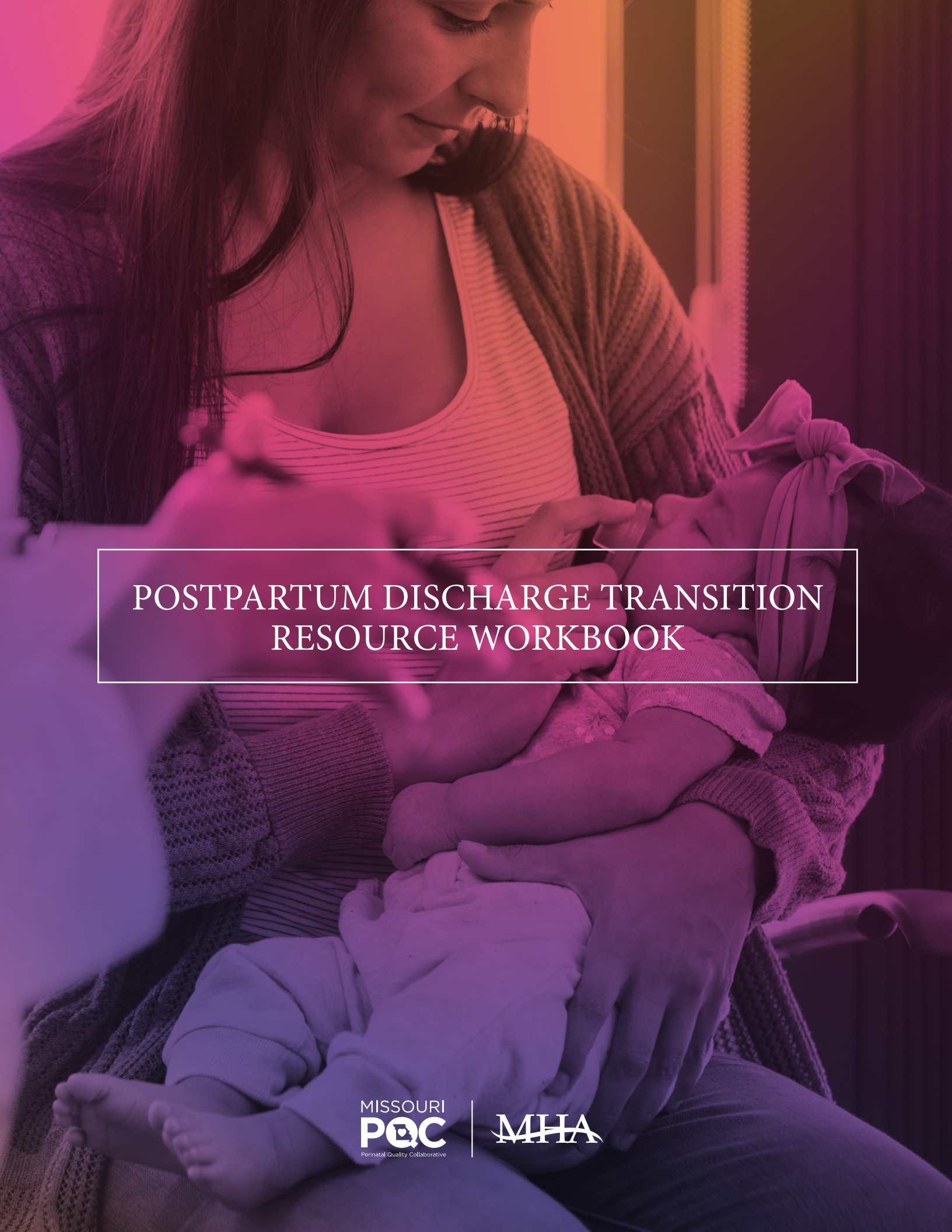

POSTPARTUM DISCHARGE TRANSITION RESOURCE WORKBOOK

MISSOURI PQC Perinatal Quality Collaborative | MHA

Acknowledgements

Improving the health outcomes of maternal and infant populations is a critical priority in Missouri. The Missouri Perinatal Quality Collaborative serves as a statewide convener, resource, and change agent to support decreased variations in care and outcomes, support optimized use of evidence-based practice, and support clinical-community integration — all noted gaps in achieving equitable and improved health.

These efforts would not be possible without the collective vision and collaboration of the Missouri Department of Health and Senior Services, Missouri Hospital Association, and members of the Missouri Maternal-Child Learning and Action Network. MC LAN members represent a diverse group of stakeholders from clinical backgrounds, professional associations, government agencies, community-based organizations and community representatives who have committed support to reducing maternal morbidity and mortality in Missouri, including the March of Dimes, Missouri Section of the American College of Obstetricians and Gynecologists, Missouri Chapter of the American Academy of Pediatrics, Missouri Primary Care Association, Missouri DHSS, Missouri Department of Social Services MO HealthNet Division, Missouri Foundation for Health, Missouri Chapter of the Association of Women's Health, Obstetric and Neonatal Nurses, Nurse Practitioners in Women's Health Association, Missouri Chapter of the Amniotic Fluid Embolism Foundation, Generate Health, St. Louis Integrated Health Network, Bootheel Perinatal Network, Healthy Blue MO, Home State Health, United Healthcare, Nurture KC, Promise 1000, M-Brace Birthing, SafiMoms365, the Doula Foundation and Simply Strategy. These partners successfully aligned efforts to bring Alliance for Innovation on Maternal Health initiatives to Missouri in 2019 and connect directly to the Missouri Pregnancy-Associated Mortality Review Board, which identifies leading causes of morbidity and mortality.

The MO PQC also acknowledges the contributions of AIM, the national, cross-sector commitment designed to lead in developing and implementing patient safety bundles to promote safe care for every U.S. birth. Founded in 2014 through a cooperative agreement funded by the Health Resources and Services Administration and executed by ACOG, the AIM program provides expert technical support and capacity building to multidisciplinary state-based teams, most often perinatal quality collaboratives, leading targeted rapid-cycle quality improvement via implementation of patient safety bundles. An AIM patient safety bundle is a structured way of improving the process of care and patient outcomes: a small, straightforward set of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcomes. Patient safety bundles are developed by expert multidisciplinary working groups, supported by the AIM staff at ACOG. Working groups include representatives appointed by professional member organizations, known experts and researchers specializing in the clinical topic, and patients with lived experience. The bundle development process includes design of measures and metrics for implementation and multiple levels of review from engaged stakeholders.[1]

The MO PQC leverages AIM patient safety bundles as one option to support implementation of evidence-based practice and care delivery redesign for birthing units, providers and communities throughout the state.

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The Evidence

Maternal mortality in the United States is far higher than in other developed nations, and it has been on the rise for several years, falling slightly in 2022.[2,3] In addition, significant racial disparities in health outcomes exist for pregnant and postpartum patients.[3] More than 50% of pregnancy-related deaths occur one week to one year after pregnancy, and more than 80% of pregnancy-related deaths are deemed preventable.[4] Currently, as much as 40% of birthing people do not attend a routine postpartum visit, and few receive all recommended elements of postpartum care.[5]

The postpartum period provides an important opportunity to support birthing people and their families. It is often a time of increased patient motivation, engagement and access to insurance. Intervention in the postpartum period can contribute to long-lasting maternal health and family benefits. It is critical to ensure that birthing people receive comprehensive care and support during the postpartum period.

Traditionally, postpartum care has consisted of a single checkup six weeks after birth. In 2018, ACOG released updated postpartum guidance, signaling the move from a single postpartum touchpoint to a continuum of postpartum care through 12 weeks. Included in this recommendation is an early postpartum checkup within the first three weeks postpartum, followed by ongoing care as needed and concluding with a comprehensive postpartum visit no later than 12 weeks after birth. This visit should include a full assessment of physical, social and psychological well-being, including the following domains: mood and emotional well-being; infant care and feeding; sexuality, contraception and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance. Patients with clinical, psychological, and/or social diagnoses may require even earlier and more frequent health care management. There also should be an emphasis on a transition of care beyond postpartum, through patient education and the identification of a primary care physician and/or specialists for the management of chronic medical conditions.[5]

Recognizing that discharge and transition periods are complex, facilitating effective and supportive hospital discharge and warm hand-offs to outpatient obstetric care, ongoing specialist care, and community supports and services is critical to addressing the immediate postpartum period.

Missouri's Call to Action

The Missouri PAMR Board reviews all deaths of women and birthing people while pregnant or within one year of the end of the pregnancy. Pregnancy-associated death is the overarching term used when referring to maternal deaths. Within this broad categorization are more specific terms to describe the cause of death, including pregnancy-related death; pregnancy-associated, but not related (PANR) death; and pregnancy-associated, but unable to determine relatedness.[6]

Pregnancy-related death: Death occurring during or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiological effects of pregnancy[6]

PANR: Death during or within one year of pregnancy from a cause that is not related to pregnancy[6] (e.g., pregnant person who dies in a natural disaster)

Pregnancy-associated, but unable to determine relatedness: Cases when the board was unable to determine if a death was pregnancy-related or PANR[6]

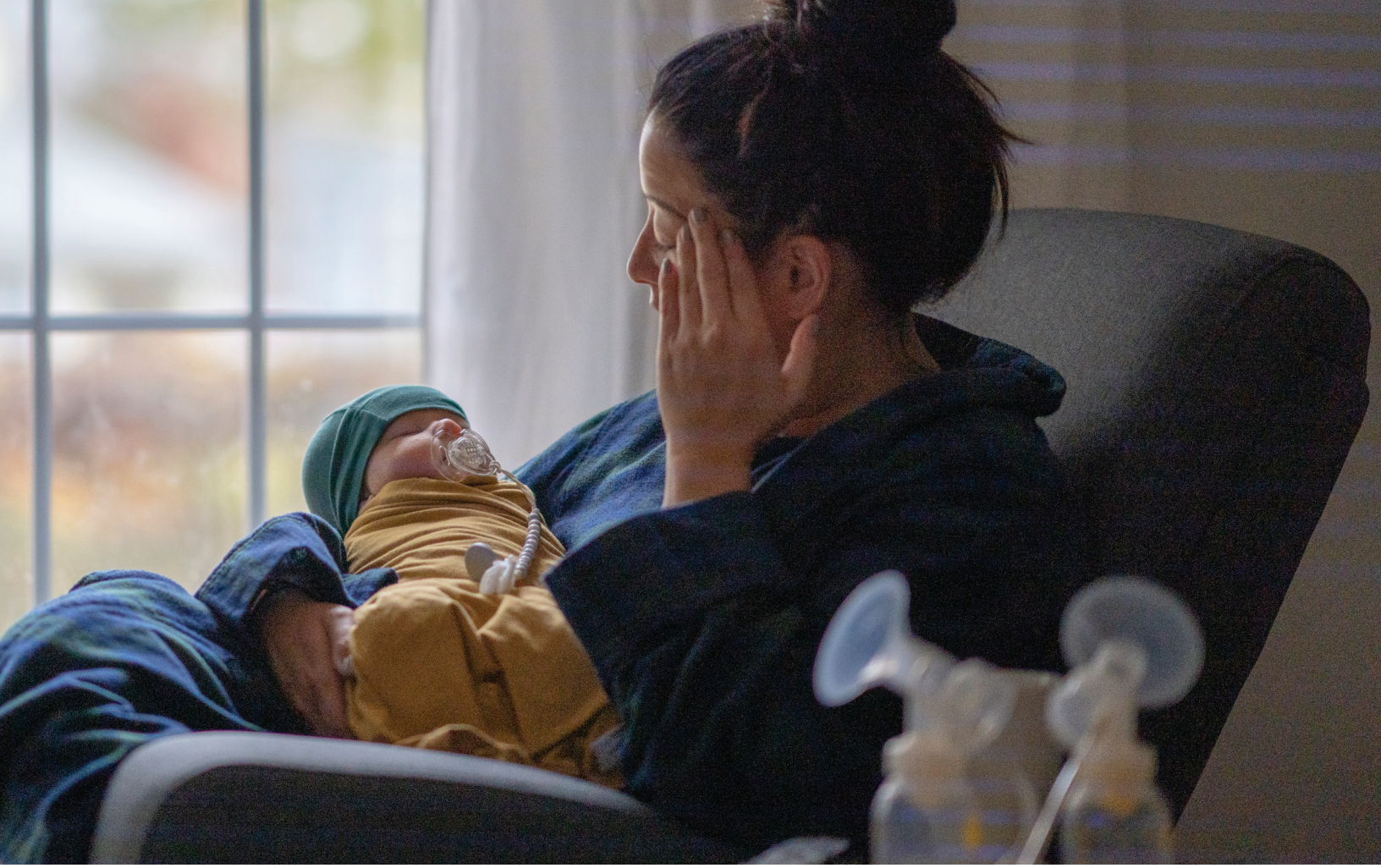
Maternal morbidity: Any health condition attributed to and/or aggravated by pregnancy and childbirth that negatively impacts women's health short-term or long-term (Updated June 2024).[6]

Maternal mortality: The World Health Organization defines a maternal death as "a death while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by pregnancy or its management, but not from accidental or incidental causes."[3] In Missouri, the term maternal mortality is used to describe the death of a person during pregnancy, childbirth and the postpartum period up to 365 days from the end of a pregnancy (Updated June 2024).[6]

The 2023 Missouri PAMR report, reviewing maternal deaths from 2018 to 2020, found the majority (81%) of pregnancy-related deaths occurred in the postpartum period.[7] In the case of pregnancy-related deaths during the first 42 days after delivery, underlying conditions were primarily mental health conditions, hemorrhage, infection and cardiovascular disease. Pregnancy-related deaths during the 43-365 days postpartum period were primarily attributed to mental health conditions, followed by cardiovascular disease and injury. The breadth of underlying causes highlights the need for improvements across the board rather than within a targeted clinical topic. An approach that improves care coordination while also integrating clinical, psychological and social care needs in an equitable way will be required to reduce harm and death in both early and late postpartum periods. And, since most (49%) of the deaths occurred between 43 days and one year postpartum, and 85% of all deaths were deemed preventable, it is critical that early identification and timely treatment are initiated to prevent progression of postpartum conditions.[7]

As recommended by ACOG, optimal postpartum care should be an ongoing process with, at minimum, a check-in within three weeks of delivery and a comprehensive visit by 12 weeks post-delivery. However, this guidance has not yet been broadly adopted, with only 50% of obstetric providers establishing the recommendations in their practices, according to one survey.[8] A review of electronic health record data across three organizations in North Carolina showed only 61% of patients received comprehensive postpartum care that addressed all recommended topics while only 31% received both ACOG recommended visits.[9]

Perhaps even more concerning is that many people don't receive *any* postpartum care. While the rate of postpartum visit attendance varies substantially across studies,[10] Centers for Medicare and Medicaid Services data for the most recent reporting year showed that **only 53.8% of Missouri Medicaid and CHIP participants with a live birth attended a postpartum visit.**[11]



The lack of sufficient clinical providers, including obstetricians, primary care providers and mental and behavioral health providers, adds a greater burden to those providing postpartum care. **In Missouri, 93% of counties are fully designated as primary care professional shortage areas with another 4% partially designated.**[12] Similarly, mental health professional shortage areas cover 96% of counties, with an additional 2% partially designated.[13]

These data demonstrate the many opportunities for improved postpartum care for all individuals, and particularly for those with disparate maternal health outcomes, including individuals with only a high school education or GED, those with a Medicaid-covered pregnancy and Black women.[7] Key objectives for improving postpartum care include ensuring smooth hand-offs between the various clinical and nonclinical providers following discharge and beyond, increasing the rate of attendance at postpartum visits, and improving the effectiveness of postpartum interactions.

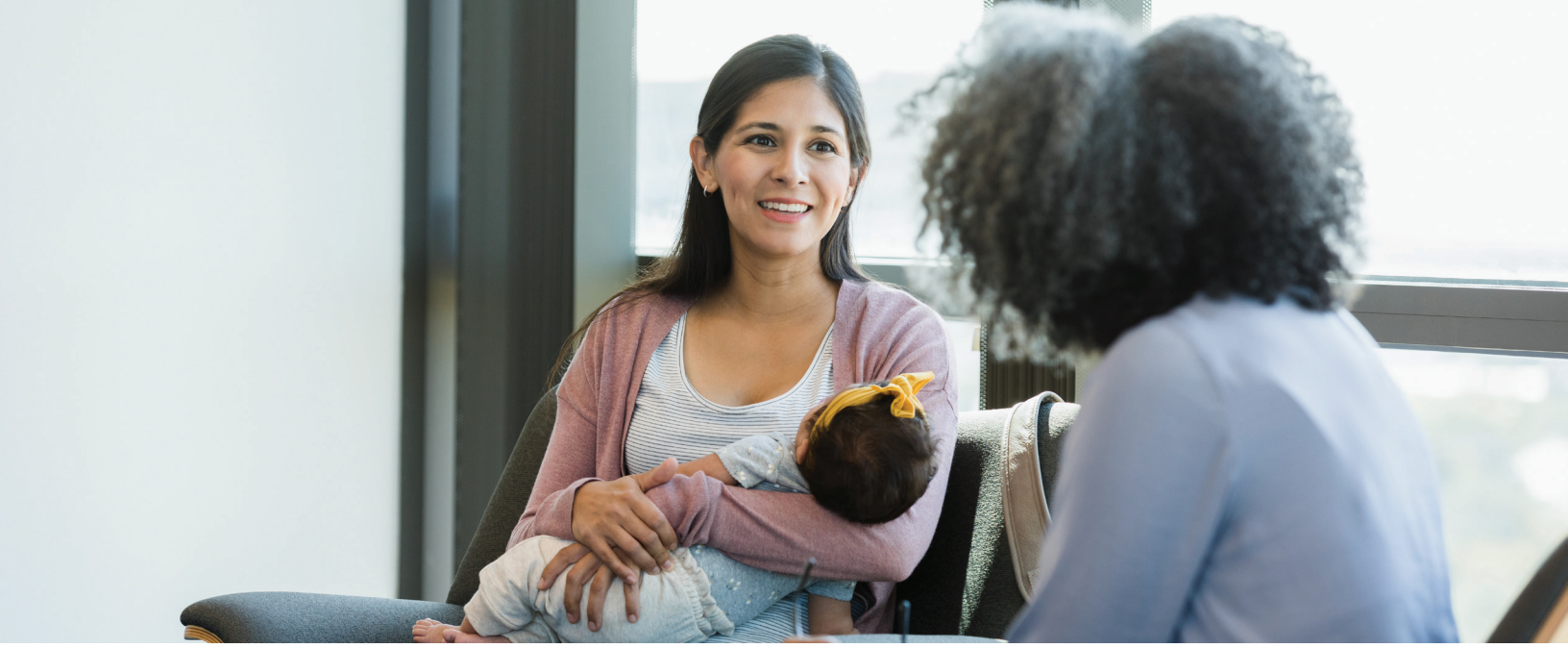
Nonclinical providers and community-based resources, such as health departments, navigator programs and social support agencies, complement the role of clinical providers and can help provide critical support for birthing people and their families in the postpartum period. Building upon and leveraging additional workforce opportunities, such as doulas, community health workers and peer recovery coaches, also may support improved maternal and infant outcomes by increasing access to medical and social support.[14] Early patient engagement in medical and social care and resource referrals increases opportunities to educate the patient, results in fewer conflicts in care needs at the time of birth, improves patient-provider relationships and produces better overall health outcomes.[15]

While this document focuses primarily on the early postpartum period, often referred to as the "fourth trimester," the period beyond — the transition from postpartum obstetric care to specialty providers or primary care providers — is equally as important. As part of a nationwide movement, Medicaid coverage in Missouri was extended in 2023 to provide coverage for a full 12 months following delivery. To date, 47 states and the District of Columbia have implemented this policy change.[16] Given the significant portion of pregnancy-related deaths beyond postpartum milestones such as the traditional six-week visit, the updated ACOG-recommended 12-week postpartum period and the historical 60-day Medicaid coverage ending, this extension provides a promising opportunity to improve outcomes for some of our most vulnerable populations. Medicaid benefits during this time provide additional pathways to identify health concerns and can be leveraged by patients and providers to stabilize underlying conditions and support the transition beyond pregnancy and postpartum to well-woman care.

It is critical to establish successful postpartum care transitions, recognize immediate care needs, and ensure timely and effective responses to postpartum complications and concerns. Health care institutions, community-based organizations, and both clinical and nonclinical providers should implement evidence-based practices and ensure a continual level of readiness to best care for postpartum patients. These include the following.

- use of a postpartum discharge template
- implementation of ACOG recommendations for an early postpartum touchpoint within three weeks and a comprehensive visit by 12 weeks
- universal screening for mental health conditions and substance use disorders
- universal screening for social drivers of health, including intimate partner violence
- development and utilization of strong referral networks for mental health providers, community health workers, home visiting programs, doulas, WIC, community-based organizations, and other relevant local resources to support identified mental health, substance use, and social needs
- warm hand-offs for referrals and transitions of care
- patient, family and provider education on maternal warning signs
- identification of physician for transition to extended postpartum care, treatment for chronic conditions and/or transition to well-woman care
- patient and provider education of Medicaid benefits through 12 months post-delivery, if applicable

The MO PQC encourages all stakeholders in maternal-infant health to take action to reduce severe maternal morbidity and mortality by planning for postpartum patients and their health care needs after pregnancy. The purpose of this resource workbook is to provide a framework for evidence-based care and lay the foundation for respectful, equitable and supportive care for all during the postpartum period. Birthing organizations interested in learning more about postpartum discharge transition may register with the MO PQC.



AIM Bundle Components[17]

An AIM patient safety bundle is a structured way of improving the process of care and patient outcomes: a small, straightforward set of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcomes.

Readiness — Every Unit

- ☐ Develop and maintain a set of referral resources and communication pathways between obstetric providers, community-based organizations, and state and public health agencies to enhance services and supports for pregnant and postpartum families.
  - ☐ Communication pathways may include phone or medical record-based communication.
  - ☐ Resources should include the following.
    - ☐ specialist care
    - ☐ social driver needs
    - ☐ mental health supports
    - ☐ substance use disorder treatment
- ☐ Establish a multidisciplinary care team to design coordinated clinical pathways for patient discharge and a standardized discharge summary form to give to all postpartum patients prior to discharge.
- ☐ Provide multidisciplinary staff education to clinicians and office staff on optimizing postpartum care, including why and how to screen for life-threatening postpartum complications.
  - ☐ Staff education on postpartum complications should include the following.
    - ☐ medical conditions
    - ☐ mental health conditions
    - ☐ substance use disorders
    - ☐ social and structural drivers of health
- ☐ Develop trauma-informed protocols and trainings to address health care team member biases to enhance quality of care.
- ☐ Educate outpatient care staff on how to use a standardized discharge summary form to review patient data and ensure that recommendations made for outpatient follow-up and community services/resources have been carried out.

Recognition and Prevention — Every Patient

- ☐ Establish a system for scheduling the postpartum care visit and needed immediate specialty care visit or contact (virtual or in-person visit) prior to discharge or within 24 hours of discharge.
- ☐ The postpartum care visit and immediate specialty care visit should be inclusive of emergency behavioral health care and based on known risk factors and conditions. These visits also may include telehealth strategies of care to improve access.
- ☐ Screen each patient for postpartum risk factors and provide linkage to community services/resources prior to discharge.
    - ☐ Screening for community support needs and resources should include the following.
        - ☐ medical conditions
        - ☐ mental health needs or conditions
        - ☐ substance use disorder needs
        - ☐ structural and social drivers of health
    - ☐ All provided resources should align with the postpartum patient's health literacy, cultural needs, language proficiency, and geographic location and access.
- ☐ In all care environments, assess and document if a patient presenting is pregnant or has been pregnant within the past year.
- ☐ Offer reproductive life planning discussions and resources, including access to a full range of contraceptive options in accordance with safe therapeutic regimens. Reproductive life planning considerations may include the following.
    - ☐ using shared medical decision making
    - ☐ congruence with patient's goals and values
    - ☐ contraceptive options
    - ☐ birth spacing and pregnancy intention
    - ☐ chest or breastfeeding
    - ☐ other health and parenting choices as prioritized by the postpartum patient
- ☐ Facilitate and assure linkage to relevant services in outpatient settings for care identified for postpartum risk factors.

Response — Every Event

- ☐ Provide patient education prior to discharge that includes life-threatening postpartum complications and early warning signs, including mental health conditions, in addition to individual patient-specific conditions, risks, and how to seek care.
    - ☐ Patient discharge education should include the following.
        - ☐ who to contact with medical and mental health concerns, ideally stratified by severity of condition or symptoms
        - ☐ physical and mental health needs
        - ☐ review of warning signs/symptoms including what conditions they might be related to, allowing for advocacy if an approached provider is not obstetrical or of another clinical specialty
        - ☐ reinforcement of the value of outpatient postpartum visits
        - ☐ summary of birth events
        - ☐ home monitoring process and parameters for blood pressure, blood glucose and/or other monitoring metrics
    - ☐ Patient education provided should be in appropriate lay terminology; aligned with the postpartum person's health literacy, culture, language and accessibility needs; and include a designated support person for all teaching with patient permission (or as desired).

- [ ] Provide each postpartum patient with a standardized discharge summary form that details key information from pregnancy and delivery. A standardized discharge summary should include the following.
    - [ ] name and age
    - [ ] support person's contact information
    - [ ] gravida/para status
    - [ ] date and type of birth, gestational age at birth, relevant conditions and complications
    - [ ] name, contact information and appointments for relevant providers, including OB-GYN specialists, mental health providers, etc.
    - [ ] positive screening for medical risk factors, mental health and substance use
    - [ ] medications and supplements
    - [ ] unmet actual and potential social drivers of health needs
    - [ ] suggested community services and supports
    - [ ] need for specific postpartum testing, such as glucose testing or complete blood count
- [ ] Conduct a comprehensive postpartum visit, which should include the following.
    - [ ] screening for social and structural drivers of health and postpartum risk factors, including mental health and substance use disorders with linkage to needed referrals and services and/or provision of treatment as needed
    - [ ] assessment of physical recovery from delivery and pregnancy-associated conditions
    - [ ] assessment of chronic diseases (pre-pregnancy onset or enduring from pregnancy-onset conditions), with management or referral to primary or specialist care
    - [ ] establish care congruent with the patient's reproductive life plan, including access to highly effective methods of contraception if desired
    - [ ] transition to ongoing well-person care including provision of or scheduling of indicated health maintenance services with transition to appropriate provider as needed
- [ ] Encourage the presence of a designated support person during all instances of care as desired, and particularly when teaching or education occurs.
- [ ] Engage in dialogue with the postpartum patient around elements of postpartum self-care prior to discharge. Postpartum care elements should include the following.
    - [ ] emotional well-being
    - [ ] medication and substance use
    - [ ] physical recovery
    - [ ] sleep/fatigue
    - [ ] sexual health and activity
- [ ] Implement a multidisciplinary discharge process to provide a coordinated pathway for clinical postpartum discharge, which may include multidisciplinary rounding.

Reporting and Systems Learning — Every Unit

- ☐ Convene inpatient and outpatient providers in an ongoing way to share successful strategies and identify opportunities for prevention of undesired outcomes in the postpartum period, including emergency and urgent care clinicians and staff.
- ☐ Consider a multidisciplinary huddle for postpartum patients identified as higher risk for complications to identify potential gaps or adjustments to the standardized discharge process.
- ☐ Develop and systematically utilize a standard comprehensive postpartum visit template.
- ☐ Identify and monitor postpartum quality measures in all care settings. Postpartum quality measures, per available data, may include the following.
    - ☐ postpartum readmissions
    - ☐ postpartum visit attendance
    - ☐ screening rate for recommended postpartum preventive screenings
    - ☐ rate of postpartum visits scheduled prior to discharge from birth hospitalization
    - ☐ patient education rate for postpartum warning signs
- ☐ Monitor data related to completed postpartum comprehensive visits in each office, with disaggregation by race and ethnicity at a minimum, to evaluate disparities in rate of follow-up visit completion.

Respectful, Equitable and Supportive Care — Every Unit/Provider/Team Member

- ☐ Include each postpartum person and their identified support network as respected members of and contributors to the multidisciplinary care team.
    - ☐ Inclusion of the patient as part of the multidisciplinary care team supports the following.
        - ☐ establishment of trust
        - ☐ informed, bidirectional shared decision making
        - ☐ development of a comprehensive postpartum care plan
        - ☐ patient values and goals as the primary driver of this process
    - ☐ Patient support networks may include nonfamilial supports, such as doulas and home visitors, who, with the postpartum person's permission, should be welcomed when any teaching or planning is provided.
- ☐ Engage in open, transparent, and empathetic communication with pregnant and postpartum people and their identified support network to understand diagnoses, options, and treatment plans.

Resources

Postpartum care covers a variety of clinical topics. Additional topic-specific workbooks and guidance documents, including universal mental health and SUD screening, cardiac conditions, hypertensive disorders, injury prevention, and others, can be found on the Missouri Perinatal Quality Collaborative website (mopqc.org).

General

AIM: Postpartum Discharge Transition Patient Safety Bundle
ACOG: Optimizing Postpartum Care
ACOG: ACOG Postpartum Toolkit for Health Care Providers
American Academy of Family Physicians: Postpartum Care: An Approach to the Fourth Trimester
Alliance for Innovation of Maternal Health Community Care Initiative: Community Care for Postpartum Safety and Wellness

Checklists and Templates

4th Trimester Project: Postpartum Healthcare Plan Template
4th Trimester Project: Postpartum Support Plan for New Parents
4th Trimester Project: Postpartum Visit Checklist
Postpartum Support Virginia: Postpartum Plan for Parents and Families
ACOG: Postpartum Care Checklist
Society for Maternal-Fetal Medicine Special Statement: Postpartum visit checklists for normal pregnancy and complicated pregnancy
SMFM Special Statement: Checklist for postpartum discharge of women with hypertensive disorders
Women's Preventive Services Initiative: Recommendations for Well-Woman Care

Telehealth and Mental Health Resources

MHAP: Missouri Maternal Health Access Project
Health Resources and Services Administration: National Maternal Mental Health Hotline
Federal Communications Commission: 988 Suicide and Crisis Lifeline
AIM CCI: Community Care for Postpartum Safety and Wellness
Postpartum Support International: HelpLine

Education

Health Care Professional-facing Materials
The 4th Trimester Project: Postpartum in Practice: Practice Guidelines and Billing
The 4th Trimester Project: Clinical Tools for Care Teams
Centers for Disease Control and Prevention: Hear Her® Campaign
Reproductive Health National Training Center: Recognize Postpartum Warning Signs

Patient-facing Materials

CDC: Hear Her® Campaign (also available in various languages)
AIM: Urgent Maternal Warning Signs
ACOG: Pregnancy Status Signs in English and Spanish

Huddles and Debriefings

Institute for Healthcare Improvement: Patient Safety Essentials Toolkit: Huddles
Agency for Healthcare Research and Quality: Daily Huddle Component Kit
AHRQ: Improving Patient Safety and Team Communication through Daily Huddles
AHRQ: Debriefing for Clinical Learning
AHRQ: Action Planning Template
Clinical Excellence Commission: Post-Event Safety Huddles

Respectful, Equitable and Supportive Care

ACOG: Communication Strategies for Patient Handoffs
AHRQ: Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families
March of Dimes: Beyond Labels: Do Your Part to Reduce Stigma
ACOG: Respectful Care eModules
Institute for Healthcare Advancement: 10 Elements of Competence for Using Teach-back Effectively
IHA: Always Use Teach-back! Training Toolkit
IHA: Teach-back Quick Guide
Ottawa Hospital Research Institute: Patient Decision Aids: Implementation Toolkit
AHRQ: SHARE Approach Curriculum Tools
CMS: Providing Language Services to Diverse Populations: Lessons from the Field
Rural Health Information Hub: Enhancing Services for Deaf, Hard of Hearing, and Deafblind Patients in Rural America

Trauma-informed Care

SAMHSA: Concept of Trauma and Guidance for a Trauma-Informed Approach
Trauma-Informed Care Implementation Resource Center: All Resources
Journal of Obstetric, Gynecologic & Neonatal Nursing: National Partnership for Maternal Safety: Consensus Bundle on Support After a Severe Maternal Event
AIM: Patient Support After a Severe Event: The Importance of Providing Trauma-Informed Care
AIM: Implementing a Clinician and Staff Peer Support Program
Crisis Prevention Institute: 3 Keys to Help Staff Cope With Secondary Trauma

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