Postpartum Care in the Pregnancy Medical Home: Improving women's health and future pregnancy outcomes

Community Care of North Carolina

Postpartum Care

- An opportunity for prevention
  - Address the many immediate needs
  - Address chronic conditions
  - Transition to well women care
  - The “first interconception care” visit
    - 40% of pregnant Medicaid patients lose coverage at the end of the postpartum period, so it may be the only visit
    - Of those who retain coverage, how many have an established relationship with a primary care provider?

Value of Interconception Care

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- Management of modifiable risk factors for future pregnancy
  - Interventions to improve future pregnancy outcome
- Access to reproductive health care
  - Potential for fewer unintended pregnancies and for optimal birth spacing
- Higher likelihood of early prenatal care in future pregnancy
  - 1/3 of Medicaid pregnancies do not receive first trimester care

By the numbers…

- There were 120,948 births in NC in 2014
- 56,026 of NC births occurred to women with Medicaid coverage – 46.3 % of all NC births
  - Excludes 7,761 births (6.4%) to women with “emergency Medicaid” coverage for the delivery only
  - All of these women have postpartum coverage with no co-pay
- 10% of women with Medicaid coverage are pregnant again within 12 months of giving birth
  - Short inter-pregnancy interval (<18 months) is an independent predictor of preterm birth
  - Women with Medicaid coverage are already at an increased risk of preterm birth

Postpartum visit expectations

- HEDIS measure and Adult Core Measure for Medicaid healthcare quality
  - National HEDIS 2014 measure of postpartum visits between 21-65 days for Medicaid HMOs is 61.8%
  - NC Medicaid's 2014 rate using HEDIS method is 46.5%
- Postpartum visit within 60 days of delivery is core expectation of NC Pregnancy Medical Home providers

Postpartum visit measurement

- More than half of maternity care for NC Medicaid patients is billed using the global fee, a bundled code that does not capture the postpartum visit
  - Office visit and/or pap smear between 21-56 days postpartum counts as postpartum visit
- Pregnancy Medical Home created a unique claim for the $150 postpartum incentive payment to better measure postpartum visits
  - PMH postpartum visit rate based on incentive payments is 42%
- What is the true rate for the Medicaid population?

Comprehensive postpartum visit: timing

Timing of Postpartum Care

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Pregnancy Medical Home Care Pathway:

- **Recommend comprehensive visit for ALL women at 14-42 days post-delivery**
- **BP check at 7-10 days post-delivery (not post-discharge) for all patients with hypertensive disorders**
- **Diabetes screening at 6-12 weeks postpartum**
- **Perinatal mood disorder risk factors: screening 7-14 days post-delivery**

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

Comprehensive Postpartum Visit: Content

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- Pregnancy and delivery review
- BP screening
- Depression screening and referral
- Reproductive life planning and access to contraception
- Immunization review and vaccination
- Breastfeeding support
- Smoking screening and counseling
- Healthy lifestyle evaluation and counseling
- Screening tests

Predictors of not having a postpartum visit

- Some women are less likely to receive a postpartum visit*:
  - Women whose pregnancies resulted 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 (but not gestational DM)

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

Pregnancy Medical Home Postpartum Quality Improvement Project:

A CCNC clinical priority in 2016

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PMH Postpartum QI Project Participants – THANK YOU!

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- Ashe Women's Center
- Ashley Women's Center
- Cabarrus Health Alliance
- Cape Fear Valley OB/GYN
- Carmel OB/GYN
- Carolina Women's Health Associates
- Carolina Women's Health Center
- Carteret OB/GYN
- Catawba Women's Center
- Center for Women's Health
- CMC North Park
- Craven County Health Department
- Dr. John Lane
- Duke Perinatal
- Gaston County Health Department
- Harnett OB/GYN
- Lyndhurst OB/GYN
- MAHEC OB/GYN
- McDowell OB/GYN Piedmont Healthcare Women's Center
- Mt. Airy OB/GYN
- New Hanover Regional Medical Center OB/GYN Specialists
- NHRMC Coastal Family Medicine
- Novant Health OB/GYN (Brunswick)
- Physicians East – Greenville OB
- Pinehurst Surgical
- Premier Women's Health
- Salisbury OB/GYN
- Sampson County Health Department
- Shelby Women's Care
- Southeast OB/GYN
- UNC
- Wake Forest Baptist Health (MFM)
- Wayne County Health Department
- Wayne Women's Clinic
- Westside OB/GYN

PMH Postpartum QI Project Goals

1. Improve data quality
   - Use CCNC data reports to identify changes coding/billing processes to increase the alignment between completed postpartum visits and paid PMH incentives
   - “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 Tests of Change

- Scheduling of visit:
  - During late third trimester prenatal visit
  - Prior to hospital discharge – By whom? How?
  - Within 1 week of hospital discharge
- Timing of visit:
  - Schedule all visits at 21 days postpartum
  - 14 days or 28 days depending on contraceptive method
- Outreach:
  - Reminder calls, texts, postcards
  - Care manager
  - Immediate callbacks for missed visits – by whom?

Postpartum Tests of Change

- Education:
  - Importance of postpartum visit and what happens
  - Early and often during prenatal care
  - Difference between incision check/BP check and comprehensive visit
- Special considerations:
  - Postpartum sterilization procedures
  - Coordination of antepartum/intrapartum/postpartum transitions for patients not delivered by their prenatal care provider

Access to Highly Effective Contraception in the Postpartum

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May 23, 2016
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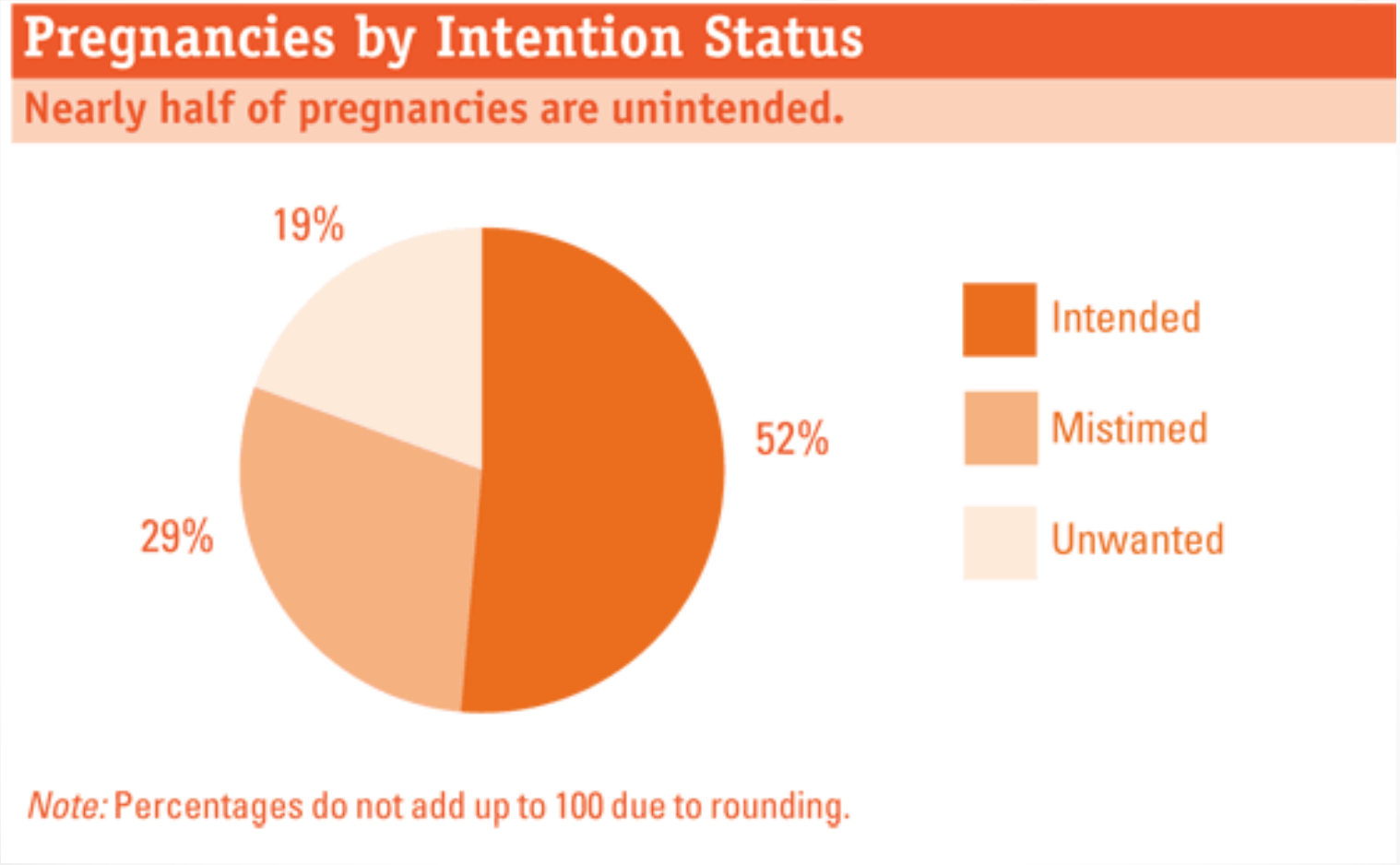
Disclosures

- I have no financial disclosures
- I will be talking about some off label use of medications
- All opinions expressed are my own, and do not represent the important organizations where I work

Objectives

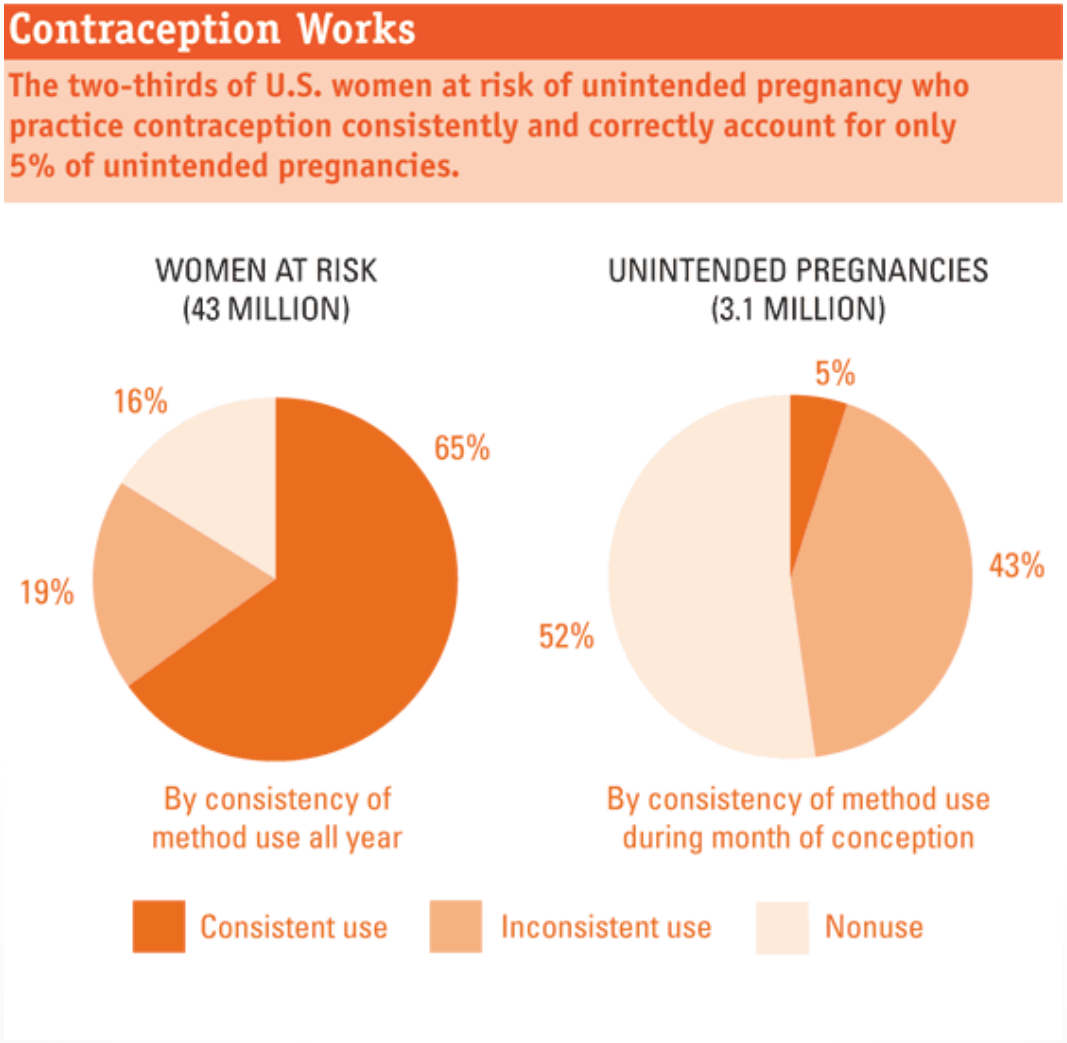
- Background: Unintended pregnancy & rapid, repeat pregnancy
- LARC: Long-acting reversible contraception
  - Intrauterine contraception
  - Contraceptive implants
  - New opportunities: postpartum LARC
  - Breastfeeding in the postpartum
  - Implications in perinatal health
- Reproductive Justice:
  - Sterilization/ Patient-centered counseling

Unintended pregnancy



https://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html

Unintended pregnancy

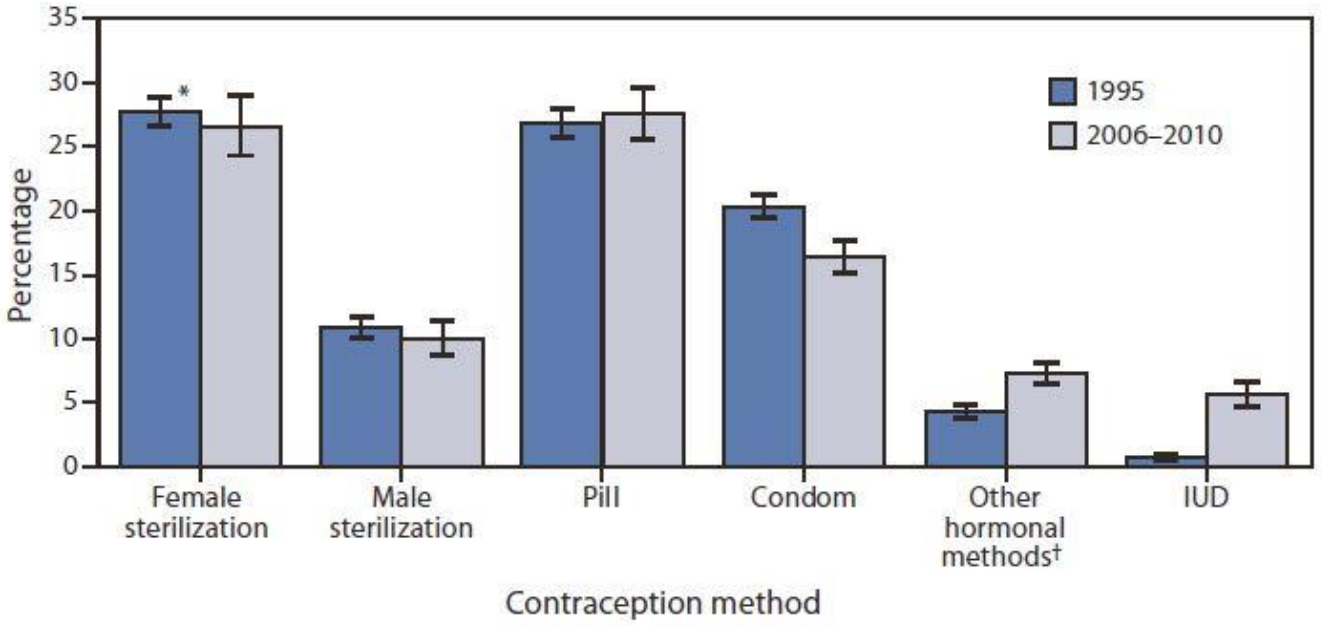


https://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html

Contraception in the US?

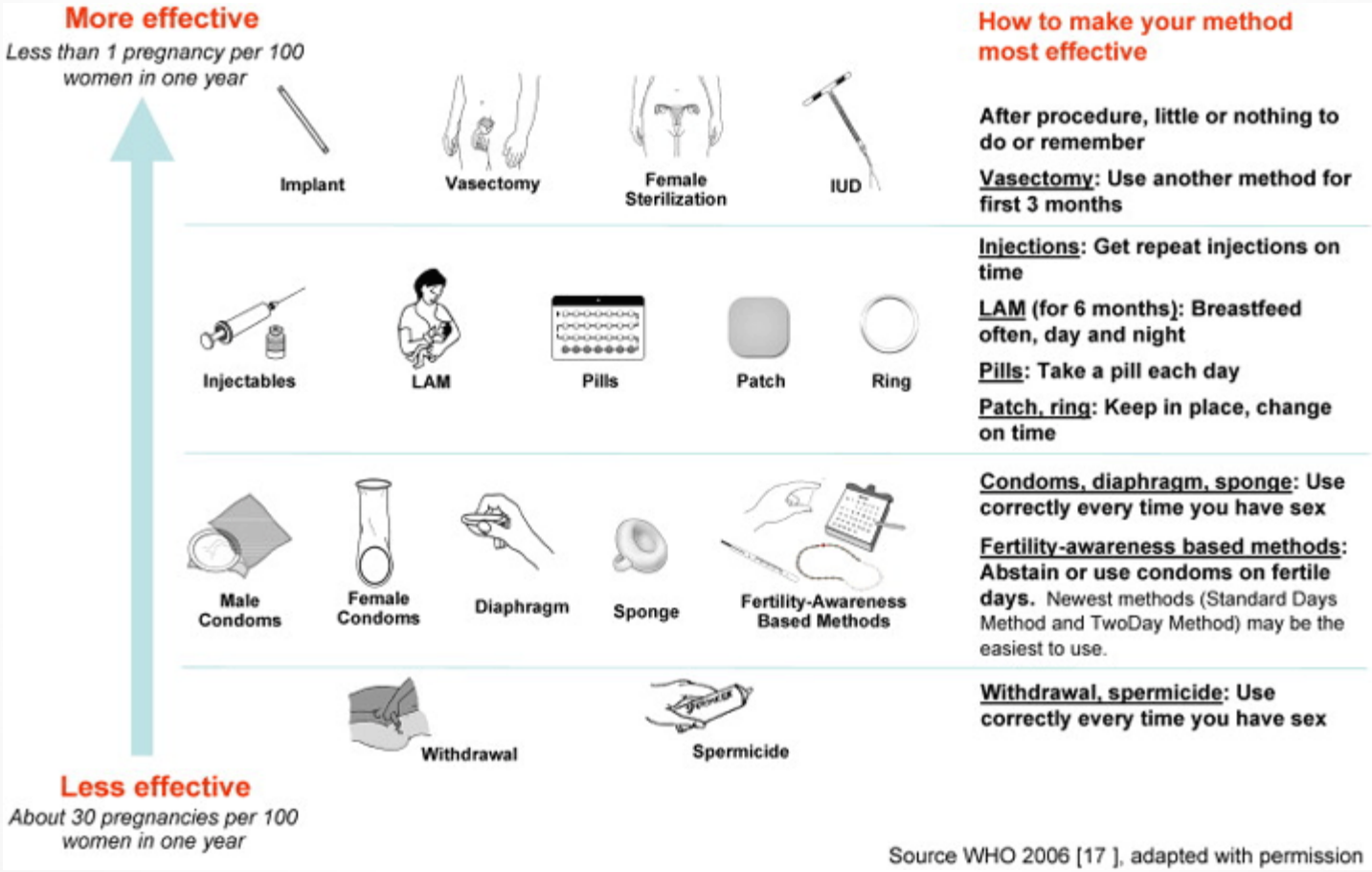
QuickStats: Use of Selected Contraception Methods Among Women Aged 15-44 Years Currently Using Contraception — National Survey of Family Growth, United States, 1995 and 2006-2010

Weekly
December 21, 2012 / 61(50);1031



Abbreviation: IUD = intrauterine device.

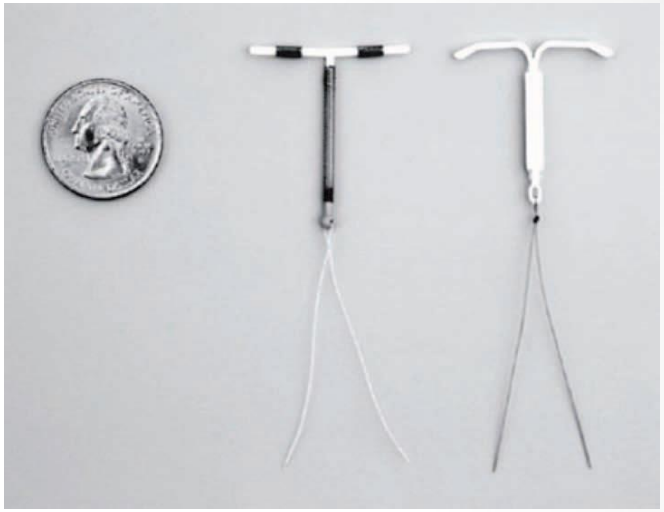
Effectiveness by tiers



Source WHO 2006 [17], adapted with permission

Why LARC is Preferred?

- No daily / weekly/ monthly medications
- No coitus specific actions
- Always perfect use



Available LARC

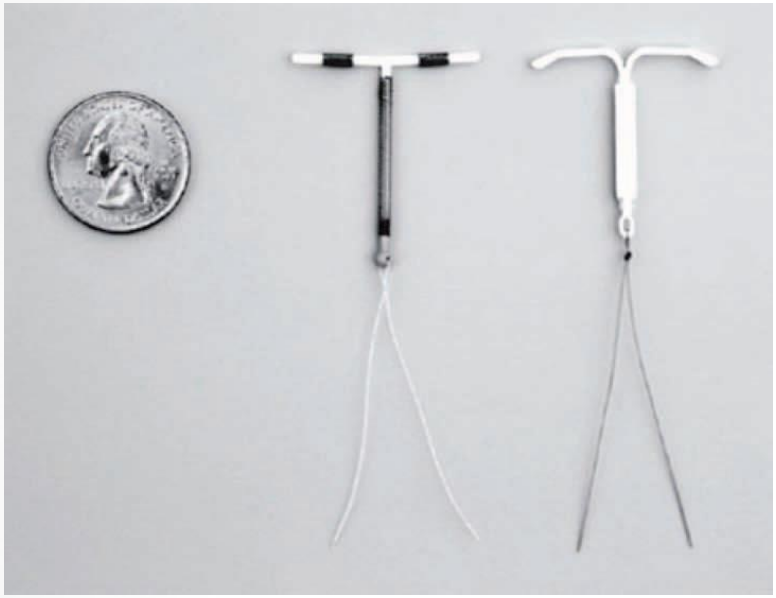
Risk of rapid, repeat pregnancy

- Optimal interpregnancy interval:
  - 18 months – 5 years
  - Reduction in preterm birth
- 38% of US pregnancies have short intervals
- LARC: demonstrated reduction in rapid, repeat pregnancy
- State-wide data (CA) showed improved ideal birth spacing with LARC

Conde-Agudelo, 2006; Teal, 2014; US DHHS, 2012; Baldwin, 2013; de Bocanegra, 2013

LARC

LARC: Long-acting reversible contraception



LARC: IUD's

- Efficacy: 99%
- 2 types: Copper and medicated (progesterone)
- Duration of use: 3-10 years
- Contraindications:
  - Active uterine infection or cancer
  - Severe uterine distortion
  - Allergy to IUD components
  - Liver disease or hormonal cancer (progesterone)
  - Copper allergy (copper)

LARC: Implant

- Efficacy: 99%
- Only 1 in use in the U.S.: Nexplanon
- Duration of use: 3 years
- Contraindications:
  - Blood clots
  - Breast cancer
  - Liver disease
  - Hypersensitivity to any component

LARC: Evidence

- Supported by ACOG & AAP
- 2 large studies have recently demonstrated impact
- CHOICE Project, St. Louis:
  - 10,000 patients
  - 75% LARC uptake
  - Reduction of main barriers:
    - Provider education
    - Patient education
    - Cost

Winner, 2012; Peipert, 2012

LARC: Evidence

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Effectiveness of Long-Acting Reversible Contraception

Brooke Winner, M.D., Jeffrey F. Peipert, M.D., Ph.D., Qiuhong Zhao, M.S., Christina Buckel, M.S.W., Tessa Madden, M.D., M.P.H., Jenifer E. Allsworth, Ph.D., and Gina M. Secura, Ph.D., M.P.H.

LARC: Evidence

2 large studies have recently demonstrated impact

- CHOICE Project, St. Louis:
  - 10,000 patients
  - 75% LARC uptake
- Colorado: Offered > 30,000 LARC devices
  - 40% reduction in teen birth

Winner, 2012; Peipert, 2012; Ventura, 2014

Postpartum LARC

- Fertile population
- Patients with contraceptive insurance coverage
- Multiple interactions with healthcare team
  - Ability to address contraception
- Motivated to consider reproductive life planning
- Challenges:
  - Reimbursement
  - Provider and patient education about safety
  - Changing practice patterns

CDC's Medical Eligibility Criteria (MEC)

1	No restriction for the use of the contraceptive method for a woman with that condition
2	Advantages of using the method generally outweigh the theoretical or proven risks
3	Theoretical or proven risks of the method usually outweigh the advantages – not usually recommended unless more appropriate methods are not available or acceptable
4	Unacceptable health risk if the contraceptive method is used by a woman with that condition

http://www.cdc.gov/mmwr/pdf/rr/rr5904.pdf

TABLE 3. Summary of recommendations and risk classifications* for hormonal contraceptive methods and intrauterine devices during the postpartum period

Condition	COC/P/R	POP	DMPA	Implants	LNG-IUD	Cu-IUD
Postpartum (nonbreastfeeding women)						
a. <21 days	4	1	1	1		
b. 21 days to 42 days						
i. With other risk factors for VTE (such as age ≥35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI ≥30, postpartum hemorrhage, postcesarean delivery, preeclampsia or smoking)	3†	1		1		
ii. Without other risk factors for VTE		1	1	1		
c. >42 days	1	1	1	1		
Postpartum (breastfeeding women§)						
a. <21 days	4	2	2	2		
b. 21 to <30 days						
i. With other risk factors for VTE (such as age ≥35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI ≥30 kg/m^2, postpartum hemorrhage, postcesarean delivery, preeclampsia or smoking)	3†	2		2		
ii. Without other risk factors for VTE	3	2	2	2		
c. 30--42 days						
i. With other risk factors for VTE (such as age ≥35 years, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI ≥30, postpartum hemorrhage, postcesarean delivery, preeclampsia or smoking)	3†	1	1	1		
ii. Without other risk factors for VTE	2	1	1	1		
d. >42 days	2	1	1	1		
Postpartum (breastfeeding or nonbreastfeeding women, including postcesarean delivery)						
a. <10 min after delivery of the placenta					2	1
b. 10 min after delivery of the placenta to <4 wks					2	2
c. ≥4 wks					1	1
d. Puerperal sepsis					4	4

Abbreviations: COC = combined oral contraceptives; P = combined hormonal patch; R = combined vaginal ring; POP = progestin-only pill; DMPA = depot medroxyprogesterone acetate; IUD = intrauterine device; LNG-IUD = levonorgestrel-releasing IUD; Cu-IUD = copper-bearing IUD; VTE = venous thromboembolism; CHC = combined hormonal contraceptive; BMI = body mass index (weight [kg] / height [m^2]).

Postpartum IUDs and Implants= Category 1 or 2

CDC MEC: Free app

http://www.cdc.gov/reproductivehealth/unintendedpregnancy/usmec.htm ,
Or search: "CDC MEC app" – first hit

IUDs in the postpartum

When?

- Immediate postpartum(< 10 min after vaginal delivery)
- Early postpartum (<48 hrs after vaginal delivery)
- Intracesarean
- 2-3 weeks postpartum (supported by research)
- 4-6 weeks postpartum (standard)

IUD insertion training demonstration

Dr. Paul Blumenthal: https://www.youtube.com/watch?v=uMcTsuf8XxQ

IUDs in the postpartum: Immediate post-placental, vaginal delivery

- Within 10 min of placenta delivery
- Expulsion rates vary (10-38%)
  - High-risk patients: 50% no show
- Similar user rates at 6 months
  - High patient acceptability
- Learning curve of providers
  - Experience of clinician matters

Dahlke, 2011, Chen 2010, Stuart, 2014, Lopez 2015

IUDs in the postpartum: Early postpartum, vaginal delivery

- Different than immediate post-placental:
  < 48 hours postpartum, morning after delivery
- Higher expulsion rates: 5-70%
- Copper IUD less expulsion than LNG-IUS
- Learning curve of providers
  - Experience of clinician matters
- Increased role internationally

Dahlke, 2011, Stuart 2012, Stuart,2014, Lopez 2015

IUDs in the postpartum: Intracesarean

- Post-placental, at time of cesarean delivery
- Expulsion lower vs. post-placental vaginal insertion
- Requires minimal training
- Challenges:
  - String visibility in office
  - Reimbursement
  - Logistics

Levi 2015, Lester 2015

IUDs in the postpartum: 2-3 weeks postpartum

- Uterus 66% involuted, day 14 postpartum
- Pregnancy is physiologically impossible
- Benefit of a 2 week postpartum visit
  - Convenience for mom
  - Combining pediatric & maternal visits
- Recently published RCT supported its use (Baldwin)

Belachew, 2012; Speroff 2008; Baldwin 2016

IUDs in the postpartum: 6 weeks postpartum

- Standard protocol for most providers: 6 weeks
- Problems:
  - Ovulation in those not exclusively breast feeding
  - Resumption of intercourse
  - Poor adherence to 6-week visit among high-risk
  - 2 visit protocols
- Potential solution: 2-3 week visit with same day insertion

CDC 2010; Stuart 2014; Teal, 2015; Zerden, 2015

Postpartum LARC: Contraceptive Implant, Nexplanon

- CDC MEC:
  - Non-breastfeeding = 1
  - Breastfeeding = 2
  - RCT: No difference in breastfeeding when placed 1-3 days vs. 4-8 weeks postpartum
- Challenges:
  - Reimbursement
  - Hospital participation

Gurtcheff, 2011

Breastfeeding considerations

- Integrate into prenatal care
- ACOG/ AAP: 6 months exclusive, 12 months continuation
- Infant benefits, reductions:
  - Infectious risk (GI, otitis media, respiratory infections); chronic diseases (obesity, autoimmune conditions including asthma and diabetes mellitus type I); infant mortality from SIDS
- Maternal benefits, reductions:
  - Breast & ovarian cancer risk; diabetes mellitus type II; hypertension; hyperlipidemia; & cardiovascular diseases

Stuebe, 2010

Breastfeeding considerations: LARC

- Copper IUD (ParaGard): No concerns
- Levonorgestrel IUD:
  - Small systemic progesterone levels
  - Limited evidence, reduction in breastfeeding
  - Now with 3 available types in the US
- Contraceptive Implant (Nexplanon)
  - Higher systemic progesterone levels
  - Best evidence: no change in breastfeeding

Chen, 2011; Gurtcheff, 2011

Implications for perinatal health

- Importance of reproductive life planning
  - Improve unintended pregnancy rates
  - Focus on those with history of high risk pregnancy
    - Post-NICU clinics
- LARC – powerful tool
  - High efficacy & patient satisfaction
  - Few contraindications
- Partner with pediatricians, family medicine
- Advocate together for increased access
- Engage partners and family

Implications for perinatal health

Human Reproduction, Vol.29, No.10 pp. 2163–2170, 2014
Advanced Access publication on August 1, 2014 doi:10.1093/humrep/deu191

human reproduction

ORIGINAL ARTICLE *Fertility control*

Estimated disability-adjusted life years averted by long-term provision of long acting contraceptive methods in a Brazilian clinic

Luis Bahamondes*, Bruna F. Bottura, M. Valeria Bahamondes, Mayara P. Gonçalves, Vinicius M. Correia, Ximena Espejo-Arce, Maria H. Sousa, Ilza Monteiro, and Arlete Fernandes

Human Reproduction Unit, Department of Obstetrics and Gynaecology, School of Medical Sciences and the National Institute of Hormones and Women's Health, University of Campinas (UNICAMP), Campinas, SP, Brazil

Implications for perinatal health

- 50,000 charts included
- 20,000 using LARC or Depo > 1 year
- Prevented:
  - 37-60 maternal deaths
  - 315-424 child mortalities
  - 634-853 combined maternal morbidity and mortality w/ child mortality
  - 1056-1412 unsafe abortions

Bahamondes, 2014

Implications for perinatal health

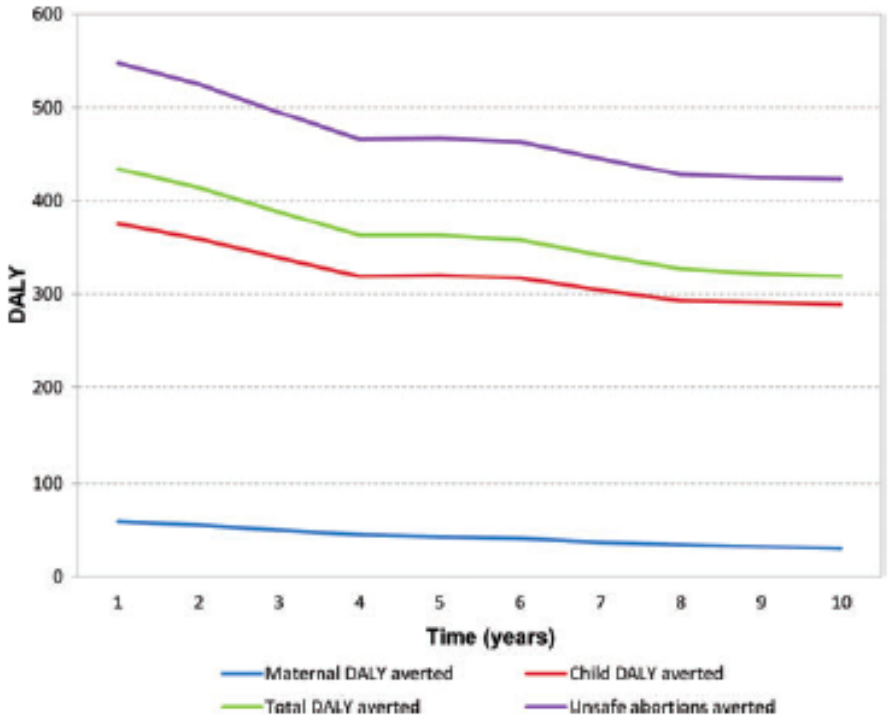


Figure 2 Estimated disability-adjusted life year (DALY)—maternal morbidity and mortality, child mortality, total mortality and unsafe abortions averted.

Bahamondes, 2014

Reproductive justice

- "The economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities"
  - http://strongfamiliesmovement.org/assets/docs/ACRJ-A-New-Vision.pdf

- The right to have children, the right to not have children, the right to raise children with dignity and in safety

Reproductive Justice: Sterilization

- Tier 1
- High rates of failed sterilization requests
  - 54% in one recent study, follows vaginal delivery
- Women desiring sterilization, who do no receive it
  - 47% had an unintended pregnancy within 1 year
- Obstacles: cumbersome Medicaid approval
  - Disproportionately impacts women of color
- Need to revise Federal Medicaid consent

Zite, 2005; Thurman, 2010; Potter, 2012 & Borrero, 2013; Borrero, 2014

Reproductive justice

- Evidence-based contraception counseling
- Free of coercion
- Culturally-sensitive, patient-centered counseling
  - Break away from the traditional, provider informing the patient
  - Use of videos and apps
    - https://youtu.be/u9SHoy1C3tU
    - Or in Spanish: https://youtu.be/HgenzQUCugg
    - ARHP's Method Match: http://www.arhp.org/methodmatch/
- Fulfilling sterilization requests
- LAM counseling
- Offering LARC throughout postpartum

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Questions?


Nexplanon
(etonogestrel implant) 68mg
Radiopaque
Mirena
(levonorgestrel-releasing intrauterine system) 20µg/day
Liletta
(levonorgestrel-releasing intrauterine system) 52 mg
ParaGard T 380A
intrauterine copper contraceptive
Skyla
(levonorgestrel-releasing intrauterine system) 13.5 mg