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Pennsylvania Perinatal Quality Collaborative

## A Family Approach to Postpartum Discharge Transition

## *Alliance For Innovation On Maternal Health Patient Safety Bundle*

The U.S. maternal mortality rate in 2024 was approximately 17.9 deaths per 100,000 live births, according to preliminary CDC data, compared to the rate of 18.6 in 2023.[1] In addition, significant racial disparities in health outcomes exist for pregnant and postpartum patients.[2] 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.[3] Currently, up to 40% of birthing people do not attend a routine postpartum visit, and few receive all recommended elements of postpartum care.[4]

In the PA 2025 MMRC report on deaths occurring in 2021, approximately half of pregnancy-related cases (48%) died 43 days to one year after the end of pregnancy. About 31% of the pregnancy-related cases died while pregnant, showing a greater frequency of pregnancy-related deaths occurring after pregnancy (69%). These statistics highlight the need for continued postpartum services both prior to and past the traditional 6 to 12 weeks.[5]

In addition, the 2022-2024 Pennsylvania Title V Interim Needs & Capacity Assessment identified ongoing unmet needs in accessing patient-centered, respectful care at all stages of pregnancy; focusing on meeting family needs and addressing social determinants of health; improving availability and receipt of preventative, behavioral and mental health services; and parent/caregiver social support and education on infant care and safety.[6]

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

### Initial PA PQC Successes

- In 2025, 39 PA PQC hospitals participated in an Urgent Maternal Warning Signs sprint series, focused on patient education, and engagement with the ED, outpatient settings, and community partners to create a broad awareness of identifying and responding to urgent maternal warning signs.

- From the baseline June 2024 to December 2025 for the Maternal Sepsis initiative, healthcare teams reported:
    - An increase from 60% to 81% ***having linguistically/culturally appropriate patient education materials*** on urgent postpartum warning signs.
    - An increase in ***ED standardized verbal screening as part of triage process*** from 22% to 40%.
    - Processes in place for educating ***ED staff on detecting potential obstetric emergencies***, increasing from 30% to 43%.

## Statewide Goals for the July 2026 through June 2027 Implementation Period

- Recruit 30 multidisciplinary healthcare teams to participate in the Family Approach to Postpartum Discharge Transition initiative.
- Increase the percentage of participating healthcare teams who have ED screening fully in place from 40% to 52%.
- Increase from 81% to 90% of participating healthcare teams who have begun the process to develop a system for patient debriefs after a severe maternal event
- Specific target goals for the following will be determined after July 2026 baseline data collection:
    - Increase the percentage of participating healthcare teams who have begun the process to develop a system for debriefs with the family after a severe neonatal event
    - Increase percentage of hospitals scheduling a postpartum visit before or within 24 hours of discharge from birth hospitalization
    - Increase percentage of hospitals scheduling the first newborn visit before discharge from birth hospitalization
    - Increase percentage of hospitals implementing a comprehensive postpartum visit template
    - Increase percentage of hospitals implementing a standardized, validated tool to screen for Social and Structural Drivers of Health (SSDOH) at the time of discharge

## Key Interventions

- Educate OB provider and nursing on Respectful & Equitable care
- Educate pediatric or neonatal provider and nursing on Respectful & Equitable care
- Establish a standardized verbal screening process as part of ED triage process

- Establish a standardized process to conduct debriefs with families after severe maternal events
- Establish a standardized process to conduct debriefs with families after severe neonatal events
- Establish a system for scheduling the postpartum care visit and needed specialty care visits or contact prior to discharge or within 24 hours of discharge
- Establish a system for scheduling the initial pediatric visit prior to discharge
- Establish a comprehensive postpartum visit template to share with affiliated outpatient sites
- Screen each family for risk factors and assess family and social support needs
- Refer patients for follow-up services including medical, behavioral, and support services

## Measures to Track Goals and Key Interventions

**Process Measures:**

- Cumulative proportion of OB provider and nursing who, in the last 2 years, have received education on Respectful & Equitable care
- Cumulative proportion of pediatric or neonatal provider and nursing who, in the last 2 years, have received education on Respectful & Equitable care
- Cumulative proportion of OB provider and nursing who, in the last 2 years, have received education on Life-Threatening Postpartum Concerns
- Percentage of patients with postpartum visit scheduled before or within 24 hours of discharge, disaggregated by race/ethnicity and payor
- Percentage of patients with a first pediatric visit scheduled prior to discharge to occur within 48-72 post discharge
- Percentage of patients who were screened for SSDOH using a standardized, validated tool by time of discharge from birth admission, disaggregated by race/ethnicity and payor

**Structure Measures:**

Survey questions to assess whether the following are in place at each participating hospital:

- Standardized process to conduct debriefs with patients after a severe maternal event
- Standardized process to conduct debriefs with the family after a severe neonatal event
- Patient education materials on urgent postpartum warning signs that align with culturally and linguistically appropriate standards

- Standardized verbal screening for current pregnancy and pregnancy in the past year as part of ED triage process
- Standardized process to screen for SSDOH using a standardized, validated tool by discharge from birth hospitalization
- Comprehensive list of community resources, customized to include resources relevant for pregnant and postpartum people, that will be shared with all postpartum inpatient nursing units and outpatient OB sites
- Established a process to schedule the postpartum visit before or within 24 hours of discharge from birth hospitalization
- Established a process to schedule the initial pediatric visit prior to discharge from birth hospitalization
- Postpartum visit template, shared with affiliated outpatient sites, that includes at minimum all elements of a comprehensive postpartum visit as outlined in the AIM Postpartum Discharge Transition Bundle Implementation Details

## References

[1] Maternal Mortality Rates in the United States, 2024. CDC National Center for Health Statistics. CDC. March 2026

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[3] Four in 5 pregnancy-related deaths in the U.S. are preventable. Centers for Disease Control and Prevention. https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html. Accessed April 20, 2023.

[4] Committee Opinion Number 736: Optimizing Postpartum Care. American College of Obstetricians and Gynecologists. https://www.acog.org/en/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care. Accessed April 20, 2023.

[5] PA Maternal Mortality Review 2021 Case Data Infographic. PA Department of Health. https://www.pa.gov/content/dam/copapwp-pagov/en/health/documents/topics/documents/programs/2025%20Pennsylvania%20Maternal%20Mortality%20Review%20Infographic%E2%80%8B.pdf. October 16, 2025.

*2025 PA Maternal Mortality Review Annual Report, Deaths occurring in 2021 (Full Report). https://www.pa.gov/content/dam/copapwp-

pagov/en/health/documents/topics/documents/programs/2025%20MMR%20Report.pdf. August 2025.

[6] McAdow et al., 2025. *Dyadic Care Interventions and Outcomes for Mothers and Their Infants: A Scoping Review*. Pediatrics. https://publications.aap.org/pediatrics/article-abstract/156/6/e2025073023/205466/Dyadic-Care-Interventions-and-Outcomes-for-Mothers