Recommendations of the New Jersey Perinatal Care During COVID-19 Work Group

Issued by the New Jersey Health Care Quality Institute
May 7, 2020

Thank you to The Nicholson Foundation for your generous support.

The effects of the COVID-19 pandemic and the public health measures necessary to mitigate the spread of the virus has a significant impact on pregnant individuals. Infertility treatments, options counseling, ongoing prenatal care, and post-partum care for the patient and infant, and other necessary health and social services, remain essential for the health outcomes and wellbeing of New Jerseyans. It is crucial that these services remain accessible and that efforts to maintain social distancing practices do not inhibit service provision and quality.

Already vulnerable pregnant populations (such as individuals of color, those with low-incomes, or individuals with a disability, mental health illness, limited health care access, or underlying medical conditions) faced an increased risk of maternal mortality and other pregnancy-related complications prior to COVID-19, and the current crisis only exacerbates these disparities. Efforts to promote high-quality care must be cognizant of the needs of vulnerable populations and recognize where additional resources and individualized care are needed to optimize the health of patients and infants under these circumstances.

This report presents the recommendations of the New Jersey Perinatal Care During COVID-19 Work Group, which was led by the New Jersey Health Care Quality Institute and included a wide array of subject matter experts. This report is divided into the following topics in order to facilitate its use by health care workers, policy makers, and other readers:

A. **Prenatal Care**
B. **Triage & Testing Guidance for Facilities**
C. **Labor & Delivery**
D. **Postpartum Care**
E. **Alternative Birthing Sites**

In addition, this report includes the following Appendices with useful information and additional resources:

Appendix A: Short- and Longer-term Policy Recommendations
Appendix B: Opportunities to Support Studies to Advance Knowledge on COVID-19
Appendix C: Patient Education Resources
Appendix D: Professional Resources
Appendix E: Postpartum Contraceptive Care Resources
Appendix F: Suggested Supplies
Appendix G: Resource Support Through Insurers

This report includes recommendations which garnered broad Work Group consensus and conceptual agreement. Recommendations were based on available research, data, expert opinion, and best practices from Work Group members as well as the following entities: Centers for Disease Control and Prevention (CDC), American College of Obstetricians and Gynecologists (ACOG), Society for Maternal-Fetal Medicine (SMFM), International Federation of Gynecology and Obstetrics, and Royal College of Obstetricians and Gynecologists. The recommendations were drafted to recognize that the COVID-19 pandemic is a fluid situation and different facilities

have differing resources. We also recognize that evidence and data on COVID-19 are limited, will evolve, and may need to be updated in this report as new evidence becomes available.

Most importantly, these recommendations were created to align with the work of Nurture NJ, which focuses on improving collaboration and programming between departments, agencies, and stakeholders to make New Jersey the safest place in the country to give birth and raise a baby. Nurture NJ is designing a comprehensive, statewide strategic plan to reduce maternal mortality by 50% over five years and eliminate racial disparities in birth outcomes. Our statewide response to perinatal care during COVID-19 will affect our ability to meet these important goals.

Finally, within Appendix A, there are short- and longer-term policy recommendations that the Work Group refers to the State for further consideration in conjunction with its on-going Maternal and Child Health initiatives to promote safe, equitable, and person-centered perinatal care for individuals throughout New Jersey.

I. Prenatal Care

While other reproductive health services, such as gynecologic care and pregnancy options counseling, are essential services, this document is focused exclusively on perinatal care. This section of the document focuses on prenatal care.

A. Recommendations for Obstetric Visits

1. In-person office visits should be minimized to the extent possible while maintaining patient safety. Where appropriate and feasible, routine prenatal visits can be conducted via telehealth. We recommend health care providers consider visit schedules similar to the Henry J. Kaiser Family Foundation's model, which outlines a model of telehealth and in-person visits for low-risk patients.
    - Patients should be assessed for their ability to complete telehealth visits (i.e. ability to access a phone or video chat platform and access to supplies which may be necessary for telehealth visits, such as a blood pressure ("BP") cuff).
2. Patients who have a moderate or high-risk pregnancy, or emergent obstetrical needs, may need to be seen in person more often or have additional telehealth visits for follow-up on comorbidities and social service needs.
3. We recommend health care providers follow best practice protocols aimed at maintaining both patient and health care worker safety. These best practices include:
    - Pre-screening patients who need an in-person visit for COVID-19 exposure and symptoms should be done by phone the day prior to the visit, when possible.
        a. Patient history and triage should also be performed in advance by phone whenever possible.
    - Social determinants of health screens should be conducted early in the patient's pregnancy and continue to be re-evaluated throughout the pregnancy in order to provide early treatment and appropriate referrals or resources.
        a. Patients covered by a government-sponsored plan should be screened using the state's Perinatal Risk Assessment Tool.

  b. Psychosocial assessments should be conducted at the first visit, and as needed at future visits.
  c. Referrals for social work should be made as appropriate.
  d. Referrals to the Nurse-Family Partnership should also be made as appropriate.
- Patients should be encouraged to attend their visit alone, when possible. Certain circumstances may necessitate the need for others to be present and should be discussed on a case-by-case basis (i.e. childcare issues or patient trauma).
- If possible, providers should develop a system for patients to wait for their appointment outside of the office to limit the number of individuals in the office at one time, keeping in mind that not all patients have a car they can wait in. Providers should also reconfigure office areas so that patients can maintain social distancing recommendations (i.e. space out chairs in waiting rooms or other shared spaces).

4. In all obstetrical populations, there has been a rise of Intimate Partner Violence (IPV) during the COVID-19 crisis. During intake and with serial assessments and screenings, IPV assessments should be incorporated into workflows and appropriate resources or referrals should be provided to patients.

B. Recommendations for Outpatient Assessment and Management of Patients with Suspected or Confirmed COVID-19

1. We recommend health care providers follow guidelines developed and updated by ACOG and SMFM, which are outlined in their algorithm: Outpatient Assessment and Management for Pregnant Women with Suspected or Confirmed Novel Coronavirus (COVID-19).

C. Recommendations for Prenatal Education and Support

1. In addition to providing patients routine prenatal education, consideration should be given to additional education and the support needs of patients during the COVID-19 pandemic.
   - Providers should consider when technology can be used to include the patient's support person or other family members in the office visit remotely, if that is requested by the patient.
   - Prenatal education and support should include:
     a. Reproductive health education and contraceptive counseling (see Appendix E for Postpartum Contraceptive Care Resources).
     b. Lactation education.
     c. Education regarding BP assessment at home if the patient is at high-risk, including teach-back of how the patient can check their own BP and obtain their own BP cuff (see Appendix G for Resource Support).
     d. Appropriate contact information for when the patient goes into labor as each practice/setting may have different procedures.
     e. Detailed information and instructions regarding the birthing facility's procedures for labor, admission, and other OB emergencies.

f. Identification of the patient's primary support person. Patients should be advised that their support person will need to stay with them for the duration of the admission and may have on-going COVID-19 screenings while at the birthing facility (and that facilities may change these guidelines as new evidence becomes available).
g. Plans for a secondary, or alternate, support person should also be discussed in the event the primary support person screens positive for or develops COVID-19 symptoms.
h. Patients should be educated on the known benefits of breastmilk as well as what we know so far on how it relates to COVID-19. Options such as breastfeeding, expressing milk, and donor milk should be discussed. Shared decision-making should fully involve the patient and, if they choose, their support person. Patients wishing to express milk should be provided information on necessary supplies and how to obtain them (see Appendix G for Resource Support).
i. Review of education taught during prenatal classes.
j. Guidance on supplies which will be needed during the postpartum period. During a public health crisis, needed supplies may be limited and hard to find. The patient should be encouraged to gather these supplies before delivery.
    - The care team could consider providing patients with a "checklist" of important items (see Appendix F for Suggested Supplies and Appendix G for Resource Support).

- Prenatal education group classes should be encouraged and conducted via telehealth. Other web-based resources should be provided to further the patient's education on important pregnancy, childbirth, and postpartum topics (see Appendix C for Patient Education Resources).

D. Recommendations for Patient Communication

1. Providers should add signage in and outside the office to help patients navigate changing protocols. Changing protocols should be:
    - Made visible on signage in multiple languages of patient population.
    - Included on voicemail greetings, the patient portal, and office website.
    - Discussed during pre-screening or appointment reminder communications.
2. Inform patients and support persons of methods to communicate via HIPAA compliant telehealth platforms when possible. However, non-HIPAA compliant audio and video platforms, such as Facetime and WhatsApp, may be used during the COVID-19 crisis. (Facetime and WhatsApp do not use a lot of data and may be viable free options for patients with access to a cell phone.)
3. Patients should receive education on what to expect when they arrive at the birthing facility (i.e. new triage procedures around labor support and discharge).
4. Information on COVID-19 testing site locations can be found on New Jersey's COVID-19 information hub.

E. Recommendations for Health Care Provider/Staff Communication

1. It is crucial to ensure all health care providers communicate and relay information on procedure and policy changes to community workers who may be communicating with patients and support persons more frequently. This will help ensure that they too are relaying consistent and accurate information to patients and families.
2. See Appendix D for additional resources that health care providers can look to for support when providing care and guidance to patients and families.

II. Triage & Testing Guidance for Facilities

Patients who are pregnant may be arriving to a facility due to illness, pregnancy- or nonpregnancy-related complications, in labor, and/or for scheduled inductions or c-sections. Ideally, all pregnant patients should be rapidly assessed based on the facilities' guidelines to allow the health care team to best guide the birthing process and maintain patient, infant, and health care worker safety.

A. Recommendations for Triage

1. Facilities should have a plan in place as to where pregnant patients should be directed when they arrive to a facility for any of the reasons previously mentioned.

B. Recommendations for COVID-19 Testing in Facilities

1. *If COVID-19 PCR testing or rapid antigen testing methods are available*, all pregnant patients should be tested prior to or at the time they present at the facility. Ideally, the availability of rapid-COVID testing results would allow health care teams and the patient to identify the best plan of care as clinical guidance may change in the setting of a positive COVID-19 test result. If resources are widely available, facilities should also consider testing all support persons.
2. *If COVID-19 PCR testing or rapid antigen testing methods are limited*, testing should be prioritized based on the patient's clinical presentation, history, and infection prevention recommendations. In the event testing methods are limited, patients suspected for COVID-19 or with recent exposure should be prioritized.

C. Recommendations for Patient Communication

1. Patients should be made aware of changing protocols prior to their arrival at the facility. This includes providing patients with information on:
   - Who to contact when they are in labor or have any concerns.
   - What to expect when they arrive at the facility.
   - Protocols for their support person, including where the support person should wait during the patient's triage and the need to stay with the patient for the duration of the admission
   - Personal Protective Equipment (PPE) protocols for the patient, their support person, and staff (i.e. expectations regarding when to wear a mask)

2. Information should be made available in multiple languages and posted on the facility's website.

D. Recommendations for Health Care Provider/Staff Communication

1. Appropriate personnel should be made aware of changes to the facility's normal operating procedures. Examples of appropriate personnel may include:
    - All staff on Labor and Delivery and Mother-Baby units.
    - Security at facility entrances.
    - Emergency Departments.
    - Personnel answering main telephone lines (i.e. at main lobby desk).
    - Other staff as appropriate for each individual facility.

II. Labor & Delivery

Standard obstetrical best practices should be maintained for labor management including no early elective deliveries or inductions for nonmedical reasons. Confirmed COVID-19 status alone is not an indication for induction.

A. Recommendations for Support Persons

1. On March 29, 2020, the New Jersey Department of Health issued guidance requiring that one, asymptomatic support person be allowed to be with the patient for the duration of their birthing experience. The guidance can be found here. This guidance applies to all pregnant patients, including those who have suspected or confirmed COVID-19. The guidance focuses on the need for infection control during COVID-19 and limiting unnecessary exposure. As Personal Protective Equipment (PPE) becomes more available, the Department should consider modifying its guidance to allow birthing facilities to allow a doula, who is part of a patient's care team, to be present for the duration of the admission in addition to the patient's designated support person.
2. Health care providers should use telehealth, as possible, for the inclusion of additional support persons in the patient's care.

B. Recommendations for Personal Protective Equipment (PPE) Protocols

PPE shortages during a public health crisis pose a significant risk to health care workers, patients being cared for, and others visiting the facility. All health care providers and institutions should follow the CDC's recommendations, which are supported by ACOG and SMFM, for PPE use when caring for a patient with suspected or confirmed COVID-19, including their strategies to optimize PPE use. These recommendations can be found on the CDC website and seen on the CDC's Personal Protective Equipment (PPE) for Healthcare Personnel diagram. As PPE becomes more available, health care providers and institutions should promptly resume traditional PPE practices.

1. Staff should be educated on how to don and doff their PPE equipment.
2. All departments should be educated on proper infection control and transmission prevention procedures.

C. Recommendations for Labor and Delivery Protocols

1. L&D units should have plans in place to accept patients being admitted with suspected or confirmed COVID-19, including:
    - The placement of patients into designated rooms. If resources allow, patients should be placed in single-patient, negative pressure rooms.
    - Staff interaction with the patient should be limited to essential personnel.
    - The bundling or cohorting of care, when possible.
    - Notification of essential personnel.
2. Transfer agreements and transfer for maternal levels of care need to be realized, in advance, and communicated with established regional perinatal centers.
3. The mode of delivery for patients with suspected or confirmed COVID-19 should be guided by obstetric assessment and the patient's and infant's physiological stability (i.e. cardiorespiratory status).
4. To the extent possible, telehealth consultations should be considered to limit patient and staff exposure to COVID-19.
5. Water birth or water labor is not recommended at this time.
6. Delayed cord clamping should be encouraged.
7. Placentas should not be allowed to be taken home during the COVID-19 pandemic.
8. Health care providers should give consideration to skin closure methods for c-section deliveries and vaginal tears. Where possible, closures that will not require the patient to return for an in-person visit sooner should be considered (i.e. staple closures).

D. Recommendations for Labor Management and Support

1. Pain Management
    - There is currently limited evidence regarding the cleaning, filtering, and potential aerosolization of nitrous oxide labor analgesia systems in the setting of COVID-19. As such, its use should be suspended during COVID-19.

E. Recommendations for Patient Communication

1. Patients and their support person should be informed of changes to a facility's support person, visitor, and labor and delivery protocols during the prenatal period and again upon arrival to the facility. Communications should include the rationale behind any changes.
    - The patient and their support person should be informed of the following:
        a. The support person will be screened and stay with the patient for the duration of their admission.
        b. If the support person leaves, they will not be able to return to the facility.

  c. How meals will be provided for support persons.

- All changes should be made available in multiple languages, in written form on appropriate units, and posted on the facility's website.

F. Recommendations for Health Care Provider/Staff Communication

1. Changes to protocols should be communicated to staff on impacted units.
    - Education around protocol changes should include:
        a. Visitor and support person policies
        b. Labor and Delivery policies
        c. PPE protocols
2. Staff should be provided education on available translation services and acceptable methods to access and use these resources, such as use of facility designated phone lines or the use of staff/patient's personal cell phone lines.
3. As appropriate, team drills and simulation exercises are encouraged to help ensure staff are comfortable and knowledgeable about changing protocols, especially for emergency cases needing surgery.
4. See Appendix D for additional resources that health care providers can look to for support when providing care and guidance to patients and families.

III. Postpartum Care

A. Recommendations for Separation of Infants from Patients with Suspected or Confirmed COVID-19

1. Patients should be educated early in their admission on the benefits of skin-to-skin contact, including bonding, increased infant regulatory capacities, and lower risk of postpartum depression and anxiety. The patient should also be made aware of the potential for horizontal transmission of COVID-19 to infants, including being in close proximity with the infant and the potential risk of transmission via respiratory or direct contact. Shared decision-making should fully involve the patient.
2. The patient's ability to maintain separation at home should be assessed and considered.
3. Patients declining separation should be educated on infection prevention plans, including:
    - The use of a face mask when close to or in contact with the infant.
    - When and how to wash hands and breasts.
    - Infection transmission and prevention education.
    - Infant distancing in the room, such as through placing the bassinet greater than 6 feet away with a barrier or best alternatives if distancing may not be possible.
    - Documenting this decision in their Electronic Health Record (EHR).
4. If patient and infant separations do occur, health care providers should:
    - Make a plan for an earlier post-discharge follow-up visit and earlier screenings for postpartum depression and anxiety.
    - Implement more frequent infant behavioral assessments.
    - Arrange kangaroo care or babywearing for separated babies, when possible.

- Record the patient's voice and play for the infant, when and if possible.
- Communicate to pediatrician that the patient and infant were separated.
- Be aware that separated infants may need more intensive follow-up and developmental screens.

B. Recommendations for Lactation Guidance

All patients should be encouraged to provide breastmilk and be provided education on the benefits of the infant receiving breastmilk, such as the presence of antibodies in breastmilk that strengthen the infant's immune system. To date, COVID-19 has not been detected in breastmilk. However, evidence is limited, and researchers continue to study the breastmilk of patients with COVID-19. The primary concern remains whether a mother with COVID-19 may transmit the virus to her infant through respiratory droplets while breastfeeding.

1. All patients should be provided education on the known protective benefits of breastfeeding, such as bonding, lifelong health and developmental advantages for infants, and reduction of breast and ovarian cancer risk for the patient, as well as the potential risks of direct breastfeeding, including the risk of transmission via respiratory droplets with direct contact. Shared decision-making should fully involve the patient.
2. Patients choosing to breastfeed their infant should be educated on additional precautions to take to prevent the spread of COVID-19 to the infant while breastfeeding, including:
    - When and how to wash hands and breasts.
    - Patient wearing a surgical mask while breastfeeding.
3. Patients choosing to express breastmilk with a manual or electric breast pump should be educated on additional precautions to take to prevent the spread of COVID-19 to the infant while feeding, including:
    - Use of a dedicated pump.
    - Washing hands before touching any pump or bottle parts.
    - Having the individual feeding the infant wear a surgical mask.
    - Following recommendations for proper pump cleaning after each use.
    - Considering having someone who is asymptomatic and has not had any recent exposure feed the expressed breastmilk to the infant.
4. Provide education to patient and support person, if present, that a surgical mask or any face covering should not be placed on the infant. Surgical masks or face coverings are not recommended for children under 2 years old.
5. Lactation guidance should follow the latest evidence available from entities such as:
    - Centers for Disease Control and Prevention (CDC)
    - World Health Organization (WHO)
    - American Academy of Pediatrics (AAP)
    - American College of Obstetricians and Gynecologists (ACOG)

C. Recommendations for NICU Protocols

1. Infants born to mothers with suspected or confirmed COVID-19 at the time of delivery should be considered infants with suspected COVID-19.
2. Infants with suspected or confirmed COVID-19 should be isolated from asymptomatic or COVID-19 negative infants.
3. Consideration should be given to the patient's and infant's clinical condition in determining immediate needs. Patients and support persons should be educated on the benefits of skin-to-skin contact and immediate bonding with the infant as well as the potential risks of close contact, including the potential risk of transmission via respiratory droplets or direct contact. Shared decision-making should fully involve the patient.
    - If a decision is made to separate an infant from the patient and/or their support person with the goal of preventing horizontal transmission of COVID-19 to the infant, consideration should be given to the following *before* the infant is separated from the patient and placed in the NICU or another restricted area:
        a. The ability of the patient to maintain separation or colocation once discharged.
        b. The facility's capacity to accommodate separation.
        c. The fact that separation of the infant is not without risk of infant exposure to COVID-19 by an asymptomatic health care provider.
        d. Whether a better use of the patient and infant's admission stay would be to educate the patient and the support person, if present, on strategies to prevent COVID-19 transmission and protect the infant.

D. Recommendations for Length of Stay/Discharge

1. Early discharge should be considered when possible while maintaining patient and infant safety.
    - Psychosocial considerations should be taken into account when discharging a patient and/or infant home early, including the home environment and the patient's depression screen.
    - Necessary referrals should be considered early in the admission and reviewed until discharge, such as referrals for social work, the Nurse-Family Partnership, or lactation consultant, among others.
    - The patient's first postpartum visit and the infant's first pediatric visit should be scheduled prior to discharge.
2. In addition to routine postpartum discharge education, discharge education should also include (see Appendix C for Patient Education Resources):
    - Guidance and contact information if the patient is not coping well at home, including parameters of when the patient should call their provider.
    - Monitoring of COVID-19 signs and symptoms for the patient and infant.
    - Safe sleep practices, such as Back to Sleep recommendations.
    - Wound care.
    - Infant feeding and how to assess proper weight gain.

- Confirm the patient's reproductive health decisions made during their prenatal visit and provide support and instructions for further follow-up.
- Advise patient on protocol changes for postpartum and pediatric follow-up visits during COVID-19 and what to expect.
- Provide patients a "go-kit" which includes necessary supplies when possible (see Appendix F for Suggested Supplies). Review signs of possible postpartum complications and provide patients with a copy of AWHONN's POST-BIRTH Warning Signs patient education sheet for immediate reference.

E. Recommendations for Postpartum Visits

1. In-person or home visits can be replaced with telehealth visits as appropriate. The decision to use telehealth services should be based on needs and health of the patient and infant.
    - Recommended 1-3 week postpartum telehealth visit, if the patient or health care provider does not have concerns requiring an in-person visit.
    - Recommended 4-8 week in-person comprehensive postpartum visit, depending on patient needs.
2. The following can be considered for telehealth visits:
    - Lactation consultations.
    - Confirmation of reproductive health decisions (see Appendix E for Postpartum Contraceptive Care Resources).
    - Mental health care.

F. Recommendations for Patient Communication

1. For patients choosing to breastfeed, detailed instructions and support should be provided on lactation guidance prior to discharge.
2. For patients choosing to express milk, detailed instructions and support should be provided on how to use and clean a breast pump prior to discharge.
3. Patients should be provided web-based resources and/or classes for education on routine postpartum topics and further education during COVID-19 (see Appendix C for Patient Education Resources), such as:
    - Monitoring of COVID-19 signs and symptoms for the patient and infant.
    - POST-BIRTH warning signs.
    - Infection transmission prevention.
    - When to call the physician, when to call 911, or when to go to the Emergency Room.
    - Screening for mood disorders. (Postpartum depression may be compounded by social isolation or financial stressors during COVID-19.)
    - Opportunities for individual or group support.
    - Opportunities to interact with other moms.
4. Detailed postpartum instructions should be available in a variety of languages.

IV. Alternative Birthing Sites

Patients may be anxious about giving birth during the pandemic. They may be concerned about being in a hospital or current protocols in place at their hospital, including limitations on visitors or support persons. Because of this, patients may be looking to other locations for their delivery, such as birthing centers or home deliveries. At this time, the Work Group did not see a shortage of access to maternity units or the need for additional birthing centers to support births in New Jersey. As a longer-term policy, as discussed more fully in Appendix A, Short- and Longer-Term Policy Recommendations, patients may want more choice or additional options for low-risk birthing locations, such as alternative maternity units. More data is needed on this topic, especially regarding how COVID-19 will impact a hospital's capacity longer-term and the availability of trained health care workers to staff such alternative sites on an on-going basis. For now, patients should be encouraged to talk with their physician or midwife before changing their birthing plans. Patients should be made aware that hospitals and licensed birthing centers are putting protocols in place for birthing during COVID-19.

Closing and Acknowledgments

We would like to acknowledge and thank the following individuals for contributing their time and expertise to our research and consensus development process to create these recommendations. Please note the final product is not specifically endorsed by any individual or organization.

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Appendix A

Short- and Longer-Term Policy Recommendations

During the development of these recommendations for Perinatal Care During COVID-19, Work Group members raised a variety of short- and longer-term policy topics. The suggestions that garnered broad based support or interest in further research and consideration are set forth below. The Work Group recognizes that the COVID-19 pandemic has negatively impacted the State's budget and its ability to invest in new or expanded programs, no matter how worthy. Therefore, as appropriate, these policy ideas should be considered as recommendations for public-private partnerships, especially given the philanthropic community's incredible commitment to Maternal Child Health in New Jersey.

The State's Nurture NJ strategic planning work is already considering many of these recommendations. Moreover, the pandemic has caused us to collectively view these topics in another light. Through further planning and consideration of these topics in the face of COVID-19, we can build a more resilient and inclusive system of perinatal care which will serve New Jersey throughout and long-after this public health crisis. While the policy topics discussed below are not specifically included in the Work Group's recommendations, the Work Group recommends that they be considered in conjunction with Nurture NJ's strategic planning process and the on-going efforts of multiple state agencies to build and expand programs to improve Maternal and Child Health.

Policy Topic	Short-Term vs Longer-Term Change	Description	Proposed Next Steps
1. Review regulatory waivers and policy changes made because of COVID-19 and determine which of these should and could remain in place after COVID-19 to continue supporting patients, access to care, and affordability.	Short- and Longer-Term	Many emergency changes have been made to the administration of public and commercial health care coverage that could have longer-term implications to improve quality and access of care. Determine whether there is opportunity to carry emergency changes into longer-term delivery of health care coverage.	1. Review emergency waivers and policy changes that have been made during COVID-19 response and determine rationale, if any, and viability of continuing. 2. Research benefits and compare to other states and federal government policy. 3. Note which changes would need federal action as well. 4. Vet with state, consumers, providers, and payers to consider effects on access,

			equity, cost/budget, program integrity, safety, quality.
2. Continue to assess whether health care providers have adequate telehealth platforms and that patients have access.	Short- and Longer-Term	Temporary use changes were made to allow providers to use multiple methods of reaching patients to provide care via telehealth. Not all are approved options outside of the pandemic provisions. Some are not HIPAA compliant. Need to identify clinician market needs and patient needs to facilitate quality care, protected communications, and access and equity. Focus on need for low to no-cost technology for both clinician and patients, and how to continue its use long term.	1. Conduct market scan of current state of telehealth in NJ (post-COVID-19); include feedback on which platforms and types of telehealth worked effectively for which populations and types of care; 2. Consider federal funding opportunities; 3. Consider interoperability and connection to electronic health records (EHRs) and other technology to support best evidence, high value and convenient care; 4. Support NJDOH's steps to move forward with telehealth Commission and advance regulations that support goals outlined herein in longer term and keep all emergency changes in place until new regulations adopted, as long as they meet the discussed goals.
3. Continue and enhance efforts to integrate doulas and other community-based perinatal health workers to provide education and support during pregnancy, labor, delivery, and the postpartum periods.	Short- and Longer-Term	With shifts in how many support person(s) are allowed at bedside during labor and delivery, as well as changes to site of patient visits and education during the perinatal period, there may be an even greater need for community-based health workers and doulas. This includes direct visits and telehealth enabled visits between patient and CHW/doula. Further connectivity between hospitals and doulas could enable policy change for the doula to be considered part of the bedside care team,	1. State could enhance communication with providers and hospitals to disseminate info about doula programs and the support they provide. 2. DOH may want to delegate to the three maternal child health consortia as conduits to: DOH/DHS/other state agency community-based programs; insurers, hospitals; RHHs; communities for dissemination of info. 3. Consider doulas partner with hospital systems and their practicing providers to

		there to support the patient. Further connectivity to OBGYN and midwife practices could lead to greater referrals to and utilization of doulas.	develop sustainable funding models. 4. Improve workflow between multiple sites. 5. Could be part of other required perinatal public education work that is already mandated.
4. Launch the existing required public education campaign and utilize other communication strategies to increase public awareness of prenatal and POST-BIRTH warning signs. Utilize materials already developed by the DOH and national organizations such as AWHONN.	Short- and Longer-Term	Support state's efforts to bring consistency and improve outreach to pregnant patients, their support persons, and new parents regarding understanding warning signs that may lead to significant health concerns. Using existing materials and a coordinated outreach effort across the state could positively impact maternal morbidity and mortality and increase seeking medical care when warning signs are noticed.	1. Partner with Nurture NJ, DOH and other organizations to determine outreach strategy, develop or adapt existing materials, and create a roll-out strategy. NOTE: This is already required but strategic next step would be to identify all mandates that are in the early or pre-implementation phase along with on-going work in NJ funded by state or foundations and align efforts for best results.
5. Continue to research use of alternative sites for labor and deliver.	Short- and Longer-Term	During this pandemic, many women are hesitant to use traditional hospital settings for labor and delivery as they view it as an elevated risk of exposure to the novel Coronavirus. Many are exploring other options for L&D, including supervised home births and alternative sites of care.	1. Conduct landscape review of labor and delivery alternative sites of care including feasibility, cost, demand for creating temporary sites or developing new birthing centers. 2. Understand payment and coverage for care at these sites 3. Explore quality and accessibility of sites. 4. In the short-term, to allay concerns during COVID-19, develop an outreach plan to encourage pregnant patients to discuss their birth plan with their care team, including questions about safe options for a birthing

			facility depending on their needs. 5. Obtain insights from home birth midwives to view their perspective on how things have changed during COVID and input on potential future implementation of out of hospital births.
6. Identify sustainable strategies to ensure access to resources needed during perinatal period such as: a few weeks of healthy food for mom, diapers, toiletries, blood pressure cuffs, thermometers, tape measures and simple scales. Consider what is covered by insurance and how to support uninsured patients.	Short-Term	Certain basic household items and medical equipment that could be used to facilitate telehealth visits may be needed to facilitate care. For patients covered through Medicaid, subsidized plans or are uninsured, they may need support in obtaining items to facilitate telehealth and better transitions home postpartum when food and toiletries are more difficult to obtain.	1. Determine and share what communications and concrete steps insurers are taking to address these issues and what is a covered benefit. 2. Identify and address through contract or regulatory changes any hurdles to including these items as covered services or benefits. 3. Create consistent messaging and access to these supplies as part of coverage for Medicaid health plans and subsidized ACA plans (focus on most vulnerable). 4. Identify source of funding for women/families that are uninsured.
7. Improve care and case management and closed loop referrals and technology systems for assess to social services and programs such as WIC, Healthy Start, Nurse Family Partnership.	Longer-Term	With agencies and providers offering limited or no in-person services, there is a need to understand how to deliver and provide essential community and home services to women and families in need.	1. Review current service delivery options, including highlighting best practices for remote or tele-care delivery. 2. Review the current capacity, quality, outcome measures for referral platforms such as Central Intake, 211, NowPow and Aunt Bertha. Suggest options for quality improvement, interoperability with HIEs, HIN, EHRs.

			3. Expand/improve ability of these programs to provide services remotely including consideration of client needs and ability to connect.
8. Continue to support and invest in a diverse perinatal workforce, including doulas and midwives who can provide culturally appropriate care.	Longer-Term	Women of color experience high rates of poor birth outcomes, including cesarean section, preterm births, low birthweight, and infant mortality. Doula care has been linked to improvements in many perinatal outcomes. Use of midwives has been associated with several benefits for mothers and babies including a reduction in the use of epidurals as well as fewer episiotomies or instrumental births. Women that used midwives were less likely to experience preterm birth or lose their baby before 24 weeks' gestation.	1. Suggestion to combine this policy change with doula/CHW policy change above; 2. Identify current training and recruiting venues and programs for training and developing a diverse and well trained doulas and CHWs; 3. Look to best practice models to identify next steps and goals; 4. Consider the sustainability strategies discussed in other policy section to ensure that recruited and trained doulas will be employed in sustainable programs; have access to care teams; and that their services will be communicated and shared with patients who may want to access them. 5. Issue guidance on the above, which may be adopted into regulations and/or certification program to create an on-going sustainable role and program that is part of the perinatal eco-system. 6. Identify and develop systems to foster and support educational opportunities for midwifery students, especially for students of color. 7. Update DOH regulations for hospitals and birth centers to support the full scope of midwifery practice.

			8. Improve reimbursement rates for midwifery services. NJ Medicaid's reimbursement is currently at 70%, among the lowest in the nation. CMS recommends a 100% reimbursement rate.
9. Extend Postpartum coverage for Medicaid to six months.	Longer-Term	The postpartum period can be a medically vulnerable period for many women. Many cases of maternal mortality and pregnancy-related depression occur in the postpartum period. Assuring that low-income women have continuous coverage after pregnancy would support improvements in infant and maternal outcomes.	1. The State applied to CMS for a waiver to allow it to expand eligibility for woman who are up to 200% of the FPL from 60 days post-partum to 180 days post-partum. 2. If waiver is approved, this will go into effect as long as it is funded. 3. Additional action to take is to communicate the benefits to all pregnant woman covered by Medicaid during perinatal period to support and encourage post-partum care and to make sure that MCOs and Medicaid provide outreach to support enrollment thereafter in ACA subsidized plan if applicable.
10. Increase funding for prenatal and reproductive health care for undocumented women.	Longer-Term	Free or low-cost prenatal services are available through hospital women's health clinics and FQHCs. Providers are reimbursed by the New Jersey Supplemental Prenatal Care. But the program's funding has been capped for decades and effectively runs out by the third month of each fiscal year. Once exhausted, hospitals and FQHCs continue to provide services as charity care - a small portion of which is reimbursed under	1. Educate policy makers on this problem and costs and benefits of fixing; 2. Demonstrate longer term budget savings in providing prenatal care; 3. Build 12 months of funding into the existing charity care program and directly link it to care provided at each setting. 4. Issue annual report to demonstrate benefits.

		their respective (hospital and FQHC) charity care programs	
11. Continue efforts to address disparities in health care.	Longer-Term	Description: Disparities in health outcomes (mortality and morbidity) for birthing persons of color, especially Black people, have been well documented. These disparities have also been observed during COVID-19, with higher mortality rates for people of color, again especially for Black people. The combined impact of perinatal and COVID-19 on perinatal outcomes is a major concern for people of color.	1. Expand efforts to obtain accurate perinatal data on disparities. 2. Expand efforts to address the drivers of disparities, including systemic and institutional racism, explicit and implicit bias, and structural and social determinants of health. 3. Ensure that COVID-19 does not set back on-going efforts to address this critical issue.
12. Explore how a tiered level of maternity care may impact the safety and quality of perinatal care.	Longer-Term	The state currently categorized birthing hospitals based on the resources and support available for the neonate at the time of birth. It is also important to understand the varying levels of care that need to be provided to a pregnant woman during birth and in the immediate post-partum period, which vary based on the resources of each hospital and their ability to respond to different types of emergencies.	1. Research tiered maternity care based on best practices in other states and health care systems. 2. Using convening across a diverse group of stakeholders, discuss a tier system that may be supported in New Jersey hospitals. 3. Understand how a tiered system of care would impact: access, payment, reduced sites of care delivery, quality, and safety.

Appendix B

Opportunities to Support Studies to Advance Knowledge on COVID-19

We encourage the State, providers, and residents to support research that will advance our collective knowledge on COVID-19. Listed below are various opportunities to volunteer to participate in such research. Please share this information with your patients and colleagues.

- University of California San Francisco (UCSF) – Priority Study: Pregnancy Coronavirus Outcomes Registry
- Mother to Baby – COVID-19 in Pregnancy Study will examine the short- and long-term effects of the COVID-19 virus in pregnancy and breastfeeding
- Rutgers Public Health Research Institute – COVID-19 research study is searching for volunteers ages 18 and older who are not pregnant and who have tested positive for COVID-19 to participate in a one-time blood draw study.

Appendix C

Patient Education Resources

During a public health crisis, like the COVID-19 pandemic, access to maternity care is even more difficult. Patients may need extra educational resources to support their self-care and monitoring, their telehealth visits, and better transitions home postpartum when so many additional issues and questions arise.

Below you will find recommended patient education resources to share with your patients, clients, and members throughout the perinatal period.

- Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) – POST-BIRTH Warning Signs Education, available in multiple languages
- CDC – Tips for Managing Stress and Coping with COVID-19
- Evidence Based Birth – Birthing in the Time of COVID-19 Series
- Family Larsson-Rosenquist Foundation – Guidance for Breastfeeding Persons with COVID-19, available in multiple languages
- Greater Newark Healthcare Coalition – Patient Education Materials, in English and Spanish
- International Society of Ultrasound in Obstetrics and Gynecology – Coronavirus and Pregnancy, available in multiple languages
- Lamaze International – Free and paid online classes
- March of Dimes – COVID-19: What You Need to Know About Its Impact on Moms and Babies
- Motherly – Becoming Mama free online birth class
- New Mom Health – Resources and information for families
- Nurse-Family Partnership – Resources for new moms
- Nurture NJ – a statewide awareness campaign committed to reducing infant and maternal mortality and morbidity, and ensuring equity in care
- Preeclampsia Foundation – COVID-19 and Preeclampsia
- Safe to Sleep Campaign – Information and resources on helping infants sleep safely
- Southern New Jersey Perinatal Cooperative – Free virtual support sessions
- The Bloom Foundation – Peer-to-Peer Support Groups for parents and families
- UCSF's Weill Institute for Neurosciences – Resources to support your mental health during COVID-19

Appendix D

Professional Resources

During a public health crisis, like the COVID-19 pandemic, professionals may want to access resources to support them in engaging their patients, clients, and members in different ways while continuing to provide safe, equitable, person-centered care. Below you'll find recommended resources.

- American Academy of Pediatrics
- American College of Obstetricians and Gynecologists
- American Public Health Association
- Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) – POST-BIRTH Warning Signs Education
- California Maternal Quality Care Collaborative
- California Perinatal Quality Care Collaborative
- CDC
- Centering Health Institute
- Early Childhood Development Action Network
- Human Milk Banking Association Milk Handling for COVID-19
- Illinois Perinatal Quality Collaborative COVID-19 Information
- Perinatal-Neonatal Quality Improvement Network of Massachusetts
- Society for Maternal-Fetal Medicine
- Rutgers Robert Wood Johnson Medical School Project Echo for COVID-19
- Vermont Oxford Network Neonatal COVID-19 Impact Audit Tool helps newborn care teams understand the impact of COVID-19 in their own units
- World Health Organization Mental Health and Psychosocial Considerations During the COVID-19 Outbreak
- Zero to Three

Appendix E

Postpartum Contraceptive Care Resources

"Would you like to become pregnant in the next year?" and other key questions are important for health care providers to discuss with their patients and clients. This care should not be ignored during COVID-19. Set forth below are recommended resources to support comprehensive reproductive health, including postpartum contraceptive care.

- American College of Obstetricians and Gynecologists (ACOG) – Postpartum Birth Control FAQs
- ACOG – Committee Opinion Number 670: Immediate Postpartum Long-Acting Reversible Contraception
- ACOG – Options for Postpartum Contraception
- ACOG and The LARC Program – Contraceptive Counseling for the Immediate Postpartum Period
- Before, Between, and Beyond Pregnancy – Reproductive Life Plan
- CDC – Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use
- Envision Sexual & Reproductive Health – PATH Framework
- Family Planning National Training Center – Birth Control Options Chart in English
- Family Planning National Training Center – Birth Control Options Chart in Spanish
- NJ FamilyCare – Plan First Program
- Power to Decide – One Key Question
- National Women's Health Network and SisterSong – Long-Acting Reversible Contraception Statement of Principles

Appendix F

Suggested Supplies

During a public health crisis, like the COVID-19 pandemic, access to personal care and food can be even more difficult. Below you'll find suggested supplies for patients and infants. Some insurers, Regional Health Hubs, and other organizations in New Jersey are providing new mothers with "Go Kits" at home or in the birthing facility to bring home with them.

- Baby wipes
- Blood pressure cuffs for home monitoring
- Batteries for blood pressure cuffs
- Diapers
- Feminine hygiene products
- Formula and bottles
- Hand sanitizer or soap
- Non-clinical cloth mask for patient (reminder: children under 2 should not wear a mask)
- Peri-bottles
- Stool softeners
- Thermometers – adult and infant

"Go-kits" should also include educational materials covering important topics such as:

- AWHONN's POST-BIRTH Warning Signs
- Signs and symptoms of COVID-19
- Other COVID-19 guidance: handwashing, prevention, when & how to seek care
- How to take blood pressure at home
- How to conduct kick counts at home
- What to look for with a newborn, such as number of soiled diapers and temperature
- Postpartum anxiety and mood disorder symptom list
- Breastfeeding and milk expression tip sheet

Appendix G

Resource Support Through Insurers

During a public health crisis, like the COVID-19 pandemic, access to perinatal care is even more difficult. Patients may need support in obtaining items to facilitate telehealth visits and better transitions home postpartum when food, toiletries, and equipment may be more difficult to find.

Below you'll find information available to date from health insurers on resources and communication they are providing to their members. *(This will be updated as additional information is received from each insurer).*

Plan: UnitedHealthcare (UHC) Community Plan

Resource	Does plan offer coverage for item/service?	Cost-sharing/ co-pay	How is your plan outreaching to beneficiary about covered service?	Additional information
Telephone Access and data plan	Member should contact Lifeline	No cost	UHC is conducting aggressive outreach activities to their maternity members assessing items such as: access to Prenatal/postpartum care, newborn care (follow-up appointments), WIC, food/formula insecurities, issues with medications, durable medical equipment, and private duty nursing/home care services	UHC is providing formula for members in need for a one-time one month supply. Delivery is less than one week.
Medical equipment: blood pressure cuff (BP), thermometer, scale	Yes	No cost	UHC Healthy First Steps program is making aggressive outreaches to their high-risk maternity population, assessing for at home health monitoring, and ordering equipment from contracted DME providers who ship directly to member's homes.	N/A
Virtual Education: prenatal classes,	Yes, these services are		UHC Healthy First Steps program provides	N/A

breastfeeding, parenting education	typically covered in person, and as a result of the COVID pandemic are now covered virtually.		aggressive outreaches to assess need and educate on services.	
Screening and referrals: mental health, partner violence, food, housing (SDOH)	Yes	No cost	UHC Healthy First Steps program provides aggressive outreaches. The Nurse Case Managers perform a comprehensive clinical and mental health assessment to address and assist with needs, gaps, and barriers. They will refer to UHC internal departments, such as our Behavioral Health Advocate, Social Work, and Housing Assistance.	UHC Healthy First Steps program utilizes our internal Optum Behavioral Health Team for mental health counseling and referral to outpatient services. For food/formula needs, UHC is supporting members through our Food/Formula food insecurity program.
Postpartum supplies: breast pump, pads, stool softeners, diapers, food, scale for newborn, tape measure, thermometers, etc.	Yes	No cost	UHC performs aggressive outreaches to our members to assess for postpartum needs and barriers to care. Supplies will be ordered through our contracted durable medical companies.	Referrals to Community Based services for supplies, clothing, cribs, and car seats. UHC Case Managers and Community Health Workers have an up to date resource guide per county.

Plan: WellCare Health Plan

Resource	Does plan offer coverage for item/service?	Cost-sharing/ co-pay	How is your plan outreaching to beneficiary about covered service?	Additional information
Telephone Access	Yes, Tracfone	No cost	Upon identification, the member is outreached for engagement and assessment to the care management program. OB program brochures are currently being developed.	N/A

Data plan for telephone/ telehealth	Safelink-Telehealth	No cost	Upon identification, the member is outreached for engagement and assessment to the care management program. OB program brochures are currently being developed.	N/A
Medical equipment: blood pressure (BP) cuff, thermometer, scale	Yes	No cost	Upon identification, the member is outreached for engagement and assessment to the care management program. OB program brochures are currently being developed.	BP cuff, scale, and glucometer are offered to the member if needed at the time of care management enrollment. For the Dual Special Needs Plans and Medicare Plans, there is $65 over-the-counter benefit every three months.
Virtual Education: prenatal classes, breastfeeding, parenting education	Yes	No cost	Upon identification, the member is outreached for engagement and assessment to the care management program. OB program brochures are currently being developed.	• Lactation consultant offered via Aeroflow. • Perinatal mental health webinar series offered thru Partnership of Maternal & Child Health of NJ. • Family Support Program-home visitation using telehealth and other virtual tours are offered thru Partnership of Maternal & Child Health of NJ. • Breastfeeding Education via Sistahs Who Breastfeed, a support group whose program mission is to support the feeding choices that women make surrounding feeding their babies. • Saint Joseph's Health Teen Obstetrics program provides specialized care to

				pregnant adolescents up to the age of 21. The services offered include medical care, social work counseling, prenatal education, and financial/insurance assistance.
Screening and referrals: mental health, partner violence, food, housing (SDOH)	WellCare's Community Connections Help-Line (CCHL) assesses callers SDOH needs through a standardized SDOH screening tool and makes community-based eligible referrals using WellCare's internal database. Callers are connected to social services and programs such as prenatal and postpartum education/ resources, parenting classes, support groups, utility, rent, food insecurity, etc.	No cost	Upon identification, the member is outreached for engagement and assessment to the care management program. OB program brochures are currently being developed.	• Referral to the WellCare Community Advocacy Department for community referrals such as food, shelter, caregiver support, behavioral healthcare management, and utility resources. • Referral: Computerized Cognitive Behavioral Therapy (COBALT CCBT) referral process for mental health. • Screening: Hurt, Insult, Threaten, and Scream (HITTS) screening Perinatal Risk Assessment Screening and Edinburg Screen for Postpartum Depression. • Referral: Cut, Annoyed, Guilt, Eye-opener (CAGE) screening for alcohol abuse. • Novuhealth- Healthy Rewards Program offers rewards for screenings (Dental checkup, prenatal care visit, postpartum care visit, diabetic eye exam, diabetic blood testing (A1C), and diabetic BP control. Member receives a $25 reward for the screenings.

Postpartum supplies: breast pump, pads, stool softeners, diapers, food, scale for newborn, tape measure, thermometers, etc.	Yes	No cost	Upon identification, the member is outreached for engagement and assessment to the care management program. OB program brochures are currently being developed.	Members are referred to NJ SNAP (benefits). • Breast pump offered via Aeroflow, NJ. • Transportation offered via Logistic Care. WellCare's Community Connections Help- Line (CCHL) assesses callers SDOH needs and makes community-based eligible referrals using WellCare's internal database connecting to social services and programs such as prenatal and postpartum education/ resources, parenting classes, support groups, financial assistance/utility, rent, food insecurity, etc.

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Report Issued on May 7, 2020.