Safety Action Series

Establishing a Program for the Transition from Maternity to Well-Woman Care
Speakers

Sarah Jernigan, MSN, ACNP-BC, CSC
Patient Advocate

Rachel Urrutia, MD, MSCR
Assistant Professor,
UNC at Chapel Hill, Department of Obstetrics and Gynecology
Disclosures

- Sarah Jernigan, MSN, ACNP-BC, CSC has no real or perceived conflicts of interest.
- Rachel Urrutia, MD, MSCR has no real or perceived conflicts of interest.
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Objectives

- Review the postpartum period as a critical time for preventive care
- Discuss comprehensive models for establishing a smooth transition from maternity to well-woman care
  - Provide examples that will help implement elements of the Postpartum Care Basics Bundle
- Address complications and implementation barriers to promoting postpartum safety
- Hear a patient’s postpartum story and understand the importance of personalized care
What is the Postpartum Period?

- Begins immediately following delivery

- Ends?
  - 6 weeks?
    - Many biologic parameters return to baseline
  - 12 weeks?
    - “The Fourth Trimester”
  - Up to 12 months?
    - Many musculoskeletal and genitourinary changes return to baseline
  - When the global billing period ends?
    - Varies by insurer and mode of delivery up to 90 days
  - When lactation ends?
    - Unique metabolic and hormonal changes return to baseline
Why is this Period so Important?

- High risk time for mothers
- Many long-lasting health changes that are inadequately addressed
- Patients care

Image available, CDC https://www.cdc.gov/reproductivehealth/maternalinfanthealth/index.html
Preventing pregnancy-related death every step of the way.

Death can happen up to a year after delivery.

- **33%** 1 week to 1 year after delivery
- **31%** During pregnancy
- **36%** During delivery and up to 1 week afterward

SOURCE: CDC Vital Signs, May 2019

[www.cdc.gov/vitalsigns/maternal-deaths](http://www.cdc.gov/vitalsigns/maternal-deaths)
Top 3 causes of pregnancy-related deaths by time—postpartum

Data from Pregnancy Mortality Surveillance System, United States, 2011-2015
Racial/Ethnic Inequities

- Pregnancy-related mortality ratio 2-3 fold higher in black and native populations than among white populations
- Inequity was greater for postpartum deaths
- Severe morbidity postpartum: 40% higher in black v. white women

Peterson MMWR 2019 Liese J Racial and ethnic health disparities 2019

Image: Jared Rodriguez / Truthout
Maternal Health Continuum

- Healthy Moms
- Minor Complications
- Severe Morbidity
- Death
Mental Health and Quality of Life Postpartum

- 89% of new Australian moms report 1 or more sexual health issues in first 3 months postpartum
  - 30% had persistent pain at 12 months
  - 51% low libido at 12 months (versus 42% prior to pregnancy)
- 1-7% of new moms meet criteria for new onset PTSD after delivery
- 1 in 9 moms meet criteria for postpartum depression

Chronic Disease Risk Postpartum

- Mean postpartum weight retention at 12 months: 11.8 pounds
- 75% of women heavier postpartum
- US prevalence of pregnancy complications leading to increased cardiovascular risk
  - Hypertensive disease of pregnancy: 9%
  - Gestational Diabetes: 6-9%
  - Preterm Birth: 10%

CDC PRAMS and Vital Statistics Data
Postpartum Visit and Primary Care Postpartum

- Postpartum visit rate US: 90%
  - Lower for women with insufficient prenatal care and lower education

- Primary care visits within 12 months of delivery
  - Medically complicated, Medicaid: 57%
  - Routine, Medicaid: 52%
  - Medically complicated, Private Insurance: 60%
  - Routine, Private insurance: 50%

CDC PRAMS data 2015; Bennett JGIM 2014
Patient Perspectives

- **Health consequences of pregnancy as perceived by mothers and clinicians**, Seattle, Focus groups, 1998
  - Insufficient knowledge about postpartum health (both groups)
  - Wanted more maternal health info
  - Concerned about improving their economic status as a way to health

- **Listening to Mothers**, US online survey of over 1000 mothers, 2012
  - 10% no postpartum visit
  - 24% no contact number for health concerns
  - 43% insufficient information about family planning
  - 70% insufficient information about sexuality

- **Fourth Trimester Project**, Stakeholder meeting 2016
  - Imbalance between intensity prenatal and postpartum care
  - **Practice guidelines not aligned with lived experience**
  - Comprehensive care difficult to achieve
  - Six important postpartum themes: mood, medications/substances, physical recovery, sleep, sexuality/reproduction, infant feeding

#1 “WOW! You have a BIG baby!”
- Induction at 41-1
- Failed epidural during transition
- Cephalopelvic disproportion- emergency Csection
- Complications: Postpartum depression, postpartum pain/ lower extremity weakness, no milk production, postpartum hypertension

#2 “Placenta what?”
- 18 week anatomy scan discovered complete placenta previa and increta
- 22 weeks of pelvic rest and no exercise
- Planned c-section at 34 weeks, vertical incision, uterine embolization, hysterectomy.
- Witnessed my daughter’s respiratory arrest/resuscitation in the OR
Postpartum Recovery: Immediate/Eary

First Pregnancy
- Lower extremity weakness
- Back pain (meningeal irritation)
- Delayed bonding
- Shock/ “Stress”/ depression
- No milk
- Postpartum hypertension,
- 70lb weight gain

Second Pregnancy
- Pain
- Allergic reaction to vacuum dressing adhesive, limited ability to manage pain due to frequent trips to NICU and nowhere for me to rest while spending time there
- Prolonged lifting restriction of 6 weeks
Postpartum recovery: Late

2-6 weeks:
- Exhaustion (slow to heal)
- Back pain
- Anxiety
- Sexual dysfunction/severe pain

6 weeks - 1 year:
- Anxiety
- Sexual dysfunction
- Back pain/core instability (3+ diastasis)
- De Quervaine’s

>1 year:
- Persistent sexual dysfunction/low drive,
- Back and hip pain,
- Increased anxiety, insomnia, intrusive thoughts. PTSD diagnosis did not come until 2 1/2 years postpartum
- De Quervaine’s release
- Difficulty losing weight
- Infertility
“See you in 6 weeks...”
Recommendations for Establishing a Smooth Transition Between Postpartum and Well-Woman Care
The 4\textsuperscript{th} Trimester Project Recommendations

- Continuum of care
- Tailored care
- Compassionate, culturally sensitive and nonjudgmental communication
- Innovative approaches

Tully J Behav Med 2018; 4th trimester.web.unc.edu
ACOG: Redefining the Postpartum Visit

- “Ongoing process” versus single encounter
- Services and support tailored to individual needs

ACOG Committee Opinion 736 2018

<table>
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<tr>
<th>Postpartum Process</th>
<th>Contact with all women within first 3 weeks</th>
<th>Ongoing follow-up as needed 3-12 weeks</th>
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<td>BP check 3-10 days</td>
<td>High risk f/u 1-3 weeks</td>
<td>Comprehensive postpartum visit and transition to well-woman care 4-12 weeks, timing individualized and woman-centered</td>
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6-Week Visit

- Traditional period of rest and recuperation from birth 0-6 weeks
- 6-week visit
ACOG Provider Guidelines for Transition to Well-Woman Care

- Identify provider for ongoing primary care/medical home
- Make appropriate referrals
- Ensure appropriate communication with primary care provider
- Provide written recommendations of the above to patients, the health care team and in the medical record
CDC Recommendations for Providers

- Provide high-quality care for mothers up to one year after birth, which includes communicating with patients about warning signs and connecting to prompt follow-up care.
- Help patients manage chronic conditions
- Communicate with patients about warning signs
- Use tools to flag warning signs early so women can receive timely treatment

Peterson EE, et al., 2019
Strategies to Improve the Transition from Postpartum to Well Woman Care
Some easy ways to individualize care...

- Read your patient’s chart before going in the room!!
  - Be sensitive to secondary infertility.
  - Informed providers are safer providers and inspire confidence in patients.
- Ask questions:
  - What are you most concerned about today?
  - How have you processed your difficult birth experience?
  - Are you feeling shocked or traumatized by your birth?
- Postpartum changes in mood (Depression, anxiety, PTSD), sexual dysfunction, energy level, wound healing can last far beyond 6 weeks.
- Continuity of care should be available to the high risk/MFM patient beyond the 6 week follow up.
Individualizing care continued

- “Common” ≠ “normal”
- Be aware the tendency to become desensitized to things your patients find distressing (some normal and some abnormal). YOU may be distressed if it was happening to YOU.
- There’s no such thing as too much empathy!
- Be savvy with local resources and what types of help they can offer. (i.e. postpartum mood disorders, pelvic PT, counseling, support groups, education)
- Discuss common early complications of childbirth and when it’s reasonable to pursue additional medical (shock/depression/anxiety/PTSD, incontinence, sexual dysfunction, diastasis recti, back/hip pain, etc)
Pelvic PT is more than just good kegels...

- Benefits to doing kegel exercises:
  - Ease menopausal symptoms
  - Provide support to several organs
  - Facilitate normal vaginal delivery
  - Prevent or control urinary incontinence
  - Improve sex health
  - Restore erectile function
  - Ease prostate problems

Images depict various benefits of kegel exercises, including improved bowel and bladder control, better sexual health, and overall physical health.
Be Aware of and Share Other Resources

- Research Studies
- Local and County Resources
- National/International Support groups (facebook, pinterest, google)
  - https://www.hopeforaccreta.org
  - Maternal Near Miss Survivors Facebook
  - 4th Trimester Project (facebook); @4thtrimesterproject (Twitter)
  - Postpartum support international: psichapters.com
  - Multiple Other Links to National Support groups: https://pqcnc-documents.s3.amazonaws.com/aim/PQCNCOBHPHRResources20180327.pdf
The North Carolina Experience

Community Health Partners
North Carolina: Working to Improve Postpartum Visit Attendance

- Successful clinical strategies to improve postpartum visit attendance in the North Carolina Medicaid population:
  - Schedule postpartum visit(s) during late 3\textsuperscript{rd} trimester visits
  - Ensure patients leave hospital with postpartum follow-up scheduled, if not arranged earlier
  - Bring patients back early
    - 1-2 weeks if warranted (high risk of depression, blood pressure check, operative delivery, lactation difficulties)
    - 3-4 week comprehensive postpartum visit
  - Reminder texts, personalized notes, phone calls
  - Quick follow-up for any missed visits
North Carolina: Working to Improve Postpartum Visit Attendance

- Provider-focused strategies to improve postpartum visit attendance:
  - Incentives to providers for timely postpartum follow-up (within 60 days of delivery) with expectations:
    - Screen for postpartum depression
    - Address reproductive life plan, including access to the desired contraceptive method
    - Ensure warm hand-off to ongoing source of primary care
  - Ongoing quality improvement support, including access to timely data, to “hardwire” strategies such as missed visit calls
North Carolina: Improving quality of postpartum care

- Statewide network of “physician champions” – local opinion leaders to offer peer support, educate on best practices and emerging evidence, and bring local feedback to state level

- Physician champions representing multiple health systems and practice settings (public/private) collaborate to develop standardized, evidence-based guidance and disseminate best practices (care pathways)
North Carolina: Developed Pathway for Ensuring a Transition to Well Woman Care


Provide all patients with guidance about value and timing of primary care follow-up.

- Yearly visits for all women
- More frequent for women with medical complications such as diabetes or hypertension
- Identify appropriate care setting for continuing primary care outside of pregnancy, within the current practice or provide referral.

Note: practices should identify and be able to provide a list local safety net providers for those patients with under-/un-insurance ([https://www.freeclinics.com/](https://www.freeclinics.com/), [https://findahealthcenter.hrsa.gov/](https://findahealthcenter.hrsa.gov/))
Have a Health Equity Lens

- Ask yourself: “How would your interventions be modified if you could not claim success without racially equitable outcomes?”
- Integrate social determinants into plan
- Challenge your own implicit biases
- Resources:
  - Implicit Bias Testing: [https://implicit.harvard.edu/implicit/takeatest.html](https://implicit.harvard.edu/implicit/takeatest.html)
  - Black Lives Matter: Claiming a space for evidence-based outrage in obstetrics and gynecology: [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5024373/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5024373/)
  - Black Mamas Matter Toolkit: [https://blackmamasmatter.org/toolkit-download/?download_nonce=24bdb044ef](https://blackmamasmatter.org/toolkit-download/?download_nonce=24bdb044ef)
Treat the Postpartum Visit as an Opportunity for Well Woman Care

- Pap ≠ Well Woman Care
- Available Resources
Chronic Disease Support

- Patients may not be transitioning to “well” woman care but to primary care for chronic disease management.

- Strategies for postpartum women with chronic disease:
  - Early and ongoing postpartum follow-up
  - Access to a local provider in the patient’s community
  - Community-based supports, such as care management, pharmacy support, behavioral health, especially for vulnerable populations
  - Optimize reproductive life planning to align patient’s reproductive intentions with disease management priorities
Optimize Billing and Advocate for Better Coverage

- **Ideal World**
  - 1-14 days: incision check, mood screen, BP monitoring, review of complications, lactation support
  - 15-60 days: contraception, mood screen
  - 60-90 days: full preventive visit equivalent to annual exam

- **Routine** global fee (59400, 59510), postpartum package (59410/59515) or postpartum only (59430) covers 1-2 clinic visits
  - Problem visits can and should be coded as E&M visits with the appropriate ICD10 even within the global period (e.g. Mastitis, Postpartum Depression, Pelvic Pain)
  - Enrollment in Family Planning Medicaid after Pregnancy Medicaid ends in non-expansion states

- **Disconnect? → Advocacy**
Consider Alternate Models: Group Prenatal Care

- Long-term (2 years later) changes in behavior related to nutrition, parenting and family communication

- Improved postpartum contraception uptake

- Improved perception of peer support and improved breastfeeding rates

Hackley J Midwifery Women’s Health 2019; DeCesare J Reprod Med 2017; Chae Arch Womens Mental Health 2017
Consider Alternate Models: Pregnancy Complications Clinics

- Maternal Health Clinic, Ontario Canada
  - Invites all women with gestational diabetes, hypertensive diseases in pregnancy, growth restriction, preterm birth, and placental abruption
  - Cardiovascular risk screening done at 6 month postpartum appointment
  - Communication provided to primary care doctor
  - Follow-up for high risk women with cardiology, lifestyle recommendations and Cardiac Rehab


Cusimano AJOG 2014
Consider Alternate Models: Doula Programs

- Investigational approach to improve birth and postpartum outcomes especially among women of color
  - Chicago: postpartum home visiting support with doulas improved some infant safety behaviors
  - New York City Healthy Start: 4 postpartum visits over 6 months 1-2 hours long
    - “I would’ve had no one there; it was just me and her. If it wasn’t for her, maybe I wouldn’t even get through it, because she really helped a lot”

Hans Mat Child Health J 2018; Thomas Mat Child Health J 2017
AWHONN developed post-birth warning signs educational tool

- Majority of nurses surveyed: “helpful” and “easy to use”
- Available in English, Spanish, Arabic, and Mandarin: [https://www.awhonn.org/page/POSTBIRTH](https://www.awhonn.org/page/POSTBIRTH)

Suplee Nursing for Women’s Health 2016
Conclusions

- The transition to well woman care has public health and quality of life importance
- The transition to well woman care is frequently suboptimal
- Simple changes can significantly improve quality of care
- Postpartum care providers should aim for:
  - Excellent communication before and after pregnancy
  - Patient-centeredness
  - A health equity lens
  - Willingness to think outside the box
  - Advocacy for better coverage
References

References

Q&A Session
Press *1 to ask a question

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Your line will be unmuted by the operator for your turn

*Please note: this teleconference is being recorded. Comments from speakers and participants will be live on the website shortly.*

A recording of this presentation will be made available on our website:
www.safehealthcareforeverywoman.org
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Obstetric Drill Program for
Postpartum Hemorrhage

Friday, June 14
2 pm Eastern

Tamika C. Auguste, MD, FACOG
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MedStar Health
Associate Professor, Obstetrics & Gynecology
Georgetown University School of Medicine

Shad Deering, MD, Colonel (retired), FACOG
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