Postpartum Think Tank Meeting
December 4, 2014

Welcome!
Wifi: waswe2014
Postpartum Think Tank Meeting
December 4, 2014

Setting the Stage

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Today

• Common Understanding
  • Current system of care for new mothers is not adequate
  • Change can and must happen
  • Focus on develop specific, actionable recommendations to take on one piece of the apple pie / elephant / puzzle at a time
  • Parking lot items won’t be left unattended forever
  • Change agents are in this room
Our Focus

• Fourth Trimester (3 months postpartum)
  • Recover from impact of pregnancy, labor & delivery and newborn care
  • Early postpartum contraception, depression and breastfeeding are sensitive periods of time that link to life course outcomes
  • Linkages to ongoing care & services
  • Healthy People 2020 Postpartum Health and Behavior:
    • (Developmental) Reduce postpartum relapse of smoking among women who quit smoking during pregnancy
    • (Developmental) Increase the proportion of women giving birth who attend a postpartum care visit with a health worker
• Interconception Care
  • Care in between pregnancies with specific focus on improving next birth outcome – generally defined as two years
• Well Woman Care
  • Care across the life course regardless of pregnancy intention
Stars are Aligning for Change

- MCHB HRSA CoIN Projects - Interest in Postpartum
- MIECHV and Healthy Start Programs
- Every Mother Initiative – Maternal Mortality & Morbidity Prevention
- Pregnancy Case Management services
- Health Care Reform
- CMS Postpartum Visit Initiative
- 1,000 Days Campaign
Multi-Faceted Approach

- Women
- Providers
- Health System
- Public Health & Community
Anderson Model

- Predisposing factors
  - Demographic and SES characteristics, past diagnoses and health beliefs, knowledge and values
- Enabling factors
  - Income, health insurance, usual source of care, community characteristics
- Need
  - Perceived by patient / evaluated by provider
New Model of Care: Women as Focus

- Initiation of Prenatal Care
- Labor & Delivery
- Hospital Discharge
- Postpartum Visit
- Well-Woman & Contraceptive Care
- Postpartum Visit
Becoming a mother...
Babies are Transformational

- Time of great joy for a woman, couple and extended family
- Fulfillment of a life goal / reproductive life plan
- Joining the circle of mothers
- The majority of women want to become mothers
- Motherhood as a source of empowerment and creativity
It’s Not Easy Being a New Mom

- Fatigue / Sleep loss (56% overall / 21% major)
- Stress (54% overall, 17% major)
- Physical exhaustion (51%, 16% major)
- Sore nipples/breast tenderness (48%, 12% major),
- Backache (46%, 12% major)
- Weight control (45%, 16% major)
- Lack of sexual desire (43%, 13% major)
- C-section numbness (48%, 12% major) and itchiness (51%, 13% major)
- Six months later 1:3 mothers were still feeling stressed, had problems with sleep loss, weight control. Women with a C-section - 20% still had numbness and itchiness

Listening to Mothers III, 2013
It’s Not Easy Being a New Mom

- Headaches
- Hair loss & acne
- C-section / episiotomy site / breast pain – 80% of early postpartum women
- Constipation
- Hot flashes & dizziness
- Pain with intercourse
- Bleeding
- Iron depletion / anemia / thyroid dysfunction
It’s Not Easy Being a New Mom

• Breastfeeding initiation 79% vs continuation 49% (6 mos) and 27% (12 mos)*
• One in three mothers reported “feeling down, depressed or hopeless” (35%) or having “little interest or pleasure in doing things” (36%) for at least several days in the past two weeks
• Postpartum depression (17%-20% or nearly 1:5 new moms)
• Tobacco recidivism (up to 70%)
• Less than 6 months between pregnancies
  • 40% increased risk of preterm birth
  • 61% increased risk of low birth weight
  • 26% increased risk of being small for gestational age
  • 1/3 of US pregnancies occur within 18 months after delivery

* Varies by population
Postpartum Preparation

- Postpartum women are not adequately prepared for specific, common postpartum physical and emotional symptoms
  - Only 24% were prepared for urinary incontinence and less than half were prepared to expect breastfeeding problems, hair loss, hemorrhoids, large mood swings or anxiety
  - 24% were not prepared in general
- Providers may not want to worry women about problems they may not have.
- Women who perceived themselves as adequately prepared for postpartum had higher satisfaction with their physician or midwife and were more likely to return for their postpartum visit.
  - Women with higher incomes and greater education reported higher satisfaction with their providers and greater preparation

Howell, OB/GYN, 2010
Postpartum Preparation

• Providers found their patients had inaccurate expectations regarding severity of pain following delivery, amount of bleeding, changes in sex drive and not losing pregnancy weight right away.

• Disconnect between what providers viewed as normal postpartum recovery and what mothers considered major problems.

• Providers are focused on postpartum problems that indicate serious conditions while women are more focused on the impact of symptoms on their daily functioning.

• Women look to their providers for support and think it is their role to link them with additional resources like lactation specialists and social workers.

• Women thought a phone call in the first week would be helpful.
Postpartum Preparation

• Much of the education provided prior to delivery focused on infant care and breastfeeding
• When women were aware of problems to expect (depression, sore breasts and vaginal bleeding) they didn’t have a clear picture about how the symptoms would appear, develop over time, last and impact on daily lives
• Women and providers are concerned about lack of continuity of care and absence of maternal care during the early postpartum period. After intense prenatal care mothers felt support disappeared in the first six weeks.

  *When you see them and you’ve been seeing them, it’s a continuation of a discussion you’ve been having for nine months.*

  *You kinda miss that critical time...you’re like a reporter at the end of 6 weeks and say so what did you manage to do in this past six weeks?*

Martin et al, MCHJ, 2013
Resources for Family Planning
High-Risk Moms

• Regaining Normality
  • This may be swift for some women making them feel much better than before (e.g. hyperemesis)
  • May not happen as hoped – particularly for women with pre-existing conditions that were aggravated by pregnancy

• Feelings of Neglect or Abandonment
  • Close monitoring and support during pregnancy followed by immediate shift in focus on baby with little to no postpartum follow up

• Future Threats to Health
  • Fears about recurrence in future pregnancy
  • Worries about longer-term impact on health
  • Worries about risk for future chronic disease
It’s Not Easy Being a New Mom

• Motherhood has also been described as “all-encompassing, guilt-provoking, unrelenting, labor intensive and emotionally charged”
• Public expectation: happy with quick recovery
• Changes in body image, disruption in life styles along with daily 24-hour demands of infant care, fatigue and loss of personal time and space as well as dealing with relationships with parents, partner and other children
• Many different variables (young moms, older moms, first time moms, moms with other children, infant temperament) require woman-centered resources and support
It’s Not Easy Being a Parent

- Many public health messages competing for attention
  - Safe Sleep
  - Purple Period of Crying
  - Breastfeeding
  - Car seats
  - Tobacco cessation
  - And more
- Potential info overload at antenatal classes and/or hospital discharge
- Research is needed as to the timing of when information should be delivered and how.
Materials for New Moms

Taking care of YOU
Your Postpartum Health and Visit

www.everywomannc.org
march of dimes www.marchofdimes.com
POSTPARTUM VISIT, TIMING & CONTENT OF CARE
Utilization

• Lu and Prentice (2002) found that 85% of women had received outpatient care within 6 months postpartum
• HEDIS 2013
  • 80.7% Commercial HMO
  • 70.9% Commercial PPO
  • 61.3% Medicaid
• PRAMS 2011 (14 states)
  • Range from 87.7% to 95.4%
• Listening to Mothers III – 90%

• NOTE: There is wide variation by population
Reasons for Missing Visit

• Feel fine (top response)
• Thought maternity care had ended
• Lack of child care (for baby and/or older children – not all providers have clear policies about bringing baby to visit)
• Inability to get off of work / need for work clearance varies
• Lack of transportation (plus bus & van policies)
• Adjusting to being a new mom (feeling overwhelmed / too hard to get to visit)
• Discontinuation of insurance coverage
• Dissatisfaction with care
• Perception of poor continuity of care vs connection with clinical and office staff
• Women with complications like GDM - fear of negative prognosis and/or feeling fine and low perceived risk
• Focused on infant recovery / health
At Risk for Not Receiving Care

- Late access to prenatal care / no prenatal
- Non-Hispanic African American mothers
- Unmarried
- Less than a high school education
- Medicaid recipients
- Higher parity
- Women with disabilities
- Substance use (including tobacco)
- Lower income (8x more likely to have health care barriers)
System Issues

• Lack of relationship with provider / continuity of care between prenatal care / labor & delivery / postpartum care
• Slow and/or incomplete provider communication / medical record exchange across systems (EMRs offer opportunity)
• Health departments can provide “one stop shopping” with WIC, pharmacy, infant and maternal services but fewer women are now receiving their prenatal care in this way
• Study found that women with pregnancy complications were more likely to attend primary care visits post delivery compared to a low risk group but overall visit rates were low – innovative models for prevention health services after delivery are needed to target women at higher risk for chronic disease development
Strategies

• Appointment Reminders (Calls, Text & Mail)
• Leave hospital with an appointment
• Open Access Appointments
• Incentives for moms – needs more research
• Reminders during the first well-baby exam
• Ensure proper documentation in medical record
• Use of correct diagnosis and procedure codes
• Relationship / connectedness of patient with provider
• Positive but inconclusive evidence of enhanced PNC
• More research needed on link between home visiting and PPV utilization
Content of Visit / Care

- Weight
- Nutrition counseling & supplementation
- Blood pressure
- Physical Exam – Breasts, Abdomen, Pelvic
- Screening & counseling (physical & mental abuse, STIs, substance use)
- Reproductive plan with contraception
- Address chronic conditions or other problems that emerge from pregnancy
- Linkage to other services as needed
- Breastfeeding
- Maternal infant bonding
- Depression screening / assess emotional status of women with a loss
- Healing of birth trauma/menses/uterus/scars
- Immunizations
- Counseling regarding future health and pregnancies
- Infections
Content

- Katz in Obstetrics 2007
  - Adds thyroid function, cardio vascular system and coagulation, energy, sexuality, PTSD

- Key Informants
  - Comprehensive evaluation of how the pregnancy went – prenatal to postpartum
  - Evaluation of chronic medical conditions
  - Evaluate behavior and psychosocial risks
  - Develop a treatment or prevention plan for identified problems with specifics steps and transition to care
  - Develop reproductive life plan
Interconception Care Project of CA

Provider Algorithms

- Anemia Algorithm
- Chronic Hypertension Algorithm
- Domestic Violence Screening Algorithm
- Gestational Diabetes Algorithm
- Gonorrhea & Chlamydia Algorithm
- Hepatitis Algorithm
- HIV Algorithm
- Immunizations Algorithm
- Migranes Algorithm
- Overweight and Obesity Algorithm
- Postpartum Depression Algorithm
- Preeclampsia Algorithm
- Premature Birth Algorithm
- Prior Cesarean Section Algorithm
- Seizure Algorithm
- Substance Use Algorithm
- Syphilis Algorithm
- Thrombocytopenia Algorithm
- Thyroid Disorder Algorithm
- Tobacco Use Algorithm
- Alcohol Use Algorithm

Patient Handouts

- Alcohol Use Patient Handout
- Anemia Patient Handout
- Chronic Hypertension Patient Handout
- Domestic Violence Patient Handout
- Gestational Diabetes Patient Handout
- Gonorrhea & Chlamydia Patient Handout
- Hepatitis B & C Patient Handout
- HIV Patient Handout
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- Thyroid Disorder Patient Handout
- Tobacco Use Patient Handout
The National Preconception Care Clinical Toolkit was designed to help primary care providers, their colleagues and their practices incorporate preconception health into the routine care of women of childbearing age.

The tool kit is designed to help primary care providers meet their patients' needs based on their response to this "vital sign" question: "Are you hoping to become pregnant in the next year?" Her answer will allow you and your colleagues to individualize her primary care to best meet her overall and reproductive health needs.

The goal of the toolkit is to help clinicians reach every woman who might someday become pregnant every time she presents for routine primary care with efficient, evidence-based strategies and resources to help her achieve:

- healthier short and long term personal health outcomes,
- increased likelihood that any pregnancies in her future are by choice rather than chance,
- and, if she does become pregnant, that her pregnancy and her infant(s) have the lowest likelihood of problems.
Welcome to the National Preconception Care Clinical Toolkit, designed to help primary care providers, their colleagues and their practices to incorporate targeted attention into the routine care of women of childbearing age.

### Desires Pregnancy:
**Family Planning and Contraception**

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**At Your Fingertips**
- Family Planning and Contraception
- Nutrition
- Infectious Disease and Immunizations
- Chronic Disease
- Medication Use
- Substance Use
- Previous Pregnancy Outcomes
- Genetic History
- Mental Health History
- Interpersonal Violence

**At Risk / Unsure**

**Does Not Desire Pregnancy**
Not Just the Content – the Delivery

- Length of time allocated for the visit – does it vary?
- How counseling is done
  - Negative experiences in postpartum contraception
    - Insufficient counseling
    - Impersonal counseling
    - Physician did not initiate counseling
    - Not listening to the patient’s opinions
Timing of Care

- WHO: 48-72 hours, 7-14 days and 6 weeks
- NICE: within 1st 7 days and between 2-8 weeks
  - European countries also have home health visitors
- ICSI, AAP, ACOG, AHRP: one visit between 4-6 weeks
  - US postpartum home visits via case management programs are not typically considered postpartum care – not delivered by a health care provider
  - Some providers may recommend an earlier visit if women were discharged early from the hospital or for other specific needs
- Focus on individualized approach to timing of the postpartum visit but this can also create confusion
- Mother-centered approach to the timing of the visit(s)
Timing of Care

- Large body of review articles supporting earlier and more frequent postpartum visits – one within 1-2 weeks postpartum along with traditional 6 week.
  - Increased maternal satisfaction
  - Decreased risk of depression
  - Increased adherence to breastfeeding
  - Contraception
- Lu et al call for an earlier visit at 2 weeks and also care at 6 weeks, 6 months and annual follow up visit. Cheng et al also call for increased availability of postpartum visits up to a year. Key informants also called for an earlier visit.
- Clinic capacity for additional visits?
- Limited evidence – need for research
Research Needed

• Timing of the visit / Number of visits
• Successful models of postpartum care with strong data
• Effective communication / education methods to motivate and support new mothers to adopt / continue positive health behaviors. Timing for health behavior change / messaging
• Specific needs of high-risk populations – mothers with NICU babies, women with disabilities, women who had high-risk pregnancies, women experiencing infant loss and women who use substances
• Insufficient evidence to recommend routine telephone support for women accessing maternity services (including prenatal) as the evidence from trials is neither strong nor consistent
More Research Needed

- Cochrane Review 2013 on frequency of home visits, the length of engagement, the intensity and different types of interventions found that findings were inconsistent. Postnatal home visits may promote infant health and maternal satisfaction however the frequency, timing, duration and intensity of visits should be based on local needs. Further RCTs evaluating this intervention are required to create the optimal package.
Challenges

- No incentives for providers for the patient to return for the visit - low value
- Content needs definition
- Variation in quality of care – what are the benchmarks needed to hold providers and patients accountable?
- The most vulnerable women often don’t access postpartum care and many that need ongoing care are no longer eligible for insurance
- Need for smooth transition to next stage of care – this is challenging for many reasons
- In some areas there continues to be limited access to prenatal care which is then reflected in challenges with postpartum services.
Barriers

• Hard to screen women for problems for which comprehensive treatment & services are not available
• Addressing a patient’s obesity, HT and diabetes if she has no insurance to continue her care
• Difficult to track postpartum visits due to bundled payment for OB services
• Barriers to contraception – unable to perform LARC in hospital; coverage issues with Paraguard and Mirena in general (lose money with Medicaid); often have to come back for another visit to get contraception
Barriers

• Breastfeeding support is often lacking. Poorly available support services; lactation consultant often not present in practices. Electric pump coverage issues.
• Medicaid usually expires at 6-8 weeks. Many states have a family planning waiver, should streamline process. Does not cover the chronic disease issues that increase risk – ACA supposed to change this...but has not yet in states who have not expanded Medicaid
• Importance of birth spacing on pregnancy outcomes not widely known among patients or providers
• Home visiting programs focus on infants primarily – need training and quality metrics to expand services
POLICY & FINANCING CHALLENGES
Figure 1: Potential Coverage Options for Pregnant Women in 2014 and Future Years

Federal Poverty Level


Insurance Affordability Programs (IAP)

APTC = advanced premium tax credit
CSR = cost sharing reductions
Coverage Options for Women
Beyond Employer-Sponsored Insurance
and Traditional Medicaid

If she is NOT pregnant at application
and becomes pregnant

- Medicaid expansion
- CHIP
- Medicaid (based on pregnancy status)
- Marketplace QHP

“This approach enables pregnant women who are enrolled in a QHP prior to becoming pregnant and eligible for Medicaid or CHIP on that basis to choose to enroll in coverage under Medicaid or CHIP, or to remain enrolled in their QHP with continued receipt of APTC and CSR, but not to choose both.”
Coverage in the Postpartum Period
Beyond Employer-Sponsored Insurance and Traditional Medicaid

Medicaid expansion

States can offer postpartum coverage up to 60 days, then redetermination

Coverage would remain the same

CHIP

She would have to be re-determined after 60 days postpartum

Medicaid (based on pregnancy status)

Marketplace QHP

Would remain in coverage or could change coverage during special enrollment period
IDEAS FOR IMPROVEMENT
What Can Title V & MCH Do?

- Increase connectivity between clinicians and Title V programs
- Increase connectivity between Medicaid and Title V
- Reach beyond providers in health centers and health departments – need to engage all providers
- Support C-section data and help states decide what’s “big” and “do-able”
- Promote mom/baby group care models to FQHCs
- Create standards for care and highlight what happens to mothers who fall through the cracks
- National plan and quality measure for weight loss around the PP period.
Ideas

• Group care for mom and baby (e.g. Centering Parenting – with adequate curriculum to cover maternal/paternal health needs)
• Dyadic care for mom and baby (via well child care)
  • Issues change in 1st year – often around 6-9 months. Interconception care at WCC a good model to consider making standard. Need ability to bill for maternal risk screening coupled with WCC care
• Funding streams to increase # staff available to improve collaboration with primary care providers and other practitioners (case workers, social workers, etc.)
• Focus on quality of postpartum care for a HRSA CoINN Initiative
• Talk with consumers and local, state and payer representatives about their experiences and suggestions for improving postpartum care delivery
• Expand public education on social media to best reach new and prospective parents with key information
Ideas

- Develop National Benchmarks for adequate postpartum care – including tools and check lists
- Promote quality guidelines around postpartum care to reduce significant variation
- Improve collaboration among national initiatives
- Move payment reform forward for this care
- Plan for how to disseminate successful examples of quality, comprehensive care
- Use 3rd trimester prenatal care visits as an opportunity to provide anticipatory guidance for the postpartum period
- Develop and distribute information to new mothers that describes all the normal postpartum physical and emotional consequences with specific information about their impact on daily life and how to effectively manage symptoms (e.g. telling her to get more sleep and manage stress better isn’t going to help much)
Ideas

• Focus on continuity of care and patient/provider relationship from prenatal care through labor & delivery and postpartum care – particularly for mothers with Medicaid. If an OB/GYN plans to act as a medical home they need to be able to respond to health needs such as colds and flu
• Home visiting teams for women who don’t come for appointment or families identified as high risk
• Explore hybrid group models of care – extended childbirth classes and postpartum new parent support groups
Ideas

• Utilize home visiting programs as a way to connect new mothers who live near each other to foster social support and networks
• Recent study indicated that mothers were open to discussion topics including depression, smoking and alcohol use at pediatric care visits (over 85%)
• Provision of mental health services and other maternal care may need to happen in pediatric settings given the many missed opportunities women experience in receiving this information elsewhere
What Can Title V & MCH Do?

- Facilitate focus groups with consumers, providers and payers
- Advocate for increased health coverage for mothers at least 1 yr PP
- Identify ways in which postpartum screening services are reimbursable and integrate into pay for performance structure within medical homes to ensure more consistent universal screenings and appropriate follow up
- Encourage collaboration of services between primary care and mental health resources such that maternal mental well-being is supported seamlessly between systems.
- Monitor reproductive health and infant outcomes among women with depression and anxiety.
Merck for Mothers is supporting the development of an app to educate women in the US about health related matters after childbirth. This app will empower women to take responsibility for their own care and their newborn’s care in the critical weeks between giving birth and the six-week postpartum visit. The app will translate guidelines based on the latest evidence-based recommendations into an easily understandable, engaging format available via smartphone.
New Models of Care: IMPLICIT

- IMPLICIT is an MCH Family Practice QI collaborative
- From 1/12 until 10/14, the IMPLICIT Network looked at 8,309 Well Child Visits from 2,631 different babies across 6 sites
- Mothers accompanied their babies to 8,125 WCVs (97.8%)
- Women were screened for ICC at 5,058 WCVs (62.3%)
- There was significant variation in the rate of ICC delivery across the sites
- Of the mothers screened for ICC at the 5,058 WCVs:
  - 20.7% reported current tobacco use
  - 8.4% had risk of current maternal depression
  - 33.7% were not compliant with contraception
  - 38.6% were not using a multivitamin
  - Intervention rates varied from 16.8% to 100.0%
Comprehensive Breastfeeding Support in Wake County, NC

- WIC
- Hospital-based lactation specialists
- Home visitors
- Pregnancy Medical Home case managers
- Peer Counselors
- Postpartum Clinic Visit
- Well Child Clinic

- Team approach was also applied to encouraging utilization of the postpartum visit and contraception.
- At the end of the project the team felt that new mothers in general needed more and longer term support and began some focus on social media.
Ohio Moves the Margin

- GDM Collaborative is designing and implementing a QI project to improve the % of Medicaid women who undergo PP screening for T2DM
- Medicaid initiated a grant-funded PP QI pilot project in Cincinnati to improve the occurrence and content of the PPV, focus on reducing disparities in care and ID potential interventions for statewide implementation
- Medicaid includes postpartum care as 1 of 22 QI measures
- Several Medicaid managed care plans have implemented incentive programs to reward mothers who complete perinatal and PPV. They also offer a home visit and are working to enhance services such as tobacco cessation and group care
- ODH supports PPV through local grantees
Newly Funded Project in NYC

• Innovative partnership between the Icahn School of Medicine at Mount Sinai, Healthfirst and The New York Academy of Medicine aims to improve care for low-income, postpartum patients in New York City

• “Our project aims to improve quality of care for high-risk postpartum patients by combining a social work-case management intervention with a new payment system designed to incentivize clinicians.”

• “This project builds on the strong existing partnership between Healthfirst and Mount Sinai to study the impact of an innovative payment and delivery model that can provide high quality, efficient and equitable health care for our members and the communities that we serve.”
Other Work / Strategies

- Community Care of North Carolina Pregnancy Medical Home in partnership with Medicaid offers a financial incentive to providers for delivering a postpartum visit (~$150). They are also working hard on promoting postpartum LARCs and looking at contents of the postpartum visit.

- OTHERS TO SHARE
Richmond & Kotelchuck, 1983