

Postpartum Discharge Transition Change Package



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Contents

Introduction	4
Why is this important?	4
What is a change package?	5
How to prioritize changes?	6
Change Package	7
A Note on Symbols	7
Respectful, Equitable, and Supportive Care	7
Additional Considerations	7
Readiness	8
Recognition & Prevention	13
Response	19
Reporting and Systems Learning	22
Respectful, Equitable, and Supportive Care	25
Appendix A	28
Appendix B	39
Implicit Bias and Respectful Care Training Resources	39



Introduction

The Alliance for Innovation on Maternal Health (AIM) is a national data-driven maternal safety and quality improvement (QI) initiative. AIM works through state and community-based teams to align national, state, and hospital-level QI efforts to reduce preventable maternal mortality and severe morbidity across the United States.

The AIM Patient Safety Bundles are a core part of this work. To promote the successful implementation of these bundles, AIM partnered with the Institute for Healthcare Improvement (IHI) to create a series of associated change packages. This specific change package is designed to support Perinatal Quality Collaboratives (PQCs) and other state-based initiatives to leverage the AIM Postpartum Discharge Transition Patient Safety Bundle more effectively.

Why is this important?

Maternal mortality in the United States is far higher than in other developed nations, and it continues to rise.^{1,2} In addition, significant racial disparities in health outcomes exist for pregnant and postpartum patients.² More than 50 percent of pregnancy-related deaths occur one week to one year after pregnancy, and more than 80 percent of pregnancy-related deaths are deemed preventable.³ Currently, up to 40 percent of birthing people do not attend a routine postpartum visit, and few receive all recommended elements of postpartum care.⁴

The postpartum period provides an important opportunity to support birthing persons and their families, as it is often a time of increased patient motivation, engagement, and access to insurance. Intervention in 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.

Optimal postpartum care should be an ongoing process with, at minimum, three- and 12-week postpartum visits. Care during the postpartum period should include screening for mood and substance use disorders, diabetes and cardiovascular disease, and cancer. Additional elements of optimal postpartum care include screening for social determinants of health and linkage to specialty care and services; management of pregnancy-specific health conditions; anticipatory guidance addressing the transition to parenthood and well-woman care; comprehensive contraceptive counselling; interpregnancy and preconception counseling; and immunizations.

This change package aims to aid teams implementing the AIM Postpartum Discharge Transition Patient Safety Bundle by preparing their institution to facilitate postpartum care transitions; recognize immediate care needs to prevent severe maternal morbidity and maternal mortality; and ensure timely and effective responses to postpartum complications and concerns. In addition, this change package lays the foundation for respectful, equitable, and supportive care for all during the postpartum period.

What is a change package?

A change package is a document listing evidence-based or best-practice changes specific to a topic and is usually organized around a framework or model. In this case, the Postpartum Discharge Transition Change Package is structured around the [Postpartum Discharge Transition Patient Safety Bundle](#).⁵

Changes packages, including this one, are structured around the following components:

- **Primary Drivers:** Major processes, operating rules, or structures that will contribute to moving toward the aim. In this change package, the primary drivers are based on AIM's Five Rs Framework (Readiness, Recognition & Prevention, Response, Reporting/Systems Learning, and Respectful Care).
- **Change Concepts:** Broad concepts (e.g., "move steps in the process closer together") that are not yet specific enough to be actionable but that will be used to generate specific ideas for change. In this change package, the change concepts are represented by the AIM Bundle Elements.
- **Change Ideas:** Actionable, specific ideas for changing a process. Change ideas can come from research, best practices, or from other organizations that have recognized a problem and have demonstrated improvement on a specific issue related to that problem.

Taken as a whole, a change package has the potential to seem overwhelming. Based on the priorities of your state and community, we encourage you to start small by testing a couple of ideas connected to the aim you set. Through iterative tests of change (also known as Plan-Do-Study-Act (PDSA) cycles), you will have an opportunity to learn what works and what does not in your efforts to improve your processes. Initially, these cycles are carried out on a small scale (e.g., one patient on one day) to see if they result in improvement. Teams can then expand the tests and gradually incorporate larger and larger samples until they are confident that the changes will result in sustained improvement.

How to prioritize changes?

No team is expected to test all the listed change ideas. Consider this a menu of options from which you may choose what to tackle first. Each team will review their baseline data, progress to date, organizational priorities, and select an area(s) to prioritize. For example, some may start with one driver. Others may start by tackling one idea across all drivers. Start by choosing an area that you think could lead to an easy win.

You can also leverage the following tools to help you decide where to start:

1. [Pareto chart](#): A type of bar chart in which the various factors that contribute to an overall effect are arranged in order according to the magnitude of their effect. This ordering helps identify the "vital few" — the factors that warrant the most attention.⁶
2. [Priority matrix](#): A tool that can better help you to understand important relationships between two groupings (e.g., steps in a process and departments that conduct those steps) and make decisions on where to focus.⁷
3. [Impact-effort matrix](#): A tool that helps identify which ideas seem easiest to achieve (least effort) with the most effects (highest impact). The ideas identified via this tool would be a great place to start.⁸

Change Package

A Note on Symbols

Respectful, Equitable, and Supportive Care

In the latest revision of the AIM Postpartum Discharge Transition Patient Safety Bundle, a fifth R was added; Respectful, Equitable, and Supportive Care. This R is integrated throughout the change package, and all change ideas that fall under this R are marked with a ♦ symbol.

Additional Considerations

It is understood that every team utilizing this change package will be at a different point in this work. If your organization is further along in your postpartum discharge transition improvement work and has found reliability in some of the change ideas below, we suggest testing the additional considerations in *italics* and marked by the * symbol.

Readiness

AIM Bundle Element	Change Idea	Key Resources and Tools
Develop and maintain a set of referral resources and communication pathways between obstetric providers, community-based organizations, and state and public health agencies to enhance services and supports for pregnant and postpartum families	Identify a team and designated lead responsible for conducting an annual inventory of community resources and updating resource lists to confirm contact information, hours, eligibility, and other relevant information <i>Check with your state PQC or state health department to review what is available at the state level and integrate relevant resources *</i> <i>Engage in ongoing conversations with community-based organizations as partners to identify and strengthen resources. Encourage site visits to support shared understanding of services and supports available. *</i>	Illinois Perinatal Quality Collaborative (ILPQC) Mapping Tool: Resources/Services in Hospital's Service Area to Address Patients' Social Determinants of Health⁹ ILPQC Mapping Tool Example: Winnebago County Resources¹⁰ ILPQC Example Resource List for Social Determinants of Health (SDoH) Needs¹¹ An Inside Look at Partnerships between Community-Based Organizations and Health Care Providers¹²
	Create electronic mechanisms to share resource lists and provide links to existing platforms such as central websites and interactive maps with search features by zip code. Offer tools for postpartum care planning. <i>Work with outpatient practices and community-based organizations that serve your hospital to ensure resources are shared in the third trimester and during postpartum visits *</i>	FindHelp Platform¹³ Example Online Resource: Connecting NJ¹⁴ 4th Trimester Project: Postpartum Toolkit Materials¹⁵ Centers for Medicare and Medicaid Services (CMS): Improving Access to Maternal Health Care in Rural Communities: Issue Brief¹⁶

	Review resource lists to ensure availability in primary languages spoken in the community, and when possible, refer patients to resources and services that are available in their primary language ♦	
	Survey postpartum patients about their experiences accessing and using community supports and services. Share results with care teams to inform updates and ensure that resource lists are comprehensive and refer to services that are useful to families ♦	
Establish a multidisciplinary care team to design coordinated clinical pathways for patient discharge and a standardized discharge summary form to give to all postpartum patients prior to discharge	Identify collaborating specialties and departments to be listed in team rosters for ongoing relationship development, communication, training, and referrals	
	Convene an interdisciplinary team of inpatient and outpatient providers to develop a standard patient-facing discharge summary form that highlights risk factors, complications or diagnoses, necessary follow-up, and health system contact information <i>Consider updating or adapting existing EHR templates *</i> <i>Engage people with lived experience in development of patient-facing discharge summary documents to ensure they are clear, understandable, and meet patient needs * ♦</i>	California Maternal Quality Care Collaborative (CMQCC): Appendix H: Patient Clinical Summary: Severe Maternal Event¹⁷
Provide multidisciplinary staff education to clinicians and office staff on optimizing postpartum care, including why and how to screen for life-threatening postpartum complications	Provide training and educational materials on postpartum warning signs for all clinicians and staff who interact with postpartum patients. Address pace of delivery, depth, and tailoring so that care team members are equipped to provide comprehensible, relevant information <i>Include outpatient providers in system-wide trainings on postpartum care and in grand rounds *</i>	Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN): Post-Birth Warning Signs Education Program¹⁸ Centers for Disease Control and Prevention (CDC): Urgent Maternal Warning Signs¹⁹ AIM: Urgent Maternal Warning Signs²⁰

		4th Trimester Project: Postpartum Toolkit Materials ¹⁵
	Conduct simulations and interactive education for assessment and follow-up of common postpartum symptoms and complications throughout the year with labor and delivery teams, postpartum units, and emergency department <i>Develop standard processes for training at new staff orientation, any time a change to policy or procedure occurs, and annually (or more frequently if possible) on a continual basis *</i> <i>Include people with lived experience in simulations, and ask for their feedback during simulation debriefs, to address interpersonal dynamics as well as clinical management * ♦</i>	ILPQC: Mother and Newborns Affected by Opioids SBIRT Simulations Guide²¹ CMQCC: The Role of Medical Simulation²² The Joint Commission: Case Example #7 - Part 1: Severe maternal disparity²³ American College of Obstetricians and Gynecologists (ACOG): Safe Motherhood Initiative Severe Hypertension Resources²⁴
	Include specialties outside of obstetrics in simulations and interactive education (e.g., emergency medicine, cardiology, psychiatry, pediatrics) <i>Include staff from urgent care facilities and emergency departments at local hospitals that do not serve obstetric patients *</i>	
	Provide screening tools and checklists to screen for postpartum complications in inpatient and outpatient care settings	ILPQC Early Postpartum Visit: Maternal Health Safety Checklist²⁵ ACOG: My Postpartum Care Checklist²⁶ City Birth Trauma Scale²⁷
Develop trauma-informed protocols and trainings to address health care team member biases to enhance quality of care	Conduct implicit bias and respectful care trainings annually for all clinicians and staff ♦ <i>Consider developing a holistic approach to implicit bias education that moves beyond annual training, and may include e-modules, grand</i>	Summary of implicit bias and respectful care training resources (Appendix B)

	<i>rounds, skill days, and opportunities for feedback, reflections, and discussion * ♦</i>	Strategies to Overcome Racism's Impact on Pregnancy Outcomes²⁸ Duke University School of Medicine: ALLIED: Antiracism Learning, Leading and Innovating Educational Development for Faculty²⁹ Health Equity Rounds: An Interdisciplinary Case Conference to Address Implicit Bias and Structural Racism for Faculty and Trainees³⁰
	Train all staff, from reception to triage to inpatient and outpatient providers, in active listening and trauma-informed care to ensure that all patients, regardless of their race, ethnicity, religion, gender expression, sexual orientation, etc., are truly heard and respected ♦ <i>Include components related to secondary trauma and moral injury for health care providers and offer resources and support for providers *</i> <i>Invite a person with lived experience to participate in training to share their perspective with the health care team * ♦</i>	Trauma-Informed Care Implementation Resource Center³¹ Trauma Informed Care for Trans and Gender Diverse Patients³² Integrating Trauma-Informed Care into Maternity Care Practice: Conceptual and Practical Issues³³ A Trauma-informed Approach to Postpartum Care³⁴ Support for Healthcare Providers: • National Alliance on Mental Illness (NAMI): Resources for Healthcare Professionals³⁵ • Implementing the RISE second victim support programme at the Johns Hopkins Hospital: a case study³⁶

		• Schwartz Center for Compassionate Healthcare³⁷
	Develop mechanisms to identify patients who have a history of trauma upon admission, and work with patients and their support person(s) to co-design responsive and supportive care plans	ACOG Committee Opinion Number 825: Caring for Patients who Have Experienced Trauma ³⁸ Refining Trauma-Informed Perinatal Care for Urban Prenatal Care Patients with Multiple Lifetime Traumatic Exposures: A Qualitative Study ³⁹ City Birth Trauma Scale ²⁷
Educate outpatient care setting staff on how to use a standardized discharge summary form to review patient data and ensure that recommendations made for outpatient follow-up and community services/resources have been carried out	Create mechanisms to share delivery and discharge information with obstetrician (OB) or midwife and primary care provider (PCP), with consideration for situations where the delivery hospital is not part of the same system as the OB, midwife, or PCP	
	Establish processes to follow up on referrals at the postpartum visit. Ask patients if they were connected with resources that met their needs and follow up as needed. Proactively offer information and supports for services such as transportation and community health workers or perinatal navigators as available. <i>Use electronic health record (EHR) workflows to track and manage referrals and flag when referrals have not been closed *</i>	Closing the Loop on Patient Referrals in Health Care ⁴⁰ Screening and Referral for Social Determinants of Health: Maternity Patient and Health Care Team Perspectives ⁴¹

Recognition & Prevention

AIM Bundle Element	Change Idea	Key Resources and Tools
Establish a system for scheduling the postpartum care visit and needed immediate specialty care visit or contact (virtual or in-person visit) prior to discharge or within 24 hours of discharge	Develop and use discharge checklists that prompt scheduling of postpartum visit(s) and any needed specialty care. Work with patient and caregiver(s) to schedule appointments at times and locations that meet their needs ♦ <i>Create EHR scripts to prompt scheduling of postpartum visit and flag patients who may need more urgent follow-up or specialist referral *</i>	ILPQC Example Process Flow for Scheduling Early Postpartum Visit⁴² ILPQC Postpartum Visit Timeframe⁴³ Society for Maternal-Fetal Medicine (SMFM) Postpartum Visit Checklists⁴⁴
	Schedule a postpartum follow up with OB, midwife, or relevant specialist (i.e., cardiology, psychiatry) within 48 hours for patients who have experienced any delivery or postpartum complications	ACOG Committee Opinion Number 736: Optimizing Postpartum Care⁴ ACOG Practice Bulletin Number 212: Pregnancy and Heart Disease⁴⁵
	Schedule a telehealth or phone visit within 3 weeks of discharge for patients who would otherwise not be seen for an office visit for 6-8 weeks <i>Provide support and training for providers on conducting effective telehealth visits *</i>	IHI White Paper: Telemedicine: Ensuring Safe, Equitable, Person-Centered Virtual Care⁴⁶ Maternal Telehealth Access Project (MTAP)⁴⁷ American Medical Association (AMA) Digital Health Implementation Playbook⁴⁸ Health Resources and Services Administration (HRSA) Guidance on Billing for Maternal Telehealth⁴⁹

	Include information about the postpartum visit during 3 rd -trimester prenatal visits and as part of patient discharge education	Benefits of early postpartum care patient handout ⁵⁰ 4th Trimester Project: Expert-written resources and information for families ⁵¹ Proyecto 4to Trimestre: Recursos escritos por expertos e información para familias ⁵²
Screen each patient for postpartum risk factors and provide linkage to community services/resources prior to discharge	Screen for potential postpartum complications during prenatal visits and throughout hospital stay, flag potential risk factors in patient's chart, and include information in patient-facing discharge summary	Washington State Health Care Authority MSS Prenatal Screening Tool ⁵³
	As part of discharge education, provide patients with clear, jargon-free information about any complications or new diagnoses, as well as treatment options and related resources	National Partnership for Maternal Safety: Consensus Bundle on Support After a Severe Maternal Event ⁵⁴
	Conduct screening for SDoH needs for all patients (do not assume any individual's particular situation) during prenatal care and before hospital discharge; document these needs in patient chart, and make referrals based on individual needs◇ <i>Ask patients during screening whether the resources suggested, and referrals made, are appropriate and meet their needs *</i>	ILPQC Social Determinants Screening Tool Comparison¹¹ Additional Standard SDoH Screening Tools • Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) tool⁵⁵ • Center for Health Care Strategies: OneCare Vermont: Self-Sufficiency Outcome Matrix⁵⁶ • American Academy of Family Physicians (AAFP)

		Social Needs Screening Tool ⁵⁷ • CMS Health-Related Social Needs (HRSN) Screening Tool⁵⁸ Screening and Referral for Social Determinants of Health: Maternity Patient and Health Care Team Perspectives ⁴¹ ACOG Committee Opinion Number 729: Importance of Social Determinants of Health and Cultural Awareness in the Delivery of Reproductive Health Care ⁵⁹
	Train providers in both inpatient and outpatient settings on standard postpartum depression and mental health screening tools as well as appropriate next steps after a positive screen <i>Develop a list of local resources and pathways to access mental health care to share with all patients as part of mental health screening *</i>	ACOG Committee Opinion Number 757: Screening for Perinatal Depression ⁶⁰ Screening Tools: • Edinburgh Postnatal Depression Scale (EPDS)⁶¹ • American Psychological Association (APA) Patient Health Questionnaire 9 (PHQ-9)⁶² • HRSA Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)⁶³ • Screening for Perinatal Anxiety Using PASS – the Perinatal Anxiety Screening Scale⁶⁴

		Resources for Patients HRSA National Maternal Mental Health Hotline⁶⁵ UMass Chan Medical School Lifeline for Moms Perinatal Mental Health Toolkit⁶⁶
In all care environments, assess and document if a patient presenting is pregnant or has been pregnant within the past year	Partner with emergency department (ED) and urgent care teams to include the question, "Have you been pregnant in the last year?" in standard triage scripts in EHR, and ensure gender inclusivity in assessment ♦	ED hospital signage example ⁶⁷ Triage Decisions Involving Pregnancy-Capable Patients: Educational Deficits and Emergency Nurses' Perceptions of Risk ⁶⁸ ACOG ED Postpartum Preeclampsia Checklist ⁶⁹
	Embed triggers and alerts into EHR systems to stop and ask about pregnancy history for common postpartum warning signs such as shortness of breath, headache, and blurred vision	
	Push information about recent pregnancies to new providers through EHR and as a standard part of the referral process	
	Provide education and resources on postpartum warning signs and common postpartum complications to local EDs, urgent care centers, and critical access hospitals <i>Engage an ED team member as part of the QI team who can serve as champion and lead education for ED staff *</i>	CDC HEAR HER Resources for Healthcare Professionals ⁷⁰ CDC Urgent Maternal Warning Signs ¹⁹ AWHONN Post-Birth Warning Signs Education Program ¹⁸
	Educate postpartum patients and their caregivers to identify themselves as having given birth within the last year when presenting to outpatient and emergency settings with symptoms	"I gave birth" bracelets ⁷¹

		CDC HEAR HER Guide for Patients⁷² CDC HEAR HER Guide for Partners, Friends, and Family⁷³
Offer reproductive life planning discussions and resources, including access to a full range of contraceptive options in accordance with safe therapeutic regimens	Include questions about family planning and reproductive health as part of prenatal care in the 3 rd trimester, during postpartum discharge, and in regular postpartum visits	Bedsider Birth Control Resources⁷⁴ 4th Trimester Project: Contraception⁷⁵
	Facilitate access to postpartum contraceptive options and counselling, including immediate postpartum long-acting reversible contraception (LARC) placement if desired. Clearly address LARC removal processes, including financial considerations.	Bedsider Contraceptive Options Handout⁷⁶ Florida Perinatal Quality Collaborative (FPQC) Contraceptive Options Handout⁷⁷ ILPQC Postpartum LARC Brochure⁷⁸ Advancing Health Equity Through Improved Access to Patient-Centered Contraceptive Care⁷⁹
	Provide training for providers on respectful and inclusive conversations related to reproductive health and family planning to allow for shared decision making and remove possible coercion ♦	Contraceptive Counseling Model: A 5-Step Client-Centered Approach⁸⁰ SisterSong LARC Statement of Principles⁸¹ Reproductive Health National Training Center⁸²
Facilitate and assure linkage to relevant services in outpatient settings for care identified for postpartum risk factors	Make direct links (warm handoffs) to outpatient care and specialist offices instead of relying on the postpartum patient to make the connection themselves	Increasing Warm Handoffs: Optimizing Community Based Referrals in Primary Care Using QI Methodology⁸³

	Utilize perinatal navigators, case managers, social workers, and postpartum home visiting programs where available to liaise with community resources and to ensure referral loops get closed	Family Connects International⁸⁴ with examples from New Jersey⁸⁵ and Illinois⁸⁶ Nurse Family Partnership⁸⁷ Using a Patient Navigator to Improve Postpartum Care in an Urban Women's Health Clinic⁸⁸ Bridging the postpartum gap: Best practices for training of obstetric patient navigators⁸⁹ Universal Early Home Visiting: A Strategy for Reaching All Postpartum Women⁹⁰
	Connect postpartum patients with virtual supports such as peer connection groups and texting programs to offer additional postpartum health information and social support	JustBirth Space⁹¹ Text4Baby⁹²
	Partner with pediatric providers to proactively address and screen for postpartum risk factors during pediatric visits. Create mechanisms for pediatricians to refer back to OB, midwife, or PCP as appropriate. <i>Provide resources such as handouts and wall signage about postpartum warning signs in pediatric offices *</i>	American Academy of Pediatrics (AAP): Integrating Postpartum Depression Screening in Your Practice in 4 Steps⁹³ CDC Urgent Maternal Warning Signs¹⁹ AWHONN Post-Birth Warning Signs Education Program: Save Your Life Handout¹⁸

Response

AIM Bundle Element	Change Idea	Key Resources and Tools
Provide patient education prior to discharge that includes life-threatening postpartum complications and early warning signs, including mental health conditions, in addition to individual patient-specific conditions, risks, and how to seek care	Develop or use existing standard educational materials on common postpartum warning signs and provide materials to patients at multiple points during prenatal care and postpartum hospital stay <i>Engage people with lived experience in development of culturally appropriate and language-specific materials</i> ♦ *	AWHONN Post-Birth Warning Signs Education Program: Save Your Life Handout ¹⁸ CDC Urgent Maternal Warning Signs ¹⁹ 4th Trimester Project Birthing Parent Health Information Handout ⁹⁴ CMQCC Cardiovascular Disease Signs and Symptoms Infographic ⁹⁵ Postpartum Support International (PSI) Resources ⁹⁶
	Use multiple mechanisms (verbal and written) to deliver information and use teach-backs to ensure that patients and their caregivers understand warning signs and how to seek follow-up care	
	Identify a key contact on the discharge summary whom patients can call with questions about postpartum symptoms or complications <i>If possible, provide access to a 24/7 phone line for patients to call with concerns and questions after hours</i> *	
	Ensure patient education materials are aligned with their health literacy, culture, language, and accessibility needs ♦	HHS Guide to Providing Effective Communication and Language Assistance Services ⁹⁷ National Standards for Culturally and Linguistically Appropriate

		Services (CLAS) in Health and Health Care ⁹⁸
Provide each postpartum patient with a standardized discharge summary form that details key information from pregnancy and birth	Use a standard template for patient-facing discharge summaries and include a 1/2-page summary at the top with critical information such as health system contact information and resources for safety and wellness	
	Create digital and paper versions of discharge summaries to share information more easily with patients and across providers and facilities. Ensure that patients receive information on how to access the information electronically as part of discharge education	
	Ensure that any pregnancy or delivery complications and postpartum risk factors are listed clearly on a patient-facing discharge summary (e.g., on the first page, bolded) and called out clearly in the EHR	
Conduct a comprehensive postpartum visit	Consider timing of postpartum visit(s) and test models for more frequent touchpoints, such as a 2-3-week visit followed by a 6-8-week visit	ACOG Committee Opinion Number 736: Optimizing Postpartum Care ⁴ ACOG: Billing for Care after the Initial Outpatient Postpartum Visit: The Fourth Trimester ⁹⁹ ILPQC Early Postpartum Visit Billing and Coding Guidance ¹⁰⁰
	Schedule the postpartum visit for at least 30 minutes	
	Create a checklist for standard screening to take place at the postpartum visit, including mental health and postpartum depression screening as well as screening for SDoH-related needs	ILPQC Early Postpartum Visit: Maternal Health Safety Checklist ²⁵ SMFM Postpartum Visit Checklists ⁴⁴ 4th Trimester Project Postpartum Visit Checklist ¹⁰¹

Encourage the presence of a designated support person during all instances of care as desired, and particularly when teaching or education occurs	Revise hospital policies to ensure that doulas are included as part of the care team and not considered visitors ♦	Impact of Doulas on Healthy Birth Outcomes ¹⁰² Doula Care and Maternal Health: An Evidence Review ¹⁰³
	Facilitate access to doulas, nurse navigators, or patient advocates, particularly for patients who do not have a support person accompanying them ♦	
	Provide training for clinicians and staff on how to engage family members and caregivers in discharge education and planning ♦	CDC HEAR HER Guide for Partners, Friends, Family ⁷³
Engage in dialogue with the postpartum patient around elements of postpartum self-care prior to discharge. Implement a multidisciplinary discharge process to provide a coordinated pathway for clinical postpartum discharge, which may include multidisciplinary rounding.	Conduct a pre-discharge huddle with all clinicians involved in patient care to identify any complications or risk factors; identify any concerns and document action plan in discharge summary and EHR <i>Include patients and families in bedside huddles if they want to participate. Structure the timing of rounding and huddles to be patient-focused, and to protect patient and family member sleep as much as possible.</i> ♦*	FPCQ Postpartum Discharge Assessment ¹⁰⁴ FPQC Maternal Discharge Risk Assessment ¹⁰⁵
	Include education on postpartum self-care and the importance of the postpartum visit in discharge education with patients. Ensure patients have access to essential hygiene supplies.	March of Dimes Postpartum Check-up Guide ¹⁰⁶ 4th Trimester Project Postpartum Plan Template ¹⁰⁷ ACOG: My Postpartum Care Checklist ¹⁰⁸

Reporting and Systems Learning

AIM Bundle Element	Change Idea	Key Resources and Tools
Convene inpatient and outpatient providers in an ongoing way to share successful strategies and identify opportunities for prevention of undesired outcomes in the postpartum period, including emergency and urgent care clinicians and staff	Conduct formal after-action reviews for all adverse events and near misses, with a designated leader and standardized content, to identify areas for improvement in care processes <i>Include events that occurred after discharge, such as postpartum readmissions and emergency department visits, in case reviews *</i> <i>Establish standardized briefing documentation to capture successes and actionable follow-up *</i>	Agency for Healthcare Research and Quality (AHRQ) TeamSTEPPS: Briefs, Debriefs, and Huddles ¹⁰⁹ ILPQC Missed Opportunity Review/Debrief Form ¹¹⁰ CMQCC Appendix DD: Sample Labor and Delivery Event Debrief Form ¹¹¹ ACOG Obstetric Team Debriefing Form ¹¹² Checklists, Huddles, and Debriefs: Critical Tools to Improve Team Performance in Obstetrics ¹¹³
	Include staff and clinicians from multiple specialties and disciplines in case reviews, such as outpatient providers, emergency department staff, pediatricians, psychiatrists, lactation consultants, doulas, and others	
	Engage with regional networks such as Perinatal Quality Collaboratives to learn from other hospitals about best practices and share standard tools and resources for postpartum care	State Perinatal Quality Collaboratives ¹¹⁴
	Use an equity lens for all case reviews to identify bias and instances of disrespectful care ♦	Health Equity Morbidity and Mortality Conferences in Obstetrics and Gynecology ¹¹⁵ ILPQC: Guide for incorporating discussion of social determinants of health and discrimination as

		potential factors in hospital-level maternal morbidity reviews ¹¹⁶
Consider a multidisciplinary huddle for postpartum patients identified as higher-risk for complications to identify potential gaps or adjustments to the standardized discharge process	Provide standard templates for postpartum unit huddles to address common risks and needs and identify owners for any action steps	FPCQ Postpartum Discharge Assessment ¹⁰⁴ FPQC Maternal Discharge Risk Assessment ¹⁰⁵
	Include an “equity pause” to look at bias risk within multidisciplinary care planning and to ask, “What are considerations to ensure respectful care without discrimination?” ♦ <i>Consider race, ethnicity, language, gender identity, obesity, mental health, unplanned pregnancy and pregnancy history, marital status, housing status, education level, etc. as potential areas of bias for providers</i> ♦ *	
Develop and systematically utilize a standard comprehensive postpartum visit template	Convene a multidisciplinary team to create and test a standard postpartum visit template. Include patients in the development of the template to ensure the visit components meet their needs.	ILPQC Early Postpartum Visit Maternal Health Safety Checklist ²⁵ SMFM Special Statement: Checklist for postpartum discharge of women with hypertensive disorders ⁴⁴ 4th Trimester Project Postpartum Visit Checklist ¹⁰¹
Identify and monitor postpartum quality measures in all care settings	Review all process and outcome data disaggregated by race, ethnicity, and language to assess for inequities with unit-specific and leadership teams ♦ <i>Engage leaders in messaging about destigmatizing discussion and identification of inequities to move toward action</i> ♦ *	ILPQC Tip Sheet on Data Stratification ¹¹⁷ ILPQC Process Flow for Collecting Data on Patient Race & Ethnicity ¹¹⁸ Do No Harm Guide: Applying Equity Awareness in Data Visualization

	Identify alternative strategies to integrate equity considerations into reporting and systems learning in settings where use of disaggregated data may cause potential patient identifiability or unstable data ♦ *	Reducing Health Care Disparities: Collection and Use of Race, Ethnicity and Language Data ¹¹⁹ American Hospital Association (AHA): A Framework for Stratifying Race, Ethnicity and Language Data ¹²⁰
	Survey postpartum patients on their experience of respectful care during hospital stay and postpartum period, and include results in quality metrics dashboards ♦	ILPQC Patient Reported Experience Measures (PREM) Survey ¹²¹ The Mothers on Respect (MOR) index: measuring quality, safety, and human rights in childbirth ¹²²
	Engage individuals with lived experience in conversations about their experiences of care to identify areas for data collection and quality improvement ♦	MoMMA's Voices ¹²³ 100 Million Healthier Lives Engaging People with Lived Experience Tools ¹²⁴
Monitor data related to completed postpartum comprehensive visits in each office, with disaggregation by race and ethnicity at a minimum, to evaluate disparities in rate of follow-up visit completion	Share data on postpartum visit attendance with hospital systems where patients deliver and identify strategies to improve referral and scheduling processes	
	Include completion of postpartum visit as a core metric on hospital system dashboard, and stratify data by race and ethnicity ♦	
	Develop processes to follow up with patients who do not attend postpartum visits to identify underlying causes for missed visits and support needs to be addressed	

Respectful, Equitable, and Supportive Care

AIM Bundle Element	Change Idea	Key Resources and Tools
Include each pregnant or postpartum person and their identified support network as respected members of and contributors to the multidisciplinary care team	Engage patients and their caregivers in decision making about their care at every point from admission through discharge, including during rounds ♦ <i>Provide tools and scripts for providers to use for shared decision-making conversations ♦ *</i>	AHRQ: The SHARE Approach: 5 Essential Steps of Shared Decision Making ¹²⁵
	Facilitate open conversations to ensure that patient concerns are adequately addressed, and investigate possible causes when patients express that something is "off." Consider ways in which implicit bias and structural racism may influence response to patient concerns and response to pain. ♦ <i>Make an organizational policy and train teams to use an antiracism, birth equity, and social justice lens ♦ *</i>	CDC HEAR HER Resources for Healthcare Professionals ⁷⁰ 15 Bedside Manner Techniques to Improve Patient Experience ¹²⁶ IHI White Paper: Achieving Health Equity: A Guide for Health Care Organizations ¹²⁷
	Ask patients if they would like to be accompanied by their support person for any exams, procedures, and discussions ♦ <i>Create and use wall signage to inform patients that they can be accompanied by their support person for any exams, procedures, and discussions about their care ♦ *</i>	
	Provide funded opportunities for patients and families to engage in process improvement in inpatient and outpatient settings, and to co-design tools and resources ♦	National Initiative for Children's Healthcare Quality (NICHQ): Powerful Partnerships: A Handbook for Families and Providers Working Together to Improve Care ¹²⁸ IHI Innovation Case Study: Experience-Based Co-Design of Health Care Services ¹²⁹

		Successful Engagement with People Who Have Lived Experiences ¹³⁰
Engage in open, transparent, and empathetic communication with pregnant and postpartum people and their identified support network to understand diagnoses, options, and treatment plans	Provide communication in the patient's preferred language and support access to interpretation services; provide educational materials for patients in common languages spoken in your community ♦	National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care ⁹⁸
	Educate clinicians on providing respectful care by engaging in the life-long learning of cultural humility, understanding that individuals cannot learn all aspects of any culture, including their own ♦	AWHONN Respectful Maternity Care Implementation Toolkit ¹³¹ ACOG Respectful Care eModules ¹³² The Cycle to Respectful Care: A Qualitative Approach to the Creation of an Actionable Framework to Address Maternal Outcome Disparities ¹³³
	Co-design postpartum care plans (similar to a birth plan but for postpartum) that emphasize patient and family needs and wishes ♦	ACOG Committee Opinion Number 736: Optimizing Postpartum Care (Table 1) ⁴ The Fourth Trimester of Pregnancy: Committing to Maternal Health and Well-Being Postpartum ¹³⁴ 4th Trimester Project: My Postpartum Plan ¹³⁵ Oklahoma State Department of Health Postpartum Plan ¹³⁶
	Provide education during prenatal care about decisions that might need to be made in the postpartum period and provide resources to	CDC HEAR HER Guide for Patients ⁷²

	patients and their support networks on how to advocate for their needs and wishes during delivery and postpartum ♦	The New York Times: Protecting Your Birth: A Guide for Black Mothers¹³⁷ Every Mother Counts: Choices in Childbirth¹³⁸
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Appendix A

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Appendix B

Implicit Bias and Respectful Care Training Resources

Tier/Type of education process	Resource/ tool available	Brief description
E-modules: Free maternal health–focused equity and bias e-module trainings for independent completion in about an hour or less	Diversity Science	Three e-modules focused on implicit bias and reproductive justice. Option to integrate into hospital learning management systems through ILPQC access
	The Office of Minority Health: Think Cultural Health	Four e-modules focused on Culturally and Linguistically Appropriate Services (CLAS) in maternal health care
Programs: Fee-based day or multi-day trainings	Birthing Cultural Rigor: Basic Training in Obstetric Racism™ (BTOR™)	BTOR™ is a 12-week online course. The online BTOR™ is organized into six 2-hour interactive modular units and six corresponding 60-min coaching sessions.
	Perinatal Quality Improvement SPEAK UP Against Racism Training	Implicit and Explicit SPEAK UP Training is a day-long interactive workshop that outlines strategies to help individuals and groups dismantle racism, provide high-quality, equitable care, and reduce perinatal health disparities.
Other Supportive Resources	Professionalism: Microaggression in the Healthcare Setting	Article provides strategies for health care professions to address microaggressions when they come up in day-to-day interactions with other health care professionals.
	Addressing the Elephant in the Room: Microaggressions in Medicine	Article describes common microaggressions at the intersection of gender and race, and strategies providers and staff can use to respond to them.
	Protecting Your Birth: A Guide for	Guide on how racism / bias can affect pre- and postnatal care, and ideas to facilitate optimal patient-provider communication and promote respectful care

	<u>Black Mothers (and OB care team)</u>	
	<u>CDC HEAR HER Campaign</u>	Resources to raise awareness of life-threatening warning signs during and after pregnancy and improve patient-provider communication, including patient story videos and discussion tools
	<u>Harvard Project Implicit Association Test</u>	Test to check implicit bias before participating in equity training and/or the health care hiring/candidate selection