



MATERNAL HEALTH INNOVATION *Podcast*



Changing the way America cares for
women and birthing people.

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Katherine Bryant & Dr. Rachel Caskey

Katherine: Welcome to Maternal Health Innovation, a podcast from the Maternal Health Learning and Innovation Center at UNC Chapel Hill, where we connect around culture, measures, and best practices and maternal health. The purpose of these conversations is to authentically explore what's working well and think together about ways to strengthen care for birthing parents, families, and those seeking to serve them.

At the MHLIC, we're thrilled for the opportunity to speak with experts on ways we can better serve birthing people and advance maternal health equity. I'm Katherine Bryant with the Maternal Health Learning Innovation Center, where we are united and commitment and patients' perspectives, so we can better center their needs and make systems of care more accommodating. Today, I'm honored to speak with Dr. Rachel Caskey from the University of Illinois, Chicago.

Dr. Caskey is the chief of the division of academic internal medicine and associate professor of internal medicine and pediatrics and a health services researcher. And for the purposes of this conversation, she's also the principal investigator at I-PROMOTE Illinois, the innovations to improve maternal outcomes in Illinois, and somehow, some way, with all that going on, she has time for us on this podcast today. Welcome Rachel.

Dr. Rachel Caskey: Thank you, Katherine. It's a pleasure to be here.

Katherine: Rachel, can you tell us what I PROMOTE-IL is and how you got involved?

Dr. Rachel Caskey: Sure. The Innovations to Improve Maternal Outcomes in Illinois acronym, I PROMOTE-Illinois, is our HRSA-funded project. And this is a project that a group - I applied for two years ago now - with quite an ambitious goal. Our goal is to provide leadership in developing statewide strategies to reduce maternal morbidity and mortality, and to achieve maternal health equity by eliminating disparities and improving the overall health of women, pregnant persons and families in Illinois. So, it's quite an ambitious goal, but we have a multi-pronged approach to try to achieve that goal.

Katherine: Great, thank you. Can you spotlight some of the current inequities and disparities you're working on eliminating?

Dr. Rachel Caskey: Our program is focused on decreasing maternal mortality and severe maternal morbidity in Illinois. So, as you know, stark disparities exist whereby Black women are nearly three times more likely to die from a pregnancy-related

condition compared to white women. In addition, it is estimated that the majority of deaths are actually preventable.

Because this is such a complex issue, we are tackling the disparities from multiple fronts. So, for example, we have established a statewide maternal health task force. The task force has created a comprehensive strategic plan focused on improving maternal health throughout the state of Illinois. This strategic plan is really a living document, outlining a multi-pronged approach, including efforts focused on access to care and services, root causes of health inequities, and expanding universal supports across the perinatal period, just to name a few.

In addition, I PROMOTE-IL is working with the state of Illinois directly to enhance data collection and data analysis of state level data on maternal mortality and severe maternal morbidity. And this is important because the accuracy of this data collected is critical to understand who is at risk, who is dying or having poor outcomes, and we need that to inform future interventions like our own work.

Finally, we're working to improve maternal health service delivery. This includes training healthcare providers across the state on the management of maternal hypertension and hemorrhage as two examples. Ensuring home visiting programs are trained, not just in pediatric or child healthcare concerns, but are also trained to address maternal health concerns which is not often the case in home visiting programs. We're expanding psychiatric consultation services across the state of Illinois.

And finally we have developed and implemented an innovative Two Generation clinic at the university of Illinois at Chicago. This Two Gen clinic, as we call it, is one of the innovations that I am personally most excited about because we have been able to successfully enhance postpartum care to better meet the needs of postpartum persons at University of Illinois.

Katherine: That sounds like a really interesting innovation. Let's start at the beginning. How did the idea for a Two Gen clinic come about and how was it informed?

Dr. Rachel Caskey: Sure. I want to start by acknowledging that our overall I PROMOTE-IL project focuses on pregnant and postpartum persons, not all of whom identify with being women. However, I will tend to use the terms mother and women when discussing the Two Gen clinic, and I just want to acknowledge that upfront. And the reason I do that is nearly all, if not all of our patients do identify with these terms, especially that of the mother. So, I just want to acknowledge that by no means am I speaking on behalf of all pregnant and postpartum persons, but I will tend to use the term women and mother for the discussion of the clinic.

Okay, so getting back to your question, the basis for this clinic grew out of my own clinical experience actually years ago as well as some early research. So about 10 years ago, I was in clinic and I was observing that newborn infants that I was caring for were generally doing fine, overall healthy and well, but I was observing that their mothers did not appear to be doing so well. And I'll note that many of these mothers were not my patients as well, but just on observation did not seem to be doing well. Or



when we were screening for postpartum depression, we're having very high scores. And so, I started just asking some of these mothers if they were getting their own care, and many of them reported they were not, they were not able to get their own care for various reasons.

So, it kind of struck me as, wait a minute, what's going on here? We can't think about the health and wellbeing of this new baby without thinking about the health and wellbeing of the mother and family. So, I worked with a colleague of mine who was in OB GYN and we pulled some data for women at UIC. And these are women who received prenatal care and delivered at UIC. So, you could argue we were their place of care, at least at that point in their life. And so, we took about two to three years' worth of data. And at the time, this was about a decade ago, we found that less than half of these women we're receiving any care postpartum six months after delivery, but yet over 90% were routinely bringing their infants in for pediatric care.

And there's a lot of visits during that first year of life. And so, like most mothers, they were prioritizing their infants over themselves. And for many of us, we may prioritize our infant, both for ourselves, but for a lot of these mothers that have had limited resources, limited capacity to have time away from work, limited transportation, the list goes on and on, the only option was prioritizing one or the other, and of course they chose to prioritize their infant. So, this sort of was a kind of an anticlimactic aha moment, right? Like of course let's explore what we can do. It led us down this path of studying how we can best provide care for postpartum women within the context of newborn care, right.

Let's use the fact that most mothers are going to really focus on that pediatric newborn care and see if we can bring postpartum care into that. So, I've had the honor of working with a really fantastic interprofessional team over the last decade, combining researchers, clinicians, policy experts, and we've conducted a number of studies, qualitative studies, to understand women's preferences, needs barriers, and so forth. And this work also informed a number of clinical trials to study how best to integrate pediatric and postpartum care. So that was really the basis for what has since grown into this Two Generation clinic.

Katherine: I think it's wonderful to hear all of the thoughts that went into developing this model. Can you tell us more about the clinic that was built and how it works?

Dr. Rachel Caskey: So, we designed an open to this Two Generation clinic at the University of Illinois, Chicago in October of 2020, and due to pandemic, and some other reasons it was a slow start and we knew it would be, but we just did a very soft opening, which has actually proven to be a good choice.

So, this Two Gen clinic is really intended to be a proof of concept if you will, right. We are trying this at a single location to see how well it works, and the premise is to provide comprehensive primary and specialty care to mothers and infants together as a dyad. So, visits are organized very similar to a regular clinic. They're organized around the recommended visits scheduled for infants and newborns, which as you may know, are quite frequent. And this care model offers mothers and infants their own visits, but they're paired together.



So, they're back-to-back and it provides mothers with many opportunities for care during that first year postpartum and importantly many opportunities in that first two months postpartum, because infants come in for a lot more routine care in those first few weeks to months of life than with traditional postpartum care models. So, for now in our model, medical care is provided by physicians that are trained in both internal medicine and pediatrics. However, in the future, this model could work with other providers, including family medicine or pediatricians and internists working together and so forth. We also nurse practitioner's physician's assistants. The list goes on.

So, by far, the most important aspect of this clinic though is actually not the medical care, but the wrap-around care that is provided. So, the clinic includes a social worker, a nurse care manager, health coaches, lactation support, to really provide holistic support to women, children and families. In addition, I would say the second most important thing we do is we provide robust mental health support services to women and their families.

We use what's called a collaborative care model. And this, this is a model with a psychiatrist who's trained in both maternal and pediatric psychiatry. And she really helped oversee the care of many patients with trained social workers, doing a lot of the direct face to face care, and this has been a successful model in other sites around the country.

What's really nice as families can receive counseling services immediately onsite or be referred for more intensive mental health care support as needed, and we're finding this is probably one of the most important interventions we provide based on need, and timeliness. The fact that we can get services provided really quickly.

Katherine: Oh, thank you so much for sharing about this. In this process of establishing the clinic, did you encounter any specific challenges?

Dr. Rachel Caskey: Of course, changing healthcare systems of care, healthcare systems in general is always challenging, and perhaps even more so in a large healthcare organization. So, a few things that come to mind off hand. First is, this is not surprising, we had to be nimble. For example, I'll give you a specific example, to do these back-to-back appointments for mothers and babies, we had to change the way the clinic schedule is formatted, and this required a new build behind the scenes by our IT department, and it was delayed.

So, the clinic was opening, yet the new schedule build was delayed, and so we just have to be nimble and sort of work directly with the front desk staff and do some behind the scenes work, putting patients into the proper order in the schedule by hand, until we could get it up and running. It was a small delay, but again, it's one of these things where we just sort of had to figure out how to do it and just do it quickly because we didn't want to disrupt our new model of care because an IT build was not done on the timeframe we had hoped.

Because this is a new model of care, there has been occasional resistance and I think change is always hard and that's not surprising. So there have been some who are



concerned. A new care model may take patients away from another clinic, divert patients to a new site and so forth. And though all by very well-meaning individuals, I think there was just, the first thought was, is this taking patients away from A and sent to B right.

And so, what I learned through a number of conversations is I had to be very thoughtful on how I framed this new model of care when talking to colleagues or medical center leadership. And what was most important is to make it clear off the bat, why we're even doing this. We're not doing this just to have another clinic. We're not doing this because we just happen to like women and babies that we do.

We're doing this because there are real needs in Chicago and across the state of Illinois, and by no means is a single clinic going to fix all of those or even most of those, but we can start to make a dent and we can start to figure out what might be something that does make a dent across the state. Right? This is something we can look at and study and see could a model like ours actually help reduce some of the adverse outcomes that are occurring across the state of Illinois for women.

So by framing it in that way, it really helps diffuse a lot of the tension. Right. Because everyone agrees, right. Nobody is going to disagree that trying to do what's best for women and children. Isn't a good idea. So, I had to make it very clear what the purpose of the clinic was, what we intend to do, and the fact that by definition we are a collaborative clinic, meaning our goal is to always work with, not instead of, other clinics.

I've always said healthcare's best played as a team sport, and this is a great example. So I'll just one specific example is we encourage all women to see their obstetric provider for postpartum visit as well, right. And we don't, we are not intending to replace that postpartum visit. We want to be in addition to, and we're closely with both obstetricians, could be family practitioners, nurse midwives, and so forth. And we have, we've had some great relationships where we've been able to work together, providing care for that woman during the postpartum period.

Similarly there may be particular pediatric providers that we want that family to continue with and so forth. So again, it's meant to work with the larger healthcare setting, not in isolation. And when I frame it that way and really give a comprehensive approach, luckily, I've found most of the resistance does start to melt away. So those are two examples I can think of offhand for sort of initial challenges when establishing a new model of care.

Katherine: Thanks for sharing about those, those are great lessons for folks to have in mind. On the flip side, is there a particular success that you experienced that you would like to share?

Dr. Rachel Caskey: So I feel like right off the bat and just having this thing up and running is a huge success, but okay, more specifically. So I would say one of the sorts of broad successes would be that we are getting the right families referred. So what I mean by that is the Two Gen clinic is more than happy to take care of anyone right. We



were very open to any women, children, and families that are interested. However, we are best equipped to support families at risk for adverse outcomes, whether medical, social, mental health, and so on.

So what has been great is over the course of nearly a year now, as the clinic has slowly grown in size and had more and more patients joined, we have identified the fact that we are getting the right patients sent the majority, if not all the families we are taking care of, have broad care needs, right. And those are not just medical, that could be social support, mental support, and so forth. So I feel like we're getting the right patients into the clinic that is best equipped to help and support those families.

Second is really related to mental health support. And so we're finding that the vast majority of new moms that we're working with have mental health support needs. And Katherine, this is even more than I would have predicted based on personal experience, national data and so forth. And perhaps some of this is pandemic related. It is hard to know, but regardless I am so grateful that we went into this model of keeping mental health as a really robust pillar of care, because the ability to get these women and families in for support services immediately has been just really, I think life-changing for some of them.

And as you probably know, access to timely, mental health care is such a huge disparity in our country, both geographical disparities, right, but also in terms of the type of insurance, you have an economic means, huge disparities exist in terms of ability to access mental health care services in a timely fashion. So I think that has been enormous, and the collaborative care model we've built. To provide mental health support has worked very well, whereby very few women or families need a psychiatrist directly. Most need counseling and support services, and then there are a small percentage that do go on and need direct psychiatric care. And it's, it's the model that so far is working very well for the clinic.

Katherine: So thinking about folks that are in other communities that might be interested in establishing a similar clinic, can you share a bit about how the financing works or other factors that should be considered?

Dr. Rachel Caskey: Sure. So the model is a mix of billable services and grants supported services at this time. Our hope is for that to change. So our goal of course, is to maximize all billable services. Of course, all the medical care provided is traditional billable services. But one of the things we are currently underway exploring is the psychiatric collaborative care model, which I just told you about is technically a billable service.

But this was new for many of us. We had not billed for that type of care and we didn't know the nuances. So we're working with billing experts at our institution and nationally to understand, okay, how does this work? What kind of billing is available, what documentation is required and how do we have to run that collaborative care meeting to achieve the expectations for documentation? And so we're hoping to really become experts on a lot of those billable services that many of us. In outpatient care, we don't currently bill for, and much of it is because we either don't know, or it feels very onerous



to go through some of the documentation hoops and so forth. So that's an area where we're really working to expand.

And then the big picture, of course, we're looking at overall sustainability. Over the next two years, we'll be planning and hopefully executing an economic analysis of the clinic as a whole to really understand how this model can be most financially evaluable. And so that will include what services are available, which ones are not, and, perhaps more importantly, what services make the biggest impact.

And that might be hard to tease out, but it's one of the things we're going to try to understand is certainly there's time to remain, just need to have services available because it's the right thing to do for families. Not necessarily because those are services that can be billed for, and that'll be an important part of our analysis.

And I think understanding that will be the key for others across Illinois and perhaps nationally, who might be interested in a model of care like this, because as I talked to people about it, the first thing I'm asked is, well, how do you pay for it? Right. Well, you only can do this because you have a big grant. Well, part of that's true. Part of this is currently grant funded, but going in our goal was that this only makes sense to do if we are fairly confident we could keep it a model of it running without grant funding in the future. So we're, we are committed to doing that.

Katherine: So let's talk a little bit more. If folks in other communities might be interested in establishing a similar model, is there anything unique to Illinois that made this possible? Or should this be something that they could do anywhere?

Dr. Rachel Caskey: Yeah, good question. Nothing unique to Illinois, other than we just had the opportunity through this grant to test this model out, but really nothing unique. And we hope this is a model that could be replicated in any state, in any community, urban, rural, et cetera. And that's really one of our goals is we try to understand financing staffing, how best to sort of package this, this Two Gen model, if you will, and make it something that others could take, probably modify a little right for their community, perhaps modify a lot, and then implemented within their community. But yes, the goal is that this is something that could be used nationally.

Katherine: So what other information do you think is key for healthcare administrators or legislators or others to have in their minds if they're considering this approach?

Dr. Rachel Caskey: So we've taken the holistic approach to individuals and families, right? So we're looking not just as individuals holistically, but really as family units and the health and wellbeing as a family unit is so critical to the health and wellbeing of any individual in that family. And so I think that's important.

It's not novel, right? We're not the first to do that, but it is not the model of traditional health care in our country. We tend to have a very individualistic approach to patients, right. Individual patients. And sadly, it's still not a common practice to sort of take a holistic, comprehensive approach. So hopefully beyond just our clinic, more and more of that happens in healthcare across the country.



But I think we're a good example of, we will likely have better outcomes, or we're hoping we're going to have better outcomes because of that more holistic or comprehensive approach. Similarly compensation needs to be outside the box, right. We need to start to think outside the traditional billable services model.

And though I just spoke about the billable services that we are going to be analyzing, we know that there's a lot of services that may not be billable and, or even if they are, may not be financially viable, even if they are billable, just due to the reimbursement rate. And so there's a lot of things like care coordination, patient navigators, community health workers, et cetera, that I think could serve very, very important roles, not just in our clinic, but in other clinics and might be something that either we need to figure out how to fund, right, through payers or insurance companies or through health care systems. And so I think we have to think outside the box for both how we approach the care of individuals and families, as well as how we're willing to pay for that care.

Katherine: Are you considering expanding the Two Generation clinic beyond one location?

Dr. Rachel Caskey: We are. So we started very small in a single location, right on campus at University of Illinois, Chicago, and due to the success of that clinic, we are looking to expand to a second site. And we are intentionally selecting a part of the city of Chicago that has recently lost a number of healthcare resources, some pretty substantial healthcare resources, both for medical care, as well as mental health support services that have closed in the last year. So we're going to, we will be, adding a second site hopefully in the very near future. So we're excited about that.

Katherine: So let's say we have a follow-up conversation a year from now. What will you have accomplished?

Dr. Rachel Caskey: Well, I hope a year from now, we have two sites robust and up and running, and that we have been able to work with many more families. Our numbers have been growing beautifully, but again, I hope we can really accommodate many more families into the clinic. And I would also love to see us being nimble enough to meet the needs of families as they evolve.

And so one example of that is an increasing need in the city of Chicago for individuals who are living with addiction. And this is due to, unfortunately, some of the addiction support services closing in the last year. And many of the individuals served by one particular provider were women, and they were cared for in a family model actually within that site. And so I hope we can be nimble enough where we can really keep an eye on what is the need, right.

Okay. How can we help fill that gap? We might not be able to perfectly do what someone else was doing, but could we at least try to help and do we need to make sure all of our providers are trained in Suboxone or medication assisted therapy? Do we need to link ourselves, collaborate with other resources for individuals living with addiction and so forth? So that's just an example of an area where I see us going, needing to go down those paths. But I think we have to take the approach that we



always have to be ready, right? What is the next need for families that we're working with and how do we best tackle those needs? within the constraints of the healthcare system.

Katherine: Really appreciate you sharing your vision for the next year and what you're hoping to accomplish. So how can a listener connect with you?

Dr. Rachel Caskey: Sure, they're welcome to email me. I can find me through the UIC website. We also do have a Two Generation clinic website as well through the university, its UI health, University of Illinois Health System. and that can be found online. So I'm, and I'm delighted to have anyone reach out who has questions, thoughts, or ideas as well.

Katherine: Great. Thank you so much.

Dr. Rachel Caskey: Thank you.

Katherine: Thank you so much for coming on the show, Dr.. Caskey, and thank you for listening, everyone. For more podcasts, videos, blogs, and maternal health content. Visit the Maternal Health Learning and Innovation Center website at maternalhealthlearning.org. I'm Katherine Bryant, and we'll see you soon on Maternal Health Innovation.

