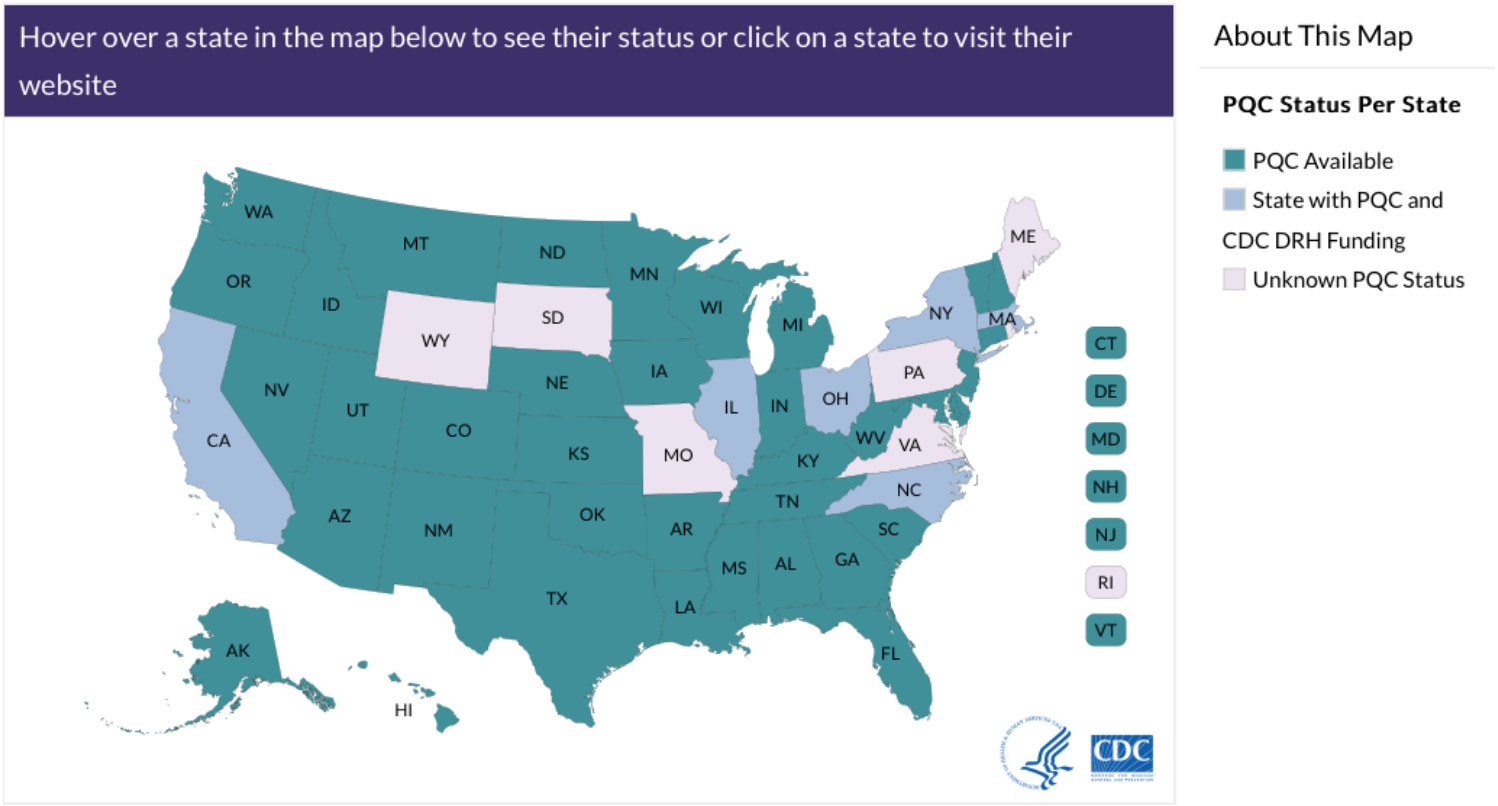
Update: New Mexico Perinatal Collaborative

Eve Espey, MD MPH
University of New Mexico

What is a Perinatal collaborative?

- Multidisciplinary group of state stakeholders who come together to improve care and outcomes for women and babies
  - Quality
  - Cost savings

CDC – Perinatal Collaboratives



https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc-states.html

Collaboratives

New Mexico
Perinatal Collaborative

Hospital association
Private providers
University providers
Administrators
Insurance companies
Indian Health Service

- Department of Health
- March of Dimes
- Professional organizations
- Community members

Common Issues Addressed

- Prevention of pre 39 week deliveries
  - Savings range from $2.4 million -$9 million/year.
- Improving rates of breastfeeding
- Decreasing unplanned pregnancy
- Reducing preterm births

Methodology

- Collect data
- Implement evidence-based practice/intervention
- Collect data
  - Health improved?
  - Saved money?

Achievements

Perinatal Quality Collaborative

SUCCESS STORY

New York
Collabora
Babies Bc

Every week of p
full-term (from 3
preterm (before

Some early deliv
medical reasons
or cesarean sect
could be postpc

Perinatal Quality Collaborative

SUCCESS STORY

California Maternal Quality Care Collaborative's Data Center Tool Helps Hospitals Reduce Severe Maternal Morbidity

The most severe pregnancy complications, commonly referred to as severe maternal morbidity, can result in longer hospital stays, long-term rehabilitation, and higher direct medical costs. Tracking performance on maternity care metrics, such as severe maternal morbidity, informs clinical practices and drives quality improvement.

Maternity care is the highest-volume health service delivered by most

12% reduction in severe complications occurred

2013: New Mexico Perinatal Collaborative is Born!

STATE OF NEW MEXICO
DIANNA J. DURAN
SECRETARY OF STATE

August 8, 2014

Att LINDA SIEGLE
NEW ...ATAL COLLABORATIVE
P.O. BOX 720
CERILLOS NM 87010

RE: NEW MEXICO PERINATAL COLLABORATIVE
Entity ID: 4944437

The Office of the Secretary of State has approved and filed the Articles Of Incorporation for the above captioned corporation effective August 6, 2014. The enclosed Certificate Of Incorporation is evidence of filing, and should become a permanent document of the corporation's records.

The referenced approval does not constitute authorization for the above referenced corporation to transact any business which requires compliance with other applicable federal or state laws, including, but not limited to, state licensing requirements. It is the corporation's sole responsibility to obtain such compliance with all legal requirements

Funding….

SENATE BILL 189

51ST LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2014

INTRODUCED BY

Nancy Rodriguez

AN ACT

RELATING TO PUBLIC HEALTH; PROVIDING FOR THE ESTABLISHMENT OF A STATEWIDE PERINATAL COLLABORATIVE; MAKING AN APPROPRIATION.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. [NEW MATERIAL] STATEWIDE PERINATAL

McCUNE CHARITABLE FOUNDATION

NEW MEXICO DEPARTMENT OF HEALTH

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS • WOMEN'S HEALTH CARE PHYSICIANS • 1951

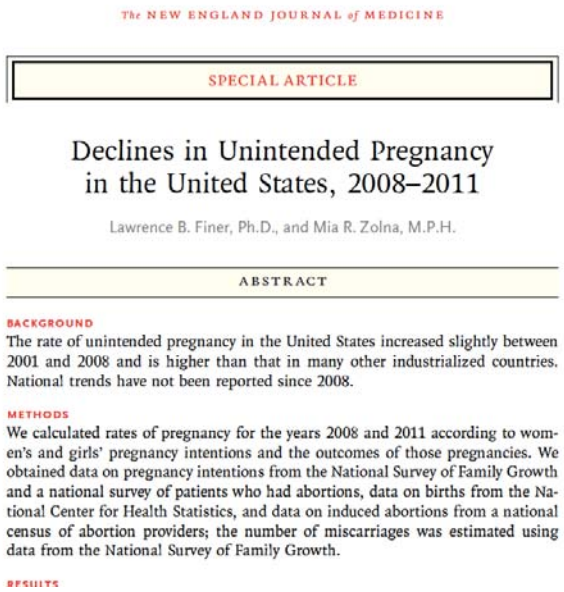
NATIONAL INSTITUTE FOR REPRODUCTIVE HEALTH

Current status

- Direction
  - Administrative assist: Lisa Bowdey
  - Executive Director: YOUR NAME HERE..
- Projects
  - Immediate postpartum LARC
  - Neonatal abstinence
  - Reducing M&M from OB-hemorrhage
  - Maternal mortality review

We almost have a website

Unintended pregnancy in US and NM



The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Declines in Unintended Pregnancy in the United States, 2008–2011

Lawrence B. Finer, Ph.D., and Mia R. Zolna, M.P.H.

ABSTRACT

BACKGROUND

The rate of unintended pregnancy in the United States increased slightly between 2001 and 2008 and is higher than that in many other industrialized countries. National trends have not been reported since 2008.

METHODS

We calculated rates of pregnancy for the years 2008 and 2011 according to women's and girls' pregnancy intentions and the outcomes of those pregnancies. We obtained data on pregnancy intentions from the National Survey of Family Growth and a national survey of patients who had abortions, data on births from the National Center for Health Statistics, and data on induced abortions from a national census of abortion providers; the number of miscarriages was estimated using data from the National Survey of Family Growth.

RESULTS

- Unintended pregnancy at lowest level ever
- Navajo women
  - 52% of Navajo mothers did not intend to become pregnant
  - The teen pregnancy rate in New Mexico was 72/1,000 teens in 2010, ***highest in the country***.

Guttmacher, 2016
PRAMS and Navajo Epidemiology Center

Immediate postpartum opportunity

- Nationally, 35% experience “rapid repeat pregnancy”
- Many women
  - have unprotected sex before the postpartum visit.
  - do not attend a postpartum visit
  - who intend to use an IUD postpartum do not obtain it.

(ACOG Committee Opinion 670, August 2016)

What about IUD expulsion risk?

- Interval insertion: 2-8% in the first year of use
- Immediate PP insertion: <10% if inserted within 10 minutes of placental delivery
- Immediate PP > 10 minutes: 2-37% if placed 2-72 hours after delivery.
- Provider experience has a major influence

Grimes DA, Lopez LM, Schulz KF, Van Vliet HA, Stanwood NL. Immediate post-partum insertion of intrauterine devices. Cochrane Database of Systematic Reviews 2010, Issue 5.

What about breastfeeding and LARC?

		LNG-IUD and implant	Copper-IUD
Postpartum (in breastfeeding or non-breastfeeding women, including post- caesarean section)	a) < 10 minutes after delivery of the placenta	**2**	**1**
	b) 10 minutes after delivery of the placenta to < 4 weeks	**2**	**2**
	c) ≥ 4 weeks	**1**	**1**
	d) Puerperal sepsis	**4**	**4**

Centers for Disease Control and Prevention. "U S. Medical Eligibility Criteria for Contraceptive Use, 2016."

Current ACOG Recommendations

- *"**Immediate postpartum LARC should be offered** as an effective option for postpartum contraception; there are few contraindications to postpartum IUDs and implants."*

- *"Obstetrician-gynecologists, other obstetric care providers, and institutions should develop the resources, processes, and infrastructure, including stocking LARC devices in the labor and delivery unit and coding and reimbursement strategies, to support immediate LARC placement after vaginal and cesarean births."*

(ACOG Committee Opinion 670, August 2016)

NMPC Project:
Immediate postpartum LARC

Phone call: "Hi Medicaid… just wondering why…."

State of New Mexico
Medical Assistance Program Manual
Supplement

HUMAN SERVICES DEPARTMENT

DATE: **NUMBER: 13-05**

TO: PROVIDERS PARTICIPATING IN THE NEW MEXICO MEDICAID PROGRAM

FROM: JULIE B. WEINBERG, DIRECTOR, MEDICAL ASSISTANCE DIVISION

SUBJECTS: **I. LIMITING PAYMENT FOR INDUCTIONS AND CESAREAN SECTIONS THAT ARE NOT MEDICALLY NECESSARY**

II. BILLING WHEN C-SECTIONS OR INDUCTIONS ARE MEDICALLY NECESSARY

III. HYSTERECTOMY CONSENT FORM

IV. INSERTION OF LONG ACTING REVERSIBLE CONTRACEPTIVES AT TIME OF AN INPATIENT DELIVERY STAY

3 years later….

- UNM only hospital inserting and ”successfully” billing Medicaid

Total Denials

Count of Denial Amt	Column Labels			
Row Labels	J7300	J7302	J7307	Grand Total
Attach/Doc. required to adjudicate claim	1			1
Claim lacks info needed for adjudication		2	4	6
Duplicate claim/service		1	2	3
Non-covered charge(s)		1		1
The prov is not eligible to perform svc		1	3	4
The time limit for filing has expired		1	2	3
This procedure is not paid separately.	2	9	46	57
Grand Total	**3**	**15**	**57**	**75**
Denied as % of Performed	16%	42%	34%	33%

Total Paid

	Column Labels			
	J7300	J7302	J7307	Grand Total
Count of Payment	**12**	**21**	**89**	**122**
Paid as % of Performed	63%	58%	52%	54%

Total Pending

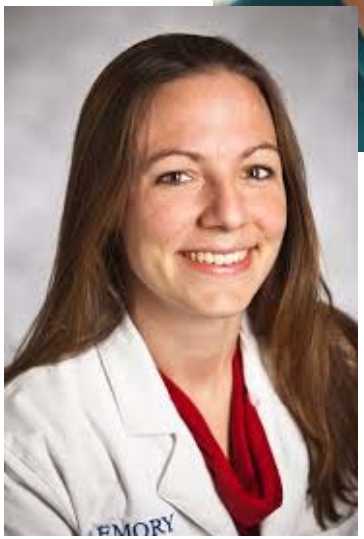
	Column Labels			
	J7300	J7302	J7307	Grand Total
Count of Pending	**4**		**24**	**28**

NMPC to the rescue

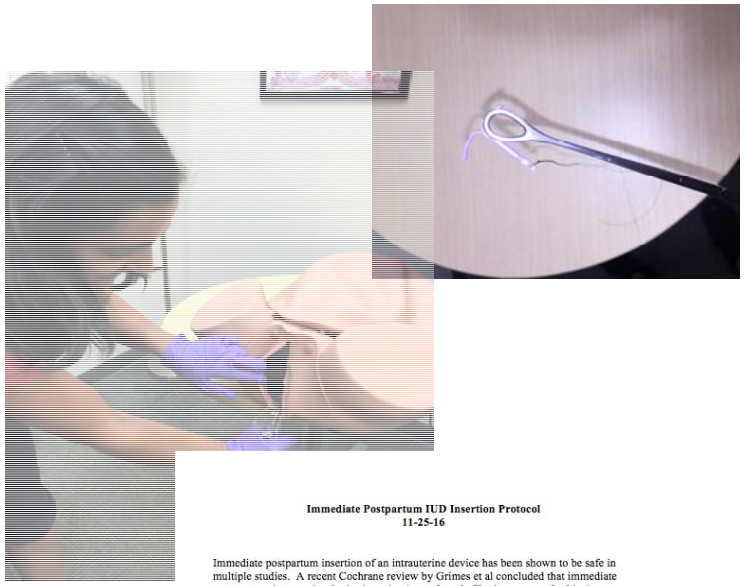
- National Institute of Reproductive Health grant
  - 50K
  - Deliverable: 3 hospitals will initiate immediate postpartum LARC including billing and reimbursement

Project immediate PP LARC

- Program manager
  - Abby Reese, CNM
- Family planning faculty
  - Dr. Lisa Hofler
- Implementation toolkit
  - Technical assistance coding, billing and reimbursement
  - Clinical training in immediate PP IUD insertion



Toolkit components



Immediate Postpartum IUD Insertion Protocol
11-25-16

Immediate postpartum insertion of an intrauterine device has been shown to be safe in multiple studies. A recent Cochrane review by Grimes et al concluded that immediate post-partum intrauterine device insertion is a safe and effective means of achieving highly effective birth control. No increase in complications with immediate insertion technique was identified. Several studies showed slightly higher expulsion rates in several studies, with an average of 12-14% for insertion within 10 minutes of placental delivery. An increased expulsion rate does not correspond to increased pregnancy rates as most expulsions are identified and addressed with insertion of another IUD or initiation of another method of contraception. A study at UNM shows that high non-insertion rates occur in patients desiring a postpartum IUD. Patients benefit with immediate postpartum insertion even if the expulsion rate is increased. Consistent with our policy that contraception should be considered an "emergency," women who present requesting an IUD or choosing an IUD after counseling are often able to receive it the same day.

Women who desire an IUD immediately postpartum should be thoroughly counseled regarding the advantages and disadvantages as well as the risks & benefits of the method. In general women are good candidates for the IUD if they are at low risk for STDs and desire contraception for at least a year. Teens may be considered good candidates for an IUD. Contraindications to postpartum IUD insertion include:

- Untreated STD or treated within the prior month
- Active intrauterine infection (chorioamnionitis)
- Uterine anomaly incompatible with placement
- Ongoing postpartum hemorrhage
- Retained placenta requiring manual removal

Counseling

- Ideally, contraceptive counseling should occur during antenatal care for a

Vendor Contracts

- Are new or updated contracts needed in order to purchase or stock LARC?

Inventory System

-Work with IT staff to adapt system to include LARC.

-Work with clinicians to estimate appropriate order volume.

Distribution Plan

-What is the best plan to assure that devices are accessible?

-IUD placement is time-sensitive, and device must be readily available at delivery.

Implementation science

- How to effectively introduce and integrate evidence based practice into standard of care
- Everything is harder and takes more time than you think
- PP LARC
  - Involves multidisciplinary team
    - Pharmacy
    - Nursing
    - Providers
    - Billing and IT staff
  - Need a champion!

Our team brings you: Immediate Postpartum LARC: Pharmacy & Reimbursement

NMPC
NEW MEXICO PERINATAL COLLABORATIVE

Obstet Gynecol. 2017 Jan;129(1):3-9. doi: 10.1097/AOG.0000000000001798.

Implementing Immediate Postpartum Long-Acting Reversible Contraception Programs.

Hofler LG[1], Cordes S, Cwiak CA, Goedken P, Jamieson DJ, Kottke M.

⊕ **Author information**

Abstract

OBJECTIVE: To understand the most important steps required to implement immediate postpartum long-acting reversible contraception (LARC) programs in different Georgia hospitals and the barriers to implementing such a program.

METHODS: This was a qualitative study. We interviewed 32 key personnel from 10 Georgia hospitals working to establish immediate postpartum LARC programs. Data were analyzed using directed qualitative content analysis principles. We used the Stages of Implementation to organize participant-identified key steps for immediate postpartum LARC into an implementation guide. We compared this guide to hospitals' implementation experiences.

RESULTS: At the completion of the study, LARC was available for immediate postpartum placement at 7 of 10 study hospitals. Participants identified common themes for the implementation experience: team member identification and ongoing communication, payer preparedness challenges, interdependent department-specific tasks, and piloting with continuing improvements. Participants expressed a need for anticipatory guidance throughout the process. Key first steps to immediate postpartum LARC program implementation were identifying project champions, creating an implementation team that included all relevant departments, obtaining financial reassurance, and ensuring hospital administration awareness of the project. Potential barriers included lack of knowledge about immediate postpartum LARC, financial concerns, and competing clinical and administrative priorities. Hospitals that were successful at implementing immediate postpartum LARC programs did so by prioritizing clear communication and multidisciplinary teamwork. Although the implementation guide reflects a comprehensive assessment of the steps to implementing immediate postpartum LARC programs, not all hospitals required every step to succeed.

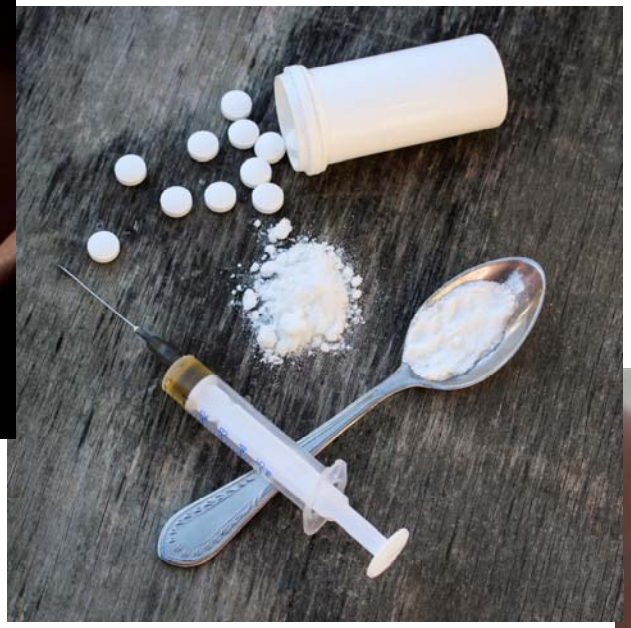
CONCLUSION: Hospital teams report that implementing immediate postpartum LARC programs involves multiple departments and a number of important steps to consider. A stage-based approach to implementation, and a standardized guide detailing these steps, may provide the necessary structure for the complex process of implementing immediate postpartum LARC programs in the hospital setting.

Hospitals implementing immediate PP LARC

- Northern Navajo Medical Center, Shiprock
- Gallup Indian Medical Center
- Espanola Hospital, Espanola
- Gila Regional Medical Center, Silver City
- Memorial Medical Center, Las Cruces

Next steps

- Ongoing follow-up to determine if immediate postpartum LARC "hard-wired"
- Evaluation research on implementation success in a statewide setting
  - Facilitators
  - Barriers
- Partner with Envision to expand from immediate postpartum to increased LARC access



Neonatal Abstinence Syndrome

NAS epidemiology

- NAS 6 per 1000 births in 2013 in US
  - >1 baby born per hour
- In New Mexico 8.5 per 1000 births in 2013, rising at 1.5% per year
- Average hospital admit cost >$50,000
- Average hospital transfer cost $5000-$7000 per baby
  - In literature NAS treatment rate 50% with in utero subutex or methadone exposure

JAMA. 2012;307(18)
Ko et al, Incidence of Neonatal Abstinence Syndrome- 28 states, 1999-2013. MMRW 2016;65:799-802.

5 top points

- Screen appropriately and observe long enough to recognize
- Use Finnegan's score but also use clinical gestalt
- Treat with an opiate
- Maximize rooming-in, breastfeeding, and non-pharmacologic treatments
- Make an outpatient follow up plan

Phase 1- Survey

- Level of neonatal care offered at each facility and gestational age cutoff
- Estimated number of infants with NAS each month
- Availability of care for opiate addicted women
- Screening methods/policies of mothers and infants
- Interested in additional training: care vs. transfer

Phase 2

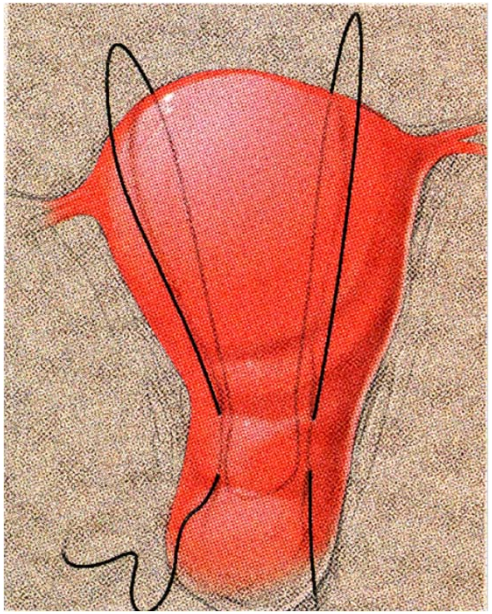
- One time site-visit
  - Grand rounds presentation and discussion on next steps with interested small group
  - Intended for delivery, diagnose, and transfer groups
- Mini- Sabbatical project
  - 3-5 days at UNM in intensive clinical observation and one on one teaching with experts
  - Intended for groups providing treatment at their site

Phase 3- Future

- Collaboration with Envision
  - Quality improvement assessment at 1-2 sites
  - Web modules accessible state wide
  - Teleconference for ongoing teaching and case questions

OB Hemorrhage

- Survey
- Implementation of OB Hemorrhage Protocol
- Implementation of OB Hemorrhage Bundle
- Trainings in Shiprock, Gallup



ANNUAL NMPC MEETING SAVE THE DATE!!

- March 31, 2017
- 10 AM to 2 PM
- UNM Cancer Center
- Updates on projects
- How you can get involved
- Join our mailing list!

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