Housekeeping Reminders

Please submit questions via the Zoom chat during the presentation.

For attendance, please type in your name and organization in the chat.

Attendees are muted upon entry. Click “Unmute” when you would like to speak. Please mute yourself after speaking.

The presentations are posted on Tomorrow’s HealthCare www.tomorrowshealthcare.org

2026 PCMH Perinatal Care in Family and Pediatric Offices Sprint Session #1

February 19, 2026

Pittsburgh Regional Health Initiative

Continuing Education Information

In support of improving patient care, this activity has been planned and implemented by the University of Pittsburgh and The Jewish Healthcare Foundation. The University of Pittsburgh is jointly accredited by the **Accreditation Council for Continuing Medical Education (ACCME)** and the **American Nurses Credentialing Center (ANCC)**, to provide continuing education for the healthcare team. **1.5 hours are approved for this course.**

As a Jointly Accredited Organization, University of Pittsburgh is approved to offer social work continuing education by the **Association of Social Work Boards (ASWB)** Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. University of Pittsburgh maintains responsibility for this course. Social workers completing this course receive **1.5 continuing education credits**.

Disclosures

No members of the planning committee, speakers, presenters, authors, content reviewers and/or anyone else in a position to control the content of this education activity **have relevant financial relationships** with any entity producing, marketing, re-selling, or distributing health care goods or services, used on, or consumed by, patients **to disclose**.

Disclaimer

The information presented at this Center for Continuing Education in Health Sciences program **represents the views and opinions of the individual presenters**, and does not constitute the opinion or endorsement of, or promotion by, the UPMC Center for Continuing Education in the Health Sciences, UPMC / University of Pittsburgh Medical Center or Affiliates and University of Pittsburgh School of Medicine. Reasonable efforts have been taken intending for educational subject matter to be presented in a balanced, unbiased fashion and in compliance with regulatory requirements. However, each program attendee must always use his/her own personal and professional judgment when considering further application of this information, particularly as it may relate to patient diagnostic or treatment decisions including, without limitation, FDA-approved uses and any off-label uses.

Learning Objectives

- ✓ Describe evidence-based strategies for providing fourth trimester and interconception care to individuals at family medicine and pediatric well-visit appointments
- ✓ Discuss examples of PCMHs quality improvement projects for providing perinatal care in family and pediatric offices
- ✓ Describe strategies to prepare for and enhance the “Do” stage of the PDSA cycle

Welcome

Robert Ferguson, MPH
Chief Policy Officer
Pittsburgh Regional Health Initiative

Pittsburgh Regional Health Initiative

PCMH
PATIENT-CENTERED MEDICAL HOME
Learning Network

HEALTH FEDERATION OF PHILADELPHIA
The keystone of community health since 1983

Leads for
Perinatal Health Sprint

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Perinatal Care in Family and Pediatric Offices

Data: Data from March of Dimes shows in 2023 approximately 74.5% of infants were born to women receiving “adequate / adequate-plus” prenatal care. 2023 HEDIS measures show Follow-Up on Positive Postpartum Depression Screening rates of 55.68%.

Number of PCMHs: 6

Examples of what PCMHs will be working on:

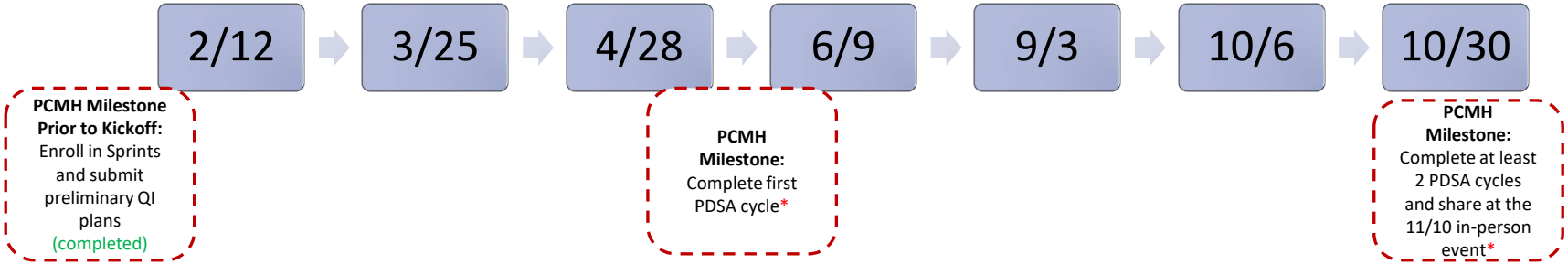
- Caregiver influenza vaccine uptake; offering and administering adult flu vaccines at pediatric visits
- Improve follow-up and connections to resources for mothers with positive post-partum depression screens
- Identify and address gaps/differences in comprehensive prenatal care services between practices.

Related initiatives: Birth Hospitals in the PA Perinatal Quality Collaborative will be improving transitions of care in 2026

2026 PCMH Learning Network Objective

Objective: *All PCMHs in the HealthChoices PCMH Program complete at least 2 cycles of a PDSA in at least 1 sprint by November 2026*

PDSA Plan Submission Dates



2026 PCMH Learning Network

Snap for 1st Half

Sprint Session 1

- **LN** provides Tactical how-to information related to PCMHs' QI plans
- **PCMHs** share PDSA Planning progress through facilitated peer-to-peer learning
- **LN** provides guidance for the next PDSA phase (e.g., completing the Plan and preparing for "Do")

Sprint Session 2

- **LN** provides Tactical how-to information related to PCMHs' QI plans
- **PCMHs** share how their preparation for the Do PDSA phase through facilitated peer-to-peer learning
- **LN** provides Guidance for Do and Study

PCMH Milestone: Complete first PDSA cycle*

Mid-Year Session: Learning Across Sprints

- One high-performing PCMH in each Sprint presents their first PDSA cycle
- Guidance on updating your Plan based on the first PDSA cycle

2026 Sprint Session Dates*

Perinatal Care in Family & Pediatric Offices

Thursday, February 19th at 1 – 2:30 pm

Wednesday, April 1st at 9 – 10:30 am

Tuesday, June 23rd at 1 – 2:30 pm

Tuesday, September 15th at 9 – 10:30 am

**Remember to ensure you are receiving emails from J. at Ashenayi@jhf.org*

Evidence-Based Strategies for Fourth Trimester and Interconception Care in Family Practice and Pediatric Settings

Mario P. DeMarco, MD MPH, Associate Professor of Clinical Family Medicine, Perelman School of Medicine, University of Pennsylvania

Penn Medicine

2026 PCMH LEARNING NETWORK

Perinatal Care in Family and Pediatric Practices

Mario DeMarco, MD MPH

Associate Professor of Family Medicine

Perelman School of Medicine, University of Pennsylvania

February 19, 2026

IMPLICIT NETWORK

Session Objectives

1

Recognize the impact of maternity care crisis and disparate outcomes across birthing people

2

Understand the relationship between primary care and maternal health outcomes – with appreciation for an “all hands on deck” approach

3

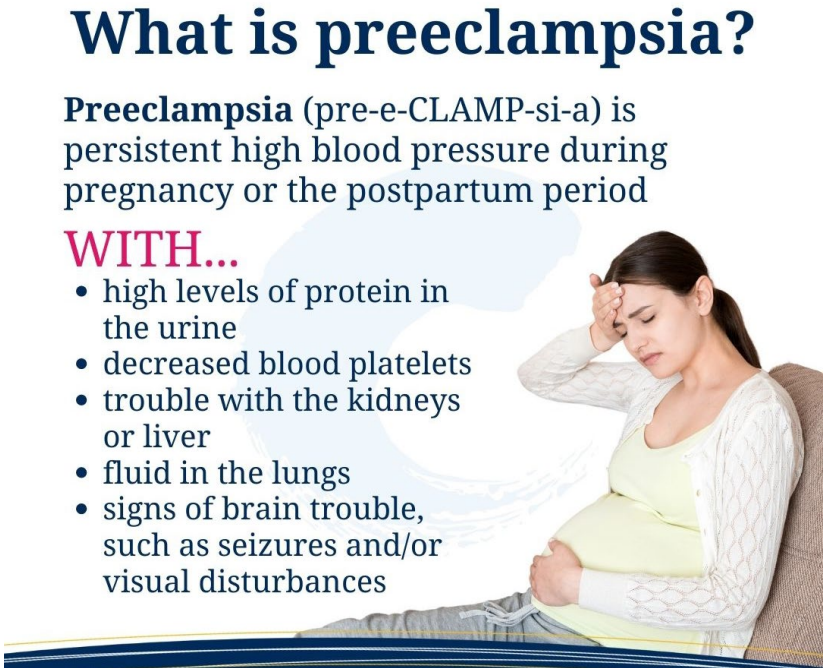
Identify practice level strategies to optimize care for women and families following childbirth

Case Presentation #1

A 28 yo G1P0 at 38.0 weeks is receiving prenatal care from your health center. She calls the office nurse line at 4:30 PM to report a headache which did not get better with Acetaminophen. She reports she has checked her blood pressure at home – 138/94. She has no vaginal bleeding, no gush of fluid and no contractions.

The portal message was routed by the nursing pool to the covering provider that night who is an adult medicine provider.

What should happen next?



Case Presentation #2

A 6 month old infant is brought into your primary care center for a visit with the pediatric provider for a “well child visit.” Upon review, you note that the child’s last WCV was at 2 months and she had a sick visit for diaper rash 1 month ago. During routine screening, the infants mother endorses feeling depressed. As you follow up for some more information, she becomes teary and states she feels like she has been a failure as a mom.

How can office workflows address family care needs?

Which members of the care team should be involved in this family’s care?

Maternity Care in the US

Pregnancy Care

Specialty driven – special providers, special practices, special hospitals

Separate from routine care

Focus is heavily on monitoring the fetus and preventing stillbirth

High engagement – visits every few weeks until delivery

Postpartum Care

Postpartum – defined by a single visit with the obstetrical provider 6 weeks after birth

Separate from routine care

Doesn't address the medical problems or chronic illness prior to pregnancy

Maternity Care in the US – some challenges

65% OF MATERNAL DEATHS OCCUR POSTPARTUM

Access is a major problem

- 50% of counties in the US do not have a practicing OB/Gyn
- In rural regions, the nearest delivering hospitals can be 1 hour away
- Many rural and regional hospitals perform < 200 deliveries per year

Maternal mortality is rising in the US

- Each year over 800-1200 women die following childbirth – and rising
- Most deaths occur between 1 week and 1 month postpartum
  - >80% of maternal deaths are preventable causes
- Maternal mortality rate for black women is 2-3X higher than white women

Poor engagement following delivery

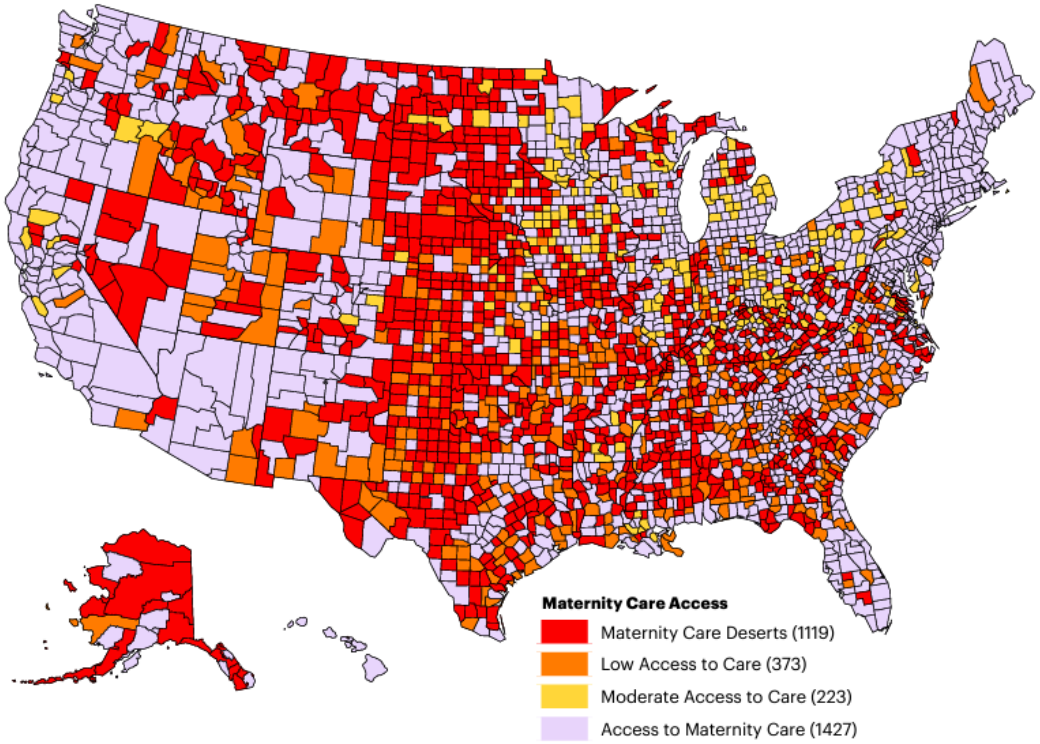
- Over 40% of mothers never attend a Postpartum visit
- Over 50% of mothers do not get any primary care in the 6 months following childbirth

Pregnancy is difficult to predict

- 50% of pregnancies in the US are unintended
- 36% of mothers conceive within 18 months of a previous live birth.

Access is a Major Problem

Figure 1: Maternity Care Deserts, 2020



Source: U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2021.

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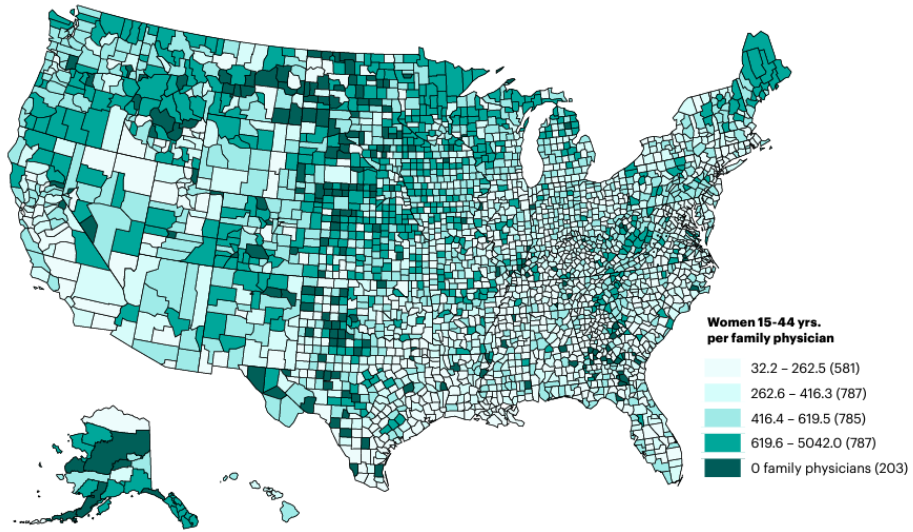
Access is a Major Problem – Primary Care helps!

Figure 8: Distribution of women of childbearing age per family physician by county, 2021



Source: American Academy of Family Physicians, 2021.

While nearly 40 percent of counties in the U.S. do not have an obstetrician or CNM, only 6.5 percent of counties (204) do not have a family physician

Of the counties without a family physician, 93.1% were maternity care deserts and 4 in 5 were rural (82.4%).

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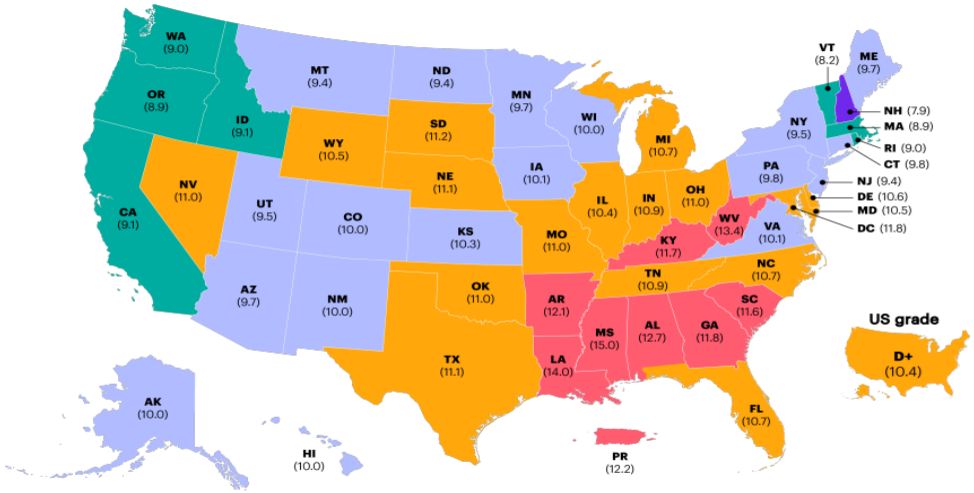
MoD 2025 Report Card

MARCH OF DIMES

The preterm birth grade was D+ in 2024; half of all US states received a D or an F

Preterm birth rate (born before 37 weeks gestation) and grade by state, 2024



11 states met the Healthy People 2030 target for preterm birth of 9.4% of all live births.

GRADE AND PRETERM BIRTH RATE

A	A-	B+	B	B-	C+	C	C-	D+	D	D-	F
7.7% or less	7.8 to 8.1%	8.2 to 8.5%	8.6 to 8.9%	9.0 to 9.2%	9.3 to 9.6%	9.7 to 10.0%	10.1 to 10.3%	10.4 to 10.7%	10.8 to 11.1%	11.2 to 11.4%	11.5% or greater

INADEQUATE PRENATAL CARE

16.1% ↑

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

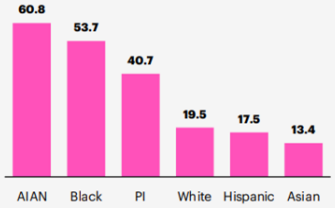
Maternal mortality has returned to pre-pandemic rates. Still, 669 maternal deaths occurred in 2023 and disparities by race/ethnicity persist

MATERNAL MORTALITY RATE

18.6

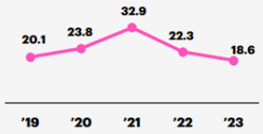
Death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Maternal mortality rate (deaths per 100,000 live births) by race/ethnicity, 2019-2023



Maternal mortality rate, 2019-2023

Changes in maternal mortality rates were statistically significant for all years shown.



More states saw preterm birth worsen than improve

19 States with **improved** preterm birth rates

21 States with **worsened** preterm birth rates

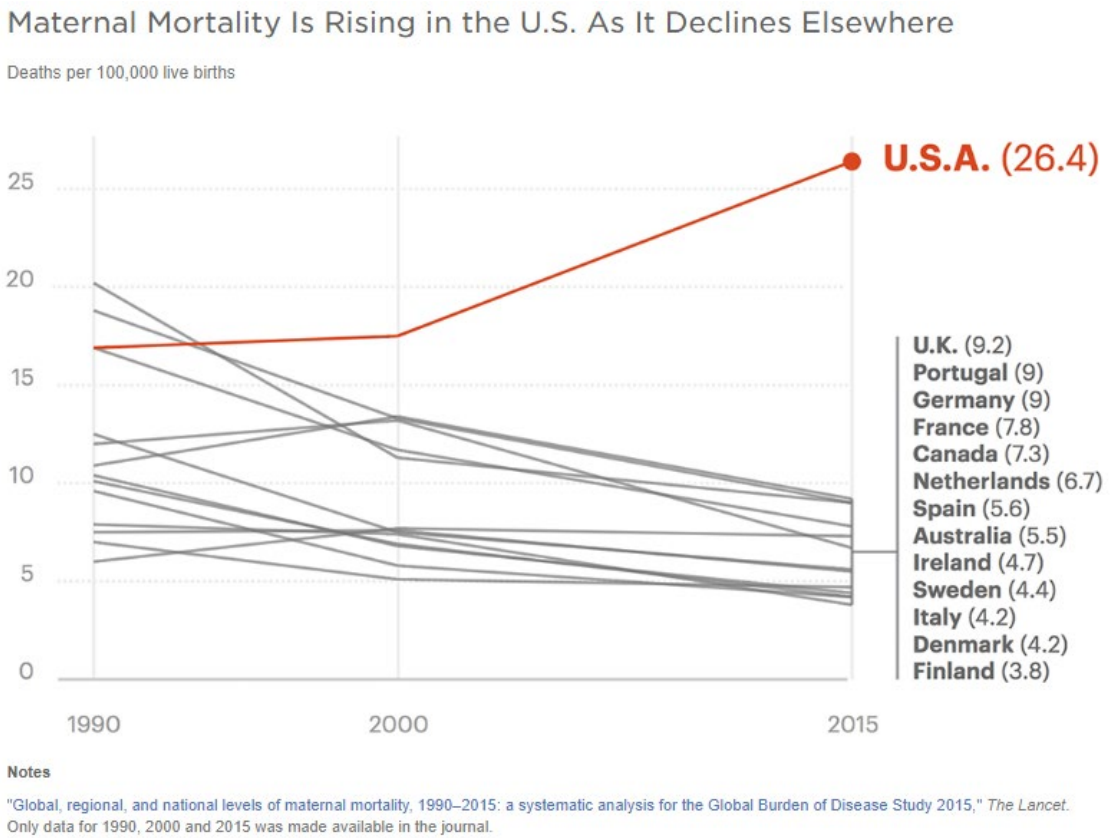
Note: Includes District of Columbia and Puerto Rico. Darker shaded circles indicate the number of stat
($P < 0.05$) in preterm birth rates compared to 2023.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics

Maternal Mortality – US Exceptionalism

26.4 DEATHS PER 100K LIVE BIRTHS EACH YEAR IN THE U.S.

RATE OF DEATH ALMOST 3X HIGHER THAN THE SECOND HIGH-RESOURCE COUNTRY (U.K.)



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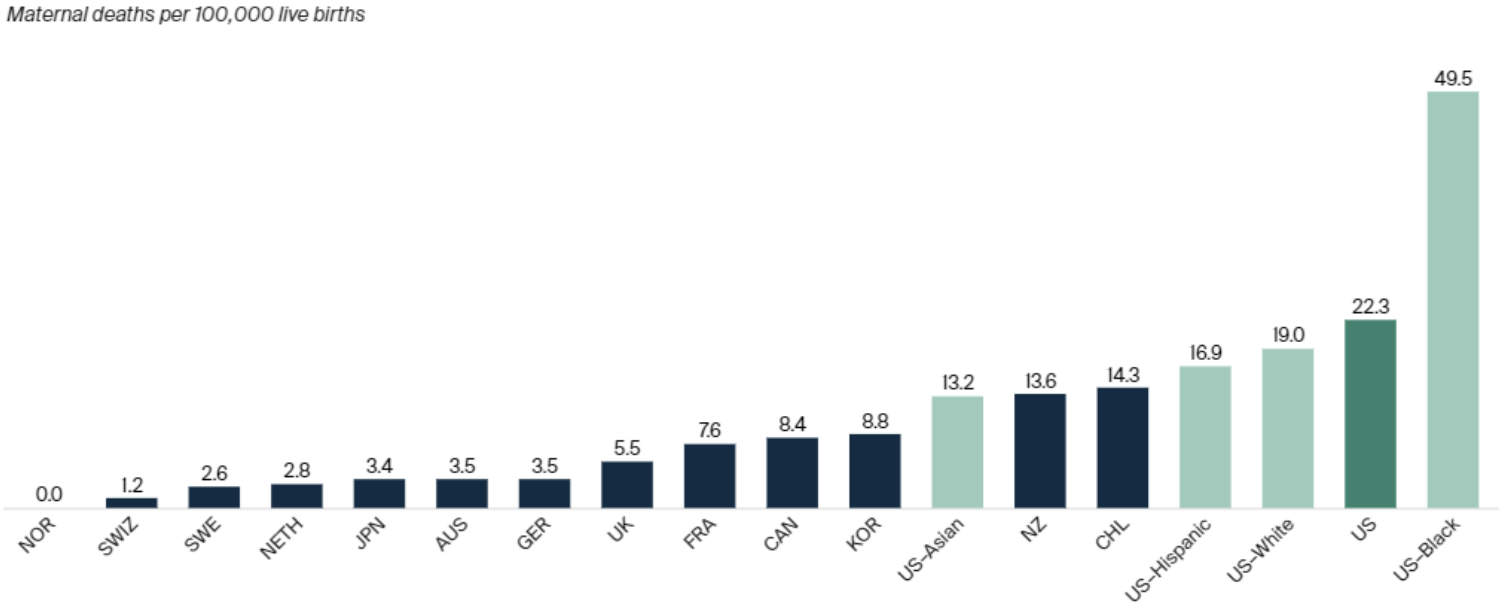
Maternal Mortality – US Exceptionalism

The United States continues to have the highest maternal death rate, with the rate for Black women by far the highest of any group.



SOURCE: MUNIRA Z. GUNJA ET AL., *INSIGHTS INTO THE U.S. MATERNAL MORTALITY CRISIS: AN INTERNATIONAL COMPARISON (COMMONWEALTH FUND*, JUNE 2024).

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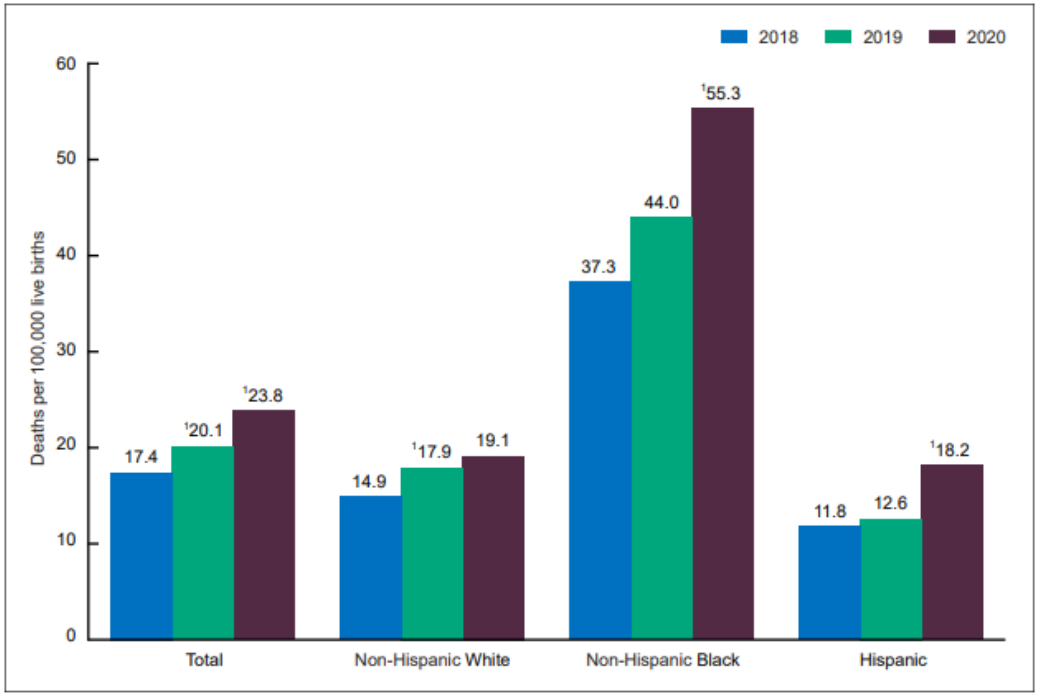
Maternal Mortality – Racial Disparities

BLACK BIRTHING PARENTS HAVE 2.9X RISK OF MORTALITY THAN NON-HISPANIC WHITE BIRTHING PARENTS.

NCHS Health E-Stats February 2022

Figure 1. Maternal mortality rates, by race and Hispanic origin: United States, 2018–2020



[1]Statistically significant increase in rate from previous year ($p < 0.05$).
NOTE: Race groups are single race.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

IMPLICIT NETWORK

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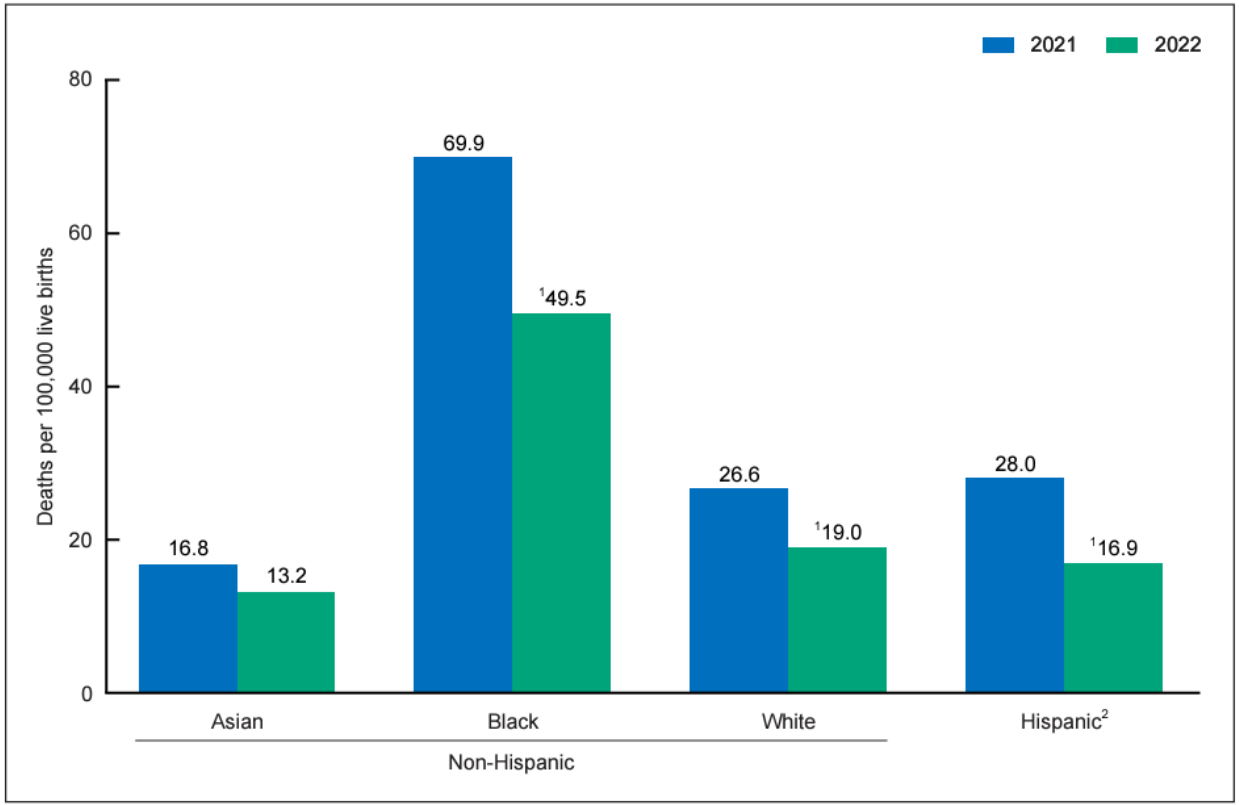
Maternal Mortality – Racial Disparities

BLACK BIRTHING PARENTS HAVE 2.6X RISK OF MORTALITY THAN NON-HISPANIC WHITE BIRTHING PARENTS.

Figure 2. Maternal mortality rate, by race and Hispanic origin: United States, 2021 and 2022



[1]Statistically significant decrease from previous year ($p < 0.05$).
[2]Hispanic people may be of any race.
NOTE: Race groups are single race.
SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data files.

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Maternal Mortality

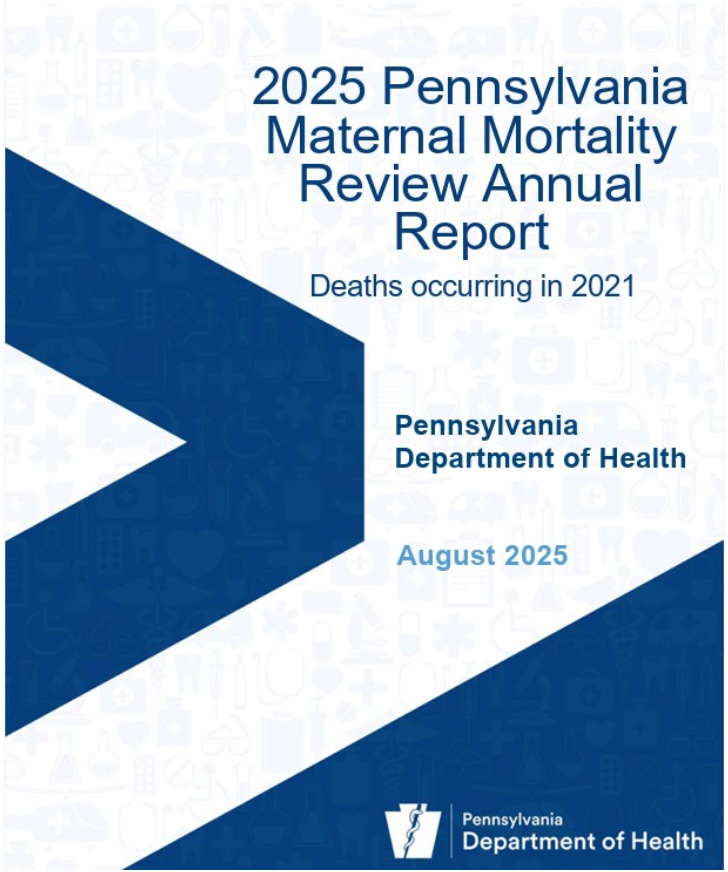


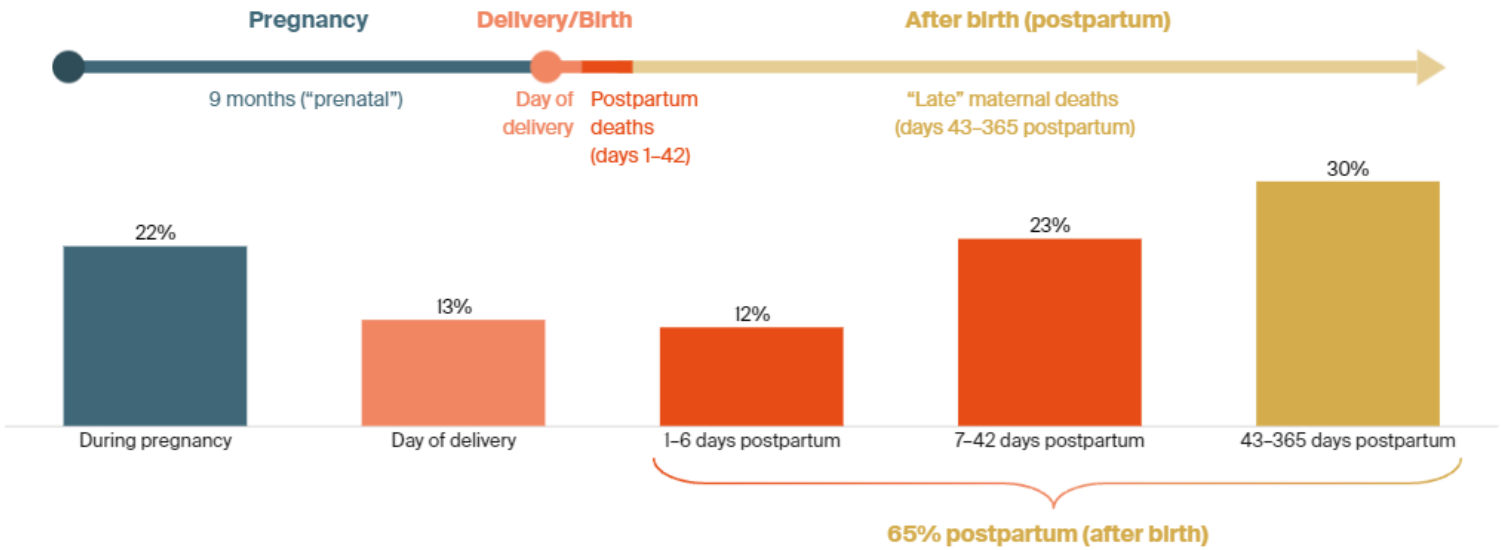
Table 1: Categories of Leading Causes of Death for 2021 Pregnancy-Associated Deaths in Pennsylvania (n=129)

Category	n	%
Mental health condition	61	47.3
Injury	19	14.7
Cardiac and coronary condition	18	13.9
Hemorrhage	8	6.2
Infection	6	4.6
Metabolic/endocrine condition	5	3.9
Pulmonary condition	5	3.9
Cerebrovascular accident	3	2.3
Cancer	2	1.6
Embolism	1	0.8
Undetermined	1	0.8

Maternal Mortality

Two-thirds of U.S. pregnancy-related deaths occur during the postpartum period.

Distribution of pregnancy-related deaths by timing of death in relation to pregnancy, 2017–2019



Notes: Data from Maternal Mortality Review Committees in 36 US states; specific timing information is missing (n=2) or unknown (n=14) for 16 (1.6%) pregnancy-related deaths.

Data: Susanna Trost et al., *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019* (Centers for Disease Control and Prevention, 2022).

Source: Munira Z. Gunja et al., *Insights into the U.S. Maternal Mortality Crisis: An International Comparison* (Commonwealth Fund, June 2024). https://doi.org/10.26099/cthn-5178

Maternity Care in the US

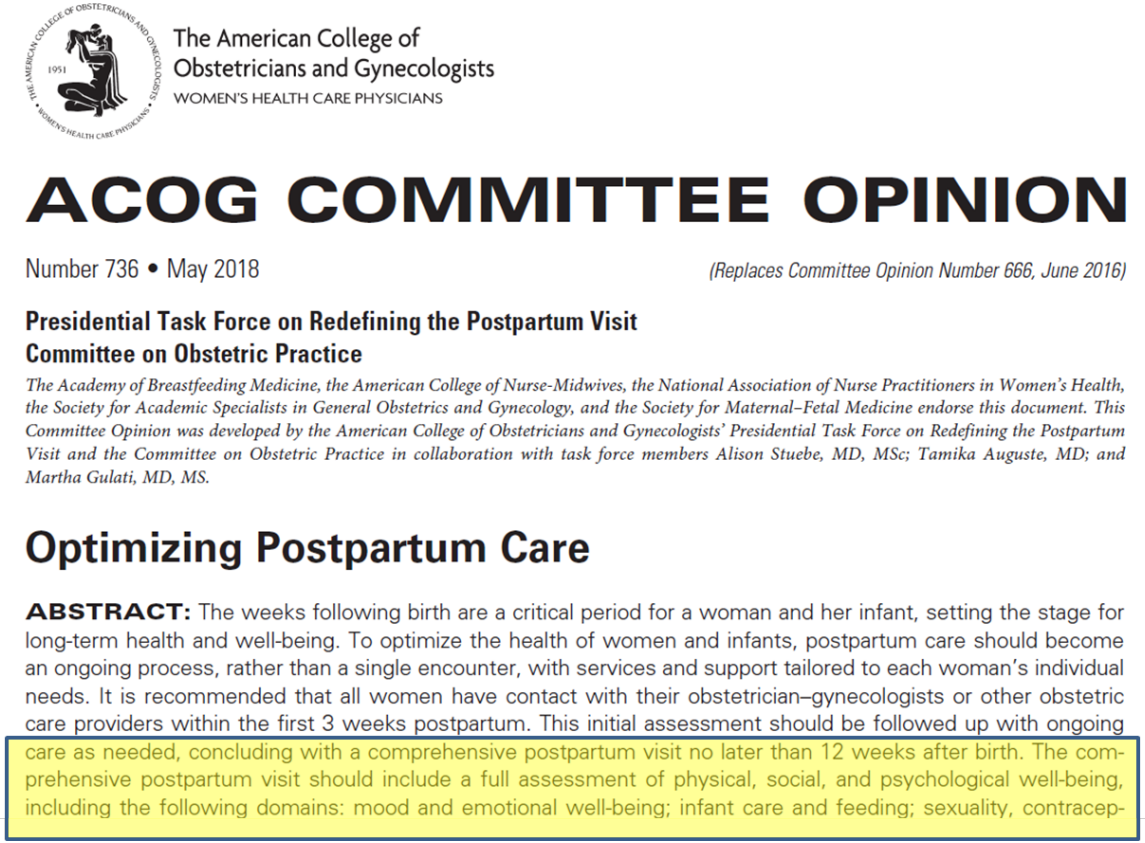
"Every system is perfectly designed to get the results it gets."

- Don Berwick and others

Maternity Care in the US – There is Hope

NEW MODELS OF CARE HAVE BEEN BUILDING PRESSURE BENEATH THE SURFACE

ACOG HAS CALLED FOR A NEW PARADIGM IN POSTPARTUM CARE (2018)



The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION

Number 736 • May 2018

(Replaces Committee Opinion Number 666, June 2016)

Presidential Task Force on Redefining the Postpartum Visit
Committee on Obstetric Practice

The Academy of Breastfeeding Medicine, the American College of Nurse-Midwives, the National Association of Nurse Practitioners in Women's Health, the Society for Academic Specialists in General Obstetrics and Gynecology, and the Society for Maternal–Fetal Medicine endorse this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Presidential Task Force on Redefining the Postpartum Visit and the Committee on Obstetric Practice in collaboration with task force members Alison Stuebe, MD, MSc; Tamika Auguste, MD; and Martha Gulati, MD, MS.

Optimizing Postpartum Care

ABSTRACT: The weeks following birth are a critical period for a woman and her infant, setting the stage for long-term health and well-being. To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs. It is recommended that all women have contact with their obstetrician–gynecologists or other obstetric care providers within the first 3 weeks postpartum. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth. The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains: mood and emotional well-being; infant care and feeding; sexuality, contracep-

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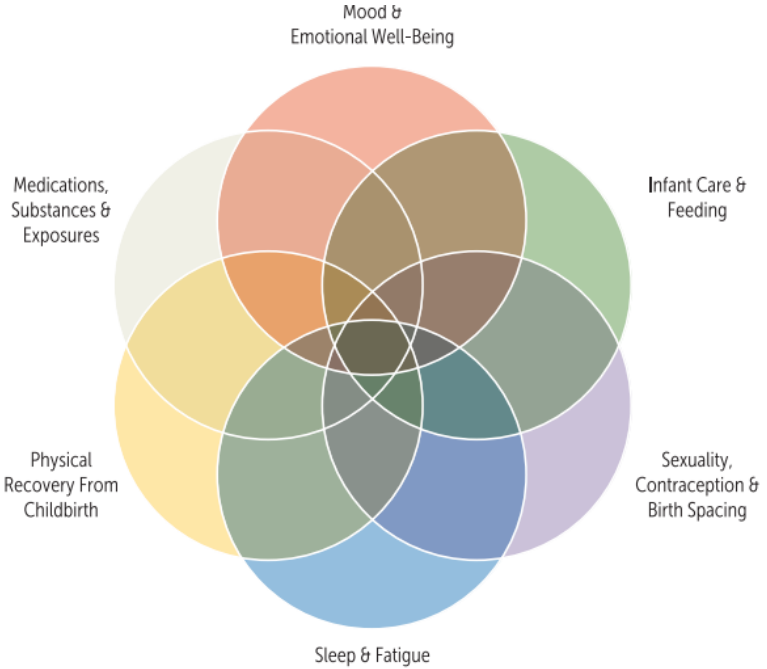
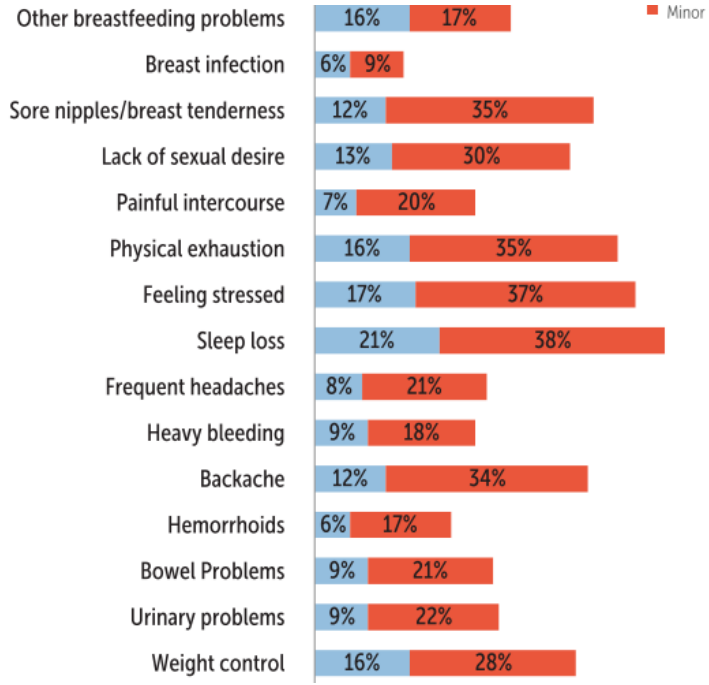
4th Trimester

VERBIEST ET AL. 2017. ZERO TO THREE (MARCH).





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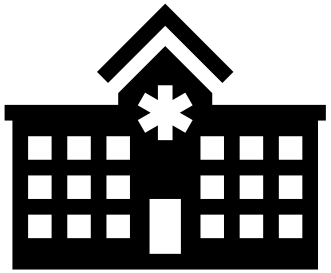
Opportunities – The Role of Primary Care



The 4 C's of Primary Care (Barbara Starfield)

- 1st **C**ontact
- **C**omprehensiveness
- **C**oordination
- **C**ontinuity

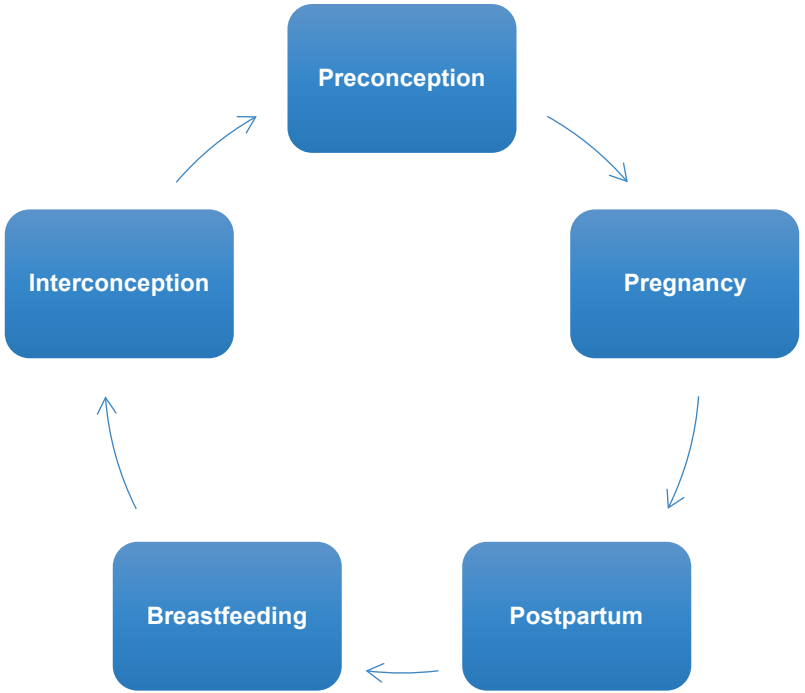
Primary Care distribution is more representative of the population distribution than any area of medicine

Primary Care is the sub-specialist for chronic disease management and prevention

Opportunity for family-based care

- 94% of birth mothers accompany their children to Well Child Visits
- 2/3 of Medicaid dollars spent on a family in the year after birth are for pediatric care

Primary Care Opportunities – Reproductive Life Cycle



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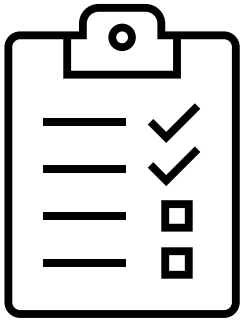
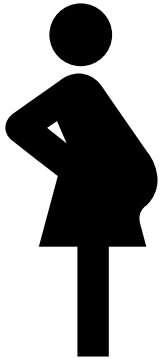
Strategies to impact maternal health in primary care settings



PRECONCEPTION

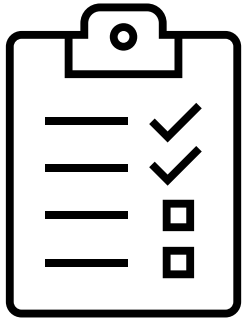


PREGNANCY

POSTPARTUM

PEDIATRIC CARE

Primary Care – Preconception



One Key Question (OKQ)®

– “Would you like to become pregnant in the next year?”

Screening for physical and mental wellness

Asking about substance use including tobacco

Address stressful or abusive environments

Recommending folic acid supplementation with 400 mcg folate or MVI

70%

Routine folic acid reduces the rates of neural tube defects

400mcg

Recommended consumption of 1 month before becoming pregnant and through the first 3 months of pregnancy

33%

of women learned about MVIs from their providers

<34%

of women with a recent live birth consumed preconception MVI

IMPLICIT NETWORK

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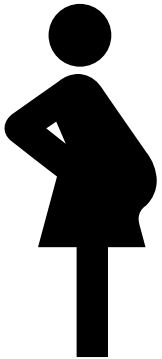
Primary Care - Pregnancy



- Facilitate early entry into prenatal care – 1st trimester
- Offer anticipatory counseling about warning signs of miscarriage
- Identify social determinants of health including food, housing, violence as early as possible
- Recognize that patients living with substance use disorders, HIV, viral hepatitis may benefit from immediate treatment
  - Don't stop – and try to provide access for – MOUD (Suboxone/Buprenorphine)
- Many infections are treated differently in pregnancy – always consult for help where able
  - UTI treatment should generally be for culture proven UTI's (but even asymptomatic bacteriuria is treated in pregnancy)
  - Antivirals for Influenza and COVID can be offered even if outside of the time window
  - Don't prescribe antibiotics for suspected viral infections including URI's and Bronchitis.
- Pregnant patients CAN go to the dentist!
- Elevated blood pressures in pregnancy should always be a red flag and never overlooked

Primary Care – Postpartum

- Postpartum visit should occur within 3 weeks of delivery (telehealth is ok!)
- Assess for the things you might imagine – vaginal bleeding, soreness, fatigue
- Assess for the things you might not imagine – chest pain, SOB, headache, edema, substance use, intimate partner violence
- Transition to Primary Care by 12 weeks
  - Primary Care may need CME or other support to integrate newer care expectations
- Providers and staff across the health facility (medical/dental/emergency care/behavioral health, etc) should know that a patient has been pregnant in the past year
- Acknowledge pregnancy conditions which impact ongoing health:
  - Gestational Diabetes
  - Preeclampsia
  - Traumatic Birth

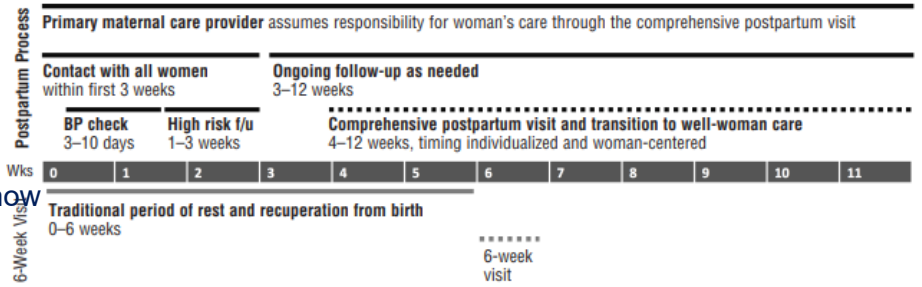


Figure 1. Proposed paradigm shift for postpartum visits. The American College of Obstetricians and Gynecologists' Presidential Task Force on Redefining the Postpartum Visit and the Committee on Obstetric Practice propose shifting the paradigm for postpartum care from a single 6-week visit (bottom) to a postpartum process (top). Abbreviations: BP, blood pressure; f/u, follow-up. ⇦

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Primary Care - Pediatric

VIEWPOINT

Addressing Maternal Mortality in the US—A Pediatrics Responsibility

Kristan Scott, MD
Division of Neonatology, Department of Pediatrics, University of Pennsylvania Perelman School of Medicine, Philadelphia.

Emily F. Gregory, MD, MHS
Division of General Pediatrics, Department of Pediatrics, University of Pennsylvania Perelman School of Medicine, Philadelphia.

Heather H. Burris, MD, MPH
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In March, the Centers for Disease Control and Prevention (CDC) reported that there were 1205 maternal deaths in 2021 in the US, marking a substantial uptrend from 861 deaths in 2020 and 754 in 2019.[1] This sharp 40% increase in the maternal mortality rate to 32.9 deaths per 100 000 live births from 23.8 per 100 000 in 2020 is striking because the US already had the highest maternal mortality rate among high-income countries.[2] Although 2021 US maternal mortality increased across all racial and ethnic groups, remarkable racial disparities remain. The maternal mortality rate among non-Hispanic Black women climbed to 69.9 deaths per 100 000, 2.6 times that of non-Hispanic White women, a disparity that has persisted for decades.[1] Physicians, even those who do not provide direct health care for pregnant and postpartum patients, have a responsibility to examine ways to help US health care systems address this massive failure to optimize maternal health.

Understanding the leading causes of maternal deaths can help elucidate the role pediatricians can play. The 2021 report captured the first full year of maternal mortality in the setting of the COVID-19 pandemic and defined maternal mortality as deaths occurring within

> Pediatricians' contact with the birthing parent-infant dyad presents our health care system with an opportunity to address the US maternal mortality crisis and its inequities.

tual maternal mortality could be even higher. Given that maternal deaths from cardiovascular disease, substance use, and depression are often preventable, strategies should be aimed at identifying and treating these conditions throughout pregnancy and in the postpartum period.

The types of health care use that occur during the first 42 days after birth and the year after birth strongly support a role for pediatricians. More than half of all maternal deaths happen after birth, with more than one-third of maternal mortality occurring within the first 42 days postpartum.[4] The American College of Obstetricians and Gynecologists has moved from traditional recommendations of a single 6-week postpartum visit to promoting more patient-centered postpartum care tailored to specific needs, with earlier and more frequent visits. However, it is insufficient to rely on the obstetric postpartum visits because 20% to 40% of patients do not attend, regardless of a complicated pregnancy.[5]

Other innovative ways to integrate care for birthing parents and infants need consideration. A 2020 study of Medicaid recipients found that 38% of dyads had no maternal preventive visits in the year after birth while still attending numerous pediatric visits.[6] In outpatient and emergency settings, pediatricians have many opportunities to engage with postpartum birthing parents during well-child checks in the clinic or during infant sick visits. Although pediatricians do not traditionally treat adults, pediatric physicians have a substantial stake in maternal outcomes because they significantly affect the health and well-being of infants.

Scott K, Gregory EF, Burris HH. Addressing Maternal Mortality in the US—A Pediatrics Responsibility. *JAMA.* 2023;329(21):1819–1820. doi:10.1001/jama.2023.6234

"Although pediatricians do not traditionally treat adults, pediatric physicians have a substantial stake in maternal outcomes because they significantly affect the health and well being of infants."

- Check maternal BP at newborn visits
- Screening for maternal depression
- Lactation support
- Care navigation services
- Maternal preconception screening (IMPLICIT ICC)

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What is IMPLICIT ICC?

ICC is a brief, innovative model that **screens** mothers/birthing people at well child visits from 0 -24 months to address **4** modifiable risk factors.

What are the risk factors?

Smoking

Depression

Family Planning

Prenatal & Multivitamin Use

The Stats:

of mothers/birthing people attend their child's well child visit!

of mothers/birthing people are willing to receive health advice from their child's doctor!

of mothers/birthing people screened positive for one or more ICC risk factors during a well child visit!

Why ICC?

Interconception Care (ICC) is the care that is given to women/birthing people **BETWEEN** pregnancies. It allows us to identify and address risk factors prior to the next pregnancy.

Early and adequate prenatal care is not enough to prevent premature and low birth weight infants.

1 in 10 infants in the United States are born prematurely.

52%

Non-Hispanic Black women/birthing people are 52% more likely to experience premature birth as compared to their white counterparts.

ICC Screening Overview

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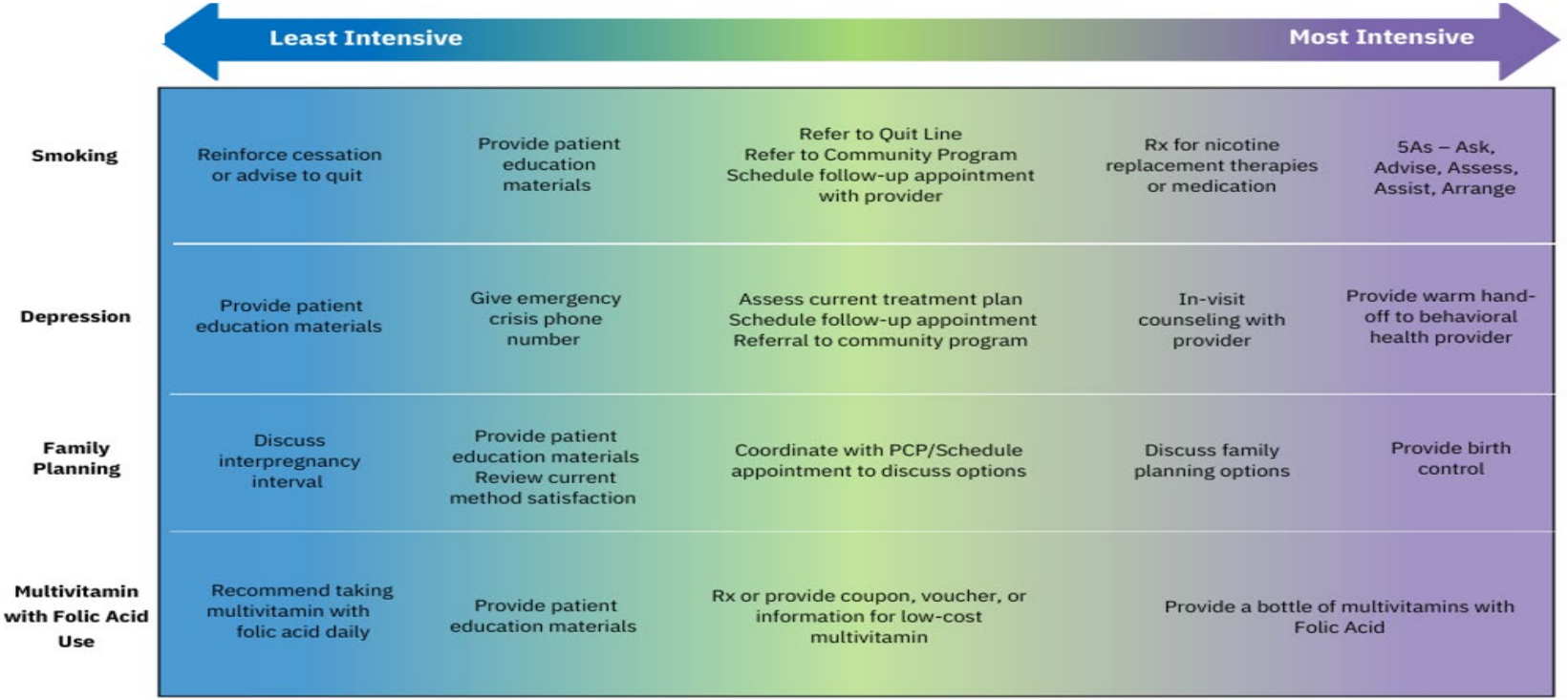
ICC – Intervention Spectrum



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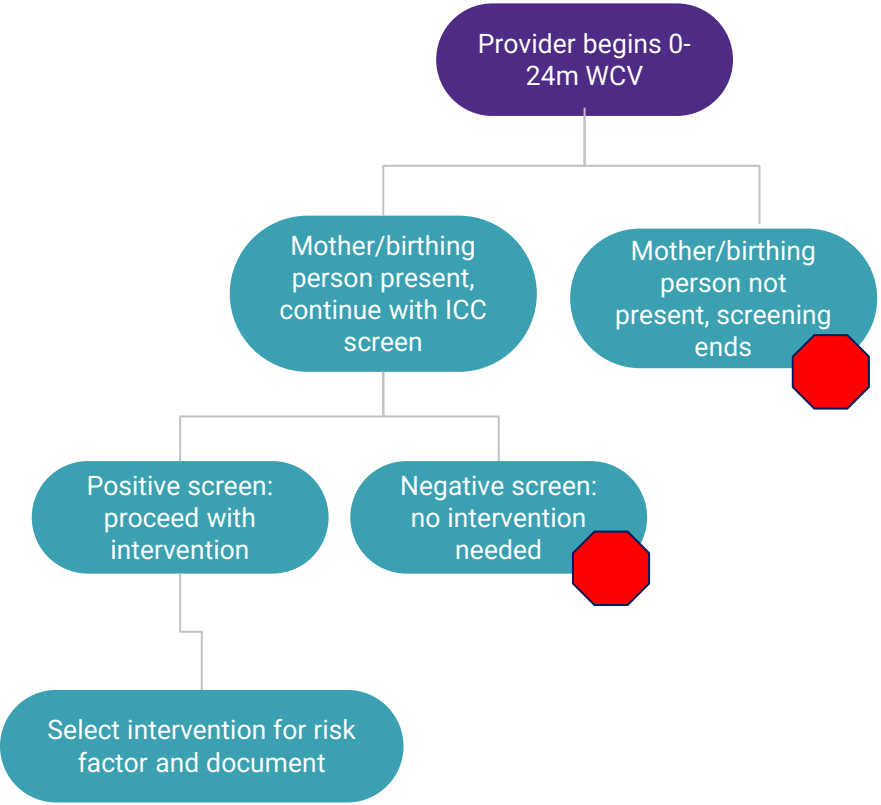
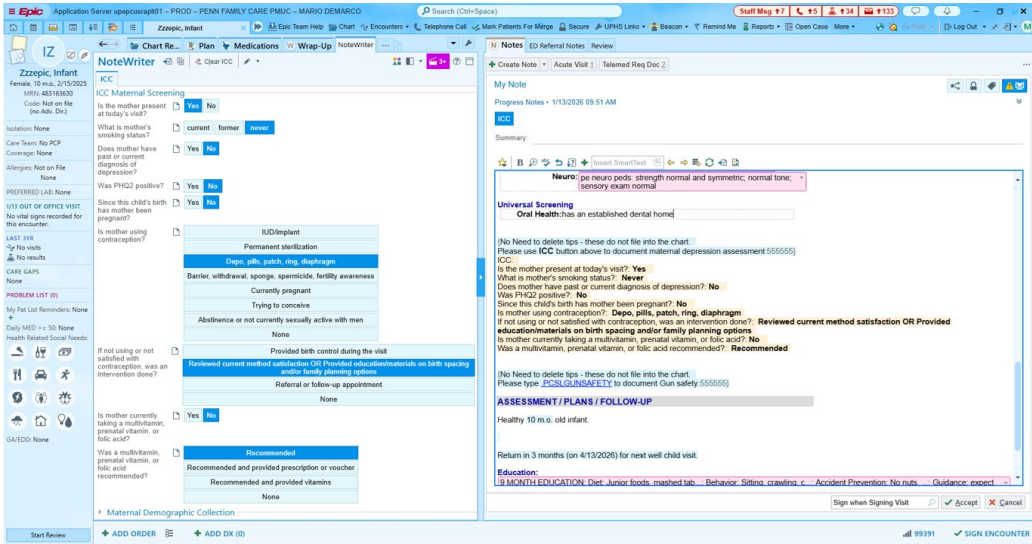
Why Use the IMPLICIT ICC Model?

THE IMPLICIT ICC MODEL PROVIDES A UNIQUE MODEL OF CARE FOR MOMS WITHIN THE CONTEXT OF THEIR CHILD'S WELL CHILD VISIT.

- **Connect More** – up to 11 visit opportunities within 0-24 months
  (healthy mom = healthy baby)
- **Captive Audience** – no need for separate, additional visits for mother/birthing person (unless needed)
- **Child's Chart** – you don't need to open mother/birthing person's chart to do ICC
- **Comprehensive Risk Factor Screening** – broad screening for smoking, depression, family planning, and multivitamin with folic acid use
- **Continuous Quality Improvement (CQI)** – the IMPLICIT team
  works with providers to refine the model based on individual site needs

Workflow Sample: Penn Family Care





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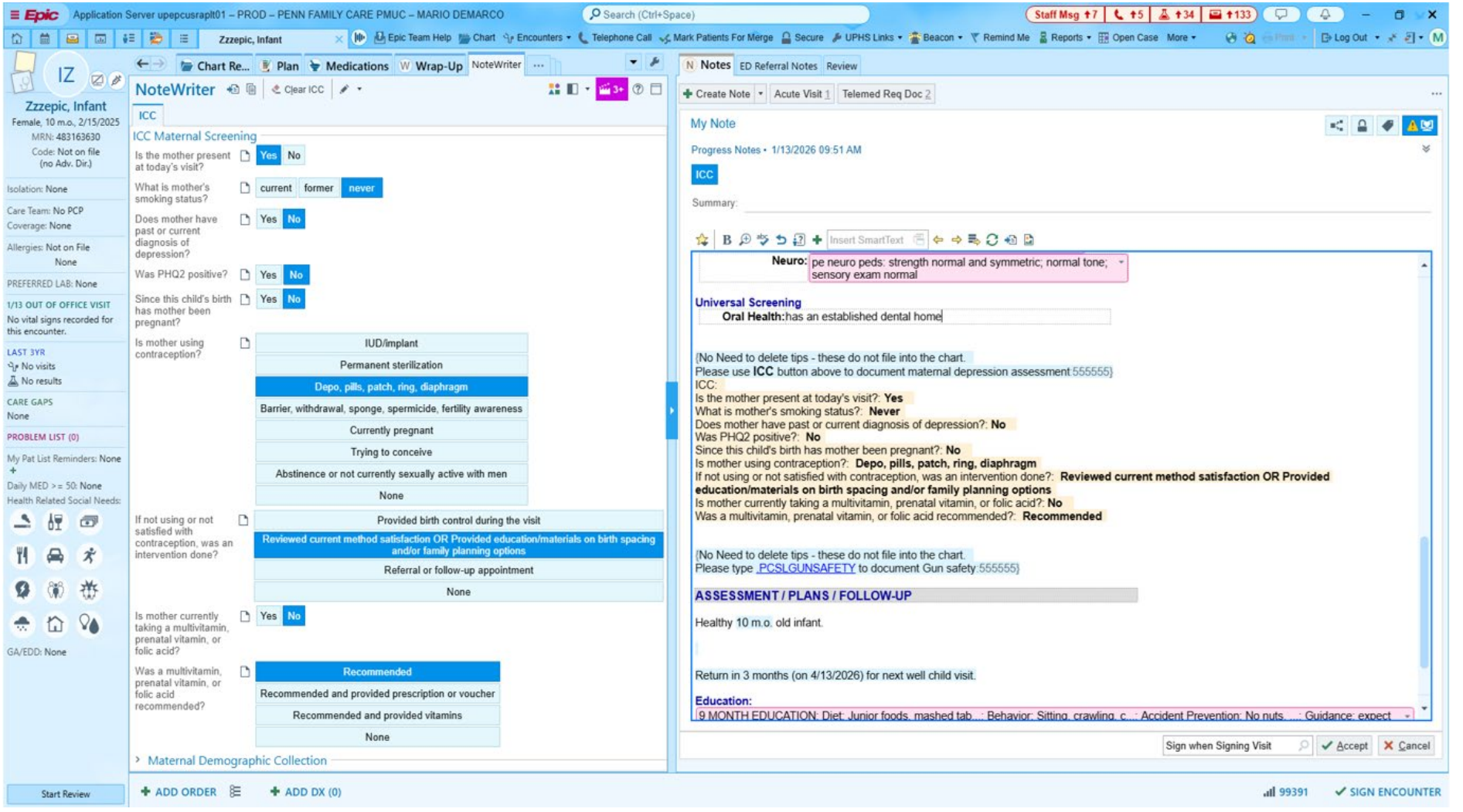
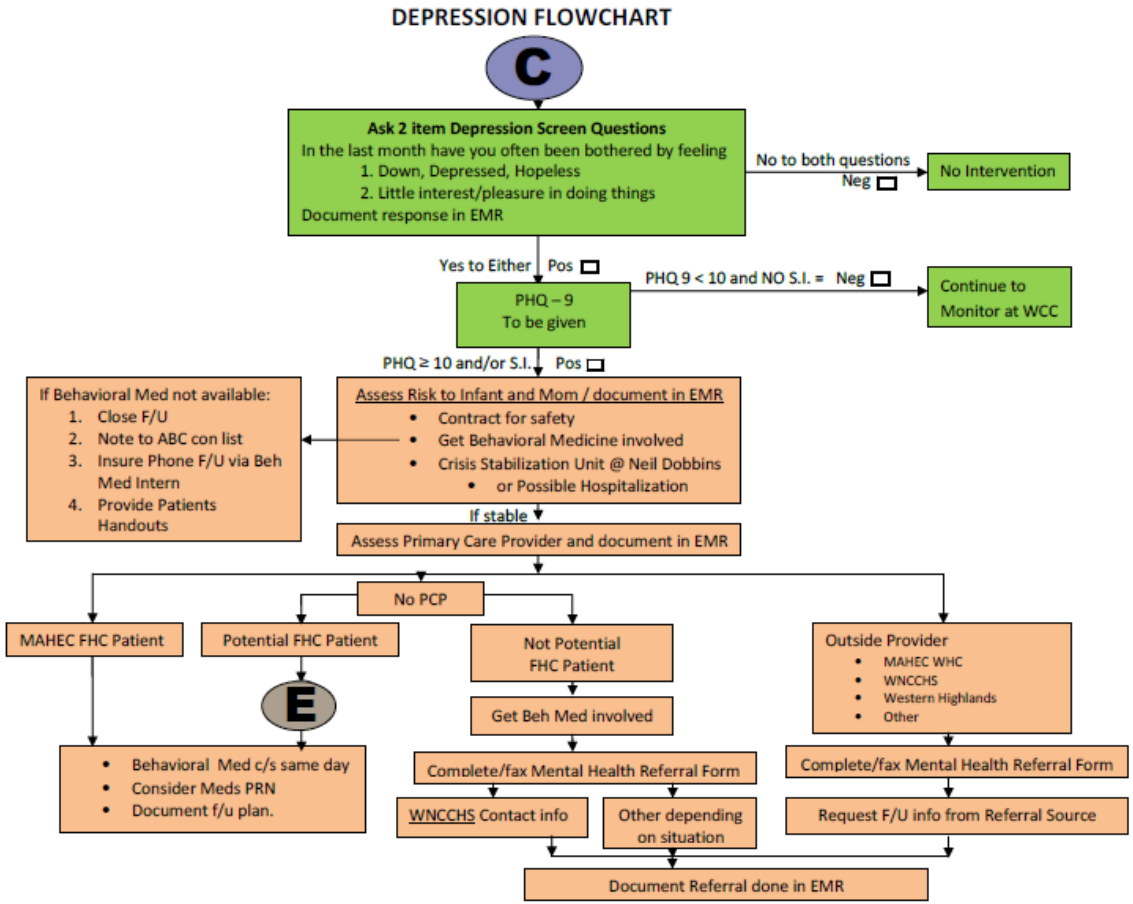

Application Server upepcusraplt01 – PROD – PENN FAMILY CARE PMUC – MARIO DEMARCO
Search (Ctrl+Space)
Staff Msg 7
5
34
133
Zzzepic, Infant
Epic Team Help
Chart
Encounters
Telephone Call
Mark Patients For Merge
Secure
UPHS Links
Beacon
Remind Me
Reports
Open Case
More
Log Out
IZ
Zzzepic, Infant
Female, 10 m.o., 2/15/2025
MRN: 483163630
Code: Not on file
(no Adv. Dir.)
Isolation: None
Care Team: No PCP
Coverage: None
Allergies: Not on File
None
PREFERRED LAB: None
1/13 OUT OF OFFICE VISIT
No vital signs recorded for this encounter.
LAST 3YR
No visits
No results
CARE GAPS
None
PROBLEM LIST (0)
My Pat List Reminders: None
Daily MED >= 50: None
Health Related Social Needs:
GA/EDD: None
Start Review
Chart Re...
Plan
Medications
Wrap-Up
NoteWriter
NoteWriter
Clear ICC
ICC
ICC Maternal Screening
Is the mother present at today's visit?
Yes
No
What is mother's smoking status?
current
former
never
Does mother have past or current diagnosis of depression?
Yes
No
Was PHQ2 positive?
Yes
No
Since this child's birth has mother been pregnant?
Yes
No
Is mother using contraception?
IUD/implant
Permanent sterilization
Depo, pills, patch, ring, diaphragm
Barrier, withdrawal, sponge, spermicide, fertility awareness
Currently pregnant
Trying to conceive
Abstinence or not currently sexually active with men
None
If not using or not satisfied with contraception, was an intervention done?
Provided birth control during the visit
Reviewed current method satisfaction OR Provided education/materials on birth spacing and/or family planning options
Referral or follow-up appointment
None
Is mother currently taking a multivitamin, prenatal vitamin, or folic acid?
Yes
No
Was a multivitamin, prenatal vitamin, or folic acid recommended?
Recommended
Recommended and provided prescription or voucher
Recommended and provided vitamins
None
Maternal Demographic Collection
Notes
ED Referral Notes
Review
Create Note
Acute Visit 1
Telemed Req Doc 2
My Note
Progress Notes • 1/13/2026 09:51 AM
ICC
Summary:
Insert SmartText
Neuro: pe neuro peds: strength normal and symmetric; normal tone; sensory exam normal
Universal Screening
Oral Health:has an established dental home
{No Need to delete tips - these do not file into the chart.
Please use ICC button above to document maternal depression assessment 555555}
ICC:
Is the mother present at today's visit?: Yes
What is mother's smoking status?: Never
Does mother have past or current diagnosis of depression?: No
Was PHQ2 positive?: No
Since this child's birth has mother been pregnant?: No
Is mother using contraception?: Depo, pills, patch, ring, diaphragm
If not using or not satisfied with contraception, was an intervention done?: Reviewed current method satisfaction OR Provided education/materials on birth spacing and/or family planning options
Is mother currently taking a multivitamin, prenatal vitamin, or folic acid?: No
Was a multivitamin, prenatal vitamin, or folic acid recommended?: Recommended
{No Need to delete tips - these do not file into the chart.
Please type .PCSLGUNSAFETY to document Gun safety:555555}
ASSESSMENT / PLANS / FOLLOW-UP
Healthy 10 m.o. old infant.
Return in 3 months (on 4/13/2026) for next well child visit.
Education:
9 MONTH EDUCATION: Diet: Junior foods, mashed tab...; Behavior: Sitting, crawling, c...; Accident Prevention: No nuts, ...; Guidance: expect
Sign when Signing Visit
Accept
Cancel
ADD ORDER
ADD DX (0)
99391
SIGN ENCOUNTER



Depression Screen Workflow: Example 1

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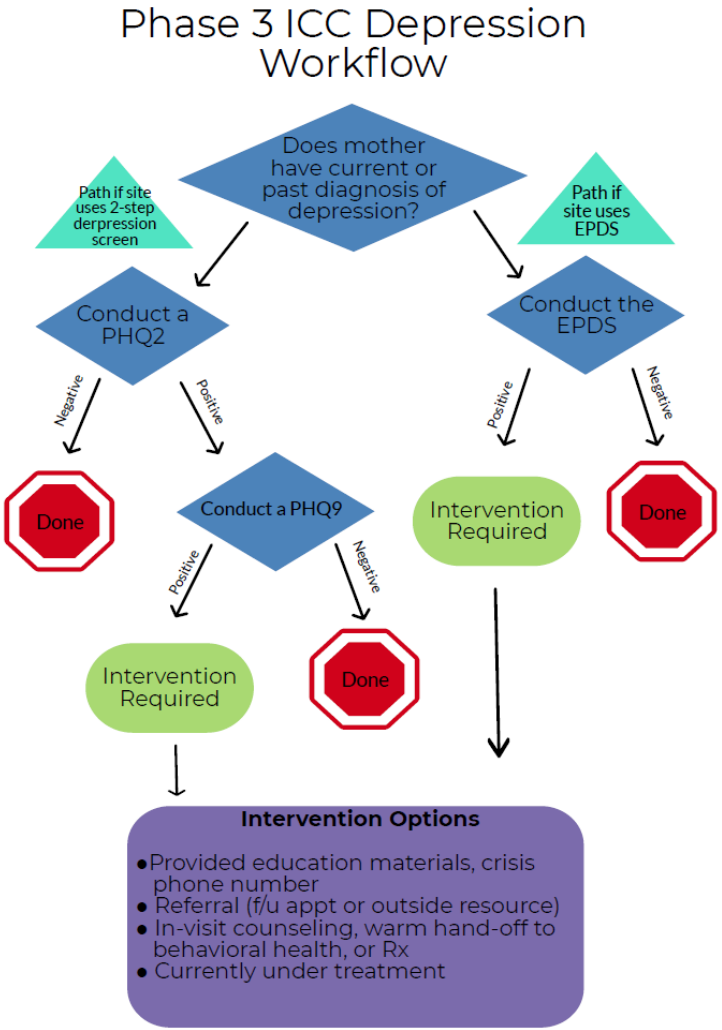

Depression Screen Workflow: Example 2

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Postpartum Opportunities: 4th Trimester Care

IMPLICIT 4th Trimester Care Model

3rd Trimester Visit
(~36 weeks)

- Identify preexisting conditions/risk factors
- Create plan for postpartum period

Hospital Discharge
(2-3 days from birth)

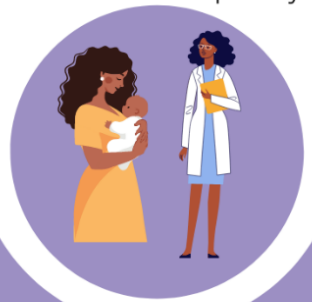
- Identify delivery/recovery complications
- Communicate with outpatient care team

Early Postpartum Visit
(within 21 days from birth)

- Assess signs of biomedical/psychosocial conditions
- Provide support services as indicated

Routine Postpartum Visit
(6-8 weeks from birth)

- Review engagement with services
- Comprehensive recovery assessment
- Ensure connection to primary care



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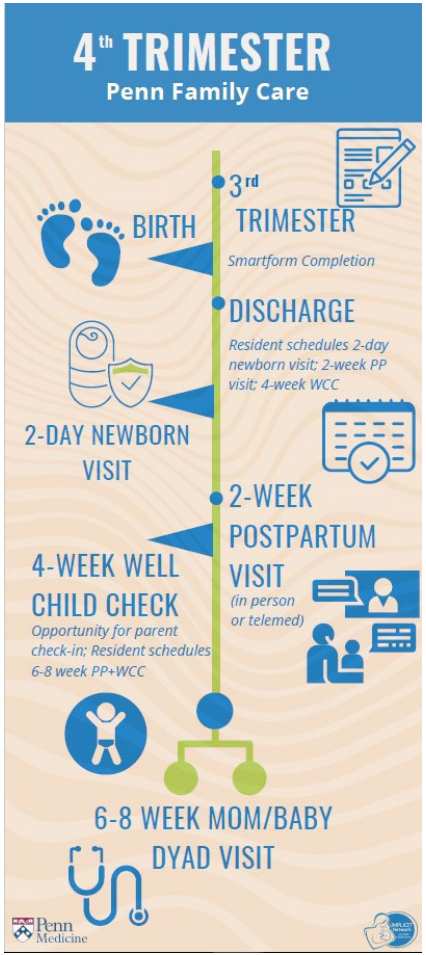
Family Medicine - Implementing 4th Trimester

Implementation of the 4TM model increased early postpartum care and postpartum care in general

	Year 1	Year 2
• Visit ≤ 21 days:	15% → 56%	→ **64%**
• Visit ≤ 28 days:	27% → 64%	→ **71%**
• Any PP visit:	78% → 93%	→ **93%**
• No PP visit:	22% → 7%	→ **7%**

PP engagement is equal between Black and Non-Black patients at PFC

Earlier visits can identify key symptoms and risks that drive morbidity and mortality for birthing people



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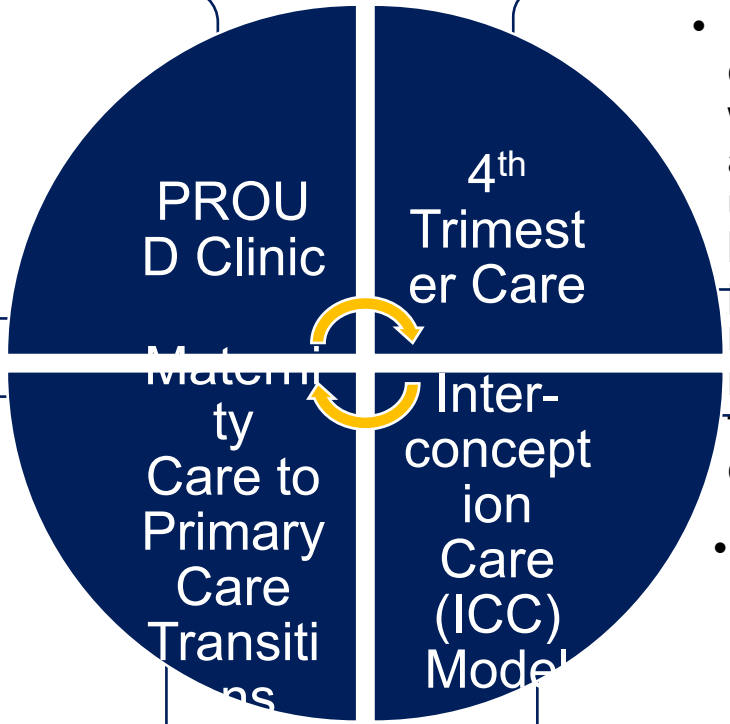
Conceptual Model for Maternity Care in Primary Care Settings

- Addressing care needs of families affected by Opiate Use Disorder before, during and after pregnancy.



- High touch care model which addresses unique biomedical and psychosocial needs in the months following childbirth
- Utilizing well child visits for children age 0-24 months as an opportunity to provide maternal support and

- Re-conceptualizing primary care to play a larger role in postpartum care and preconception

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Summary

- Despite health care spending, maternity care is woefully broken
- The challenges that many women experience postpartum have been grounded in primary care for decades
- Primary care focused practices can leverage their opportunity to care for families to strengthen the health of mothers before, after and in between pregnancies
- Innovation in care delivery has the potential to make care earlier, more accessible and higher quality…but we need to scale it up

Best Practice Recommendations

Ensure all women/birthing persons have an initial assessment/touch point, either in person or by phone, within the first 3 weeks postpartum to address acute postpartum issues.

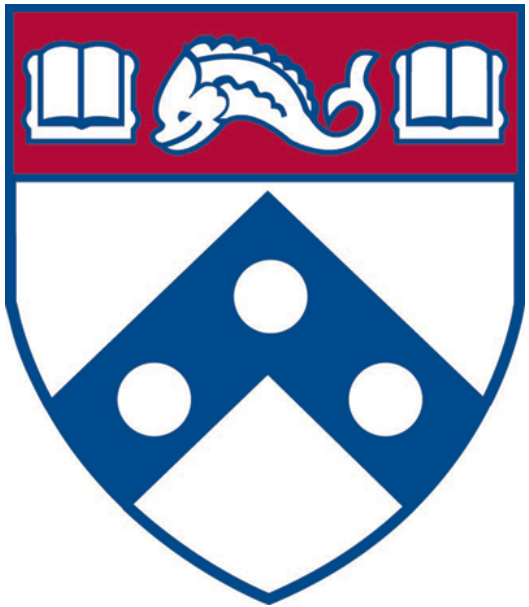
Assess every woman/person of childbearing age that presents for care to determine if symptoms are a pregnancy/postpartum related condition by asking if they have been pregnant in the last year.

Obtain comprehensive obstetrical history and record of ongoing medical and mental health issues, inclusive of high-risk or severe maternal conditions, genetic conditions, chronic diseases, and birth trauma experienced during pregnancy and/or labor and delivery by building trust.

Educate and validate knowledge of staff members, appropriate to scope of practice, on utilizing trauma informed approaches, cultural and racial humility for all screenings and response protocols.

IMPLICIT

NETWORK



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PCMHs' Sharing of PDSA Plans and Peer-to-Peer Learning

Next Steps, Wrap Up & Session Evaluation

Robert Ferguson

Pittsburgh Regional Health Initiative

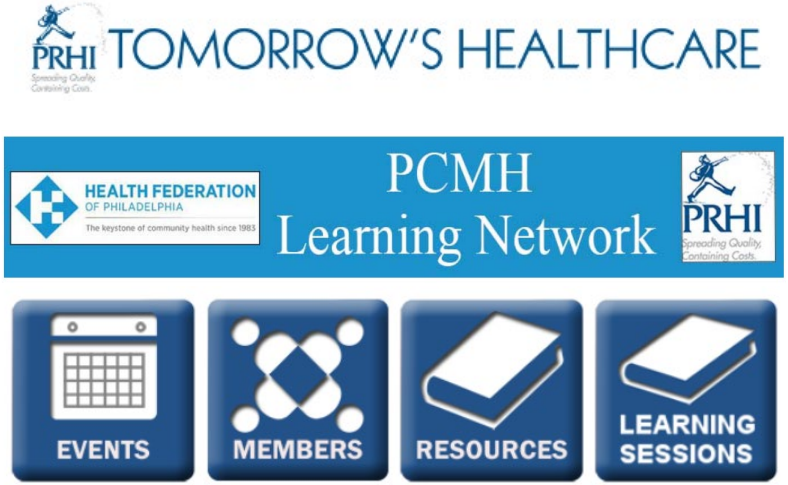
Next Steps from Today's Session

1. Update and submit Plans for **PDSAs by March 25th** and prepare for the "Do" phase
2. Reach out with any questions or to request 1:1 support or TA
3. Make sure you and your team are registered for the next session – **Wednesday, April 1st at 9 – 10:30 am**

PCMH Online Community

https://www.tomorrowshealthcare.org/

Members of your PCMH's multi-disciplinary learning team will receive log-ins



- Access the session materials in "Learning Sessions"
- Look for guides and tools in "Resources"
- Find session dates and registration links under "Events"

CEU Process

You will receive a follow up email with links to:

Complete the survey at: https://www.surveymonkey.com/r/WGZQPKY by Thursday, February 26

1. Please be sure to designate which CEU credits you are requesting **CME, CNE, Social Worker or Certificate of Attendance**. If you already have an account with the UPMC Center for Continuing Education, please be sure the email you enter on the survey matches the UPMC CCE account email that you create.

2. The UPMC Center for Continuing Education will follow up with you via email after February 26th with instructions on how to claim your credits.
   - ❑ To prepare, we recommend you create an account with UPMC CCE via this website https://cce.upmc.com.

Thank You!