Postpartum Care in the Pregnancy Medical Home Setting: A Quality Improvement focus to improve women's health and future pregnancy outcomes

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Postpartum Care

- An opportunity for prevention
  - Address the many immediate needs
  - Address chronic conditions and transition to well women care
  - The “first interconception care” visit
    - For some women, this visit may be the only visit before the next pregnancy due to subsequent loss of Medicaid coverage or lack of an established relationship with a primary care provider

More women now retain Medicaid coverage after pregnancy

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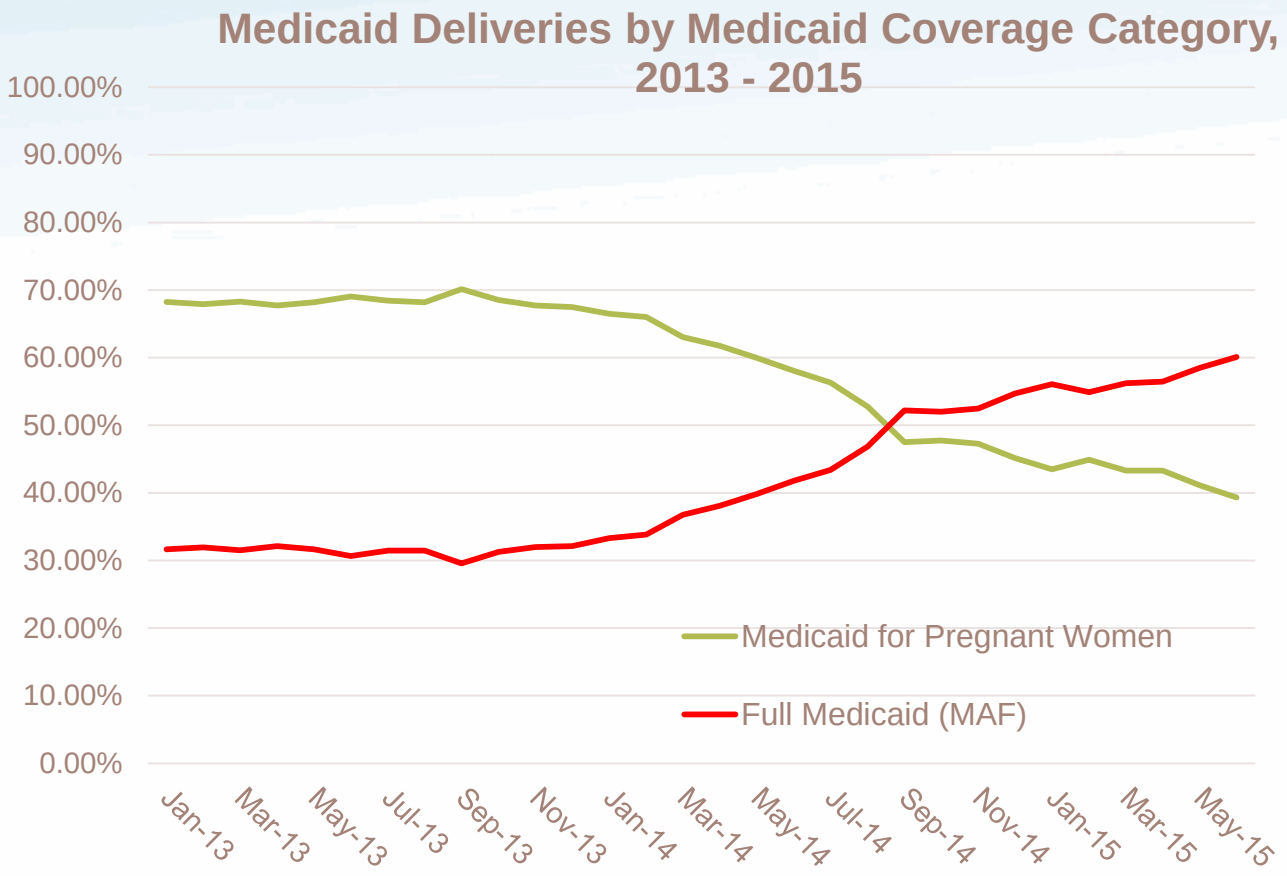

>50% of 2015 Medicaid pregnancies have ongoing coverage, opening up opportunities for improved transition to primary care

Pregnancy Medical Home

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Core practice level expectations:

- Complete standardized risk screening on all OB patients
- Offer/provide 17p to eligible patients
- Avoid elective delivery <39 weeks
- Meet primary c-section rate benchmark
- **Postpartum visit** including standardized depression screening, reproductive life planning and transition to ongoing/primary care
- Coordinate/collaborate with pregnancy care manager

Postpartum Visit

- Comprehensive postpartum visit is an essential opportunity to accomplish several important goals:
  - Depression screening
  - Contraception/reproductive life planning
  - Chronic disease management
  - Breastfeeding support
  - Health behavior counseling/weight management
  - Transition to primary care

Timing of postpartum care

- PMH Care Pathway on Postpartum Care* and the Transition to Well Woman Care recommends a "**comprehensive postpartum visit"** at **14-42 days**
  - Other care, such as BP measurement or diabetes follow-up, may be needed at different intervals

*https://www.communitycarenc.org/population-management/pregnancy-home/pmh-pathways/pmh-care-pathways-postpartum-care-and-transition-w/

Value of Interconception Care

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- Management of modifiable risk factors for future pregnancy
  - Interventions to improve future pregnancy outcome
- Potential for fewer unintended pregnancies and optimal birth spacing
- Higher likelihood of early prenatal care in future pregnancy

Postpartum contraception

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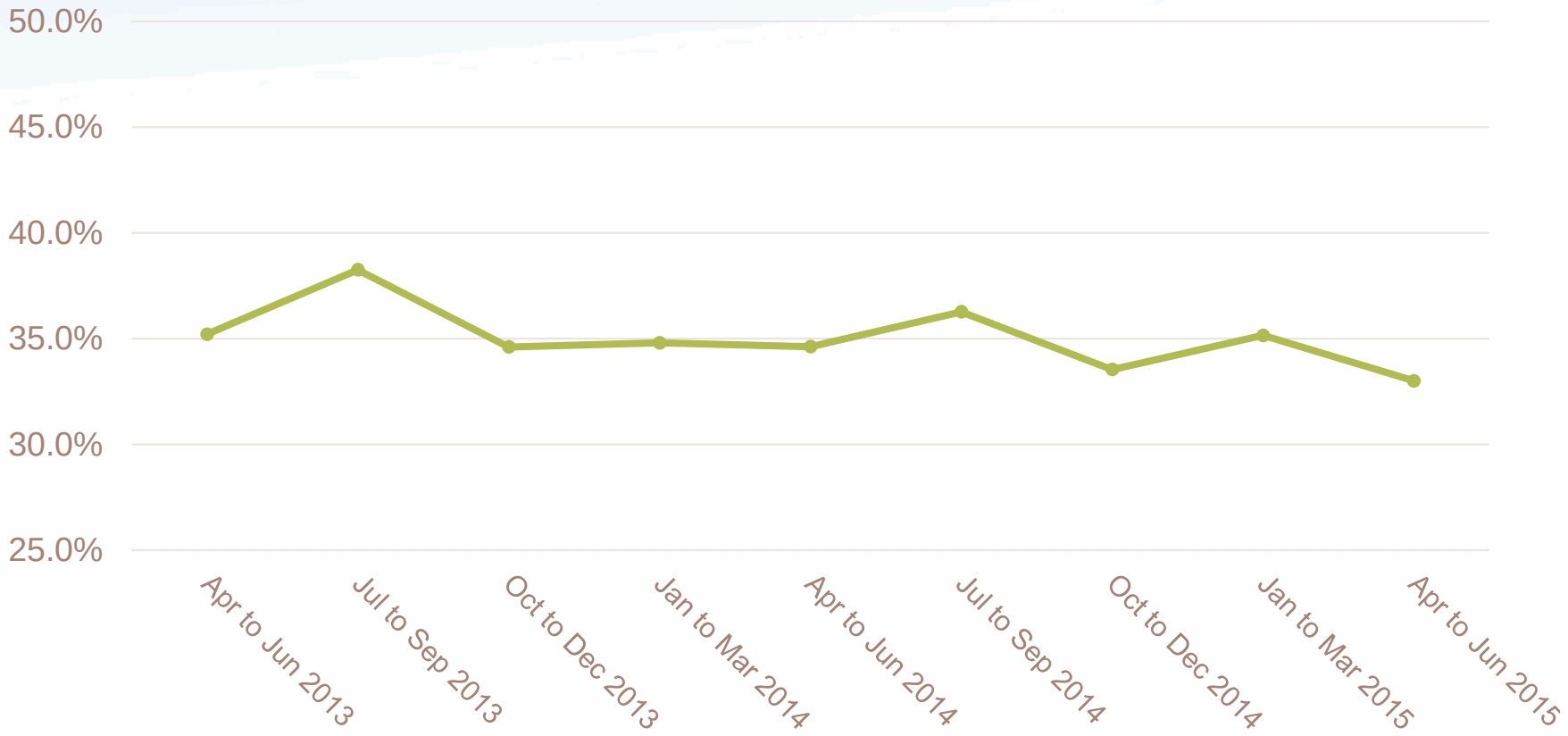
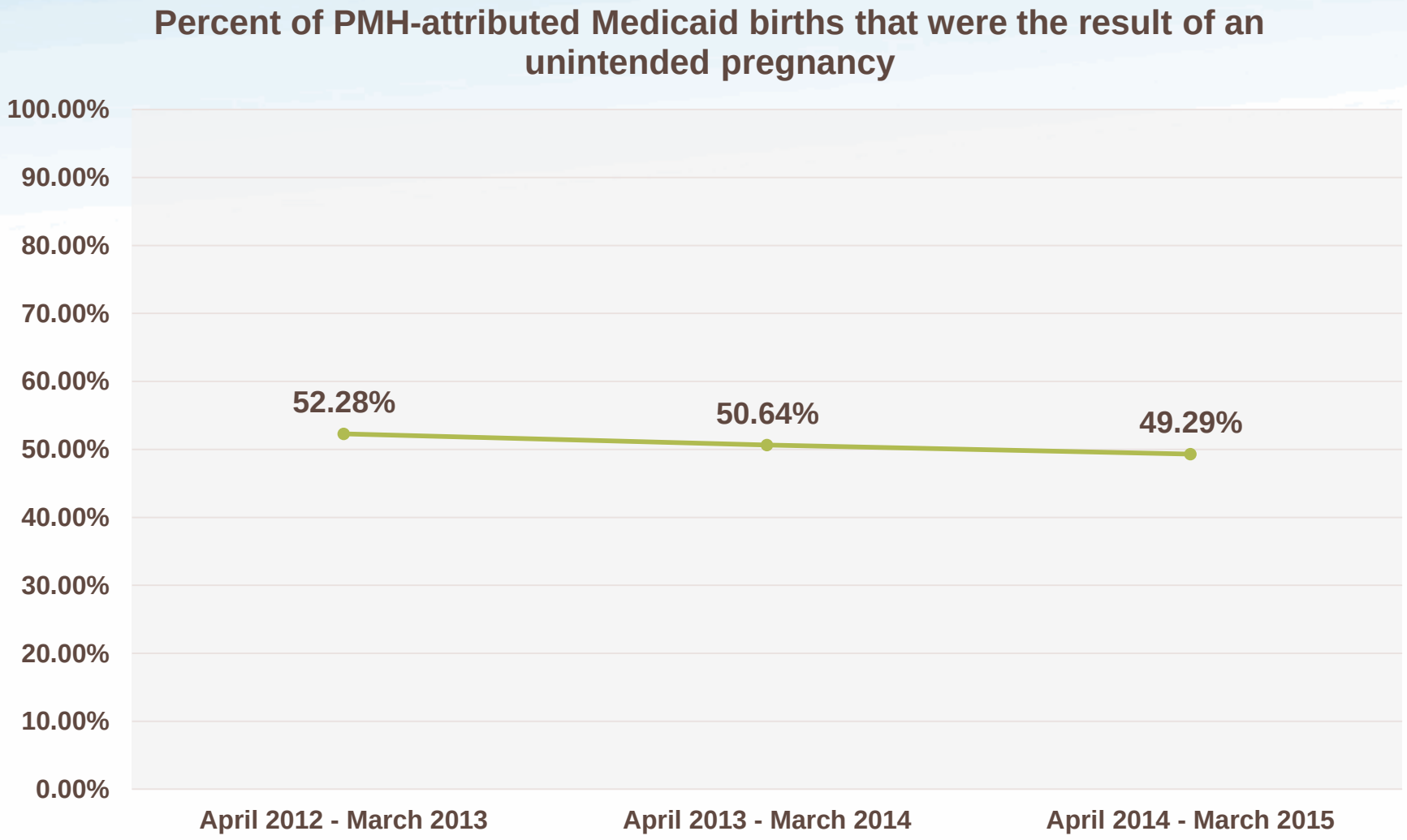
Percent of PMH-Attributed Births with a **Paid Contraceptive Claim** (including sterilization) within 60 Days of Delivery



Unintended pregnancy



Postpartum Visit Rate

- The postpartum visit rate among Pregnancy Medical Home patients who delivered in January – June 2015 is 42%
  - Based on paid claims for the PMH postpartum incentive
  - The range by practice is 0% - 80% among practices with a substantial volume of Medicaid patients
- Accurate measurement of the postpartum visit rate is a longstanding challenge
  - Global fee used in >50% of deliveries; can't verify postpartum visit occurred because billed at time of delivery
  - PMH incentive claims were intended to be a strategy to improve measurement

Predictors of not having a postpartum visit

- Some women, including those who may be most in need of comprehensive postpartum care, are less likely to receive a postpartum visit*:
  - Women whose pregnancies result in a low birth weight/ preterm delivery
  - Older women, those with less than high school education, and multiparous women
  - Non-Hispanic Black women
  - Women who did not receive first trimester prenatal care
  - Women with chronic diabetes

*Based on CCNC analysis of data from Medicaid claims, birth certificates, and PMH risk screening forms

Pregnancy Care Management and Postpartum Care

- Pregnancy Care Management at the time of delivery is associated with adherence to the postpartum visit
  - Pregnancy Care Managers work with higher-risk women, who are less likely to keep the postpartum visit
- Pregnancy Care Managers are essential partners in practice-based activities to improve the postpartum visit rate in the Medicaid population

PMH Postpartum QI Project:
Goals and Logistics

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2015 Postpartum Pilot

- 7 Pregnancy Medical Home practices participated in a 2015 pilot
  - Part of an 11-state initiative sponsored by CMS at the federal level
- Most pilot sites were able to make changes and show significant improvement in postpartum visit rate within a six-month timeframe
  - Even sites with a high baseline rate (>75%) achieved major improvements
  - Special consideration for patients at practices that do not offer delivery

Postpartum QI Project Goals

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1. Improve data quality
   - Use PMH practice-based data reports combined with record review to determine “true” baseline postpartum visit rate
   - Implement changes in coding/billing processes to increase the alignment between completed postpartum visits and paid PMH incentives (S0281 claims)
   - “Win-win” – increased revenue to practice and improved accuracy of PMH data
2. Increase the number of Medicaid patients who receive a postpartum visit
   - Test practice-specific strategies to increase adherence to the postpartum visit

Postpartum Data - Baseline

- Local CCNC OB teams will help participating PMH practices use the “OB1” report to generate a list of patients for whom there is no paid PMH postpartum incentive claim (S0281)
- Practice will conduct record review of those without a paid S0281 claim to determine if there was no postpartum visit or if it occurred >60 days post-delivery
  - Practices with a large volume should use a sample
- Use findings to determine “true” baseline rate, adjusting billing practices, and identify potential changes to test (scheduling, patient education, etc.)

Postpartum Data – Follow-up

- Participating PMH practices should use the CCNC-provided tracking sheet (or a practice-specific tool) to track deliveries each month, beginning with January deliveries, and whether they received postpartum care
- CCNC OB team will provide ongoing technical support

Postpartum Visit Rate

- Practices should brainstorm possible changes to test, then implement a series of brief Plan-Do-Study-Act (PDSA) cycles to see if a change results in an improved postpartum visit rate
  - Testing only 1-2 changes at a time makes it easier to determine which strategies are effective
  - CCNC OB team can provide technical assistance
- When effective strategies are identified, determine how to implement them more widely and sustainably in the practice

Postpartum Visit Rate

- CCNC OB teams have a PMH Postpartum QI Project toolkit, including a list of sample changes to test
- 2015 pilot sites identified successful strategies to improve postpartum visit adherence:
  - Scheduling practices – e.g., schedule prior to delivery or discharge, schedule within 21 days of delivery
  - Patient outreach – e.g., reminder phone calls/postcards/texts, immediate phone outreach for missed visits, care manager follow-up
  - Patient education – during pregnancy, purpose of visit, reinforcement at multiple visits

Next Steps

- Let your local CCNC OB team know that you will participate
- Assemble a project team
  - Each practice should have a team lead for this project
  - The team should include at least one clinician (MD, NP, CNM, PA) from the practice
  - Ensure multiple perspectives are included and valued – front desk, practice management, nurse, medical assistant, billing personnel
  - Include the Pregnancy Care Manager(s) covering this practice on the project team
- Work on determining the true baseline postpartum visit rate and set an improvement goal
- Develop a list of possible changes to test and a schedule for implementing PDSA cycles

Project Timeline

- CCNC will formally support the PMH Postpartum QI Project through the end of 2016
  - Some sites will complete their work and move into "maintenance" by the 2nd half of the year
- Commitment to local CCNC OB team by February
- Determine "true" baseline rate, establish project team, and set a practice-specific goal by end of February
- Begin testing strategies to improve postpartum visit rate in March
  - Simultaneously work on adjusting coding/billing processes
- Some practices may need to adjust this timeline

CCNC Support

- We are here to help!
- Local CCNC OB Nurse Coordinators and Physician Champions will support your work and help to address any barriers you encounter
  - CCNC networks have Quality Improvement specialists who can be engaged as needed
- CCNC central office team will schedule ongoing webinars to provide guidance on PDSA cycles and measurement/data collection and to facilitate exchange of ideas among participating practices about challenges and successes

Thank you!

- This initiative is the first-ever opportunity for multiple Pregnancy Medical Homes across the state to work together on a focused quality improvement initiative
- This project will result in meaningful improvement in care and outcomes for the pregnant Medicaid population
- Opportunity to demonstrate the value of the PMH model at the state level
- We look forward to working with you and hope you will choose to join other PMH providers in this important effort to improve postpartum care in the Medicaid population

Questions?

Use the “chat window” at the bottom of your screen to submit a question

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