Maternal care in its infancy in U.S.

By Linda Genen

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As a neonatologist, I've seen a lot change over the last two decades. When I started, the very practice was just a bit older than I. An evidence-based protocol to properly care for these preemies was, as they say, barely a wink in anyone's eye. I started to witness inconsistencies that caused catastrophic delays in care. Ever since those early days spent watching preventable tragedies unfold, developing standardized protocols has become a passion of mine.

Over the last 20 busy years, neonatology has advanced in leaps and bounds. Processes have been standardized and technologies developed: enhanced respiratory support, new monitors for oxygen saturation, phototherapy, brain imaging technique, kangaroo bonding, advanced nutritional support — the list goes on and on. Innovations, developments and breakthroughs in our field have entirely improved the outlook for our young born too early. Whereas once, not too long ago, they were unlikely to survive, today's premature babies are granted a chance to thrive.

How is it we can make such advances in one area, yet stall so completely in the next?

I am, of course, speaking of our mothers. The maternal mortality rate in 2020 was 23.8 deaths per 100,000 pregnancies, up 14 percent from the year before. For Black women, the rate is drastically higher. At 37.1 per 100,000, it exactly mirrors the death rate from six decades ago, in 1960, the year neonatology was born.

When I think about the two fields — so interconnected yet moving in such opposing directions — I can only draw one conclusion: Today, we are in the infancy of maternal care. How else to explain our abysmal mortality rate, and our inability to keep it from rising, even as we watch in horror?

And so, we must begin developing our practice anew. Just as we did for our infants decades ago, we need to band together for mothers. We must identify processes, allocate resources, expand care teams, and create a repeatable medical and behavioral journey so that the road to motherhood is finally made safer. Here's how we can implement an evidence-based approach for a consistent, standardized and equitable framework of maternal care for all.

Preconception through the first trimester

Ideally, I'd prescribe preventative medicine with roots in the teenage years. Whole-person care centered around nutrition, mental health, activity, health education and physical care will help create a nourishing foundation and baseline for pregnancy. For those actively planning for a family, all insurance providers could offer access to a nutrition coach and benefits that support prenatal supplements and care. It takes a lot to fuel a fetus. Identifying social determinants of health early will be paramount. While physicians may not have enough time to provide in-depth screenings, perhaps insurance carriers can sponsor partnerships with community organizations to identify and document potential gaps in care that will have a huge impact on mom and baby alike. To make these observations actionable, defined pathways for interventions will be key. Groups can develop partnerships with local food banks, mental health providers, child care, job search and housing resources. It takes a village, and community-based maternal care has been shown to make a difference.

The second and third trimesters through delivery

During pregnancy, continued connection to community and educational resources will be key. Virtual pregnancy groups are a low-cost way to connect women at similar points in their pregnancies. On a mentorship level, doulas and midwives can be invaluable in supporting women — mentally, physically and emotionally — through their pregnancy journeys. Ideally, obstetricians and midwives will partner to help extend care outside of office walls, address disparities, and even help provide culturally relevant connections to care. Through this time, in groups and through trusted relationships with midwives and other care providers, women would be receiving lessons on C-sections, natural vaginal birth, breastfeeding, postpartum self-care and more. Care teams will be identifying and developing care plans for preexisting conditions that may have an impact on the mother's health during delivery and in the months that follow.

Postpartum

This is an especially turbulent time for new mothers. While most carriers offer only a single postpartum checkup, more than half of all maternal fatalities occur in the days, weeks and months following delivery. If we offer additional checkups during the postpartum experience, I believe we could make a humongous impact. Experts estimate that 67 percent of maternal fatalities could be avoided if symptoms are caught early. If remote patient monitoring devices such a blood pressure cuffs are distributed, many of these visits could be conducted remotely. Home visits can help mom bond with baby, and ensure lactation, breastfeeding, sleeping, nutrition and mental health are all being looked after. Real change takes time, but baby steps help. Alone, these efforts won't shift the paradigm entirely; we need massive systemic and policy changes that consider — and help cover — preexisting conditions and gaps in care caused by social determinants of health, adverse childhood experiences, mental health challenges, substance use, coverage gaps and many other factors. We all must act to push this agenda forward; 861 deaths is too many. Let us say *never again.*

Because when true progress is made, you can feel it. And the best illustration of real change in action is a complete reversal of fortune: Whereas a 1-kg premature infant born in 1960 had a mortality risk of 95 percent, by 2000, that same 1-kg infant had a survival probability of 95 percent.

While neonatology's progress gives me hope, we don't have 20 years to wait. We must apply the same rigor and the same passion to adopt actionable measures now that save the lives of mothers today. For all our sakes.

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