Gathering the **R**ural **O**B **W**orkforce in **WI**

GROW-WI ECHO Program

How to Join:
https://iecho.org/public/program/PRGM17425658124325CC96FHKX3

For attendance purposes, please text the code NERSOH to 608-260-7097.

Session Date: February 24, 2026
Facilitator: Allegra Ponshock, MD

	Topic	Presenter
Case Presentation	Neonatal Palliative Care in the Small Hospital Setting	Charles Pearce, MD CDR (FMF) MC USNR/Surgical Co Alpha, 4th Med BN VPMA/CMO Upland Hills Health Physician MEP Health Dodgeville, WI
Educational Presentation	4th Trimester Care	Lee Dresang, MD, Professor Rural FMOB Fellowship Co-Director UW Department of Family Medicine and Community Health Madison, WI

Agenda:

7:30 – 7:35 AM – Welcome and Introductions

-Text-in your attendance, even if you do not plan to claim Continuing Education credits.

7:35 – 8:00 AM – Case Presentation & Discussion

8:00 – 8:30 AM – Educational Presentation

Continuing Education Credits:

To claim CE credit, **you must complete the evaluation form after each session**.
ICEP will email you a link to the evaluation form after texting in for attendance.

Interprofessional Continuing Education Partnership
UNIVERSITY OF WISCONSIN–MADISON

GROW-WI ECHO (Gathering the Rural OB Workforce in WI)
2025-2026
4th Trimester Care
February 24, 2026
Lee Dresang, MD; Charles Pearce, MD

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:
MD/DO, RN, APRN, Physician Assistants, Certified Nurse Midwives, Students

Objectives:
1. Summarize the Fourth Trimester Model of Postpartum care as a continuum of tailored care that begins with prenatal anticipatory guidance and continues to planning for ongoing prevention and chronic disease management past the 12-week postpartum visit
2. Identify ways fourth trimester care is unique in rural settings
3. Describe how rural providers can improve fourth trimester care

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** **Ineligible companies** are those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. The ACCME does not consider providers of clinical service directly to patients to be ineligible companies.*

Name	Role	Financial Relationship Disclosures	Discussion of unlabeled/unapproved uses of drugs/devices in presentation	COI completion date
Lee Dresang, MD	Presenter	No relevant financial relationships with ineligible companies to disclose.	No	1/5/2026
Charles Pearce, MD	Presenter	No relevant financial relationships with ineligible companies to disclose.	No	2/2/2026
Jillian Landeck, MD	RSS Chair	No relevant financial relationships with ineligible companies to disclose.	NA	12/2/2025
Jenny White	RSS Coordinator	No relevant financial relationships with ineligible companies to disclose.	NA	12/1/2025
Katherine Breitenmoser, CPM, LM	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	12/2/2025
Bonnie Brown, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	12/4/2025
Jensena Carlson, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	12/10/2025
Lee Dresang, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	12/1/2025
Rachel Hartline, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	12/10/2025
Caitlin Hill, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	12/12/2025
Ryan Luellwitz, DO	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	12/12/2025
Allegra Ponshock, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	12/1/2025
Ryan Spencer, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	12/4/2025
Cindy Stippich, CNM	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	12/8/2025

Accreditation Statement

In support of improving patient care, the University of Wisconsin–Madison ICEP is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

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The University of Wisconsin–Madison ICEP, as a member of the University Professional & Continuing Education Association (UPCEA), authorizes this program for 0.1 CEUs or 1.0 hour.

Welcome!

We will get started shortly.

Feel free to share your name, specialty/role, and practice location in the chat.

For attendance purposes please text the code NERSOH to 608-260-7097.

Please text for attendance, **even if you are *not* claiming** continuing education credit.

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American Nurses Credentialing Center (ANCC)

The University of Wisconsin–Madison ICEP designates this live activity for a maximum of 1 ANCC contact hour.

Continuing Education Units

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- The planning committee has no conflicts of interest to disclose.

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Attendance

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Continuing Ed Credit

To receive continuing education credit:

1. Log your attendance (as above)
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2. Fill out the session evaluation form to receive credit – **REQUIRED for credit.**
   - A link to the evaluation will be sent after you text the code.

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Update on Midwife CEUs

For **Certified Professional Midwife** Continuing Education Credit:

- We are unable to meet MEAC Continuing Education credit requirements.
- The GROW-WI ECHO sessions may be used to meet the NARM Continuing Education Category 2 CEUs.

For **Certified Nurse Midwife** Continuing Education Credit:

- The ACNM Continuing Education Committee accepts AMA PRA Category 1 Continuing Education Credit.
- The GROW-WI ECHO sessions are approved for this.

For **Everyone:**

- To receive any Continuing Education credits, participants must:
  - Create a free ICEP account.
  - Text the attendance code at the time of the session.
  - **Fill out the evaluation** at the end of the session.

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Planning Team – Updates!

Katherine Breitenmoser, CPM, LM – Windy Hill Midwifery, LLC, Merrill, WI

Bonnie Brown, MD – UW DFMCH

Jensena Carlson, MD – UW DFMCH

Lee Dresang, MD – UW DFMCH

Rachel Hartline, MD* – Upland Hills Health, Dodgeville, WI

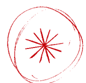
Caitlin Hill, MD – Emplify Health, La Crosse, WI

Jillian Landeck, MD* – UW DFMCH

Ryan Luellwitz, MD – UW OB GYN

Allegra Ponshock, MD* – Mile Bluff Med Ctr, Mauston, WI

Ryan Spencer, MD – UW OB GYN



Cindy Stippich, CNM – Prairie Ridge Health, Columbus, WI

Jenny White* – UW DFMCH

Thank you to previous planning committee members!

Korina Bauer, RN, CPM, LM
Rebecca Pfaff, MD
Shannan Stephens, MD

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* Core Facilitation Team

Friendly Reminders

- Video appreciated
- Use chat function to ask questions or raise hand if able
- Mute microphone when not speaking
- Maintain confidentiality, no PHI
- Didactic will be recorded
- Mission is to empower those working in rural settings
- Our diversity of perspectives, specialties, practice scopes are our strength
- **"Coming together is a beginning. Keeping together is progress. Working together is success."** - Henry Ford

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Announcements

- **Next Session:** Mar 24th
- **Rural EMS OB Preparedness**
  James Small - Rural EMS Outreach Program Manager
  UW School of Medicine and Public Health
  Wisconsin Office of Rural Health

- Case by **Craig Tschautscher, MD, MS, DRTM (RCSEd), FACEP, FAMPA**
  Flight Physician, UW Med Flight
  Director of Prehospital Resident Education
  Assistant Professor (CHS)
  Division of Prehospital Medicine

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Interested in sharing a case?

Email jennifer.white@fammed.wisc.edu

- Slide template shared, 10 min for details of case
- Priority to cases from rural and resource-limited settings
- No PHI
- Include on CV as a state presentation

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Rural OB Case Presentation

Charles Pearce, MD

Upland Hills Health

02/24/2026

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Disclosures & Disclaimers

No Disclosures

PATIENT RELATIONSHIP DISCLAIMER

PLEASE NOTE that Project ECHO® case consultations do not create or otherwise establish a provider-patient relationship between any clinician and any patient whose case is being presented in a Project ECHO® setting.

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Case Introduction

25yo G3P2002 @ 36.3 wks w/ no prenatal care until 32 wks w/ 3rd trimester US revealing for exencephaly/encephalocele, marked craniofacial abnormalities, clubbed feet and VSD; seen by MFM, plans for palliative care consultation and expected delivery in Madison.

Primary question for discussion: Neonatal palliative care in the 'lower' resourced Critical Access Hospital environment.

Obstetrical/Prenatal History:	Past Medical History:
G1: SVD, 2018, delivered in Guatemala **G2*:** SVD, 2024, delivered at Meriter; late presentation for prenatal care, complex social situation noted *h/o precipitous delivery	• Microcytic anemia h/o blood transfusions • B12 Deficiency

Social History

- Home country: Guatemala, moved to US in 2024
- Spanish speaking only
- Concern for spousal abuse
- No tobacco/illicit drugs
- No food insecurity

Prenatal History

Late term establishment of care

12/17: Establish care w/ FP OB; US ordered (by LMP 32.0wks)

1/2: Follow up, no US obtained (34.2wks)

1/6: *US obtained*

1/8 MFM evaluation, plan for palliative care eval (35.1wks)

Prenatal History

MFM note from 1/8:

. . . Would do IOL if not labored by due date. Given poor prognosis- VD ok- consider no monitoring. CS for fetal distress would not change outcome. CS only if they desire a liveborn fetus. Additionally, there is increased risk of prolonged labor without pressure on the cervix of the bony skull. Given the neonatal prognosis, every effort is made to achieve a vaginal delivery unless there is a clear maternal indication for CS.

Labor History

1/17: 36.3wks

- 1301: EMS call for laboring pt
- 1305: L&D updated, on-call Ob/Gyne updated; team briefed
- 1307: EMS arrives on scene
- 1310: EMS updates ER
- 1315: EMS report, pt info provided, chart accessible
- 1318: Mother/Child arrive to the ER
- 1350: Mother to OR, Child to nursery

Maternal Exam:	Maternal Labs & Imaging:
AF, HR 94, BP 110/67, RR 16, Sats 98%	8.3>11.3/34.7<301
Uncomfortable/tearful, not unwell	
RRR	137/3.7 107/17 13/0.71 <86
CTAB	
Minimal but ongoing vaginal bleeding (could not tolerate exam, went to OR for EUA, small vaginal tear)	INR 0.99
Firm fundus	
No LE edema	
Neuro intact	

Neonatal Exam:

96.1, HR 160s, BP n/o, RR 48, Sats 98%

Exencephalic, able to visual gyri, ?cerebellar partial rotation

Unable to close left eye

Nares widely displaced w/ marked midface cleft, easily visualized epiglottis/arytenoids

Lungs clear w/ quickly resolved respiratory distress

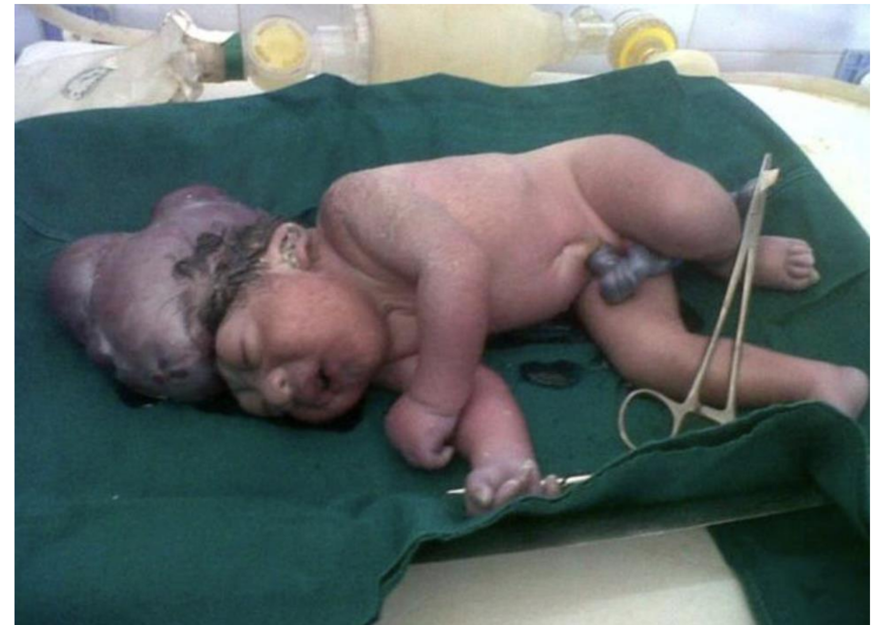
Abdomen soft, umbilical stump intact, 3V cord

Bilateral clubbed feet

Neonatal Labs & Imaging:

None obtained

Representative photos (not our pt):



Proposed diagnoses/management plan:

- Discussion with UW Neonatology to review in detail prognostics, expected course, any special considerations.
- Detailed discussion with Mother/Father re: above, parents wishes w/ shared decision-making
- Huddled with UHH L&D nursing staff prior to discussion w/ on-call FP on for newborns
- Conversation w/ UHH on-call FP, plan for no painful interventions, holding/swaddling/soothing, PRN lorazepam/morphine

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Key learning points:

- Recognizing goals of care, quickly pivoting from neonatal resuscitation to aggressive/compassionate palliation.
- Community care plans provided to Mother/Parents, local EMS and Emergency Department.
- Small hospital setting can (did) provide world class care for complex child and mother.
- Sometimes the world pays attention.

Systems Issues/Area for Improvement:	Team successes:
• Emergency Services, Emergency Department awareness of high risk/complex case in community • No IV access of mother • Cord unclamped on presentation • No care plan in Epic • No EMS access to Spanish Interpreter* • Low staffing (L&D side of house) • Mother/Child L&D v Med/Surg/ICU	• EMS communicated mother information, permitting rapid Epic review • Ob/Gyne was in-house, FP OB was in-house, PA student was former Doula/Spanish interpreter, L&D RN 25+ years experience • On-call FP for newborns dual-hatted as system Palliative care/Hospice medical director • No critically ill patients in the ER, no one checked in during the hour of managing mother/child

Open Discussion

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4th trimester care in a rural setting

Lee Dresang, MD, Professor

University of Wisconsin Dept of Family Medicine and Community Health

February 24, 2026

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Disclosures & Disclaimers

- No disclosures

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Learning Objectives

1. Summarize the Fourth Trimester Model of Postpartum care as a continuum of tailored care that begins with prenatal anticipatory guidance and continues to planning for ongoing prevention and chronic disease management past the 12-week postpartum visit
2. Identify ways fourth trimester care is unique in rural settings
3. Describe how rural providers can improve fourth trimester

What do we mean by “fourth trimester”?

- New paradigm for postpartum care
- Ongoing rather than a single visit
- Individualized rather than standard
- First contact within 3 weeks of delivery (many instances should be earlier given issues regarding pain, breastfeeding, mental health)
- Comprehensive postpartum visit no later than 12 weeks after birth

(ACOG 2018)

What is wrong with old model postpartum care?

- 40% of women do not attend a postpartum visit
- Lower rate of postpartum visits among people with limited resources (such as rural areas) and among black postpartum patients (Thiel de Bocanegra 2017); contributes to disparities
- Lack of care can lead to higher maternal and infant morbidity and mortality

(ACOG 2018)

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What are consequences of poor fourth trimester care?

- The US is the only high-income country where maternal mortality has been increasing instead of decreasing over the last three decades.
- The US maternal mortality rate:
  - 32.9 deaths per 100,000 live births in 2021 (Hoyert 2021)
  - 8.0 in 1990 (CDC 1995)
  - 18.8 in 2000 (MacDorman 2016)
- Black US maternal mortality rate:
  - 69.9 deaths per 100,000 live births in 2021 (Hoyert 2021)
- Wisconsin state maternal mortality rate has increased over last 10 years (Wisconsin Office of Rural Health 2024)
- Higher Maternal Mortality for Wisconsin non-Hispanic Black, Asian and Latine women (Wisconsin Office of Rural Health 2024)

Photo courtesy of PACE MD

When do pregnancy related deaths occur?

Timing	Percentage of deaths
During pregnancy	22
Day of delivery	13
1-6 days postpartum	12
7-42 days postpartum	23
43-365 days postpartum	30

(Trost 2022)

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What are top causes of pregnancy related deaths?

Cause	Percentage of deaths
Mental health condition	23
Hemorrhage	14
Cardiac condition	13
Infection	9
Embolism-thrombotic	9

(Trost 2022)

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Why is fourth trimester care important?

- Sets the stage for long-term health and well-being

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Fourth trimester begins during pregnancy

- Discuss purpose and value of post-partum care
- If scheduled delivery, can schedule postpartum visits prior to delivery

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Comprehensive visit by 12 weeks

- Full physical, social and psychological assessment
- Address: Breastfeeding, infant care and feeding, sexuality, contraception, birth spacing/plans, sleep and fatigue, physical recovery from birth, chronic disease management and health maintenance
- Address: hypertensive disorders, high BMI, diabetes, thyroid disorder, renal disease, mood disorder
- Healthy diet and exercise
- Sleep ☺

Medicaid Expansion passes Wisconsin Assembly February 19, 2026!!!

- Postpartum Medicaid will cover 12 months rather than 60 days after delivery
- Wisconsin was next to last state to pass
- Passed state senate unanimously April 2025 but Speaker Robin Vos had not let out of committee
- When he did, bipartisan bill passed overwhelmingly the next day

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Rural fourth trimester issues

- Access issues
- Hospital closures
- Workforce shortages
- Lower rates of depression screening (Interrante 2022)
- Lower rates of contraception counseling (Interrante 2022)

(ACOG 2018)

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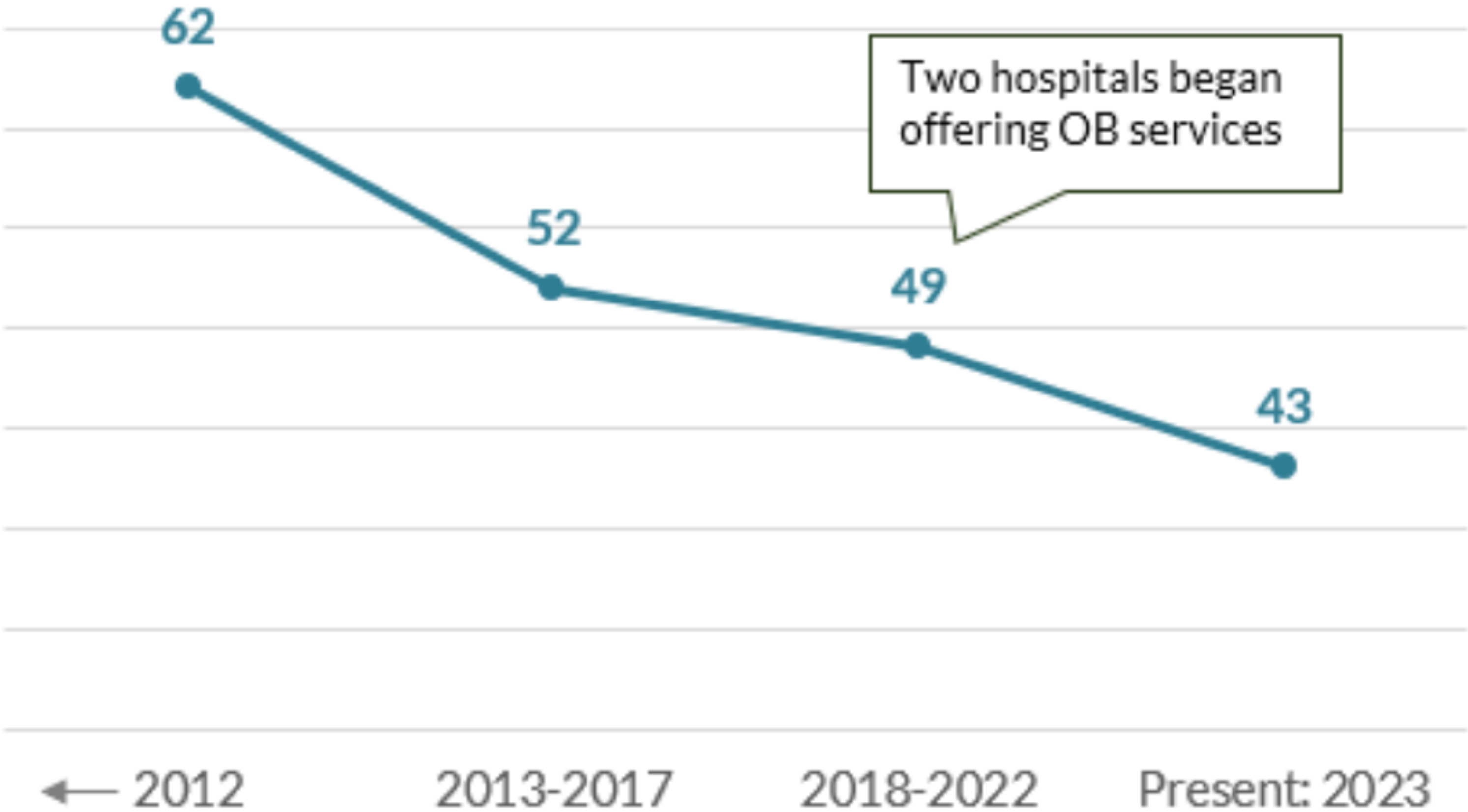
Access issues

- 2.3 million women of reproductive age (1 in 12 US women) live in counties with limited or no pregnancy care/postpartum services (March of Dimes 2020)



(Wisconsin Office of Rural Health 2024)

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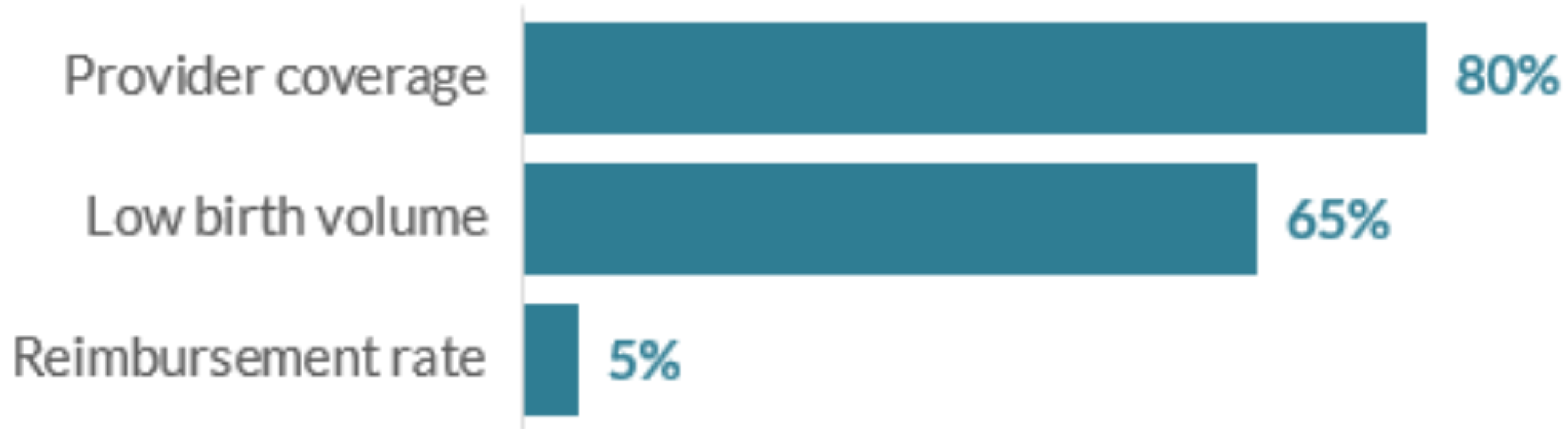

(Wisconsin Office of Rural Health 2024)

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Workforce issues

- Family physicians attend deliveries in over half rural hospitals (Wisconsin Office of Rural Health 2024)
- Nursing shortages

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Rural fourth trimester issues

- 2019 rural postpartum parents, 2191 rural infants, 12,112 urban postpartum parents and 13,088 urban infants
- In rural areas: less likely to see an OB/GYN (p = 0.002) more emergency department (ED) visits (p = 0.030), more hospitalizations (p = 0.041), more frequently uninsurance (p = 0.006), and lost Medicaid coverage after pregnancy (p = 0.006).

(Handley 2025)

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Rural fourth trimester issues

- People who live in a rural area but deliver in an urban are have higher rates of postpartum severe maternal morbidity and mortality

(Hung 2025)

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“Lost mothers” series

In the US every year:

- Hundreds of women who give birth do not survive their baby’s first 3 months of life.
- Hundreds of women who give birth attempt suicide in their baby’s first year of life.
- Thousands of women experience major medical complications including organ failure, brain damage, excessive bleeding, loss of reproductive organs, and infertility.
- Hundreds of thousands of women suffer from debilitating depression and anxiety.

(Hamilton 2018; Pro Publica 2023)

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Lost mother:
Joonyper Light

- 21yo G1P1 with history of heroin addiction
- Drug treatment program in pregnancy
- Postpartum difficult to get to rehab (rural challenge)
- Breastfeeding and afraid to take antidepressant
- 2 months after delivery, had relapse and husband Matt found dead of overdose on bathroom floor

(Pro Publica 2023)

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Rural peripartum mental health

- The risk of perinatal depression is 21% higher among rural versus urban women (OR = 1.21, 95% CI: 1.05-1.41) adjusted for race, ethnicity, and maternal age (Nidey 2020)
- Women in rural areas are significantly less likely to seek care, be screened for or receive treatment for perinatal mental health conditions (Miller 2024)
- Rural women identify stressors including financial stress, lack of employment and affordable housing, extended family interconnections, gossip, isolation, loneliness and boredom (Bloom 2012)

Mental health and pregnancy related mortality

- 8.4% of pregnancy related deaths are suicides
- 2.9% of pregnancy related deaths are homicides

(Trost 2022)

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Postpartum depression and anxiety

- Postpartum depression up to 10% (Paladine 2019)
- ACOG recommends all patients are screened at least once in the peripartum period for depression and anxiety using a standardized, validated tool
- The Edinburgh Postnatal Depression Scale (EPDS) is most frequently used
- There is evidence that screening alone improves outcomes
- Initiation of treatment or referral to mental health providers can provide maximum benefit

(ACOG 2018)

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Counseling for those at risk

- The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions – Class B Recommendation

(ACOG 2018)

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Medication Choice for Depression and Anxiety

- ACOG recommends that selective serotonin reuptake inhibitors be used as first-line pharmacotherapy for perinatal depression and anxiety. Serotonin-norepinephrine reuptake inhibitors are reasonable alternatives.
- Pharmacotherapy should be individualized based on prior response to therapy (if applicable). If there is no pharmacotherapy history, sertraline or escitalopram are reasonable first-line medications. (Strong recommendation, low-quality evidence)
- ACOG recommends that benzodiazepines be avoided or prescribed sparingly as a treatment for perinatal anxiety. (Strong recommendation, moderate-quality evidence)

(ACOG No 5 2023)

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Zuranolone (Zurzuvae)

- First FDA approved oral med for postpartum depression
- Approved August 2023
- Once per day for 14 days
- Neuroactive steroid acting on $GABA_A$ receptors
- Side effect – Drowsiness, diarrhea, UTIs
- Cost -- $16,000 for 14 day course

(Montgomery 2025)

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Postpartum depression screening at well child visits

- Prospective comparison of care as usual vs screening for postpartum depression at well child visits at 1, 3 and 6 months
- Fewer depressed patients at 9 months (OR 0.28; 95% CI 0.12-0.63)

(van der Zee-van den Berg 2017)

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Take advantage of well child visits

- IMPLICIT network – screen for postpartum depression at well child visits: https://www.fmec.net/implicit

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Rural 4th trimester case

- 28yo G1P0@37w4d admitted with blood pressures 160s/100s. No HA/vision change RUQ pain. Cervix 6/80/0. FHT category 2 with mod variability and accels but variable decels. Labs normal except platelets of 80K.
- Gallup Indian Medical Center
- Communication with Albuquerque
- Decision deliver in Gallup

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Rural 4th trimester case

- Healthy 6#5oz girl APGARs 9,9
- Mag through 24 hours postpartum; pressures stable on nifedipine XL 60mg
- Platelets every 6 hours: 72K, 64K, 48K, 39K, 53K, 76K

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Hypertensive disorders of pregnancy

- In 2019, 13 percent of pregnant individuals had a hypertensive disorder (Ford 2022)
- Number one cause of maternal death in the US is cardiovascular (16.2%), number three is cardiomyopathy (12.5%) and number 6 is stroke (7%) (CDC 2013)

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Hypertensive disorders of pregnancy

- Monitor for 72 hours inpatient or equivalent (48 hours plus BP check the next day in clinic)
- Clinic visit at 7-10 days
- Again at 4-6 weeks
- Also 6 months and 12 months

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When do you readmit for postpartum hypertension?

- 16% of Eclampsia is beyond 48 hours postpartum
- Usually preceded by headache and other neurologic symptoms
- Negative consequences of readmission and of magnesium
- Focus on close blood pressure control outpatient (when possible)
- Consider Lasix 20mg po daily for 5 days
- Reserve magnesium therapy for patients with neurologic symptoms

(Cagino 2023)

Cardiovascular disease

- Cardiovascular health needs 4th trimester focus not only on hypertension but also factors including weight, blood sugar, depression, lactation and pre-pregnancy cardiovascular issues (Choi 2022)
- Adverse pregnancy outcomes (APOs) (Gestational hypertension, pre-eclampsia, gestational diabetes, preterm delivery, small for gestational age infant) increase risk for cardiovascular disease.
- APOs also associated with LVH, CKD and CVD after reproductive years.

(Wu 2021)

Breastfeeding in rural US

- Breastfeeding rates are significantly lower in rural than urban US (USPSTF 2025)
- In Georgia, breastfeeding initiation was approximately 15% lower (60% vs 75%) in rural vs urban areas persistent over 10 year study (Hamilton 2020)
- Double challenge of fewer face to face services and less access to broadband and virtual resources (Grubesic 2020)

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Child benefits of breastfeeding

Lower rates of:

- asthma
- respiratory
- gastrointestinal tract infections
- infant mortality

(UPSTF 2025)

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Maternal benefits of breastfeeding

Lower rates of:

- ovarian cancer
- Hypertension
- Type 2 diabetes mellitus

(UPSTF 2025)

Breastfeeding in rural US

- The USPSTF recommends providing interventions or referrals, during pregnancy and afterbirth, to support breastfeeding. (B recommendation)

(USPSTF 2025)

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Breastfeeding resources from USPSTF

- The Centers for Disease Control and Prevention provides resources for families and public health programs (https://www.cdc.gov/breastfeeding/php/about/index.html)
- The Eunice Kennedy Shriver National Institute of Child Health and Human Development provides educational materials for patients (https://www.nichd.nih.gov/health/topics/breastfeeding).
- The US Department of Labor provides a fact sheet on Fair Labor Standards Act protections for employees to pump breast milk at work (https://www.dol.gov/agencies/whd/fact-sheets/73-flsa-break-time-nursing-mothers).
- The National Institutes of Health has created a drug and lactation database, LactMed, that contains information on drugs and other chemicals that may pass from breast milk to the infant (https://www.ncbi.nlm.nih.gov/books/NBK501922/).

(UPSTF 2025)

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Strategies to improve 4th trimester care

- Discuss prenatally
- Continuity of care
- Schedule appt prenatally or before leaving hospital
- Engage others to promote postpartum care: clinic reception workers, clinic MAs and RNs, intrapartum support staff, postpartum nurses, discharge planner, doula, family members
- Utilize technology with reminders, promotions (EMR, texts, calls)
- Consider web-based curricula, Home visitation, patient navigation, other novel approaches (Phillips 2023)

Hospital to clinic transition

- Maybe different EMR and different providers
- Potential to lose follow-up of important issues such as
  - Pregnant person: hypertension during labor, PPH with transfusion
  - Baby: hyperbili, low weight, breastfeeding struggle, heart murmur

(UPSTF 2025)

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Postpartum alert bands

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Community partnerships

- Community Doula Alliance: https://communitydoulaalliance.com/doulas/
- La Leche League: https://llli.org/
- March of Dimes: https://www.marchofdimes.org/find-support/topics/postpartum
- Nacer Sano: https://nacersano.marchofdimes.org/
- Postpartum support international: https://postpartum.net/
- Black Mamas Matter Alliance: https://blackmamasmatter.org/

Doulas

- DONA International: https://www.dona.org/
- The Doula Network: https://www.thedoulanetwork.com/
- National Black Doula Association: https://www.blackdoulas.org/
- Planned Parenthood: https://www.plannedparenthood.org/
- Substance Abuse and Mental Health Services Administration: https://www.samhsa.gov/

15 minutes and a phone call

- Intervention: 15 minutes of anticipatory guidance followed by a phone call at 2 weeks
- Decrease in depression and increase breastfeeding duration through 6 months

(Howell 2012; Howell 2014)

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World Health Organization (WHO) recs

- World Health Organization (WHO) recommends evaluation of postpartum person and child dyad at 48-72 hours, 7-14 days and 6 weeks after delivery (WHO 2022)

(Howell 2012; Howell 2014)

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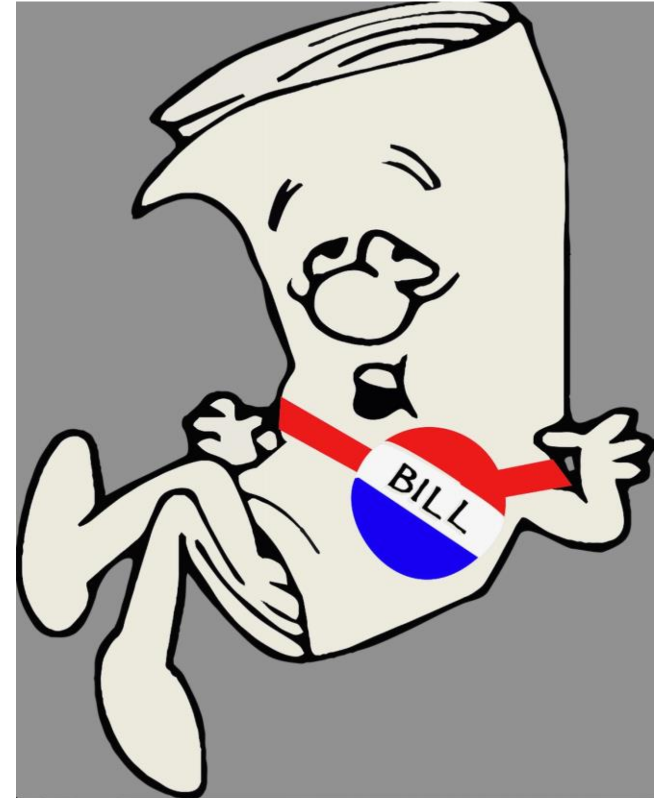
Paid Family Medical Leave

- 27 percent of private sector workforce has paid family leave
- Thirteen states (California, Colorado, Connecticut, Delaware, Maine, Massachusetts, Maryland, Minnesota, New Jersey, New York, Oregon, Rhode Island and Washington and Washington DC) have their own paid family medical leave (PFML) programs
- Federal legislation has been proposed – FAMILY ACT – would include 12 week of paid leave



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Practice Recommendations (All SOR C)

- Paradigm shift is needed where postpartum care is an ongoing process rather than a single event.
- Address rural 4th trimester challenges
- ACOG recommends visit within 3 weeks and a complete assessment within 12 weeks of delivery
- WHO recommends visits at 3 days, 7-14 days and 6 weeks postpartum
- Utilize dyad care! Schedule birthing person visit with initial postpartum visits

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Thank you!!!

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