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Informational Notice

Date: September 29, 2015

To: Physicians, Advanced Practice Nurses, Federally Qualified Health Centers, Encounter Rate Clinics, Rural Health Clinics, Local Health Departments, Hospitals, Managed Care Entities

Re: Postpartum Visits and Perinatal Care Transitions

The purpose of this notice is to outline the department's policy for postpartum visits, encourage providers to educate women on the importance of postpartum care, share best practices and expectations related to perinatal care transitions, and provide resources to assist in transitioning patients between providers and across settings. Care transition is the movement of patients from one health care practitioner or setting to another as their condition and care needs change, ensuring coordination and continuity of care. Accurate and timely communication is the cornerstone to care transitions which greatly impacts quality patient centered care and patient safety.

For the last several years, Illinois Department of Healthcare and Family Services (HFS) covered almost 55% of the State's births and 95% of all teen births; and of those total births, 60% were unintended. This data and the following data were reported in the [2014 Illinois Perinatal Report to the General Assembly](#) and demonstrates great room for improvement:

- 55% received postpartum care between 3 weeks and 6 weeks
- 60% received family planning services within 6 months after delivery
- 56% are second or higher level births and about 25% of these subsequent births occur within 18 months
- 43% of births were non-normal (i.e., prematurity, low birth weight, very low birth weight, infant mortality)

The transition from delivery/postpartum care in the hospital setting to outpatient postpartum care is one of several transitions that occur during the perinatal period. The postpartum visit should be scheduled or confirmed prior to hospital discharge and discharge instructions should include the appointment date, time and location. Assuring that women receive a postpartum visit is a key strategy to improve birth outcomes. The postpartum visit allows for a physical exam, supportive guidance on healthy behaviors, assessment of health conditions, including depression, preconception counseling, and reproductive life planning, including discussion/initiation of birth control, if not previously initiated. These interventions can help women prevent or plan for safer future pregnancies, address chronic health conditions, and

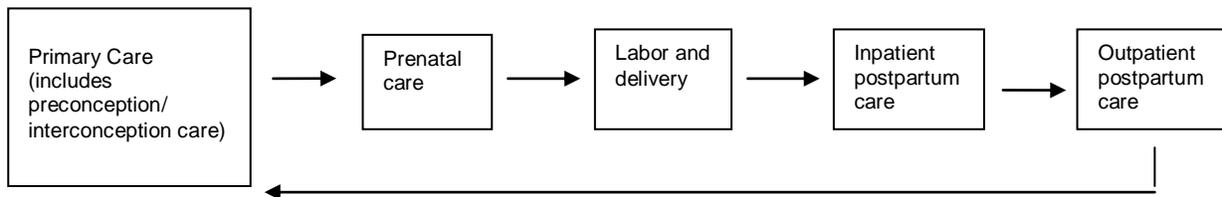
space pregnancies to allow for full physical recovery from a previous pregnancy, thereby reducing unintended pregnancies and improving future birth outcomes.

The postpartum visit is an essential component in the continuum of well-woman care and assuring that women receive a postpartum visit is a key strategy to improve birth outcomes. HFS policy allows reimbursement for one comprehensive postpartum visit. Additional visits for related issues outside the routine postpartum visit are also payable if supported with appropriate coding/documentation.

The transition from postpartum care to primary care is critical. The postpartum provider should ensure that women are linked back to their primary care provider (PCP) after the postpartum visit. This is especially important if the patient was diagnosed with hypertension, diabetes or other medical conditions or complications during pregnancy, or has preexisting co-morbidities. If the PCP is unknown, a Quick Reference Tool is provided as an attachment to this notice to assist in identifying the patient's PCP.

The following chart depicts the various transitions that occur during perinatal care, including the transition from postpartum care to ongoing primary care. Successful transitions across providers and care settings assure the continuum of well-woman care.

Continuum of Well-Woman Care



Successful care transitions include information sharing/communication, logistical arrangements/care coordination, and patient and family education/engagement. In light of our complex health care system, assisting women through care transitions supports continuity and optimizes health outcomes for women and their families. Successful care transitions involve a multidisciplinary team and ongoing collaboration with care coordination entities (e.g., managed care plans). And most importantly, pregnant women who are considered high risk should be identified early and closely monitored within a robust care transition system.

As HFS continues to roll-out its new care coordination delivery system, more emphasis will be placed on care transitions. A best practices checklist for perinatal care transitions, adapted from national recommendations, can assist providers and staff in adopting strategies to improve the safety and quality of perinatal care transitions.

Felicia F. Norwood
Director

Best Practices Checklist for Perinatal Care Transitions

Share Information/Communicate

- Assure the prenatal electronic health record (EHR) or obstetrical flow sheets clearly identify the current primary care provider (PCP) and specialists, if applicable. Ensure the EHR template requires entry of the PCP/specialist.
- Send prenatal records including labs and clear due date (EDC) identification to the designated delivery hospital or birthing center in early 3rd trimester and again with updated information near term and verify receipt of those records by the receiving entity. Ensure practice/clinic system has a way to systematically identify/track records sent and provide alerts when the records have not been sent.
- Give health information to patients. Print summaries of office visits and hospital stays for patients and encourage them to use this information to actively participate in care transitions and share this information with care providers. Recommend that patients carry an updated prenatal record summary in the event they present at a hospital other than the hospital where prenatal records were sent.
- Establish a process to ensure that a delivery note and pertinent postpartum notes are electronically transferred or faxed to the prenatal care/delivery provider and the primary care provider and confirmation of receipt is obtained from the receiving entity.
- Adopt structured methods for ensuring hand off of patient care in any setting that requires teamwork and communication. Consider use of Situation-Background-Assessment-Recommendation (SBAR) technique¹ or TeamSTEPPS^{TM2}, system developed by the Agency for Healthcare Research and Quality.

Arrange Logistics/Coordinate Care

- Immediately upon identification of pregnancy, provide options counseling to discuss a woman's choices and make timely referrals to appropriate services. Provide referral to obstetrical and a newborn care provider if PCP does not provide obstetrical and newborn care services.
- Clearly identify postpartum contraceptive method, 24-hour call number of obstetrical provider, location of delivering hospital, and signs and symptoms of labor and preterm labor with every prenatal visit.
- Ensure women understand their choices for postpartum birth control, including permanent sterilization or long acting reversible contraceptives (LARCs). Accurately and legibly sign [federal consent](#) at least 30 days prior to EDC for voluntary sterilization. Ensure the hospital and the patient have copies of the signed consent form. If the patient desires LARC, offer immediately postpartum at the hospital or at the postpartum visit.
- Schedule or confirm the postpartum visit prior to hospital discharge and include the appointment date, time, location and contact information in discharge instructions.
- Ensure patients are linked back to their primary care provider after the postpartum visit. This is especially important if the patient was diagnosed with hypertension, diabetes, other medical conditions or complications during pregnancy, or has preexisting co-morbidities. If the PCP is unknown, use the Quick Reference Tool to identify the patient's PCP (last page of this notice).
- Order lactation consultant referrals and provide nurse line and support groups information for acute breastfeeding issues upon discharge.

Educate Patient and Family

- Encourage patients to connect with their case managers or care coordinators, especially if identified as high risk. Educate clients on revealing accurate medical histories such as prior preterm birth or prior preeclampsia to allow for early evidence based interventions.
- Counsel and educate on contraceptive options, with the most effective method first (i.e. LARCs- intrauterine device and contraceptive implant). Discuss the importance of healthy birth spacing (18-24 months) and developing a reproductive life plan. Every annual exam for women of childbearing age and all men should include basic questions about reproductive life planning. See [HFS' birth control link](#) for more information.
- Provide education on the content of the postpartum visit(s). HFS provides reimbursement for one comprehensive postpartum visit. Visits for acute issues outside the routine postpartum visit are payable when¹ supported with appropriate coding/documentation.

¹ Institute for Healthcare Improvement. SBAR technique or communication: a situational briefing model. Available at: <http://www.ihl.org/resources/Pages/Tools/SBARToolkit.aspx>. Retrieved December 30 2014.

² Agency for Healthcare Research and Quality. Team STEPPSTM: national implementation. Available at: <http://teamstepps.ahrq.gov>. Retrieved December 30, 2014.

Quick Reference: Identify a Medicaid Patient's Primary Care Physician (PCP)

**Patient in Managed Care Plan
MCO or MCCN**



Option 1:

Plan Member ID card

- PCP and WHCP name
- Plan toll-free phone number

Option 2:

**Electronic Eligibility Verification
Requires patient SSN or RIN**

- Medical Electronic Data Interchange ([MEDI](#))
- Automated Voice Response System (AVRS) – **1-800-842-1461**
- Recipient Eligibility Verification System ([REV](#))

NOTE: Plan and toll-free phone number identified in “Managed Care Organization Segment”

Option 3:

Contact plan: MCO/MCCN Contact List (below)

Plan	Contact Information
Aetna Better Health	866-212-2851 www.aetnabetterhealth.com/illinois
Blue Cross/Blue Shield	888-657-1211 www.bcbsil.com
Cigna-HealthSpring	(866) 487-4331 www.specialcareil.com
Community Care Alliance of Illinois	(866) 871-2305 www.ccaillinois.com
County Care (Cook County only) (MCCN)	312-864-8200 www.countycare.com
Family Health Network (MCCN)	888-346-4968 www.fhnchicago.com
Harmony Health Plan	800-608-8158 www.harmonyhpi.com
Health Alliance Connect	800-851-3379 www.healthallianceconnect.org
Humana Health Plan	(800) 626-2741 www.humana.com
IlliniCare Health Plan	866-329-4701 www.illinicare.com
Meridian Health Plan	866-606-3700 www.mhplan.com
Molina Healthcare of Illinois	855-766-5462 www.molinahealthcare.com

**Patient in Coordinated Care Plan or Fee-for-Service
ACE, CCE, IHC**



Option 1:

**Electronic Eligibility Verification
Requires patient SSN or RIN**

- Medical Electronic Data Interchange ([MEDI](#))
- Automated Voice Response System (AVRS) – **1-800-842-1461**
- Recipient Eligibility Verification System ([REV](#))
- IHC “[Who’s My PCP?](#)”

NOTE: ACE and toll-free number identified in “Accountable Care Entity Segment”. CCE and toll-free number identified in “Care Coordination Entity Segment”.

Option 2:

Illinois Health Connect – 1-877-912-1999

Option 3:

MediPlan card

- No PCP or plan information is printed on the MediPlan card
- Coordinated Care plans have the option of providing a sticker for enrollees to affix to the MediPlan card that identifies their PCP/plan.

Key:

- PCP Primary Care Provider
- WHCP Women’s Health Care Provider
- MCO Managed Care Organization
- MCCN Managed Care Community Network
- ACE Accountable Care Entity
- CCE Care Coordination Entity
- IHC Illinois Health Connect