Optimizing postpartum care in Canada as rates of comorbidity in pregnancy rise

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In this issue of *CMAJ*, Dzakpasu and colleagues[1] show that hypertensive disorders of pregnancy have increased 40% over the last decade in Canada, although early recognition and treatment have curtailed the severe adverse pregnancy outcomes associated with untreated hypertension. Chronic conditions — such as obesity, diabetes, and hypertension — also now affect 1 in 5 people pre-pregnancy, and the number of pre-pregnancy chronic conditions is associated with the risk of adverse maternal outcomes in a dose–response relationship.[2,3] This growing population of high-risk obstetrical patients should alert health policy-makers that more people need easily accessed, specialized obstetrical care, including in the postpartum period.

The first 2 weeks postpartum are a time of increased maternal morbidity and mortality, especially for people with medical conditions preceding pregnancy.[3] Yet scheduled access to ambulatory obstetrical care effectively disappears in the postpartum period, particularly for those at highest risk, which warrants urgent attention. As an example, a person with hypertension during pregnancy should have their blood pressure checked at least twice in the first 2 weeks after delivery and are instructed to do so with their primary care provider.[4] As 1 in 5 people in Canada are now without a regular primary care provider,[5] the emergency department may be the only available option to see a health care provider who is comfortable managing postpartum hypertension. Yet an overcrowded waiting room of an emergency department is not an ideal place for a person who has just delivered a baby to have their blood pressure checked, especially with their neonate accompanying them.

Scheduled postpartum care is often hard to access for people with other indicators of high-risk pregnancy too.[6] Such patients are more often cared for by obstetricians, whereas people with low-risk pregnancies are cared for by midwives and family physicians, who tend to provide earlier and more frequent outpatient infant and postpartum care than specialists. Most obstetricians provide clinic-based antenatal care, and routine follow-up occurs 6 weeks after birth. If complications arise after delivery, patients are instructed to seek care with their family physician or in an emergency department.[6,7]

An indicator of the gap in ambulatory obstetrical care for people who are no longer pregnant is higher utilization rates of emergency departments during the postpartum period in Canada than peer countries.[8] An Ontario study found that pregnancy-related use of emergency departments skyrocketed and peaked in the first 5 days after delivery, compared with other times during pregnancy.[9] A study from Alberta found that 45% of people had an emergency department visit in the year after giving birth, and a third of those visits were within the first 6 weeks after delivery. In the latter study, only 5.2% of the emergency department visits resulted in hospital admission, which suggests that a large proportion could have been prevented or managed in outpatient settings.[8] Both the Ontario and Alberta studies found that rural residence increased the risk of an emergency department visit in the postpartum period.[8,9]

Rural communities that face higher rates of pre-pregnancy comorbidities than urban and suburban regions, as well as persistent attrition of their maternity services, have implemented new models of care to sustain and maintain access to small-volume maternity care, including cesarean deliveries. The Rural Surgical and Obstetrical Networks project in British Columbia, which began in 2018, supports multidisciplinary teams of obstetricians, midwives, family physicians, and nurses in 8 rural communities. In interviews and focus groups of 169 providers who were part of this program, participants reported that expanded maternity care teams led to fewer gaps in coverage and allowed for improved continuity of postpartum care.[10] These rural communities have also connected to BC's virtual supports, including the Maternity and Babies Advice Line, whereby rural providers can seek consultation from peers with obstetrical expertise. Providers described these virtual supports as critical because they enabled access to specialist or peer advice in real time.[10]

Urban and suburban hospitals are also launching team-based care, including scheduled home visits in the first 2 weeks postpartum, for a growing population of patients with high-risk pregnancies. London Health Sciences Centre launched the Interprofessional Midwifery/Maternal–Fetal Medicine Expanded program.[11] For patients deemed too high risk for midwifery care, midwives collaborate with maternal–fetal medicine physicians to provide both prenatal and postpartum care for 6 weeks after

delivery. During early postpartum home visits, midwives support newborn care and infant feeding while monitoring for postpartum complications, such as hypertension and preeclampsia, and facilitate communication with specialists in maternal–fetal medicine if complications arise.

Dzakpasu and colleagues'[1] description of patterns of hypertensive disorders of pregnancy highlight the increasing demand for obstetrical care providers with the expertise to care for high-risk patients, supported by appropriate models of care both before and after delivery. As the number of obstetricians will be unable to conceivably meet the needs of the growing population entering their reproductive lives with more comorbidities than the preceding generation, scaling team-based maternity care may help people receive the right care, at the right time, in the right place, by the right provider.

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Competing interests: www.cmaj.ca/staff

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