BRIDGING THE GAP: A MULTI-DISCIPLINARY PROGRAM TO CARE FOR WOMEN WITH HYPERTENSIVE DISORDERS OF PREGNANCY ACROSS THE LIFESPAN

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BACKGROUND

• Hypertensive disorders of pregnancy (HDP) including preeclampsia are associated with later life cardiovascular disease.
• 2/3 women who experience preeclampsia will die of CV disease
• Gap in care after pregnancy – “4th trimester”
• Lack of communication, education, and follow-up are barriers to coordination of ongoing care.

Multi-disciplinary Postpartum Hypertension Clinics can bridge this gap. As experts in the field, we are uniquely poised to develop this innovative program

VISION

OBJECTIVES

• Demonstrate the feasibility of a postpartum collaborative clinic for women with HDP at Magee-Womens Hospital of UPMC
• Improve adherence to follow-up appointments in the first year postpartum for women with HDP
• Establish a system of ongoing cardiometabolic risk factor screening, education, and risk modification within the first year postpartum

APPROACH / WORK TO DATE

• The team: Maternal-Fetal Medicine and Women’s Cardiology
• Developed a clear template for visit + method of communication to health care team
• Educational materials for patient and provider
• Referral base (inpatient, remote BP program, outpatient)
• Ancillary services – social work, behavioral health, nutrition, weight loss programs, smoking cessation, sleep medicine, endocrinology
• Space/personnel/resources
• EMR, billing/coding issues
• Create a network of PCPs and cardiologists with interest/expertise in women’s health for ongoing care
• Key stakeholders engagement
• Pivot to virtual visits during COVID
• Junior faculty development / Clinical research

OUTCOMES

Visit Compliance

• Soft launch early 2020; Two half-days per month with MFM and cardiology; 190 encounters to date
• Outstanding visit compliance
• Mean time for visit is 11 weeks after delivery
• 72% preeclampsia, 25% chronic hypertension, and 3% peripartum cardiomyopathy
• Representative diverse population (60% White, 33% Black)
• Appropriate “at risk” population
• Demand>>Availability
• Primary care follow-up recommendations made for 100% of patients to date

At Risk Population

• Mean SBP (mmHg) ± SD

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<th>SBP (mmHg)</th>
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<td>126/82</td>
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Feedback Survey:

• Press-Ganey Survey – universally positive
• Patient: “I didn’t really understand my diagnosis (preeclampsia) and what it meant. Drs X and Y have empowered me with a clear plan to improve my health before another pregnancy and to stay healthy for my family”
• Provider: “Thank you for the specific recommendations for management. I was not aware that preeclampsia had long term consequences”

NEXT STEPS

• Ongoing tracking of process/outcome measures
• Expansion via telehealth
• Dissemination of information nationally
• Engage UPMC Health Plan
• Clinical trials – intervention studies
• Successful Prototype for other multi-disciplinary clinics

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