses has always been a lactation specialist. I'll put her on the phone with the patient right away. Have the patient come in and maybe get. But you have to also make the time. You have to make the times for the adjustments and that schedule. Keep in mind that patients, sometimes they're driven, they've been in clinic all day, they've seen two providers, whose visit are you going to skip? The baby's visit or your visit. It has to be very, very seamless. And since most women are not necessarily needing a pelvic exam, the time in the postpartum period is really meant to be talking and counseling.

Megan: Here's a question. Are there certain things home visitors should or could look at, look out, which may be indicative of peripartum cardiomyopathy or other cardiovascular risks?

Dr. Brown. Yes. In fact, you know, most patients should get rid of their edema. And think about just looking at the patient and seeing or asking her whether she's actually been able to get rid of her fluid weight. And if the patient says, you know, "I can barely make it around. I've got all this fluid. I just feel so tired. My heart seems to be beating so fast." Those are classic signs. Seeing is believing. Seeing is believing. And no one may have made that observation and pressure the patient has had, a pregnancy complication like preeclampsia, which is one of the things that may, you know, that patients ultimately come back in with heart failure. Within two to three weeks who will develop a cardiac biopsy. So if you're doing a visit and you have the luxury of doing that, you're going to pick up on those type of things and say, you know, maybe we want to have you go in and be checked.

I love the home visit, but that's also why I like the facetime visit, you know. Most of the time you do facetime the patient is just, oh, so happy, she's chatting, and you for that patient you can hang up and say, "Okay. It looks like you are really doing great. We'll see you when you come in for your postpartum visit." But for the other patient, you can see her, you can tell she's depressed. You can tell she's worn out, you can tell that she's absolutely a mess. And if you have rapport with her, she's like, "Don't say, you know, I'm a mess, I'm having issues." But you know, we've got to care enough to care.

Megan: I like that. So here's the question you mentioned centering pregnancy and so this person wants to know a little bit more about the benefits of group postpartum care. So how's the postpartum visit handled in group care and do participants get individual visit or does the group reconvene for postpartum check? Can you share a little more on that?

Dr. Brown: Well, it's interesting because you can do exactly the same thing for postpartum, particularly when it comes to education on certain topics. And then you could individualize for certain types of things like we do prenatally now if the patient has a need for an examination beyond that or she has personal things that she wants to talk about. But one of the things that centering does it allows you to be able to talk about the bigger things a little bit more openly, so you don't feel like you're calling on people. If you're talking about achieving a healthier weight between pregnancies, finances. If you're talking about, you know, pregnancy spacing, if you're talking about, oh, by the way, you had a cesarean, maybe you have opportunities to VBAC. If, oh, you know, these are

the signs and symptoms of postpartum depression. Those patients are looking at each other.

If they'd been in the same centering group, they've gotten to know each other a little bit and then they have a tendency to say to each other, "You know, maybe you go talk to Dr. Brown. It sounds like you may be having more problems." And keep in mind this is so important for patients. We used to do this for diabetes education all the time. We had a diabetes clinic. We actually did it as a group. And I remember very well my patients would say, "Oh my goodness, Dr. Brown is going to be so upset with you and your blood sugars." And I say, "You're probably right." I am going to be like, "So you've been really messing up." And the patients would tell each other those types of things. Again, it was my clinic. I was seeing them almost every time. And that was the consistency behind what we used to do. You have a lot of inconsistencies in the care now. So it really does not, but you can still do that in many of the environments because the providers in most facilities are the same, particularly in rural access clinics.

Megan: Let's do one more question here. So this person shares that, we encourage and educate our patients about early postpartum visits, but if providers continue to contradict us and schedule them until six weeks after delivery, how can we assist them then?

Dr. Brown: Amen. There you… So here is the issue, now I have released two documents now talking about early postpartum care and redesigned the postpartum paradigm. And I actually passed it out at a conference that I was doing last week down in Sarasota, Florida. I asked the providers, how many of them seen it. Not so good, right? And then I started talking to the nurses who were in the audience. And I said, "Well, here's a copy for everybody." So when you are rounding with your doctor tomorrow in the hospital, tell them you've heard Dr. Brown say, "You know, she needs to come back sooner." Tell the patient that. And, oh, by the way, get on the phone with her and help her to do it. But that's not my job. Well, you know, the bottom line is education, so we are going to have to educate the patients and the public and the policymakers about this. The insurance companies who will also emphasize these types of things is going to be a group effort. And I would tell you that it's not necessarily going to be easy, but I know I can count on you all in the Healthy Start world to start telling those patients the next time you see them, like tomorrow.

Megan: Very much so. Well, Dr. Brown, let's check in. Potentially if someone has a comment or question they can chat them in and potentially we could follow up. But let's revisit those two questions we did at the beginning to see if anybody's responses have changed. So the knowledge check question was

almost 25% of maternal deaths are due to unmet need for contraception. Is that true or false? Responses are coming in. And you know, as the responses come in and we tally them, I wanted to share also one of the things you highlighted Dr. Brown with telemedicine. We are looking at doing a webinar on telemedicine in the context of Healthy Start, and related to Healthy Start. So I feel like you set that up beautifully for, you know, in the context of maternal mortality too. So we'll be revisiting that topic as well.

Okay. So it looks like a lot of folks did shift their response and it is a true. The answer was true and Dr. Brown did share some information on that. Okay. Here's the second question folks. Ramifications of lack of postpartum follow-up include contributes to health disparities, pregnancy spacing, undiagnosed, postpartum depression and anxiety disorders are all of the above. All of you said, it seems like it's a similar response to last time. So let's just skip to the results. It's all of the above. That's correct everyone. And so last thing I was gonna share is just a couple of upcoming discussion groups that we have the discussion group for certified lactation counselors going on October 11th. It was the timeslot is cut off here.

Dr. Brown: Perfect timing for me to talk about that. I love it. Very good.

Megan: Perfect timing. So it's from 3:00, actually it's 3:00 to 4:30 Eastern Time and you can email the Healthy Start inbox if you want to find out, but it is for those CLCs, those that are trained for CLCs. And then we do have another, the second of the discussion group on fatherhood and male involvement that's on schedule for October 16th. And then the third one would be November 20th. And those are set for 1:00 p.m. to 2:30 p.m. Eastern Time. And one other thing I wanted to share, we will be releasing a maternal mortality resource package for Healthy Start. It's coming up and it'll be posted to our website by the end of this month. So look out for that. We'll put that in our training alerts as well, so you all know when that resource is available. And Dr. Brown, I don't know if those two documents, you said you shared it at the conference are available that we could post on our Epic Center website. If they are available, I can connect with you later on that.

Dr. Brown: Absolutely. The postpartum ACOG committee opinion was published in May, so it is readily available now. The postpartum toolkit was just released this morning and I can send you the links to both of those so that you can have them, and you can post them on your website.

Megan: Wonderful. I'll definitely do that. And I'll follow up to this. I'll send an email out to all of you who've registered for this with those two resources that were shared. I just would like to say on behalf of the Epic Center and Division

of Healthy Start and Perinatal Services, Dr. Brown, thank you for sharing your wisdom with the group today. We really do appreciate it. And your presentation, it was wonderful. And as you can see in the chat box, so folks were saying that as well.

Dr. Brown: [inaudible 01:01:10] accolades, oh my goodness.

Megan: That's wonderful.

Dr. Brown: A mother would be very proud.

Megan: Thank you.

Dr. Brown: And thank you all again, this is just another way for us to educate other things that we're doing and you are the front line of making sure that patients receive the kind of care that we want them to receive.

Megan: Great. Thank you so much, and thanks to you all for participating and taking time out of your day today. So this concludes our webinar for today.