KPQC General Meeting

FTI Data Worksheet 5.24.22

Name of FTI Champion: ________________________________

Birth Facility Name: ________________________________

<table>
<thead>
<tr>
<th>NICU Level: 1 2 3 4</th>
<th>Maternal Care Level: BC 1 2 3 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Use “Levels of NICU Care”</td>
<td>*Use “Levels of Maternity Care”</td>
</tr>
<tr>
<td>Project</td>
<td>Yes</td>
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<tr>
<td>We currently screen all postpartum moms prior to discharge for maternal mental health</td>
<td>Yes</td>
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<tr>
<td>We now have a PP policy that requires screening for Maternal Mental Health prior to discharge home</td>
<td>Yes</td>
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<tr>
<td>We are one of the KCC Maternal Mental Health TA sites</td>
<td>Yes</td>
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<tr>
<td>We have completed POSTBIRTH Training at my facility</td>
<td>Yes</td>
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<td>POSTBIRTH education is now part of training for all new staff in our unit</td>
<td>Yes</td>
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<tr>
<td>We now have a Policy that incorporates POSTBIRTH education for all postpartum patients</td>
<td>Yes</td>
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<tr>
<td>We currently make postpartum appointments prior to discharge</td>
<td>Yes</td>
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<tr>
<td>Our PP policy includes postpartum appointment scheduling prior to discharge</td>
<td>Yes</td>
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<td>We currently have a community resource list</td>
<td>Yes</td>
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<tr>
<td>Question</td>
<td>Yes</td>
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<tr>
<td>We currently are connected to our Public Health Dept</td>
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<tr>
<td>For PP Discharge, how many different clinics would possibly see your patients PP</td>
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<td>Does your unit currently participate in Birth Equity training</td>
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<tr>
<td>We are working with our ED to train and recognize POSTBIRTH</td>
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<tr>
<td>Do you use ACOGs Maternal Hypertensive Bundle (algorithms?) in your Unit's policy</td>
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<tr>
<td>We are handing out the POSTBIRTH magnets at the time of PP Discharge</td>
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</table>
KPQC General Meeting

FTI Retreat

AGENDA

Morning agenda is planned for both FTI Members and KPQC Members. FTI Members will join in-person and the KPQC Members will join the meeting virtually.

8:30 am    Registration
9:00 am    Welcome!
            Dr. Cara Busenhart &
            Kasey Sorell, MBA, BSN, RN, CPC
9:05 am    Agenda & Introductions
            Terrah Stroda, CNM
9:10 am    MoMMA’s Voices: Lived Experiences*
            Quantrilla Ard, Bekah Bischoff &
            Emily Taylor
10:00 am   Unlocking Implicit Bias*
            Dr. Jabraan Pasha
11:00 am   The Kansas Birth Equity Network: Creating Equitable, Intentional,
            Respectful Care for Black Women in Kansas*
            Dr. Sharla Smith
11:30 am   Working Lunch (lunch provided)
            KPQC Business Meeting

Afternoon meeting will continue on-site for FTI Members.

12:00 pm   Fourth Trimester Champions: Huddle Up!
            Terrah Stroda, CNM
3:00 pm    Adjourn

*Virtual Guest Speakers
In every patient, in every birth setting, in every protocol:

- Maternal Warning Signs
  - POSTBIRTH Education & Recognition
  - Screen all
  - Identify Medical/Social Red Flags: refer prior to discharge
- Maternal Mental Health
  - Screen all
  - Refer + Screen
  - Educate All (POSTBIRTH)
- PP Appointment prior to discharge
- Breastfeeding
  - High 5 for Mom & Baby, Baby Friendly
- Family Planning
  - Offer prior to discharge, Refer for services
- SSDOH
  - Screen all
- PP Care Team: Pt included
  - Who? How? When?
- Pt debriefs
- ED/EMS Triage
- Link Up! (MCH, Outpatient clinics, etc)

ACOG: Standardized DC Summary

Should include:
- ✓ Name and age
- ✓ Support person 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 provider, 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 CBC
Process map current discharge workflow

<table>
<thead>
<tr>
<th>OB Provider</th>
<th>OB Provider tasks are complete</th>
<th>Prescription plan/orders complete in EMR or e-pharmacy</th>
<th>Complete AVS (d/c) instructions and signed off in EMR specific to patient</th>
<th>Test – work with patient to call the provider's office to schedule postpartum visit during postpartum discharge education on early warning sign and importance of early postpartum visit</th>
<th>Complete discharge note</th>
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</thead>
<tbody>
<tr>
<td>Verify OB Provider to see patient and place d/c order</td>
<td>Complete birth record activities or verify parental plan for birth record completion</td>
<td>Complete discharge education for mother and baby</td>
<td>Resolve care plan &amp; complete d/c tasks (security system, infant transportation, tests, etc)</td>
<td>Order for pp room to be cleaned</td>
<td>Send admitting notification on patient's discharge</td>
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Steps for completing mapping tool

1. Identify local referral services/ resources using provided lists/ databases.
2. Begin preliminary list of potential resources for each referral need in your service area.
3. Contact resources to gather information and specifics about each resource.
4. Complete mapping tool and create process flow to show care team key linkage steps.
5. Finalize mapping tool & process flow and distribute per hospital protocol (intranet, EMR, etc.).
6. Review and update mapping tool annually.
Process Flow for Scheduling Early Postpartum Visit

1. Patient meets all discharge criteria
   - Patient counseled on need for early postpartum visit at 2 weeks and will help make appointment before discharge

2. Provide patient education materials on the benefit of early postpartum visit, warning signs/symptoms to seek care (ie. AWHONN hand out), and information on benefits of pregnancy spacing/family planning options.

3. Able to schedule early postpartum appointment before discharge
   - Yes
   - No
     - Arrange follow up with patient to schedule 2 week postpartum visit after discharge

4. Appointment scheduled and appointment date and time added to patient’s discharge paperwork

5. Document counseling, education and postpartum care plan in discharge summary / instructions and ensure patient has follow up plan

Draft Your Process Flow: Maternal Warning Signs

1. Intrapartum Screening

2. Immediate PP Screening

3. + Screen = Discharge Referral
Draft Your Process Flow: MMH

1. Intrapartum Screening
2. Immediate PP Screening
   + Screen = Discharge Referral

Draft Your Process Flow: MMH

Postpartum Care Team
- Inpatient Referral
- Outpatient Referral

Inpatient Referral
- Who
- Completion, further referrals?

Outpatient Referral
- Who
- Navigation needed? SDOH impact?
- Referral & Appt Made prior to discharge
Connecting Dots

Postpartum Visit
- Primary OB Provider, Home Visitor, etc
- Breastfeeding, Family Planning
- High Risk Needs: Internal Med, etc
- MWS, MMH referral?

Standardized PP Visit
- Visit Schedule
- Visit Template
- Navigation needed? SDOH impact?
- Referrals
## KPQC Fourth Trimester Initiative

### Champion Timeline

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<tr>
<th>Fit Project</th>
<th>Start</th>
<th>Finish</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
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<tr>
<td>POSTBIRTH Training</td>
<td>Current</td>
<td>June 2022 (up to Sept 2022)</td>
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<td>KBEN Training</td>
<td>May 24, 2022</td>
<td>Sept 30, 2022 (check in June 2022, July 2022)</td>
<td>June “Check in”</td>
<td>July “Check in”</td>
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<td>MMH TA</td>
<td>Current</td>
<td>Ongoing thru 2022</td>
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<td>PP Policy Update</td>
<td>Current</td>
<td>Ongoing thru 2022</td>
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<td>PP Appointment</td>
<td>Current</td>
<td>December 2022</td>
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<td>Data Entry</td>
<td>June 2022</td>
<td>Ongoing thru 2022</td>
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<td>PP Care Team/PP Referrals/Community Resource List</td>
<td>July 2022</td>
<td>December 2022</td>
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<td>Breastfeeding</td>
<td>June 2022</td>
<td>Ongoing thru 2022</td>
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<td>SSDOH Screening &amp; Referral to CRL</td>
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<td>Standardized Discharge Summary</td>
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<td>Reproductive Life Planning</td>
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<td>Patient Voice</td>
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Notice: TBD indicates that the timeline is not yet determined.