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Bridging the Chasm between Pregnancy and Health over the Life Course: A National Agenda for Research and Action

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Abstract

Background: Many pregnant people find no bridge to ongoing specialty or primary care after delivery, even when clinical and social complications of pregnancy signal need. Black, indigenous and all other women of color are especially harmed by fragmented care and access disparities, coupled with impacts of racism over the life course and in health care.

Methods: We launched the initiative "Bridging the Chasm between Pregnancy and Health across the Life Course" in 2018, bringing together patients, advocates, providers, researchers, policymakers, and systems innovators to create a National Agenda for Research and Action. We held a 2-day conference that blended storytelling, evidence analysis, and consensus building to identify key themes related to gaps in care and root causes of inequities. In 2019, more than 70 stakeholders joined six working groups to reach consensus on strategic priorities based on equity, innovation, effectiveness, and feasibility.

Findings: Working groups identified six key strategic areas for bridging the chasm. These include: 1) progress toward eliminating institutional and interpersonal racism and bias as a requirement for accreditation of health care institutions, 2) infrastructure support for community-

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Author Descriptions

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Judith Bernstein, RNC, PhD, is Professor Emerita of Community Health Sciences, Boston University School of Public Health. Her interests include access to quality care for reproductive age women and long-term consequences of pregnancy events for women's health over the life cycle.

The 70 Bridge the Chasm (BtC) Collaborative members include patients, advocates, clinicians, researchers, health care innovators, and policy experts, whose affiliations are noted. They bring extensive expertise in women's health reflected in the BtC National Agenda for Research and Action presented here.

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based organizations, 3) extension of holistic team-based care to the postpartum year and beyond, with integration of doulas and community health workers on the team, 4) extension of Medicaid coverage and new quality and pay-for-performance metrics to link maternity care and primary care, 5) systems to preserve maternal narratives and data across providers, and 6) alignment of research with women's lived experiences.

Conclusions: The resulting agenda presents a path forward to remedy the structural chasms in women's health care, with key roles for advocates, policymakers, researchers, health care leaders, educators, and the media.

A distinct, siloed system of maternity care exists to optimize the health of pregnant people during pregnancy and to achieve the birth of healthy infants. The structure of specialties (e.g., obgyn vs. internal medicine) and differences in clinical training, reimbursement policies, and quality metrics limit focus to pregnancy and the immediate postpartum period. Such an approach perpetuates the division of women's bodies into "reproductive" and "other" parts, forcing women to switch back and forth between distinct and largely non-communicating specialties and care settings with little continuity of care. Whereas pediatric well-child care sustains attention on the health and development of infants, no such system exists to support women's health after the official postpartum period (6–12 weeks). Despite calls for inter-conception care (Johnson et al., 2006; Weisman, Chuang, & Scholle, 2010), once the immediate postpartum period ends, new mothers typically find that they are without a bridge to primary care for themselves (Bennett et al., 2014) and have few, if any, practices and policies to protect their health going forward (Johnson, Applegate, & Gee, 2015). The recent initiative of the American College of Obstetricians and Gynecologists, "Optimizing Postpartum Care," (American College of Obstetricians and Gynecologists, 2018) is the first step towards expanded postpartum care (it calls for multiple visits in the "fourth trimester"), but does not address the chasm between maternity and primary care.

Research has demonstrated that pregnancy is a form of stress test, predicting future challenges to a woman's health. Complications such as gestational diabetes mellitus (GDM), pregnancy-induced hypertension, depression, and substance use disorder point to the risk for future chronic illness (Allalou et al., 2016; Honigberg et al., 2020; Seely et al., 2020). For example, women with GDM have 10 times the risk of developing type 2 diabetes (9.51; 95% confidence interval, 7.14–12.67; $p < .001$) as healthy controls (Vounzoulaki et al., 2020) and have a two-fold higher risk of cardiovascular events in the following decade (Kramer, Campbell, & Retnakaran, 2019). Despite these alarming statistics, women worldwide with a history of GDM continue to have low rates (20%–55%) of recommended follow-up glucose tolerance testing and monitoring (Shah, Lipscombe, Feig, & Lowe, 2011). In the United States, this gap is further exacerbated by racial and ethnic inequities in health care (Martin et al., 2018; McCloskey et al., 2019b). Black, Latina, and Native women are least likely to be tested and followed despite their disproportionate risk of type 2 diabetes (Jones, Hernandez, Edmonds, & Ferranti, 2019). These observations highlight the asymmetry between the significant attention to and investment in pregnant people aimed at healthy babies versus the under-investment in women's own health and well-being before, between, and beyond pregnancy.

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Fragmentation in women's health care can only be understood and addressed through the lens of health equity, racial and social justice, and human rights, paying attention to both upstream and downstream effects that require comprehensive solutions. Structural and interpersonal racism, experienced in communities of color across the life course, affects health status and ability of the immune system to respond effectively to challenge; this is the upstream story that requires a racial and social justice lens. Then discontinuities and fragmentation in systems of care combine with concrete barriers of access to further reduce the likelihood of positive health outcomes; this is the downstream story that requires a health equity/human rights lens. For example, compared with their White and Latina counterparts, Black women experience twice the rate of severe maternal morbidities and three times the rate of pregnancy-related deaths (Eichelberger, Doll, Ekpo, & Zerden, 2016), with one-third of the deaths occurring in the extended postpartum period (between 1 week and 1 year after birth) (Petersen et al., 2019).

Structural racism (Bailey et al., 2017; Garcia & Sharif, 2015; Hardeman et al., 2016), implicit bias and unequal treatment (Collins et al., 2000; Dominguez, Dunker-Schetter, Glynn, Hobel, & Sandman, 2008; Mustillo et al., 2004; Vedem et al., 2017), and well-documented inequities in health care access (Institute of Medicine, 2012) are important determinants of these adverse maternal and infant outcomes. The interpersonal and institutional racism historically embedded in the medical system (Bailey, Feldman & Bassett, 2020) and the lack of culturally and linguistically appropriate services for Latinas and women of other ethnicities lead many women to avoid care or seek care in other ways (Timmons, 2002). National Culturally and Linguistically Appropriate Standards were instituted in 1995 and affirmed again in 2020 (Office of Minority Health & U.S. DHHS 2020). This set of 15 action steps was intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. However, application of these standards has been slow and spotty, and there are no penalties for violations (Diamond, Wilson-Stronks, & Jacobs, 2010). The lack of access to respectful and equitable care, to well-matched, diverse providers, and to adequate health care resources in segregated urban areas and many rural communities in the United States contributes to longstanding health inequities between Black, Latina, and Native women and more privileged and resourced White women (Cyr, Etchin, Guthrie, & Benneyan, 2019; Kozhimannil, Hernandez, Mendez, & Chapple-McGruder, 2019).

Remedies have not yet emerged for the siloed nature of women's health care and the manifestations of systemic racism within maternal health care in particular. Clearly, such remedies must be multifaceted to: 1) address fragmentation, especially the lack of continuity when women transition from pregnancy to care across the life course; 2) undo institutional and interpersonal racism that produces unequal treatment and inequitable outcomes; 3) center the voices of birthing people in the design of health services/systems, research projects, and policies intended to serve them (Vedem et al., 2019); and 4) translate into action what we now know about links between pregnancy complications and health across the life course.

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"Bridging the Chasm (BtC) between Pregnancy and Women's Health across the Life Course" was conceived and implemented as a national initiative to engage advocates, patients, clinicians, researchers, policy makers, and health system innovators to forge a path towards holism, continuity, and equity in women's health care, with a focus on the period after and between pregnancies with particular attention to the needs of Black, indigenous and all other women of color (BIWOC). The overall aims of this project were to 1) form a network of diverse stakeholders to collectively create an Agenda for Research and Action to Bridge the Chasm (referred to hereafter as the Agenda), bringing together all forms of expertise, and 2) set the stage for policy, research, and practice changes needed to create a coherent, holistic, equitable health care system and experience for all birthing people across the life course.

BtC was conceived and carried out as a "women's health initiative"; as such, we largely refer to "women" and "mothers" throughout this article. We recognize that transgender and nonbinary people who experience pregnancy are all too often invisible, inadequately cared for, and discriminated against before, during, and beyond pregnancy (Hoffkling, Obedin-Maliver, & Sevelius, 2017); thus, we also use the more inclusive language "birthing people" or "pregnant people." The BtC Agenda applies to all birthing people.

Methods

To produce a strategic path that could lead to a sustainable movement for change, we adapted an existing systematic consensus-building methodology and implemented it in an iterative fashion. The manual Seeds for Change (2013), designed for cooperatives and communities, operationalizes the directives for consensus building put forward in *Principles for Community Engagement* (Centers for Disease Control and Prevention, 2011). Table 2 chasms in women's health care, took to adapt and implement the model in a three-phase project over a two-year period.

In Phase 1, we recruited the BtC Stakeholder Engagement Leadership Council (SELC), consisting of community and advocacy organizations and academic partners whose missions aligned with BtC, to plan and guide the project. We selected organizational partners for the SELC that would represent each of the key stakeholder "sectors" that BtC sought to engage: patient engagement and advocacy (Black Women's Health Imperative, Diabetes Sisters, National Alliance for Hispanic Health); health systems innovation (Primary Care Collaborative), federal policy-makers (Office of Research on Women's Health); and cross-specialty clinical care (Boston University Schools of Medicine (ob-gyn and primary care), Public Health, and Social Work; and communication and theatre art specialists). Members of the SELC are starred in Table 2. We conducted a systematic review of literature describing gaps in health care following delivery, with a focus on the impact of pregnancy complications on women's ongoing health status and access to care. The review focused on gestational diabetes as the case in point. We selected GDM for reasons noted in the introduction—its relevance to women's longitudinal health and missed opportunities for prevention, the disproportionate toll on Black, Latina, Native and Asian women and the need for systems change to break the cycle of risk. See www.pcori.org/research-results/2017/

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bridging-the-chasm-be-tween-pregnancy-and-women's-health-over-the-life-course for the full report of the literature review methods and findings.

In Phase 2, we convened a 2-day BtC conference that engaged a diverse network of 75 stakeholders (advocates, patients, clinicians, researchers, policy experts, and health care innovators) to co-create the outline for the National Agenda for Research and Action. Each organizational member of the SELC invited constituents to the conference to assure equal participation across all stakeholder groups. The conference attendees included 17 patient representatives, 15 academic researchers, 10 members of health care advocacy organizations, nine government and non-governmental policy and funding agency representatives, and six members of health care transformation organizations, in addition to SELC members and eight theater artists and documentarians. A full list of attendees is presented in Table 1. The conference was supported by funding from the Patient Centered Outcome Research Institute (PCORI) Eugene Washington PCORI Engagement Award, and two agencies of the National Institutes of Health: the National Institute of Diabetes, Digestive, and Kidney Diseases and the Office of Research on Women's Health.

Table 2 details the conference methodology. Day 1 began with short welcome and keynote talks, proceeded with improvisational theatre activities to engage and build trust among participants across stakeholder groups, and culminated in the sharing of stories crafted in workshops. Day 2 began with highlights from the annotated bibliography that had been distributed prior to the conference and proceeded with roundtable discussions to generate ideas for strategic approaches to bridge the chasm. Conference leaders gathered and clustered the ideas into 11 approaches, and participants joined roundtable discussions to identify strategic priorities for each. The process resulted in a framework for the Agenda.

In Phase 3 (Year 2) we clustered the approaches identified at the conference and convened 70 stakeholders (a mix of conference attendees and new recruits) into six working groups (Table 3). We created an online portal to serve as the communication hub for the ongoing work of BtC. Each working group, co-led by two members of the BtC Collaborative, included volunteer representatives from all stakeholder groups. Working group facilitators are designated by a "+" in Table 1.

Each working group held five conference calls over 5 months and advanced the Agenda through a consensus process to create 1) a problem statement, 2) a synthesis of findings based on an analysis of peer-reviewed and gray literature and key informant interviews, 3) a ranked order list of the strategic priorities to constitute the Agenda for Action and Research to Bridge the Chasm. Refer to Table 2 for details on the methodology.

Working group members deliberated on the merits of strategies based on four criteria: promotion of health equity, effectiveness, innovation, and feasibility. Following the rigorous process of evidence review and synthesis, we used a two-tiered Qualtrics survey process to elicit from all working group members their ranking of proposed strategies based on four criteria: likelihood of increasing equity, effectiveness, level of innovation, and feasibility. In the final step, we held a conference call with the SELC members and working group facilitators to review survey results, refine the groupings of highly ranked priorities, identify

strategies that cut across working groups, and sort strategies by who (which constituencies) could act on them.

Results

We describe here the final planks of the BtC Agenda. Within each, we present the specific strategies that the WGs identified as having the greatest potential to achieve the desired transformation of the health care system for women's care, with the justification and evidence base for each. See www.pcori.org/research-results/2017/bridging-the-chasm-between-pregnancy-and-women's-health-over-the-life-course for the full report of BtC deliberations. Table 3 presents the detailed actions for each of the strategic priorities below. The first two planks presented here are fundamental to each of the planks and strategies that follow.

Eliminate Disrespect and Bias in Health Care

> Ensure accountability to principles and practices of anti-racism at interpersonal and institutional levels among all professionals (clinical and administrative) in maternity and primary care, through design of a longitudinal, experience-based curriculum with ties to accreditation and quality metrics.

Rationale

There is extensive evidence that unconscious biases can lead to differential treatment of patients and affect health outcomes (Hall et al., 2015; Institute of Medicine, 2003; Joint Commission, 2016). Discrimination by race, gender, weight, age, language, income, and insurance status results in overuse and underuse of services; affects patient safety for Black, Latina, Native and Asian women and immigrants (Cooper & Roter, 2003); and creates physiologic inflammation that leads to or exacerbates chronic illness in later life (Slopen et al., 2010; Sullivan et al., 2019). Evidence of racism and disrespect of Black women in maternal health care, with its dire consequences, has been laid bare by investigations of maternal and infant deaths (Martin & Montagne, 2017; Taylor, Novoa, C., Hamm, & Phadke, 2019). Tackling disrespect and racism within maternal health care and establishing a culture of equity and safety is a prerequisite to other meaningful structural changes. Accreditation bodies are already considering steps as proposed by Hardeman, Medina, and Boyd (2020) to divest from racial health inequities, desegregate the health care workforce, make mastering the health effects of structural racism a professional medical competency, and mandate and measure equitable outcomes.

> Regulatory bodies (e.g., the Accreditation Council for Graduate Medical Education, the Accreditation Commission for Education in Nursing, the Commission on Collegiate Nursing Education and others) should engage recognized experts in health equity to develop a mandatory competency-based longitudinal professional training curriculum as a precondition for accreditation, and require continued demonstrated progress and accountability for the elimination of all forms of institutional and interpersonal racism and bias in policies and in clinical practice.

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Invest in Communities and Community-Led Organizations

> Provide sustainable funding and technical support for community-based organizations (CBOs) run by and for BIWOC and dedicated to the health of women.

Rationale

CBOs are well-situated to support women across the chasm between pregnancy and ongoing health, and to partner with policymakers and researchers to find solutions. Small- and moderate-sized CBOs are at an enormous disadvantage when competing for limited financial resources. Both public and private funding streams are limited, have restrictions, require data or evidence that is often out of reach, are geared toward larger and well-established organizations, and fail to cover costs of infrastructure building. Consequently, many CBOs fail to thrive, and the vibrancy and connectivity offered by community-centered organizations–especially those run by, for and with BIWOC–can be lost.

> The federal government should create a tax break to incentivize private and public funders to allocate a significant percentage of annual expenditures for capacity building and infrastructure development when they award grants that include partnerships with small CBOs. (“Small” is defined as an annual budget of <$1 million). Build capacity of CBOs dedicated to the health of BIWOC over the life course.

Rationale.

CBOs play a vital role in caring for and uplifting BIWOC voices across the life course. In particular, organizations that deliver care for birthing and parenting people are renowned for meeting critical needs that larger institutions cannot address. Organizations led by BIWOC, including midwives and doulas, that care for women and their families during and after pregnancy typically do so with holism, respect, and cultural dignity. They advocate for and support mothers, engage in community activism, and often struggle to raise funds and maintain their businesses. Examples include those in the BtC Collaborative, such as BoldDoula, Mother Earth Doula Care, iCare Connect Healthcare, Inc., Quietly United in Loss Together, Resilient Sisterhood, and many others with innovative pregnancy care models. Some wish to expand their scope of services beyond pregnancy, but the lack of infrastructure support makes if challenging to do so.

> Private foundations should fund a Center for CBO Capacity Building that would provide technical support to grassroots organizations owned or managed by BIWOC, whose missions relate to women’s health and well-being over the life course. The Center would also consolidate leadership, management, and grant writing resources currently available on the local level from nonprofits and universities, and it would connect CBOs to existing services.

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Health Systems Transformation

> Redesign health care delivery to address longitudinal women's health needs, re-imagining health systems and models of care to ensure continuity, holism, and equity.

Transform and extend the model of care

> Extend high-touch, comprehensive, collaborative models of care throughout pregnancy and the full postpartum year and beyond.

Rationale.—Comprehensive care models offered by collaborative teams with holistic and "high touch" approaches offer a pathway to equity and continuity for all birthing people, and are especially important for those with social and clinical challenges during pregnancy. "High touch" refers to models of care designed to offer frequent check-ins and support consistent with women's choices and needs, delivered by trusted caregivers. "Collaborative" encompasses integration, communication, and coordination across disciplines. Collaborative care has a long history in obstetrics, family medicine, and emergency medicine (Avery et al., 2018; Achkar, Hanauer, Colavecchia, & Seehusen, 2018; Institute of Medicine, 2011). Integration of behavioral health and primary care has also been a major focus (Green & Cinfuentes, 2015), yet integration and communication across specialties have been the exception in the chasm between maternity and primary care. Where team approaches do exist, they do not, in many cases, include practitioners with community-rooted doulas and community health workers (CHWs), who are critical to achieving equity in maternal health. The Black Mamas Matter Alliance sets the standard for holistic care for Black women who are disproportionately impacted (Muse, 2018). A robust body of evidence supports the safety and effectiveness of the womancentric nurse-midwifery model of care (Johantgen et al., 2012) as well as its value for continuity, cost savings, and patient satisfaction (Centers for Medicare and Medicaid Services [CMS] Findings at a Glance, 2019; Institute for Medicaid Innovation, 2020a). Collaborative teams that include nurse-midwives, doulas, and CHWs can extend care across the chasm, ensure standards of holism and "high touch," and position women for care across the life course (Celi et al., 2019). Racial and ethnic diversity among team members is especially important given the current lack of diversity among physicians and nurses.

> The CMS should incentivize collaborative, team-based models, using the competitive funding process for Accountable Care Organization designation and a cost containment bonus for Integrated Delivery Networks. These models should extend to at least a year post-delivery and ensure a warm handoff to a primary care home, particularly focusing on pregnancies complicated by social determinants and/or clinical complications.

> Build on successful models of group care to support mothers in the postpartum year.

Rationale.—Evidence is growing to support the effectiveness and benefits of group prenatal care in diverse populations (Carter et al., 2016; Catling et al., 2015). Group prenatal care reduces preterm birth and low birthweight (Cunningham et al., 2019) and provides

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greater satisfaction with prenatal care among women with Medicaid insurance (Abshire, Mcdowell, Crockett, & Fleischer, 2019), fosters mental health (Heberlein et al., 2016 Ickovics, et al., 2011; Kennedy et al., 2009, 2011), and improves outcomes for women with high risk profiles (Byerley & Haas, 2018; Ickovics et al., 2016), GDM (Schellinger et al., 2017), and opioid use disorder (Sutter et al., 2019). The largest study of group prenatal care for pregnant people with Medicaid insurance, *Strong Start*, had mixed results but found that costs, emergency room visits, and very low birthweight were lower for group care participants than those in individual clinical care with enhancements (CMS Findings at a Glance, 2019). CenteringParenting, an evidence-based two-generation intervention, emphasizes infant health and parenting challenges in the postpartum period. Studies of its feasibility and effectiveness are small and as yet inconclusive. Group care that focuses on the health, well-being, and self-care of women in the full postpartum year should be considered based on existing and emerging evidence.

> Medicaid Health Plans of America should develop and pilot a group model of maternal healthcare to be offered during the full year postpartum, geared to women's lived experience, information and story-sharing, follow-up of pregnancy complications, that assures connection to a primary care home.
>
> Build on the evidence-based patient-centered medical home model to create women's health homes to provide comprehensive primary care.

Rationale.—Patient-centered medical homes generally improve utilization, reduce cost, and enhance quality (Jabbapour, DeMarchis, Bazemore, & Grundy, 2017). The Veterans Administration is the only known system to implement patient-centered medical homes for women, offering multispecialty care coordination across time with reported success (Chuang et al., 2017; Clancy & Sharp, 2013; Yano et al., 2010). Key elements of the model include team-based care inclusive of CHWs; integration of physical, mental, and social health; quality metrics and system-level accountability; a systems focus on chronic illness and preventive care; accountability to specified populations; and a culture of patient-centeredness (Bodenheimer & Pham, 2010).

> Medicaid Health Plans of America should develop and pilot a Women's Health Home model that directly addresses equity, engages patients and community members in the design and local implementation of the model, and includes "community health doulas" and/or "community women's health workers" as full participants on the health care team. The model should be piloted and evaluated among women covered by Medicaid with an eye to eventually expanding to privately insured populations. This is particularly important in light of Medicaid's ability to demonstrate how doulas and CHWs can be equitably reimbursed and included in team-based care plans.
>
> Establish initiatives to support women's health in the postpartum year and beyond in communities where women live, work, and bring their families.

Rationale.—Reaching busy new mothers with resources and supports for their own health requires co-locating information and referrals where they already gather: at pediatric clinics

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(Verbiest, Bonzon, & Handler, 2016; Henderson et al., 2016), Head Start programs (Silverstein et al., 2017, 2018), and community locations such as places of worship and beauty salons (Linnan, D'Angelo, & Harrington, 2014; Campbell et al., 2007).

> Local and state public health departments should fund CBOs and advocacy groups to bring resources and information to mothers where they live, work, and gather with family and friends.

Workforce transformation

> Support and sustain the role of doulas and CHWs on clinical care teams across the chasm.

Rationale.—Doulas are widely recognized as community-rooted birth workers whose woman-centric, holistic approach to care is crucial for bringing equity to maternal health in the United States. Doula support during pregnancy, childbirth, and the immediate postpartum period is associated with improved overall satisfaction among mothers, reduced preterm birth and cesarean rates, increased breastfeeding initiation, improved parenting practices, increased mother-child interaction, and decreased postpartum depression (Bohren, Hofmeyr, Sakala, Fukuzawa, & Cuthbert, 2017; Campbell, Lake, Falk, & Backstrand, 2006; Fortier et al., 2015; Gentry, Nolte, Gonzalez, Pearson, & Ivey, 2010; Hans et al., 2013; Narvaez, 2018). Doulas, as well as specially trained maternal CHWs, can go on to play a vital role in the full postpartum year as mothers navigate both their own and their infants' health and connections to needed community resources. A rapidly growing grassroots movement is advocating for state and national legislatures to support doula care as a critical component of maternity care, including reimbursement at an equitable rate (Bakst, Moore, George, & Shea, 2020; Health Connect One, 2019). State Medicaid programs also have the authority to adopt this approach and an increasing number are considering doing so (National Health Law Program, 2019). Challenges to incorporating doulas in clinical settings include establishing state-by-state certification and training requirements and standards for reimbursement; reporting of best practices for adoption of doula care will be an important task.

> State Medicaid programs and health care institutions should support doulas as essential maternity care providers, increase reimbursement, and extend the role of doulas across the continuum from pregnancy through 1 year postpartum.

> Develop and implement cross-training models to prepare inter-professional teams to collaborate effectively and equitably together.

Rationale.—Interprofessional teams need interprofessional education (IPE) to work collaboratively together, because experiential training increases cohesiveness and ensures safety, quality, equity, and patient satisfaction. IPE training models are prevalent in emergency and family medicine residency programs (Achkar et al., 2018), and evidence suggests that team training enhances inpatient outcomes (Sobero, Farley, Mattke, & Lovejoy, 2008). The Blueprint for Advancing High-Value Maternity Care (National Partnership for Women and Families, 2018b) also recommended IPE. An experiential training model for IPE teams at the intersection of maternity and primary care is a key innovation for BtC; it

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must be coupled with evaluation of outcomes, because the evidence for change in practice behaviors after training is inconclusive (Kwant, Custers, Jongen-Hermus, & Kluijtmans, 2015). The engagement of doulas and CHWs in the cross-training is critical to ensure a culture of equity on teams and for patients.

> The CMS Innovation Center should incentivize academic medical centers to create and implement cross-training models for collaborative teams composed of Ob-Gyns, family practice physicians, nurses and nurse-midwives, physician assistants, and CHWs and doulas.
>
> Develop educational units required for licensure that link maternity care with primary care.

Rationale.—Primary care for women is limited by a shortage of primary care providers, especially women's health specialists; coverage barriers to seeking care; and chronic underinvestment (Zephyrin, 2020). Referral to primary care is an essential component of the postpartum visit after a complicated pregnancy. This requires providers to understand and convey potential future health concerns and assume responsibility for continuity of care (McCloskey et al., 2019a). Requiring modules for accreditation ensures that clinicians obtain necessary knowledge, although evidence that training modules lead to changes in practice behaviors is inconclusive (Kwant et al., 2015).

> All accrediting bodies for maternity and primary care training programs in medicine and nursing should require a creditbearing unit that ties together maternity and primary care for women.

Policy Supports to Support and Sustain Equitable and Quality Health Care across the Chasm

Medicaid policy reforms

> Expand Medicaid insurance coverage, payment, and benefits to support women across the full postpartum year.

Rationale.—As the insurer for almost half of all U.S. births annually (Centers for Disease Control and Prevention, 2011; Markus, Andres, West, Garro, & Pellegrini, 2013), Medicaid has a vital role to play in assuring continuity of coverage and care. However, women who are eligible for Medicaid only on the basis of pregnancy lose coverage after 60 days postpartum, and many lack another source of coverage (Equitable Maternal Health Coalition, 2020; Ranji, Gomez, & Salganicoff, 2019). Moreover, 4 out of 10 Medicaid beneficiaries do not have a postpartum visit in the 6-10 weeks after giving birth (Rodin, Silow-Carroll, Cross-Barnet, Courtot, & Hill, 2019). Medicaid coverage has a positive impact on timely use of prenatal care (Daw, Hatfield, Swartz, & Sommers, 2017; Johnson et al., 2015); extending coverage beyond the postpartum period may similarly allow new mothers to tend to their own health. A recent study (Gordon, Sommers, Wilson, & Trivedi, 2020) found that new mothers in a state without Medicaid expansion had greater loss of Medicaid insurance and fewer outpatient visits between 1 and 6 months postpartum, compared to counterparts in a state with expansion and lower rates of coverage loss at 60 days postpartum. The difference was greatest among those with chronic conditions. These

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findings point to the potential of this strategy to prevent maternal deaths. There is strong federal- and state-level momentum for this strategy, with support from the Equitable Maternal Health Coalition (2020) and at least six bills posted during the 116th Congress (Babbs et al., 2021; Black Maternal Health Momnibus Act, H.R. 6142, 116th Cong., 2020; Johnson et al, 2020). While insurance coverage is a necessary strategy to promote continuity of care across the chasm, it must also be accompanied by payment and benefit reforms (Johnson et al., 2015).

> The 117th Congress should pass legislation that ensures automatic, continuous enrollment in Medicaid through the postpartum year for all enrollees eligible through the pregnancy option, and reforms payment through an extended bundle or unbundled postpartum payment to optimize maternal health in year after delivery.

> Establish a mechanism to reward documented, effective referrals from obstetrics to primary care.

Rationale.—Health care transitions that are accompanied by clear communication with patients, between providers, and across systems lead to better processes of care, outcomes, and patient satisfaction. Evidence from the transition between adolescent and adult care (Schmidt, Ilango, McManus, Rogers, & White, 2020) and between cancer screening and treatment (Zapka et al., 2004) provide excellent examples. Maternity and primary care providers should be accountable for referrals between them (Kripalani et al., 2007). Such handoffs are an essential component of safe, preventive care for women after complicated pregnancies. Institutionalizing transition best practices through payment and quality metrics helps to ensure that warm handoffs become a standard of care. For practitioners, incentives have been shown to be more effective for changing practice than disincentives (Ashcroft, Silveira, & Mckenzie, 2016).

> The CMS should use its program authority to support the development, implementation, and evaluation of new ways to support linkage to primary care through pay-for-performance policies that reward: 1) warm handoffs between obstetric and primary care providers and 2) documentation of handoff in the medical record.

> Integrate social determinants of health into all aspects of health care during pregnancy and throughout the postpartum year through ACOs and Integrated Delivery Networks.

Rationale.—ACOs and Integrated Delivery Networks across the country are addressing specific social determinants of health (SDOH) issues (LaPointe, 2017; Center for Health Law and Policy, 2019), and existing models can be used as templates for the extended postpartum year (e.g., a preventive food pantry accessed by prescription at Boston Medical Center, employment and transportation assistance at Advocate Health Care in Chicago, a housing program in Hennepin County, Minnesota, and an Immigrant Medical Legal Partnerships in Nebraska.) The PRAPARE toolkit offers a map for SDOH risk assessment and implementation (National Association of Community Health Centers, Inc., 2019).

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The CMS should promote partnerships between ACOs and CBOs to address SDOH (see examples elsewhere in this article), using the Innovation waiver process.

Quality Measures

Address lack of quality measures specific to the transition from postpartum to primary care and to women's health care experiences.

Rationale

Quality metrics are integral to our health care system and its accountability to payers and patients; they play a significant role in the era of value-driven care and reimbursement. In maternal health care, quality metrics in the Healthcare Effectiveness Data & Information Set have been extremely limited, confined to measures of prenatal and postpartum care attendance. When measures are overly focused on easy-to-measure items or developed without patient and community input, they can lack meaning and be counterproductive (Saver et al., 2015). The National Quality Forum has convened a multistakeholder task force to recommend new measures related to maternal mortality and morbidity, and the National Birth Equity Coalition and the California Maternal Care Quality Collaborative are developing patient reported experience measures based on input from hundreds of BIWOC across the nation. The BtC Agenda calls for a cluster of measures that focus on continuity and equity across the chasm, can be built into or from existing efforts, and can have an impact on maternal mortality and morbidity in the extended postpartum period and on prevention of chronic illness.

The National Quality Forum should develop and Healthcare Effectiveness Data & Information Set implement new postpartum quality measures, including 1) completion of a glucose tolerance test for women with GDM within 1 year postpartum, 2) discharge with a blood pressure cuff for women with pregnancy-induced hypertension, 3) patient reported experience measure that captures patient experiences of respect/disrespect and implicit and explicit bias/fair treatment during prenatal, intrapartum and postpartum care, and 4) documentation of completed referral (warm handoff to primary care provider at the conclusion of postpartum care). Measures #3 (patient reported experience measure) and #4 (warm hand off to primary care) also should be pay-for-performance measures within Medicaid, given their critical importance to continuity and equity.

Preserve the Narrative through Data System Innovations

Institute innovations for patients and providers to fill gaps in the medical record.

Rationale

Improving the flow of information and communication between providers and patients and within and across health data systems raises complex challenges: time constraints, the absence of appreciation for the patient's story, and lack of electronic "highways" to connect health records across specialties, time, and illness episodes. Electronic medical records (EMRs) have improved documentation of medical details (Haskew et al., 2015; Manca, 2015), but have also added burdens for providers (Backman et al., 2017) and reduced time

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for meaningful patient-provider communication (Gawande, 2018; Haskew et al., 2015; Johnson et al., 2017; Koven, 2016; Varghese, 2018). Furthermore, the "problem list" in a birth discharge record is not automatically saved in most EMR versions and advanced to non-obstetric providers; this gap is a woman-specific case of "treat and release" akin to the lack of handoffs from emergency room care to appropriate providers in the general population (Cheung et al., 2009). Accessibility of key information is critical for preventing morbidity and mortality in the year after childbirth and chronic illness over the life course. Birthing people's experiences during pregnancy and childbirth have an impact on their mental and physical health and whether they seek further care, yet they are not reflected in the medical record (Fogel, 2018; Koven, 2016). Inviting pregnant people to read clinical notes in the EMR and record brief stories (in ways providers could read or hear) can empower them and inform their providers about important issues that might otherwise have been missed (Leveille et al., 2020).

EMR companies (or institutions with capacity to revise EMR structure) should develop an electronic record postpartum discharge template with coded fields specific to patient risks for future pregnancies and long-term health, as well as key transition information for primary care providers and patients, and create a place in the record for mothers to write or record their own notes.

Place information and self-care strategies in women's hands, either by harnessing digital technology or creating a hard-copy *Mother's Health Book*

Rationale

Web-based online platforms have been shown to improve outcomes after GDM (Nicklas et al., 2014), increase postpartum visits (Himes et al., 2017), provide emotional and informational support to women with or at risk for postpartum depression (Lee, Denison, Hor, & Reynolds, 2015), and allow postpartum women to monitor their blood pressure at home (Hirshberg, Aviles, & Srinivas, 2019). These platforms can be adapted to diverse populations and should augment and not substitute for systems change.

Private funders (e.g., non-profits, tech companies, pharmaceutical foundations) should establish initiatives for development of digital technologies (web- and mHealth-based) to place in women's hands the tool needed to follow their own health needs after pregnancy, across the chasm and through connection to primary care.

Enrich data sources on maternal mortality and severe morbidities that occur in the postpartum period.

Rationale

State-wide Maternal Mortality Review Committees (MMRCs) provide one important way for maternal deaths to be understood and scrutinized for preventable causes. In the United States, an estimated 40 states have MMRCs, yet they vary in methods and accountability and generally address only clinical data. The patient experience and family narrative is missing, a gap that is especially (but not only) problematic for postpartum deaths, and review panels rarely include patient representatives. In December 2018, the Preventing Maternal Deaths

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Act (HR 1318) was passed into law. As noted by Kozhimannil et al. (2019), the Act is an important first step to support existing MMRCs, but not a panacea. Additional legislation is needed to inform efforts to eliminate preventable pregnancy-related deaths and near misses and remove intolerable racial inequities in these outcomes.

> The 117th Congress should pass legislation that expands the Preventing Maternal Deaths Act of 2018 to require all states to implement MMRCs, standardize types of data collected and reported on, expand scope to include severe maternal morbidities, and include family interviews to capture the patient experience.

Align Research with Women's Lived Experience

> Expand funding for longitudinal, holistic, culturally based and racially just research in women's health that centers their lived experience, with an emphasis on the use of community-based participatory research methodology.

Rationale

Funding opportunities for research in women's health are often narrowly focused on pregnancy or specific medical conditions to the exclusion of SDOH or women's holistic lived experience. Medical research involving women is divided up territorially by body parts, with different agencies responsible for specific organ systems. For women with GDM and hypertensive diseases of pregnancy and their children, holistic research on effective practices for preventive testing, surveillance, and treatment of potentially chronic diseases across the life span is best accomplished through funding multidisciplinary collaborations that center the voices and agency of women and their lived experience, including community-based participatory research (Chung et al., 2010; Wallerstein & Duran, 2010).

> The National Institutes of Health, Health Resources & Services Administration, and private foundations should create new research funding sources, new approaches to patient and community engaged research, and a new focus on study of outcomes of health care innovations during the postpartum year. They should prioritize mentoring and funding for BIWOC to conduct this research, because what becomes evidence depends on who is asking the questions.

Discussion

BtC between Pregnancy and Health over the Life Course

A National Agenda for Research and Action is the first national initiative to synthetize the expertise of diverse stakeholders to address persistent gaps and inequities in women's health care between pregnancy and primary care over the life course. The BtC Agenda is the product of a national stakeholder leadership council and a network of more than 150 members with expertise based in lived experience and technical knowledge. Co-created by patients, advocates, providers, researchers, policymakers, and health system innovators, the Agenda reflects a shared commitment to continuity, holism, and, above all, equity in women's health care across the life course. It draws on and expands upon myriad efforts now underway to transform maternity care in the United States (Black Mamas Matter Alliance, 2018; Institute for Medicaid Innovation, 2020b; National Partnership for Women

and Families, 2018a), extending the reach to the full postpartum year and beyond. The BtC Agenda addresses two deeply rooted problems—siloed specialties and structural racism—that stand in the way of quality care for women across the life course, and presents an ambitious blueprint that, if implemented, will prevent pregnancy-related deaths and morbidities in the postpartum year as well as disability and premature death from preventable chronic illness across the life course.

Implications for Practice and/or Policy

Research publications and media interest have focused significant attention on gaps and inequities in access and quality in maternity care and the postpartum period, largely focused on preventable pregnancy-related mortality and severe morbidities. Less attention has been paid to gaps in the transition to primary care in the extended postpartum period and beyond, with a broader focus on solutions that would prevent chronic illness over the life course. Solutions that have been proposed and tested tend to be issue-specific and lack the comprehensive lens of multiple stakeholders. The BtC Agenda, in contrast, is a comprehensive, multipronged approach to break down the myriad structural barriers to seamless, high quality, and equitable care for all women after pregnancy and the immediate postpartum period. Conference attendees and the multiexpertise working groups that followed identified key strategic areas with specific actions designed to bridge the chasm. These include areas 1) progress toward eliminating institutional and interpersonal racism and bias as a requirement for accreditation of health care institutions, 2) infrastructure support for CBOs, 3) extension of holistic team-based care to the postpartum year and beyond, with integration of doulas and CHWs on the team, 4) extension of Medicaid coverage and new quality and pay-for-performance metrics to link maternity care and primary care, 5) systems to preserve maternal narratives and data across providers, and 6) alignment of research with women's lived experiences. Table 3 describes in detail specific tasks needed to achieve the goal of eliminating inequities and improving care and outcomes, and Table 4 lists them in a format that can be readily adopted and supported by all who have a role to play: state and federal government agencies, researchers and funders, foundations, health care organizations, professional organizations, private sector quality measure developers, advocacy organizations, educators, and journalists. Taken together, the BtC Agenda provides a roadmap to transform health care in the reproductive years and beyond for everyone giving birth in the United States, while also eliminating deeply entrenched race-based inequities in care and the growing inequities in outcomes across the life course.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 2

The Bridging the Chasm Community Consensus Process and Skills: Active Listening, Summarizing, and Synthesis*

Steps to Consensus	Conference Day 1	Conference Day 2	Year 2: Advancing the Consensus Process
Step 1: Introduce/clarify the issue(s) to be decided. 1. Share relevant information. What are the key questions? 2. Build sense of community and trust between participants.	Issue framing: the four components of the chasm were introduced; keynote speakers shared perspectives from advocates, patients, clinicians, and health care system innovators. In storytelling exercises, led by a team of drama coaches, experiences as recipients and providers of clinical care became shared narratives, building cohesion and trust.	Day 1 homework: participants were tasked with re-visiting a review of the literature and asked to bring in three ideas for change. Assignment to different groups and networking during lunch allowed cross-communication. Small group leaders (SELC members) facilitated participation.	Snowball recruitment identified additional experts consistent with the BtC mission. Discussion with the SELC resulted in formation of 7 working groups (WGs) drawn from 11 Day 2 topics. We reviewed literature (peer and gray) on WG topics and developed a portal to exchange information, build consensus, and work collectively.
Step 2. Explore the issue, look for ideas, and refine. 1. Gather thoughts, issues, and concerns. 2. Collect/write down problem solving ideas. 3. Hold a broad-ranging discussion of pros & cons; decide as a group to eliminate some ideas and short list others.	12 participants volunteered to share their stories on video with the large assembly. These narratives became a reference point against which to evaluate potential strategies for Bridging the Chasm for relevance and significance.	Roundtables–*World Café 1*: Small groups mixed by roles and regions used flipcharts and large sticky notes to generate a list of ideas, with brainstorming based on insights from experience (Day 1) and data (annotated bibliography).	35 conference calls over 5 months resulted in a problem statement, a synthesis of existing literature on the WG topic, a menu of strategy options with rationale for the importance of each strategy, and strategy generation.
Step 3. Look for emerging proposals (synthesis). 1. Weave together the best elements of the ideas presented and discussed. 2. Look for solutions that address key concerns.	The group was struck by the commonality and intensity of the emotions expressed in stories, and the huge impact of pregnancy complications and lack of post-delivery care on storytellers' lives (patients and clinicians).	Ideas were clustered into 11 topic areas by leadership, with extensive group discussion. Some topics were renamed, proposed strategies were refined, and some ideas were shifted from one topic to another.	Each WG selected and prioritized 3 strategies with rationales, and evaluated each strategy for stakeholders, potential collaborators, related initiatives, supportive factors, challenges, and action steps.
Step 4: Discuss, clarify, and amend. 1. Ensure that remaining concerns are heard and that everyone can contribute. 2. Amend to enhance consensus. Step 5. Test for agreement. 1. Check for blocks, stand-asides and reservations.		*World Café 2*: 11 small groups (self-selected) identified, discussed, and refined three ideas for equity, innovation, feasibility, and effectiveness. Results were reported out to the assembly and discussed. No blocks nor stand-asides occurred, and there were few reservations.	In a Qualtrics survey the WGs prioritized and evaluated strategies against the 4 criteria of equity, innovation, feasibility, and effectiveness. WG facilitators and BtC leadership refined and bundled the options and surveyed WG members to assess for priority and consensus.

* Adapted from: *A Consensus Handbook: Co-operative Decision-Making for Activists, Co-ops and Communities*, Seeds for Change, 2013. ISBN: 978-0957587106 (www.seedsforchange.org.uk/handbookweb.pdf).

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Table 3

Recommended Strategic Steps, in Detail

Agenda Planks	Strategic Steps
I. Eliminate disrespect and bias in health care	Create a regional or national board of experts in health equity to promote best practices, assess and approve the quality of curricula, develop and disseminate measures of accountability for continued progress by individuals and institutions in the elimination of racism and bias in clinical practice, and oversee evaluation of the impact of such curricula on practices; Engage patients in the design and implementation of the curriculum; Embed the curriculum longitudinally in the initial training of all health care workers and licensing of clinical providers; Address directly the historic/structural roots of racism in institutional policies and clinical practice, and encourage the American College of Obstetrics and Gynecology to establish administration of the Jackson-Hogue stress scale to Black women as a standard of practice (Jackson, Hogue, & Phillips, 2005); Incorporate innovative methods/best practices to strengthen empathy, knowledge, and understanding (drawing from narrative medicine, theater, film, and the visual arts); and Fund evaluation of education programs to establish impact on clinicians' behaviors over time and tie the results to accreditation of training programs.
II. Invest in communities: Build technical capacity of CBOs dedicated to the health of BIWOC over the life course	Create a tax break to incentivize public/private funders to allocate 2% of annual expenditures for CBO capacity building and infrastructure building; and Fund a technical support center to collect and disseminate resources for: Governance and board development; Financial management and operations and 501(c)(3) process; Donor relations, fundraising, grant writing, and strategic partnering for innovative grantmaking; Program development, budgeting, and monitoring and evaluation; Communication to increase visibility and funding; Community engagement skills and advocacy strategies for policy change; Identification of local legal and business resources for pro bono services; and Acquisition of paid seats at the table of local public.

Agenda Planks	Strategic Steps
III. Transform and extend the model of care for the postpartum year: 1. Develop team-based approaches	Create multidisciplinary teams composed of clinicians (physicians, advanced practice nurses, midwives, social workers, mental health therapists) and CHWs (doulas, and/or peer navigators); Equip nurse-midwives and extend the nurse-midwifery model to care for women across the chasm and across reproductive years, with special attention to the needs of those whose pregnancies signal a risk for chronic illness based on pregnancy complications or substantial SDOH; Enhance existing education and certification mechanisms to equip team members for extended postpartum collaborative practice AND create innovative cross-training for collaborative teams; and Extend the CMS bundled payment in amount and timeframe to cover the entire postpartum year, or create a new reimbursement bundle that allows for multidisciplinary, integrated services after the postpartum period.
2. Develop group models of care	Medicaid Health Plans of America should develop and pilot an in-person model based on lessons learned from CenteringPregnancy and CenteringParenting; Conduct feasibility studies regarding the best setting for group model extended postpartum care–obstetrics, pediatrics, primary care, or other site based on how services for women are organized; and Investigate feasibility of virtual models to accommodate demanding schedules of new mothers, transportation and childcare issues, and geographic distances.
3. Create patient-centered Women's Health Homes	Fund new models for comprehensive primary care (structural transformation), and Use CMS innovation program authority to support WHHs to provide structure for connectivity and integration in women's health care before, during, and after pregnancy for at least 1 and up to 3 years, to be piloted by Medicaid Health Plans of America.
4. Develop/implement cross-training models for IPE	Create/sustain Regional/National Training Centers, led by representatives of all the components of the newly expanded workforce, to design competency-based training modules for the postpartum year and conduct innovative, experiential team-based training; Incorporate BtC competencies and resources into existing training and certification processes for doulas, CHWs, and patient navigators (peers) to tie together maternity and primary care; Identify opportunities for cross-training community-based caregivers (CHWs, doulas, patient navigators); and Enhance competencies for Nurse-Midwifery and Advanced Practice Nursing Education Programs (including continuing education) to prepare for collaborative practice at the intersection of postpartum and primary care.
IV. Transform health care systems 1. CMS policy reforms	Pass federal and state legislation to extend Medicaid coverage from 60 days post-delivery to12 months for all states, not just those with waivers or expanded Medicaid under the Affordable

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Agenda Planks	Strategic Steps
	Care Act. Extend the CMS bundled payment or create new bundled reimbursement for the period between 10 weeks postpartum (last postpartum visit) and 1 year postpartum. Use CMS program authority to support development and evaluation of new ways to support linkage to primary care through pay-for-performance policies that reward: 1)warm handoff between obstetric and primary care providers, and 2) documentation of handoff templates in electronic medical systems. Fund ACO partnerships with CBOs to identify and address local SDOH through CMS Innovations and Expand the Preventing Maternal Deaths Act to require all states to implement MMRCs for both severe maternal morbidity and mortality in order to collect and apply data related to SDOH impact.
2. New quality measures	Design and implement new quality measures for the NQF/HEDIS, including follow-up of gestational diabetes, discharge with blood pressure cuff for gestational hypertension, and documentation of a warm handoff to primary care; Develop a PREM that captures patient experience of implicit bias/racism within maternity and postpartum care and use it as an evaluation tool for an institution to measure its progress toward health equity and accreditation by the JCAHO; The PREM capturing racism/bias and the warm handoff to primary care should be pay-for-performance measures within Medicaid as well as quality metrics within HEDIS for accreditation; Encourage states to use the set of postpartum measures defined by the Physician Consortium for Performance Improvement (i.e., family planning, postpartum depression screening, postpartum glucose screening) following GDM as Medicaid quality measures for the postpartum visit; and Design and implement new quality measures for the NQF/HEDIS that support adoption of the Women's Clinical Preventive Services covered under the Affordable Care Act, in Medicaid and private insurance;
V. Preserve the narrative through data systems innovations	Develop an electronic record postpartum discharge template with coded fields (i.e., not free text), including specifics about patient risks and key information for the PCP, and preparation for next pregnancy, with a copy for patients; Create structure and support for women to write or narrate significant experiences during pregnancy and childbirth, focused on what they see as most important for providers to hear and what will impact their health and health care going forward; Fund digital technologies (web- and mHealth-based) or a hard-copy *Mother's Health Book* geared to promoting follow-up and primary care after pregnancy complications for medical and social stressors; and Pass legislation to require MMRCs in all states and expand

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Agenda Planks	Strategic Steps
	scope to include severe maternal morbidity and family interviews and have people with lived experience on review panels.
VI. Align research with women's lived experience	Develop new funding sources dedicated to Bridging the Chasm (RFAs, cooperative grants, multisource collaborations) in both public and private venues, with review by a special emphasis panel; Develop and test interventions with patient engagement to address the role of social, behavioral, and environmental factors responsible for ethnic, immigrant, racial, and sociodemographic disparities in pregnancy complications; Conduct patient-engaged research to further define what kind of information diverse women with pregnancy complications will want, need, and find easy to use; Evaluate outcomes associated with innovations (e.g., Women's Health Home model); Test the effectiveness of a multipronged, high-touch approach (e.g., group-based care at intervals throughout the postpartum year, enhanced by frequent in-person or patient-facing technology contacts) to engage women in their own care and facilitate care plans; and Study the impact of providing consistent, comprehensive care to women through an extended postpartum period, in women's health home models, by practitioner type, within states/regions that extend Medicaid to 12 months postpartum; and NIH should assess investigator qualifications (lived experience and close ties to communities under study) as part of the proposal review process.

Abbreviations: ACO, Accountable Care Organization; BIWOC, Black, indigenous and all other women of color; BtC, Bridge the Chasm; CBOs, community-based organization; CHWs, community health workers; CMS, Centers for Medicaid and Medicare Services; GDM, gestational diabetes; HEDIS, Healthcare Effectiveness Data & Information Set; IPE, interprofessional education; JCAHO, Joint Commission on Accreditation of Health Care Organizations; MMRC, Maternal Mortality Review Committees; NIH, National Institutes of Health; NQF, National Quality Foundation; PCP, primary care provider; PREM, patient reported quality measure; RFA, request for application (NIH); SDOH, social determinants of health; WHH, Women's Health Homes.

Table 4

Implementing the Agenda: Tasks by Constituency

What Each Constituency Can Do:
Government and state/federal agencies
Pass federal and state legislation to extend Medicaid coverate to 12 months post-partum with automatic enrollment, and promote women's medical homes for continuity and integration of care pre-pregnancy through the postpartum year; Workforce development: Incentivize entry to primary care, home visiting for postpartum women and team-based care; Actively support inclusion of community-based organizations in state and local planning; Co-locate information and resources for the postpartum year; at sites where women gather and trainstaff to refer; and Fund a National Workforce Development Center to increase the number of Black and Latinx health care providers. Researchers and funders Develop requests for proposals to fund knowledge gaps; Evaluate new models of care; Develop/fund templates for discharge to primary care; and Study the long-term impact of pregnancy complications and social predictors of health on future health. Foundations Fund and grow community-based organizations to bridge the chasm; and Allocate significant dollars for infrastructure support (training and resources).
Health care organizations
Require anti-racism training and assessment; Develop flexible postpartum models of support and wrap-around care (doulas, community health workers and navigators) Negotiate with national electronic medical systems to develop a template for transfer of pregnancy history to primary care and record handoffs to primary care at discharge from the obstetrical service; Implement a *Mother's Health Book* for personal record keeping and instructions for transfer to primary care; Support women to share their stories with providers and motivate providers to listen; and Promote a Centering Model of Care for the postpartum year, especially after pregnancy complications.
Professional organizations
Develop guidelines for integrated care in the postpartum year and require them for accreditation; Educate members about the need to develop research that ties pregnancy complications to future health outcomes, especially chronic disease; Collaborate to associate new quality metrics with outcomes that can be tied to accreditation; and Require anti-racism training for professional licensure and renewal. Corporations and businesses Create woman-friendly practices and policies for the postpartum year (flexible hours, paid family leave, etc.).
Quality measure developers

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Create standards of care for the postpartum year; and
Design and promote quality metrics and pay for performance measures that promote warm handoff to primary care and metrics that incorporate the patient experience.

Advocacy organizations and community-based organizations

Advocate for state and federal legislation to exptend the postpartum period to 1 year with coverage and support;
Lobby state and local agencies for participation in planning processes; Testify at legislative hearings to highlight the impact of pregnancy experiences on future health; and Lead anti-racism education efforts.

Educators

Form inter-professional collaborations for continuing medical education offerings that connect pregnancy experiences with future health;
Develop and implement anti-racism training and assessment; and
Create innovative technologies to connect women to each other, to providers, and to resources.

Media experts

Develop public service announcements to enhance the value of women's health to society;
Create an anti-racism campaign to address inequities in maternal morbidity and mortality and the health of Black, Latina, Native and Asian women over the life cycle; and
Develop fundraising videos for community-based organizations that demonstrate accomplishments that can increase fundability.

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