Best Practices from ACOG Postpartum Visit

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Disclosures

No financial disclosures

Goals and Objectives

- New paradigm of postpartum care
- Components of postpartum care
- Implementation of postpartum care

Things we will not talk about

- Coding
- Billing/reimbursement
- Maternal mortality and postpartum care
- Work/paid leave
- Training
- Research directions

Why focus on postpartum care?

- Largely ignored in past
- Sets stage for long-term health and well-being
- Fragmentation between maternal and pediatric care
- > 50% of maternal deaths occur postpartum
- Major ACOG initiative in 2017

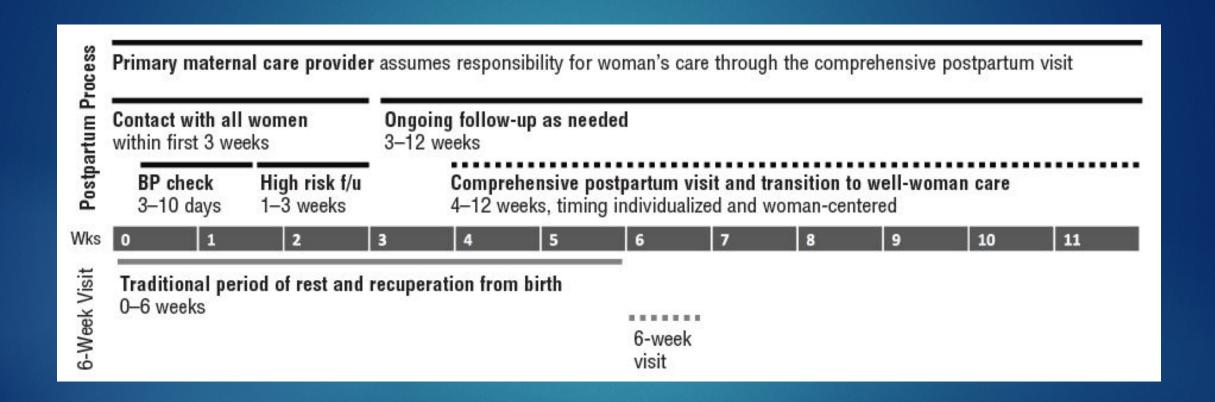
Postpartum Period

- Multiple changes
 - Recovering physically
 - Adjusting to hormonal changes
 - Learning to feed and care for newborn

- Multiple challenges
 - Lack of sleep/fatigue
 - Pain
 - Breastfeeding difficulties
 - Stress
 - Exacerbation/new onset mental health issues
 - Lack of sexual desire
 - Incontinence

Redefining postpartum care

- Overarching Principles
 - Not the end of a medical event, but a beginning
 - Ongoing process, not a single encounter
 - ▶ Tailor process to individual needs
 - Ideal
 - Initial assessment within 3 weeks
 - Ongoing care as needed
 - Comprehensive visit no later than 12 weeks postdelivery



Increasing engagement

- 81% of commercially insured have postpartum visit
- ▶ 50% of Medicaid-insured have a postpartum visit
- Uninsured/self pay likely much lower
- Result:
 - Undermanagement of chronic illnesses
 - Access to contraception

Why poor attendance?

- Inconvenient for new mother
- Competing priorities
- Not sure of purpose
- Previous poor experience with visit
- Unresolved trauma about birth experience
- Fear of scolding
- No connection with provider
- Improper framing: end of health care event rather than beginning of rest of woman's life

Prenatal preparation

- Discussion topics
 - Infant feeding
 - "Baby blues"
 - Emotional health
 - Challenges of parenting
 - Postpartum recovery
 - ▶ Long-term mgmt. of chronic health conditions
 - Expectations for pain management

Transition from intrapartum to postpartum care

- Postpartum care plan reviewed after birth
 - ▶ ¼ women in US did not have provider phone number for concerns
 - Need primary point of contact
- Hypertension
 - ► HDP- seen within 7-10 days
 - Severe HTN- seen within 72 hours
- What is a "visit"?
 - Office visit, home support, phones/text, remote BP monitoring, app based support
 - "Contact' by 3 weeks postpartum

Transition from intrapartum to postpartum care

- Hypertensive disease of pregnancy
 - Contact within 1 week
- Severe hypertension
 - Contact within 3 days
- Epidemic of readmissions for postpartum hypertension
 - Strategies to reduce?
 - More liberal use of anti-hypertensives postpartum?
 - Remote BP monitoring?
 - ► Lasix?
 - Apps/texting?

Comprehensive well woman visit

- Timing should be individualized
 - ▶ 4-12 weeks post-partum
 - Serves as transition point to well-woman care

Components of comprehensive exam

- Immunizations
- Incontinence
- Pain and sexual function
- Breastfeeding
- Reproductive life planning and contraception
- Depression screening
- Intimate partner violence
- Substance abuse
- Weight and exercise
- Chronic medical problems
- Future pregnancies

Immunizations

- Postpartum is a good time to revisit recommended vaccinations
- ▶ Tdap for mom if not given in 3rd trimester
 - Household contacts/caregivers
- Influenza if flu season and not already vaccinated
- All vaccines fine in breastfeeding except smallpox
- Resource: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html

Urinary Incontinence

- Incidence: 3-40% in postpartum women
- Most resolves within 3 months of delivery
 - Roughly 10% persists
- Risk factors: vaginal delivery, prolonged 2nd stage, age, parity, ZBMI, macrosomia
- Screening: discussed with all women v standardized questions
- Diagnosis: symptoms + physical exam; r/o UTI
- Treatment: etiology first; FPMRS, Kegel's, pelvic PT (?)

Do you usually leak urine when you cough, laugh or sneeze?	Yes	No
	Vaa	NE
Do you usually leak urine when you have a strong urge?	Yes	No
Do you feel like you need to urinate more often than you should?	Yes	No
Do you ever have a feeling that your bladder does not empty completely?	Yes	No
	V	
Do you ever have a bulge that you can see or feel in your vaginal area?	Yes	No
Do you ever experience pressure or heaviness in the pelvic area?	Yes	No
Do you ever have to push up on the vaginal area to empty your bladder or move		
your bowels?	Yes	No

Fecal incontinence

- Incidence 10%
 - ► OASIS in 18% of vaginal deliveries
 - ▶ 13-25% of these will have some incontinces
- Risk factors similar to UI (plus forceps)
- Screening: we need to ask!
- Diagnosis: physical exam and endoanal sonography
- Treatment: etiology first

Perineal pain, dyspareunia, sexual function

- Pain- up to 10% at 1 year post vaginal delivery
- Dyspareunia- 17% 6 months after delivery
- Risk factors: operative delivery, laceration, breastfeeding (hypoestrogenic)
- Screening: We need to ask!

Breastfeeding

- Improving in US- numerous health benefits
 - ▶ 81% breastfed to start; >50% at 6 months
- Factors associated with not breastfeeding: age, race, poverty
- Review health history and medications (LactMed)
- Contraception discussion (wait 1 month for combined OCP's)
 - Lactational amenorrhea- fully breastfeeding + amenorrhea is reasonable contraception for 6 months
- Lactation consultants

Reproductive life planning and contraception

- "One key question"- would you like to become pregnant in the next year
- Contraception counseling
- Interpregnancy interval

Fertility and lactation

- Lactational amenorrhea (Bellagio consensus)
 - Breast feeding can be used for birth spacing if 3 criteria are mot
 - Amenorrhea
 - Fully or nearly fully breastfeeding (no interval of > 4-6 hours before breastfeeding)
 - <6 months postpartum</p>

Birth spacing and risk of adverse perinatal outcomes (JAMA 2006)

- Meta-analysis/Meta-regression
 - 67 observational studies included
- ▶ IPI < 6mos
 - ↑ preterm birth (OR 1.4)
 - ↑ low birth weight (OR 1.6)
 - → ↑ small for gestational age (OR 1.3)
 - Also increased risk with IPI 6-18 months
- ▶ IPI > 60 mos
 - ↑ preterm birth (OR 1.2)
 - ▶ ↑low birthweight (OR 1.4)
 - → small for gestational age (OR 1.3)
- ▶ Ideal IPI 18-59 months

Postpartum Depression

- Incidence: 11-20%
- Risk factors: depression, anxiety, stressful events, PTD/NICU, low support, breastfeeding issues
- Screening: use a validated tool
 - Edinburgh Postnatal Depression Scale
 - Beck Depression Inventory
- Treatment: peer counseling, cognitive therapy, anti-depressants
 - ▶ OB providers seem to be more comfortable prescribing anti-depressants
 - Should see improvement in EPDS or other tool

Perinatal Behavioral Health Service at Wash U

- Joint program between adult and child psychiatry, social work, psychology
- Started as program for mothers in NICU
- Expanded to high-risk pregnant mothers (fetal anomalies)
- Now screen all of our postpartum mothers in house and see any prenatal consultations with follow-up
 - Cognitive therapy and meds
- Funded by grants and hospital foundations

Intimate Partner Violence

- Definition: "physical, sexual, or psychological harm by a current or former partner or spouse"
- Prevalence: lifetime risk of 25% and occurs in all groups
- Women in military and vets seem to be at increased risk

Framing Statement

"We've started talking to all of our patients about safe and healthy relationships because it can have such a large impact on your health."*

Confidentiality

"Before we get started, I want you to know that everything here is confidential, meaning that I won't talk to anyone else about what is said unless you tell me that...(insert the laws in your state about what is necessary to disclose)."*

Sample Questions

- "Has your current partner ever threatened you or made you feel afraid?" (Threatened to hurt you or your children if you did or did not do something, controlled who you talked to or where you went, or gone into rages.)†
- "Has your partner ever hit, choked, or physically hurt you?" ("Hurt" includes being hit, slapped, kicked, bitten, pushed, or shoved.)†

▶ For women of reproductive age:

- "Has your partner ever forced you to do something sexually that you did not want to do, or refused your request to use condoms?"*
- "Does your partner support your decision about when or if you want to become pregnant?"*

Substance abuse

- Opioids, other drugs, alcohol
 - Impaired parenting, depression/mental health, poor nutrition/homelessness
- ▶ Smoking- 18% in US
 - ▶ SIDS, asthma/wheeze
- Routine screening and referral as needed

Box 2. Clinical Screening Tools for Prenatal Substance Use and Abuse =

4 Ps*

Parents: Did any of your parents have a problem with alcohol or other drug use?

Partner: Does your partner have a problem with alcohol or drug use?

Past: In the past, have you had difficulties in your life because of alcohol or other drugs, including prescription medications?

Present: In the past month have you drunk any alcohol or used other drugs?

Scoring: Any "yes" should trigger further questions.

NIDA Quick Screen[†]

Screen Your Patients

Step 1. Ask patient about past year drug use—the NIDA Quick Screen

Step 2. Begin the NIDA-Modified ASSIST

Step 3. Determine risk level

Conduct a Brief Intervention

Step 4. Advise, Assess, Assist and Arrange

CRAFFT—Substance Abuse Screen for Adolescents and Young Adults*

C Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs?

R Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?

A Do you ever use alcohol or drugs while you are by yourself or ALONE?

F Do you ever FORGET things you did while using alcohol or drugs?

F Do your FAMILY or friends ever tell you that you should cut down on your drinking or drug use?

T Have you ever gotten in TROUBLE while you were using alcohol or drugs?

Scoring: Two or more positive items indicate the need for further assessment.

Alcohol

- Third leading cause of preventable deaths for women
- 55% of non pregnant women use alcohol in past 30 days
- Estimated prevalence of binge drinking in last 30 days 18%
- Women who stop during pregnancy very likely to restart

TACE Screening

- ▶ T-Tolerance: How many drinks does it take to feel buzzed? (2 points)
- A-Annoyed: Have people annoyed you by criticizing your drinking?
 (1 pt)
- C- Cut down: Have you ever felt you should cut down on drinking?
 (1 pt)
- ► E: Eye-opener: Have you ever had a drink first thing to steady nerves or quell a hangover? (1pt)
- 2 or more points is a positive screen

Tobacco cessation

- ▶ 5-A model
 - Ask, Advise, Assess, Assist, Arrange
 - ▶ Takes less than 5 minutes
 - Physicians, nurses, assistants can all employ
 - Markedly increases cessation rates
- Resource:
 - ▶ Tobacco use and Womens Health- ACOG

Healthy weight

- ► Obesity: BMI > 30
 - ▶ 65% of women are overweight or obese
- Risk factors: sedentary lifestyle, high calories, family history
- Physical activity in pregnancy is good
- Postpartum women
 - ▶ 150 min of moderate exercise per week
 - ▶ 20-30 minutes per day

Healthy weight

- Uncomplicated vaginal delivery
 - Don't have to wait 6 weeks
 - Individualize care- exercise can start earlier
- Uncomplicated cesarean
 - ► Full activity by 4-6 weeks
 - Individualize care
- Breastfeeding
 - Need additional calories
 - Exercise does not effect production

Weight- Practical advice

- Normalize the topic and be patient centered
 - "One of the things we talk about with every woman is weight- Have you thought about a weight that would be a good goal for you?"
- Don't talk BMI
- Don't stress the negative- "overweight, obese, morbidly obese"
 - Stress healthy weight
- Be reasonable- maybe start with discussing losing weight gained during pregnancy
- Nutritionist, diet, exercise

Chronic Medical Problems

- Some can be exacerbated or flare in postpartum period
 - Cardiomyopathy
 - Multiple sclerosis
 - Rheumatoid arthritis
 - Asthma
- Work toward early visit with medical specialist to develop treatment and follow up plan

Chronic Medical Problems

- Some will require rapid changes in medication dosage
 - Hypothyroidism
 - Diabetes
 - Hypertension (if superimposed pre-e)
- Some can be effectively treated after pregnancy
 - Hepatitis C

Pregnancy Outcomes and Future Health

Adverse Pregnancy Outcomes at CV Disease

- Systematic Review- 2017
 - ▶ 22 studies included (6.4 mil women)- pre-ecs and later CV disease
 - ▶ Heart failure RR 4.19, 95% CI 2.09-8.38
 - Coronary heart disease RR 2.50, 95% CI 1.43-4.37
 - ▶ Death from cardiovascular disease RR 2.21, 95% CI, 1.83-2.66
 - Stroke (RR 1.81, 95% CI 1.29-2.55)
- Other factors
 - Severity of pre-eclampsia
 - Gestational age at delivery
 - # of recurrences

Adverse Pregnancy Outcomes and CV Disease

- Other APO's to consider
 - ▶ GDM
 - Preterm birth
 - Growth restriction
 - Miscarriage
- All associated with later cardiovascular disease

Adverse Pregnancy Outcomes and CV Disease

- Unanswered questions.....
 - Does it add significantly to risk prediction?
 - Much overlap with other established risk factors
 - Timing of increased risk? When should surveillance begin?
 - CV screening strategies in those with prior APO?
 - CV prevention strategies with prior APO?
 - Knowledge of internal Med docs of these associations?

Discuss Future Pregnancy Management

- Pre-eclampsia risk- baby ASA
- Prior PTD
 - ▶ 17-P
 - Vaginal progesterone
 - Cerclage
- Prior stillbirth
- ▶ Folic acid, healthy weight

More work, how to do it?

- Review prenatal and intrapartum record before visit
- Engage women- previsit assessments
 - ▶ Top 3 health concerns
 - **EPDS**
 - Desired weight
 - Future pregnancy?
 - Preferred contraceptive
- Train and optimize staff

Conclusion

- Increased focus on postpartum care from ACOG
 - Individualized visits
 - More flexibility and patient centerdness
 - Earlier visits for women with HTN