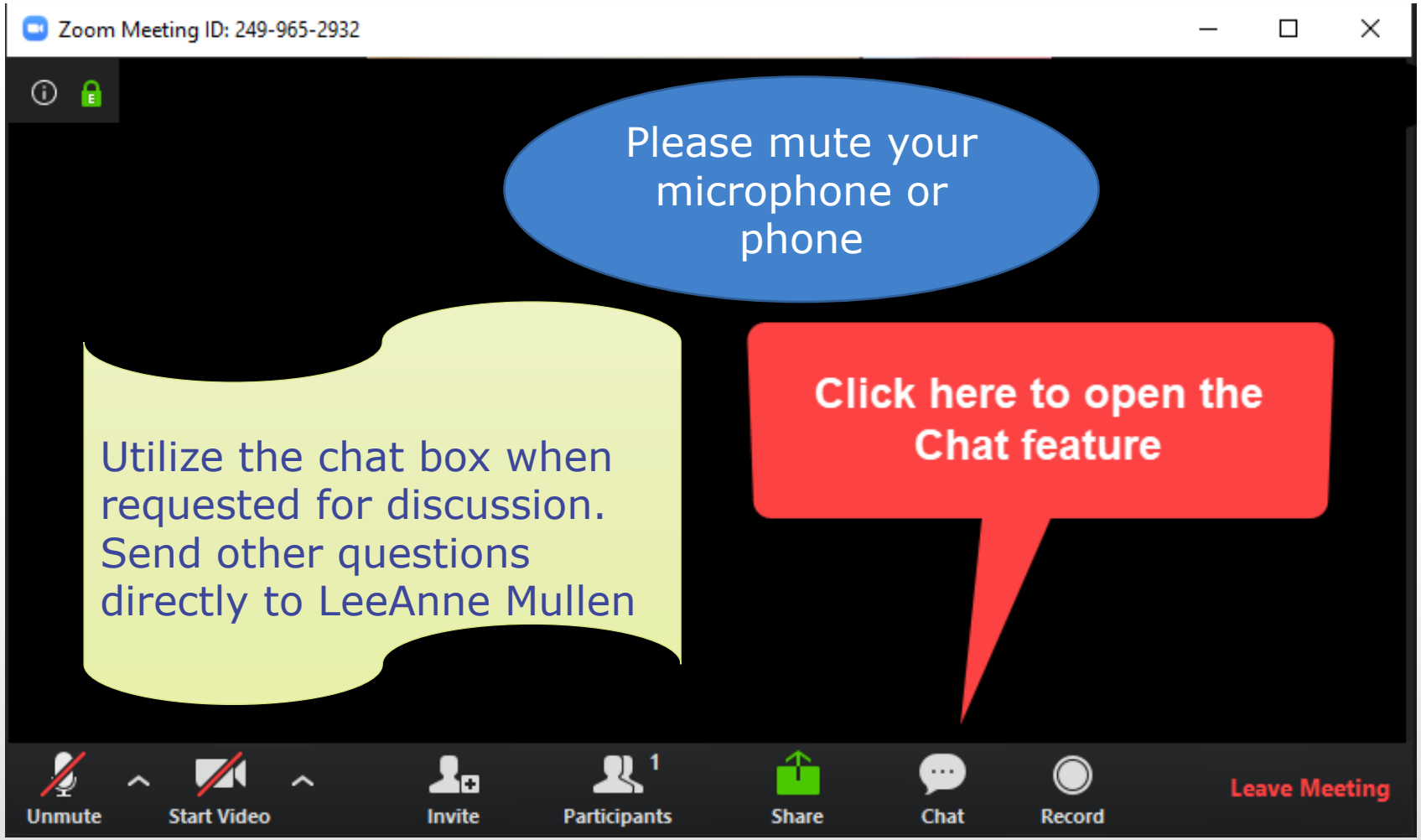
KPQC

Kansas Perinatal Quality Collaborative

Learning Forum

March 30th, 2021


Zoom Meeting ID: 249-965-2932
Please mute your microphone or phone
Utilize the chat box when requested for discussion. Send other questions directly to LeeAnne Mullen
Click here to open the Chat feature
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Participants
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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

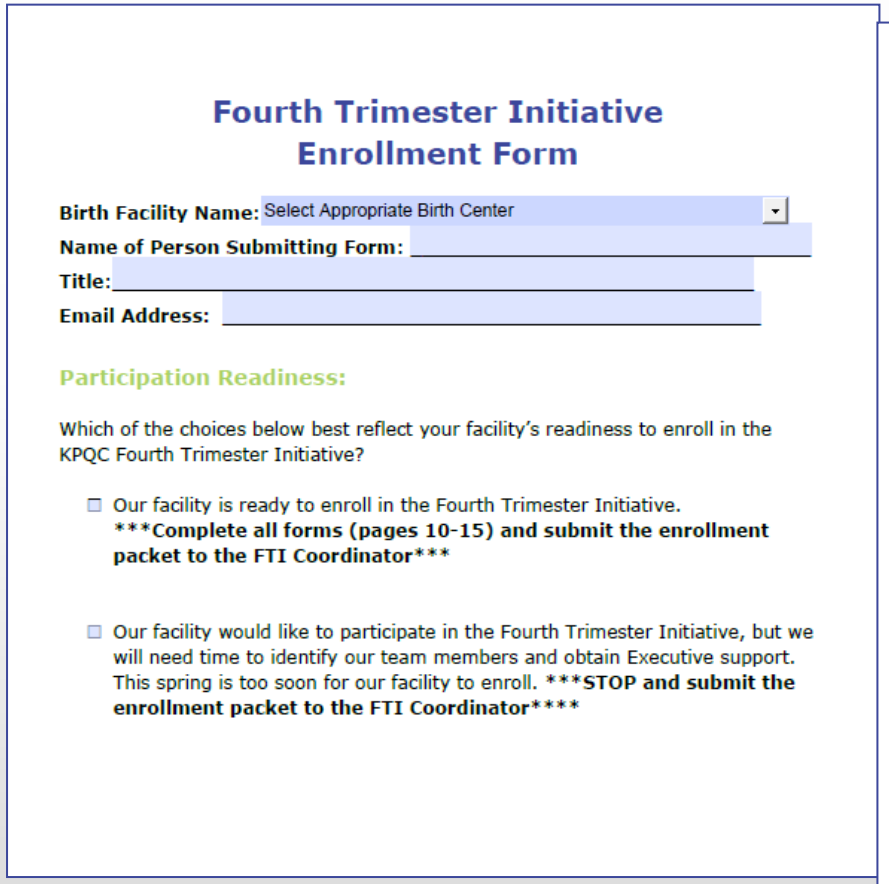
Enrollment is OPEN!!!!

- ✓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?



Fourth Trimester Initiative Enrollment Form

Birth Facility Name: Select Appropriate Birth Center

Name of Person Submitting Form: _____

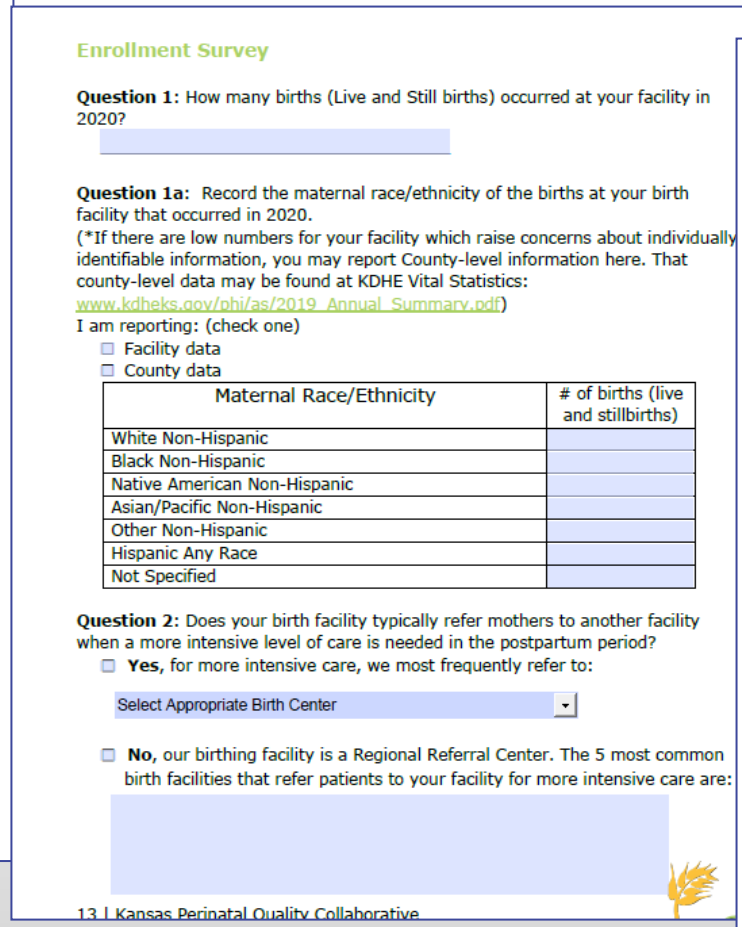
Title: _____

Email Address: _____

Participation Readiness:

Which of the choices below best reflect your facility's readiness to enroll in the KPQC Fourth Trimester Initiative?

- ☐ Our facility is ready to enroll in the Fourth Trimester Initiative. ***Complete all forms (pages 10-15) and submit the enrollment packet to the FTI Coordinator***
- ☐ Our facility would like to participate in the Fourth Trimester Initiative, but we will need time to identify our team members and obtain Executive support. This spring is too soon for our facility to enroll. ***STOP and submit the enrollment packet to the FTI Coordinator****



Enrollment Survey

Question 1: How many births (Live and Still births) occurred at your facility in 2020?

Question 1a: Record the maternal race/ethnicity of the births at your birth facility that occurred in 2020.
(*If there are low numbers for your facility which raise concerns about individually identifiable information, you may report County-level information here. That county-level data may be found at KDHE Vital Statistics: www.kdheks.gov/phi/as/2019_Annual_Summary.pdf)
I am reporting: (check one)

- ☐ Facility data
- ☐ County data

Maternal Race/Ethnicity	# of births (live and stillbirths)
White Non-Hispanic	
Black Non-Hispanic	
Native American Non-Hispanic	
Asian/Pacific Non-Hispanic	
Other Non-Hispanic	
Hispanic Any Race	
Not Specified	

Question 2: Does your birth facility typically refer mothers to another facility when a more intensive level of care is needed in the postpartum period?

- ☐ **Yes**, for more intensive care, we most frequently refer to:

Select Appropriate Birth Center

- ☐ **No**, our birthing facility is a Regional Referral Center. The 5 most common birth facilities that refer patients to your facility for more intensive care are:

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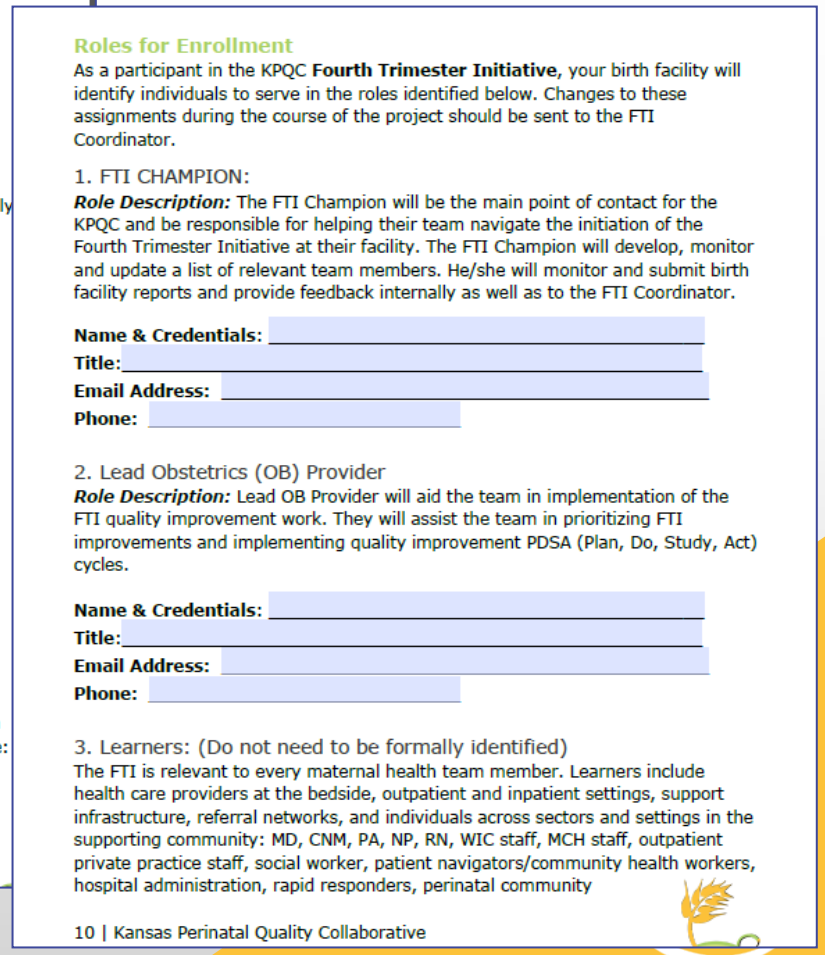

Roles for Enrollment

As a participant in the KPQC **Fourth Trimester Initiative**, your birth facility will identify individuals to serve in the roles identified below. Changes to these assignments during the course of the project should be sent to the FTI Coordinator.

1. FTI CHAMPION:

Role Description: The FTI Champion will be the main point of contact for the KPQC and be responsible for helping their team navigate the initiation of the Fourth Trimester Initiative at their facility. The FTI Champion will develop, monitor and update a list of relevant team members. He/she will monitor and submit birth facility reports and provide feedback internally as well as to the FTI Coordinator.

Name & Credentials: _____
Title: _____
Email Address: _____
Phone: _____

2. Lead Obstetrics (OB) Provider

Role Description: Lead OB Provider will aid the team in implementation of the FTI quality improvement work. They will assist the team in prioritizing FTI improvements and implementing quality improvement PDSA (Plan, Do, Study, Act) cycles.

Name & Credentials: _____
Title: _____
Email Address: _____
Phone: _____

3. Learners: (Do not need to be formally identified)

The FTI is relevant to every maternal health team member. Learners include health care providers at the bedside, outpatient and inpatient settings, support infrastructure, referral networks, and individuals across sectors and settings in the supporting community: MD, CNM, PA, NP, RN, WIC staff, MCH staff, outpatient private practice staff, social worker, patient navigators/community health workers, hospital administration, rapid responders, perinatal community

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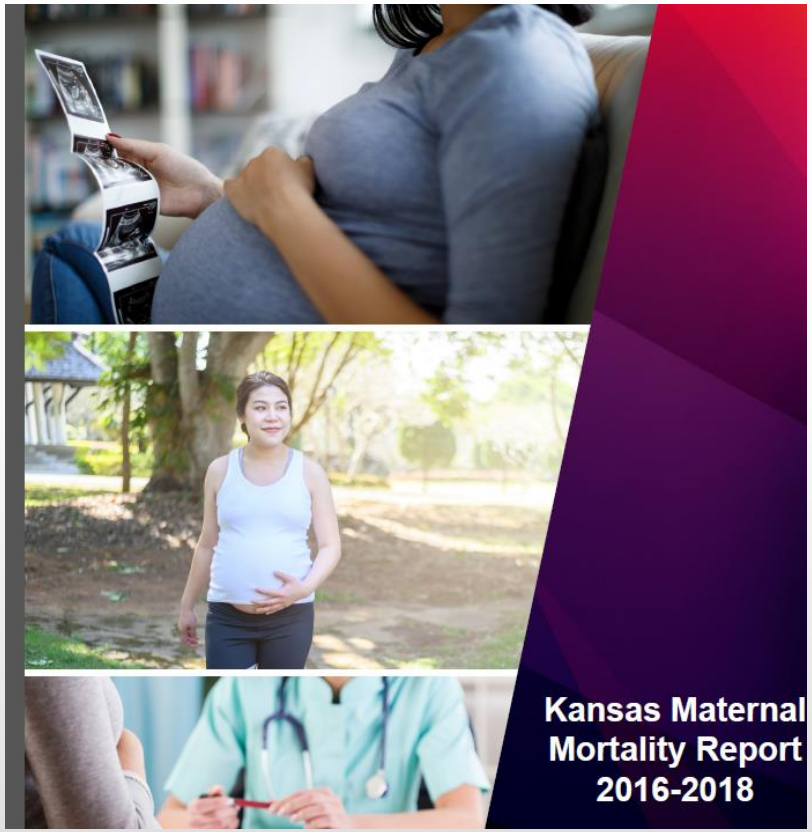
April Learning Forum:
Black Maternal Health Lunch & Learn

Rapid Response: KCC Packet

Rapid Response: Survey Results!



Kansas Maternal Mortality Review Committee

KMMRC 2020 Survey Highlights

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

*Not all birth facilities answered every question.

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%).

Sexual and domestic violence	97.5%
Tobacco	95.0%
Substance use	95.0%
Mental health	92.5%
Chronic and infectious disease	92.5%
BMI	77.5%
Social determinants	62.5%
Reproductive health	57.5%

KMMRC 2020 Survey Higlights

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 – 18.6%**
- **Social work referral from inpatient to outpatient setting – 66.7%**
- **Healthcare Navigator is in charge of referrals – 19.0%**
- **OB clinic is in charge of referrals – 35.7%**

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We were right….darn

We have to decideD 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

Infant Health provider

Specialty Provider

Support persons

OB Provider

PCP

Lactation Support

OB Navigator

Home Visitor

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How does this connect to improved maternal outcomes postpartum?

ACOG: Committee Opinion 736

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*

Element	Components
Care team	Name, phone number, and office or clinic address for each member of care team
Postpartum visits	Time, date, and location for postpartum visit(s); phone number to call to schedule or reschedule appointments
Infant feeding plan	Intended method of infant feeding, resources for community support (eg, WIC, Lactation Warm Lines,

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION

Number 736 • May 2018 (Replaces Committee Opinion Number 666, June 2016)

Presidential Task Force on Redefining the Postpartum Visit
Committee on Obstetric Practice

The Academy of Breastfeeding Medicine, the American College of Nurse-Midwives, the National Association of Nurse Practitioners in Women's Health, the Society for Academic Specialists in General Obstetrics and Gynecology, and the Society for Maternal–Fetal Medicine endorse this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Presidential Task Force on Redefining the Postpartum Visit and the Committee on Obstetric Practice in collaboration with task force members Alison Stuebe, MD, MSc; Tamika Auguste, MD; and Martha Gulati, MD, MS.

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*

Element	Components
Care team	Name, phone number, and office or clinic address for each member of care team
Postpartum visits	Time, date, and location for postpartum visit(s); phone number to call to schedule or reschedule appointments
Infant feeding plan	Intended method of infant feeding, resources for community support (eg, WIC, Lactation Warm Lines, Mothers' groups), return-to-work resources
Reproductive life plan and commensurate contraception	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
Pregnancy complications	Pregnancy complications and recommended follow-up or test results (eg, glucose screening for gestational diabetes, blood pressure check for gestational hypertension), as well as risk reduction recommendations for any future pregnancies
Adverse pregnancy outcomes associated with ASCVD	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.
Mental health	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
Postpartum problems	Recommendations for management of postpartum problems (ie, pelvic floor exercises for stress urinary incontinence, water-based lubricant for dyspareunia)
Chronic health conditions	Treatment plan for ongoing physical and mental health conditions and the care team member responsible for follow-up

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.

The Postpartum Care Team 411

Table 2. Postpartum Care Team*

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

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

OB Provider

Infant Health provider

Specialty Provider

PCP

Support persons

OB Navigator

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!

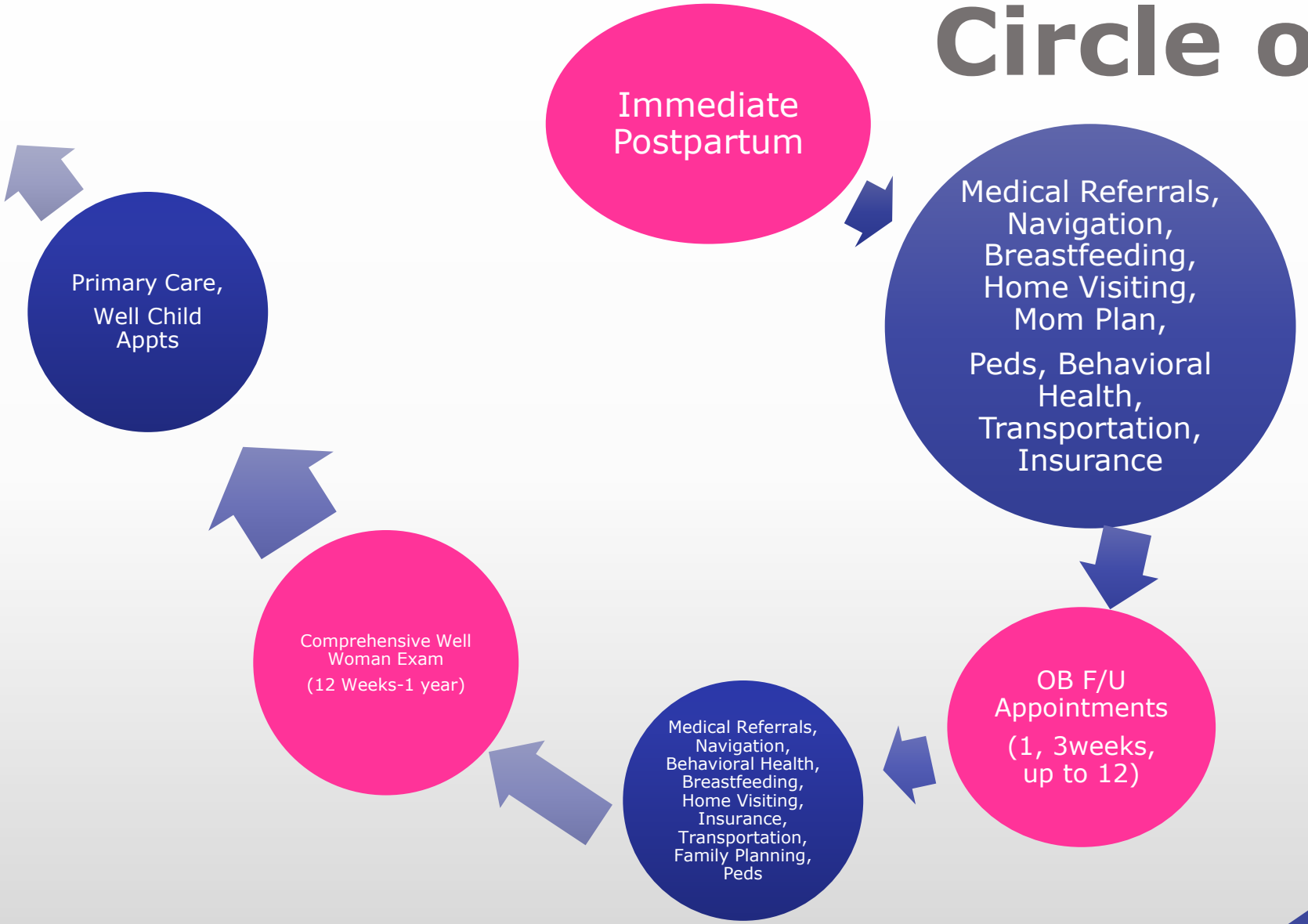
How many of you have an established PP Care Team?

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

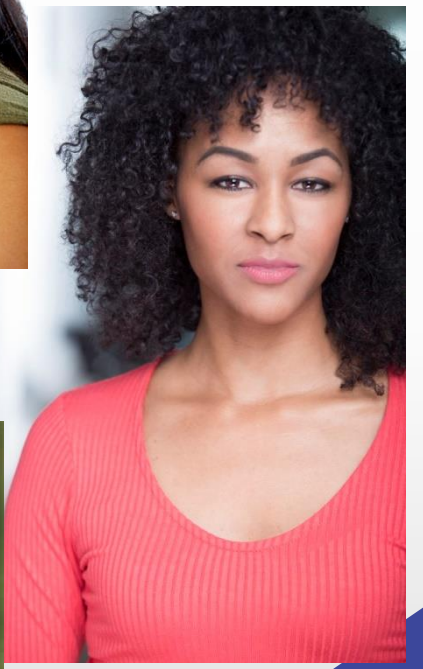
Outpatient
- Navigators
- MCH partners
- FQHCs
- Free-standing Clinics
- Private Practice Clinics
- WIC
- KanCare
- MCOs
- Home Visitors
- PAT (School Districts)
- MORE!

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
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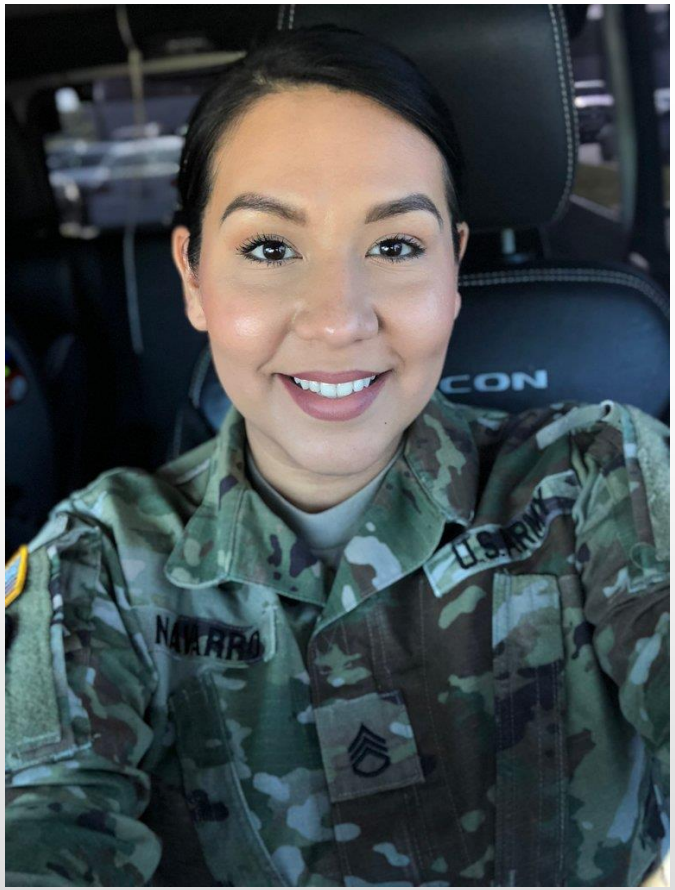
Case Study #2

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
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  - ➢ 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
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Stay Tuned

PP Care Team +Discharge Planning Protocols

Best Practice Models

ACOG Committee Opinion 2018

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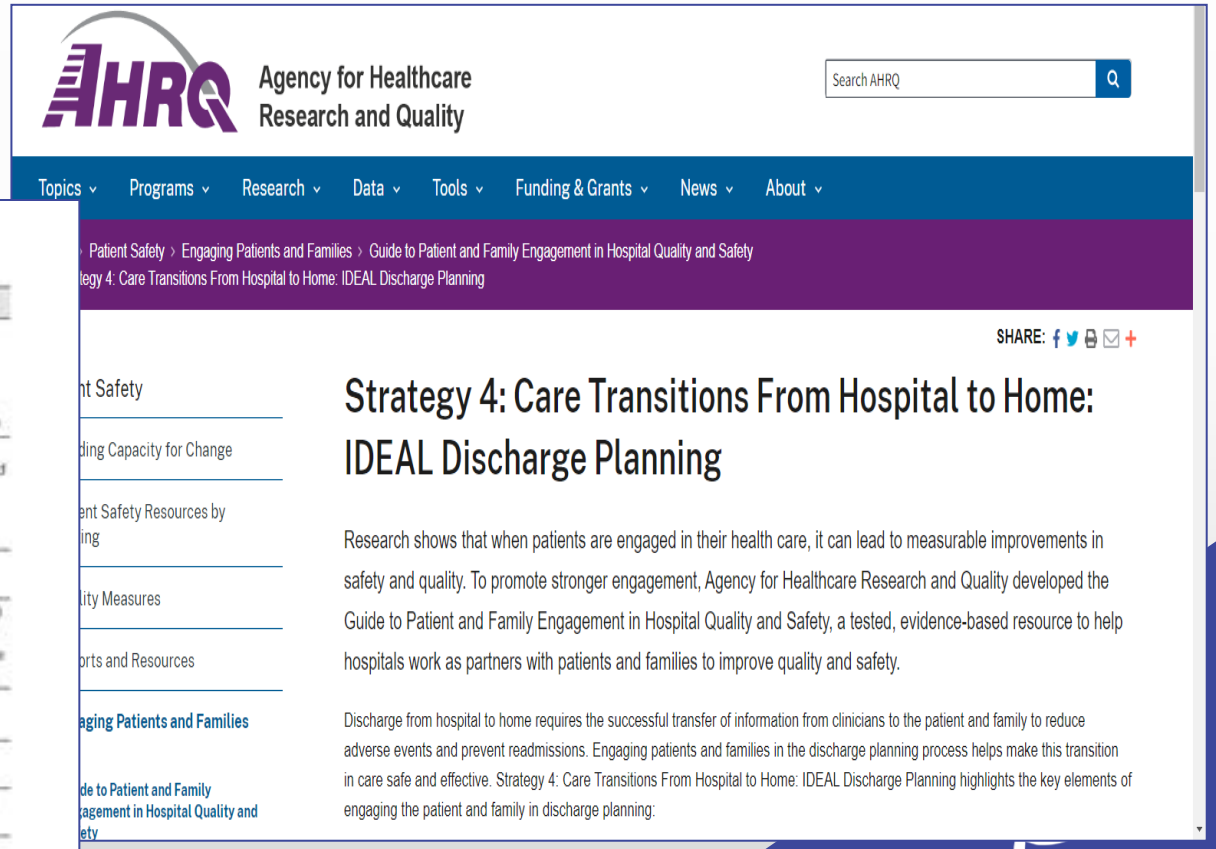

Improving Discharge Outcomes with Patients and Families

Evidence for engaging patients and families in discharge planning

Nearly 20 percent of patients experience an adverse event within 30 days of discharge.[1,2] Research shows that three-quarters of these could have been prevented or ameliorated.[1] Common post-discharge complications include adverse drug events, hospital-acquired infections, and procedural complications.[1] Many of these complications can be attributed to discharge planning problems, such as:

- Changes or discrepancies in medications before and after discharge[3,4]
- Inadequate preparation for patient and family related to medications, danger signs, or lifestyle changes[3,4,5]
- Disconnect between clinician information-giving and patient understanding[3]
- Discontinuity between inpatient and outpatient providers[3]

Involving the patient and family in discharge planning can improve patient outcomes, reduce unplanned readmissions, and increase patient satisfaction.[6,7]

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 2012 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.

AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Key elements of IDEAL Discharge Planning

Include 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
  - 15th: BMHW webinar (12-1pm)
  - 16th: Enrollment for FTI due
- May 11th: General Meeting (1-4pm)
- June & July: Regional Trainings