Improving Long-Term Health Outcomes for Women After Childbirth

Dear Colleague:

All primary care and women’s health practices care for a population of patients who have recently given birth. Historically, we have relegated the care of these women to obstetricians and midwives. However, prenatal findings and postpartum status are both critical data sets for primary care providers to review and potentially manage.

Why is Postpartum Care Significant?

There is a growing recognition of the importance of the postpartum visit both for monitoring the health of women with chronic illness and as a way to connect vulnerable women with the healthcare system.

Significant racial/ethnic disparities exist for diabetes, hypertension, and postpartum depression, with black/African American and Hispanic/Latina women versus white women having higher prevalence rates of all three conditions, experiencing a disproportionate burden of short- and long-term consequences of these diseases, and—in the case of postpartum depression—being one half as likely to receive treatment1–5.

Many low-income women with hypertension, diabetes, or other illnesses fail to get appropriate medical follow-up postpartum, putting their long-term health at risk. This is alarming, because pregnancy complications such as HTN and GDM have been associated with an elevated risk of cardiovascular disease events6.

In the case study above, the young patient may encounter the healthcare delivery system in one of multiple ways—obstetrics, gynecology, or family practice for contraceptive services and/or pediatrics for routine well care. At Healthfirst, our goal is a consistent approach to managing these patients and to identifying those women at risk for poor health outcomes. For the patient in this case study, there are multiple historical and examination considerations that could portend poor overall health outcomes.

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**Case Study**

A high-school-age patient returns six weeks postpartum. Her baby was born by NSVD and she is bottle feeding. The patient lives with and is helped by her mom, who holds the baby and does almost all the talking during the visit.

The patient entered prenatal care at 24 weeks, when she began to “show.” Her pregnancy was complicated by chlamydia, gestational diabetes. She was managed by the high-risk prenatal practice.

BP today is 141/73 and BMI is 38.27 kg/m²
- Physical exam OK.

**Plan**

✓ Gardasil initiated
✓ 2h GTT
✓ RTC three months to check contraception

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In this Spectrum of Health bulletin, we outline HEDIS requirements for postpartum follow-up and summarize current evidence that may be used as a foundation for assessment and management of women who are managed post childbirth.

Thank you for your care and service to this important population of our members, your patients.

Warm regards,

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HEDIS Standards for Postpartum Care: Minimum Medical Record Requirements

- Postpartum visit to an OB/GYN practitioner or midwife, family practitioner, or other PCP on or between the 21st day or between 21 and 56 days after delivery
- Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and at least one of the following:
  - Pelvic exam
  - Evaluation of weight, BP, breasts, and abdomen
  - Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component
  - Notation of postpartum care including, but not limited to: “postpartum care,” “PP care,” “PP check,” “six-week check”
  - A preprinted “Postpartum Care” form on which information was documented during the visit

2016 Codes that Represent Postpartum Care

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code Type</th>
<th>Bill Above?</th>
</tr>
</thead>
<tbody>
<tr>
<td>57170</td>
<td>Diaphragm, cap fitting</td>
<td>CPT</td>
<td></td>
</tr>
<tr>
<td>58300</td>
<td>Insert IUD</td>
<td>CPT</td>
<td></td>
</tr>
<tr>
<td>59430</td>
<td>Postpartum care only (separate procedure)</td>
<td>CPT</td>
<td></td>
</tr>
<tr>
<td>99501</td>
<td>Home visit for postnatal assessment and follow-up care</td>
<td>CPT</td>
<td>Yes</td>
</tr>
<tr>
<td>0503F</td>
<td>Postpartum care visit</td>
<td>CPT</td>
<td>Yes</td>
</tr>
<tr>
<td>G0101</td>
<td>Cervical or vaginal cancer screening; pelvic and clinical breast examination (G0101)</td>
<td>HCPCS</td>
<td></td>
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<tr>
<td>Z01.411</td>
<td>[Z01.411] Encounter for gynecological examination (general) (routine) with abnormal findings</td>
<td>ICD10CM</td>
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</tr>
<tr>
<td>Z01.419</td>
<td>[Z01.419] Encounter for gynecological examination (general) (routine) without abnormal findings</td>
<td>ICD10CM</td>
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</tr>
<tr>
<td>Z01.42</td>
<td>[Z01.42] Encounter for cervical smear to confirm findings of recent normal smear following initial abnormal smear</td>
<td>ICD10CM</td>
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</tr>
<tr>
<td>Z30.430</td>
<td>[Z30.430] Encounter for insertion of intrauterine contraceptive device</td>
<td>ICD10CM</td>
<td></td>
</tr>
<tr>
<td>Z39.1</td>
<td>[Z39.1] Encounter for care and examination of lactating mother</td>
<td>ICD10CM</td>
<td></td>
</tr>
<tr>
<td>Z39.2</td>
<td>[Z39.2] Encounter for routine postpartum follow-up</td>
<td>ICD10CM</td>
<td></td>
</tr>
</tbody>
</table>
Improving Long-Term Health Outcomes for Women After Childbirth
Screening and Management of Common Complications of Pregnancy

Hypertension (HTN)

- Hypertension is one of the most common complications of pregnancy.
- The American College of Obstetricians and Gynecologists classifies hypertension during pregnancy into four categories: 1) preeclampsia-eclampsia, 2) chronic hypertension (of any cause), 3) chronic hypertension with superimposed preeclampsia, and 4) gestational hypertension.
- While all types of hypertension during pregnancy need to be monitored and may require treatment, women who have suffered from preeclampsia are at particularly high risk of later adverse outcomes.
- An abundance of data suggests women who suffer from preeclampsia are at an increased risk of later-life CV disease. This increase ranges from a doubling of risk in all cases to an eightfold to ninefold increase in women with preeclampsia who gave birth before 34 and 0/7 weeks.
- Several studies have demonstrated the association of preeclampsia with future development of chronic hypertension.
- Pregnancy complications have the potential to be CVD risk “stress tests” to identify women who would most benefit from efforts to reduce CVD risk.
- Primary prevention can reduce CVD incidence.

Management

- Optimal management requires close observation for signs and symptoms. After the diagnosis is established, delivery should be performed at the optimal time for maternal and fetal well-being.
- In women with gestational hypertension, preeclampsia, or superimposed preeclampsia, it is recommended that blood pressures (BPs) be monitored in the hospital or that equivalent outpatient surveillance be performed for at least 72 hours postpartum AND again between 7 and 10 days postpartum.
- BPs should be checked earlier in women with symptoms.
- All women should receive information about the signs and symptoms of preeclampsia:
  - Persistent headache
  - Visual changes
  - Right upper quadrant or epigastric pain
  - Elevated blood pressure
- The importance of prompt reporting of any such symptoms to their provider should be stressed.

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Screening and Management of Common Complications of Pregnancy  (Cont.)

Gestational Diabetes (GDM)

- Every year, between 2% and 10% of pregnancies in the United States are complicated by gestational diabetes mellitus (GDM)\(^9\)
- Gestational diabetes is a condition in women who have carbohydrate intolerance, with onset or recognition during pregnancy
- The prevalence of GDM is in direct proportion to the prevalence of type 2 diabetes in a population or ethnic group
- Increased prevalence of GDM in Hispanic/Latina, black/African American, Native American, Asian, and Pacific Islander women
- Women with gestational diabetes are at increased risk for developing type 2 diabetes mellitus, hypertension, and cardiovascular disease in later life\(^{10,11}\)
- Once the diagnosis of GDM is made, it is managed not only to improve pregnancy outcomes but also to identify and potentially decrease risk factors for the later development of DM2

Management

- All women with GDM should have their glucose levels tested at six weeks postpartum
  - As many as a third of affected women will have DM or IGT (impaired glucose tolerance) at their postpartum screenings
  - 15%–50% of women will develop DM in the decades after their affected pregnancy
  - Overall, women with a history of GDM have a sevenfold-increased risk of developing type 2 diabetes compared to women without a history of GDM\(^{12}\)

  - Postpartum screenings:
    - Either a fasting plasma glucose test or the 75g two-hour glucose tolerance test is appropriate for diagnosing DM or IGT postpartum
    - Fasting test is easier to perform but lacks sensitivity for other forms of abnormal glucose metabolism
    - The two-hour test helps detect IGT

  - Follow-up:
    - The American Diabetes Association recommends repeat testing at least every three years for women who have had a pregnancy affected by GDM and normal results of postpartum screening


**Diagnostic Criteria: IGT and DM**

<table>
<thead>
<tr>
<th>Test</th>
<th>Diabetes</th>
<th>Impaired Fasting Glucose</th>
<th>Impaired Glucose Tolerance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting plasma glucose</td>
<td>Fasting plasma glucose is greater than or equal to 126</td>
<td>Fasting plasma glucose is 100–125</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fasting plasma glucose is greater than or equal to 126 or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>75g two-hour oral glucose tolerance test</td>
<td>Fasting plasma glucose is greater than or equal to 200</td>
<td>Fasting plasma glucose is 100–125</td>
<td>Two-hour plasma glucose is 140–199</td>
</tr>
</tbody>
</table>

**Management: IGT and DM**

- **Gestational diabetes**
  - FPG or 75g two-hour OGTT at 6–12 weeks postpartum

- **Diabetes Mellitus**
  - Impaired fasting glucose or IGT or both
    - **Refer for diabetes management**
      - Consider referral for management
      - Weight loss and exercise counseling as needed
      - Consider metformin if combined impaired fasting glucose and IGT
      - Medical nutrition therapy
      - Yearly assessment of glycemic status

- **Normal**
  - Assess glycemic status every three years
  - Weight loss and exercise counseling as needed
Postpartum Depression

Postpartum depression is depression that occurs after having a baby. After childbirth, many women suffer from postpartum blues. They may feel a range of emotions—tearfulness, anxiety, irritation, or restlessness. These feelings are normal and usually go away after a few days or a week.

Postpartum depression is a serious illness that can begin anytime within the first year after childbirth and can last for months; these feelings can be mild or severe. If a mother is experiencing the below symptoms for two weeks or more and these feelings get in the way of day-to-day life and routines, she should call her doctor.

Mothers with postpartum depression may feel that they:

- Have a hard time feeling close to their baby
- Have little interest or pleasure in activities
- Feel down, depressed, or hopeless
- Have trouble falling asleep or are sleeping too much
- Feel tired or have little energy
- Have poor appetite or overeat
- Feel bad about themselves or feel like a failure
- Have trouble concentrating on things
- Have thoughts of suicide or hurting themselves

Affects up to 20% of women and is associated with multiple adverse consequences for mothers and babies.\(^{13,14}\)

Management

Postpartum screening (which may be provided by primary care providers) and appropriate referral of all women following childbirth is recommended.\(^{15}\) The Edinburgh Postnatal Depression Scale appears on the following page; it can be completed by postpartum women over the age of 13.

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Edinburgh Postnatal Depression Scale (EPDS)

Name: ____________________________________________
Address: ___________________________________________

Your Date of Birth: _____________________________ Baby's Date of Birth: _____________________________
Phone: ___________________________________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here's an example already completed.

I have felt happy:
☐ Yes, all the time
☒ Yes, most of the time
☐ No, not very often.
☐ No, not at all

Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
☐ As much as I always could
☐ Not quite so much now
☐ Definitely not so much now
☐ Not at all

2. I have looked forward with enjoyment to things
☐ As much as I ever did
☐ Rather less than I used to
☐ Definitely less than I used to
☐ Hardly at all

3. I have blamed myself unnecessarily when things went wrong
☐ Yes, most of the time
☐ Yes, some of the time
☐ Not very often
☐ No, never

4. I have been anxious or worried for no good reason
☐ No, not at all
☐ Hardly ever
☐ Yes, sometimes
☐ Yes, very often

5. I have felt scared or panicky for no very good reason
☐ Yes, quite a lot
☐ Yes, sometimes
☐ No, not much
☐ No, not at all

6. Things have been getting on top of me
☐ Yes, most of the time I haven’t been able to cope at all
☐ Yes, sometimes I haven’t been coping as well as usual
☐ No, most of the time I’ve coped quite well
☐ No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
☐ Yes, most of the time
☐ Yes, sometimes
☐ Not very often
☐ No, not at all

8. I have felt sad or miserable
☐ Yes, most of the time
☐ Yes, quite often
☐ Not very often
☐ No, not at all

9. I have been so unhappy that I have been crying
☐ Yes, most of the time
☐ Yes, quite often
☐ Only occasionally
☐ No, never

10. The thought of harming myself has occurred to me
☐ Yes, quite often
☐ Sometimes
☐ Hardly ever
☐ Never

Administered/Reviewed by: __________________________ Date: __________________________

Users may reproduce the scale without further permission providing they respect copyright by quoting the names of the authors, the title, and the source of the paper in all reproduced copies.
Frequently Asked Questions

What if I perform postpartum care before 21 days or after 56 days?
As always, Healthfirst thanks you for seeing the patient for this important care. However, this care will not be within the timeframe to meet the HEDIS quality guidelines nor credited towards your HQIP performance.

As a PCP, I don’t provide prenatal care. Why should I provide postpartum care?
The postpartum period is an exciting, dynamic time in a woman’s life, and the family physician plays an important role in promoting a smooth transition through this period. Physicians can ensure quality postpartum care through a thorough evaluation of medical and psychological conditions.¹

Are there “best practices” for collaborating with patients to ensure a timely postpartum visit?
Planning for the postpartum visit along with planning for the delivery. You may not be able to provide the exact date, but having an idea about day of the week and potential barriers to returning for the postpartum visit BEFORE delivery is critical. For example, the patient may let you know that she will be staying at a different address after the baby’s birth, or the patient may not understand why the visit is necessary. In either case, you may want to plan on making the postpartum visit a home visit.

Why must I use specific codes for postpartum care?
Specific postpartum care codes are used to accurately identify the service provided. By using one of the codes endorsed by NCQA, you can streamline the data collection process for HEDIS/QARR and help eliminate the need for medical-record review in your office. These codes are also important for HQIP purposes and are used to determine compliance.

I am concerned that the parents of new babies in my practice could suffer from anxiety or depression and I may not know it. Are there resources to help?

Here is a list of some excellent perinatal and postpartum resources for your families:

**The Bronx Health Link**  
198 East 161st Street, Suite 201 | Bronx, NY 10451 | 1-718-590-2647  
www.bronxhealthlink.org

The Bronx Health Link, Inc., created in 1998, is a unique collaboration between the Bronx’s four major healthcare institutions: Bronx-Lebanon Hospital Center, Montefiore Medical Center, Our Lady of Mercy Center, and St. Barnabas Hospital; and the Office of the Bronx Borough President.

**Caribbean Women’s Health Association**  
123 Linden Boulevard | Brooklyn, NY 11226 | 1-718-826-2942  
www.cwha.org

Caribbean Women’s Health Association, Inc. (CWHA) was founded in 1982 by Yvonne J. Graham and a group of Caribbean women in the health profession who shared a commitment to improving access to health-related services for low-income and indigent populations, and to assist immigrants in adjusting to their new host environment.

CWHA is dedicated to transforming lives, strengthening families, building bridges across culturally diverse communities, and opening doors to citizenship. CWHA operates five (5) Community Service Centers located throughout Brooklyn and Queens.

**Centers for Disease Control and Prevention (CDC)**  
www.cdc.gov/reproductivehealth/depression

Information for women, their families, and other members of their support system. Includes practical, easy-to-read information in an engaging format.

**LactMed, Drugs and Lactation Database**  
U.S. National Library of Medicine  

The database contains information on drugs and other chemicals to which breastfeeding mothers may be exposed. It includes information on the levels of such substances in breast milk and infant blood, and the possible adverse effects in the nursing infant. All data are derived from the scientific literature and fully referenced. A peer review panel reviews the data to assure scientific validity and currency.

**Nassau Perinatal Services Network**  
1-516-227-9456  
www.nassaucountyny.gov/3569/Maternal-and-Child-Health-Services

Information and referral service for pregnant and parenting women of Nassau County. The Network links women and their families to essential health and human services such as Prenatal Care and Day Care, regardless of citizenship or lack of insurance.

**National Institute of Mental Health (NIH)**  

“Women and Depression: Discovering Hope” includes sections on self-care and how to help a friend or relative with depression in web-based format and a printable booklet.
Northern Manhattan Perinatal Partnership, Inc.
127 West 127th Street, 3rd Floor  |  New York, NY 10027  |  1-212-665-2600
www.sisterlink.com

Northern Manhattan Perinatal Partnership’s (NMPP) mission is to save babies and help women take charge of their reproductive, social, and economic lives. NMPP is a not-for-profit, community-based organization comprising a network of public and private agencies, community residents, health organizations, and local businesses. NMPP provides crucial services to women, children, men, and families in many neighborhoods throughout Manhattan. We are conveniently located in Central Harlem, East Harlem, and Washington Heights. We are able to provide services throughout the entire borough of Manhattan.

Post-Partum Resource Center of New York
Online and phone support: 1-855-631-0001
www.postpartumny.org

Serving all of NYS since 1998, this organization was founded to provide emotional support, information, healthcare, and support group referrals to mothers and fathers at risk for, or suffering from, anxiety or perinatal depression.

Queens Health Coalition
163-13 Depot Road  |  Flushing, NY 11358  |  1-718-762-0346, Fax: 1-718-762-0349
www.qhcnyc.org

Queens Health Coalition, created in 1994, provides essential links between the underserved communities of Queens and quality healthcare. The goal of establishing these links is to improve and enhance the overall health and well-being of Queens residents who may not know what healthcare services exist or can be created, and how to access or gain support for them.

Suffolk Perinatal Coalition
475 East Main Street, Suite 207  |  Patchogue, NY 11772  |  1-631-475-5400
www.spcbabies.org

The Suffolk Perinatal Coalition is a not-for-profit agency comprising professionals and community residents whose common goals are to reduce infant mortality, low birth weight, and prematurity, and to promote the health of women, infants, and families.

Support and Training to Enhance Primary Care for Postpartum Depression (STEP-PPD)
www.step-ppd.com

STEP-PPD provides information and resources to help providers better understand the symptoms of PPD. Its goal is to provide education, resources, and support to primary care providers for improved management of PPD in primary care settings.

U.S. Department of Health and Human Services
Maternal and Child Health
www.mchb.hrsa.gov

The Maternal and Child Health Bureau provides leadership, in partnership with key stakeholders, to improve the physical and mental health, safety, and well-being of the maternal and child health (MCH) population. Resources available include A Comprehensive Approach for Community-Based Programs to Address Intimate Partner Violence and Perinatal Depression toolkit and Depression During and After Pregnancy: A Resource for Women, Their Families, and Friends.

Thank you to Elizabeth Howell, M.D., MPP, Jennifer Amorosa, M.D., and Amy Balbierz, MPH from the Icahn School of Medicine at Mount Sinai for their contribution to this bulletin.