Centers for Medicare & Medicaid Services
MATERNAL & INFANT HEALTH
Initiative

TECHNICAL ASSISTANCE RESOURCE

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Resources on Strategies to Improve Postpartum Care Among Medicaid and CHIP Populations

Introduction

To support states participating in the Postpartum Care Action Learning Series, the Centers for Medicare & Medicaid Services (CMS) developed a resource for strategies that may be effective in increasing the postpartum care visit rate and improving the content of the visit among states' Medicaid and CHIP populations. The information presented in this resource reflects materials gathered from the peer-reviewed literature; reports from state Medicaid programs and Medicaid managed care organizations (MCOs); and materials for providers and patients produced by health plans, MCOs, and other organizations.

While not exhaustive, the resource includes a range of evidence-based strategies, best practices, and advice to providers. The materials cover approaches to increasing the number of women who make and keep a postpartum visit and to improving the measurement process in clinical settings. Many of the projects or programs described in the guide include multiple interventions. The guide also presents information on interventions that have been tested at the MCO, provider, and member level, and across the prenatal, postpartum, and interconception periods.

This resource contains three components:

- **Table 1—Strategies to improve the postpartum care visit rate and the content of care.** This table describes approaches to improving the postpartum care visit, organized by the type or level of intervention. The table contains a detailed summary of the changes (or interventions), the relevant sites and populations, and outcomes if they are available.

Using Quality Improvement Strategies in Postpartum Care

The Centers for Medicaid and CHIP Services (CMCS) has established the Maternal and Infant Health Initiative to improve the postpartum visit rate by 10 percentage points in at least 20 states over 3 years (among other goals). The Improving Postpartum Care Action Learning Series is one of the Initiative's projects, in which 11 states are using quality improvement (QI) strategies to identify changes and test them in a Plan, Do, Study, Act cycle. By employing the QI process in a variety of settings, the series will increase knowledge about how to improve the postpartum care visit rate and also inform state policies to support CMCS in achieving its goals.

- **Table 2—Drivers and change ideas to increase postpartum visits for Medicaid and CHIP populations.** This table summarizes the changes described in Table 1, organized by their relationship to four primary drivers of postpartum care quality:
  - Engage women in their care
  - Redesign the delivery system
  - Identify community supports
  - Align Medicaid and CHIP and MCO policies
- **References**—This component provides references related to the changes described in Table 2 and some additional resources on postpartum care.

For More Information

Please email MACqualityTA@cms.hhs.gov if you have questions or comments about the information in this resource.

This technical assistance resource is a product of the Medicaid/CHIP Health Care Quality Measures Technical Assistance and Analytic Support Program, sponsored by the Centers for Medicare & Medicaid Services. The program team is led by Mathematica Policy Research, in collaboration with the National Committee for Quality Assurance and Center for Health Care Strategies.

Table 1. Strategies to improve the postpartum care visit rate and the content of care

Change strategy	Timing of intervention	Study site(s)	Population	Description of intervention	Outcomes	Source
Peer supports						
Establish prenatal partners (bilingual, bicultural cultural brokers) • Showed pregnant women how to navigate the health system, encouraged self-advocacy for women and their children, and helped improve communication with providers • Helped women develop a plan for their PNC and postpartum visits by identifying barriers to accessing health care and possible solutions to challenges	Prenatal visits starting, on average, at 5 months (but not after 34 weeks)	Hospital-based urban clinic in Phoenix, Arizona	Latinas, the majority of whom were low-income, first-generation immigrants; 81 percent Mexican heritage: • Inclusion criteria: age 18 or older, Latina, no prior PNC for current pregnancy, less than 34 weeks pregnant • Intervention (n = 221); usual care (n = 219)	Women were randomized to usual care or to receive intervention of meetings with prenatal partners: • Bilingual and bicultural social work students were trained as prenatal partners (study emphasizes lay workers can be trained for this role and prenatal partners did not perform counseling) • Patients met with prenatal partners in waiting room before seeing provider for first visit and then after each subsequent prenatal visit • Prenatal partners provided education on PNC, discussed patient concerns, encouraged women to advocate for their health in visits with provider and communicate concerns • Prenatal partners followed up with women who missed PNC visit and identified barriers and solutions to enable them to attend visits 4-month intervention Patient-driven conversations	• 73 percent with prenatal partners had PPC visit versus 51 percent in control group • 79 percent who met with prenatal partner 5 to 20 times had PPC visit versus 62 percent who met with prenatal partner 1 to 4 times	Marsiglia, F.F., M. Bermudez-Parsai, and D. Coonrod. "*Familias Sanas:* An Intervention Designed to Increase Rates of Postpartum Visits among Latinas." *Journal of Health Care for the Poor and Underserved,* vol. 21, no. 3, suppl. 2010, pp. 119–131. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2944022/
Establish doula program • Community women trained as certified doulas • Support high-risk, primarily African American women	Pregnancy, delivery, and postpartum in-hospital period	Seven hospitals and birth centers affiliated with University of Pittsburgh Medical Center	Pregnant women in Medicaid MCO from Allegheny county referred to the doula program	• Voluntary participation • Doulas assisted with scheduling and keeping prenatal, postpartum, newborn appointments, answered questions, provided general support and education, reinforced provider messages, assisted women in creating a birth plan, linked women to MCO's case managers for care coordination and support	Women paired with doulas had a 10 percent higher PPC visit rate than women without doulas	Greenberg, L. "Treatment Adherence Best Practices Compendium." Washington, DC: Medicaid Health Plans of America, Center for Best Practices, 2012, p. 26. http://www.mhpa.org/_upload/adherencecompendiumweb2.pdf

Change strategy	Timing of intervention	Study site(s)	Population	Description of intervention	Outcomes	Source
Postpartum care patient education and outreach						
Implement comprehensive set of interventions targeted to women and providers	Prenatal and postpartum periods	CareNet (Virginia Medicaid MCO)	Medicaid population	• Educational mailings to members • Communications to providers (remind providers about maternity incentive program and include information on HEDIS® measures and rates) • Transportation services (when eligible) • Home visits • Member incentive for making and keeping the postpartum appointment • High-risk OB case management • Postpartum phone calls • Postpartum depression information and assessments • Wrap-around mental health services	• Increase in the Medicaid MCOs PPC rate over three years, from 62.7 to 70.6 percent • Moved from 10th HEDIS percentile in 2007 to 75th percentile in 2011	Greenberg, L. “Treatment Adherence Best Practices Compendium.” Washington, DC: Medicaid Health Plans of America, Center for Best Practices, 2012, p. 18. http://www.mhpa.org/_upload/adherencecompendiumweb2.pdf
• Provide PNC and PPC information packets • Use OB care managers and individual care plans for high-risk women	Prenatal through postpartum period	AMERI-GROUP, Taking Care of Baby and Me (Medicaid MCO)	Medicaid population	• Women received PNC and PPC information packets and a list of community resources such as childbirth education classes • OB care managers surveyed pregnant women on risk factors and created personalized care plans • Care managers maintained contact at least once per month to ensure women received PNC and PPC • Women received gift incentives (such as baby care items) to encourage them to keep appointments	100 percent of participants attended their PPC visits compared with 49 percent of nonparticipants	America’s Health Insurance Plans. “Innovations in Medicaid Managed Care: Health Plan Programs to Improve the Health and Well-Being of Medicaid Beneficiaries.” Washington, DC: America’s Health Insurance Plans, Center for Policy and Research, March 2005, p. 40. https://www.ahip.org/Innovations-in-Medicaid-Managed-Care-Report/

Change strategy	Timing of intervention	Study site(s)	Population	Description of intervention	Outcomes	Source
Comprehensive case management and care management						
• Use OB care managers for high-risk women • Provide information by telephone and mail • Provide regular telephone follow-up • Follow-up after missed appointment	Prenatal through postpartum period	Kentucky Passport Health Plan, Mommy and Me (Medicaid MCO)	Medicaid population	• Plan representatives called members and encouraged PNC, assessed risk factors, and suggested community resources such as WIC • Nurse care managers sent women a guide designed for low-literacy readers on healthy pregnancy and encouraged use during telephone calls • Followed-up with patients for missed appointments and addressed barriers • Nurse care managers called high-risk mothers at least monthly to provide support • Care managers called 2 and 4 weeks post-delivery to encourage PPC visits, assess for depression, and offer referrals	PPC visit rate increased from 58 percent to 75 percent over four years	America's Health Insurance Plans. "Innovations in Medicaid Managed Care: Health Plan Programs to Improve the Health and Well-Being of Medicaid Beneficiaries." Washington, DC: America's Health Insurance Plans, Center for Policy and Research, March 2005, p. 42. https://www.ahip.org/Innovations-in-Medicaid-Managed-Care-Report/
Implement intensive outreach and monetary Incentives	Prenatal to postpartum period	Wisconsin Badger Care Plus (Medicaid) pregnant or parenting women in Dean Health Plan Pilot site located in Madison	Medicaid population	• After receiving introductory letter or full packet of material about program, provided brief health assessment during telephone call • Provided assistance in scheduling prenatal, PPC, or referrals • Gave $25 gift cards for prenatal appointment in first trimester or within 42 days of enrolling in plan; $25 for PPC visit 21 to 56 days postpartum; enrollment in $100 cash raffle for attending additional PNC visits; enrollment in $100 cash raffle for signing healthy living pledge • Intensive outreach and coordination started after eligible pregnant women were identified	Prenatal care visit rates improved No significant change in postpartum care visit rate: • 2007: 72 percent • 2008: 77percent • 2009: 70 percent Lesson learned from focus group and survey: • Women are more motivated by their health and baby's health rather than by incentives	Wisconsin Department of Health Services. "Do Incentives Work for Medicaid Members? A Study of Six Pilot Projects." Madison, WI: Wisconsin Department of Health Services, May 2013. http://www.dhs.wisconsin.gov/publications/p0/p00499.pdf

Change strategy	Timing of intervention	Study site(s)	Population	Description of intervention	Outcomes	Source
Implement comprehensive pregnancy care management program; monetary incentives, use of technology	Prenatal to postpartum period	Ohio Centene, MCO	Medicaid population	Case managers identified high-risk pregnant members: • Used a notification of pregnancy form • Assigned a nurse case manager to a member for coordination of care • Enhanced other program components Member education: • Handbook, materials, journey book, MP3 players, website, smartphones, texting Member incentives: • CentAccount rewards card, gift cards, baby gifts Postpartum outreach: • Counseling, pediatric care education, NICU kits, diapers • Postpartum depression needs, lactation program, family planning	• Improved PNC visits and reduced preterm births • No data collected on postpartum visits	Centene Corporation. "Start Smart for Your Baby. Ohio Collaborative to Prevent Infant Mortality." St. Louis, MO: Centene Corporation, October 27, 2011. http://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/beacon/42711centenestartsmart.ashx
Enhance care management: • Outreach activities and contacts with the member • Initial and ongoing assessments • Interventions and educational activities • Links to and recommendations for community services and resources • Appointments with maternity health care professionals	Pregnancy confirmation to 60 days postpartum	Aetna Better Health, MCO	Medicaid population in multiple states	Perinatal case managers worked closely with all high-risk members to develop a customized care plan that included: • Providing authorization of additional specialists services and/or testing, as needed Resolving barriers to care such as transportation needs • Providing culturally and linguistically appropriate education materials for mother and family • Serving as a center point for communication among all involved parties and identifying community resources to assist members • Enrolling members with a history of drug/alcohol abuse in a treatment program and ensure these women go to the "front of the line" for treatment • Identifying members with a history of prior delivery requiring NICU services, identify the reason, and determine if it is likely to recur and/or is preventable • Providing members who are anemic with iron supplements and an early referral to WIC program	PPC visit rate improvements between 2007 and 2009: • Maryland: from 60.3 percent to 72.2 percent • Delaware: from 59.8 percent to 67.2 percent • Missouri: from 70.8 percent to 72.2 percent • Arizona: from 58.1 percent to 68 percent	2011 response to Medicaid RFP found at: http://dhh.la.gov/assets/docs/Making_Medicaid_Better/Resources/CCN_RFP_Proposals/AetnaBetterHealth/LA_CCN_RFP_Section_J_06.27.11-FINAL.pdf (Note: This document is the response to an RFP that includes information about the MCO's past performance in improving PPC visit rates)

Change strategy	Timing of intervention	Study site(s)	Population	Description of intervention	Outcomes	Source
Provider education and provider-focused interventions						
• Distribute postpartum depression screening and treatment guidelines for PCPs and OB/GYNs • Add postpartum depression educational material to post-delivery letter sent to new mothers	Postpartum period	Community Health Group, MCO (California)	Medicaid population	• Distributed postpartum depression program description with screening and treatment guidelines to PCPs and OB/GYNs • Added postpartum depression educational materials targeted to mothers of newborns and their families to post-delivery letter sent to new mothers	PPC visit rate increased from 23.1 percent to 41.7 percent in 12 months	Delmarva Foundation. “Medi-Cal Managed Care External Quality Review Organization: Quality Improvement Projects Report 2nd Quarter.” Easton, MD: Delmarva Foundation, August 2006, p. 8. http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/QIPs_2Q06_Report.pdf
Tips for providers	Prenatal period	Affinity Health Plan, MCO	Medicaid population (New York)	Affinity Health Plan disseminates provider tips: • Schedule PPC visit for 4-5 weeks after delivery, so that it can be rescheduled if necessary • Schedule PPC visit within 4 weeks before expected delivery date • Schedule PPC visit back-to-back with newborn visits if at same site • Inform patients during prenatal period of importance of PPC visit and who to see • Conduct active outreach to “no shows” • Wound checks performed before 21 days are not PPC visit—inform patient of need to return before 8 weeks • Remind providers they can bill a PPC visit code more than once and be reimbursed; wound checks before 21 days post-op may be followed up with a PPC visit between 21 and 56 days	No data on effects on postpartum visit rates	Affinity Health Plan. “Strategies to Increase Postpartum Visit Adherence.” New York: Affinity Health Plan, 2010. https://www.affinityplan.org/uploadedFiles/Affinity/Providers/QM_Updates/Postpartum%20Visit.pdf

Change strategy	Timing of intervention	Study site(s)	Population	Description of intervention	Outcomes	Source

Tips for providers	Prenatal to postpartum period	Not specified	Massachusetts Medicaid providers	• During prenatal visits, educate patients about importance of PPC visit
				• Start PPC with visit or educational materials while patient is in hospital
				• Educate patients who come for early incision check about importance of later PPC visit
				• Tips on scheduling:
				  • Conduct active outreach
				  • Track all appointments (scheduled, utilized, canceled, “no shows”)
				  • Update patient information at every prenatal visit
				  • Arrange transportation or interpreter services as needed
				  • Schedule PPC visit before leaving hospital and within 6 weeks in case need to reschedule
				  • Communicate with prenatal services for continuity of care
				• Offer information on community resources: WIC, the Ride, lactation support groups
				• For eligible women, promote nurse PPC home visits
				• Improve medical record documentation to ensure postpartum visits are counted towards HEDIS performance rate, postpartum visit date and one of following must be included in medical record:
				  • Pelvic examination
				  • Evaluation of weight, blood pressure, breasts (or breastfeeding notation), and abdomen
				  • Notation of “postpartum care,” “PP care,” “PP check,” or “6-week check”
					No data on effects on postpartum visit rates	Thorn, K. “Improving the Management of Postpartum Visits.” MassHealth Home Health Agency Physician Bulletin 95, July 2013.
						http://www.mass.gov/eohhs/docs/masshealth/bull-2013/phy-95.pdf

Provider office outreach to patients	Postpartum period	Provider-level	Not specified	• Nurses call patients within 2 weeks after delivery to check in on mother’s well-being, breastfeeding, and screen for depression • If appointments are not scheduled, nurses follow up with telephone calls and letters • Practice plans to ask pediatricians to remind mothers of PPC visit because many of the clinic patients take their children to the same pediatricians	No data on effects on postpartum visit rates	Blue Care Network Best Practices: Prenatal and Postpartum Care http://www.bcbsm.com/providers/newsletters/bcn-provider-news/bcn-best-practices-library/communication-and-patient-relationships-are-integral-to-increasi.html

Change strategy	Timing of intervention	Study site(s)	Population	Description of intervention	Outcomes	Source
• MCO increases tracking of high-risk pregnant women by paying providers to complete an assessment • MCO engages providers in documenting PPC visits by providing guidance on coding • MCO provides free diapers to women who make PPC visit	Prenatal and postpartum periods	Boston Medical Center HealthNet Plan Massachu-setts, MCO; providers and clinics	Medicaid MCO	• Between October 1, 2013, and September 30, 2014, plan paid providers $25 to complete ACOG prenatal assessment to identify high-risk women • Paired women with high-risk pregnancies with Sunny Start program care managers (Sunny Start is a care management program for pregnant and postpartum women that includes care coordination, appointment reminders, education, assistance with transportation and connecting to community resources, and access to a registered nurse for any pregnancy needs) • To document PPC visit, providers were instructed to submit category II CPT 0503F code along with global billing • Providers were encouraged to sign form confirming the PPC visit to qualify MassHealth members to receive a free box of diapers	No data on effects on postpartum visit rates	Boston Medical Center HealthNet Plan. “Provider News.” March 2014. http://www.bmchp.org/~/media/fdce0a4667aa4f53be71281a49ec66dc.pdf Sunny Start program description: http://www.bmchp.org/members/care-management-program/pregnancy
Facilitate access to PPC visit appointments						
Conduct PPC home visits	Postpartum period	Molina Healthcare, MCO	Medicaid population (Michigan)	To remove barriers to receiving postpartum visits, MCO representatives made home visits. The visits included • Postpartum assessment • Education for the mother • Postpartum depression screening	HEDIS rate increased from 64.10 percent in 2012 (25th percentile) to 72.79 percent in 2014 (75th percentile)	Michigan Association of Health Plans. “Taking Services into Homes, Using Data to Target High Use Individuals, Boosting Immunizations among 2014 MAHP Pinnacle Award Winners.” Lansing, MI: Michigan Association of Health Plans, September 17, 2014. http://www.mahp.org/sites/default/files/MAHP%20issues%20Pinnacle%20awards.pdf

Change strategy	Timing of intervention	Study site(s)	Population	Description of intervention	Outcomes	Source
Schedule postpartum appointment while woman is still in the hospital after delivery or by telephone after discharge if the delivery occurs on a weekend or holiday	At time of hospital stay for delivery	Hospital-based urban clinic in Honolulu, Hawaii	Women who received PNC at the hospital-based urban clinic; study population was largely insured with children • Pre-intervention: April 2006 to March 2007 (n = 106) • Post-intervention: April 2007 to April 2008 (n = 115)	Retrospective chart review comparing outcomes before intervention to outcomes after intervention: • Provided women date and time of postpartum visit before they left the hospital via an appointment card with a congratulatory letter • Photographed mother and baby at the first PPC visit and gave a photo album at the second PPC visit	Primary outcome: • After intervention, women significantly more likely to have PPC visits (86.2 percent versus 71.7 percent) Secondary outcomes: • Increased breastfeeding reported at first PPC visits (28.7 percent versus 12.3 percent) • Increased use of contraception (84.3 percent versus 71.7 percent)	Tsai, P.-J.S., L. Nakashima, J. Yamamoto, L. Ngo, and B. Kaneshiro. "Postpartum Follow-up Rates Before and After the Postpartum Follow-up Initiative at Queen Emma Clinic." *Hawaii Medical Journal,* vol. 70, no. 3, 2011, pp. 56–59. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3071902/
Other strategies: technology and patient incentives						
Improve mother engagement and education using new technology, incentives	Prenatal and postpartum period	United HealthCare, MCO	Medicaid populations in eight states	• Email or text reminders before and after scheduled appointments • Interactive PNC and PPC boards on website and mobile site to engage patients in their care • Reward program gives incentives to patients to schedule and attend appointments (choice of two options each visit; for example, postpartum visit options are Fisher-Price blocks or $20 Old Navy gift card) • Pregnancy and parenting tips provided at each checkpoint	• Prenatal rates increased 11 percent in 2012 compared with previous year • No postpartum data presented	Egan, E., and S. Hendrick. "Medicare & Medicaid Best Practices: A Compendium of Managed Care Innovations." Washington, DC: American Action Forum (no date) http://americanactionforum.org/uploads/files/research/Compendium2.pdf

Change strategy	Timing of intervention	Study site(s)	Population	Description of intervention	Outcomes	Source
Text messaging related to PPC	Prenatal to postpartum period and through first year of well-child care	Partnership among state Medicaid agencies, CMS, and Text4baby founding partners: Voxiva and the National Healthy Mothers, Healthy Babies Coalition	• Medicaid populations in California, Ohio, Oklahoma, and Louisiana (original pilot projects) • PPC module recently introduced in Massachusetts	Text4baby is a free mobile information service that promotes maternal and child health through text messaging: • Women receive three personalized text messages per week, timed to their due date, covering a range of topics such as breastfeeding and labor warning signs • Appointment reminders are available • Four states are tailoring messages to improve PPC visit attendance along with other health measures and are also trying to increase Medicaid enrollment in the service • Massachusetts is now integrating postpartum visit information into its Text4baby service • Massachusetts' PPC module includes appointment reminders; state-specific resources; and information to prompt mothers to discuss issues such as contraceptives, type 2 diabetes, and emotional/physical well-being	No data on effects on postpartum visit rates	https://www.text4baby.org/index.php/miscellaneous/460-cms-pilot-project Thorn, K. "Free Enhanced Text Messaging Service to Support Pregnant Women and New Mothers." MassHealth All Provider Bulletin 247, September 2014. http://www.mass.gov/eohhs/docs/masshealth/bull-2014/all-247.pdf
Provide monetary incentives to reward MCOs and clinics for HEDIS performance	Prenatal and postpartum period	Wisconsin Department of Health Services and MCO partnership (Children's Community Health Plan is one of many participating MCOs and serves as an example here)	Medicaid population	• Wisconsin's Department of Health Services withholds a percentage of the MCOs' capitation fees, which is returned to participating plans pending their HEDIS performance • The Children's Community Health Plan, one of the participating MCOs, intends to distribute a portion of the money they earn back to clinics according to the clinics' HEDIS performance • PPC is one of several HEDIS measures included in this initiative	No data on effects on postpartum visit rates	Children's Community Health Plan. "Pay-for-Performance (P4P) Provider Incentive." *Provider Notes,* fall 2014. http://www.childrenschp.com/display/displayFile.asp?docid=38926&filename=/Groups/CCHP/ProviderNotesThirdQuarter2014.pdf

CMS = Centers for Medicare & Medicaid Services; CPT = current procedural terminology; GYN = gynecologic; HEDIS = Health Employer Data and Information Set; MCO = managed care organization; NICU = neonatal intensive care unit; PNC = prenatal care; PPC = postpartum care; OB = obstetric; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children.

Table 2. Drivers and change ideas to increase postpartum visits among Medicaid and CHIP populations

Drivers and Changes	Level where Intervention or Change was Tested				Timing			Reference
	State Policy	MCO	Delivery System or Provider	Patient or Woman	Prenatal	Delivery	Post-partum	
Primary driver: Engage women in their care								
Secondary driver: Provide educational materials about postpartum period and need for care								
Mail educational materials to members about importance of prenatal and postpartum care		X		X	X			2, 6
Provide postpartum depression educational material in post-delivery letter to new mothers		X		X			X	5
Provide member education using technology such as web-based interactive platforms, audio recordings, texting	X			X	X		X	4, 6
Secondary driver: Provide culturally relevant education and connect women to resources								
Use bilingual, bicultural perinatal partners to support Latina women (promote self-advocacy, answer questions, identify barriers to PPC visits, offer solutions)			X	X	X			8
Use community women, trained as doulas, to assist in education and support for African American women		X	X	X	X	X	X	6
Secondary driver: Provide incentives to women								
Provide member incentives for keeping postpartum appointment		X	X	X			X	2, 3, 4, 6, 10, 12
Secondary driver: Ensure an optimal care experience for every patient, every time								
Ask women what matters most to them at each visit			X	X	X	X	X	7
Engage in joint problem-solving			X	X	X	X	X	7, 8
Engage in joint goal-setting			X	X	X	X	X	7, 8
Engage in shared decision-making			X	X	X	X	X	7
Primary driver: Redesign the delivery system								
Secondary driver: Facilitate scheduling postpartum appointments for women								
Schedule postpartum appointment while woman is still in hospital after delivery or by telephone if she delivers on a weekend or holiday			X	X		X	X	11
Schedule PPC visit appointment no more than 4 to 5 weeks after delivery so that missed appointment can be rescheduled before 56 days		X	X	X		X	X	1
Follow-up with women who miss appointments and identify and address barriers		X		X			X	2, 8

Drivers and Changes	Level where Intervention or Change was Tested				Timing			Reference
	State Policy	MCO	Delivery System or Provider	Patient or Woman	Prenatal	Delivery	Post-partum	
Primary driver: Redesign the delivery system (continued)								
Secondary driver: Increase access to postpartum care visits								
Provide women with transportation to their PNC and PPC visits	X	X		X	X		X	6
Offer postpartum home visit		X	X	X			X	6, 9
Secondary driver: Use care/case managers to facilitate access to services and supports								
Use staff to conduct postpartum phone calls (check-in, remind about PPC visit appointment)		X		X			X	6, 12
Use OB care managers for high-risk women; call women to assess problems after delivery		X		X	X	X	X	2, 3, 4
Use community women, trained as doulas, to link African American women to MCO case managers		X	X	X	X	X	X	6
Secondary driver: Educate providers about postpartum care								
Provide postpartum depression screening guidelines for primary care and OB/GYN providers		X	X				X	5
Primary driver: Identify community supports								
Secondary driver: Connect women to community resources								
Include list of community resources with prenatal and postpartum care information packets		X		X	X		X	2
Use plan representatives to call members to encourage PNC visits and suggest community resources such as WIC		X		X	X			2
Primary driver: Align Medicaid and MCO policies								
Secondary drivers: Educate providers about the PPC visit codes and measures								
Educate providers about PPC visit measure by including information on HEDIS measures and rates in provider newsletter		X	X		X		X	6
Remind providers they can bill a PPC visit code in addition to wound check after a C-section		X	X					1
Provide guidance to providers on billing codes for PPC visit	X	X	X					1
Secondary driver: Offer provider incentives to identify high risk women								
Pay providers to complete ACOG prenatal assessment to identify high-risk women		X	X		X			3

ACOG = American Congress of Obstetricians and Gynecologists, GYN = gynecologic; HEDIS = Health Employer Data and Information Set, MCO = managed care organization, OB = obstetric, PPC = postpartum care, PNC = prenatal care; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children.

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Additional resources on postpartum visits

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