Timely Postpartum Care Guidance Document

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This document is a resource to help Coordinated Care Organizations (CCOs), health systems, quality improvement professionals, and providers improve their approach to the Timely Postpartum Care measure. This document will be updated as appropriate to reflect any changes in policy, regulation, and measurement.

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Why Is This Measure Important?

The postpartum period is critical for creating a foundation of lifelong health for women and infants. Postpartum care visits provide important opportunities to assess the mother's physical and psychosocial well-being, and to connect the mother and infant to ongoing care and services.

Postpartum care is essential because, in the weeks after birth, a woman is at risk of serious and sometimes life-threatening complications and must adapt to multiple physical, social, and psychological changes. She must recover from childbirth, adjust to changing hormones, and learn to feed and care for her newborn. In addition to joy and excitement, new mothers face fatigue, stress, physical pain, depleted iron stores, depression, breastfeeding challenges, lack of sexual desire, and urinary incontinence. Some women experience a loss, such as a miscarriage or fetal or neonatal death, and have unique needs. Women may be working to maintain healthy prenatal behaviors (such as tobacco cessation), lose their postpartum weight, and address their reproductive health needs. Women may need to navigate preexisting health issues, such as diabetes, hypertension, obesity, substance use disorders, intimate partner violence, and other concerns.[1] Additionally, many women are returning to work in the early postpartum period. In the United States, 23% of employed women return to work within 10 days postpartum, and an additional 22% return to work between 10 days and 40 days.[2] Furthermore, during the postpartum period, medical care transitions and linkages to ongoing care and services are important.

Despite longstanding recommendations on postpartum care, in 2017, data reported by coordinated care organizations (CCOs) showed that statewide, only about half of women enrolled in a CCO received a postpartum care visit on or between 21 and 56 days after delivery.[3] Attendance rates may be even lower among populations with limited resources[4] and women with complicated pregnancies.[5]

Women report a number of barriers to receiving postpartum care. The Listening to Mothers survey, a national survey of mothers who gave birth in US hospitals, reports that the leading reasons why women did not have a postpartum office visit were that "I felt fine and didn't need

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[1] American College of Obstetricians and Gynecologists' Presidential Task Force on Redefining the Postpartum Visit and the Committee on Obstetric Practice https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care?IsMobileSet=false

[2] Abt Associates. Family and Medical Leave Technical Report, 2012. https://www.dol.gov/asp/evaluation/fmla/FMLA-2012-Technical-Report.pdf

[3] Oregon Health System Transformation: CCO Metrics 2017 Final Report https://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/2017-CCO-Metrics-Report.pdf

[4] Bryant AS, Haas JS, McElrath TF, McCormick MC. Predictors of compliance with the postpartum visit among women living in healthy start project areas. Maternal Child Health J 2006; 10:511–6.

[5] https://www.hopkinsmedicine.org/news/media/releases/fewer_than_half_of_women_attend_recommended_doctors_visits_after_childbirth_

to go" (42%), followed by "I felt that I had already completed all of my maternity care" (18%), "too hard to get to office" (12%), and "didn't have insurance" (7%).[6] In Oregon, five listening sessions were conducted with women of reproductive age to better understand their experiences of preventive care. Participants described the following barriers to receiving preventive care: Health care provider and staff attitudes; distrust/fear of health care providers; preventive care not being a priority for women; lack of culturally appropriate care; discomfort with pelvic examinations; transportation issues and lack of childcare.[7] Postpartum care is often fragmented among health care providers, and communication between inpatient and outpatient settings is inconsistent.

The role of prenatal and postpartum care in achieving both improved maternal and child outcomes directs attention to the importance of a Life Course Perspective. The Life Course Perspective suggests that perinatal outcomes are determined by the entire life course of the woman prior to pregnancy, not just the nine months of pregnancy. Preconception, interconception, and well-woman care are important opportunities to assure that women are healthy before becoming pregnant, that pregnancies are intentional, and that pregnancies are spaced at intervals that promote healthy birth outcomes for babies and good health for mothers.

Timely postpartum care has been added to the CCO incentive measure set for 2019, evolving from previous work on timely prenatal care. Timely prenatal care was included in the CCO incentive measure set since the program began in 2013. However, given improvements in the rate of timely prenatal care among CCO members and data indicating postpartum care rates in the state were decreasing, the Metrics & Scoring Committee chose to incentivize timely postpartum care beginning in 2019.

The timely postpartum care measure is also a stepping stone to measuring the quality of postpartum care. The Health Plan Quality Metrics Committee (HPQMC)[8] has indicated its intention to measure the quality of the postpartum visit, with a new metric in place as early as 2021. Unlike the current measure, which simply assesses whether women attend a postpartum visit within a certain timeframe, the future measure would assess whether the postpartum visit includes four key components: breastfeeding evaluation and education; post-partum depression screening; postpartum glucose screening for patients with gestational diabetes; and

[6] http://transform.childbirthconnection.org/reports/listeningtomothers/

[7] Oregon Health Authority. Well Woman Care. Listening to Women and Health Care Providers. https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/DATAREPORTS/MCHTITLEV/Documents/OHA8234_WW_Report_Final.pdf

[8] HPQMC creates a menu of health quality measures from which the Metrics & Scoring Committee chooses the incentive measures for CCOs.

family planning and contraception. Incentivizing timely postpartum care visits in 2019 helps to set CCOs up for success when assessment of the quality of the visit begins in the future.

Measurement Details

Overview: Percentage of live birth deliveries for which there is a subsequent, timely postpartum visit.

Data Source:

Denominator (deliveries): Administrative data (MMIS/DSSURS)

Numerator (visits): MMIS/DSSURS, medical records (hybrid: chart review and claims)

Equation:

$$= \frac{\text{A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery}}{\text{All live birth deliveries with estimated delivery date (EDD) in the 'intake period': between November 6 of the year prior to the measurement year, and November 5 of the measurement year, and the members of the organization who meet the continuous enrollment criteria.}}$$

Continuous Enrollment Criteria: 43 days prior to the Estimated Date of Delivery (EDD) through 56 days after EDD with no gaps

Measurement Notes:

- OHA identifies the live birth deliveries from administrative data and provides CCOs with a random sample delivery list for the chart review (411 per CCO).
- Chart review criteria
  - ✓ A postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other primary care provider.
  - ✓ Documentation in the medical record must include a note indicating the date on which a postpartum visit occurred, and documentation of specific care provided (e.g., pelvic exam).

Detailed technical measure specifications, including information on codes, etc., can be found here: https://www.oregon.gov/OHA/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx

How Can CCOs Improve on This Measure?

Optimal postpartum care calls for increased collaboration to provide the needed support for a successful transition to motherhood. Partners include wrap-around clinical, behavioral, and physical health services; public health services including home visiting and Special Supplemental Nutrition Program for Women, Infants and Children (WIC); and, community organizations. Integrated services and seamless care transitions are necessary from preconception through well woman care.

The strategies presented here reflect information gathered from literature as well as reports from CCOs, health care providers, public health professionals and other partners. The strategies include a range of evidence-informed strategies, best practices, and innovations.

Legend

* CCO strategy
* Clinic strategy
* Community strategy

Care Delivery Strategies

Provide patient education and outreach

* Send educational mailings on the importance of postpartum care to members.

* * * Partner with the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) to provide education on the importance of prenatal and postpartum care, postpartum nutrition, lactation services and supplemental foods.

* * * Partner with Oregon MothersCare (OMC). OMC provides patient navigation to newly pregnant women, assisting with insurance enrollment, and referring them to prenatal care, WIC services, dental care, home visiting services, and other pregnancy resources. These services are currently provided at 29 sites serving 26 counties.

  * Provide anticipatory guidance about the postpartum period and importance of postpartum care during prenatal care visits.

Offer peer support

* * * Partner with Traditional Health Workers who provide patient navigation, encourage self-advocacy for women, and help improve communication between patients and providers.

* * * Establish a doula program so that doulas can provide perinatal women with physical and emotional support and assist women with scheduling and keeping appointments.

Offer enhanced Maternity Care models[9] including:

* * Offer Centering Pregnancy/group visits – group prenatal care that incorporates peer-to-peer interaction in a facilitated setting for health assessment, education and psychosocial support.

* * Provide prenatal care at birth centers – comprehensive prenatal care facilitated by teams of health professionals including peer counselors. Services include collaborative practice, intensive case management, counseling and psychosocial support.

* * Establish Maternal Medical Homes – enhanced prenatal care including psychosocial support, education and health promotion in addition to traditional prenatal care. Services provide expanded access to care, improved care coordination and provide a broader array of health services.

Provide comprehensive case management and care management

* * * Offer activities such as: outreach; initial and ongoing assessments; interventions and educational activities; links to and recommendations for community services and resources; and, scheduling appointments.

* * * Provide case management by phone, in the office or at home by CCO or clinic staff or by partnering with existing home visiting programs that provide case management services. These include Nurse-Family Partnership, Babies First! and Healthy Families Oregon.

Facilitate access to appointments

* Provide women with transportation to their prenatal care and postpartum care visits. Proactively communicate and support women in accessing the non-emergency medical transportation available to all Oregon Health Plan members.

* * * Offer home visits. Intervention could include CCO or clinic staff providing home visits or partnering with existing public health nurse home visiting programs including Babies First! and Nurse-Family Partnership.

* * * Offer telehealth visits.

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[9] CMS Strong Start for Mothers and Newborns: Findings at a Glance
https://innovation.cms.gov/Files/reports/strongstart-prenatal-fg-finalevalrpt.pdf

* * * Provide interpretation services as needed.

* * Schedule postpartum visits during prenatal care, before hospital discharge, by phone after hospital discharge, or at early newborn care visits.

* * Provide postpartum care at the newborn visit or schedule postpartum visits back-to-back with newborn visits if at same site.

* * * Follow-up with women who miss appointments and identify and address barriers.

* * * Provide childcare for prenatal and postpartum care visits.

Use technology and incentives

* * Use email, texts, or apps to remind women to schedule postpartum follow-up. Text4baby is a free mobile information service that promotes maternal and child health through text messaging.

* * Use incentives to motivate women to seek prenatal and postpartum care. Potential interventions could include direct financial incentives or items such as baby supplies.

* * Use data to identify women who are due for care or have missed appointments.

Payment Strategies

* Provide guidance to providers on documentation and billing codes for prenatal and postpartum care visits.

* Develop mechanisms to encourage providers to prioritize postpartum care visits such as paying more for postpartum visits.

* Provide bonuses for priority components of postpartum care that may not be incentivized, such as lactation support, or screening and treatment of maternal depression.

* Consider reimbursement strategies that support mom-baby dyad visits.

Spotlights

Maternal Medical Homes

Yamhill Community Care

Yamhill County Health and Human Services and the Yamhill CCO have collaborated to create a Maternal Medical Home. Goals of the program include in-office behavioral health and public health case management and home visiting services, streamlining referral services, and strengthening relationships between patients and primary care providers. For more information, contact Lindsey Manfrin by email at manfrinl@co.yamhill.or.us

Primary Health of Josephine County

Primary Health has partnered with Women's Health Center of Southern Oregon to develop a maternal medical home. Efforts include population health monitoring, risk stratification, care management collaboration, warm hand-offs and integration of behavioral health services, and dental referrals.

Incentives

AllCare CCO

The Babe Store provides a store front where women can redeem vouchers they receive for attending medical appointments, classes, WIC appointments, and receiving home visits. Vouchers are given to women by community partners and health care providers and can be redeemed for supplies such as diapers, wipes, and breastfeeding supplies. The Babe Store model also incorporates telephone outreach to all pregnant AllCare members to engage them in the voucher program and in care coordination based on their risk level.

Jackson Care Connect

Starting Strong offers incentives for Jackson Care Connect members who are pregnant and/or parenting and children up to four years of age. Members can receive vouchers from community partners and providers for taking actions like: Attending prenatal, post-partum and dental appointments, well-child check-ups; attending childbirth preparation, parenting, nutrition and diabetes management classes; and, keeping appointments with social workers, counselors, and at WIC. A certified Community Health Worker/Certified Lactation Counselor/trained Peer Support Specialist provides guidance, support and case management services to members at the office location where vouchers for items like diapers, wipes, car seats, breastfeeding supplies, home safety items, and cooking supplies can be redeemed. For more information and current program materials, contact Riki Rosenthal by email at startingstrong@jacksoncareconnect.org or rosenthalr@careoregon.org.

Columbia Pacific CCO

The First Steps program provides Amazon.com gift cards to pregnant women for attending prenatal visits and reducing tobacco use. Reward activities include:

- $10 for every prenatal (pregnancy) appointment (up to 15)
- $25 for having your first prenatal appointment before your 12th week of pregnancy
- $25 for reducing tobacco use
- $50 for quitting tobacco use
- $10 for every postpartum visit (up to 3)
- $25 for dental visits
- And more!

For more information: http://www.colpachealth.org/for-members/wellness-benefits/first-steps

Case Management

Central Oregon Perinatal Care Coordinators

Crook, Deschutes, and Jefferson Counties, and the Central Oregon Health Council collaborated to develop and implement a regional approach to a perinatal continuum of care model. The system includes prenatal high-risk nurse home visiting services and linkage to community resources provided by a team of public health care coordinators embedded in specific obstetrics provider clinics throughout the community.

Trillium Community Health Plan Start Smart for Your Baby Program offers phone-based case management and support to pregnant members. Services are determined by an assessment of risk. The care coordinators and case managers exchange treatment plans with the members' providers. Postpartum support is offered to all members in addition to being given a postpartum and Edinburgh depression assessments.

For More Information

- Centers for Medicare and Medicaid Services. Maternal and Infant Health Initiative. Resources on Strategies to Improve Postpartum Care Among Medicaid and CHIP Populations https://www.medicaid.gov/medicaid/quality-of-care/downloads/strategies-to-improve-postpartum-care.pdf

- National Partnership for Women and Families. Transforming Maternity Care. http://transform.childbirthconnection.org/blueprint/paymentreform/recommendations/

- CCO Metrics & Scoring Committee. https://www.oregon.gov/OHA/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx

- For questions about this document, please contact the OHA metrics team at metrics.questions@dhsoha.state.or.us