AIM

ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

Postpartum Discharge Transitions Element Implementation Details

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Recognizing that discharge and transition periods are complex, further details are offered here to support portions of Postpartum Discharge Transition Bundle implementation. While ideally all elements of a patient safety bundle would be implemented in all relevant settings, this may be aspirational for some settings based on capacity and resources. For this reason, elements that are considered foundational to addressing morbidity and mortality in the postpartum period are **bolded** both in the bundle and below.

Readiness — Every Unit

Readiness Element	Key Points
Referral resources and communication pathways	• Communication pathways may include phone or medical record-based communication
Staff education of postpartum complications for should include:	• Medical conditions • Mental health conditions • Substance use disorders • Social and structural drivers of health
Resources should include:	• Specialist care • Social driver needs • Mental health supports • Substance use disorder treatment

Recognition & Prevention — Every Patient

Recognition Element	Key Points
Reproductive Life Planning	Considerations may include: • Using shared medical decision-making • Congruence with patient's goals and values • Contraceptive options • Birth spacing and pregnancy intention • Chest or breastfeeding • Other health and parenting choices as prioritized by the postpartum patient

Recognition & Prevention — Every Patient (continued)

Recognition Element	Key Points
Postpartum care visit and immediate specialty care should be:	• Inclusive of emergency behavioral health care • Based on known risk factors and conditions • May include telehealth strategies of care to improve access

Screening for community support needs and resources provided	Screening should include:
	  • Medical conditions
	  • Mental health needs or conditions
	  • Substance use disorder needs
	  • Structural and social drivers of health
	
	All provided resources should align with the postpartum patient's:
	  • Health literacy
	  • Cultural needs
	  • Language proficiency
	  • Geographic location and access

Response — Every Event

Response Element	Key Points

Patient discharge education	Should include:
	  • Who to contact with medical and mental health concerns, ideally stratified by severity of condition or symptoms
	  • Physical and mental health needs
	  • Review of warning signs/symptoms including what conditions they might be related to, allowing for advocacy if an approached provider is not obstetrical or of another clinical specialty
	  • Reinforcement of the value of outpatient postpartum visits
	  • Summary of birth events
	  • Home monitoring process and parameters for blood pressure, blood glucose, and/or other monitoring metrics

Response — Every Event (continued)

Response Element	Key Points
Patient discharge education	All education provided should be: • In appropriate lay terminology • Aligned with the postpartum person's health literacy, culture, language, and accessibility needs • Include a designated support person for all teaching with patient permission (or as desired)
Standardized discharge 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
Postpartum self-care elements	Should include: • Emotional well-being • Medication and substance use • Physical recovery • Sleep/fatigue • Sexual health and activity

Response — Every Event (continued)

Response Element	Key Points
Comprehensive postpartum visit	Should include: • Screening for social and structural drivers of health and postpartum risk factors including mental health and substance use disorders with linkage to needed referrals and services and/or provision of treatment as needed • Assessment of physical recovery from birth and pregnancy-associated conditions • Assessment of chronic diseases (pre-pregnancy onset or enduring from pregnancy-onset conditions), with management or referral to primary or specialist care • Establish care congruent with the patient's reproductive life plan, including access to highly effective methods of contraception if desired • Transition to ongoing well-person care including provision of or scheduling of indicated health maintenance services with transition to appropriate provider as needed

Reporting and Systems Learning - Every Unit

Reporting Element	Key Points
Postpartum quality measures, per available data, which may include:	• Postpartum readmissions • Postpartum visit attendance • Screening rate for recommended postpartum preventive screenings • Rate of postpartum visits scheduled prior to discharge from birth hospitalization • Patient education rate for postpartum warning signs

Respectful, Equitable, and Supportive Care — Every Unit/Provider/Team Member

Respectful Care Element	Key Points
Inclusion of the patient as part of the multidisciplinary care team	• Establishment of trust • Informed, bidirectional shared decision-making • Development of a comprehensive postpartum care plan • Patient values and goals as the primary driver of this process
Patient support networks may include nonfamilial supports, such as doulas and home visitors, who, with the postpartum person's permission should be welcomed when any teaching or planning is provided.	