Welcome to the Pregnancy Medical Home "First Tuesdays" Webinar: Postpartum Care and the Transition to Well Woman Care

- Webinar will begin at 7:30am
- Connect to audio by computer
- Submit any questions through chat

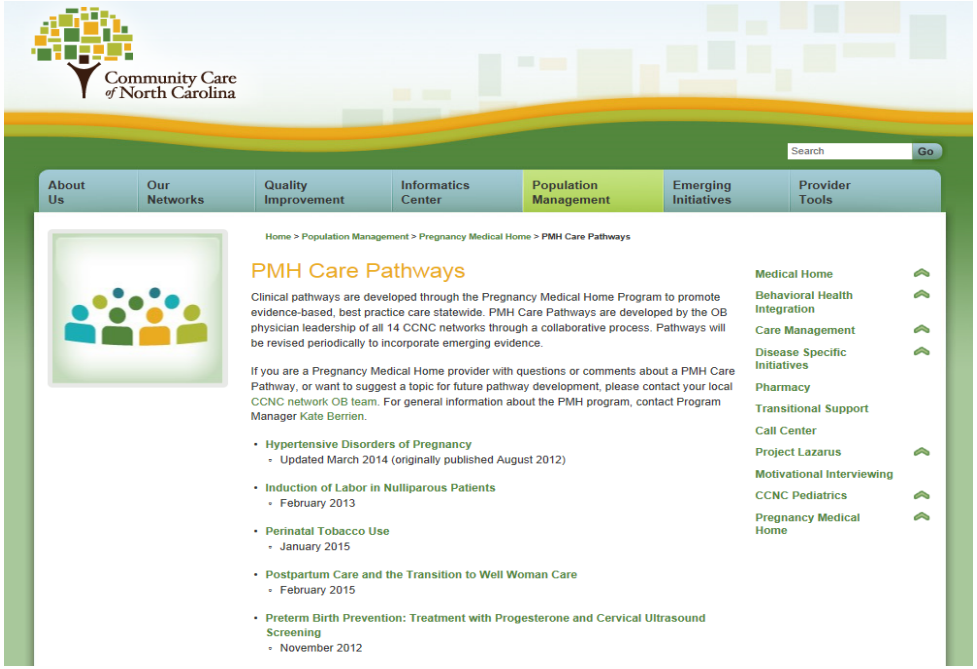
Community Care of North Carolina

Pregnancy Medical Home

- The Pregnancy Medical Home (PMH) program is a statewide model to improve quality of care, improve outcomes and reduce health care costs in the pregnant Medicaid population
  - Primary focus is on preterm birth prevention
  - Funding/oversight from NC Division of Medical Assistance (Medicaid), operated by Community Care of North Carolina, a private, non-profit population management organization
  - CCNC has 14 networks and a central office in Raleigh
    - "OB teams" in each network/central office include physician champions and nurse coordinators
  - 1,700 maternity providers in 380 practices
  - 57,000 "non-Emergency" Medicaid deliveries/year in NC

PMH Care Pathways

- PMH physician leadership from across the state (network OB Champions) collaborate to create clinical guidance for maternity providers
- Evidence-based guidance to promote best practices, improve quality and improve outcomes
- PMH Care Pathways shared on PMH webpage on CCNC's website



PMH Care Pathways

Currently available PMH Care Pathways:

- Hypertensive Disorders of Pregnancy
- Induction of Labor in Nulliparous Patients
- Perinatal Tobacco Use
- Postpartum Care and the Transition to Well Woman Care
- Preterm Birth Prevention: Treatment with Progesterone and Cervical Ultrasound Screening

https://www.communitycarenc.org/population-management/pregnancy-home/pmh-pathways/

Pregnancy Medical Home
"First Tuesdays" Webinar Series

Community Care of North Carolina

Today's session:

Postpartum Care and the Transition to Well Woman Care

Upcoming Webinars:

- **May 5: Management of Substance Use in Pregnancy**
- **June 2: Reproductive Life Planning and the Use of Long-Acting Reversible Contraception**

Postpartum Care and the Transition to Well Woman Care

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Postpartum Pathway Presentation: Outline

- Background: Evidence-base and importance
- Pathway: organization and additional resources
- Pathway: care transitions
- Pathway: content of comprehensive visit

Postpartum Care: Background

- Lack of evidence regarding optimal timing and content of postpartum care
  - Main reference: 2012 American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care
  - Other ACOG guidelines and taskforce statements regarding gestational diabetes and gestational hypertension
- Other recommendations based on evidence and guidance behind specific preventive interventions for all reproductive age women

Postpartum Pathway Principle

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The postpartum period is an important opportunity for preventive care and ensuring a smooth transition to well woman care.

Comprehensive Postpartum Visits in NC, 2012

- NC Medicaid reimbursed a postpartum visit incentive payment for fewer than 50% of Pregnancy Medical Home patients in 2012
- Risk factors for no postpartum visit:
  - Multiparity
  - Poor birth outcomes
  - Low educational attainment
  - Older age

CCNC, 2014, unpublished data

Postpartum Pathway Additional Resources

- **Checklist: *Coming Soon!!!***
- **Appendix A** – Additional Content Guidance
- **Appendix B** – Ongoing Health Insurance Info
- **Appendix C** – Medicaid Reimbursement for postpartum care (including $150 incentive)
- **Appendix D** – Resources for postpartum care

Postpartum Care Pathway

- Care Transitions in the Postpartum Period
  - Timing of postpartum visits
  - Coordination of primary care
- Content of the Comprehensive Postpartum Visit

Care Transitions: Prior to Discharge

- Provide contact information for postpartum care provider and reasons to contact provider
  - Provide 24 hour lactation support contact information
- Review immunization history and provide vaccines
- Address smoking cessation
- Evaluate for signs or symptoms of postpartum preeclampsia

Care Transitions: Scheduling Comprehensive Postpartum Visit

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- **Schedule a comprehensive postpartum visit for ALL women at 14-42 days post-delivery**
- Strategies which may improve adherence to the postpartum visit:
  - Use of pregnancy care managers
  - Schedule the visit prior to delivery or discharge
  - Reminder letters/phone calls
  - Schedule the visit earlier to allow time for rescheduling if necessary
  - Immediate outreach to patients after missed visits

Care Transition: Other Implications for visit timing

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- All gestational diabetics should have glucose screening 6-12 weeks after delivery.
- Certain family planning methods have recommended time for initiation after delivery per the CDC:
  - **IUD:** insertion immediately postpartum or ≥4 weeks postpartum
  - **Implant:** no restrictions
  - **Combined oral contraceptive pills, contraceptive patch and contraceptive ring:** 30 days postpartum if no VTE risk factors; 42 days with risk factors for VTE
  - **Diaphragm:** fit ≥6 weeks after delivery

Care Transitions: Early Follow-up

- Gestational hypertension: 7-10 day post-delivery blood pressure check
- Risk factors for postpartum mood disorder: 7-14 days post-delivery depression screen
  - Mental health history
  - Lack of social support
  - Recent stressful events
  - Other (provider determines)
- Consider for other factors:
  - Operative delivery
  - 3rd/4th degree perineal lacerations
  - Diabetes
  - Lactation difficulties

Comprehensive Postpartum Visit Content

- Review of complications of pregnancy and/or delivery
  - Educate the patient about risks for future pregnancies, long-term health implications

Comprehensive Postpartum Visit Content

- Blood pressure measurement
  - Perform after patient has rested for >5 minutes

Comprehensive Postpartum Visit Content

- Screening for postpartum depression using a validated screening tool
  - Links to screening tools and other resources: Appendix A
  - Develop a referral protocol for complicated and uncomplicated depression

Comprehensive Postpartum Visit Content

- Reproductive life planning
  - Encourage the woman to discuss short- and long-term pregnancy intentions with partner
  - Promote optimal birth spacing
  - Assist women to select a family planning method that aligns with their reproductive life plan
  - Provide access to or referral for the patient's preferred method
  - Adhere to the CDC recommendations regarding timing of specific methods postpartum

Comprehensive Postpartum Visit content

- Immunization review/provide immunizations
  - Focus on influenza, Tdap, MMR and Varicella
  - Others may be indicated: Pneumonia, Hepatitis, Meningitis, HPV

Comprehensive Postpartum Visit Content

- Breastfeeding support
  - At comprehensive visits assess breasts and lactation history
  - Discuss and treat problems
  - Discuss return to work and lactation

Comprehensive Postpartum Visit Content

- Smoking cessation – utilize the “5 A’s”
  - Ask all patients about current smoking status
  - Advise to quit with personalized message
  - Assess willingness to quit
  - Assist: Provide a brief intervention to current smokers, consider pharmacotherapy, and initiate a proactive referral to the NC Quitline
  - Arrange follow-up visit
  - See Perinatal Tobacco Use Pathway

Comprehensive Postpartum Visit Content

- Healthy lifestyle behavioral advice
  - Measure BMI
  - Provide weight loss counseling to women with BMI ≥25 and recommend intensive lifestyle intervention
  - For ALL women:
    - Adequate physical activity
    - Daily multivitamin with folic acid
    - High quality, healthful diet

Comprehensive Postpartum Visit Content

- Pap smear if indicated by ASCCP guidelines
  - Every 3-5 years for women 21-65

Transition to primary care: Ongoing Health Insurance

- Some patients have ongoing Medicaid coverage
- For patients in the MPW category, coverage ends on the last day of the month in which the 60th postpartum day occurs
  - Healthcare.gov for insurance with possible subsidies
  - Medicaid Family Planning coverage
    - Annual exam
    - Periodic visits
    - STI testing/treatment
    - Some labs
    - Almost all contraceptive methods

Transition to primary care

- Educate all patients about the value/timing of primary care in the reproductive years
  - Annual visits for all women
  - More frequent visits for women with medical complications
- Identify a source of ongoing primary care
  - Insured patients: continue with current practice or PCP referral
  - Uninsured patients: Safety net provider referral
  - Warm hand-off for medically complicated patients

Questions?

- Next webinar:

  Tuesday May 5, 7:30am – Management of Substance Use in Pregnancy

- Slides from today's webinar, recording of today's webinar, and all PMH Care Pathway materials are available on the Postpartum Pathway page on CCNC's website:

https://www.communitycarenc.org/media/files/postpartum-care-and-transition-well-woman-care-appendix-c.pdf