Utilize the chat box when requested for discussion. Send other questions directly to LeeAnne Mullen.

Please mute your microphone or phone.

Click here to open the Chat feature.
Goal: Enrollment & PP Care Teams
“Intentional Effort”

Eight Keys to FTI Success

➢ Guideline-Driven, Best Practice Healthcare
➢ Mechanisms to assure timely referral and follow up
➢ Postpartum Care Team
➢ Standardized Screening (Medical, social needs, etc)
➢ Personalized Patient Plan of Care/Mom Plan
➢ Reproductive Health Planning
➢ Address racial disparities and health equity
➢ Ongoing insurance coverage
Enrollment is OPEN!!!!

✓ Enrollment Packet
✓ Next Steps
✓ Birth Facilities, then Birth Centers, then PCCs
✓ Common Questions
✓ Open Mic
Shout out to #1 FTI Enrolled Facility

Hiawatha Community Hospital
Enrollment! Why? When? How?
April Learning Forum: Black Maternal Health Lunch & Learn

Join Us

VIRTUAL LUNCH AND LEARN
In recognition of Black Maternal Health Week, the Kansas Department of Health and Environment will be hosting a Lunch and Learn to discuss Black maternal health disparities in Kansas.

Thursday, April 15, 2021
Noon - 1 p.m.

NO REGISTRATION REQUIRED
To join: us02web.zoom.us/j/82751389732
Rapid Response: KCC Packet

Kansas Connecting Communities

A collaborative initiative to improve the mental health and well-being of pregnant and postpartum women.
**Rapid Response: Survey Results!**

**KMMRC 2020 Survey Highlights**

A total of 128 survey responses were collected representing 42% of 66 birth facilities in Kansas.

### Screenings for Pregnant or Postpartum Women

Of the 40 affiliated birth facilities who provided at least one response to this question, the use of sexual and domestic violence screenings was reported the most (97.5%), while the use of reproductive health, including goal-setting, screenings was reported the least (57.5%).

<table>
<thead>
<tr>
<th>Screening Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual and domestic violence</td>
<td>97.5%</td>
</tr>
<tr>
<td>Tobacco</td>
<td>95.0%</td>
</tr>
<tr>
<td>Substance use</td>
<td>95.0%</td>
</tr>
<tr>
<td>Mental health</td>
<td>92.5%</td>
</tr>
<tr>
<td>Chronic and infectious disease</td>
<td>92.5%</td>
</tr>
<tr>
<td>BMI</td>
<td>77.5%</td>
</tr>
<tr>
<td>Social determinants</td>
<td>62.5%</td>
</tr>
<tr>
<td>Reproductive health</td>
<td>57.5%</td>
</tr>
</tbody>
</table>

**KMMRC 2020 Survey Highlights**

**Referral Mechanisms for Postpartum Women**

Of the 42 birth facilities who provided at least one response to this question, the most common referral mechanism reported was ‘patient is provided resources and self-refers’ (78.6%). The least common referral mechanism reported was ‘healthcare navigator is in charge of referrals’ (19.0%).

- **Patient is provided resources and self-refers** – 78.6%
- **Local Health Department providers are in charge of referrals** – 33.3%
- **OB provider is in charge of all referrals** – 69.0%
- **Other responses, such as EHR or other staff** – 16.6%
- **Social work referral from inpatient to outpatient setting** – 66.7%
- **OB clinic is in charge of referrals** – 35.7%
- **Healthcare Navigator is in charge of referrals** – 19.0%
We were right....darn
We have to decide together... NOT on my watch
Postpartum Care Team: Member #1 is MOM!

Remember to see the faces in the numbers
There is no “I” in Team

The Postpartum Care Team
“New” Model: The Postpartum Care Team

Nurses

OB Provider

PCP

Infant Health provider

Specialty Provider

Support persons

OB Navigator

Lactation Support

Home Visitor
How does this connect to improved maternal outcomes postpartum?
inclusive of family and friends who will provide social and material support in the months following birth, as well as the medical provider(s), who will be primarily responsible for care of the woman and her infant after birth (19). Suggested components of the postpartum care team and care plan are listed in Table 1 and Table 2. The care plan should identify the primary care provider and other medical providers (eg, psychiatrist) who will assume care of chronic medical issues after the postpartum period. If the obstetrician–gynecologist serves as the primary care provider, then transition to another primary care physician is unnecessary.

Transition From Intrapartum to Postpartum Care

The postpartum care plan should be reviewed and updated after the woman gives birth. Women often are uncertain about whom to contact for postpartum concerns (27). In a recent U.S. survey, one in four postpartum women did not have a phone number for a health care provider to contact for any concerns about themselves or their infants (12). Therefore, it is suggested that the care plan include contact information and written instructions regarding the timing of follow-up postpartum care. Just as a health care provider or health care practice leads the woman’s care during pregnancy, a primary obstetrician-gynecologist or other health care provider should assume responsibility for her postpartum care (15). This individual or practice is the primary point of contact for the woman, for other members of the postpartum care team, and for any maternal health concerns noted by the infant’s health care provider. When the woman is discharged from inpatient care but prolonged infant hospitalization remote from the woman’s home is anticipated, a local obstetrician–gynecologist or other health care provider should be identified as a point of contact and an appropriate hand-off should occur. Such a referral should occur even if delivery did not take place at a local hospital.

Substantial morbidity occurs in the early postpartum period; more than one half of pregnancy-related maternal deaths occur after the birth of the infant (6). Blood pressure evaluation is recommended for women with hypertensive disorders of pregnancy no later than 7–10 days postpartum (28), and women with severe hypertension should be seen within 72 hours; other experts have recommended follow-up at 3–5 days (29). Such assessment is critical given that more than one half of postpartum strokes occur within 10 days of discharge (30). In-person follow-up also may be beneficial for women at high risk of complications, such as postpartum depression (31), cesarean or perineal wound infection, lactation difficulties, or chronic conditions such as seizure disorders that require postpartum medication titration. For women

Table 1. Suggested Components of the Postpartum Care Plan

<table>
<thead>
<tr>
<th>Element</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care team</td>
<td>Name, phone number, and office or clinic address for each member of care team</td>
</tr>
<tr>
<td>Postpartum visits</td>
<td>Time, date, and location for postpartum visits; phone number to call to schedule or reschedule appointments</td>
</tr>
<tr>
<td>Infant feeding plan</td>
<td>Intended method of infant feeding, resources for community support (eg, WIC, Lactation Warm Lines,</td>
</tr>
</tbody>
</table>
Optimizing Postpartum Care

Recommendations and Conclusions
The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions:

- To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman’s individual needs.
- Anticipatory guidance should begin during pregnancy with development of a postpartum care plan that addresses the transition to parenthood and well-woman care.
- Prenatal discussions should include the woman’s reproductive life plans, including desire for and timing of any future pregnancies. A woman’s future pregnancy intentions provide a context for shared decision-making regarding contraceptive options.
- All women should ideally have contact with a maternal care provider within the first 3 weeks postpartum. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth.
## The Postpartum Care Plan

### Table 1. Suggested Components of the Postpartum Care Plan*

<table>
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</tr>
<tr>
<td>Infant feeding plan</td>
<td>Intended method of infant feeding, resources for community support (e.g., WIC, Lactation Warm Lines, Mothers’ groups, return-to-work resources)</td>
</tr>
<tr>
<td>Reproductive life plan and contraception</td>
<td>Desired number of children and timing of next pregnancy; method of contraception, instructions for when to initiate, effectiveness, potential adverse effects, and care team member to contact with questions</td>
</tr>
<tr>
<td>Pregnancy complications</td>
<td>Pregnancy complications and recommended follow-up or test results (e.g., glucose screening for gestational diabetes, blood pressure check for gestational hypertension), as well as risk reduction recommendations for any future pregnancies</td>
</tr>
<tr>
<td>Adverse pregnancy outcomes associated with ASCVD</td>
<td>Adverse pregnancy outcomes associated with ASCVD will need baseline ASCVD risk assessment, as well as discussion of need for ongoing annual assessment and need for ASCVD prevention over lifetime</td>
</tr>
<tr>
<td>Mental health</td>
<td>Anticipatory guidance regarding signs and symptoms of perinatal depression or anxiety; management recommendations for women with anxiety, depression, or other psychiatric issues identified during pregnancy or in the postpartum period</td>
</tr>
<tr>
<td>Postpartum problems</td>
<td>Recommendations for management of postpartum problems (i.e., pelvic floor exercises for stress urinary incontinence, water-based lubricant for dyspareunia)</td>
</tr>
<tr>
<td>Chronic health conditions</td>
<td>Treatment plan for ongoing physical and mental health conditions and the care team member responsible for follow-up</td>
</tr>
</tbody>
</table>

Abbreviations: ASCVD, atherosclerotic cardiovascular disease; WIC, Special Supplemental Nutrition Program for Women, Infants, and Children.

*A Postpartum Care Plan Template is available as part of the ACOG Pregnancy Record.

VOL. 131, NO. 5, MAY 2018

Committee Opinion: Optimizing Postpartum Care e143
# The Postpartum Care Team 411

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family and friends</td>
<td>• Ensures woman has assistance for infant care, breastfeeding support,</td>
</tr>
<tr>
<td></td>
<td>care of older children</td>
</tr>
<tr>
<td></td>
<td>• Assists with practical needs such as meals, household chores, and</td>
</tr>
<tr>
<td></td>
<td>transportation</td>
</tr>
<tr>
<td></td>
<td>• Monitors for signs and symptoms of complications, including mental</td>
</tr>
<tr>
<td></td>
<td>health</td>
</tr>
<tr>
<td>Primary maternal care provider (obstetrician–gynecologist, certified</td>
<td>• Ensures patient’s postpartum needs are assessed and met during the</td>
</tr>
<tr>
<td>nurse midwife, family physician, women’s health nurse practitioner)</td>
<td>postpartum period and that the comprehensive postpartum visit is</td>
</tr>
<tr>
<td></td>
<td>completed</td>
</tr>
<tr>
<td></td>
<td>• “First call” for acute concerns during postpartum period</td>
</tr>
<tr>
<td></td>
<td>• Also may provide ongoing routine well-woman care after comprehensive</td>
</tr>
<tr>
<td></td>
<td>postpartum visit</td>
</tr>
<tr>
<td>Infant’s health care provider (pediatrician, family physician, pediatric</td>
<td>• Primary care provider for infant after discharge from maternity care</td>
</tr>
<tr>
<td>nurse practitioner)</td>
<td></td>
</tr>
<tr>
<td>Primary care provider (also may be the obstetric care provider)</td>
<td>• May co-manage chronic conditions (e.g., hypertension, diabetes,</td>
</tr>
<tr>
<td></td>
<td>depression)</td>
</tr>
<tr>
<td></td>
<td>• Assumes primary responsibility for ongoing health care after</td>
</tr>
<tr>
<td></td>
<td>comprehensive postpartum visit</td>
</tr>
<tr>
<td>Lactation support (professional IBCLC, certified counselors and educators,</td>
<td>• Provides anticipatory guidance and support for breastfeeding</td>
</tr>
<tr>
<td>peer support)</td>
<td>• Co-manages complications with pediatric and maternal care providers</td>
</tr>
<tr>
<td>Care coordinator or case manager</td>
<td>• Coordinates health and social services among members of postpartum</td>
</tr>
<tr>
<td></td>
<td>care team</td>
</tr>
<tr>
<td>Home visitor (e.g., Nurse Family Partnership, Health Start)</td>
<td>• Provides home visit services to meet specific needs of mother–infant</td>
</tr>
<tr>
<td></td>
<td>dyad after discharge from maternity care</td>
</tr>
<tr>
<td>Speciality consultants (i.e., maternal–fetal medicine, internal medicine</td>
<td>• Co-manages complex medical problems during postpartum period</td>
</tr>
<tr>
<td>subspecialist, behavioral health care provider)</td>
<td>• Provides postpregnancy counseling for future pregnancies</td>
</tr>
</tbody>
</table>

Abbreviation: IBCLC, international board certified lactation consultant.

*Members of the care team may vary depending on the needs of the mother–infant dyad and locally available resources.*
“New” Model:
The Postpartum Care Team

Nurses

Infant Health provider
Specialty Provider
Support persons
OB Navigator
OB Provider
PCP
Lactation Support
Home Visitor
Sizing up your PP Care Team

QI: Assess baseline at Enrollment
Complete prior to AIM Bundle start

- Patient
- Primary Maternal Care Provider
  - Subsequently PCP
- Birth Facility nursing staff
- Infant Provider
- Lactation Support

- Care coordinator (inpatient to outpatient)
  - Social Worker, Maternal Navigator
- Home Visitor
- Specialty provider, PRN
  - MFM, Behavioral Health, Internal Med
Let’s Huddle!

How many of you have an established PP Care Team?
Collective Impact: The Postpartum Care Team and how it relates to the Screen & Refer “Circle”

**Inpatient**
- Hospitals
- Birth Centers
- Home Births
- Providers
- Nurses
- Navigators
- Social Workers

**Outpatient**
- Navigators
- MCH partners
- FQHCs
- Free-standing Clinics
- Private Practice Clinics
- WIC
- KanCare
- MCOs
- Home Visitors
- PAT (School Districts)
- MORE!
Immediate Postpartum

- Medical Referrals, Navigation, Breastfeeding, Home Visiting, Mom Plan, Peds, Behavioral Health, Transportation, Insurance

OB F/U Appointments (1, 3 weeks, up to 12)

Medical Referrals, Navigation, Behavioral Health, Breastfeeding, Home Visiting, Insurance, Transportation, Family Planning, Peds

Comprehensive Well Woman Exam (12 Weeks-1 year)

Primary Care, Well Child Appts

Circle of Care
Case Studies

- Introduce patient scenario
- Walk through what happens (include screens, referrals)
- Talk through what’s missing in their PP Care Team
- Look for: agency connections, information, adequate resources, etc
Checklist for Case studies

- Who is needed from PP Care Team?
- Who is navigating her/the team?
- Who is paying for services?
- Who is captain of her ship?
- What social determinants are occurring?
- Does race play a part?
- Family involvement matters?
- What is timeline for “next step”?
- How do you know referral happened?
- How do you ID “success” in this case?
Case Study #1

Breastfeeding G1 P1

Day of discharge
Who do you need?
Who do you have?

- Patient
- Primary Maternal Care Provider
  - Subsequently PCP
- Birth Facility nursing staff
- Infant Provider
- Lactation Support

- Care coordinator
  - Social Worker, Navigator
- Home Visitor
- Specialty provider, PRN
  - MFM, Behavioral Health, Internal Med
Case Study #2

Maternal Mental Health

G3P3
Medical Hx: PPD last two pregnancies

PPD #1
Who do you need?  
Who do you have?

- Patient
- Primary Maternal Care Provider
  - Subsequently PCP
- Birth Facility nursing staff
- Infant Provider
- Lactation Support

- Care coordinator
  - Social Worker, Navigator
- Home Visitor
- Specialty provider, PRN
  - MFM, Behavioral Health, Internal Med
Case study #3

Preeclampsia, requiring 28 week transfer & delivery at Tertiary Care Center

POD #3 s/p Primary C-Section

Med hx:
Chronic HTN, Obesity & Smoking
Who do you need?
Who do you have?

- Patient
- Primary Maternal Care Provider
  - Subsequently PCP
- Birth Facility nursing staff
- Infant Provider
- Lactation Support

- Care coordinator
  - Social Worker, Navigator
- Home Visitor
- Specialty provider, PRN
  - MFM, Behavioral Health, Internal Med
Stay Tuned
PP Care Team + Discharge Planning Protocols
Best Practice Models

ACOG Committee Opinion 2018
Improving Discharge Outcomes with Patients and Families

Evidence for engaging patients and families in discharge planning

Nearly 20 percent of patients experience an adverse event within 30 days of discharge. Research shows that three-quarters of these could have been prevented or ameliorated. Common post-discharge complications include adverse drug events, hospital-acquired infections, and procedural complications. Many of these complications can be attributed to discharge planning problems, such as:

- Changes or discrepancies in medications before and after discharge
- Inadequate preparation for patient and family related to medications, danger signs, or lifestyle changes
- Disconnect between clinician information-giving and patient understanding
- Discontinuity between inpatient and outpatient providers

Involving the patient and family in discharge planning can improve patient outcomes, reduce unplanned readmissions, and increase patient satisfaction.

More and more, hospitals are focusing on transitions in care as a way to improve hospital quality and safety. As one indicator of this, the Centers for Medicare and Medicaid Services implemented new guidelines in 2013 that reduce payment to hospitals exceeding their expected readmission rates.

To improve quality and reduce preventable readmissions, [insert hospital name] will use the Agency for Healthcare Research and Quality’s Transitions from Hospital to Home: IDEAL Discharge Planning process to engage patients and families in preparing for discharge to home.

Key elements of IDEAL Discharge Planning

In
clude the patient and family as full partners in the discharge planning process.

Discuss with the patient and family five key areas to prevent problems at home:

1. Describe what life at home will be like
2. Review medications
3. Highlight warning signs and problems
4. Explain test results
5. Make followup appointments

Educate the patient and family in plain language about the patient’s condition, the discharge process, and next steps throughout the hospital stay.

Assess how well doctors and nurses explain the diagnosis, condition, and next steps in the patient’s care to the patient and family and use teach back.

Listen to and honor the patient’s and family’s goals, preferences, observations, and concerns.

This process will include at least one meeting to discuss concerns and questions with the patient, family of their choice, and [identify staff].

What does this mean for clinicians?

We expect all clinicians to:

- Incorporate the IDEAL discharge elements in their work
- Make themselves available to the [identify staff] who will work closely with the patient and family
- Take part in trainings on the process
Dates to remember

NO Learning Forum April, May, June

• April
  7, 14, 21, 29: ECHO series, Perinatal Mood Disorder
  15<sup>th</sup>: BMHW webinar (12-1pm)
  16<sup>th</sup>: Enrollment for FTI due

• May 11<sup>th</sup>: General Meeting (1-4pm)

• June & July: Regional Trainings