ENHANCING POSTPARTUM CARE FOR CALIFORNIA'S BIRTHING POPULATION THROUGH "THE POSTPARTUM PATHWAY": A CONCEPT PAPER

July 2025

Collaboratively developed by the California Department of Health Care Services (DHCS), the Purchaser Business Group on Health (PBGH), the California Maternal Quality Care Collaborative (CMQCC), the California Department of Public Health (CDPH) and the Office of the California Surgeon General (OSG).

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DHCS California Department of Health Care Services

PBGH Purchaser Business Group on Health

CMQCC California Maternal Quality Care Collaborative

CDPH California Department of Public Health

Office of the California Surgeon General

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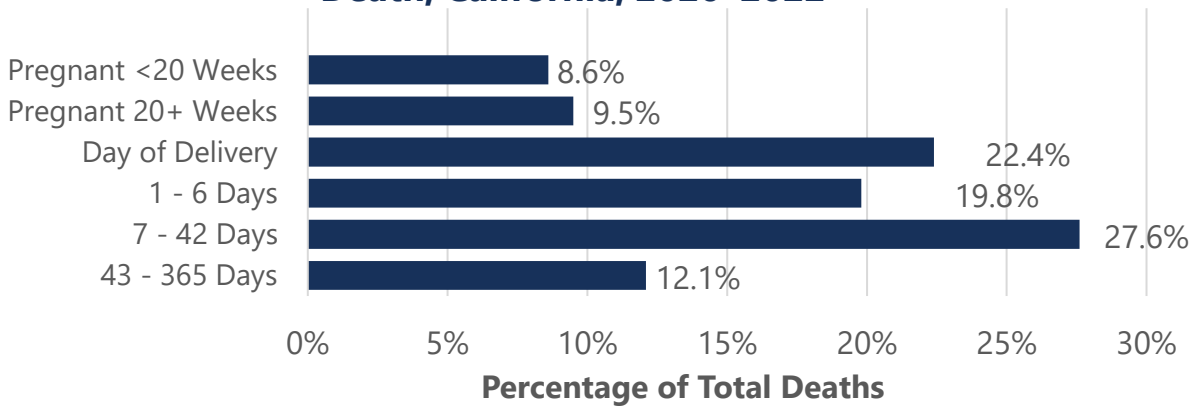
I. BACKGROUND: STATE OF MATERNAL HEALTH IN CALIFORNIA

Similar to most of the United States, California is in the midst of a maternal health crisis where a significant burden of disease and mortality occurs postpartum. Every five days an individual in California dies from a pregnancy-related complication, and more than half (59.5%) of perinatal deaths in California occur within 12 months postpartum. Among pregnancy related deaths that occurred between 2020-2022, 22.4% of deaths occurred on the day of delivery and 47.4% within six weeks after delivery (See Figure A).

Figure A: Pregnancy Related Deaths by Timing of Death, California, 2020–2022



Data Source: CDPH Pregnancy Related Mortality
Pregnancy Related Deaths by Timing to Death, California, 2020-2022
CDPH Pregnancy-Related Mortality | Date Downloaded: May 2025
Prepared by the California Department of Health Care Services

While California's pregnancy related mortality ratio—pregnancy related deaths per 100,000 births—is one of the lowest in the nation, it has been rising in recent years; the ratio was 13.4 in 2015, peaked at 21.6 in 2021, then declined to 15.0 in 2022. There were several leading causes of pregnancy related mortality from 2020-2022, including COVID-19 (25% of pregnancy related deaths), cardiovascular disease (17.2%), hemorrhage (17.7%), pulmonary embolism (8.6%), non-COVID sepsis/infection (8.2%), amniotic fluid embolism (7.8%), and hypertensive disorders of pregnancy (4.7%).[1]

[1] A pregnancy related mortality ratio is defined as deaths while pregnant or within one year of the end of pregnancy from causes related to or aggravated by the pregnancy or

California's maternal health crisis disproportionately impacts Black, American Indian/Alaska Native, and Pacific Islander pregnant and postpartum individuals. Black pregnant people in California are 3.7 times more likely to die during pregnancy or while postpartum compared to their White peers. California's Severe Maternal Morbidity (SMM) rate—events of unexpected and potentially life-threatening complications from labor and delivery (e.g., hemorrhage, infection, cardiac events) that result in significant short- or long-term health consequences per 10,000 hospital-based deliveries—is rising for all races and ethnicities. However, Black and Pacific Islander pregnant people in California are almost twice as likely to develop SMM compared to their White peers (184.3 and 185.1 SMM rate per 10,000 births among Black and Pacific Islander pregnant people respectively, compared with 94.1 SMM rate among their White peers).

Quality postpartum care is critical for positive maternal and child health outcomes and can help reduce maternal morbidity and mortality; however, many individuals do not receive timely and necessary postpartum care and support. The CDC reports that more than 80% of pregnancy-related deaths are preventable and can be reduced through routine health care[2]. Adequate postpartum care can address delivery complications, manage chronic conditions, assess physical, social, and psychological well-being—including risk for perinatal mood and anxiety disorders (PMADs)—and establish a foundation for long-term health. California data indicates that approximately 12% of individuals do not attend a postpartum visit; this rate is higher among Medi-Cal members (17.4%). More can be done to connect all Californians, including Medi-Cal members, to available postpartum services and supports; members have expressed that they do not understand what Medi-Cal benefits and public benefits/social services are available to them during pregnancy or the postpartum period, or how to access them.

II. GENESIS OF THE POSTPARTUM PATHWAY

In response to the growing maternal health crisis in California, the Maternity Coordinating Group (a multi-stakeholder group led by the Purchaser Business Group on Health (PBGH) and funded by the California Health Care Foundation (CHCF)) initiated work in 2022 to map out a new, comprehensive clinical care pathway for pregnant and

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its management per 100,000 live births. The spike in pregnancy related mortality from 13.4 in 2015 to 21.6 in 2021 is partly attributed to COVID-19, which was the primary cause of pregnancy related deaths from 2019-2021, accounting for 23.5% of fatalities.

[2] A death is preventable if there was at least some chance it could have been avoided with reasonable changes to patient, family, provider, facility, system, and/or community factors.

postpartum individuals in California. In 2023, PBGH, the California Department of Health Care Services (DHCS), and the California Maternal Quality Care Collaborative (CMQCC) built upon the work of the Maternity Coordinating Group by designing a more coordinated, patient-centric delivery of birthing care services; the David and Lucile Packard Foundation funded PBGH's and DHCS's efforts. CMQCC received Merck for Mothers funding to support their participation in this project. Also in 2023, DHCS began developing a broader, comprehensive policy and care model roadmap called the Birthing Care Pathway to cover the journey of all pregnant and postpartum Medi-Cal members from conception through 12 months postpartum.[3] Recognizing the intersection, the development of the Postpartum Pathway was coordinated with and informed, in part, by DHCS' Birthing Care Pathway.

The Postpartum Sub-Workgroup was convened to support the development and design of a postpartum care clinical practice level pathway; it was formulated as a sub workgroup of the Birthing Care Pathway's Clinical Care and Social Drivers of Health Workgroups with cross representation from both:

- **Membership.** Twenty-two experts in public health, maternity care (obstetrics and midwifery), pediatric care, primary care, and behavioral health were invited to participate in the Postpartum Sub-Workgroup.
- **Charge.** The Postpartum Sub-Workgroup was charged with designing a clinical pathway (referred to as the Postpartum Pathway) to support providers in achieving positive health outcomes during the postpartum period.
- **Design.** The Postpartum Sub-Workgroup convened six times (between late 2023 and early 2024) to discuss various issues impacting the delivery of quality care in California during the postpartum period (e.g., emerging practices in postpartum care, transitions of care, and behavioral health) and design the proposed Postpartum Pathway. The Postpartum Pathway was further refined based on feedback from Sub Workgroup members (see Appendix D for roster).

The Postpartum Pathway is a proposed measurable, clinical practice approach that aims to support the delivery of whole person care that addresses both clinical and social drivers of health needs. It is aspirational and intended to be tested by various stakeholders—health plans, hospitals or birthing facilities, primary care

[3] The Birthing Care Pathway report published in February 2025 includes a series of policy solutions that DHCS is implementing to address the physical, behavioral, and health-related social needs of pregnant and postpartum members.

provider organizations, and potentially CBOs, service agencies and behavioral health partners—to first determine operational feasibility before scaling.

Goals of the Postpartum Pathway

1. Reduce morbidity and mortality among postpartum individuals;
2. Address significant racial and ethnic disparities in maternal health outcomes among Black, American Indian/Alaska Native, and Pacific Islander individuals;
3. Reduce stress, trauma, and mood disorders of pregnancy and postpartum, including depression, anxiety, and other psychiatric conditions, ensuring timely access to treatment;
4. Reduce isolation among vulnerable and historically or currently marginalized communities during the postpartum period; and,
5. Increase access to and coordination for chronic and/or preventable conditions, including interconception care, to improve the health outcomes for subsequent pregnancies.

This concept paper summarizes the key outputs from the Postpartum Sub-Workgroup, including actionable recommendations (Section III) and the proposed Postpartum Pathway clinical model (Section IV), which together aim to enhance postpartum care delivery for all Californians. Full materials are included in the appendices:

- **Appendix A—Summary of Findings and Recommendations from the Postpartum Pathway Sub Workgroup:** Detailed origin/history of the Postpartum Pathway and Sub Workgroup, key recommendations, issues for further discussion, and an approach to test the model.
- **Appendix B—Recommended Actions Table:** Detailed tables that outline specific actions to be executed by defined implementers to accomplish the recommendations set forth by the Postpartum Sub-Workgroup.
- **Appendix C—Visual Maps of the Postpartum Pathway:** Visual aids to guide health care delivery systems and care teams in piloting the Postpartum Pathway.
- **Appendix D—List of Postpartum Sub-Workgroup Members:** Roster of members with details regarding their credentials and experience.
- **Appendix E—List of Postpartum Pathway State Collaborators:** Roster of collaborators with details regarding their credentials and experience.

III. POSTPARTUM PATHWAY RECOMMENDATIONS

Proposed recommendations from the Postpartum Sub-Workgroup fell into six categories, including:

1. **Coordinated Team Based Care:** Create a seamless patient experience as patients transition between providers, facilities, and sites of care. Require clearly defined roles and responsibilities of various health care providers, including the introduction of a "lead maternity care manager" responsible for coordinating care across different health care settings and throughout pregnancy to postpartum.
2. **Data & Interoperability:** Enhance the sharing and usage of data across different providers and systems to improve the continuity and quality of care from pregnancy through postpartum, including the creation of shared communication systems, standardized data sharing protocols, and integrated health IT systems to ensure timely and effective care delivery.
3. **Patient Centered & Personalized Care:** Tailor health care services to meet the specific needs of each patient, including social drivers of health. Emphasize flexibility in the site of care, including access to home visiting services, telemedicine, and the adaptation of health care services to the individual's history, care preferences, and geography.
4. **Patient Education:** Educate patients on managing symptoms and navigating the health care system by sharing information on health symptoms, developing tools for better decision making, ensuring patients are informed about their care options, and equipping patients with the knowledge and ability to seek care and contact their provider with concerns.
5. **Workforce Development + Support:** Enhance the capabilities, knowledge, and capacity of the health care workforce to meet the demands of maternal care and strengthen interconception counseling and treatment through training to Family Medicine, Internal Medicine, and emergency department providers. This includes training providers in social service navigation, enhancing diversity in the health care workforce, and supporting the utilization of community health workers and doulas.
6. **Behavioral Health:** Integrate and improve behavioral health care in maternal health services, including increasing screening for perinatal mood and anxiety disorders

(PMADs), coordinating care and timely referrals, and investing in the training and development of a perinatal behavioral health workforce.

See Appendix A for more details regarding these recommendations.

To guide implementation of these recommendations, the Sub Workgroup developed Recommended Actions Tables (see Appendix B), which outline key activities to achieve the recommendations listed above, as well as proposed "implementers" responsible for executing the activities, including:

- **Health Care Delivery:** Hospitals, clinics, and providers delivering direct clinical care to patients.
- **Managed Care Plans:** Managed Care Plans (MCPs), including those under Medi Cal, that administer health care services to pregnant and postpartum people through contracted provider networks.
- **Communities:** Organizations and individuals working directly within communities to deliver health services and support, including faith-based organizations, the Women, Infants, and Children (WIC) program, CalFresh (California Food Stamps), community health organizations, and other community based organizations (CBOs).
- **Regulators, Policymakers, and Purchasers:** State agencies (e.g., DHCS, CDPH, Covered California) responsible for regulating health services and developing and implementing health care policies and benefits.
- **Public Health Researchers:** Organizations and individuals such as universities and analysts who engage in research, analysis, and the development of health measures.

See Appendix B for comprehensive Recommended Actions Tables.

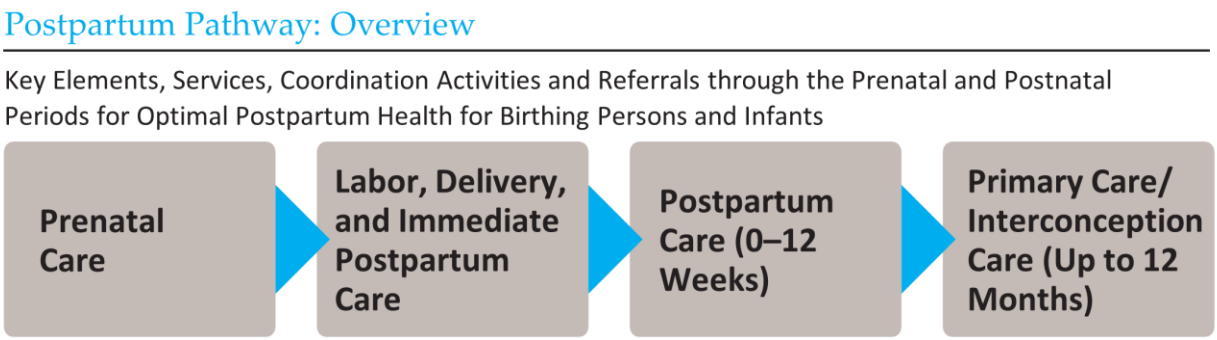
IV. POSTPARTUM PATHWAY: PROPOSED CLINICAL MODEL

Building upon the recommendations of the Postpartum Sub-Workgroup, the Postpartum Pathway (Appendix C) is comprised of key activities, cross provider coordination activities, and referrals across the following four phases of care:

- Prenatal Care
- Labor, Delivery, and Immediate Postpartum Care

- Postpartum Care (0–12 Weeks)
- Primary Care/Interconception Care Up to 12 Months Postpartum

Figure 1: Postpartum Pathway: Overview



The Postpartum Pathway delineates necessary screenings (e.g., behavioral health, social risk, intimate partner violence (IPV)) and assessments (e.g., lactation support, contraceptive care, pelvic floor therapy) for the postpartum period to identify and evaluate health risks and needs that may arise. It also specifies essential services and actions required to support patient care and includes health education and navigation strategies to help individuals manage their health and health care effectively during pregnancy and postpartum periods. Additionally, the Postpartum Pathway identifies scenarios that necessitate immediate action, including urgent referrals to specialists or services, along with subsequent monitoring protocols.

Visual Maps: Detailed visual maps of the Postpartum Pathway across the phases of pregnancy and postpartum care (see Appendix C) provide a clear and implementable template that guides medical delivery systems and care teams in piloting postpartum innovations tailored to their unique resources and the specific needs of their patients. Additionally, the visual maps offer a tangible overview of the Postpartum Pathway, enabling stakeholders to clearly observe the intersecting priorities that are essential to enhance patient experience, achieve care continuity, and improve health outcomes during the postpartum period.

See Appendix C for detailed visual maps of all four phases of the Postpartum Pathway.

V. LOOKING AHEAD: POTENTIAL NEXT STEPS

The Postpartum Sub-Workgroup identified several issues impacting postpartum outcomes that warrant additional discussion, such as: care coordination, dyadic services, behavioral health resources, transitional care services, and substance use treatment. These topics areas will be further explored through the continued development of the broader Birthing Care Pathway for Medi Cal members.

Further testing is needed to assess the operational feasibility of the Postpartum Sub-Workgroup's recommendations and the Postpartum Pathway clinical model. Managed Care Plans (MCPs), labor and delivery hospitals, freestanding birth centers (FBCs), primary care provider organizations, CBOs, service agencies, and behavioral health partners will likely be essential partners in testing elements of the Postpartum Pathway and identifying operational best practices. Efforts such as engaging with providers who deploy the model, expanding care coordination resources, enabling data sharing capabilities, and implementing provider incentives can support pilot implementation.

The definition and utilization of evaluation metrics such as patient outcomes, provider satisfaction, and cost effectiveness, among others, are recommended to measure the success of any pilot program and inform necessary refinements to the Postpartum Pathway. Stakeholders across California are invited to review the Postpartum Pathway and explore partnerships to pilot the model.

VI. APPENDICES

Appendix A: Summary of Findings and Recommendations from the Postpartum Sub-Workgroup

Overview

In the spring of 2023, the California Department of Health Care Services (DHCS) launched a project to create a comprehensive Birthing Care Pathway care model to improve maternal health outcomes, reduce disparities, and better address the needs of birthing individuals in California, from conception through 12 months postpartum. The Postpartum Sub-Workgroup was formed as part of this project to create a vision and visual to guide providers, managed care plans, regulators, and community organizations in the delivery of an integrated and coordinated care experience from birth through 12 months postpartum. The Postpartum Sub-Workgroup's efforts concentrated on enhancing an existing draft of a care pathway and considering the quality of care delivered during the postpartum period, which begins prenatally and extends through birth and the first year postpartum, while integrating both clinical and social drivers of health elements. The delivered care pathway would specify the roles and responsibilities for leading the delivery of care.

The preliminary mapping of a new, comprehensive care pathway was initiated by the Maternity Coordinating Group, a multi stakeholder group led by the Purchaser Business Group on Health (PBGH) and funded by the California Health Care Foundation (CHCF) in the summer of 2022. Together, the Department of Health Care Services (DHCS), the California Maternal Quality Care Collaborative (CMQCC), and PBGH collaborated to conceptualize a more coordinated delivery of services with the patient experience at the center. As the Birthing Care Pathway project progressed, DHCS selected PBGH to lead the Postpartum Sub-Workgroup to test and refine the concepts outlined in this preliminary draft of the pathway.

Leveraging this early pathway design work, PBGH, DHCS, and CMQCC developed goals specific to the Postpartum Pathway and necessary to defining and improving comprehensive postpartum care. They include:

1. Reduce morbidity and mortality among postpartum individuals.
2. Address significant racial and ethnic disparities in maternal health outcomes among Black, American Indian/Alaska Native (AI/AN), and Pacific Islander individuals.

3. Reduce stress, trauma, and mood disorders of pregnancy and postpartum, including depression, anxiety, and other psychiatric conditions, ensuring timely access to treatment.
4. Reduce isolation among vulnerable and historically or currently marginalized communities during the postpartum period.
5. Increase access to and coordination for chronic and/or preventable conditions, including interconception treatment, to improve the health outcomes for subsequent pregnancies.

The critical recommended actions that emerged from these Postpartum Sub-Workgroup discussions are presented in the "Postpartum Sub-Workgroup Recommended Actions Table" (see Appendix B). This narrative aims to enhance the table by defining the concepts and categories presented, discussing the underlying challenges the proposed solutions address, and providing additional context and references from the Postpartum Sub-Workgroup conversations. Additionally, PBGH updated the visual maps of the Postpartum Pathway (see Appendix C) to reflect the discussion and recommendations of the Postpartum Sub-Workgroup.

Postpartum Sub-Workgroup Process

The Postpartum Sub-Workgroup consisted of 22 representatives with expertise in public health, maternity care (obstetrics and midwifery), pediatric care, primary care, and behavioral health care (see full participant list in Appendix D). Many of the participants overlapped with the Clinical Care and Social Drivers of Health Birthing Care Pathway workgroups.

Over the course of six virtual sessions, participants reviewed critical emerging practices in postpartum care, identified implementation challenges and opportunities, and made policy and coverage recommendations to DHCS to improve maternal health care and outcomes. In September 2023, participants gathered in small groups to review the drafted postpartum care pathway and its associated goals. During these sessions, the Postpartum Sub-Workgroup selected topics for future sessions. In December, all participants reconvened to discuss **transitions of care** from birth through 14 days postpartum. The group met for the third time in January to address improved screening and treatment for **behavioral health** challenges. In each of these sessions, the Postpartum Sub-Workgroup also explored potential early adopters or pilot opportunities to test the implementation of the care pathway.

Postpartum Sub-Workgroup Recommended Actions Table

The "Postpartum Sub-Workgroup Recommended Actions Table" organizes the critical activities and themes that emerged from the Postpartum Sub-Workgroup discussions into six categories. Each category is further broken down into actions with corresponding recommendations and activities to accomplish the proposed action. The table then specifies the suggested "implementers" for their own execution of the recommendation. See category and implementer definitions below.

Category Definitions

Each category is detailed below, summarizing challenges and the proposed solutions identified by the Postpartum Sub-Workgroup Participants. This list represents a synthesized overview of the discussions and is not an exhaustive catalog of all potential solutions to the challenges faced by individuals in the postpartum period:

1. **Coordinated Team Based Care:** Aims to create a seamless patient experience as patients transition between providers, facilities, and sites of care. Require clearly defining the roles and responsibilities of various health care providers, including the introduction of a "lead maternity care manager" responsible for coordinating care across different health care settings and throughout the patient's journey from pregnancy to postpartum.
2. **Data & Interoperability:** Focuses on enhancing the sharing and usage of data across different health care providers and systems to improve the continuity and quality of care from pregnancy through postpartum. This category includes creating shared communication systems, standardizing data sharing protocols, and integrating health IT systems to ensure timely and effective care delivery.
3. **Patient Centered & Personalized Care:** Concentrates on tailoring health care services to meet the specific needs of each patient, especially through a social drivers of health lens. This category emphasizes flexibility in the site of care, including access to home visiting services, telemedicine, and the adaptation of health care services to the individual's history, care preferences, and geography.
4. **Patient Education:** Involves educating patients on managing symptoms and navigating the health care system effectively by disseminating information on critical health indicators, developing tools for better decision making, ensuring patients are informed about their health and care options, and equipping patients with the knowledge and ability to seek care and contact their provider with concerns.
5. **Workforce Development + Support:** Focuses on enhancing the capabilities, knowledge, and capacity of the health care workforce to meet the demands of

maternal care and strengthen interconception counseling and treatment through training to Family Medicine, Internal Medicine, and emergency department providers. This includes training providers in social service navigation, enhancing diversity in the health care workforce, and supporting the utilization of community health workers and doulas.

6. **Behavioral Health:** Addresses the integration and improvement of behavioral health care within maternal health services, including increasing screening for perinatal mood and anxiety disorders (PMADs), coordinating care and timely referrals, and investing in the training and development of a workforce adept in managing perinatal behavioral health needs.

Implementer Definitions

Implementers are entities with the authority, power, expertise, and/or networks needed to execute the proposed activities effectively:

- **Health Care Delivery:** Encompasses hospitals, clinics, and providers involved in delivering direct clinical care to patients.
- **Managed Care Plans:** Includes all Managed Care Plans, including those under Medi Cal that administer health care services to pregnant and postpartum people through contracted provider networks.
- **Communities:** Covers organizations and individuals working directly within communities to deliver health services and support, including faith-based organizations, the WIC program, CalFresh, community health organizations, and other CBOs, etc.
- **Regulators, Policymakers, and Purchasers:** Comprises state agencies (e.g., DHCS, CDPH, Covered California), responsible for regulating health services and developing and implementing health care policies and benefits.
- **Public Health Researchers:** This includes organizations and individuals such as universities and analysts who engage in public health research, analysis, and the development of health measures.

Solutions: Deep Dive

Coordinated Team Based Care

This category aims to create a seamless and comprehensive care experience for patients, facilitating effective transitions among providers, facilities, and sites of care. While most patients will see their prenatal care provider in the postpartum period, if this is not the case, ideally, a patient will select their postpartum care provider prenatally, as care is

more effective when the patient builds trust and feels understood by their provider. A team-based care approach[4], incorporating providers who share cultural backgrounds with their patients, can further strengthen this trust. While the optimal scenario involves a single "lead maternity care manager" coordinating care throughout the prenatal, intrapartum, and postpartum stages, a collaborative team-based approach may be more practical. This approach allows various providers to manage different aspects of the maternity journey, adapting to variations in funding, provider availability, and local programmatic needs.

This category introduces the concept of a "lead maternity care manager," an individual responsible for overseeing and coordinating care for pregnant and postpartum individuals, particularly those with significant health and social needs. Responsibilities may include coordination for standard obstetric and primary care; referrals to specialty care for urgent medical needs (e.g., obstetric complications, cardiovascular disease, hypertension, and preeclampsia); assessment and treatment for PMAD, SUD, or other behavioral health conditions; and

Perinatal Care Coordination in Medi-Cal:
Comprehensive perinatal services is a Medi-Cal benefit, operationalized in the fee-for-service delivery system as the Comprehensive Perinatal Services Program (CPSP), that provides a set of services from conception through 60 days postpartum, including obstetric services; psychosocial assessment(s) and referrals to counseling, if needed; nutrition assessment(s) and referral to counseling on food supplement programs, vitamins, and breastfeeding, if needed; health, childbirth, and parenting education; and care coordination. As described in the 2025 Birthing Care Pathway report, DHCS is exploring opportunities to modernize CPSP to ensure uniform, high-quality access to comprehensive perinatal services for all pregnant and postpartum Medi-Cal members.

All pregnant and postpartum Medi-Cal members in the managed care delivery system have available Transitional Care Services (TCS) to support their transfer from one setting or level of care to another, and may also have available to them Enhanced Care Management (ECM) and Community Supports (medically tailored meals, transitional rent) if they qualify.

[4] Team-based care, as defined by the National Academy of Medicine, is "the provision of health services to individuals, families, and/or communities by at least two health care providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated high-quality care."

connecting patients to community services for social needs (e.g., WIC, CalFresh). Since Postpartum Sub-Workgroup Participants had varying ideas and opinions on the training and expertise required for this role, the term is left intentionally vague and used throughout the table and narrative to denote a single provider who oversees the care coordination of patients prenatally through postpartum. Additional research and pilot programs are needed to further define this role.

The actions, recommendations, and activities in the Coordinated Team Based Care category address the following challenges raised by the Postpartum Sub-Workgroup:

1. **Lack of a Single Point Person:** Patients lack a designated single point person to ensure continuity in care coordination from prenatal to postpartum, leading to overlapping intake processes, competing programs, and recommendations, which can make patients feel lost.
2. **Undefined Roles:** The scope of responsibilities for a "lead maternity care manager" is not clearly defined, and capabilities for such a role vary based on the resources and programming available in different counties.
3. **Communication Gaps:** Improved communication, consultation, and coordination are needed between inpatient and outpatient providers, public health and clinical entities, and between specialty, primary care, and emergency medical system providers.
4. **Insufficient Compensation:** Many health plans offer little or no payment for care coordination services, limiting their implementation.
5. **Lack of Follow Up:** Hospitals and providers do not adequately follow up with high-risk patients post discharge, failing to address acute post delivery challenges.

Data & Interoperability

This category focuses on enhancing the sharing and utilization of data across health care providers and systems, improving the continuity and quality of care for postpartum patients. Limited data sharing between providers, facilities, and systems leads to gaps in care coordination and continuity, and, as a result, many patients experience delays in care or poor outcomes due to this lack of follow up. The lack of an electronic system to track follow up on referrals further contributes to inadequate measurement of patient outcomes. Additionally, reporting on quality measures useful for patient decision making, including practice level morbidity and mortality rates and patient experience measures, is crucial to ensuring postpartum care is responsive to individual needs.

The actions, recommendations, and activities in the Data & Interoperability category address the following challenges raised by the Postpartum Sub-Workgroup:

1. **Limited Data Sharing:** Effective care coordination and continuity are hindered by inadequate data sharing between providers, facilities, and systems related to postpartum care, leading to gaps in coordination and continuity.
2. **Inadequate Tracking:** The lack of an electronic system to track follow up on referrals and patient outcomes contributes to inadequate tracking, failing to capture whether services are patient centered and outcome oriented.
3. **Lack of Patient Centered Feedback:** Measures are not useful to patients' decision making. Making practice level morbidity and mortality data (adjusted so that similar types of facilities are compared with each other), along with patient experience measures, publicly available would help ensure postpartum care is responsive to individual needs.

Patient Centered & Personalized Care

This category concentrates on tailoring health care services to meet the specific needs of each patient, especially through a social drivers of health lens. The postpartum period spans a 12-month episode, during which the needs of patients evolve, necessitating adaptable care options. Risks for adverse outcomes can escalate from the prenatal stage to the postpartum stage, emphasizing the need to establish accessible channels for patients to reach out if experiencing physical and/or mental health struggles. The category, therefore, emphasizes flexibility in the site of care, including access to home visiting services, telemedicine, and adapting health care services to the individual's history, preferences, and geography.

The actions, recommendations, and activities in the Data & Interoperability category address the following challenges raised by the Postpartum Sub-Workgroup:

1. **Newborn Challenges:** Postpartum individuals face unique challenges once at home with a baby, such as feeding and reintegrating with family members or other children. In home visits are very effective in helping postpartum patients navigate these challenges because visits are tailored in helping postpartum patients navigate these challenges because visits are tailored to the questions and concerns of patients as they arise in their own homes.
2. **Postpartum Follow Up:** Patients face difficulties receiving timely individualized postpartum visits. Care is not well coordinated at times between obstetric or maternity providers, primary care, and subspecialists. Flexible care options (as

described above) and support mechanisms should be offered to ensure timely and continuous care.

3. **Rural vs. Urban Needs:** Rural counties have different needs than urban environments, necessitating adaptable care delivery models that address the unique health care needs and challenges of each community.

Patient Education

This category focuses on educating patients on managing symptoms and navigating the health care system effectively, ensuring they have the knowledge and resources needed for comprehensive postpartum care. Education must encompass both clinical health indicators and CBOs, addressing the holistic needs of patients and their families. Education efforts should avoid normalizing pain and suffering and instead make the patient feel supported and cared for. Efforts should focus on giving patients the tools for remote self monitoring when indicated and the knowledge about abnormal symptoms, what to do, and the confidence to act.

The actions, recommendations, and activities in the Patient Education category address the following challenges raised by the Postpartum Sub-Workgroup:

1. **Recognizing and Managing Symptoms:** Patients may lack awareness of warning signs for postpartum complications, necessitating education on potential symptoms and how to manage them effectively. Best practices examples include teaching remote monitoring of blood pressure through cuff dispersal and importance of preeclampsia wristband and wallet card (when indicated).
2. **Navigating Social Services:** Many patients, providers, and birthing facilities need guidance on available CBOs and programs, as well as how to coordinate medical care with these services. Providers are unsure when to discuss programs such as home visiting, CalFresh, and Black Infant Health, or benefits like WIC, paid family leave, disability, and Cal Learn, making it crucial to incorporate this information into postpartum care pathways.
3. **Comprehensive Lactation Support:** Patients may struggle to access lactation education and resources, encountering barriers to securing breast pumps and receiving consistent support. Comprehensive lactation education and support are necessary to ensure the well-being of both postpartum individual and child.
4. **Utilizing Public Health Programs and Other Resources to Support Medical Interventions:** Public health programs and other resources should support medical interventions such as remote blood pressure monitoring and breastfeeding support.

Workforce Development + Support

This category focuses on enhancing the capabilities, knowledge, and diversity of the health care workforce to meet the demands of maternal care and strengthen interconception counseling and treatment through training to Family Medicine, Internal Medicine, and emergency department providers. Patients desire choice in their care team and care location, seeking increased access to midwifery led models of care and doula care. Additionally, more touch points with the care team are needed for the ongoing management of symptoms and conditions. Culturally congruent care is essential for achieving high quality and equitable outcomes, particularly for patients at higher risk of poor outcomes, yet the current workforce does not reflect the postpartum population.

The actions, recommendations, and activities in the Workforce Development + Support category address the following challenges raised by the Postpartum Sub-Workgroup:

1. **Provider Shortages:** The health care workforce needs more providers, particularly those able to support care coordination, education, and enrollment in key social service programs.
2. **Training in Social Service & Medicaid Benefits:** Providers require training in available social services and Medicaid benefits to support patients effectively throughout the postpartum period.
3. **Workforce Diversity:** The current health care workforce both lacks diversity and is often unable to provide culturally and linguistically appropriate care, necessitating the development of DEI and trauma informed training programs for existing maternity and primary care providers.
4. **Access to Midwifery:** Barriers limit access to midwifery led care, including contracting challenges and inadequate reimbursement for professional and facility fees.
5. **Support for Doula Utilization:** Standardized training and integration into Medi Cal plans are needed to increase access to and utilization of doula care, along with ensuring appropriate reimbursement for their services.
6. **Training of Emergency Medical System in Postpartum High-Risk Care:** Emergency department providers and staff in addition to other emergency medicine services components should receive specialized training in care of high-risk obstetric and postpartum patients.

Behavioral Health

This category focuses on the integration and improvement of the screening, diagnosis, and treatment of perinatal mood and anxiety disorders (PMADs). Despite the high prevalence of PMADs, services and resources for treatment are limited, contributing to poor screening rates as many providers feel unequipped to respond to a positive screen. Sustainable, long-term solutions to this crisis level shortage of trained behavioral health providers must involve training, incentives, and reimbursement, along with immediate efforts to increase access to treatment options. Postpartum Sub-Workgroup Participants also emphasized the importance of training every provider interacting with a pregnant or postpartum patient, both clinical and non clinical, on how to handle a positive depression or anxiety screen. Additionally, there was a call for greater investment in upstream, evidence-based interventions to prevent depression and anxiety, rather than relying solely on treatments after symptoms emerge.

Challenges Addressed:

1. **Hesitancy to Screen:** Providers hesitate to screen for anxiety, depression, and trauma without clear follow up options for positive screens, limiting the detection and management of PMADs and trauma.
2. **Referral Follow Up:** The lack of clear processes for tracking follow up on timely referrals leads to inadequate monitoring of patient outcomes and care continuity.
3. **Shortage of Providers:** Behavioral health providers, particularly those trained in perinatal mental health and Cognitive Behavioral Therapy (CBT) contracted with Medi Cal plans, are scarce. This shortage will take years to correct, requiring immediate care options to address current needs.
4. **Limited Resources:** Both high and low risk patients need behavioral health resources, but the availability of in person and online services in multiple languages is limited, leading to inadequate treatment options and delayed interventions. Transitional behavioral health counseling exists only in certain counties and should be expanded statewide.
5. **Varied Needs:** Patients' behavioral health needs are expansive, and the strengths and challenges of addressing them vary greatly by locale, necessitating adaptable solutions to meet diverse needs (e.g., integrated behavioral health and primary care).

Addressing Inequities

The Postpartum Sub-Workgroup's discussions and recommendations are shaped by the significant racial and ethnic disparities in maternal health outcomes among Black,

American Indian/Alaska Native (AI/AN), and Pacific Islander communities in California. To meaningfully improve maternal health outcomes, all activities should be collaboratively designed and implemented in partnership with these communities.

The following activities, as detailed in the "Postpartum Sub-Workgroup Recommended Actions Table," are particularly critical for addressing racial and ethnic disparities in maternal health outcomes:

- Clearly Define the Role of Lead Maternity Care Manager
- Coordinate Care Across Settings
- Enhance Monitoring and Clinical Care Post Discharge
- Collect Patient- Centered Feedback
- Expand Access to Home Visiting Services
- Expand Access to Telemedicine & Remote Monitoring
- Improve Access to Evidence-Based Best Practices
- Integrate ACES Screenings
- Support Navigation of Social Services
- Ensure Comprehensive Lactation Support and Education
- Invest in Workforce Diversity & DEI Trainings
- Promote Access to Midwifery
- Support Doula Utilization
- Improved Availability of Behavioral Health Treatment Options

Focused engagement with these communities to deeply understand their concerns and priorities is critical for developing programs and implementation strategies that effectively meet their specific needs and narrow health disparities. Such engagement ensures that interventions are not only inclusive but are also directly responsive to the unique challenges faced by these populations.

Future Topics for Discussion

Given the six-session format of the Postpartum Sub-Workgroup, there were more ideas than time for discussion. As a result, participants identified several key topics recommended for additional discussion in other Birthing Care Pathway Workgroups (Clinical, Social Drivers and Member Voices). Topics of high interest include:

- **Care Coordination:** Strategies to improve timely coordination from discharge to primary and specialty care, streamline coordination across care managers, eliminate duplicate services, and improve coordination between providers and across public health and community support services.
- **Dyadic Services:** Provision of services for both postpartum individual and baby, including pediatric well checks, behavioral health screenings, and home visits.
- **Behavioral Health Resources:** Building capacity to treat and optimize resource utilization, including training maternity providers and behavioral health providers in perinatal and trauma informed care.
- **Transitional Care Services:** Ensuring effective care transitions for all prenatal and postpartum patients up to 12 months postpartum.
- **Substance Use Treatment:** Further exploration of inpatient and outpatient services for both postpartum individual and baby when treating substance use disorders, particularly in the context of behavioral health.
- **Management of Chronic Conditions Prior to Subsequent Pregnancy:** Assuring that postpartum individual's health behaviors and treatment of chronic conditions are monitored throughout one year postpartum.

Testing the Postpartum Care Pathway

The Birthing Care Pathway project has engaged a wide range of stakeholders who are dedicated to improving maternal health outcomes in California. This initial design phase includes a significant set of recommendations for partners to consider. Given the innovative nature of the recommended strategies, we suggest further testing to understand their operational feasibility, efficacy on clinical outcomes, and financial sustainability. In January 2025, the federal Centers for Medicare & Medicaid Services (CMS) announced California as one of 15 states selected to implement the Transforming Maternal Health (TMaH) Model. TMaH is a ten year delivery and payment model designed to test whether evidence informed interventions sustained by a value-based payment (VBP) model can improve maternal outcomes and reduce Medicaid and Children's Health Insurance Program (CHIP) program expenditures. TMaH may present an opportunity for California to test strategies outlined in this concept paper.

Who: Necessary collaborators include health plans, hospitals or birthing facilities, primary care provider organizations, and potentially CBOs, service agencies, and behavioral health partners.

Where: Test with different types of facilities in different counties across California. Ideally, sites would be different in terms of how Medi Cal patients receive their care (e.g., in an FQHC model, which is prevalent in Northern California, vs. an IPA model, which is prevalent in Southern California). By testing implementation of the pathway in areas with different characteristics, resources, and funding streams, the learnings will be more powerful, and it will be easier to scale these operational best practices to the rest of the state.

How: To pressure test elements of the Postpartum Care Pathway, efforts should be made to limit challenges and conditions that impede pilot implementation, such as:

- **Provider Engagement:** Written commitment from key stakeholders, including a Managed Medi Cal health plan, a hospital or birthing facility, a primary care provider organization, and potentially social/public health services agencies and behavioral health partners. Primary care provider involvement must include both adult and pediatric care providers to address maternal and infant needs and develop strategies for dyadic care.
- **Care Coordination Workforce:** Availability of community health workers and/or doula care providers to serve as the lead coordinators of care. The Postpartum Sub-Workgroup emphasized the importance of having one key coordinator at the center orchestrating care for patients, and it is essential to have adequate birth workers available to appropriately test out the responsibilities of this essential role. The care coordination workforce may be virtual, and the provision of virtual services must be tested for effectiveness in terms of health outcomes and patient satisfaction.
- **Data/Information Sharing Capabilities:** The ability to share data across care sites and provider types is essential to testing provider coordination. These capabilities do not have to be highly sophisticated (e.g., everyone on the same EMR), but there needs to be a base level of data sharing interoperability across settings (hospital, outpatient, community) and providers (maternity, primary care, behavioral health).
- **Provider Incentives:** Although the incentives themselves might be new, established workflows to pay providers somewhat in real time to truly incentivize care transformation and to subsidize practice level efforts to address patient needs (e.g., establishing or enhancing services, optimizing care coordination) are necessary.

Finally, use evaluation metrics to assess pilot success, including patient outcomes, provider satisfaction, and cost effectiveness. This feedback loop ensures pilot program findings are integrated back into the pathway design process.

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Appendix B: Recommended Actions Table

This table organizes the critical activities and themes that emerged from the Postpartum Sub-Workgroup discussions into six categories. Each category is further broken down into actions with corresponding recommendations and activities to accomplish the proposed action. The table then specifies the suggested "implementers" for their own execution of the recommendation. The recommended actions featured in the tables below are directed at a broad range of "implementers" across the California health care ecosystem (see Implementers sub section below).

Categories organize the proposed solutions identified by the Sub Workgroup Participants by theme. This list represents a synthesized overview of the discussions and is not an exhaustive catalog of all potential solutions to the challenges faced by individuals in the postpartum period:

1. **Coordinated Team-Based Care:** Recommendations aimed at creating a seamless patient experience as patients transition between providers, facilities, and sites of care, including clearly defining the roles and responsibilities of various health care providers and introducing a single "lead maternity care manager" where possible.
2. **Data & Interoperability:** Focuses on enhancing the sharing and usage of data across different health care providers and systems to improve the continuity and quality of care from pregnancy through postpartum. This category includes creating shared communication systems, standardizing data sharing protocols, and integrating health IT systems to ensure timely and effective care delivery.
3. **Patient Centered & Personalized Care:** Concentrates on tailoring health care services to meet the specific needs of each patient, especially through a social drivers of health lens. This category emphasizes flexibility in the site of care, including access to home visiting services, telemedicine, and the adaptation of health care services to the individual's history, care preferences, and geography.
4. **Patient Education:** Involves educating patients on managing symptoms and navigating the health care system effectively by disseminating information on critical health indicators, developing tools for better decision making, and informing patients about their care options.

5. **Workforce Development + Support:** Focuses on enhancing the capabilities, knowledge, and capacity of the health care workforce to meet the demands of maternal care. This includes training providers in social service navigation, enhancing diversity in the health care workforce, and supporting the utilization of community health workers and doulas.
6. **Behavioral Health:** Addresses the integration and improvement of behavioral health care within maternal health services, including increasing screening for perinatal mood and anxiety disorders (PMADs), coordinating care and referrals, and investing in the training and development of a workforce adept in managing perinatal behavioral health needs.

Implementers are entities with the authority, power, expertise, and/or networks needed to execute the proposed activities effectively:

- **Health Care Delivery:** Encompasses hospitals, clinics, and providers involved in delivering direct clinical care to patients.
- **Managed Care Plans:** Includes all Managed Care Plans, including those under Medi Cal, that administer health care services to pregnant and postpartum people through contracted provider networks.
- **Communities:** Covers organizations and individuals working directly within communities to deliver health services and support, including faith-based organizations, the WIC program, CalFresh, community health organizations, and other CBOs.
- **Regulators, Policymakers, and Purchasers:** Comprises state agencies (e.g., DHCS, CDPH, Covered California), responsible for regulating health services and developing and implementing health care policies and benefits.[5]
- **Public Health Researchers:** Includes organizations and individuals such as universities and analysts who engage in public health research, analysis, and the development of health measures.

[5] Some of the recommendations require additional assessment and planning to determine if implementation is feasible and would be contingent on external factors, such as legislative authority or additional state budget resources.

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Coordinated, Team-Based Care	Clearly Define Role of Lead Maternity Care Manager	+ [TCS] Define and formalize the role, responsibilities, and reimbursement of "a lead maternity care manager," a provider designated by the patient during pregnancy who will be responsible for care coordination and communication with all other providers and public health agencies throughout the first year postpartum.	X	X	X	X	X
		+ [TCS] Pilot the lead maternity care manager role across settings and counties	X	X	X	X	X
		+ [TCS] Establish early connection from early pregnancy/antepartum	X	X	X	X	X

[6] As part of DHCS' Medi-Cal Transformation PHM Program, MCPs are required to provide TCS to Medi-Cal members who are transferring from one setting or level of care to another, including discharges from a hospital to home. Pregnant and postpartum members are considered high-risk under TCS and therefore are required to have a single point of contact for the duration of their transition.

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Coordinated, Team-Based Care		throughout pregnancy/postpartum through a lead maternity care manager					
		* [TCS] Reimburse adequately for coordination of services during pregnancy and postpartum and the role of the lead maternity care manager.		X		X	
		** [TCS] Create incentives to push practices to hire lead maternity care managers or other individuals dedicated to coordinating care and services, as patients are less comfortable working with care coordinators from health plans.	X	X		X	
	Coordinate Care Across Settings	0 Scale midwifery tools such as the home birth transfer guidelines.	X	X	X	X	
		0 Improve hospital emergency department management of postpartum individuals (according to the CA Pregnancy Associated Mortality	X	X		X	

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Coordinated, Team-Based Care		Review findings), particularly in identifying postpartum complications and treatment.					
		** [TCS] Incentivize hospitals to provide risk appropriate discharge coordination		X		X	
		+ [TCS] Assess unique communication and collaboration needs across counties and entities in rural communities and scale solutions.	X	X		X	X
		** [TCS] Increase and incentivize improved collaboration between CBOs and hospital-based providers.	X	X	X		
		** [TCS] Adapt incentive programs such as those within Medi-Cal Transformation to encourage early management of postpartum patients by primary care providers.		X		X	

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Coordinated, Team-Based Care	Enhance Monitoring and Clinical Care Post Discharge	0 [TCS] Before hospital discharge, conduct a postpartum check-up and physical exam of the birthing individual (within 48 hours of birth) and schedule any necessary follow-up subspecialty appointments (e.g., within three days for cardiovascular disease)	X	X			
		0 [TCS] Monitor the implementation of screening for postpartum complications, such as tools and protocols for early detection of conditions like sepsis, hemorrhage, and preeclampsia, ensuring that providers can offer immediate and effective interventions.	X	X		X	
		0 [TCS] Develop training and resources for health care providers to equip them with the knowledge and tools they need	X	X		X	X

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Coordinated, Team-Based Care		to perform these critical assessments effectively.					
		0 [TCS] Enhance follow-up procedures and care transitions to ensure that patients receive appropriate follow-up care, which may involve multiple health care settings or specialized attention based on the identified risks.	X	X	X	X	
		0 [TCS] Create standardized workflows for handoff from maternity care to primary care for high-risk postpartum patients (e.g., those with GDM, hypertensive disorders, or PMAD risk), including role clarity, timing, and communication protocols to support care continuity beyond the fourth trimester.	X	X			X
		+ Create a clear process for providers, MCPs, and DHCS to monitor the	X	X		X	

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Coordinated, Team-Based Care		physical and behavioral health of postpartum individuals, particularly when some people may become ineligible for Medi-Cal coverage after 12 months postpartum.					
		** [TCS] Create incentives for hospitals to provide risk appropriate discharge coordination for patients at high risk for poor postpartum outcomes.	X	X		X	
		** [TCS] Create incentives for hospitals to implement screening and assessments for postpartum complications.	X	X		X	
		0 Implement home visiting programs that integrate multiple funding streams to support a diverse care team, including nurses, case managers, community health workers, and doulas,	X	X		X	

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
		ensuring comprehensive and accessible service delivery.					
Data & Interoperability	Improve Data Sharing	+ [TCS] Create a single shared electronic communication system across providers and systems related to a pregnant individual's care from pregnancy through postpartum	X	X	X	X	X
		+ [TCS] Before hospital discharge, share the labor and delivery discharge summary with the lead care manager/patient navigator, primary care physician, maternity provider, mental health provider, and subspecialty provider(s), and other supporting care team members, as appropriate.	X	X	X	X	
		0 Adapt best practices from the ACEs Aware Trauma-Informed Care Network to standardize referral and	X	X	X	X	X

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Data & Interoperability		communication protocols across different providers and health care settings for postpartum individuals.					
	Disseminate Meaningful Data	0 Enhance emergency room management of postpartum patients by implementing a standardized system for rapid identification and treatment of complications, including real-time data sharing between obstetrics and emergency departments, utilizing interoperable health IT systems for instant access to patient histories, and training ER staff on specific postpartum conditions.	X	X		X	X
		0 Capture and attribute mortality and morbidity data at the practice and provider levels in both outpatient and inpatient settings (adjusted so that	X	X			X

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Data & Interoperability		similar types of facilities are compared with each other).					
		0 Bring additional focus to the data on morbidity and mortality during the postpartum period	X	X	X	X	X
		0 Use data to develop educational and decision-making tools for providers and patients.	X	X			X
	Collect Patient-Centered Feedback	0 Share data on what perinatal and behavioral care services are available to patients at various care facilities.	X	X	X		X
		0 Develop and validate patient experience measures of perinatal care, such as those assessed in Centering programs (e.g., Black Centering).		X	X	X	X
		0 Make provider and facility morbidity and mortality data accessible to those who are not yet pregnant to inform		X	X	X	X

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Data & Interoperability		decision-making (e.g., preconception, youth populations).					
		+ Invest in the creation of new metrics to measure resilience, since resilience mitigates adversity, trauma, etc. (see emerging evidence and resilience measurement tool) and patient experience.				X	X
Patient Centered & Personalized Care	Expand Access to Home Visiting Services	0 Expand the best practice of a home or virtual follow-up visit 2-5 days postpartum. A nurse visit is appropriate for high-risk patients; all patients should receive a home or virtual visit to monitor mild symptoms and blood pressure.	X	X	X		X
		0 Ensure that a provider (registered nurse, doula, or lactation consultant) with lactation training attends home visits.	X	X	X	X	

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Patient Centered & Personalized Care		0 Increase comfort and utilization of home visits by having the home visiting provider/organization (Healthy Families America, Cal LEARN, Nurse Family Partnership, etc.) meet with birthing individuals prior to discharge from the hospital.	X	X			
	Expand Access to Telemedicine & Remote Monitoring	0 Expand distribution of blood pressure cuffs for home monitoring by implementing a unified program that includes dispensing them at hospital discharge with comprehensive patient education on usage. Expand existing efforts from the AIM Community Care Initiative to extend provision into clinic waiting rooms through WIC, ensuring continuity of monitoring from clinical to home settings. Expand distribution of preeclampsia wristbands and wallets	X	X			

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Patient Centered & Personalized Care		cares for those at risk of postpartum preeclampsia.					
		* Ensure that all home visits and virtual postpartum services enhance patient safety by supporting key health activities, such as infant feeding. These services should seamlessly integrate the use of essential tools like blood pressure cuffs to monitor health and prevent complications.				X	
		** Provide targeted reimbursements and incentives to health care providers who implement comprehensive remote postpartum care programs. These programs should prioritize patient safety, support essential newborn care practices such as infant feeding, and ensure effective use of monitoring tools like blood pressure cuffs.	X	X		X	

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Patient Centered & Personalized Care	Improve Access to Evidence-Based Best Practices	0 Leverage group prenatal programs, including Black Centering, to educate patients on feeding best practices and their overall mental health around feeding.		X			
		+ Pilot pediatric postpartum care—combined pediatric well visits and postpartum exams—as modeled at the Village of Healing in Cleveland, OH.	X				
		** Create incentives for practices to adopt Centering or group perinatal care programs to enable ongoing education for parents and families.	X	X		X	
	Integrate ACES Screenings	0 Leverage the ACEs Aware framework to identify individuals [within the household or family structure] with a history of trauma or abuse to prevent recurrence and/or treat ongoing behavioral health conditions.	X	X		X	

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Patient Centered & Personalized Care	Address Needs of Rural Health Patients and Facilities	0 Encourage expansion of group prenatal programs in rural communities to leverage the efficiency of group perinatal care.		X		X	X
		+ Identify emerging maternity deserts and expand Health Service Corps funding to incentivize family medicine (with OB care) in these areas. Involve Regional Perinatal Programs of California (RPPC) and Local Maternal, Child and Adolescent Health (MCAH) regional directors to identify regional options for cross-county solutions to expanding perinatal workforce access.	X	X	X	X	X
		* Allow for flexibility in how health plans address community needs, such as leveraging non-licensed providers, telehealth solutions or telehealth, and	X	X			X

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Patient Centered & Personalized Care		hub and spoke models to provide appropriate levels of maternity care.					
		**Allow for flexibility in incentive programs to customize solutions locally.	X	X	X	X	
		** Create incentives to promote care that addresses provider shortages in rural health geographies.		X			
Patient Education	Help Patients Identify and Manage Symptoms	0 Educate and give resources to pregnant and postpartum individuals and their families/support system regarding warning signs of complications at discharge and the importance of attending well-visits, home visits, and other postpartum appointments in the first four weeks postpartum.	X	X			
		0 Educate postpartum patients, especially those with gestational diabetes and hypertensive disorders, on	X	X			

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Patient Education		their elevated long-term health risks and the importance of engaging in ongoing primary care for monitoring and chronic disease prevention/management. Include education across discharge materials, home visits, and follow-up appointments.					
		0 [TCS] Establish 24- and/or 48-hour follow-up protocols for patients (e.g. automated phone calls) to manage symptoms and receive immediate care if symptoms worsen.	X	X		X	
		0 Leverage the California Home Visiting Program for home visits to support positive parent modeling.	X	X		X	
		0 At discharge, expand education to patients on expected postpartum pain levels and symptom duration for the		X			

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Patient Education		entire year postpartum, with clear guidance on distinguishing between normal, concerning, and chronic pain to prevent delays in seeking necessary care.					
		** Create incentives and/or reimbursement for the delivery of health education and/or the use of health educators for the effective delivery of postpartum education.		X	X	X	X
	Support Navigation of Health and Social Services	0 Communicate policies and programming that prevent suffering for all patients, including paid family leave, child tax credits, and peer support (e.g. California's Peer Support Services benefit). Revise paid family leave education materials to include expanded leave for PMAD and make	X	X	X	X	

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Patient Education		available to medical and public health entities."					
		0 Begin conversation and screen for social service needs prenatally and in hospitals, including referrals (e.g., community health workers, family navigators, doulas).	X				
		0 Encourage prenatal providers to educate pregnant individuals on lactation and feeding options during the prenatal period and follow-up postpartum.	X	X	X	X	
	Ensure Comprehensive Lactation Support and Education	0 Provide support in securing breast pumps and eliminating patient reported barriers to access (e.g., publicly available information, lifetime maximums, gestational week minimums, reimbursement issues).	X	X	X	X	

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Patient Education		0 In-home visits should include an RN, doula, or provider with lactation training.	X	X	X		
		* Create a provider lactation and feeding toolkit integrating existing resources geared toward obstetric and maternity providers, pediatricians, midwives, nurses, doulas, and community health workers.	X				
		* Train all providers interacting with pregnant and postpartum individuals in lactation support.	X	X	X		
Workforce Development + Support	Address Provider Shortages	0 Utilize community health workers and health navigators to support coordination, education, and enrollment in key social service programs.	X	X	X	X	
		+ [TCS] Optimize health care workforce efficiency by designating a consistent lead maternity care manager, whose	X	X	X	X	

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Workforce Development + Support		role is adaptable based on available resources. This position can be filled by an obstetric or maternity care provider, case manager, doula, or community health worker, to coordinate clinical care and ancillary social services, ensuring comprehensive support throughout the maternity period.					
	Train Providers in Available Social Service & Medicaid Benefits	* Train OBs, Family Medicine physicians, and Advanced Practice Providers involved in perinatal care regarding disability extensions.	X	X			
		* Leverage that Certified Nurse Midwives and Licensed Midwives are now able to certify State Disability Insurance for postpartum depression.	X	X			
		*Increase training programs for diverse maternity care providers, particularly to		X			

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Workforce Development + Support		grow midwifery and doula care providers.					
	Invest in Workforce Diversity & DEI	*Increase Diversity, Equity, and Inclusion (DEI) and trauma-informed training programs for existing maternity and primary care providers.	X	X			
		0 Include more Licensed Midwives in-network.		X		X	
	Promote Access to Midwifery	+ Streamline Medi-Cal contracting and remove barriers from participation in Medi-Cal for independent Licensed Midwives and Certified Nurse Midwives.	X	X		X	
		* Explore opportunities for technical assistance to ensure appropriate reimbursement for professional fees for midwives and facility fees for birth centers.	X	X		X	

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Workforce Development + Support		* Address additional barriers midwives face in becoming Medi-Cal providers, as outlined in University of California, San Francisco's (UCSF's) and Institute for Medicaid Innovation's (IMI's) reports.		X		X	
	Support Doula Utilization	0 Standardize doula training so that doulas are trained in trauma-informed care, breastfeeding, warning signs, etc.			X	X	X
		0 Increase access to and utilization of doula care through increased integration of doula services into Medi-Cal plans and patient education and awareness.	X	X	X	X	
		** Ensure appropriate reimbursement for doula services.		X		X	
Behavioral Health	Increase PMAD Screening	0 Scale and spread successful behavioral health integration models, such as the Collaborative Care Model. Recommend a step-by-step process for	X	X		X	

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Behavioral Health		peer counselors, and behavioral health counselors to know when to increase/ramp up the interventions as needed.					
		** Create incentives that encourage pediatricians to do behavioral health screening and referrals for parents.	X	X		X	
	Coordinate Referrals and Enrollment in Treatment	0 Integrate behavioral health providers into maternity and primary care practices and offer both individual and group therapy (e.g. the Collaborative Care Model). This establishes a warm handoff between the medical care provider and the mental health provider.	X	X		X	
		0 Identify trauma-informed therapists in all counties and designate them in provider directories.	X	X	X		

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Behavioral Health		+ Create new tracking and data sharing processes for providers on PMAD screening and timely referral practices to identify bright spots and areas that need attention.	X	X		X	X
		+ Establish team members (community health workers, doulas, prenatal coordinators, family navigators, and actual BH team members) within maternity and primary care teams to periodically follow up with the patient once they have been identified to encourage patients to keep contacting behavioral health resources.	X	X	X		
		+ Create a clear process for supporting and monitoring behavioral and psychiatric needs from pregnancy through the 12-month postpartum period when psychiatric risks arise.	X	X	X		X

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Behavioral Health	Improve Availability of Treatment Options	0 Invest in the scaling of support groups for individuals with less severe distress.	X	X	X		
		0 Expand availability of mental health providers trained to deliver trauma therapy (e.g., cognitive behavioral therapy and interpersonal therapy).	X	X	X		
		0 Train obstetric and maternity providers and pediatric providers to recognize and screen for trauma.	X	X		X	
		0 Expand trainings for all peer support specialists in the basics of PMAD and trauma-informed care. Provide more extensive training in specific areas such as substance use disorder, incarceration, etc. Leveraging non-clinical behavioral health specialists enables reservation of clinical resources for patients with more acute needs.	X	X		X	

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Behavioral Health		+ Create Peer Support Specialist Certification in PMAD.	X	X	X	X	
		+ Distribute funding to counties and systems to pursue a local quality improvement approach (gather data, look for options for solutions, test them, and spread as they are working) to address low behavioral health screening rates (e.g., PMAD) and a lack of treatment options.		X		X	X
		* Create incentives to support access to virtual therapy and treatment options, including medication management.		X		X	
	Increase Awareness	0 Promote the national perinatal psychiatric help line.	X	X	X	X	X
	Invest in Development and Training of	0 Train maternity and primary care providers in pharmacologic solutions through 12 months postpartum.	X	X	X	X	

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Behavioral Health	Perinatal Workforce	0 Create a provider toolkit about what to do with a positive screen for depression, anxiety, and adverse childhood events (McPAP for Moms, Maternal Mental Health Now).	X	X			X
		+ Ensure providers interacting with postpartum patients have training in screening and immediate follow-up referral for PMAD. Training should highlight decision points in care, where concerns may arise, and how to minimize concerns and prevent maternal suicide.	X	X	X	X	
		+ Train non-licensed professionals to screen and triage for PMAD, with licensed providers trained to do second-level screening.	X	X	X	X	

			Implementers				
Category	**Activity**	**Recommendations** (0 Scaling of a promising practice), (+ New clinical practice) (*New concept or policy change), (**New incentive), ([TCS][6] Relevant to Transitional Care Services)	**Health Care Delivery**	**Managed Care Plans**	**Communities**	**Regulators, Policymakers, Purchasers**	**Public Health Researchers**
Behavioral Health		** Establish incentives to train more behavioral health providers in perinatal mental health.	X	X		X	

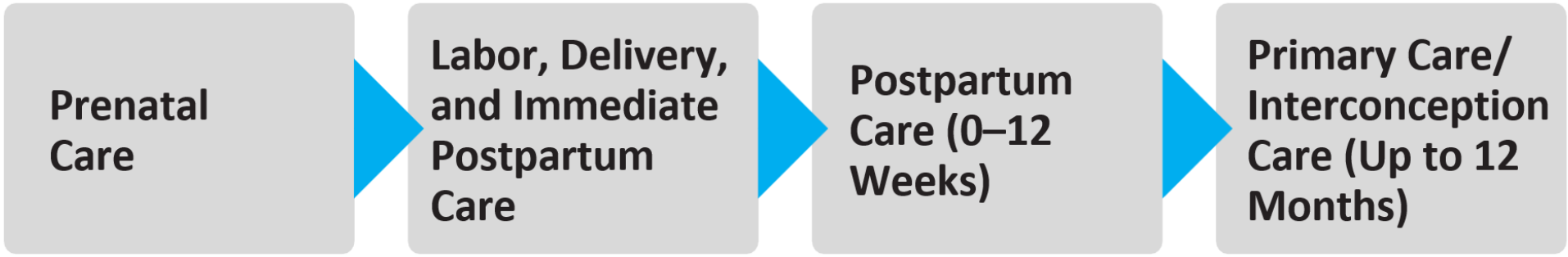
Appendix C: Visual Maps of the Postpartum Pathway

Visual Maps: Background & Purpose:

- **Background:** The following visual maps were developed as part of DHCS' Birthing Care Pathway Project and reflects highlights of the discussions and feedback provided by experts during the Postpartum Sub-Workgroup meetings (convened 9/2023 through 1/2024).
- **Purpose:** The visual maps are intended to guide health care delivery systems and care teams in piloting postpartum innovations tailored to their unique resources and the specific needs of their patients. It outlines essential elements to enhance patient experience, achieve care continuity, and improve health outcomes.
- **Intended Audience:** Providers, care teams supporting behavioral and social needs, administrators, and essential implementation partners, including payers, purchasers, and policy makers.

Postpartum Pathway: Overview

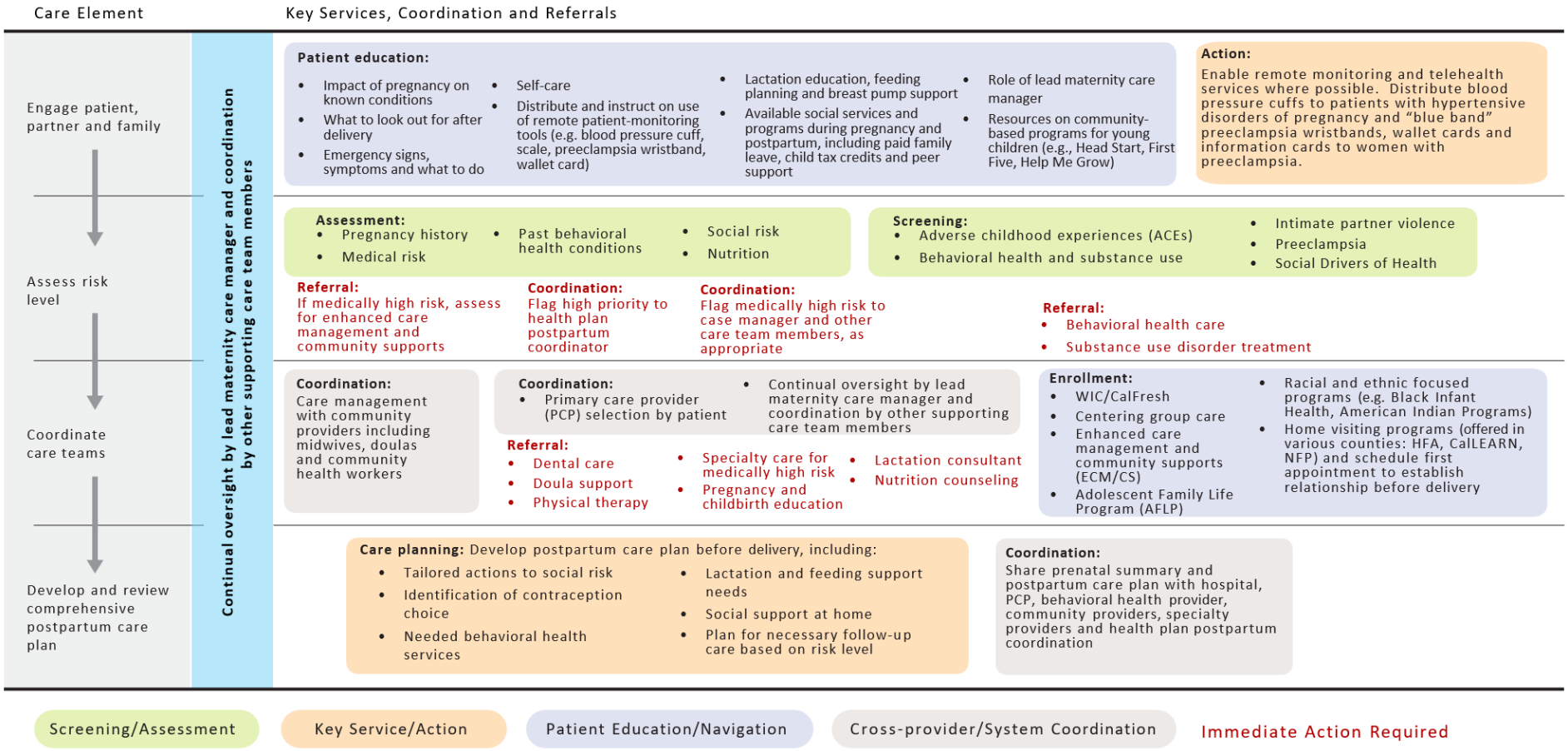
Key Elements, Services, Coordination Activities and Referrals through the Prenatal and Postnatal Periods for Optimal Postpartum Health for Birthing Persons and Infants



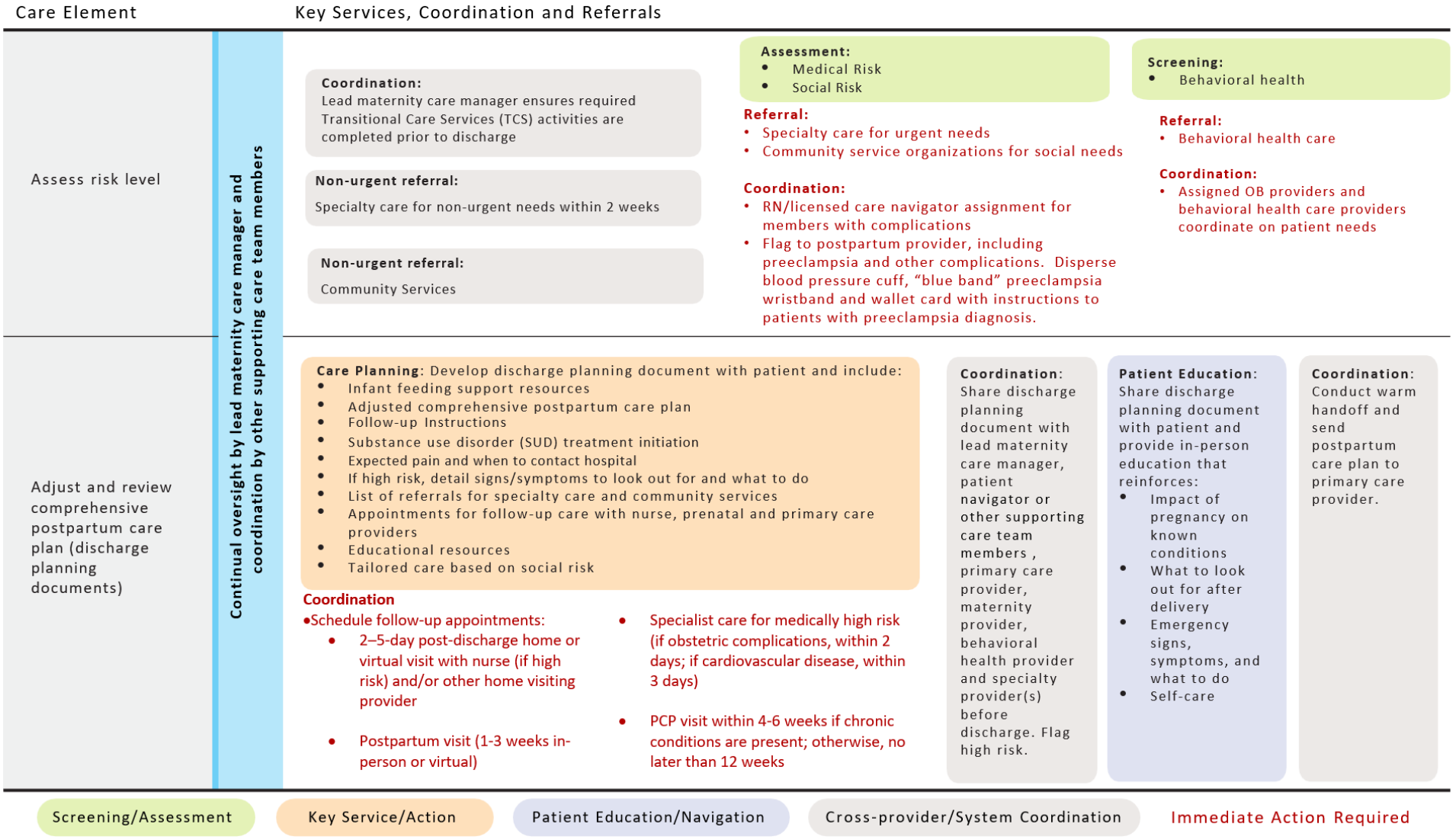
Key

Screening/Assessment	Key Service/Action	Patient Education/Navigation	Immediate Action Required
Identifying and evaluating health risks and needs.	Essential services or steps provided to support patient care.	Providing information and guidance to help patients understand and manage their health and their health care.	Urgent connection with a specialist or service and subsequent monitoring.

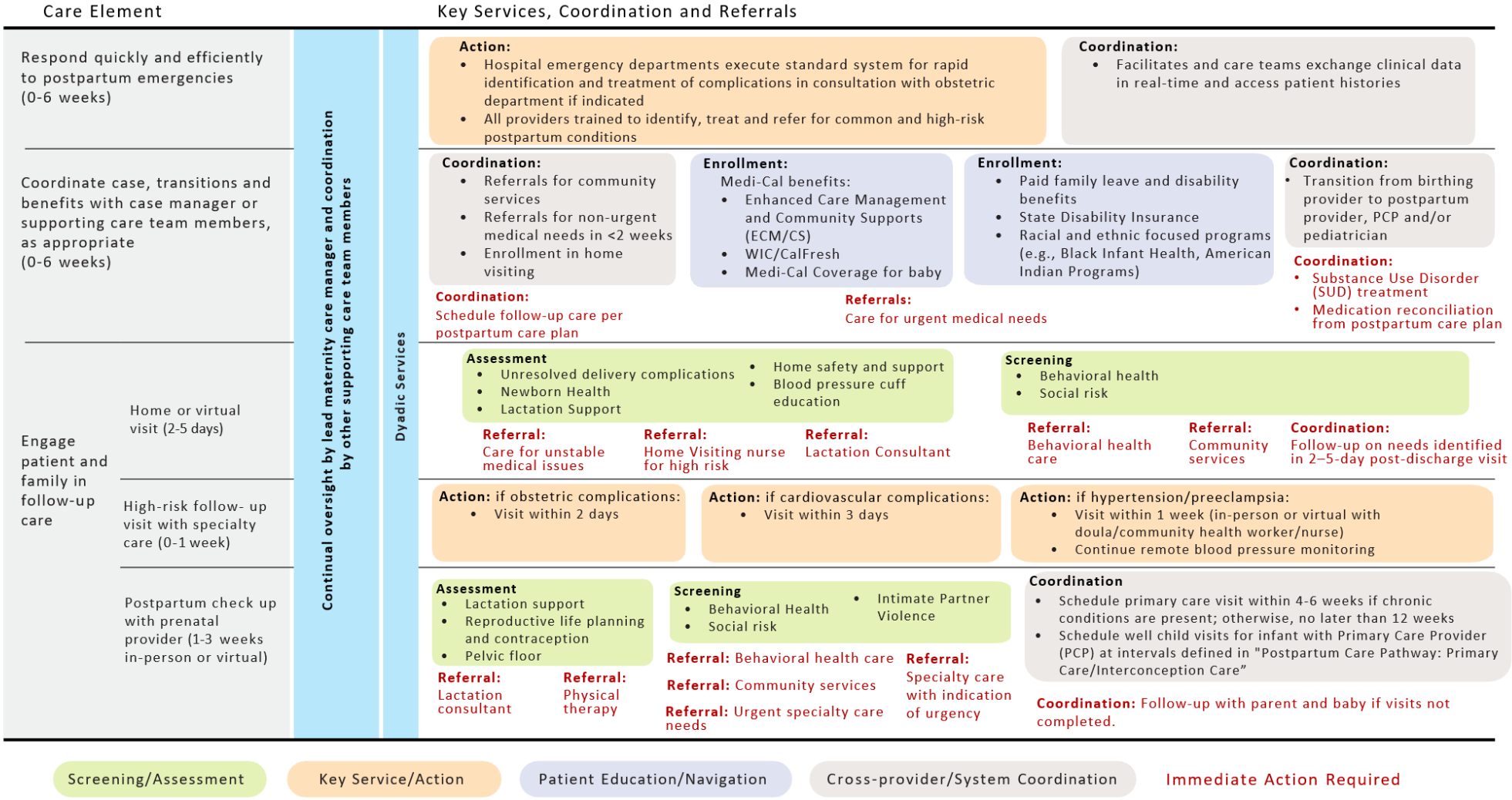
Postpartum Pathway: Prenatal Care



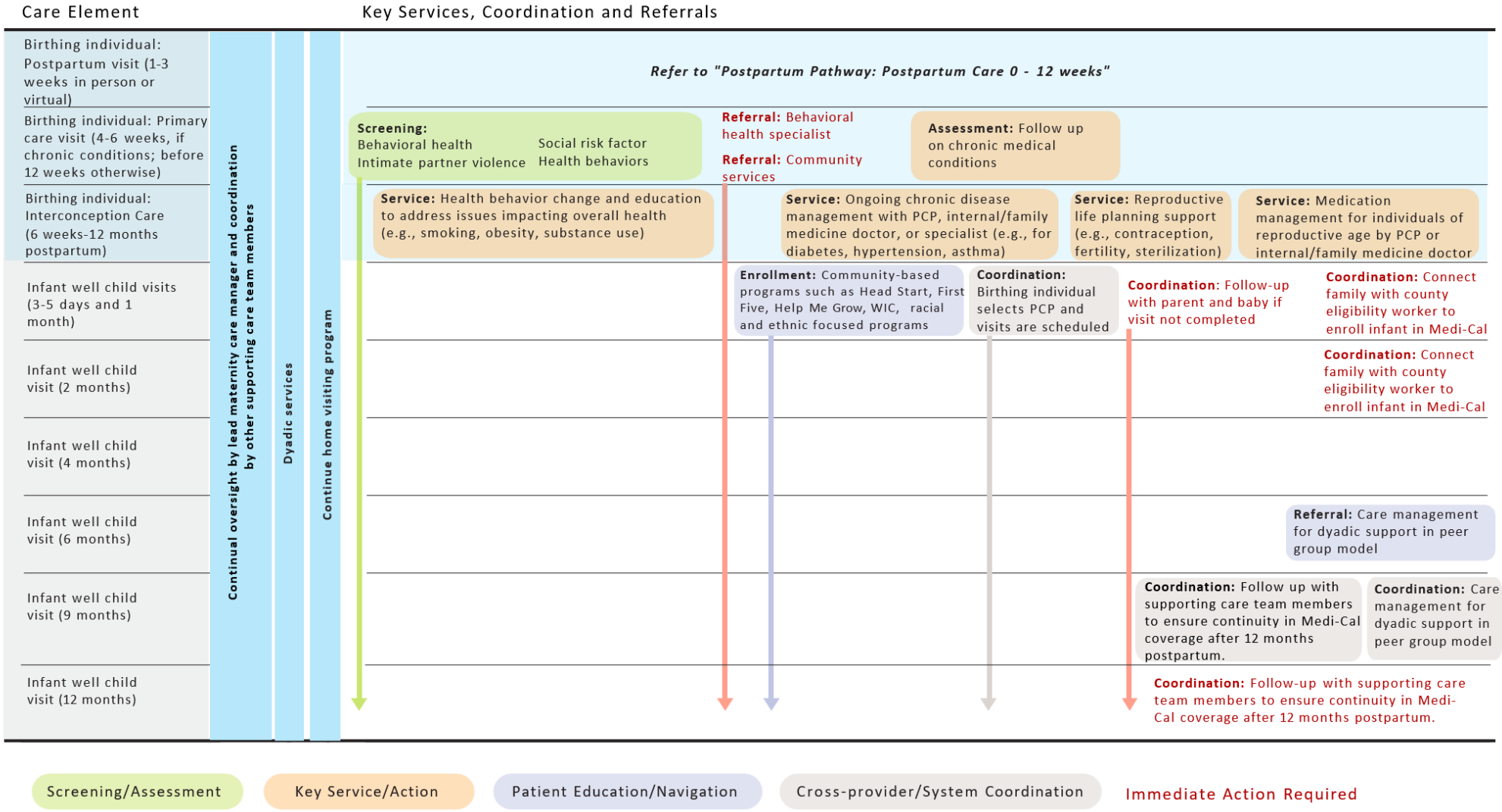
Postpartum Pathway: Labor, Delivery, and Immediate Postpartum Care



Postpartum Pathway: Postpartum Care (0–12 Weeks)



Postpartum Pathway: Primary Care/Interconception Care (Up to 12 Months)



Appendix D: List of Postpartum Sub-Workgroup Members

Birthing Care Pathway Postpartum Sub-Workgroup		
No.	**Name**	**Organization & Title**
1.	Sean Atha	» Senior Vice President of CalAIM Initiatives and Community Health Integration, Vivant Health
2.	Priya Batra	» Deputy Director, Health Promotion Bureau, Los Angeles County Department of Public Health » OB/GYN
3.	Susan D. Crowe	» Clinical Professor, Obstetrics and Gynecology—Maternal Fetal Medicine, Stanford University » District IX Executive Committee, American College of Obstetricians and Gynecologists (ACOG) » OB/GYN
4.	Shantay R. Davies-Balch	» President & CEO, BLACK (Belonging, Love, Affinity, Community, & Kinship) Wellness & Prosperity Center » Doula & Certified Lactation Educator
5.	Liz Donnelly	» Health Policy Vice-Chair, California Nurse- Midwives Association (CNMA) » Certified Nurse Midwife
6.	Emily C. Dossett	» Founder and Director, Reproductive Mental Health Consultants » Associate Clinical Professor, Departments of Psychiatry & Obstetrics & Gynecology, Keck School of Medicine, University of Southern California (USC) » Reproductive Psychiatrist
7.	Angela Egbuchulam	» Black Infant Health (BIH) Coordinator, San Joaquin County Public Health Services » Associate Clinical Social Worker (ACSW)
8.	Sayeed Khan	» Chief Medical Officer, Molina Healthcare of California » Internal Medicine Physician
9.	Tipu Khan	» Chief of Addiction Medicine, Ventura County Medical Center

Birthing Care Pathway Postpartum Sub-Workgroup		
No.	**Name**	**Organization & Title**
		» Fellowship Director, Ventura County Primary Care Addiction Medicine Fellowship » Core Faculty, Ventura Country Family Medicine Residency Program » Director of Addiction Medicine for Southern California, HealthRight 360 » Adjunct Clinical Professor, Keck School of Medicine, USC » Family Medicine Physician & Addiction Medicine Specialist
10.	Michelle Lubahn	» Community Education Manager/Project Lead, Developmental Understanding and Legal Collaboration for Everyone (DULCE) Population Health, Children's Hospital of Orange County (CHOC)
11.	Antoinette Martinez	» Family Medicine with Obstetrics, United Indian Health Services, Inc., Arcata, California » Co-Director/Associate Professor, University of California Davis (UCD) School of Medicine (SOM) Tribal Health Programs in Medical Education (PRIME) (THP) » Co-Director, Huwighurruk Postbaccalaureate Program at Cal Poly Humboldt with UCD SOM THP » Family Medicine Physician & OB/GYN
12.	Marisela Montoya	» Executive Director, South Los Angeles Health Projects (Lundquist WIC) » International Board Certified Lactation Consultant
13.	Robert Moore	» Chief Medical Officer, Partnership HealthPlan » Family Medicine Physician
14.	Malini Nijagal	» Professor, University of California, San Francisco (UCSF) Department of Obstetrics, Gynecology, & Reproductive Services (Zuckerberg San Francisco General Hospital Division) » Director, SF Respect Initiative » OB/GYN

Birthing Care Pathway Postpartum Sub-Workgroup		
No.	**Name**	**Organization & Title**
15.	Kelly O'Connor	» Executive Director, Maternal Mental Health NOW
16.	Yeri Park	» Provider, Family Care Specialists Medical Group » Teaching Faculty, Adventist Health White Memorial » Family Medicine Physician
17.	Erin Saleeby	» Chair, Obstetrics & Gynecology at Harbor-University of California, Los Angeles (UCLA) Medical Center » Associate Professor Health Sciences, UCLA David Geffen School of Medicine » Director, Women's Health Programs at Los Angeles County Department of Health Services » MD, MPH, FACOG
18.	Holly Smith	» Health Policy Chair and Legislative Coordinator, CNMA » Co-Facilitator, Midwifery Access California (MACa) » Certified Nurse Midwife
19.	Mike Weiss	» Vice President of Population Health, CHOC » Pediatrician
20.	Madeleine Wisner	» Chief Executive Officer, Welcome Home Midwifery Services » Vice President, California Association of Licensed Midwives (CALM) » Licensed Midwife, Registered Midwife (New Zealand), & International Board Certified Lactation Consultant
21.	Jyesha Wren	» Co-Founder & Program Director of BElovedBIRTH Black Centering within Alameda Health System & Founding Director of Beloved Birth Collective » Certified Nurse Midwife

Appendix E: List of Postpartum Pathway State Collaborators

Postpartum Pathway State Collaborators		
No.	**Name**	**Organization & Title**
1.	Palav Babaria	» Chief Quality & Medical Director and Deputy Director of Quality and Population Health Management, Department of Health Care Services
2.	Arlene Cullum	» Director of Special Projects, Stanford University School of Medicine
3.	Blair Dudley	» Director, Transform Maternity Care, Purchaser Business Group on Health *(former)*
4.	Crystal Eubanks	» Vice President of Care Transformation, Purchaser Business Group on Health (PBGH) » Executive Director, California Quality Collaborative (CQC)
5.	Matthew Green	» Deputy Director, Center for Family Health, California Department of Public Health
6.	Lauren Groves	» Advisor to the Office of the California Surgeon General, Office of the California Surgeon General
7.	Leslie Ann Kowalewski	» Executive Director of Maternal, Child and Family Health for California Maternal Quality Care Collaborative (CMQCC), California Perinatal Quality Care Collaborative (CPQCC), and the Prematurity Research Center (PRC)
8.	Bonnie Kwok	» Medical Consultant, Population Health Management Division, Department of Health Care Services
9.	Arlene Silva	» Nurse Consultant III (Specialist), Quality and Health Equity Division, Department of Health Care Services
10.	Julie Pham	» Medical Consultant I, Quality and Health Equity Division, Department of Health Care Services
11.	Diana Ramos	» California Surgeon General, Office of the California Surgeon General
12.	Karen Ramstrom	» Chief, Maternal & Infant Health Branch, Maternal Child & Adolescent Health (MCAH) Division, California Department of Public Health » Preventive Medicine & Public Health Physician

Postpartum Pathway State Collaborators		
No.	**Name**	**Organization & Title**
13.	Brynn Rubinstein	» Women's Health & US Health Systems Consultant, Purchaser Business Group on Health (PBGH) and California Quality Collaborative (CQC)
14.	Amanda Williams	» Clinical Innovation Advisor, California Maternal Quality Care Collaborative (CMQCC) » Interim Chief Medical Officer, March of Dimes *(former)* » Adjunct Clinical Associate Professor, Department of Obstetrics and Gynecology, Stanford University School of Medicine » OB/GYN