EDITORIAL

From Cradle to Grave: Health During Pregnancy and Over a Lifetime

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The United States is facing a crisis when it comes to the health of its people during pregnancy and their reproductive years. In 2021, 32.9 maternal deaths occurred for every 100,000 live births in the United States,[1] a rate more than 3 times higher than other high-income countries in the world,[2] and in 2017, 25,000 hospital deliveries were impacted by severe maternal morbidity (SMM), defined as "outcomes of labor and delivery that result in significant short- or long-term consequences to health."[3,4] Also concerning are the significant disparities that exist, with Black pregnant people experiencing 3 times the mortality rate of White pregnant people.[2] Social determinants of health including lack of access to care, unstable housing, and transportation barriers also impact pregnancy-related morbidity and mortality.[5]

High-risk pregnancy conditions pose not just an immediate risk during pregnancy, birth, and the first year postpartum; they are also associated with increased risk of development of chronic disease over a lifetime. Recently, hypertensive disorders of pregnancy (HDP) were found to be associated with a 63% higher rate of cardiovascular disease later in life, even when accounting for pre-pregnancy confounding risk factors.[6] Similarly, recent data show that pregnancies complicated by gestational diabetes mellitus (GDM) are associated with higher risk of incident heart failure, a risk even higher in pregnancies complicated by GDM and HDP concurrently.[7] Evolving research is linking conditions once strictly thought of as obstetrical to conditions family doctors have always known to be lifelong. As family physicians, we care for people over a lifetime, and bear witness to the impacts of pregnancy complications on the long-term health of patients. It is critical, perhaps now more than ever, to complement the work of family physicians with system-level interventions to ensure that people with high-risk pregnancies are linked to longitudinal primary care. The Association of American Medical Colleges estimates a national shortage of 22,000 obstetrician-gynecologists by 2050.[8] Family doctors, often the backbone of the health care workforce of community health centers, are needed now in the spectrum of continuity spanning pre-pregnancy, pregnancy, and postpartum.

In "A Mixed Methods Evaluation of a Quality Improvement Model to Optimize Perinatal and Primary Care in the Community Health Setting," Wallander Gemkow and colleagues directly address this critical lifesaving concept: the systematic retention of patients with high-risk pregnancies in primary care in the most vulnerable time in life where cardiometabolic risk factors are modifiable.[9] Wallander Gemkow and colleagues' study could not come at a more important time in the primary care and obstetrical history of this nation. In June 2022, the White House published the *White House Blueprint for Addressing the Maternal Health Crisis*, which identifies specific actions to reduce disparities and improve the outcomes and experience of pregnancy, birth, and the postpartum period in the United States.[10] It outlines 5 major goals that include (1) increasing access to high-quality maternal health services, (2) ensuring that the voices of birthing people are heard and health care systems are held accountable, (3) advancing data collection, transparency, and research, (4) expanding and diversifying the perinatal workforce, and (5) strengthening economic and social supports for pregnant people.[9]

The QI intervention studied by Wallander Gemkow and colleagues was implemented at Federally Qualified Health Centers (FQHCs) that exist as part of the United States health care safety net. These health centers, situated in vulnerable communities, expand access to care and are often equipped with multidisciplinary teams and cultural context to connect people to economic and social support.[11] A 2019 retrospective cohort study found that approximately 40% of these centers provide longitudinal prenatal care.[12] The type of system-level intervention Wallander Gemkow and colleagues outline, with its low cost, generalizability, and ability to scale

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up, can bolster the ability of FQHCs to provide access and support. This intervention has enormous potential to expand to other community-based health centers to improve the immediate and long-term health of pregnant people and, by extension, their families.

Key to the White House Blueprint is ensuring that birthing people are heard and systems are accountable for care. While Wallander Gemkow and colleagues thoroughly explored perspectives of FQHC clinicians and staff, they did not explore the patient experience. Future studies must include patient voices as these are the most often overlooked and the most important in the conversation. It is the voices of patients that will illuminate further pragmatic pathways to address the maternal health crisis in the United States and identify ways to improve health outcomes for high-risk pregnant people and their families in the long-term.

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Key words: pregnancy; maternal death; high-risk pregnancy; social determinants of health; primary care; collaborative care; quality improvement

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