Diagram 1

KPQC Goals & Initiatives

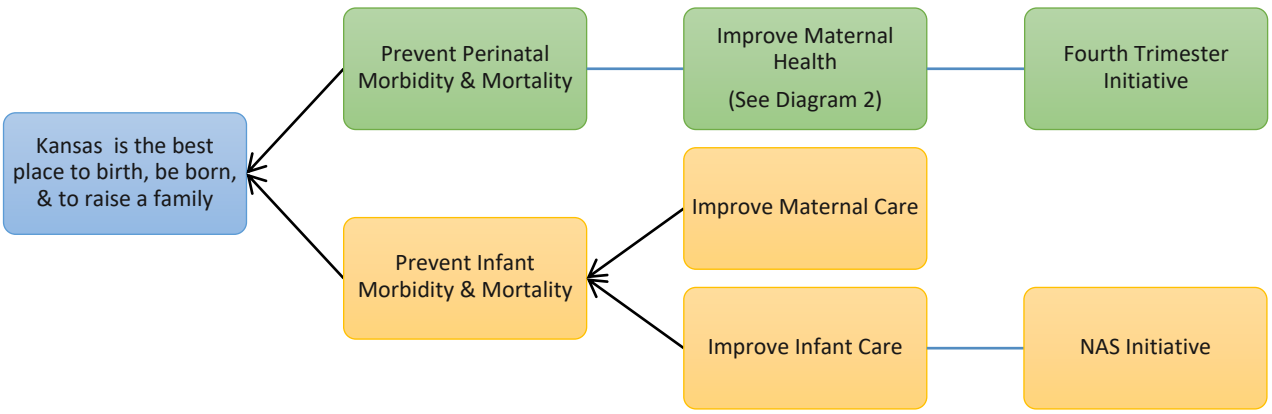
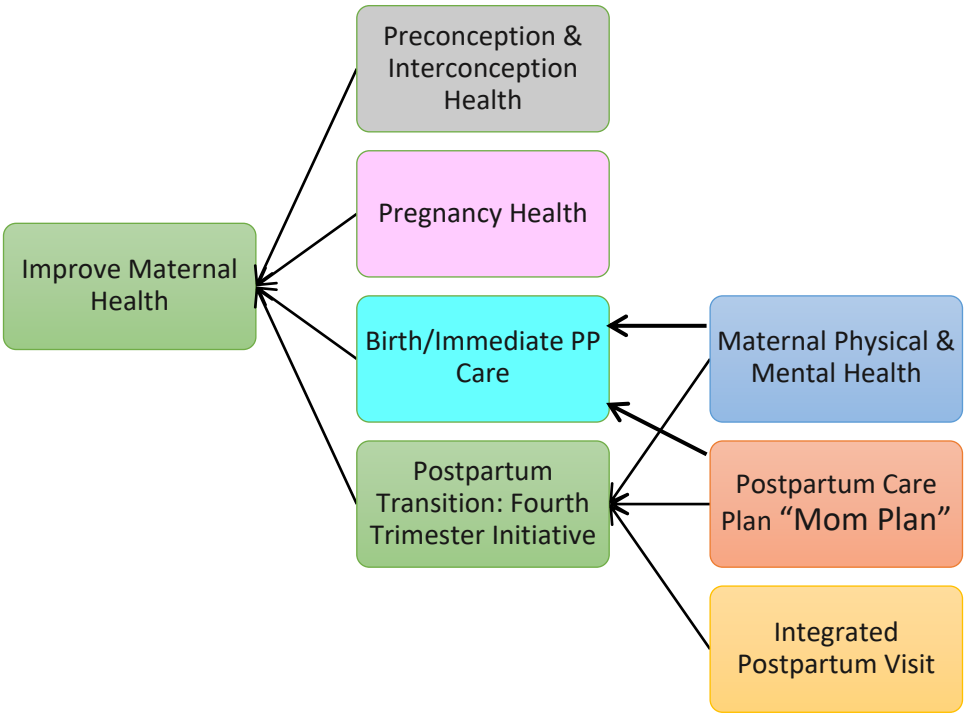


Diagram 2

KPQC Maternal Health Driver Diagram



KPQC: Fourth Trimester Initiative

Updated: 10.21

Primary Drivers | **Secondary Drivers**

AIM Goal

By September 2022, the documented attendance rate of a visit with the OB provider within 12 weeks postpartum will exceed 60%

Optimal Maternal Physical & Mental Health

Maternal Physical Health
1. Screen/Treat/Education/Referral
   a) KDHE Maternal Warning Signs (AWHONN POST-BIRTH)
   b) Maternal Hypertensive Disorders
2. Breastfeeding
3. Reproductive Life Planning
4. PP Visit Appt & Attendance (ACOG schedule)
5. PP Care Plan (see Primary Driver "PP Care Plan")
6. PP Care Team
7. Circle of Care: Referral Network

Maternal Mental Health
1. KDHE Maternal Mental Health Toolkit (Inpt/Outpt)
2. MAVIS project

Social Determinants of Health
- Social
- Structural
- Health Equity
- Trauma Informed Care
- Implicit Bias Training

Postpartum Care Plan

1. Standardized PP Discharge Summary
2. PP Visit Appointment
3. PP Care Plan
   a) Self Care
   b) Risk Assessment & Referral
   c) PP Care Team
   d) Antepartum-IP-PP: review/update
   e) Social Determinants
   f) MWS Toolkit, include POST-BIRTH
   g) Patient ID & Presence of Support Person/Team
4. PP Care Team
5. Circle of Care: Referral Network
6. "Mom Plan"

Integrated (Comprehensive) Postpartum Visits

Standardized Comprehensive PP Visit
Comprehensive Standardized PP Visit Template
ACOG PP Visit Schedule
1. Standardized Screenings at PP Visits
   a) KDHE Maternal Warning Signs (AWHONN POST-BIRTH)
   b) Maternal Hypertensive Disorders
   c) Maternal Medical Risks (KDHE defined)
   d) Review Standardized DC Summary
   e) Patient ID & Presence of Support Person
4. Navigation
   a) Circle of Care: Referral Network
5. PP Care Plan: Review & Update
6. PP Care Team
   a) Add Peds/ER/Fam Practice/Urgent Care
8. Comprehensive Well Woman Exam Toolkit
9. Insurance Reimbursement

Performance Measures

1. **Enroll Birth Facilities in FTI**
2. **Obtain Birth Facility birth numbers, including race demographics**
3. **Track rate of Postpartum Patients with Visits scheduled prior to discharge (<12 weeks PP)**
4. **Track Birth Center Postpartum Care Team formation**
5. **Identify county-level maternal health risk factors**
6. **Obtain Baseline Maternal Mental Health & Maternal Warning Signs policies**

Diagram 4

KPQC Maternal Health: Best Practice Models

Period

Best Practice & Screenings

Preconception & Interconception Health

- Healthcare Access
- Comprehensive Well Woman Visit
- Immunizations
- Insurance
- Prenatal Vitamins
- Chronic Disease Prevention
- Mental Health/SUD treatment

Pregnancy Health

- Primary OB Care
- Care Team: Navigation, Referrals
- KDHE Mental Health Toolkit
- KDHE MWS Toolkit
- Healthcare Literacy
- Nicotine Use, SUD
- Obesity
- Abuse, Neglect
- Chronic Disease (*DM, HTN, Thyroid, Asthma)*
- PCP ID
- Nutrition
- Insurance
- Transportation
- Housing
- Sig Other/Support

Birth/Immediate PP Care

MOM

- PP Hemorrhage Bundle, Maternal Hypertensive Bundle
- MWS Toolkit*: Bleeding, Infection, HTN, Breastfeeding, AWHONN POST-BIRTH Warning s/s, Social Determinants, etc*
- Patient POC "Mom Plan"
- PP Care Team/Discharge Planning: Family Planning, Mental Health, Breastfeeding, MWS Warning Signs, ACOG Appt schedule
- Maternal Warning Signs Toolkit: Standardized screening, referral
- SO/Support system

BABY

- Infant Care/Peds Provider
- Car Seat
- Safe Sleep
- Shaken Baby Syndrome
- Breastfeeding

Postpartum Transitions

Fourth Trimester Initiative

(See Diagram 3)