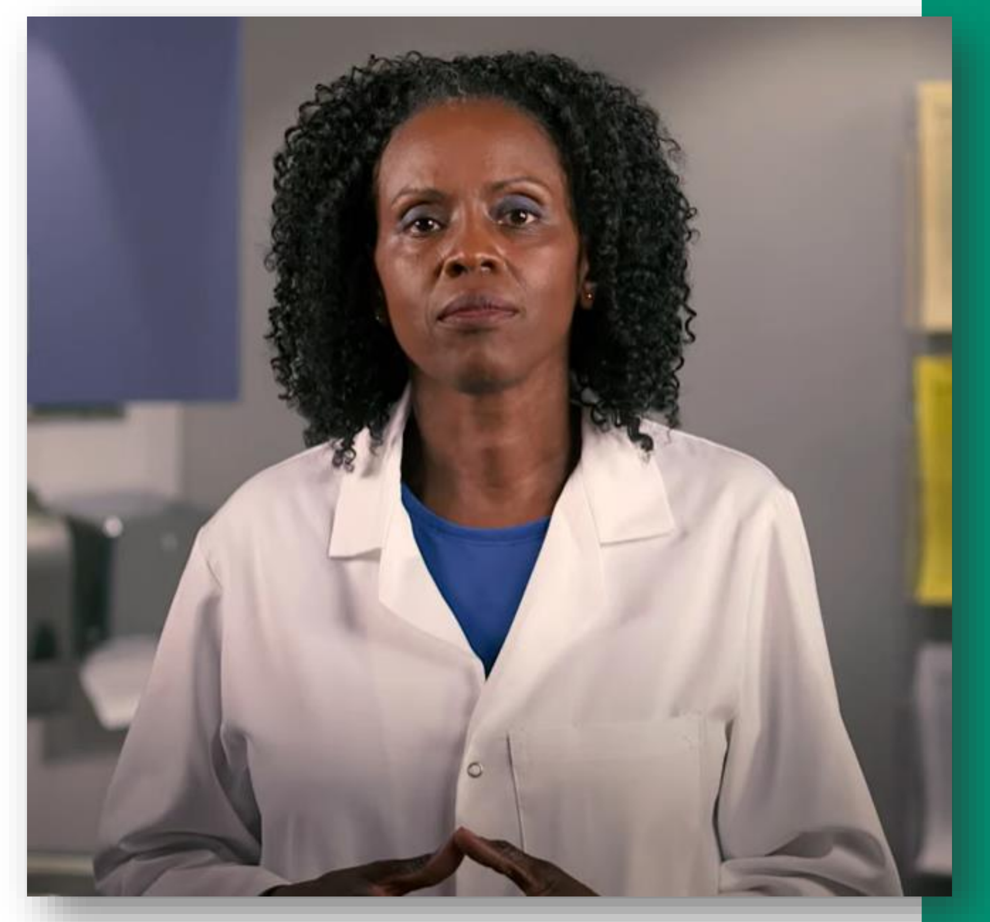
Hear Her…



Dr. Wanda Barfield, Director CDC's Division of Reproductive Health

CDC's Hear Her campaign public service announcement (PSA) is a 30-second video that aims to raise awareness of potentially life-threatening warning signs during and after pregnancy and improve communication between patients and their healthcare providers.

https://www.youtube.com/watch?v=JeHyF4Xt6Ok

FPQC

Florida
HEALTH

CDC
CENTERS FOR DISEASE
CONTROL AND PREVENTION

AIM
ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH

PACC
POSTPARTUM ACCESS & CONTINUITY OF CARE

FPQC

FPQC's Vision & Values

*"**All** of Florida's mothers, infants & families will have the **best health outcomes** possible through receiving **respectful, equitable, high quality, evidence-based** perinatal **care**."*

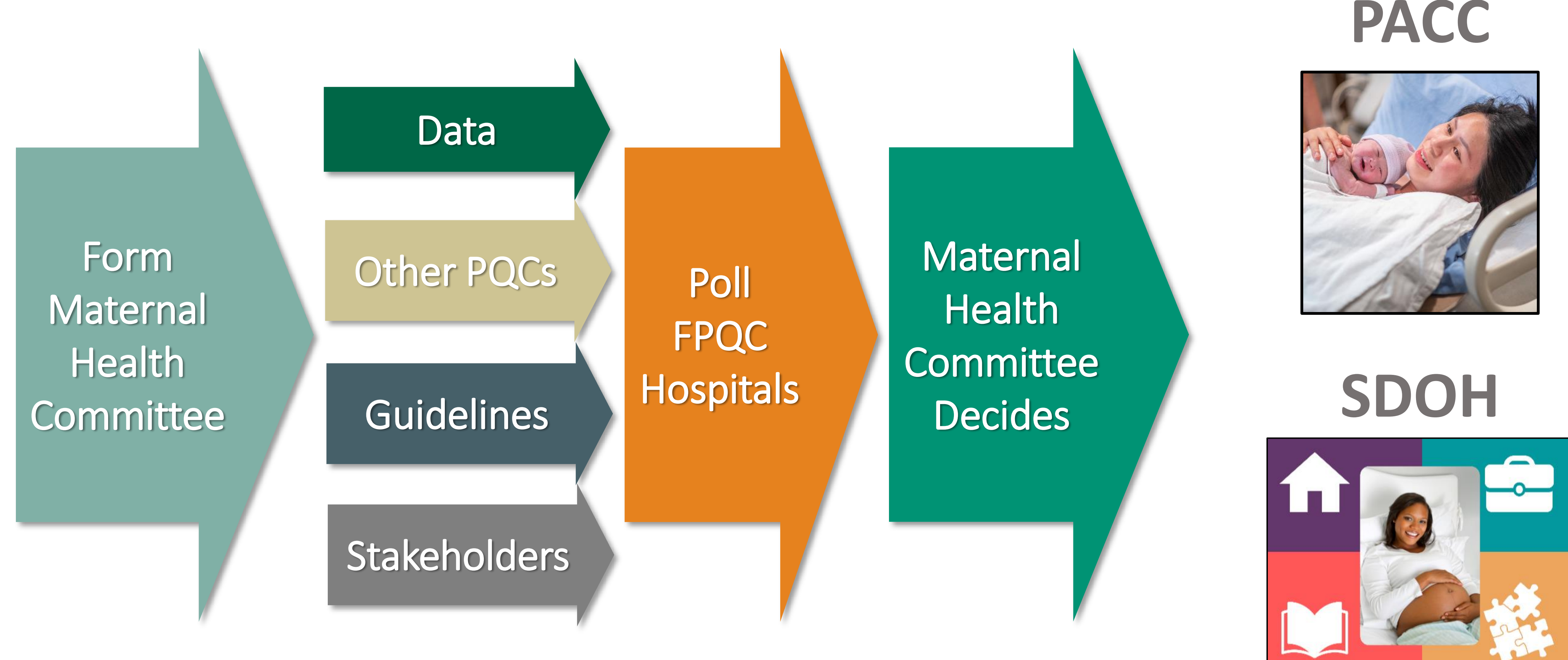
- Voluntary
- Data-Driven
- Population-Based
- Evidence-Based
- Equity-Centered
- Value-Added

FPQC Partners & Funders

Florida Society of Neonatologists

Advancing the Care of Neonates in the Sunshine State

Selecting Maternal Health Initiatives

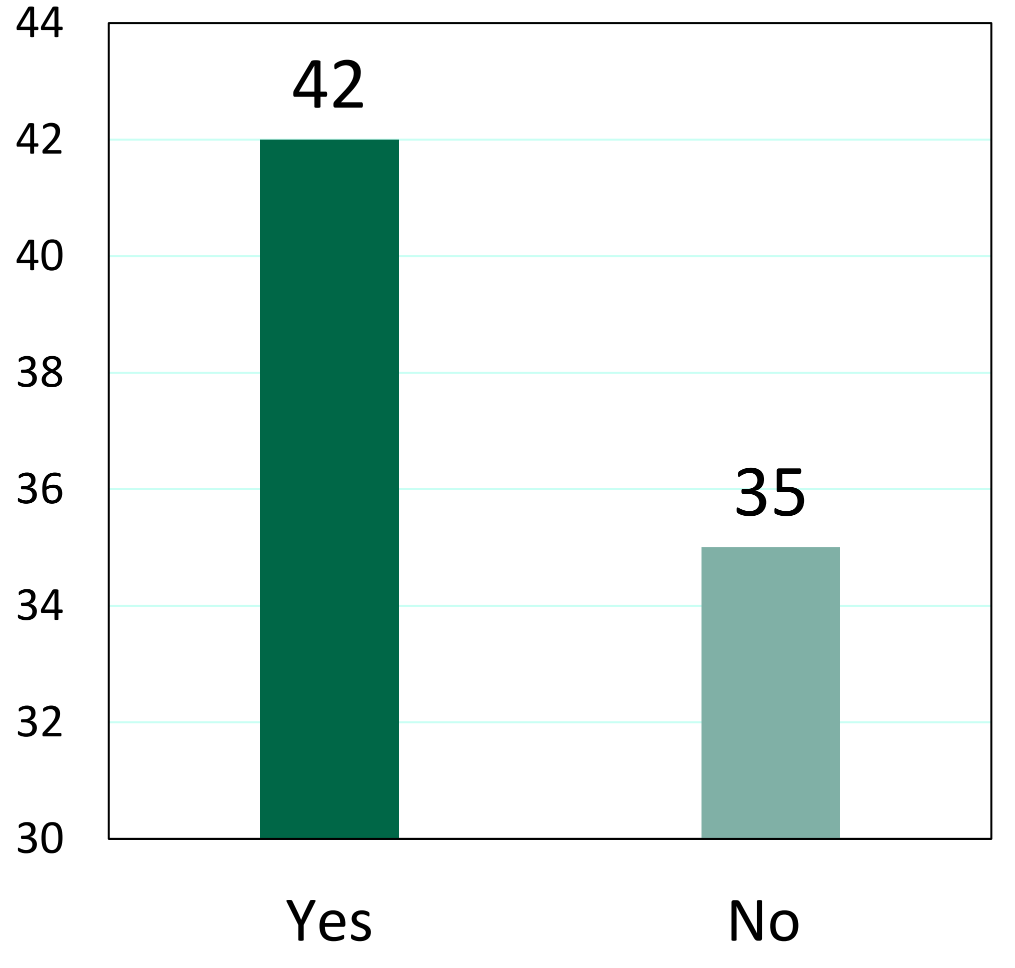


Why Postpartum Care?

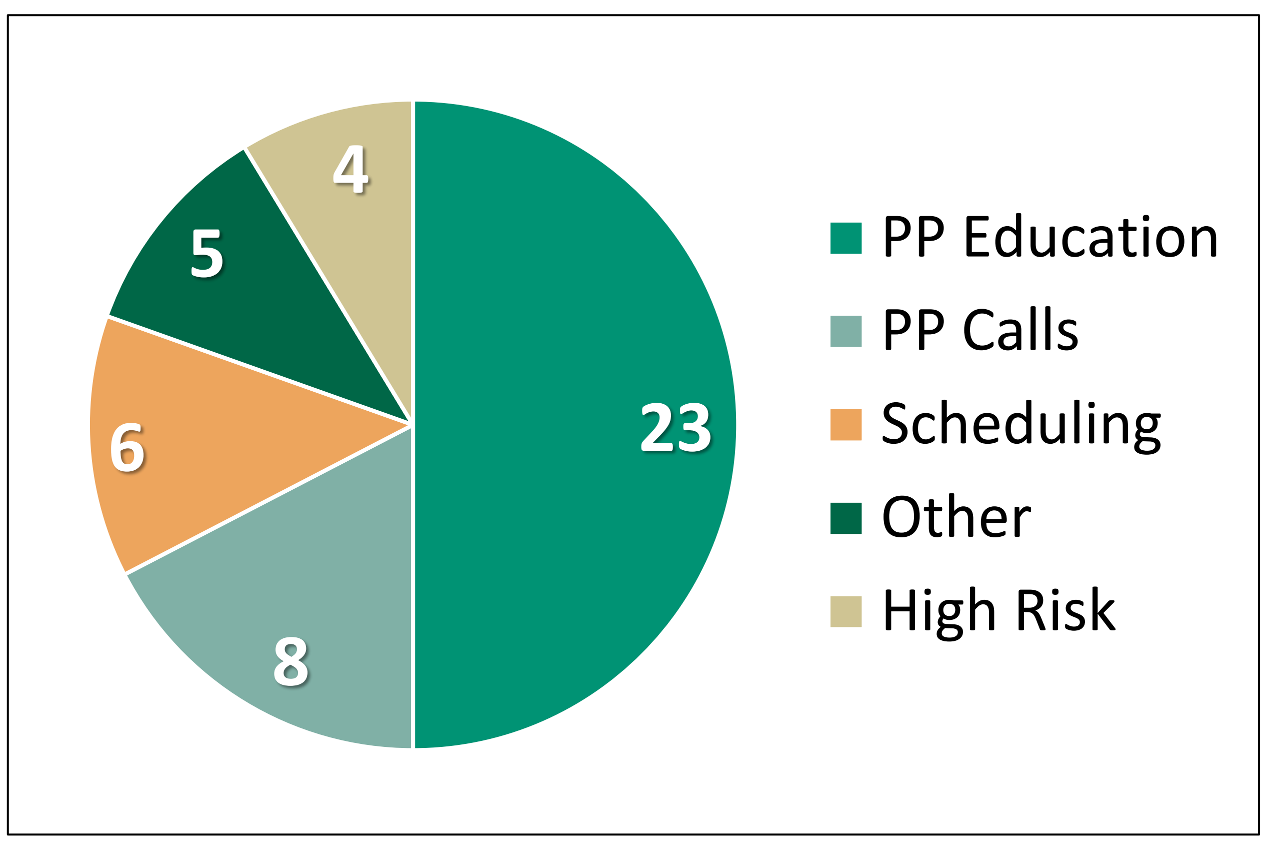
- ✓ 1/3—1/2 of Florida's pregnancy-related deaths occur after the mother goes home.
- ✓ 3/4 of Florida's drug-related deaths occur after the mother goes home.
- ✓ 50% of postpartum strokes occur within 10 days.
- ✓ 20% of postpartum mothers experience a mental health disorder.

Prior Hospital Postpartum Discharge Efforts

Prior Postpartum Efforts, PACC



Type of PP Activities, PACC



PACC Advisory Committee Members—Thank You!

- Julie DeCesare, West Florida Hospital
- Kimberly Fryer, USF Morsani College of Medicine
- Margie Boyer, FPQC
- Amanda Snyder, Winnie Palmer
- Amandla Shabaka-Haynes, FSU College of Medicine
- Angela Daniel, Certified Doula
- Angela Thompson Williams, FDOH
- Ankita Patel, Reach Up
- Anna Varlamov, Gainesville, UCF COM
- Averjill Rookwood, The Corporate Doula
- Beth Dowd, Cape Coral Hospital
- Bridget Drafahl, Sarasota Memorial Hospital
- Carol Brady, Carol Brady & Associates
- Carol Lawrence, FGCU
- Chris Cogle, Florida Medicaid, AHCA/Medicaid
- Christopher Watson, St. Vincent's Riverside
- Clarissa Ortiz, FL Assoc. of Community Health Centers
- Cynthia Tinder, Winnie Palmer Hospital
- Daniela Crousillat, USF Health Cardiology
- Danielle Carter, FL Assoc. of Family Practitioners
- Danita Burch, Ascension St. Vincent's Riverside
- David McLean, UF Health Gainesville
- Eleni Tsigas, Preeclampsia Foundation
- Helen Kuroki, Women's Care of Florida
- Helena Girouard, Florida Department of Health
- Judette Louis, USF Health
- Kelli Bottcher, AHCA
- Kim Streit, Florida Hospital Association
- Kirsten Ellingsen, Parent and Child Psychological Services
- Leah Williams-Jones, South Miami Hospital
- Lindsay Greenfield, Tampa General Hospital
- Lori Reeves, FDOH
- Lynn Berger, Medicaid
- Mallory Leblanc, University of Florida
- Mandi Gross, MoMMA's Voices
- Mark Bloom, Molina Healthcare of Florida
- Megan Deichen Hansen, FSU College of Medicine
- Melissa Rodriguez, AdventHealth Celebration
- Micah Garcia, USF College of Public Health
- Miguel Venereo, Community Care Plan
- Monica King, FL Assoc. of Healthy Start Coalitions
- Nadine Walker, Advent Health
- Nancy Travis, Lee Health
- Paloma Prata, FL Assoc. of Healthy Start Coalitions
- Randy Katz, FL College of Emergency Physicians
- Robert Yelverton, FL Maternal Mortality Review Committee
- Sandra Schwemmer, AmeriHealth Caritas
- Sara Stubben, USF College of Public Health
- Shavnay Mcclain, AdventHealth Orlando
- Stanley Lynch, UnitedHealthcare Community & State Florida
- Taisha Ortiz, Reach Up
- Tara Cockman, FDOH
- Tommy Rodgers, Humana Healthy Horizons, Humana
- T.R. Richardson, Fatherhood PRIDE Program
- Traci Thompson, Humana
- Vanessa Hux, USF Health
- Vera Beloshitzkaya, FL Department of Health
- Washington Hill, CenterPlace Health, FL MMRC

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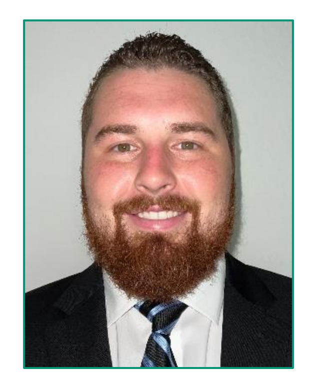
PACC Leadership Team

FPQC Leads	Provider Leads	Nurse Lead	QI Team	Data Team
William Sappenfield	Julie DeCesare	Margie Boyer	Estefanny Reyes Martinez	Estefania Rubio
Linda Detman	Kimberly Fryer		Nicole Pelligrino	 Benjamin Gessner

77 Florida Hospitals:

- 72% of birthing hospitals
- 82% of births

Maternal Levels of Care Verification

Delivering Confidence Across All Levels of Maternal Care in ***Florida***

A program to help reduce maternal morbidity and mortality outcomes by ensuring women receive risk-appropriate care.

Questions?

wsappenf@usf.edu

fpqc@usf.edu

www.fpqc.org

Florida Perinatal Quality Collaborative

Florida Perinatal Quality Collaborative

@TheFPQC

"To improve the health and health care of all Florida mothers & babies"

Hear Her…

Hear Sanari's Story

In this video from CDC’s Hear Her campaign, Sanari shares how she started to experience pain two days after delivery and was initially told it was caused by gas. But when her symptoms continued to worsen, she knew something was wrong. An abscess was eventually found on her uterus, which could have been fatal. “I’m glad I didn’t stop at ...

https://www.youtube.com/watch?v=zaFNmssfvOk

PACC Overview & Purpose:

Kimberly Fryer, MD, FACOG, MSCR
PACC Clinical Co-Lead

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PACC
POSTPARTUM ACCESS & CONTINUITY OF CARE
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Objectives

- Discuss Florida's postpartum discharge pregnancy-related mortality including leading causes of postpartum death, timing and place
- Describe quality improvement drivers to help prevent postpartum discharge related deaths
- Discuss respectful care and the family perspective
- Review the PACC QI Drivers and Toolkit to assist

Tampa Bay Times

FLORIDA'S BEST NEWSPAPER | tampabay.com | ★★★★ Sunday, August 28, 2022 | $3

Maternal mortality crisis in America

Giving birth in the U.S. entails high risk. Biden's administration pushes to reverse that.

BY AKILAH JOHNSON
The Washington Post

As part of a major push by the Biden administration to address the nation's maternal health crisis, senior officials have traveled the country for the past year, talking to midwives, doulas and people who have given birth about their experiences. They've held summits at the White House.

The result: an almost 70-page plan aimed at taking the United

Photos by LAUREN WITTE | Times

PROPUBLICA

Graphics & Data Newsletters About

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Soleil Irving "just lights up a room when she smiles," Wanda Irving, her grandmother, says. (Sheila Pree Bright for ProPublica)

LOST MOTHERS

Nothing Protects Black Women From Dying in Pregnancy and Childbirth

Maternal Mortality Definitions

Maternal Mortality (Uses death certificate only)

Death of a woman while **pregnant or within 42 days** of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Pregnancy-Associated Mortality (Uses enhanced surveillance)

Death of a woman, from any cause, while she is **pregnant or within one year of pregnancy**.

Pregnancy-Related Mortality (Based on Maternal Mortality Review)

Pregnancy-associated death that resulted from:

1) Complications of the pregnancy;
2) The chain of events initiated by pregnancy; or
3) Aggravation of an unrelated condition by pregnancy effects resulting in death.

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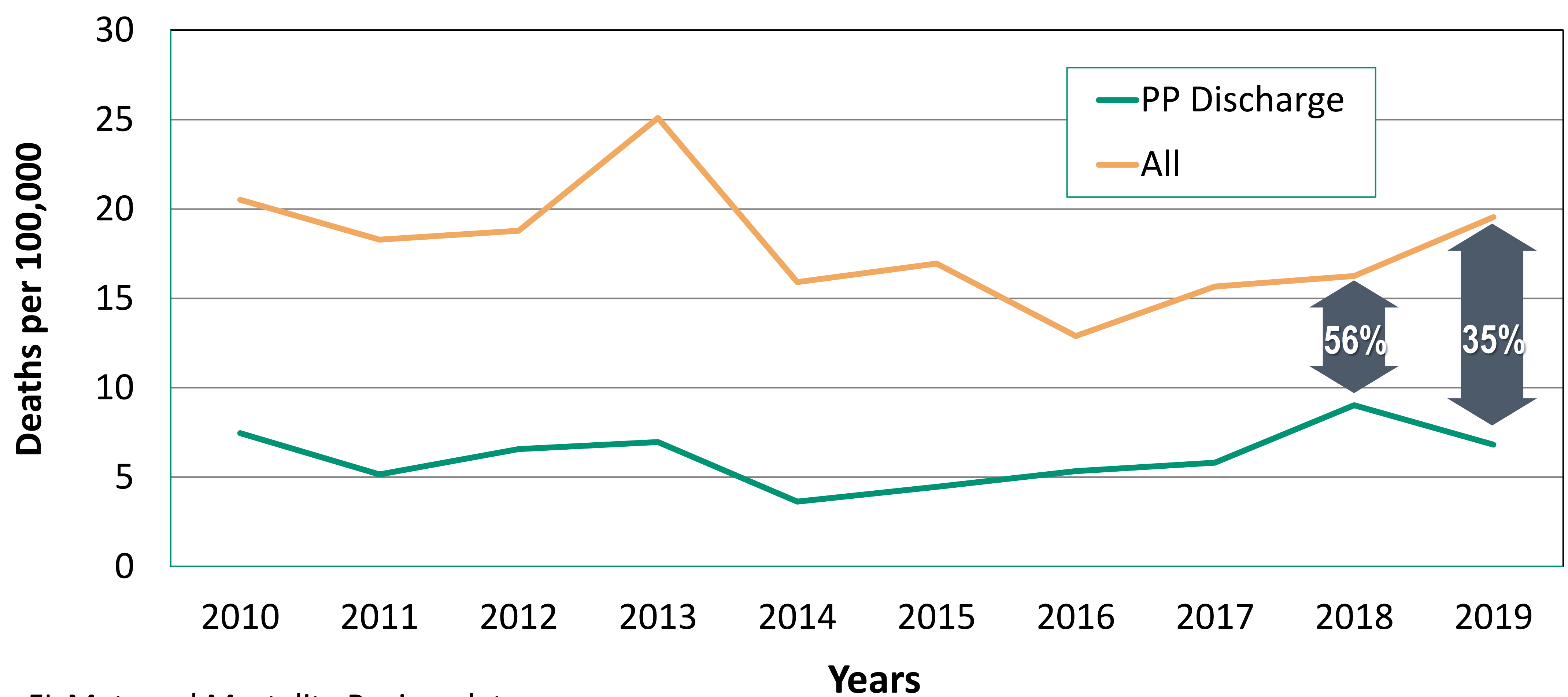
Pregnancy-Related Mortality Rates
Florida, 2010 to 2019



Source: FL Maternal Mortality Review data

Postpartum Discharge Pregnancy-Related Deaths By Time Period, Florida, 2015 to 2019

Percentage

80%
70%
60%
50%
40%
30%
20%
10%
0%

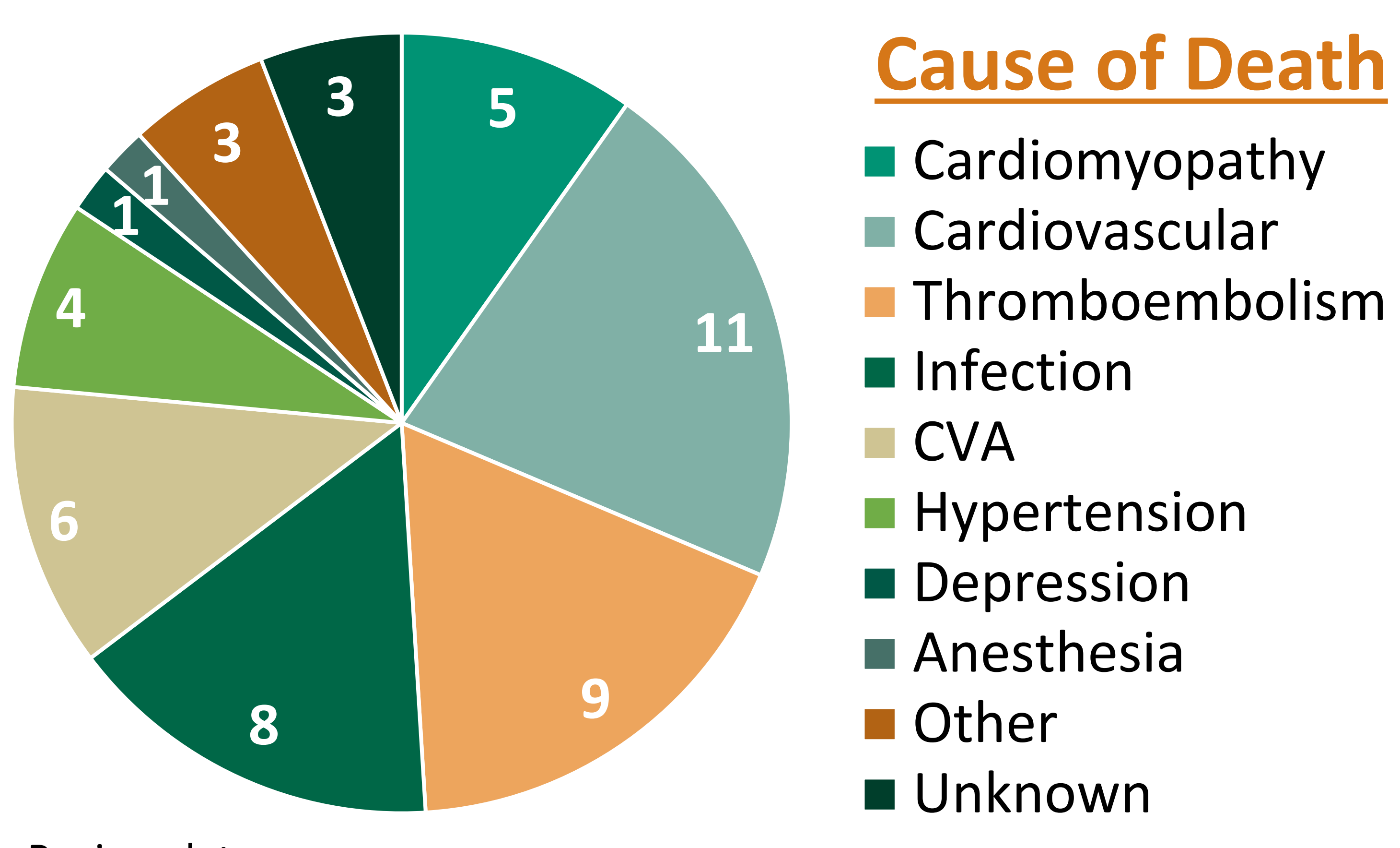
75%
13%
7%
4%

<60
60-119
120-180
180+

Days After Birth

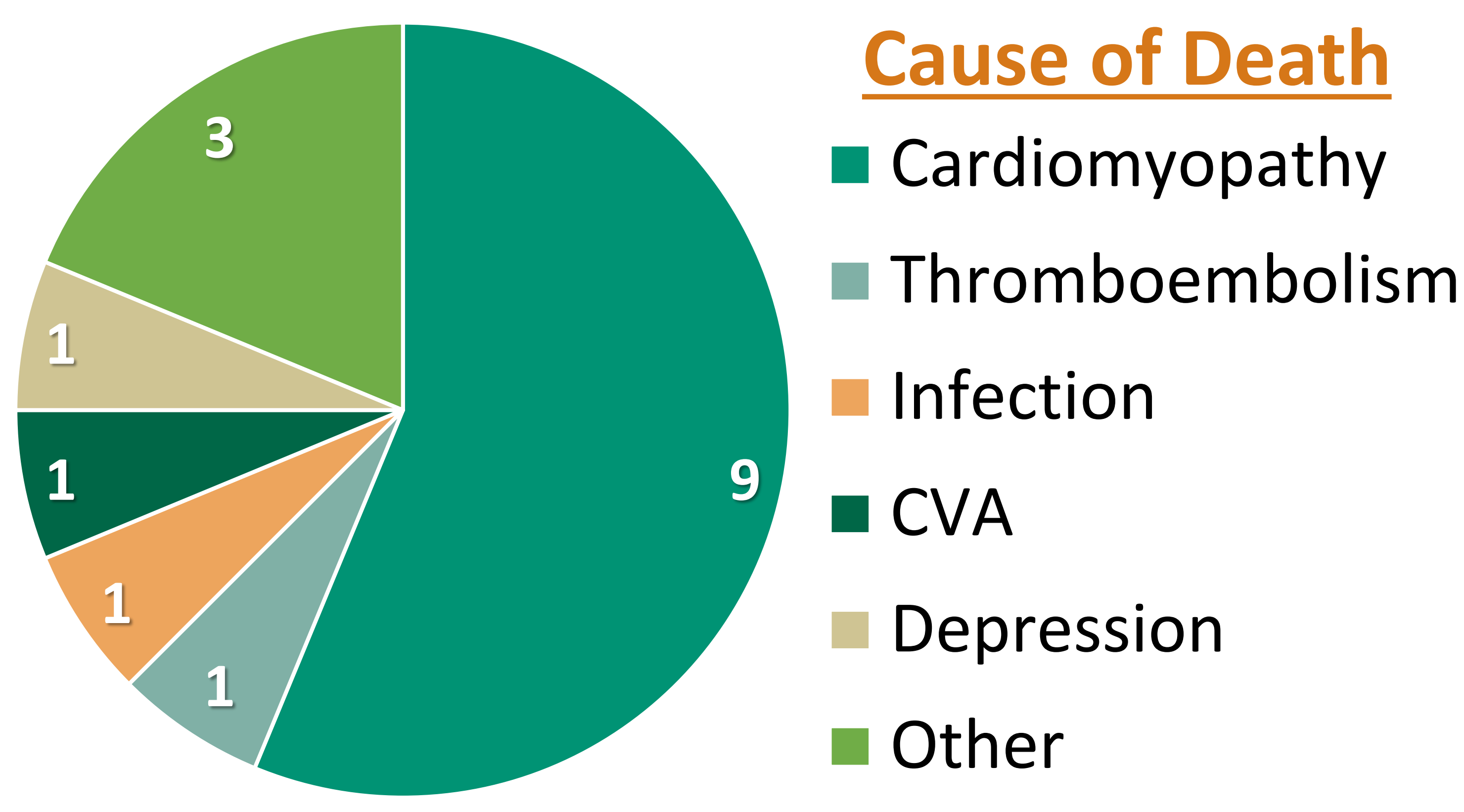
Source: FL Maternal Mortality Review data

Underlying Cause of Death for Less Than the First 60 Days Postpartum Discharge Pregnancy-Related Deaths By Time Period, Florida, 2015 to 2019



Source: FL Maternal Mortality Review data

Underlying Cause of Death for 60+ Days Postpartum Discharge Pregnancy-Related Deaths By Time Period, Florida, 2015 to 2019

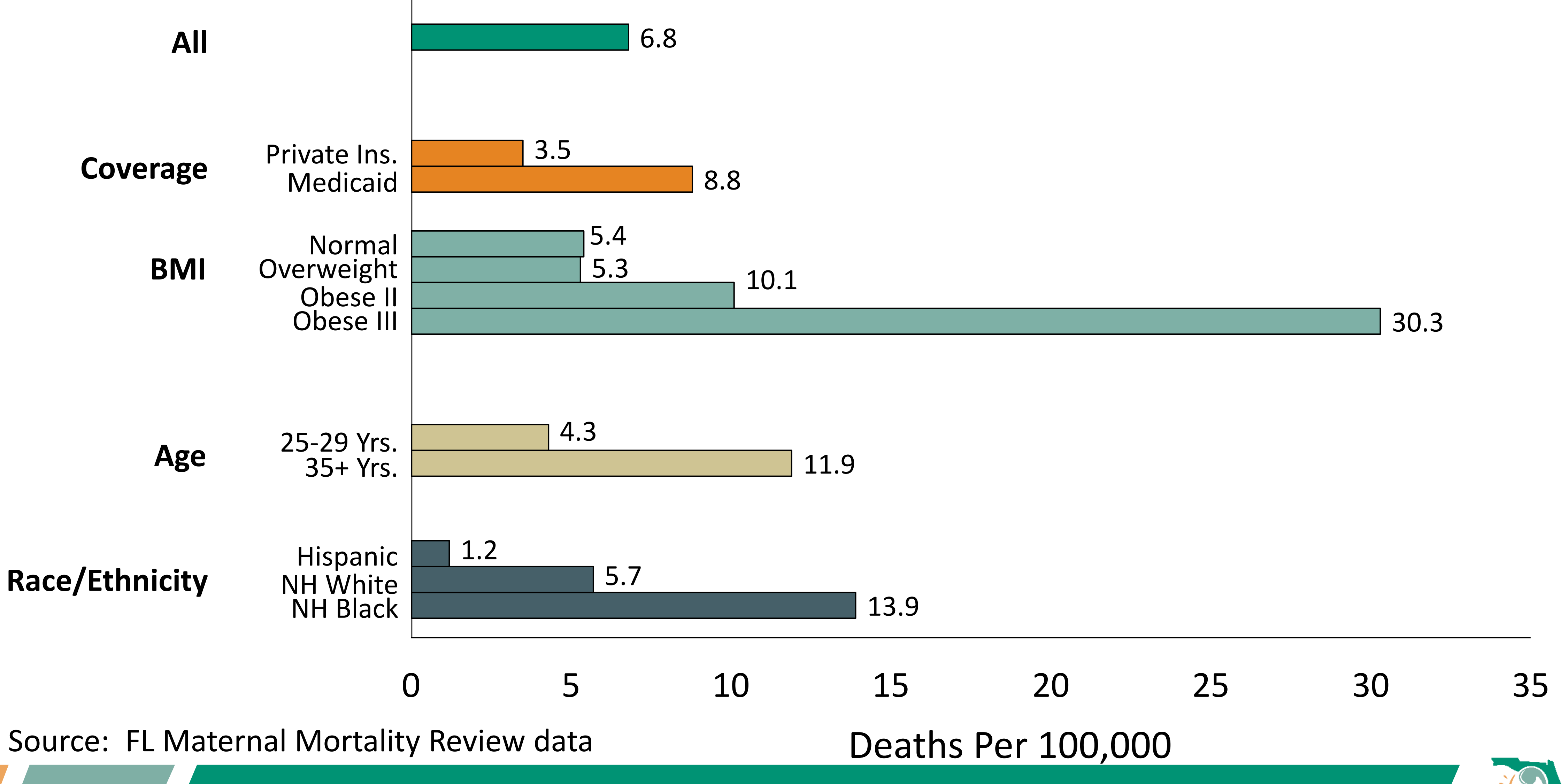


Source: FL Maternal Mortality Review data

Postpartum Discharge Pregnancy-Related Deaths with a Stand-Alone Postpartum ER Visit, Florida, 2015 to 2019

Source: FL Maternal Mortality Review data

Postpartum Discharge Pregnancy-Related Mortality Rates, Women at Risk, Florida, 2015 to 2019



Source: FL Maternal Mortality Review data

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Postpartum Discharge Pregnancy-Related Deaths By Cause and Preventability, Florida, 2015 to 2019

Cardiomyopathy
Cardiovascular
Infection
Thrombotic Embolism
Cerebrovascular Accident
Hypertensive Disorder
Depression
Anesthesia
Hemorrhage
Other
Unknown

Preventability
Substantial
Moderate
Not

0 2 4 6 8 10 12 14 16

Number of Postpartum Discharge Deaths

Topic MMRC Recommendation Themes

Improvement recommendations in the following areas:

- Chronic disease management before & after pregnancy: **33 recommendations**
- Postpartum visit: **16 recommendations**
- Provider education: **11 recommendations**
- Sepsis: protocol and provider education: **5 recommendations**

Source: FL Maternal Mortality Review data

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Source: FL Maternal Mortality Review data

Pregnancy-Associated Mortality Ratios by Cause of Death Florida, 2010-2020

Deaths per 100,000 Live Births

35
30
25
20
15
10
5
0

Drug related
Motor Vehicle Accident
Suicide
Homicide
Other

2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020

Drug-Related Deaths:

- Leading cause; More than all pregnancy complications
- More than 75% die after discharge for delivery
- More likely to have had a prior standalone ER visit than other conditions

Why Early Postpartum Care?

- 50% of postpartum strokes occur within 10 days of discharge *(Too G, et al, 2018)*

- 20% of women discontinue breastfeeding before the first 6-weeks *(Stuebe, et al, 2014)*
- Up to 40% of women do not attend the 6-week postpartum visit *(ACOG CO #736 2018)*
- As many as 1 in 5 women experience a postpartum mental health disorder

Women desire improved postpartum care

- Qualitative studies point to women's lack of satisfaction with postpartum care compared to maternal care
- With women noting a steep drop off in care in the early postpartum period
- Women reported wanting additional, early postpartum care

Martin A, et. al. Views of women and clinicians on postpartum preparation and recovery. Matern Child Health J 2014.
Tully KP, et. al. The fourth trimester: a critical transition period with unmet maternal health needs. Am J Obstet Gynecol 2017

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Redefining postpartum care: ACOG CO #736

- To **optimize** the health of women and infants, postpartum care should **become an ongoing process**, rather than a single encounter
- **All women** should ideally have contact with maternal care provider **within the first 3 weeks postpartum (2 week post birth health check)**
  - ❑ Blood pressure checks
  - ❑ Breastfeeding support
  - ❑ Mental health well-being
  - ❑ Contraception
- Initial assessment should be followed up with **ongoing care as needed**
- Conclude with a **comprehensive** postpartum visit approximately 6 weeks postpartum, **NO LATER than 12 after birth**

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

ABSTRACT: The weeks following birth are a critical period for a woman and her infant, setting the stage for long-term health and well-being. 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. It is recommended that all women have contact with their obstetrician–gynecologists or other obstetric care providers 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 comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance. Women with chronic medical conditions such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, and mood disorders should be counseled regarding the importance of timely follow-up with their obstetrician–gynecologists or primary care providers for ongoing coordination of care. During the postpartum period, the woman and her obstetrician–gynecologist or other obstetric care provider should identify the health care provider who will assume primary responsibility for her ongoing care in her primary medical home. Optimizing care and support for postpartum families will require policy changes. Changes in the scope of postpartum care should be facilitated by reimbursement policies that support postpartum care as an ongoing process, rather than an isolated visit. Obstetrician–gynecologists and other obstetric care providers should be in the forefront of policy efforts to enable all women to recover from birth and nurture their infants. This Committee Opinion has been revised to reinforce the importance of the "fourth trimester" and to propose a new paradigm for 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.

New Postpartum Care Continuum

An early postpartum visit (within 2 weeks of delivery) provides women with an essential maternal safety check including blood pressure evaluation, wound/perineum evaluation, breastfeeding support, mental health well-being, and family planning, among other essential health services.

Universal early postpartum visit within 2 weeks
-BP check within 7-10 days
-OB F/U with 2 weeks
-Family Planning
-Mood check/depression screening
Breastfeeding

Traditional 6-week postpartum visit
Full physical, social, emotional assessment, including:
-Mood and emotional well-being
-Infant care and feeding
-Family Planning
-Sleep Fatigue
-Physical recovery from birth

Transition to well-woman care
-Identify ongoing primary care provider
-Recommendations for F/U for well-women care and/or any ongoing medical issues
-Appropriate referrals to other members of health care team

Global AIM: Improve maternal health through hospital-facilitated continuum of postpartum care by coordinating and providing respectful, timely, and risk-appropriate coordinated care and services.

AIM

By 6/2024, FPQC participating hospitals will:

- **Increase the % of patients with a 2-week PP visit scheduled prior to discharge by 20%***
- **Increase patient PP education by 20%***

Respectful care is a universal component of every driver & activity

Primary Key Drivers

- Process for Maternal Discharge Risk Screening & Arranging Early Postpartum Visits
- Comprehensive Postpartum Patient Discharge Education
- Clinician Postpartum Engagement and Education

Global AIM: Improve maternal health through hospital-facilitated continuum of postpartum care by coordinating and providing respectful, timely, and risk-appropriate coordinated care and services.

Primary Key Driver	Secondary Drivers
Process for Maternal Discharge Risk Screening & Arranging Early Postpartum Visits	Develop a process flow to schedule early risk-appropriate PP visits/encounters prior to discharge and align policies and procedures accordingly
	Conduct a PP Discharge Assessment prior to discharge
	Implement universal Maternal Discharge Risk Screening for PP care & schedule/arrange risk-appropriate PP care including obstetrical, specialty, & community services before discharge

Respectful care is a universal component of every driver & activity

Global AIM: Improve maternal health through hospital-facilitated continuum of postpartum care by coordinating and providing respectful, timely, and risk-appropriate coordinated care and services.

Primary Key Driver	Secondary Drivers
Comprehensive Postpartum Patient Discharge Education	Verbally educate patients on the benefits of early risk-appropriate PP visits/encounters (Post-Birth Health Checks)
	Verbally educate all patient on PP Warning Signs and provide written materials
	Verbally educate patients on the benefits of and options for pregnancy spacing, family planning and contraceptive choice and provide written materials
	Establish a system to ensure that all patients receive recommended and documented PP education and discharge information

Respectful care is a universal component of every driver & activity

Global AIM: Improve maternal health through hospital-facilitated continuum of postpartum care by coordinating and providing respectful, timely, and risk-appropriate coordinated care and services.

Primary Key Driver	Secondary Drivers
Clinician Postpartum Engagement and Education	Develop a strategy to engage and educate inpatient and outpatient providers and staff using initiative promotional and education materials
	Plan in place to continue to engage and educate new hires
	Develop a strategy to engage and educate ER physicians & staff about pregnancy/PP care including PP screening & care practices

Respectful care is a universal component of every driver & activity

PACC Initiative Timeline

OCTOBER 2022

- Recruit leadership team
- Application deadline
- Kick Off Meeting, October 27
- Complete Pre-Implementation Survey

FALL 2023

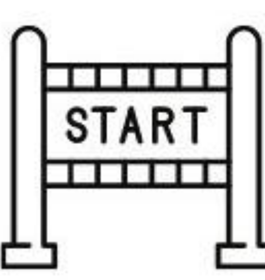
- Mid-Initiative Meeting

JUNE 2024

- Initiative completion

JANUARY 2023

- **Individual hospital Kick Offs**
- Start of:
  - Webinars/coaching calls
  - Local team/department meetings
  - On-site technical assistance
  - Data collection



MAY 2024

- Initiative hospital post-implementation survey

Only with all of us working together can we make an achievable change in the postpartum health of Florida's mothers…

FPQC

Questions?

wsappenf@usf.edu

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www.fpqc.org

Florida Perinatal Quality Collaborative

Florida Perinatal Quality Collaborative

@TheFPQC

"To improve the health and health care of all Florida mothers & babies"

Engaging the Family Perspective:

Mandi Gross

Break

PACC Initiative Drivers

Respectful Care

Nicole Pelligrino, MPH, MCHES, Certified Doula
Senior Quality Improvement Analyst

What is Respectful Maternity Care?

FPQC Vision, updated 2021:

All of Florida's mothers, infants & families will have the best health outcomes possible through receiving respectful, equitable, high quality, evidence-based perinatal care.

*****

"Respectful Maternity Care (RMC) is an approach to care that emphasizes the fundamental rights of women, newborns, and families, promoting equitable access to evidence-based care while recognizing unique needs and preferences." (Shakibazadeh et al., 2018)

Respectful Maternity Care (RMC) Universal for FPQC Initiatives

Postpartum Access & Continuity of Care (PACC)

Global AIM: Improve maternal health through hospital-facilitated continuum of postpartum (PP) care by coordinating and providing respectful, timely, and risk-appropriate coordinated care and services.

AIM	Primary Key Drivers	Secondary Key Drivers
By 6/2024, FPQC participating hospitals will: • Increase % of patients with a 2-week PP visit scheduled prior to discharge by 20%* • Increase patient PP education~ by 20%*	Process for Maternal Discharge Risk Assessment & Arranging Early PP Visits	Develop a process flow to schedule early risk-appropriate PP visits/encounters prior to discharge and align policies and procedures accordingly
		Conduct a PP Discharge Assessment prior to discharge
		Implement universal Maternal Discharge Risk Assessment & schedule/arrange risk-appropriate PP care including obstetrical, specialty & community services before discharge
	Comprehensive PP Patient Discharge Education	Verbally educate patients on the benefits of early risk-appropriate PP visits/encounters (Post-Birth Health Check) and provide written materials
		Verbally educate all patient on PP Warning Signs and provide written materials
		Verbally educate patients on the benefits of and options for pregnancy spacing, family planning and contraceptive choice and provide written materials
		Establish a system to ensure that all patients receive recommended and documented PP education and discharge information
Respectful care is a universal component of every driver and activity	Clinician PP Engagement and Education	Develop a strategy to engage and educate inpatient and outpatient providers and staff using initiative promotional and education materials
		Plan in place to continue to engage and educate new hires
		Develop a strategy to engage and educate ER physicians & staff about pregnancy/PP care including PP screening & care practices.

RMC

~ Includes benefits of early PP visits, warning signs, and family planning
* Baseline will be established with the first quarter of hospital data

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Foundations of Respectful Maternity Care (RMC)

RMC founded on the premise that women should not be mistreated in childbirth.

1970s — International recognition of the need for respectful care by women giving birth, clinicians (particularly midwives), & doulas.

1990s — Increased cohesion, particularly in Latin America, around addressing obstetric violence.

2000 — Network for the Humanization of the Childbirth was founded after the Childbirth & Birth Humanization Conference in Ceará, Brazil.

2010 — USAID Report publishes "Exploring Evidence for Disrespect and Abuse [D&A] in Facility-Based Childbirth" calling for evidence-based interventions to address RMC.

2011 — White Ribbon Alliance publishes "Respectful Maternity Care: The Universal Rights of Childbearing Women."

RMC Across Clinical Organizations

Clinical organizations continue to complement and expanded upon efforts related to RMC.

- ACOG Committee Opinion 587: Effective Patient–Physician Communication (2014, Reaffirmed 2021) provides recommendations including:

RESPECT Model

Rapport
Empathy
Support
Partnership
Explanation
Cultural Competence
Trust

(UCSF, 2002)

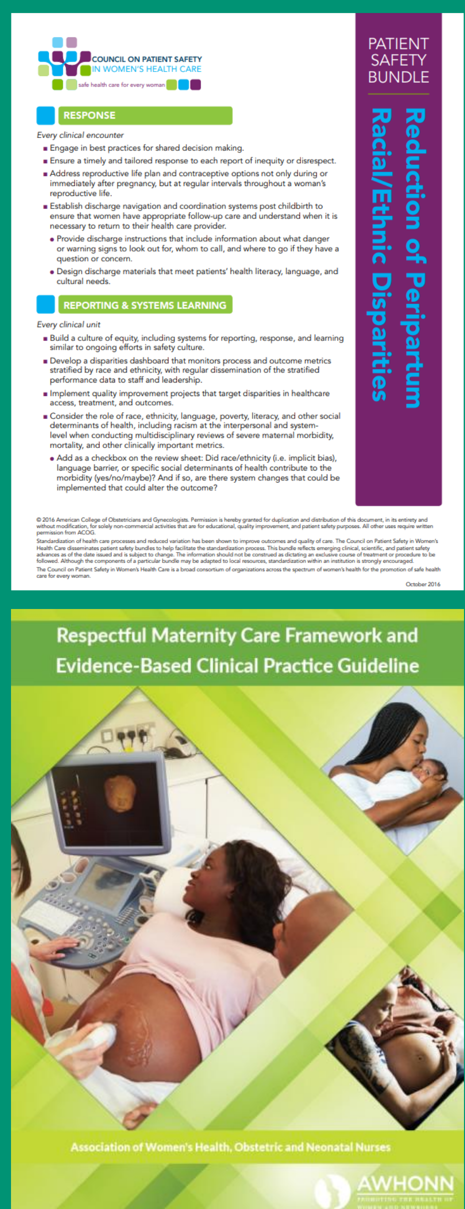
Five Step Patient-Centered Interviewing

Step 1. Set the stage for the interview (30–60 s)
Step 2. Elicit chief concern and set an agenda (1–2 min)
Step 3. Begin the interview with non-focusing skills that help the patient to express herself (30–60 s)
Step 4. Use focusing skills to learn 3 things: Symptom Story, Personal Context, and Emotional Context (3–10 min)
Step 5. Transition to middle of the interview (clinician-centered phase) (30–60 s)

(Fortin et al., 2012)

RMC Across Clinical Organizations

- **ACOG/AIM: "Reduction of Peripartum Racial & Ethnic Disparities: A Conceptual Framework & Maternal Safety Bundle" (2018):**
  - Focuses on quality/safety and highlights **Response** (e.g. establish discharge navigation systems), **Reporting** (e.g. disparities dashboards), **Readiness** (e.g. best practices for shared decision making), and **Recognition** (e.g. access to health information in a simplified format).
- **AWHONN Respectful Maternity Care Implementation Toolkit (2022):**
  - **Comes with tools and resources you can use to implement within your organization. Free for members and available to non-members for a small fee. Guiding principles:**
    - Awareness
    - Mutual Respect
    - Shared Decision Making and Informed Consent
    - Autonomy
    - Dignity
    - Accountability


COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE
safe health care for every woman

PATIENT SAFETY BUNDLE

Reduction of Peripartum Racial/Ethnic Disparities

RESPONSE

Every clinical encounter
- Engage in best practices for shared decision making.
- Ensure a timely and tailored response to each report of inequity or disrespect.
- Address reproductive life plan and contraceptive options not only during or immediately after pregnancy, but at regular intervals throughout a woman's reproductive life.
- Establish discharge navigation and coordination systems post childbirth to ensure that women have appropriate follow-up care and understand when it is necessary to return to their health care provider.
  - Provide discharge instructions that include information about what danger or warning signs to look out for, whom to call, and where to go if they have a question or concern.
  - Design discharge materials that meet patients' health literacy, language, and cultural needs.

REPORTING & SYSTEMS LEARNING

Every clinical unit
- Build a culture of equity, including systems for reporting, response, and learning similar to ongoing efforts in safety culture.
- Develop a disparities dashboard that monitors process and outcome metrics stratified by race and ethnicity, with regular dissemination of the stratified performance data to staff and leadership.
- Implement quality improvement projects that target disparities in healthcare access, treatment, and outcomes.
- Consider the role of race, ethnicity, language, poverty, literacy, and other social determinants of health, including racism at the interpersonal and system-level when conducting multidisciplinary reviews of severe maternal morbidity, mortality, and other clinically important metrics.
  - Add as a checkbox on the review sheet: Did race/ethnicity (i.e. implicit bias), language barrier, or specific social determinants of health contribute to the morbidity (yes/no/maybe)? And if so, are there system changes that could be implemented that could alter the outcome?

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Standardization of health care processes and reduced variation has been shown to improve outcomes and quality of care. The Council on Patient Safety in Women's Health Care disseminates patient safety bundles to help facilitate the standardization process. This bundle reflects emerging clinical, scientific, and patient safety advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Although the components of a particular bundle may be adapted to local resources, standardization within an institution is strongly encouraged.

The Council on Patient Safety in Women's Health Care is a broad consortium of organizations across the spectrum of women's health for the promotion of safe health care for every woman.

October 2016

RMC Across Clinical Organizations

- International Confederation of Midwives
  - **Respect Workshops: A Toolkit (FREE to all!) (2020)**

Toolkit intended for midwives, doctors, educators, researchers, nurses, health care workers, doulas, managers, policy-makers, advocates, and leaders to facilitate workshops promoting respectful maternity care. Comes with handouts, activities, and PPTs.

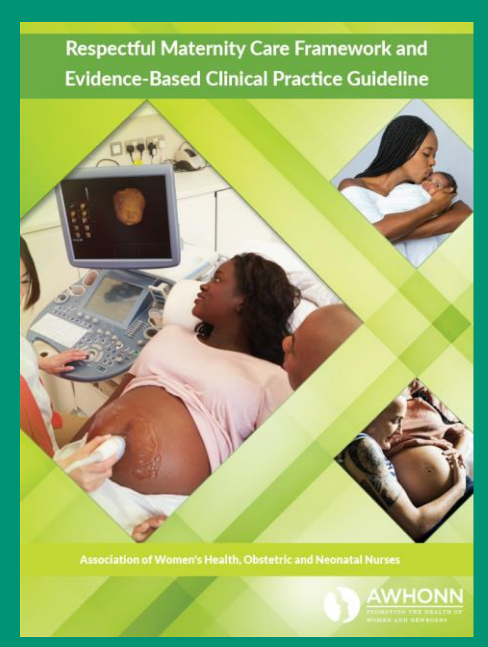
- Discusses Background to RESPECT
- Building RESPECT
- RESPECT Resources

FPQC

RMC in Action: Let's Practice!

- AWHONN Respectful Maternity Care Implementation Toolkit (2022):
    - **Mutual Respect**

According to the toolkit, *"Providing respectful care and holding mutual respect for all members of the patient, family, and health care team should become a cultural norm."*



Here are a few strategies for effective patient-centered communication promoting mutual respect:

- Giving mothers your full attention
- Actively listening to patients by matching nonverbal communication, such as eye contact, with verbal communication
- Taking the time to make small talk to get to know the patient and family
- Approaching each circumstance with positivity, information, and hopefulness

Scenario: You are meeting your postpartum patient for the first time. Turn to the person next to you and each take one minute to practice some of the listed communication strategies.

FPQC

PACC Pledge: RMC in Action

WE PROMISE TO PROVIDE RESPECTFUL POSTPARTUM (PP) PATIENT CARE TO ALL. Therefore, we will:

1. Actively listen to each patient, ensuring their voice and message is heard regarding their safe PP transition to home and needed after care.
2. Treat all patients in a respectful way that honors the patients' beliefs and practices that may be different than our own.
3. Actively engage all patients in all PP plans and decision making.
4. Encourage our patients to ask questions and raise concerns about their PP care & conditions.
5. Provide high-quality, evidence-based PP education with a focus on PP warning signs, the need for an early post birth safety check, and to seek attention early.
6. Complete all PP care appointments and referrals prior to discharge.
7. Welcome the patient's chosen support persons to be present during PP discharge education and discussions.
8. Ensure respectful care to all patients in PP policies & practices.

Driver 1: Health Risk Assessment Tools

Kimberly Fryer, MD, FACOG, MSCR
PACC Clinical Co-Lead

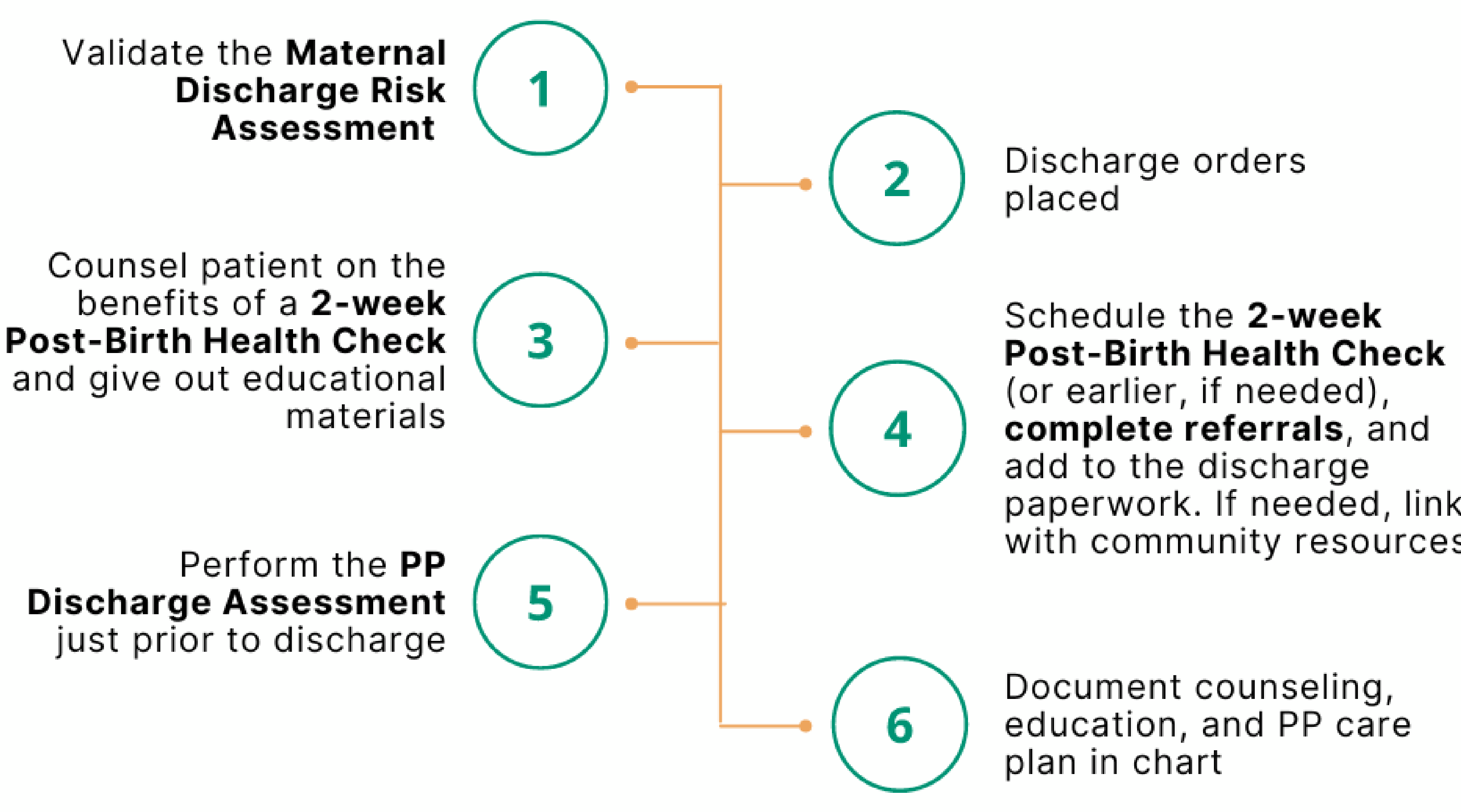
Global AIM: Improve maternal health through hospital-facilitated continuum of postpartum care by coordinating and providing respectful, timely, and risk-appropriate coordinated care and services.

Primary Key Driver	Secondary Drivers
Process for Maternal Discharge Risk Assessment & Arranging Early Postpartum Visits	Develop a process flow to schedule early risk-appropriate PP visits/encounters prior to discharge and align policies and procedures accordingly
	Conduct a PP Discharge Assessment prior to discharge
	Implement universal Maternal Discharge Risk Assessment for PP care & schedule/arrange risk-appropriate PP care including obstetrical, specialty, & community services before discharge

Respectful care is a universal component of every driver & activity

1. High Risk Assessment & Early PP Visits

Discharge Flow Chart



Maternal Discharge Risk Assessment

1. **Has the patient been diagnosed with chronic hypertension, gestational hypertension, pre-eclampsia, eclampsia, maternal heart disease, or related conditions?**
   - Schedule blood pressure check in 2-3 days & appointment with OB or PCP in 1-2 weeks.
   - If yes to maternal heart disease, schedule appointment with cardiology in 1-2 weeks.

2. **Does the patient have a history of venous thromboembolism (DVT or pulmonary embolism) this pregnancy or on anticoagulation prior to delivery?**
   - If yes, then ensure patient has 6 weeks of medication for anticoagulation in hand prior to discharge.

3. **Did the patient have a c-section or 3rd or 4th degree vaginal laceration?**
   - If yes, schedule for 1–2-week incision check with OB.

4. **Does the patient have substance use disorder or screened positive with an evidence-based verbal screening tool?**
   - If yes, perform SBIRT, refer for MAT/MOUD, provide Naloxone kit/Rx, and OB follow up in 1-2 weeks.

Maternal Discharge Risk Assessment

QUESTIONS TO ASK THE PATIENT:

5

Ask: Do you feel unsafe at home? Is there a partner from a relationship who is making you feel unsafe now?

- If yes, then refer to case manager or social worker for assessment prior to discharge.

6

Ask: Over the last two weeks have you felt down, depressed, hopeless, have little interest in doing things, or have a history of mood or anxiety disorder?

- If yes, then screen with Edinburgh Postnatal Depression Scale (recommended), contact OB provider, and schedule follow up for mood check in 1-2 weeks. Consider psych consult prior to discharge or discharge as appropriate.

7

Ask: Can I connect you to additional community resources?

- If yes, consult social worker, refer to Healthy Start, Medicaid Case Manager, or hospital financial counselor.

PP Discharge Assessment—*Just prior to discharge*)

Is the most recently blood pressure ≥160/100?	Is the most recent pulse ≥120?	Is temperature ≥100.4F/38C?	Is the respiratory rate ≥30?
• If yes, alert the provider and hold discharge	• If yes, alert the provider and hold discharge	• If yes, alert the provider and hold discharge	• If yes, alert the provider and hold discharge

Driver 2: Patient Education Tools Available

Margie Boyer, MS, RNC-OB, EFM, ONQS
PACC Lead Nurse

Global AIM: Improve maternal health through hospital-facilitated continuum of postpartum care by coordinating and providing respectful, timely, and risk-appropriate coordinated care and services.

Primary Key Driver	Secondary Drivers
Comprehensive Postpartum Patient Discharge Education	Verbally educate patients on the benefits of early risk-appropriate PP visits/encounters (Post-Birth Health Checks)
	Verbally educate all patient on PP Warning Signs and provide written materials
	Verbally educate patients on the benefits of and options for pregnancy spacing, family planning and contraceptive choice and provide written materials
	Establish a system to ensure that all patients receive recommended and documented PP education and discharge information

Respectful care is a universal component of every driver & activity

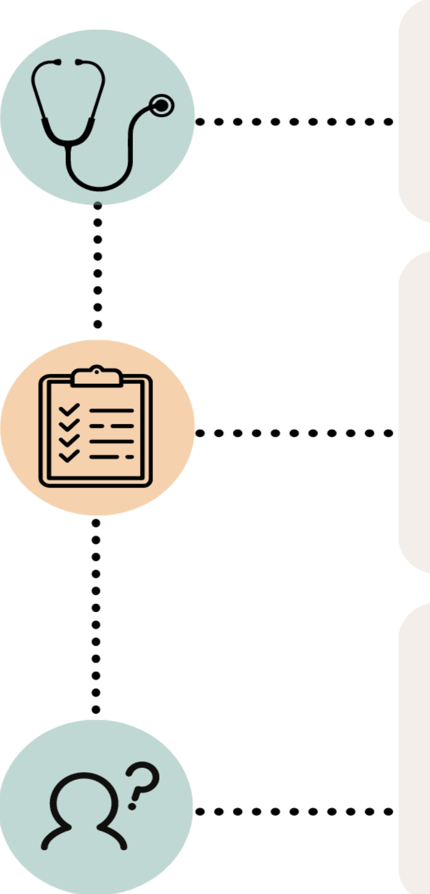
2. Comprehensive PP Discharge Education

Post-Birth Health Check

Post-Birth Health Check

It is important to continue seeing your obstetric (OB) provider after giving birth

You should plan on at least two appointments after giving birth:
The **2-week Post-Birth Health Check** and your **6-week follow-up visit**



WHY TWO WEEKS AFTER GIVING BIRTH?

- Many early warning signs or symptoms are easy to miss, that is why scheduling your 2-week Post-Birth Health Check is important.
- The 2-week Post-Birth Health Check lets your OB provider see how you are doing and address any issues before they become serious.

WHAT HAPPENS AT MY 2-WEEK POST-BIRTH HEALTH CHECK?

Your OB provider or clinical team member will:

- Check your blood pressure
- Check your bottom/stitches
- Make sure your post-birth bleeding is normal
- Discuss your mood and provide support
- Check your breasts for any concerns
- Discuss future pregnancies
- Link you to any extra health services or follow-up

WHEN SHOULD I SCHEDULE MY FIRST VISIT?

- Your first Post-Birth Health Check should be within two weeks after giving birth. Schedule this visit even if you had a birth without problems.
- Tell your nurse if your check is already scheduled.
- Be sure to have an appointment before you leave the hospital. If you go home on a weekend, call your provider's office on Monday to schedule a visit.
- Tip: Set a reminder on your phone of your upcoming appointment.

Write the following on your Post-Birth Wallet Card:

I gave birth on: ______________________________

My OB provider's name: ______________________________

My OB provider's phone: ______________________________

Date of 2-week Post-Birth Health Check: ______________________________

10/13/2022

My Post-Birth Wallet Card

My Post-Birth Wallet Card

My Name:

____

I gave birth on (date):

____

I gave birth at the following hospital:

____

My Post-Birth Health Check date:

____

My OB provider:

____

My OB's phone number:

____

See Reverse for Additional Info

Take a picture with your phone and keep with you in case of emergency!

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My Post-Birth Health Information

I had the following complications:

____

____

____

My Post-Birth Medications:

____

____

____

My Post-Birth Follow-Up Plan:

____

____

____

____

Hear Her Campaign Poster

Headache that won't go away or gets worse

Trouble breathing

Dizziness or fainting

Chest pain or fast-beating heart

Fever of 100.4 or higher

Severe swelling, redness or pain of your leg or arm

Change in your vision

Vaginal bleeding or discharge after pregnancy

Thoughts of harming yourself

Overwhelming tiredness

Multiple ER and health care contacts for same reason!

Source: CDC Hear Her Campaign

Preeclampsia Foundation

You are STILL AT RISK after your baby is born!

Postpartum Preeclampsia

What is it?

Postpartum preeclampsia is a serious disease related to high blood pressure. It can happen to anyone who has just had a baby **up to 6 weeks after the baby is born.**

Risks to You

- Seizures
- Stroke
- Organ damage
- Death

Warning Signs

Stomach pain

Severe headaches

Feeling nauseous or throwing up

Seeing spots (or other vision changes)

Swelling in your hands and face

Shortness of breath

What can you do?

- Ask if you should follow up with your doctor within one week of discharge.
- Keep all follow-up appointments.
- Trust your instincts.
- Watch for warning signs. If you notice any, call your doctor. If you can't reach your doctor, call 911 or go directly to an emergency room and report you have been pregnant.

For more information, go to www.stillatrisk.org

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2. Comprehensive PP Discharge Education

Post-Birth Warning Signs

SAVE YOUR LIFE: Get Care for These POST-BIRTH Warning Signs

Most women who give birth recover without problems. **But any woman can have complications after giving birth.** Learning to recognize these POST-BIRTH warning signs and knowing what to do can save your life.

POST-BIRTH WARNING SIGNS

Call 911 if you have:

- ❑ **P**ain in chest
- ❑ **O**bstructed breathing or shortness of breath
- ❑ **S**eizures
- ❑ **T**houghts of hurting yourself or someone else

Call your healthcare provider if you have:
(If you can't reach your healthcare provider, call 911 or go to an emergency room)

- ❑ **B**leeding, soaking through one pad/hour, or blood clots, the size of an egg or bigger
- ❑ **I**ncision that is not healing
- ❑ **R**ed or swollen leg, that is painful or warm to touch
- ❑ **T**emperature of 100.4°F or higher
- ❑ **H**eadache that does not get better, even after taking medicine, or bad headache with vision changes

Trust your instincts. ALWAYS get medical care if you are not feeling well or have questions or concerns.

Tell 911 or your healthcare provider:

"I gave birth on ________________ and
(Date)
I am having ________________."
(Specific warning signs)

These post-birth warning signs can become life-threatening if you don't receive medical care right away because:

- **Pain in chest, obstructed breathing or shortness of breath** (trouble catching your breath) may mean you have a blood clot in your lung or a heart problem
- **Seizures** may mean you have a condition called eclampsia
- **Thoughts or feelings of wanting to hurt yourself or someone else** may mean you have postpartum depression
- **Bleeding (heavy)**, soaking more than one pad in an hour or passing an egg-sized clot or bigger may mean you have an obstetric hemorrhage
- **Incision that is not healing, increased redness or any pus** from episiotomy or C-section site may mean you have an infection
- **Redness, swelling, warmth, or pain** in the calf area of your leg may mean you have a blood clot
- **Temperature of 100.4°F or higher, bad smelling vaginal blood or discharge** may mean you have an infection
- **Headache (very painful), vision changes, or pain in the upper right area of your belly** may mean you have high blood pressure or post birth preeclampsia

GET HELP

My Healthcare Provider/Clinic: ________________ Phone Number: ________________
Hospital Closest To Me: ________________

This program is supported by funding from Merck, through Merck for Mothers, the company's 10-year, $500 million initiative to help create a world where no woman dies giving life. Merck for Mothers is known as MSD for Mothers outside the United States and Canada.

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Voice of a Patient: Sarah's Story

https://youtu.be/SQW41jhNY1w

2. Comprehensive PP Discharge Education

Patient Education on Pregnancy Spacing Benefits

We recommend women wait at least 18 months before becoming pregnant again.

Do you know if and when you would like to have another baby?

I'm ready.

You want another baby soon. Being "ready" for pregnancy means that you are healthy now and plan to remain healthy throughout your pregnancy. Your doctor or healthcare provider may suggest that you wait 18 months before having another baby so you are as healthy as possible.

Not Sure?

You could get pregnant again soon after delivery, but you may not know if that's what you want right now. Tell your doctor or healthcare provider this so they can help you learn about your options, including using birth control or preparing for pregnancy.

Now is not good.

You may know that you are not ready to have another child right away. There are many different ways to prevent pregnancy (see back). Talk to your doctor or healthcare provider about which option is right for you.

Deciding What Birth Control is Right for You

You have many options to choose from!

If you think birth control is right for you, talk to your doctor or healthcare provider. The most effective and safe option for women who do not want any more children right now is long-acting reversible contraception (LARC). It prevents pregnancy for years and can be removed when you like. You can become pregnant soon after it's removed.

- Intrauterine devices (IUD) - hormonal and non-hormonal
- Hormonal implant

Other options are available:

- The shot, patch, ring, pill
- Male and female condoms (*prevent sexually transmitted diseases)
- Diaphragms
- Tubal ligation and vasectomy
- Natural family planning methods

You can always change your mind and your doctor or healthcare provider is here to help.

*Cost of birth control may depend on when and where you get it, and what kind of insurance you have.

Adapted from Centers for Disease Control and Prevention: https://www.cdc.gov/preconception/rlptool.html 10/13/2022

Driver 3: OP PP Provider Engagement & ED Components

Margie Boyer, MS, RNC-OB, EFM, ONQS
PACC Lead Nurse
William Sappenfield, MD, MPH, CPH
FPQC Director

Global AIM: Improve maternal health through hospital-facilitated continuum of postpartum care by coordinating and providing respectful, timely, and risk-appropriate coordinated care and services.

Primary Key Driver

Secondary Drivers

Clinician Postpartum Engagement and Education

- Develop a strategy to engage and educate inpatient and outpatient providers and staff using initiative promotional and education materials
- Plan in place to continue to engage and educate new hires
- Develop a strategy to engage and educate ER physicians & staff about pregnancy/PP care including PP screening & care practices

Respectful care is a universal component of every driver & activity

3. Clinician PP Engagement & Education

Outpatient Provider Letter

The American College of Obstetricians and Gynecologists

District XII Florida

CHAIR
Cole Greves, MD

VICE CHAIR
Julie DeCesare, MD

TREASURER
Daniel R. Christie, MD

SECRETARY
Andrea Friall, MD

IMMEDIATE PAST CHAIR
Shelly Holmström, MD

LIAISON TO THE JUNIOR FELLOWS
Shannon Schellhammer, MD

October 20, 2022

All Postpartum Providers:

We are pleased to announce that your maternity hospital is participating in the Florida Perinatal Quality Collaborative's Postpartum Access and Continuity of Care (PACC) Initiative. Given rising maternal morbidity and mortality rates nationally and in Florida, and with a large percentage of these events occurring in the postpartum period, there is strong interest in improving how we care for postpartum women during this critical time period. The PACC initiative supports maternity hospitals to implement recommended standards of practice for postpartum care by offering and scheduling universal early postpartum visits for a post-birth health/safety check (within 2 weeks postpartum) to improve maternal health outcomes.

Why schedule all women for an early postpartum visit within 2 weeks?

- ACOG (Committee Opinion #736) recommends postpartum care include an additional early visit before the traditional six weeks. FPQC recommends this visit be scheduled within two weeks to improve our opportunity to better manage early postpartum complications such as elevated blood pressure, wound complications, infection, breastfeeding, or mental/behavioral health concerns. It is easier to schedule this visit prior to hospital discharge and patients are more likely to attend when they have an already scheduled visit to return within two weeks for an early post birth health check.
- The obstetric provider and outpatient care team should facilitate all patients returning for a post-birth health check within two weeks of delivery. The early postpartum visit/post birth health check should include: blood pressure check and other vital signs, wound or perineum check, mood check/ depression screening, any postpartum bleeding concerns, discussion of infant feeding and supports needed, check in on any medical complications hypertension and any needed follow up plans or linkage to specialty care, review of any social supports or community resources needed (i.e. WIC, home visiting programs, lactation support groups), discussion of benefits of pregnancy spacing with review of options for family planning and encourage inter-pregnancy intervals of ≥18 months.
- Emerging best practices are recommending early postpartum visits and referrals be scheduled prior to hospital discharge.

What do I need to know?

- FPQC has developed guidance to facilitate billing and reimbursement for an early postpartum visit within two weeks of delivery for all postpartum patients in addition to the traditional six-week postpartum visit.

6816 Southpoint Pkwy, Suite 1000, Jacksonville, FL
Phone: 904-309-6265 Email: info@acogdistrict12fl.org

- **Customizable**
- **Explains scope of the PACC initiative**
- **Why 2-week PP visits are potentially life-saving**
- **What materials to share with links to the site and documents**
- **Partnerships**
- **Contact information**

3. Clinician PP Engagement & Education

Postpartum Mortality Brief (For Providers)

Postpartum discharge and Florida's pregnancy-related deaths: Are these deaths preventable?

Florida's pregnancy-related mortality rate is again **slowly increasing** after a multi-year decrease (see Figure 1). Pregnancy-related deaths are deaths of women during pregnancy and up to a year afterward due to pregnancy complications or conditions initiated or exacerbated by pregnancy. Recently, **35% to 56% of all Florida pregnancy-related deaths have occurred to mothers after giving birth and being discharged from the hospital**: postpartum discharge deaths.

Figure 1. Pregnancy-Related Mortality Rates Florida, 2010 to 2019

Deaths per 100,000
30
25
20
15
10
5
0
Postpartum Discharged
All
56%
35%
2010 2011 2012 2013 2014 2015 2016 2017 2018 2019
Years

Source: FL Maternal Mortality Review data

WHEN AND HOW DO THESE DEATHS HAPPEN?

- From 2015-2019, 75% of postpartum discharge deaths happened in less than 60 days after giving birth, and an additional 13% occurred in the next 60 days.
- The most frequent causes of these deaths were:
  - **Cardiomyopathy** (15 deaths),
  - **Other cardiovascular conditions** (11),
  - **Infections** (10), and
  - **Thrombotic embolism** (10).

Figure 2. Postpartum Discharge Pregnancy-Related Mortality Rates, Women at Risk, Florida, 2015 to 2019

All 6.8
Race/Ethnicity: Hispanic 1.2; NH White 5.7; NH Black 13.9
Age: 25-29 Yrs. 3.5; 35+ Yrs. 8.8
BMI: Normal 5.4; Overweight 5.3; Obese II (35-39) 10.1; Obese III (40+) 30.3
Coverage: Private Ins. 4.3; Medicaid 11.9
0 5 10 15 20 25 30 35
Deaths Per 100,000

Source: FL Maternal Mortality Review data

- The last three causes accounted for more than half of the deaths in the first 60 days. Cardiomyopathy accounted for more than half of the deaths for the remainder of the year.

WHO IS AT RISK?

Postpartum mothers who were Black, obese, older, and covered by Medicaid were at higher risk of dying after discharge (see Figure 2).

- **Black mothers** (13.9 deaths per 100,000 live births) were more than twice as likely to die as **White mothers** (5.7) and more than ten times as likely as **Hispanic mothers** (1.2).
- Mothers who had **category III and II obesity** were more likely to die than mothers who were **normal weight or overweight** (30.3, 10.1, 5.4 and 5.3, respectively.
- Mothers at **age 35 years and older** (11.9) were almost three times as likely to die as mothers who were **25-29 years** (4.3). These older mothers are more likely to die **due to cardiomyopathy, other cardiovascular issues, and hypertension.**
- Mothers covered by **Medicaid** (8.8) were twice as likely to die as mothers on **private insurance** (3.5) or self-pay (4.3).

3. Clinician PP Engagement & Education

Post-Birth Health Check: Provider's Offices (For Providers)

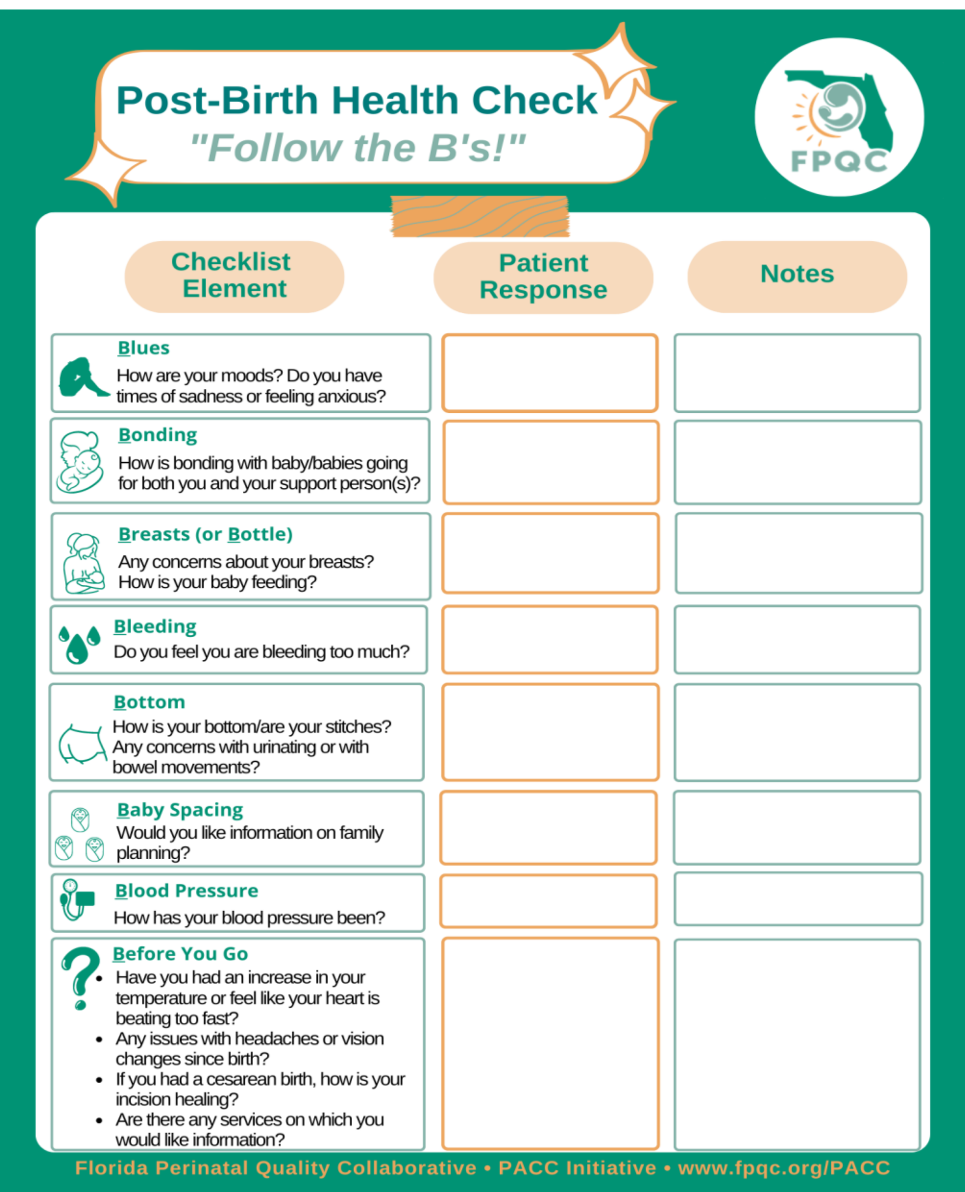
Post-Birth Health Check
"Follow the B's!"

Florida Perinatal Quality Collaborative
Postpartum Access & Continuity of Care (PACC) Initiative

	Blues	Assess mood/coping. Provide depression screening. Review signs/symptoms of mood disorders & how to get help.
	Bonding	Assess bonding with baby/babies along with support person(s). Provide resources as needed, including Healthy Start resources.
	Breast (or Bottle)	Discuss infant feeding. Provide support & additional resources.
	Bleeding	Assess bleeding. Review signs of abnormal bleeding & when to call provider (PP Warning Signs).
	Bottom	Assess perineum tear or episiotomy. Assess for issues with voiding/BMs. Ask if patient is constipated or having normal BMs. Discuss resumption of sexual activity, atrophic vaginitis, & post-coital discomfort.
	Baby Spacing	Discuss family planning & provide education as needed.
	Blood Pressure	Assess BP & any signs of preeclampsia.
	Other Best Practices	• Review signs/symptoms of infection including ↑ temperature &/or tachycardia. • Reinforce PP Warning Signs. • Discuss risk reduction in future pregnancies (e.g. aspirin for preeclampsia). • Offer community linkages as needed (e.g. WIC, home visiting, lactation support).

www.fpqc.org/PACC • fpqc@usf.edu 10/13/22

Post-Birth Health Check: Provider Offices (For Patients)



Post-Birth Health Check
"Follow the B's!"

FPQC

Checklist Element	Patient Response	Notes
Blues How are your moods? Do you have times of sadness or feeling anxious?		
Bonding How is bonding with baby/babies going for both you and your support person(s)?		
Breasts (or Bottle) Any concerns about your breasts? How is your baby feeding?		
Bleeding Do you feel you are bleeding too much?		
Bottom How is your bottom/are your stitches? Any concerns with urinating or with bowel movements?		
Baby Spacing Would you like information on family planning?		
Blood Pressure How has your blood pressure been?		
Before You Go • Have you had an increase in your temperature or feel like your heart is beating too fast? • Any issues with headaches or vision changes since birth? • If you had a cesarean birth, how is your incision healing? • Are there any services on which you would like information?		

Florida Perinatal Quality Collaborative • PACC Initiative • www.fpqc.org/PACC

Postpartum Support Help Lines

Dial 2-1-1 for Confidential Crisis Intervention & Referrals

Dial 9-8-8 for the National Suicide Prevention Lifeline

Blues

HRSA Maternal Mental Health Hotline 1-833-943-5746
TTY:711 then 1-833-943-5746 https://mchb.hrsa.gov/national-maternal-mental-health-hotline (Free national phone resource for mental health support)

Postpartum Support International Help Line 1-800-944-4773 https://www.postpartum.net/
(Free national support for help with postpartum mood and anxiety disorders)

Florida Family Health Line 1-800-451-2229
(Free hotline from Florida Department of Health for help finding community resources for postpartum & newborn care. Available in English, Spanish, & Haitian Creole)

National Domestic Violence Hotline 1-800-799-7233 https://www.thehotline.org/
Spanish 1-800-942-6908 Text START to 88788
(Free hotline to help with intimate partner/domestic violence issues)

National Suicide Prevention Lifeline 1-800-784-2433 or 988 https://988lifeline.org/
Crisis Lifeline 1-800-273-8255
Crisis Text Line Text HOME to 741741 https://www.crisistextline.org/
(Call or text if having thoughts of harming yourself or others)

SAMHSA National Help Line- 1-800-662-4357
TTY: 1-800-487-4889 https://www.samhsa.gov/find-help/national-helpline
(Free national help line for those who seeking support for substance use issues)

Breast

WIC Breastfeeding Support Hotline: 1-800-994-9662
(Free national hotline. Staff trained to help with breastfeeding support & resources)

Florida Breastfeeding Coalition https://www.flbreastfeeding.org/state-coalitions/
(Local coalition numbers, websites, and social media can be found at the link)

Additional Resources

LGBT National Hotline 1-888-843-4564 (not 24/7) https://www.lgbthotline.org/

The Trevor Project 1-866-488-7386 https://www.thetrevorproject.org/ (Youth 13-24)
Text START to 678678 (Free hotline for suicide prevention for LGBTQ+ youth)

Human Trafficking Hotline 1-888-373-7888

National Eating Disorders Help Line 1-800-931-2237 (not 24/7) https://www.nationaleatingdisorders.org/

National Sexual Assault Hotline (RAINN) 1-800-656-4673 https://www.rainn.org/
Chat line: online.rainn.org (Free, confidential 24/7 help for sexual assault survivors)

Local Resources

FPQC 10/13/22

Post-Birth Health Check: Billing & Coding Suggestions

Early Postpartum Visit "Post-Birth Health Check" Billing & Coding

OVERALL

New billing and coding strategies are necessary to receive additional reimbursement for the early postpartum visit outside of the global obstetrical reimbursement. Fee-for-service billings for additional postpartum visits should generally not be a reimbursement issue.

MEDICAID

Florida Medicaid fee-for-service and most Florida Medicaid Health Plans are fee-for-service only, so that billing for an additional postpartum visit(s) should not be an issue. Aetna and Molina are predominantly global reimbursement with some exceptions. Humana does some global obstetrical reimbursement, but does more fee-for-service.

GLOBAL REIMBURSEMENT OPTIONS

To be reimbursed for an additional postpartum visit by a physician or nurse, you must either bill outside of the global obstetrical reimbursement package or attempt to end the global obstetrical package early. Potential strategies to use depend on the Health Plan's global obstetrical reimbursement package. You will generally need to test these potential billing approaches for each Health Plan.

1. **Bill outside the global obstetrical package**—An early postpartum visit can be billed without a pregnancy diagnosis using CPT Evaluation and Management (E/M) codes 99211-99215. Append modifier 24 to the E/M code indicating care is provided outside of the global obstetrical reimbursement package and link the E/M code to an appropriate ICD-10 code for the visit diagnosis (e.g., O14.05 Mild to moderate pre-eclampsia, complicating the puerperium or O86.01 Infection of obstetric surgical wound, superficial incisional site).

2. **End the global package early**—Have the early postpartum visit (Post-Birth Health Check) serve as the comprehensive postpartum visit using E/M code 0503F. Then, schedule the second postpartum visit as a well-women/annual exam using CPT Evaluation and Management (E/M) codes 99393-99397. This will depend on whether the global ends based on this visit type or a specified timeframe after delivery.

For more information, visit the Florida Perinatal Quality Collaborative PACC site at www.fpqc.org/pacc or email fpqc@usf.edu

10/18/22

Global AIM: Improve maternal health through hospital-facilitated continuum of postpartum care by coordinating and providing respectful, timely, and risk-appropriate coordinated care and services.

Primary Key Driver	Secondary Drivers
Clinician Postpartum Engagement and Education	Develop a strategy to engage and educate inpatient and outpatient providers and staff using initiative promotional and education materials
	Plan in place to continue to engage and educate new hires
	Develop a strategy to engage and educate ER physicians & staff about pregnancy/PP care including PP screening & care practices

Respectful care is a universal component of every driver & activity

Postpartum Discharge Pregnancy-Related Deaths with a Stand-Alone Postpartum ER Visit, Florida, 2015 to 2019

Days After Birth	Percentage
0-13 days	32%
14-60 days	25%
61-180 days	31%
181+ days	67%

Y-axis: Percentage (0%–80%)

X-axis: Days After Birth

Source: FL Maternal Mortality Review data

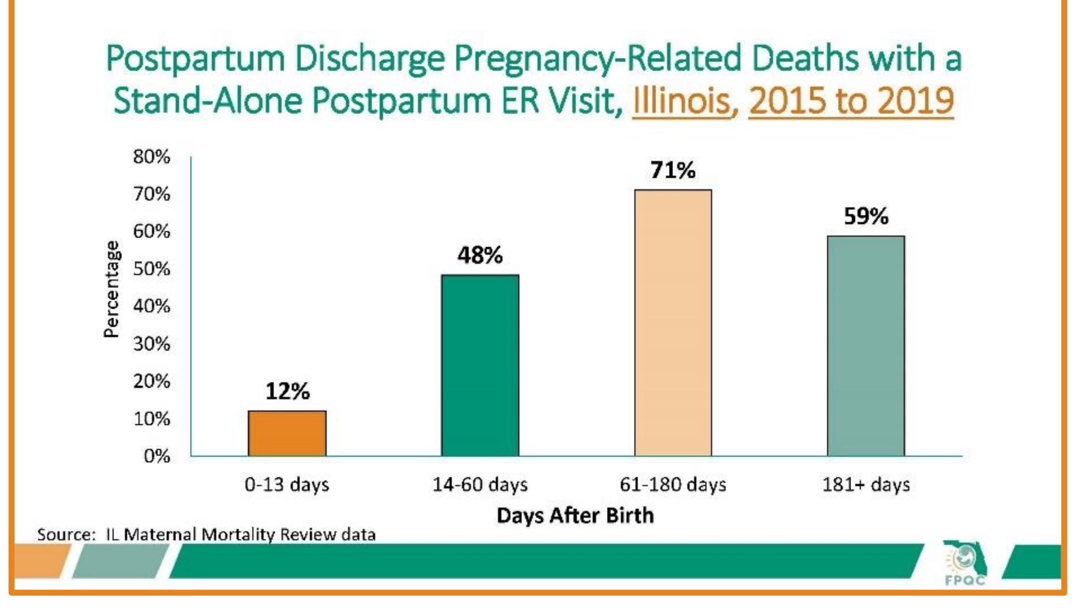
Postpartum ER Care—Mortality Prevention

ER care can prevent some postpartum deaths based on Florida Maternal Mortality Review Findings

1. Ask women ages 15-45 years if they have been pregnant in the past year?
2. If yes, add postpartum complications to your differential
3. Check for early postpartum warning signs and their medical problem list
4. If needed, review postpartum checklist descriptions
5. If unsure, seek OB consultation early
6. If discharged, arrange referral and educate when to return

Postpartum ER Care—Mortality Prevention

Provider Educational Presentation



Postpartum Mortality Brief (For Providers)

Postpartum discharge and Florida's pregnancy-related deaths: Are these deaths preventable?

Florida's pregnancy-related mortality rate is again **slowly increasing** after a multi-year decrease (see Figure 1). Pregnancy-related deaths are deaths of women during pregnancy and up to a year afterward due to pregnancy complications or conditions initiated or exacerbated by pregnancy. Recently, **35% to 56% of all Florida pregnancy-related deaths have occurred to mothers after giving birth and being discharged from the hospital**: postpartum discharge deaths.

Figure 1. Pregnancy-Related Mortality Rates Florida, 2010 to 2019

Legend: Postpartum Discharged; All. Y-axis: Deaths per 100,000 (0–30). X-axis: Years (2010–2019). Annotations: 56%, 35%.

Source: FL Maternal Mortality Review data

WHEN AND HOW DO THESE DEATHS HAPPEN?

- From 2015-2019, 75% of postpartum discharge deaths happened in less than 60 days after giving birth, and an additional 13% occurred in the next 60 days.
- The most frequent causes of these deaths were:
  - **Cardiomyopathy** (15 deaths),
  - **Other cardiovascular conditions** (11),
  - **Infections** (10), and
  - **Thrombotic embolism** (10).
- The last three causes accounted for more than half of the deaths in the first 60 days. Cardiomyopathy accounted for more than half of the deaths for the remainder of the year.

Figure 2. Postpartum Discharge Pregnancy-Related Mortality Rates, Women at Risk, Florida, 2015 to 2019

Group	Category	Deaths Per 100,000
All		6.8
Race/Ethnicity	Hispanic	1.2
	NH White	5.7
	NH Black	13.9
Age	25-29 Yrs.	3.5
	35+ Yrs.	8.8
BMI	Normal	5.4
	Overweight	5.3
	Obese II (35-39)	10.1
	Obese III (40+)	30.3
Coverage	Private Ins.	4.3
	Medicaid	11.9

Source: FL Maternal Mortality Review data

WHO IS AT RISK?

Postpartum mothers who were Black, obese, older, and covered by Medicaid were at higher risk of dying after discharge (see Figure 2).

- **Black mothers** (13.9 deaths per 100,000 live births) were more than twice as likely to die as **White mothers** (5.7) and more than ten times as likely as **Hispanic mothers** (1.2).
- Mothers who had **category III and II obesity** were more likely to die than mothers who were **normal weight or overweight** (30.3, 10.1, 5.4 and 5.3, respectively.
- Mothers at **age 35 years and older** (11.9) were almost three times as likely to die as mothers who were **25-29 years** (4.3). These older mothers are more likely to die **due to cardiomyopathy, other cardiovascular issues, and hypertension.**
- Mothers covered by **Medicaid** (8.8) were twice as likely to die as mothers on **private insurance** (3.5) or self-pay (4.3).

Postpartum ER Care—Mortality Prevention

Provider Educational Poster/Flyer

Hypertension / Preeclampsia

Key Points

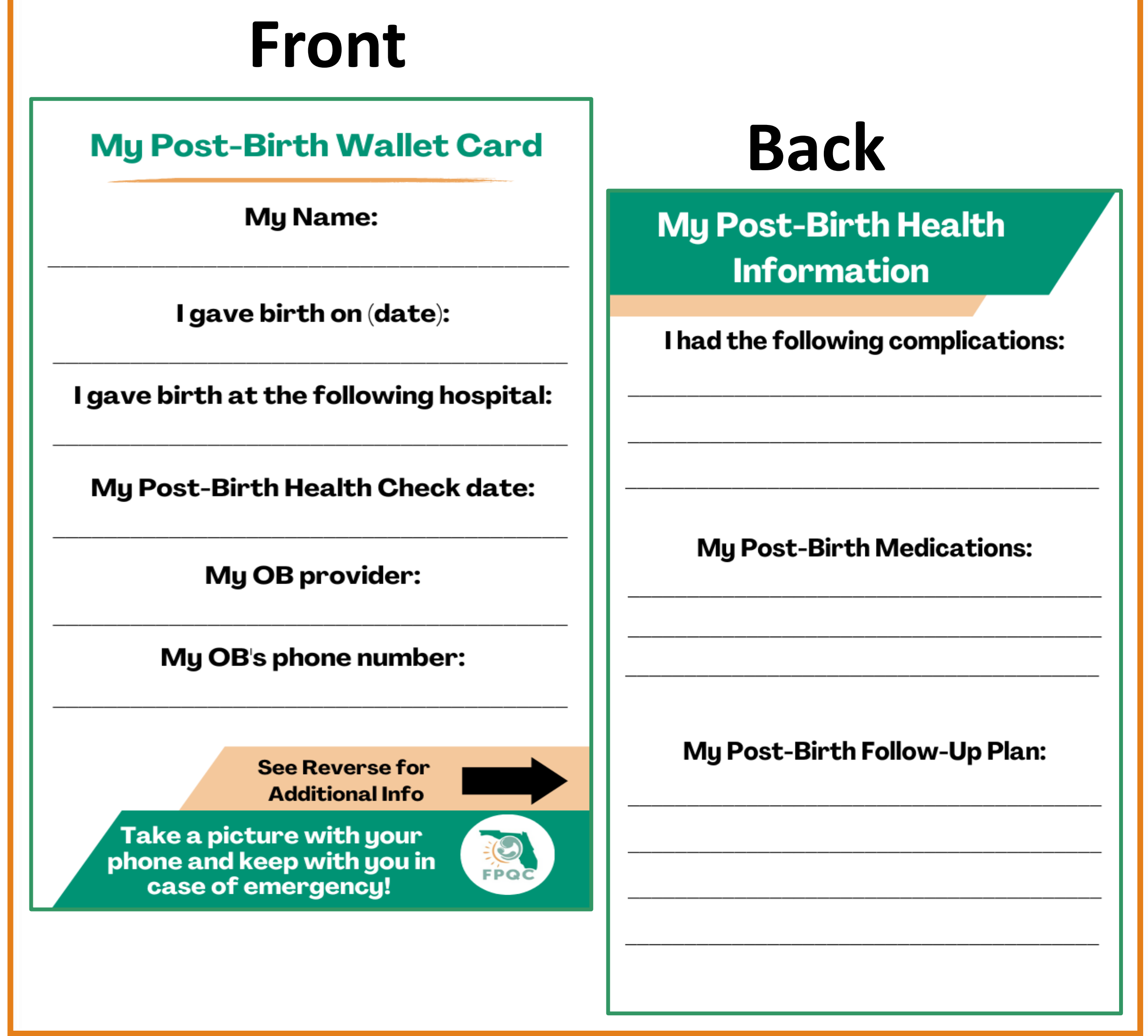
- Stabilize and transfer if necessary.
- Consider OB consultation.
- Antihypertensive treatment should be started quickly for persistent acute-onset severe hypertension (SBP $\geq$160 mm Hg or DBP $\geq$110 mm Hg) that is confirmed as persistent ($\geq$15 mins.). Research suggests that treatment should be administered within 30–60 minutes.
- Abnormal blood pressure range—140-159 systolic or $\geq$90 diastolic should require oral treatment.
- Eclampsia is usually self-limiting. Magnesium sulfate is started to prevent recurring seizures.

Synopsis

- Hypertensive disorders are a leading cause of maternal mortality and morbidity.
- Includes Gestational Hypertension, Preeclampsia, Eclampsia, and Chronic Hypertension with Preeclampsia.
- Distinguishing feature: proteinuria is a protein/creatinine ratio of 0.3 or more, a 24-hour urine protein of 300 mg/dl or more, or a urinalysis protein value of 1+ or more.
- Preeclampsia with severe features includes one or more: unrelenting headache, visual disturbances, right upper quadrant pain, thrombocytopenia, elevated transaminases, elevated creatinine and pulmonary edema.

Postpartum ER Care—Mortality Prevention

Maternal Wallet Card



Questions?

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Florida Perinatal Quality Collaborative

Florida Perinatal Quality Collaborative

@TheFPQC

"To improve the health and health care of all Florida mothers & babies"

Early Postpartum Care:

The Illinois Experience

Improving postpartum access to care (IPAC): Strategies for success

October 27, 2022

Lunch Time

Postpartum Health Literacy
Empowering clinicians to improve postpartum outcomes through recognizing early warning signs and facilitating post birth health checks
Developed by Cheryl A. Vamos, PhD, MPH, and Eliana Huffman, BA
FPQC

Health Literacy Heroes

Be a Health Literacy Hero!

Together, We Make a Difference

HLMonth Hero image courtesy of www.healthliteracy.com and www.healthliteracymonth.org

NATIONAL DAY CALENDAR

Health Literacy Month | October

#CelebrateEveryDay

Course Goal

Educate clinicians on **health literacy** and its role in decreasing **postpartum morbidity** and **mortality**.

Course Objectives

- Discuss the significance of the **postpartum transition period** and current guidance for hospital and care teams
- Define **health literacy** and its importance in postpartum care and prevention
- Apply key **health literacy principles** to postpartum patient care, especially as they apply to early postpartum warning signs and post birth health checks

Three Key Takeaway Points

Give the most important info first

1

Limit to three key messages

2

Keep it concise

3

Key Takeaway Points

#1: The postpartum period is a time of significant change, but **preventable risk**

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Key Takeaway Points

#2: Health literacy impacts **postpartum** patient outcomes

Key Takeaway Points

#3: Perinatal care clinicians can make a **meaningful difference** in patients' postpartum health literacy and help reduce deaths by:

- Preparing patients for postpartum transitions
- Promoting patients' understanding of the importance of identifying early warning signs and post birth health checks
- Facilitating follow-up and continuing care
- Prioritizing health literacy in health care organizations

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Course Objectives

- **Discuss the significance of the postpartum transition period and current guidance for hospital and care teams**
- Define health literacy and its importance in postpartum care and prevention
- Apply key health literacy principles to postpartum patient care, especially as they apply to early postpartum warning signs and post birth health checks

Introduction

- The postpartum period includes many **physical and emotional changes**
- Can be a difficult transition from pregnancy to parenthood **without adequate medical care, support and attention**
  - Almost 1 in 4 women take 10 days or less for maternity leave (ACOG, 2012)
- On a national level, more than **80%** of pregnancy-related deaths are **preventable**, and **over half** occur during the postpartum period
- Perinatal care teams and healthcare systems are crucial agents to improve health literacy for postpartum patients

Source: CDC, 2022

Source: ACOG Committee Opinion No. 736, 2018; US DOL, 2012

What Can Florida Do to Reverse Trends?

We needto...

- Improve understanding/awarenes... ...ns
- Improve early post birth ...

Which wi...

... mortality

... overall burden on the healthcare system

Address health literacy to assist in prevention efforts!

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Course Objectives

- Discuss the significance of the postpartum transition period and current guidance for hospital and care teams
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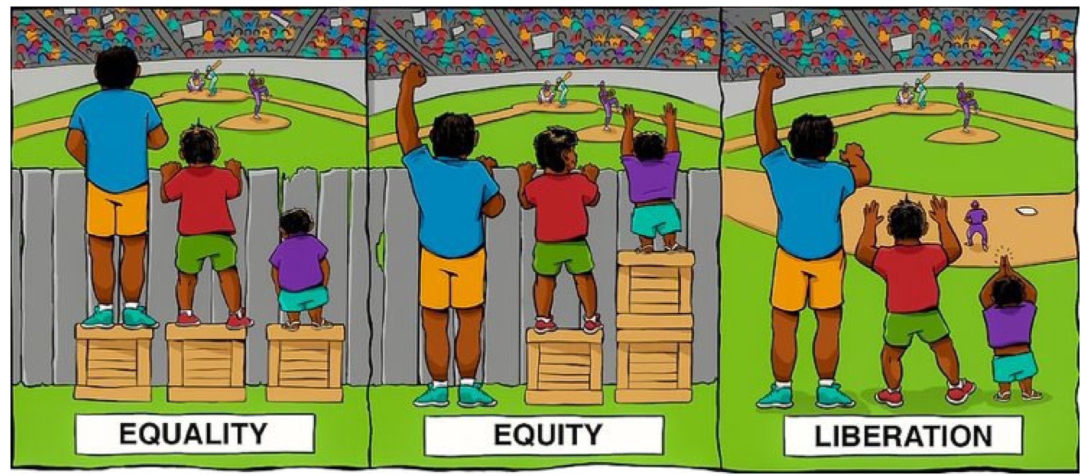
Health Literacy

- Fostering health literacy can play a key role in reducing postpartum morbidity and mortality
- Require skills and supports to navigate health-literacy related demands and complexities across all systems
- A key social determinant of health



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Everyday Health Literacy for Postpartum Patients

Postpartum women and families **are making decisions** every day about their health, careers, relationships and environment.

Key Definitions: Health Literacy

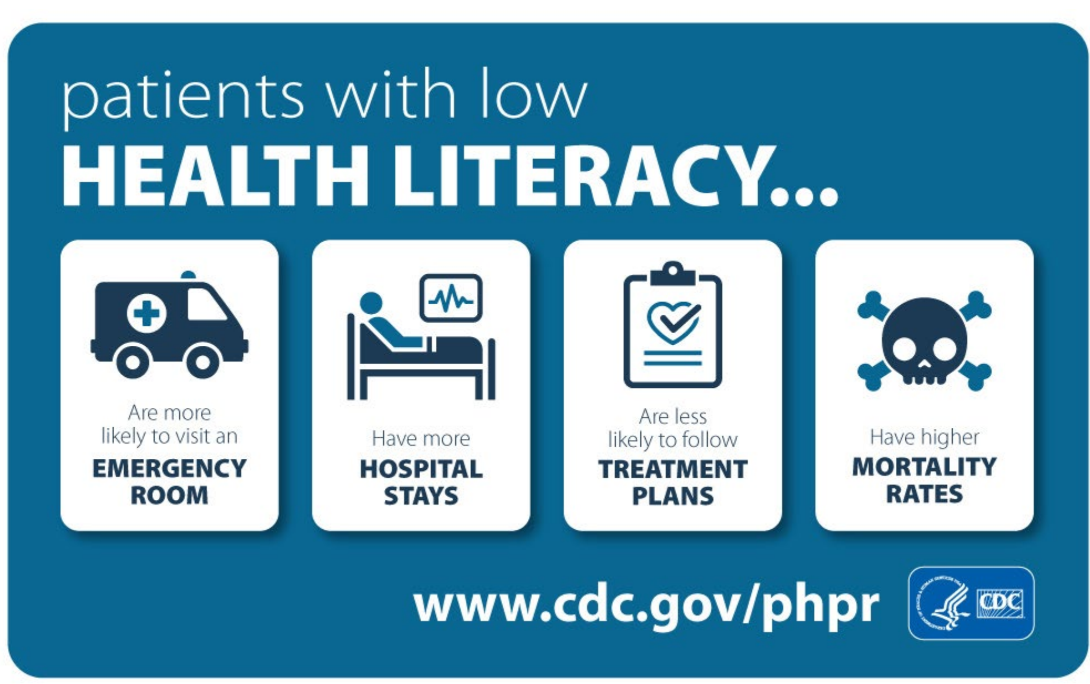
Personal health literacy is the degree to which **individuals** have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

Organizational health literacy is the degree to which **organizations equitably enable individuals** to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

- Healthy People 2030

People With Limited Health Literacy…

- ✓ Use preventative services less (e.g., flu shots, prenatal/postnatal care)
- ✓ Less likely to follow clinician and prescription orders
- ✓ Overuse of ER and hospital stays
- ✓ Have reduced capacity to act on public health alerts
- ✓ More likely to report health as poor



Both mother and baby are impacted in the postpartum period

Source: HHS, 2021

Low Health Literacy is Costly

- Besides the personal toll on patients on their health care teams, low health literacy is also financially costly
- Limited health literacy is said to cost the nation between $106 and $236 billion **annually**
- Factors: health care utilization, increased need for disease management, admin costs, etc.

Source: Eichler et al., 2009

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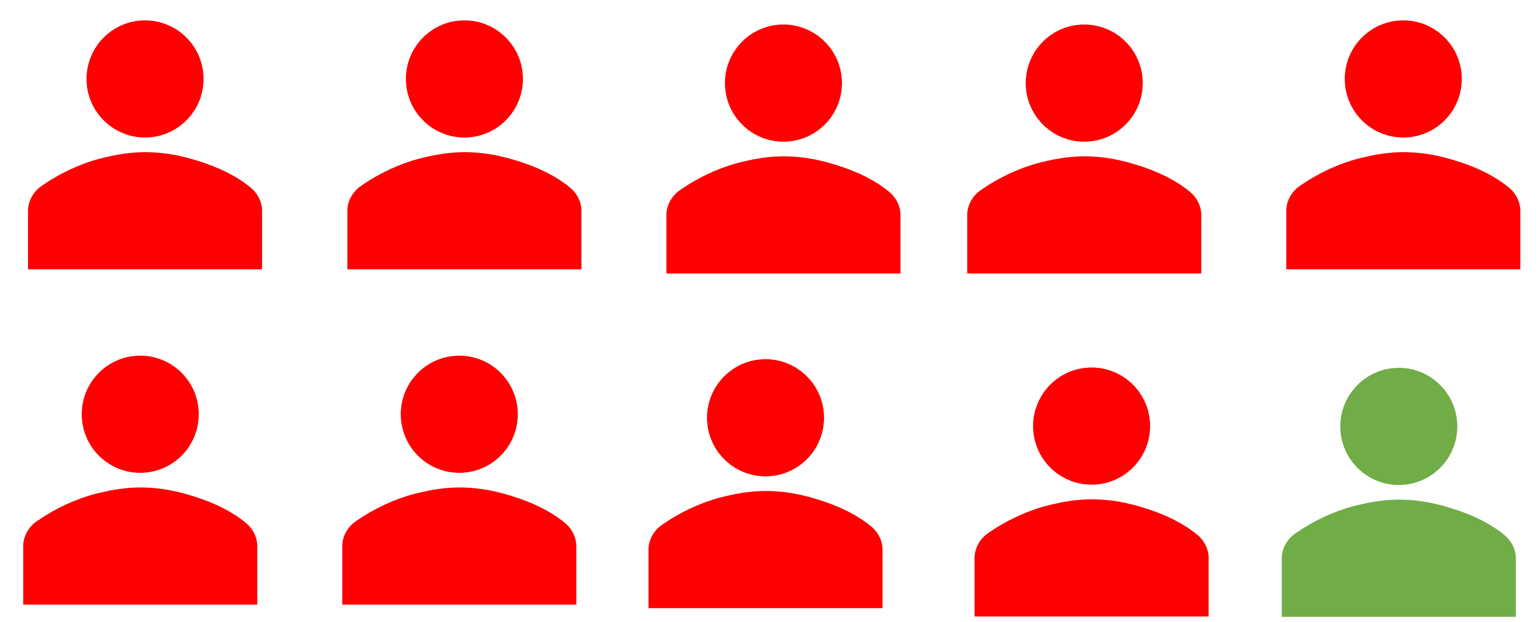
Everyone Needs Clear Health Information



Nine out of ten people struggle with low health literacy!

Source: National Library of Medicine, 2021

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Who is At Most Risk for Low Health Literacy?

In General

- Racial and ethnic minorities
- Recent refugees and immigrants
- Patients with < high school degree/GED
- Patients with low-income levels
- Non-native speakers of English
- People with compromised health status

Postpartum Patients

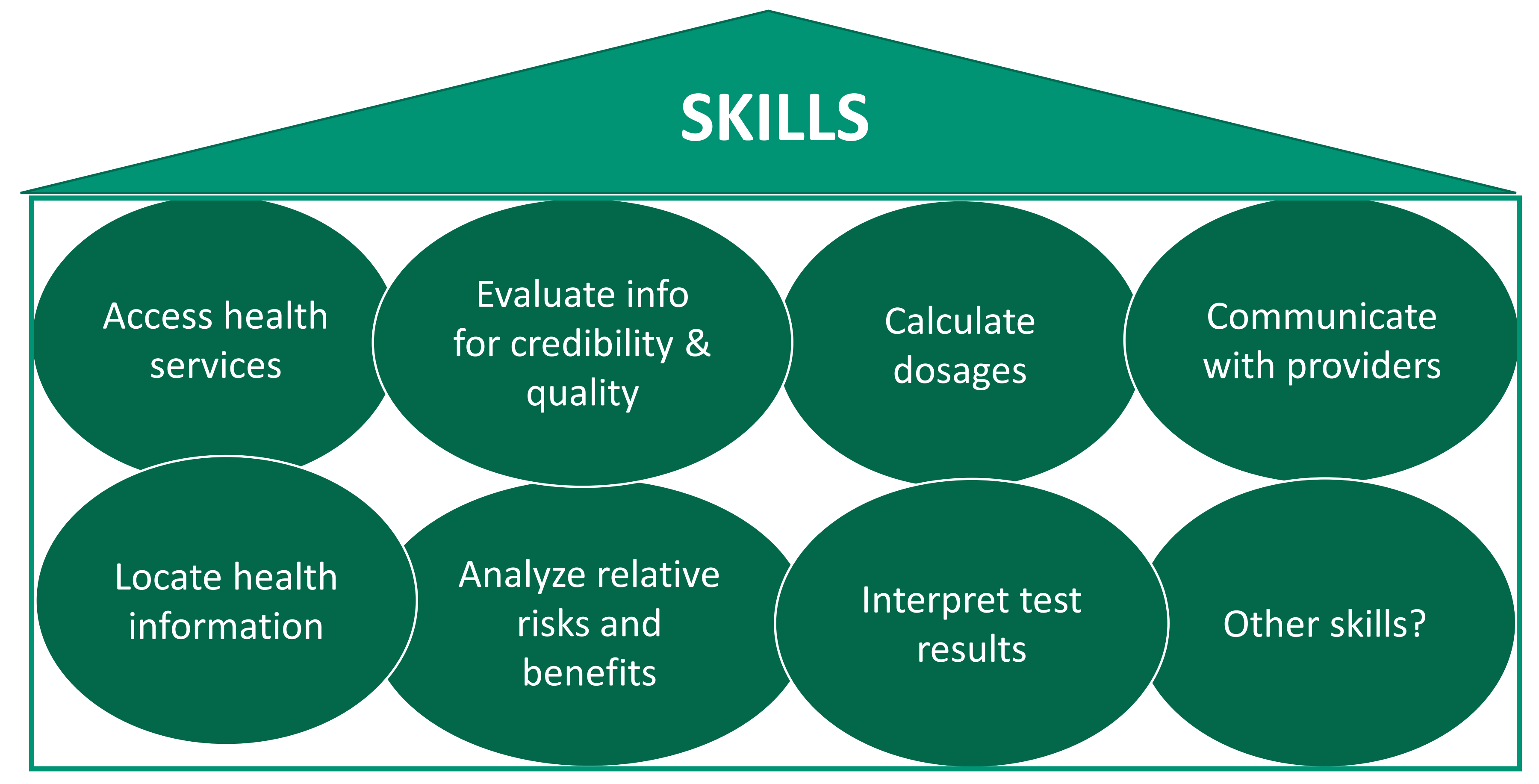
- People with transportation issues, no PTO, childcare issues
- Multiple factors can impact a patient's ability to:
  - Recognize early warning signs
  - Attend post birth health check appointment

Broader Contexts in Which Patients are Embedded

System Level	Barrier
School	Challenges implementing comprehensive (reproductive) health education
Workplace	Inadequate maternity leave, PTO Poor insurance coverage through employer or federal exchange
Community	Lack of access or availability to postpartum care/support
Health Communication	Limited patient-centered communication skills and opportunities
Health Professionals	Lack of awareness about health literacy Daily clinical and healthcare system demands
Health Care System	Challenges navigating complex health system Disconnect between policies

Health Literacy is Not Just Ability to Read

A complex group of **reading, listening, analytical** and **decision-making skills**, and ability to apply skills to **different situations**.



Course Objectives

- Discuss the significance of the postpartum transition period and current guidance for hospital and care teams
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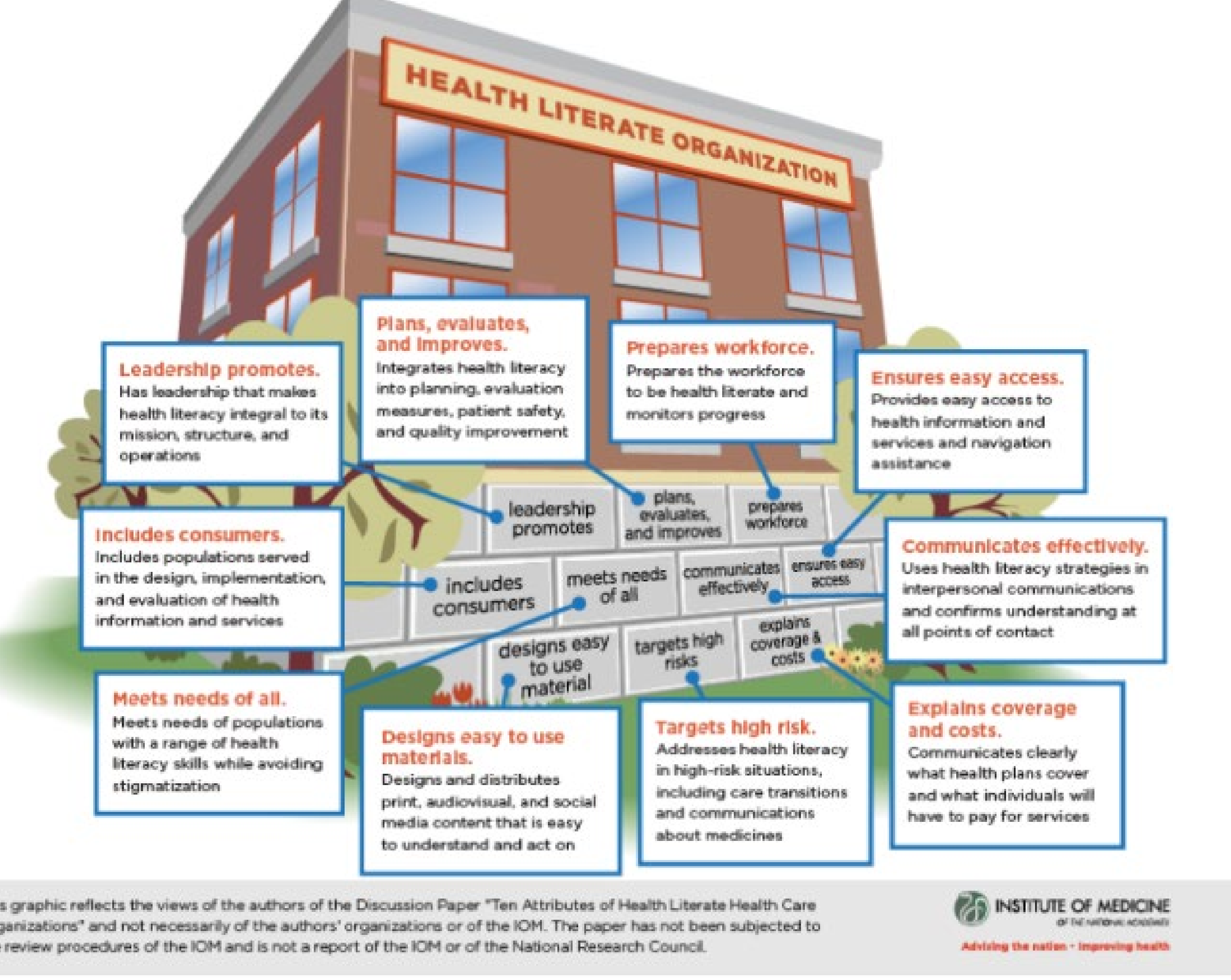
10 Attributes of a Health Literate Organization



Source: Brach, et al., 2012

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This Course is Available to You!

- Being health literate is an organizational value, not a one-time project
- Health literacy must be exemplified at all levels of an organization
- Encouraging employees to learn and understand health literacy concepts is one example of this

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#3: Prepare Workforce and Monitor Progress

Participation in FPQC PACC Initiative

Postpartum Access & Continuity of Care (PACC)

Global AIM: Improve maternal health through hospital-facilitated continuum of postpartum (PP) care by coordinating and providing respectful, timely, and risk-appropriate coordinated care and services.

AIM

By 6/2024, FPQC participating hospitals will:
- Increase % of patients with a 2-week PP visit scheduled prior to discharge by 20%*
- Increase patient PP education~ by 20%*

Respectful care is a universal component of every driver and activity

Primary Key Drivers	Secondary Key Drivers
Process for Maternal Discharge Risk Assessment & Arranging Early PP Visits	Develop a process flow to schedule early risk-appropriate PP visits/encounters prior to discharge and align policies and procedures accordingly
	Conduct a PP Discharge Assessment prior to discharge
	Implement universal Maternal Discharge Risk Assessment & schedule/arrange risk-appropriate PP care including obstetrical, specialty & community services before discharge
Comprehensive PP Patient Discharge Education	Verbally educate patients on the benefits of early risk-appropriate PP visits/encounters (Post-Birth Health Check) and provide written materials
	Verbally educate all patient on PP Warning Signs and provide written materials
	Verbally educate patients on the benefits of and options for pregnancy spacing, family planning and contraceptive choice and provide written materials
	Establish a system to ensure that all patients receive recommended and documented PP education and discharge information
Clinician PP Engagement and Education	Develop a strategy to engage and educate inpatient and outpatient providers and staff using initiative promotional and education materials
	Plan in place to continue to engage and educate new hires
	Develop a strategy to engage and educate ER physicians & staff about pregnancy/PP care including PP screening & care practices.

~ Includes benefits of early PP visits, warning signs, and family planning
* Baseline will be established with the first quarter of hospital data

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#4: Include Populations Served at All Levels

Diverse Patient Boards

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#6 Use HL in Interpersonal Communications

Choosing Carefully: Popular Words in Postpartum Care

Instead of…	Use:
Postnatal	After birth
Acute phase	Six to twelve hours after birth
Perineum	Between the vagina and the anus
Anticoagulants	Medicines that prevent blood clots
Lactating	Producing breast milk
Interconception	The time between the end of one pregnancy and the beginning of the next one

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#6 Use HL in Interpersonal Communications

Teach Back Method

- A way of checking understanding by asking patients to state in their own words what they need to know or do about their health

- A way to confirm that you have explained things in a manner your patients understand

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Post Birth Health Check

- Health literate clinicians and organizations <u>standardized</u> postpartum care and assume **all** patients have low health literacy

Vitals	If yes...	Checked
Is the most recent blood pressure ≥160/100?	Alert the provider and hold discharge	☐
Is the most recent pulse ≥120?	Alert the provider and hold discharge	☐
Is temperature ≥100.4F/38C?	Alert the provider and hold discharge	☐
Is the respiratory rate ≥30?	Alert the provider and hold discharge	☐

Comments:

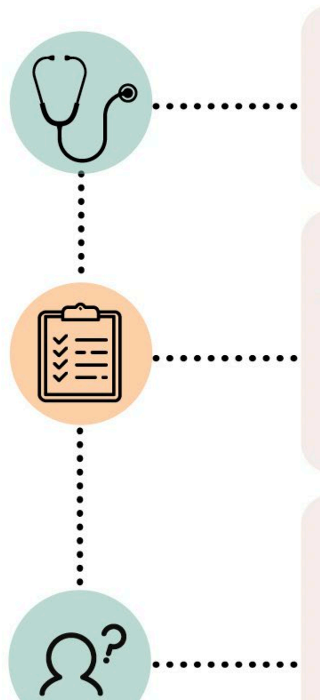
FPQC.org 10/13/2022

#8: Design Easy to Understand Visual Materials

Post-Birth Health Check

It is important to continue seeing your obstetric (OB) provider after giving birth

You should plan on at least two appointments after giving birth:
The **2-week Post-Birth Health Check** and your **6-week follow-up visit**



WHY TWO WEEKS AFTER GIVING BIRTH?

- Many early warning signs or symptoms are easy to miss, that is why scheduling your 2-week Post-Birth Health Check is important.
- The 2-week Post-Birth Health Check lets your OB provider see how you are doing and address any issues before they become serious.

WHAT HAPPENS AT MY 2-WEEK POST-BIRTH HEALTH CHECK?

Your OB provider or clinical team member will:
- Check your blood pressure
- Check your bottom/stitches
- Make sure your post-birth bleeding is normal
- Discuss your mood and provide support
- Check your breasts for any concerns
- Discuss future pregnancies
- Link you to any extra health services or follow-up

WHEN SHOULD I SCHEDULE MY FIRST VISIT?

- Your first Post-Birth Health Check should be within two weeks after giving birth. Schedule this visit even if you had a birth without problems.
- Tell your nurse if your check is already scheduled.
- Be sure to have an appointment before you leave the hospital. If you go home on a weekend, call your provider's office on Monday to schedule a visit.
- Tip: Set a reminder on your phone of your upcoming appointment.

Write the following on your Post-Birth Wallet Card:

I gave birth on: ______________________

My OB provider's name: ______________________

My OB provider's phone: ______________________

Date of 2-week Post-Birth Health Check: ______________________

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10/13/2022

My Post-Birth Wallet Card

My Name:

____

I gave birth on (date):

____

I gave birth at the following hospital:

____

My Post-Birth Health Check date:

____

My OB provider:

____

My OB's phone number:

____

See Reverse for Additional Info

Take a picture with your phone and keep with you in case of emergency!

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My Post-Birth Health Information

I had the following complications:

____

____

____

My Post-Birth Medications:

____

____

____

My Post-Birth Follow-Up Plan:

____

____

____

____

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#8: Design Easy to Understand Visual Materials

POST-BIRTH Acronym

Get Care for These POST-BIRTH Warning Signs

Most women who give birth recover without problems. **Yet any woman can develop complications after the birth of her baby.** Knowing what could be life-threatening warning signs after the birth of your baby could save your life.

Tell your partner and others you need immediate care if you experience any of the following warning signs:

Call 911 if you have:	❑ **P**ain in chest ❑ **O**bstructed breathing or shortness of breath ❑ **S**eizures ❑ **T**houghts of hurting yourself or your baby
Call your healthcare provider if you have: (If you can't reach your healthcare provider, call 911 or go to an emergency room)	❑ **B**leeding, soaking through one pad/hour, or blood clots, the size of an egg or bigger ❑ **I**ncision that is not healing ❑ **R**ed or swollen leg, that is painful or warm to touch ❑ **T**emperature of 100.4°F or higher ❑ **H**eadache that is not relieved, even after taking medication, or associated with visual changes.

Trust your instincts. ALWAYS obtain medical care if you are not feeling well or have questions or concerns.

Tell 911 or your healthcare provider:

"I had a baby on ____________ (Date) and I am having ____________ (Specific warning signs)."

Source: AWHONN, 2021

#9: Address HL in High-Risk Situations

ER care can prevent some postpartum deaths, based on Florida Maternal Mortality Review findings

1. Ask women ages 12-45 years if they have been pregnant in the past year
2. If yes, add postpartum complications to your differential
3. Check for early postpartum warning signs
4. If needed, review postpartum checklist descriptions
5. If unsure, seek OB consultation early
6. If discharged, arrange referral and educate when to return

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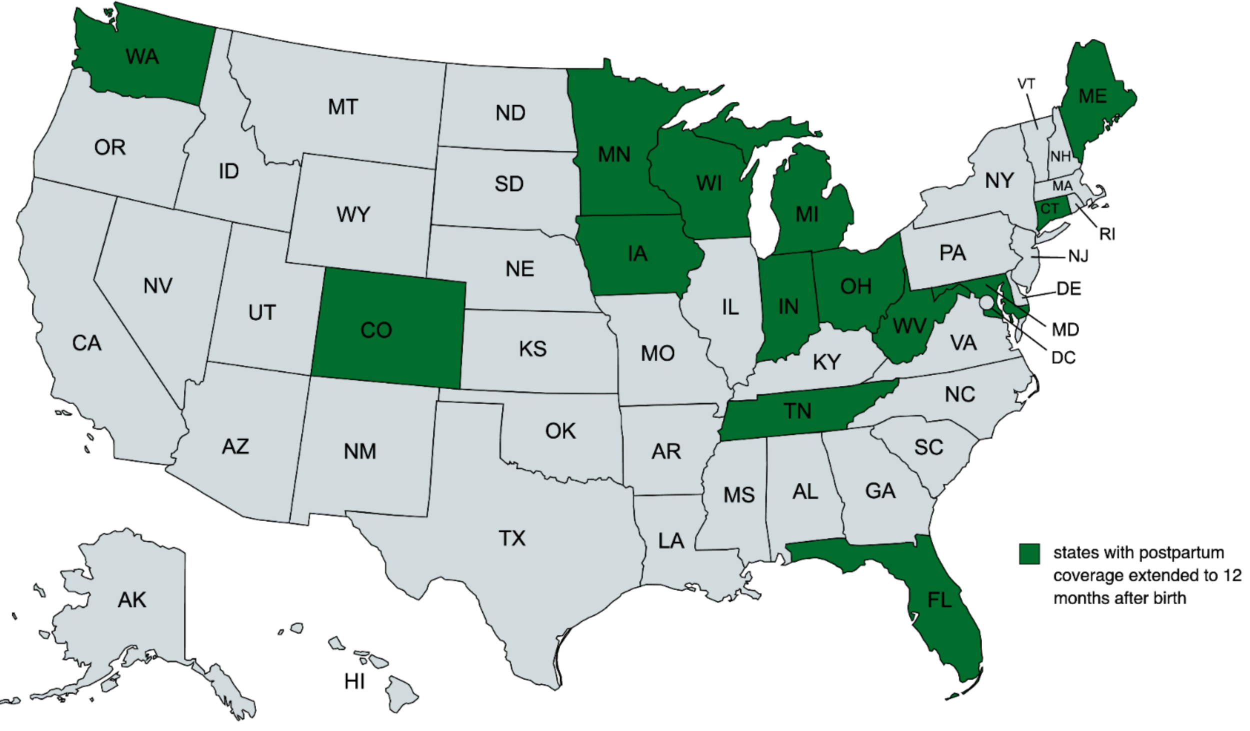
#10: Communicate Insurance & Billing Clearly



Early Postpartum Visit "Post-Birth Health Check" Billing & Coding

OVERALL

New billing and coding strategies are necessary to receive additional reimbursement for the early postpartum visit outside of the global obstetrical reimbursement. Fee-for-service billings for additional postpartum visits should generally not be a reimbursement issue.

MEDICAID

Florida Medicaid fee-for-service and most Florida Medicaid Health Plans are fee-for-service only, so that billing for an additional postpartum visit(s) should not be an issue. Aetna and Molina are predominantly global reimbursement with some exceptions. Humana does some global obstetrical reimbursement, but does more fee-for-service.

GLOBAL REIMBURSEMENT OPTIONS

To be reimbursed for an additional postpartum visit by a physician or nurse, you must either bill outside of the global obstetrical reimbursement package or attempt to end the global obstetrical package early. Potential strategies to use depend on the Health Plan's global obstetrical reimbursement package. You will generally need to test these potential billing approaches for each Health Plan.

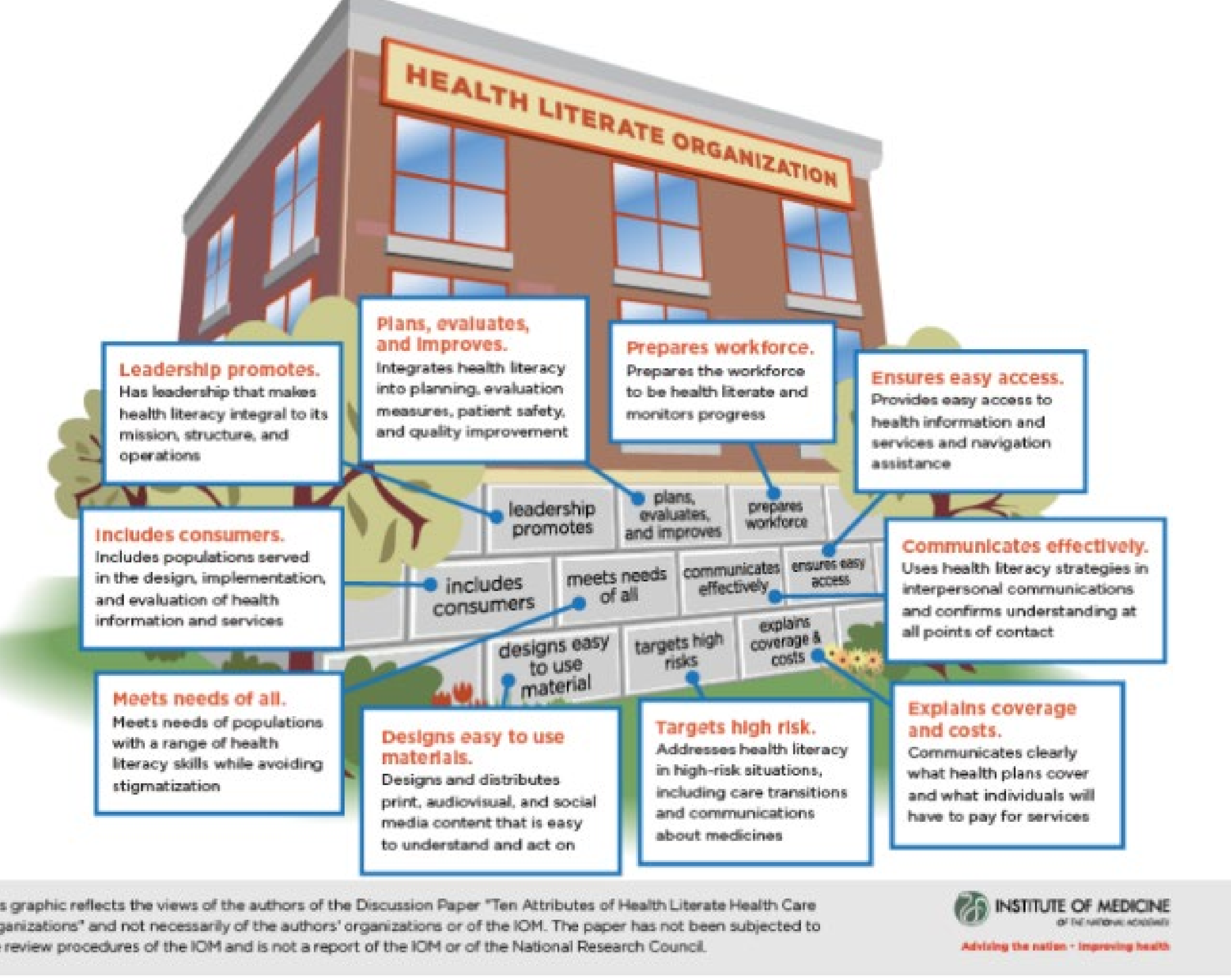
1. **Bill outside the global obstetrical package**—An early postpartum visit can be billed without a pregnancy diagnosis using CPT Evaluation and Management (E/M) codes 99211-99215. Append modifier 24 to the E/M code indicating care is provided outside of the global obstetrical reimbursement package and link the E/M code to an appropriate ICD-10 code for the visit diagnosis (e.g., O14.05 Mild to moderate pre-eclampsia, complicating the puerperium or O86.01 Infection of obstetric surgical wound, superficial incisional site).

2. **End the global package early**—Have the early postpartum visit (Post-Birth Health Check) serve as the comprehensive postpartum visit using E/M code 0503F. Then, schedule the second postpartum visit as a well-women/annual exam using CPT Evaluation and Management (E/M) codes 99393-99397. This will depend on whether the global ends based on this visit type or a specified timeframe after delivery.

For more information, visit the Florida Perinatal Quality Collaborative PACC site at www.fpqc.org/pacc or email fpqc@usf.edu

10/18/22

10 Attributes of a Health Literate Organization



Source: Brach, et al., 2012

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Practical Tips, Videos, Resources, and More!

- Create a shame-free environment
- Use visual aids
- Keep it simple
- Use plain/living room language
- Involve family and friends
- Consider culture

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Re-Visiting Three Key Course Takeaways

#1: The postpartum period is a time of significant change, but **preventable risk**

#2: Health literacy impacts **postpartum** patient outcomes

#3: Perinatal care clinicians can make a **meaningful difference** in patients' postpartum health literacy

Participate in the course to learn how YOU can make a difference!

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Questions?

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Sources

ACOG Committee Opinion No. 736: Optimizing Postpartum Care. (2018, May). *131*(5), e140-e150. doi: 10.1097/AOG.0000000000002633

Agency for Healthcare Research and Quality. (n.d.). *Consumer Assessment of Healthcare Providers and Systems (CAHPS)*. https://www.ahrq.gov/cahps/index.html

Association of Women's Health, Obstetric and Neonatal Nurses. (2021). *POST-BIRTH Warning Signs Education Program*. https://www.awhonn.org/education/hospital-products/post-birth-warning-signs-education-program/

Brach, C., Keller, D., Hernandez, L., Baur, C., Parker, R., Dreyer, B., . . . Schillinger, D. (2012, June). *Ten Attributes of Health Literate Health Care Organizations*. https://nam.edu/wp-content/uploads/2015/06/BPH_Ten_HLit_Attributes.pdf

Centers for Disease Control and Prevention. (2022, March 1). *Hear Her Campaign: Urgent Maternal Warning Signs*. https://www.cdc.gov/hearher/maternal-warning-signs/index.html

Centers for Disease Control and Prevention. (2022, September 19). *Four in 5 pregnancy-related deaths in the U.S. are preventable*. https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html

Central East Addiction Technology Transfer Center Network. (2012). *Anti-Stigma Toolkit*. https://attcnetwork.org/sites/default/files/2019-04/Anti-Stigma%20Toolkit.pdf

Sources

Colter, A., & Summers, K. (2014). Eye tracking with unique populations: low literacy users. In *Eye Tracking in User Experience Design* (pp. 331–346). Waltham, MA: Morgan Kaufmann Publishers/Elsevier.

Department of Labor. (2014, April 18). *Family and Medical Leave in 2012: Technical Report*. Retrieved from https://www.dol.gov/sites/dolgov/files/OASP/legacy/files/FMLA-2012-Technical-Report.pdf

Eichler, K., Wieser, S., & Brügger, U. (2009). The costs of limited health literacy: a systematic review. *International Journal of Public Health, 54*(5), 313-24. doi: 10.1007/s00038-009-0058-2

Florida Department of Health. (2016). *Call for the Development of Maternal Early Warning Systems (MEWS)*. https://www.floridahealth.gov/statistics-and-data/PAMR/_documents/maternal-early-warning-system.pdf

Florida Department of Health. (2021, September). *Florida's Maternal Mortality Review Committee 2019 Update*. https://www.floridahealth.gov/statistics-and-data/PAMR/fl-maternal-mortality-review-committee-2019-update.pdf

National Center for Education Statistics. (2022). *Public High School Graduation Rates*. Retrieved from https://nces.ed.gov/programs/coe/indicator/coi/high-school-graduation-rates

National Library of Medicine. (2021, December 17). *An Introduction to Health Literacy*. https://nnlm.gov/guides/intro-health-literacy

Sources

NPS Foundation. (2012, February 1). *Ask Me 3*. https://www.youtube.com/watch?v=B3EB-icaNKQ

Sørensen, K., Van den Broucke, S., Fullam, J., Doyle, G., Pelikan, P., Slonska, S., . . . HLS-EU. (2012, January 25). Health literacy and public health: A systematic review and integration of definitions and models. *BMC Public Health*. doi: 10.1186/1471-2458-12-80

The Joint Commission. (2010). *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/health-equity/aroadmapforhospitalsfinalversion727pdf

U.S. Department of Education. (2006, September). *The Health Literacy of America's Adults: Results From the 2003 National Assessment of Adult Literacy.* https://nces.ed.gov/pubs2006/2006483.pdf

U.S. Department of Health and Human Services. (2020). *Health Literacy in Healthy People 2030*. https://health.gov/healthypeople/priority-areas/health-literacy-healthy-people-2030

Sources

U.S. Department of Health and Human Services. (2021, August 24). *National Action Plan to Improve Health Literacy*. https://health.gov/our-work/national-health-initiatives/health-literacy/national-action-plan-improve-health-literacy

U.S. General Services Administration. (2010). *Law and requirements*. https://www.plainlanguage.gov/law/

UCLA Department of Nursing. (2015, September 23). *Teach-back for MedUcation*. https://www.youtube.com/watch?v=eNIbpEAVk4g

World Health Organization. (1998). *Health Promotion Glossary*. https://apps.who.int/iris/bitstream/handle/10665/64546/WHO_HPR_HEP_98.1.pdf

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Additional Resources

- CAHPS surveys: https://www.ahrq.gov/cahps/index.html
- Anti-Stigma Toolkit: https://attcnetwork.org/sites/default/files/2019-04/Anti-Stigma%20Toolkit.pdf
- AWHONN Post-Birth Warning Signs Course: https://www.awhonn.org/education/hospital-products/post-birth-warning-signs-education-program/
- AHRQ Universal Precautions Toolkit https://www.ahrq.gov/health-literacy/improve/precautions/index.html
- USDA: Simply Put - A Guide for Creating Easy-to-Understand Materials https://wicworks.fns.usda.gov/resources/simply-put-guide-creating-easy-understand-materials
- CDC Clear Communication Index https://www.cdc.gov/ccindex/index.html

PACC Implementation Guidance

Margie Boyer, MS, RNC-OB, EFM, ONQS
FPQC PACC Lead Nurse Consultant

Keys to Building a Successful Initiative

Engage Key Stakeholders from the Start

Interdisciplinary Planning and Implementation

C- Suite Support

Consistent Commitment By All Team Members

Components of Successful Participation

- Create a QI culture—a team environment emphasizing quality and patient safety
- Hold regular QI team meetings to follow and make progress
- Share important information, progress and successes with everyone impacted by PACC
- Be creative and flexible!

WHO SHOULD BE ON THE TEAM

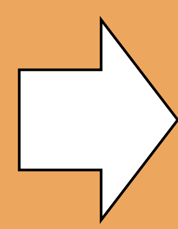
- RNs- bedside
- Physicians
- APRNs: CNM, CNS
- Nurse Manager/Director
- Quality Improvement
- Informatics expert
- Social Work/CM
- Family Reps
- Others

Create a Culture Ready for Change

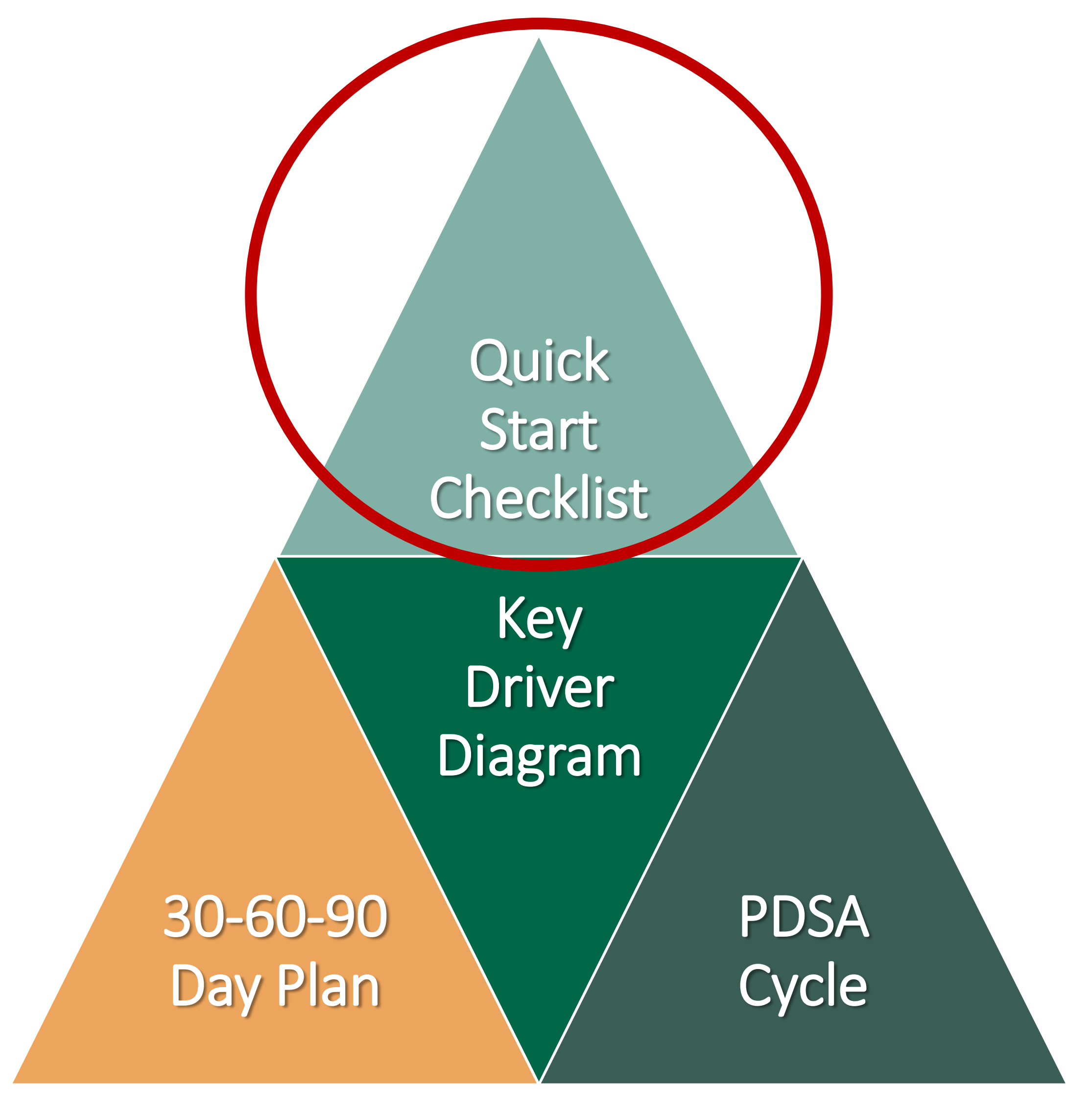
- Must be an interdisciplinary effort
- Teams must meet regularly
- Ability to provide a safe environment for:
  - Listening
  - Questioning
  - Persuading
  - Respecting
  - Helping
  - Sharing
  - Participating
- Use the Toolkit!

PACC Team Meetings

- Initially meet bi-weekly or monthly depending on work
- Include all departments impacted by initiative
- Include community/family rep
- Have an agenda and share minutes.

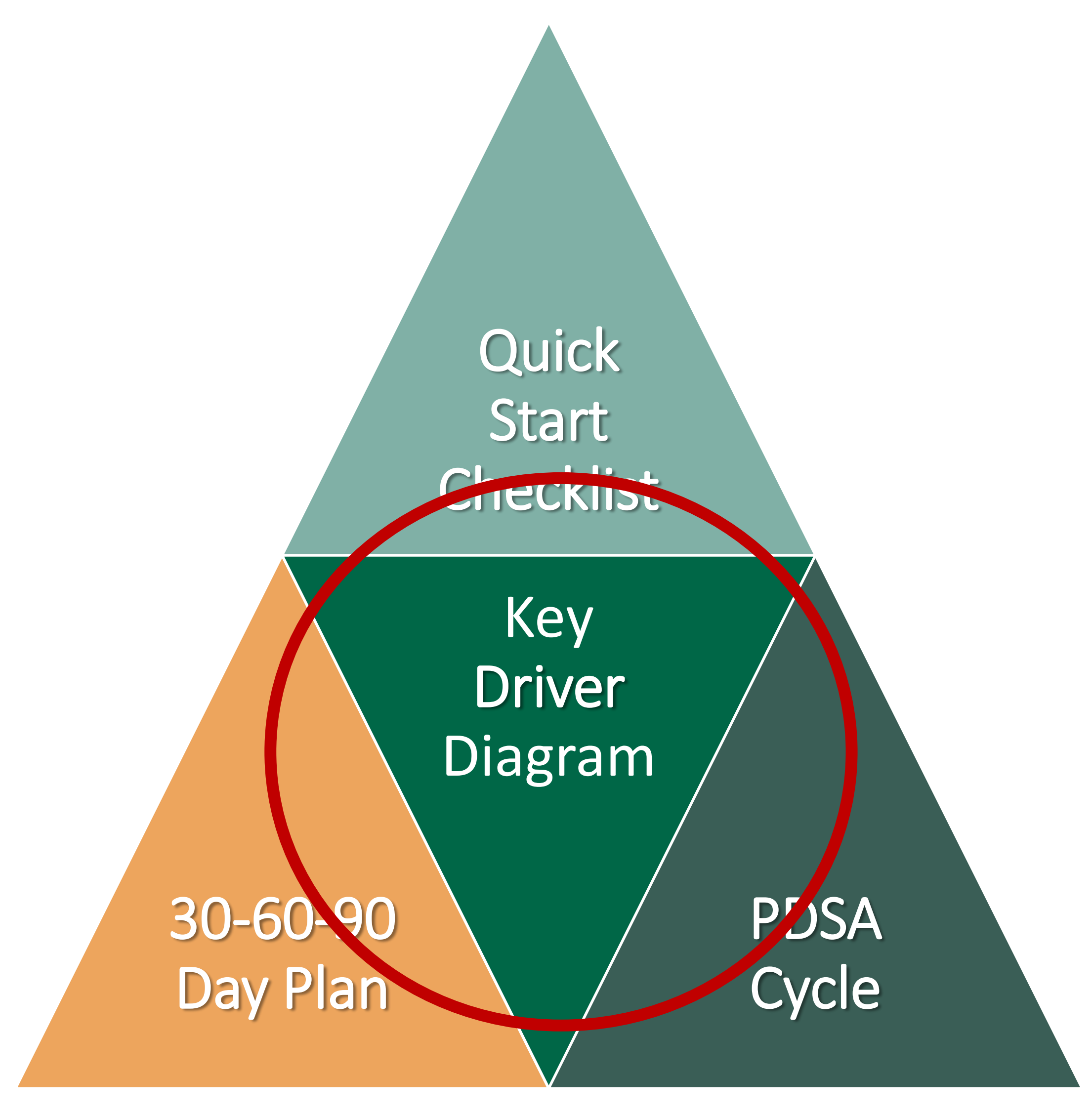


  - Review data, 30-60-90 Day Plan, PDSA cycles
  - Discuss insights from webinars/coaching calls
- Share progress and challenges with administration – follow communication plan


Quick
Start
Checklist
Key
Driver
Diagram
30-60-90
Day Plan
PDSA
Cycle

Quick Start Checklist

1. Recruit QI team – lead, physician lead, nurse lead, QI/data lead, administrative champion
2. Review, complete and return PACC Data Use Agreement
3. Attend PACC Kick-off Meeting
4. Complete the PACC Pre-Implementation Survey
5. Write down questions or concerns



Tools to Use

Global AIM: Improve maternal health through hospital-facilitated continuum of postpartum care by coordinating and providing respectful, timely, and risk-appropriate coordinated care and services.

AIM

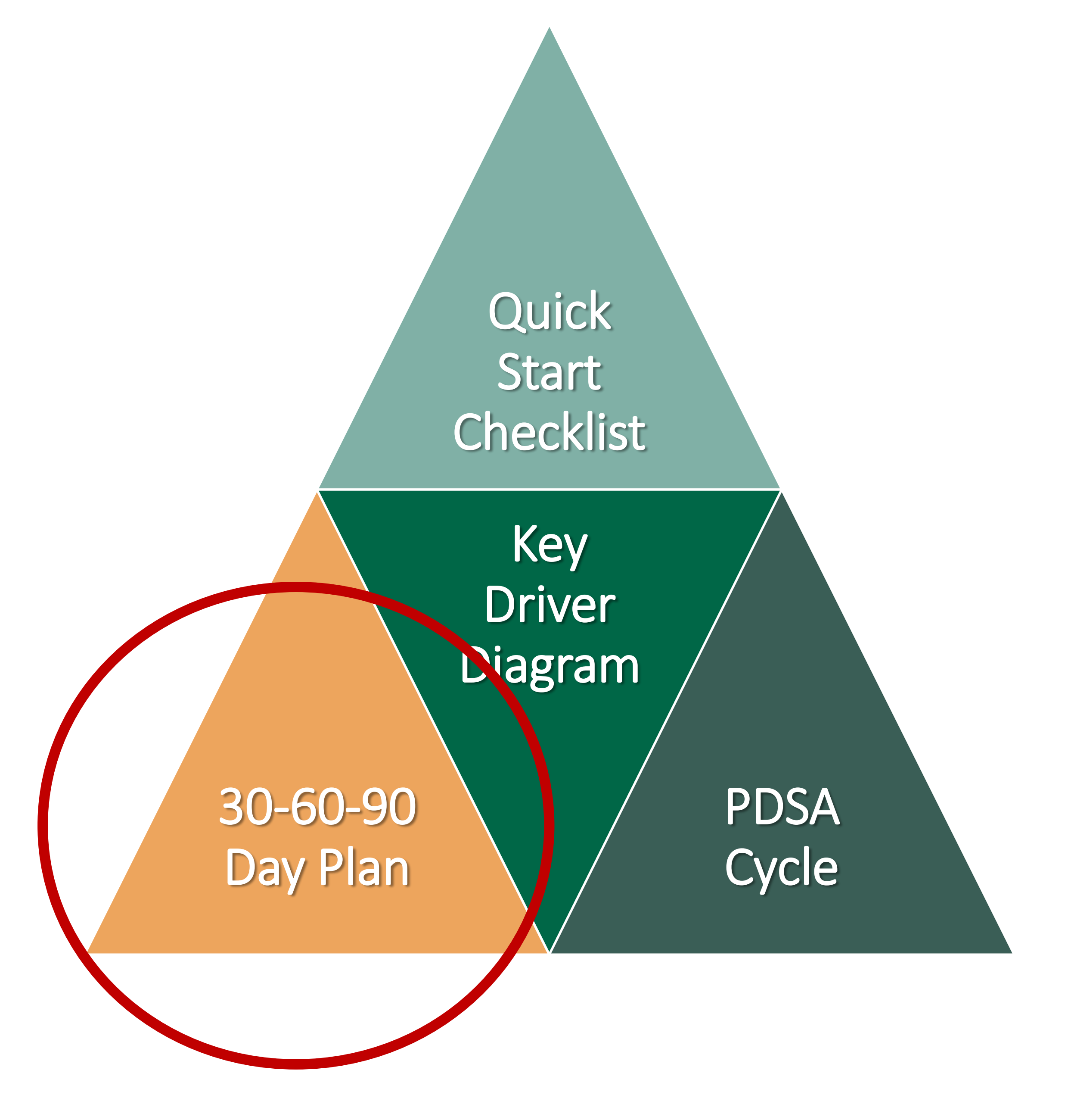
By 6/2024, FPQC participating hospitals will:

- Increase the % of patients with a 2-week PP visit scheduled prior to discharge by 20%*
- Increase patient PP education~ by 20%*

Respectful care is a universal component of every driver & activity

Primary Key Drivers

- Process for Maternal Discharge Risk Assessment & Arranging Early Postpartum Visits
- Comprehensive Postpartum Patient Discharge Education
- Clinician Postpartum Engagement and Education


Quick Start Checklist
Key Driver Diagram
30-60-90 Day Plan
PDSA Cycle

30-60-90 Day Plan

Foundations	
Strengths	
Barriers	

Looking Ahead	
Three Things to Accomplish in the Next 30 Days	
Three Things to Accomplish in Next 60 Days	
Three Things to Accomplish in Next 90 Days	

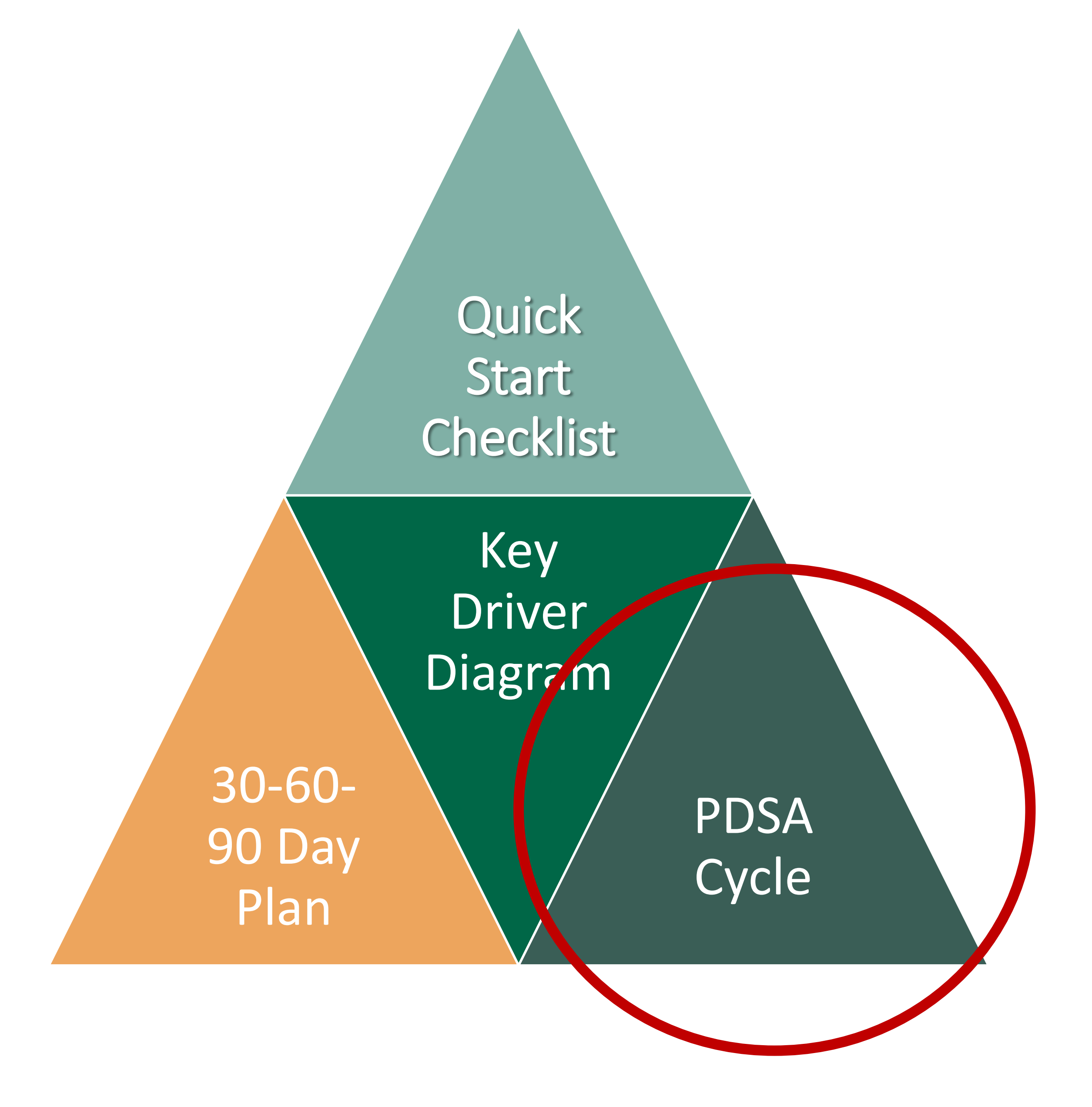
Foundations	
Strengths	*We have a strong physician champion and good administrative support*
Barriers	*Some of our providers and staff are very resistant to change*

3 Things to Accomplish in the Next 30 Days

Review interdisciplinary team members and fill any gaps

Schedule team monthly meetings for the next 6 months

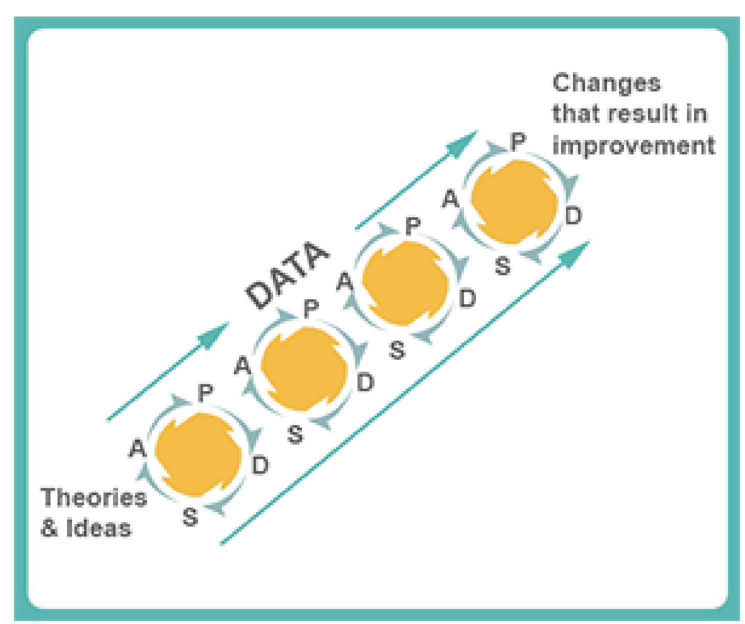
Review/revise policies, procedures and education plans


Quick
Start
Checklist
Key
Driver
Diagram
30-60-
90 Day
Plan
PDSA
Cycle

What is a PDSA cycle?

- Useful tool for developing & documenting tests of change to **for improvement**
- AKA PDCA, Deming Cycle, Shewart Cycle

P – **Plan** a test
D – **Do** a test
S – **Study** & learn from test results
A – **Act** on results



Reasons to test changes

Learn whether change will result in improvement

Predict the amount of improvement possible

Evaluate the proposed change work in a ***practice environment***

Minimize resistance at implementation

Potential Implementation Barriers & Strategies to Overcome

Potential Barrier Drivers	Strategies to Overcome
• Time limitations	• Make sure meetings are organized and succinct to decrease the impact on time • Involve bedside clinical team members- consider use of clinical ladder • Standardize meeting time for ease of scheduling; consider virtual option • Use regularly scheduled department meetings to highlight project and results- be succinct

Potential Implementation Barriers & Strategies to Overcome

Potential Barrier Drivers	Strategies to Overcome
• Resource limitations	• Connect with other hospitals or QI leaders for potential solutions; or sharing resources through collaborative work • Consider system-wide meetings to standardize best practices • Utilize your FPQC coach mentors

As the Project Continues…

- **Celebrate** successes along the way
- **Display data** by keeping it current AND interesting
- **Make it stick**
  - Routinization
- **Plan for sustainability**

Where do I
start BEFORE
I start?

Assess	Review	Attend	Plan
Assess your team to assure all critical departments included	Review PACC resources	Attend Data Collection Webinar: **11/10/22 Noon**	Plan for PACC launch – bulletin boards; staff meetings; event invitations

October-December 2022

January 2023

PACC Initiative Resources

Technical Assistance

from FPQC staff, state Clinical Advisors, and National Experts

Project-wide in-person collaboration meetings

Educational sessions, videos, and resources

Monthly and Quarterly QI Data Reports

Monthly e-mail Bulletins

Custom, Personalized webcam, phone, or on-site **Consultations & Grand Rounds Education**

Monthly Collaboration Calls with hospitals state-wide

Online Tool Box

Algorithms, Sample protocols, education tools, Slide sets, etc.

PACC Initiative Website

http://www.fpqc.org/PACC

FPQC

POSTPARTUM ACCESS & CONTINUITY OF CARE (PACC) INITIATIVE: TOOLKIT

PACC
POSTPARTUM ACCESS & CONTINUITY OF CARE

Florida HEALTH

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Florida Perinatal Quality Collaborative

Questions?

PACC

POSTPARTUM ACCESS & CONTINUITY OF CARE

FPQC

Break

FPQC

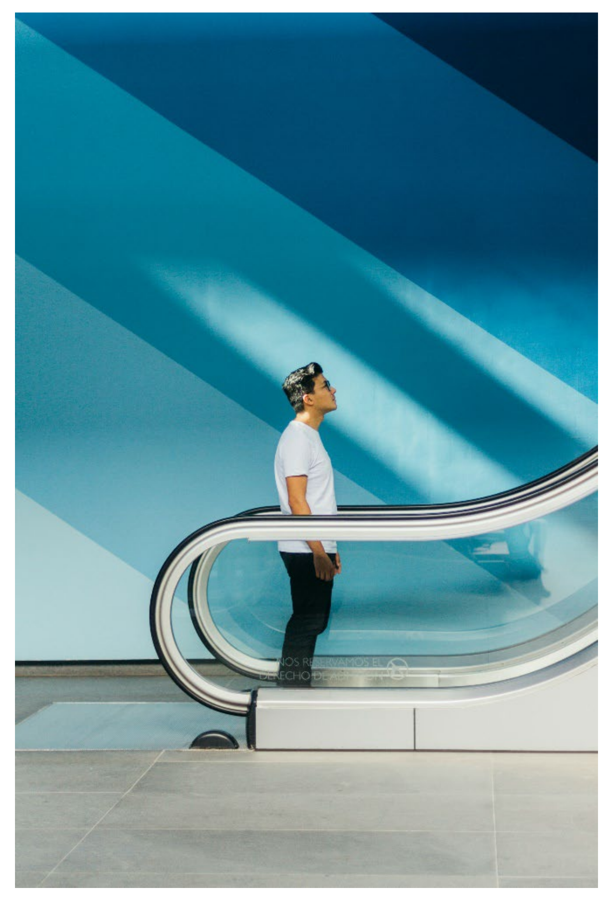
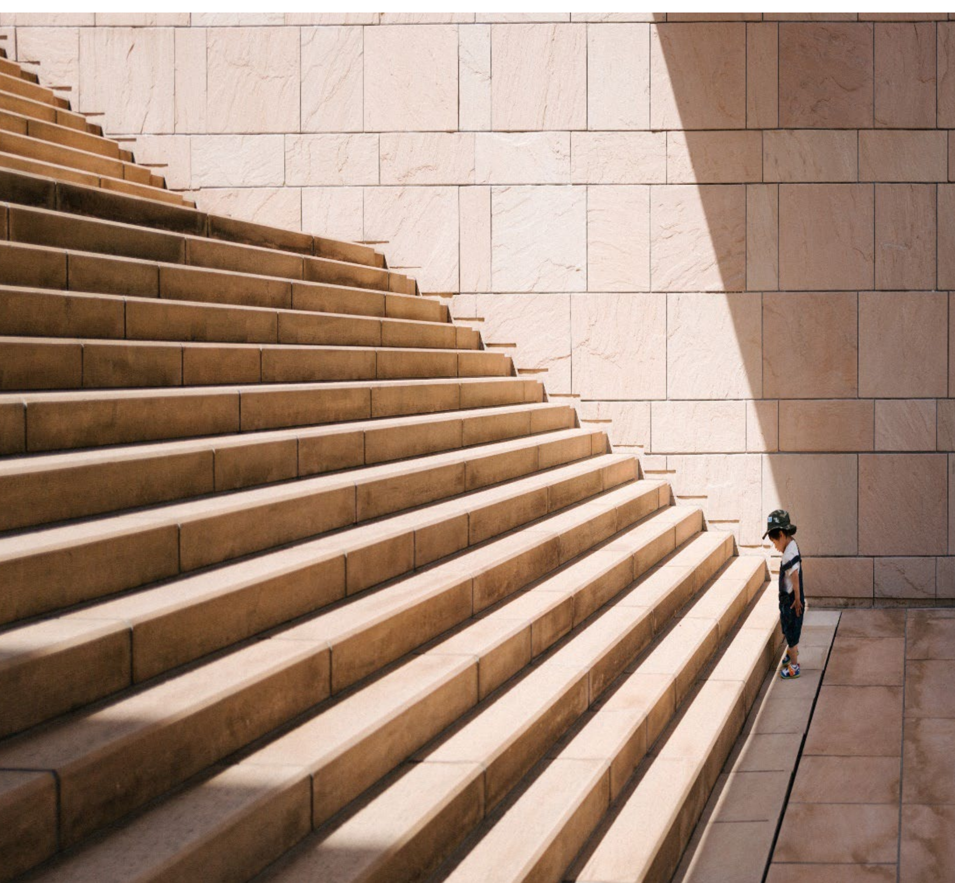
PACC Online Toolkit Review:

Estefanny Reyes Martinez, MPH, CPH
Quality Improvement Analyst

PACC QI Data Reporting:

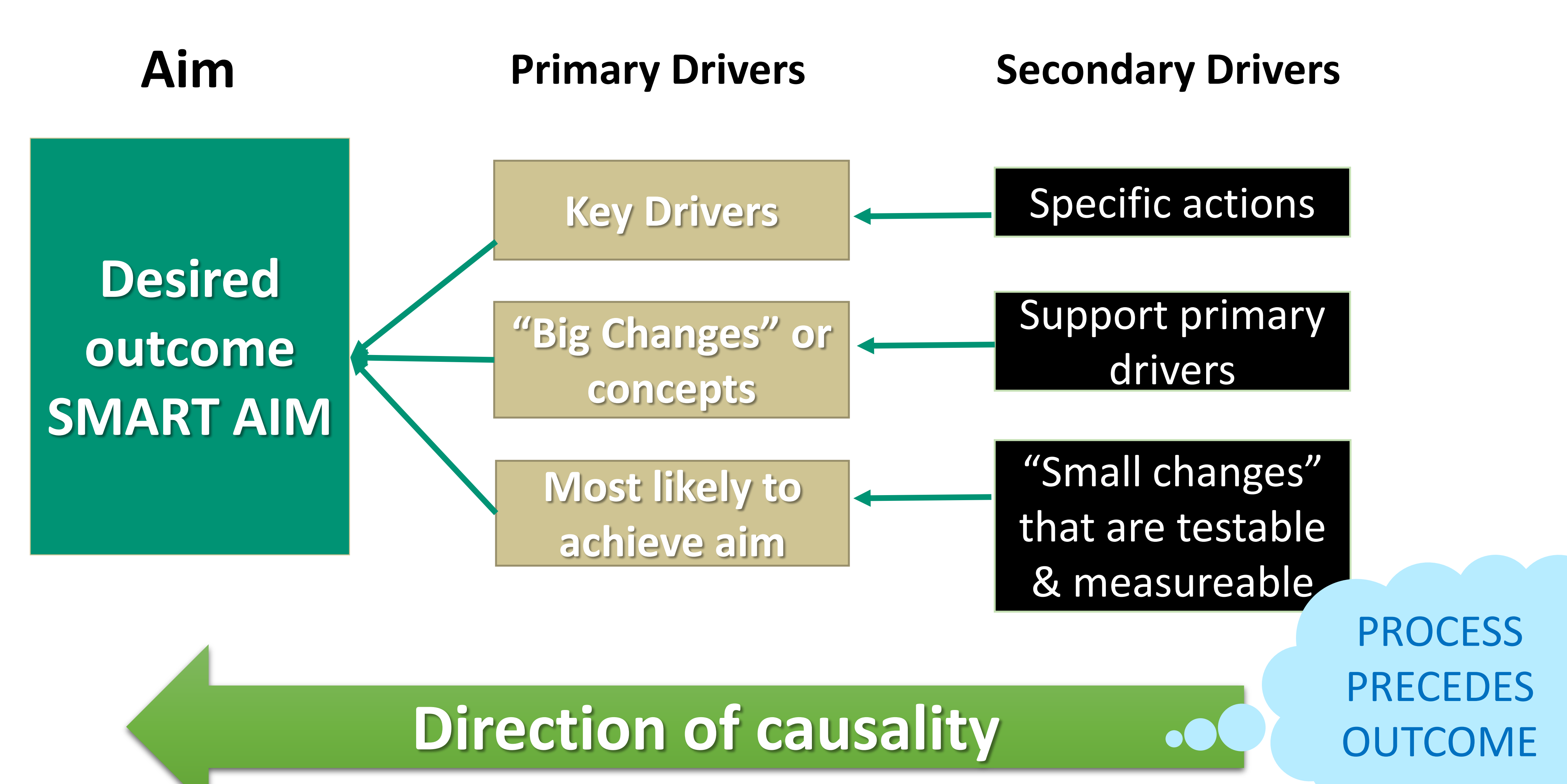
Estefania Rubio, MD, MPH, CPH
Data Manager

PACC
POSTPARTUM ACCESS & CONTINUITY OF CARE
QI DATA REPORTING

BREAKTHROUGH SERIES COLLABORATIVES = SPREAD OF ADOPTION
NOV 2018
@carolineNhs
DO NOT PASS GO
DO NOT COLLECT £200
WEEK 1
IS IT A RIPE TOPIC?
GOAL: 80% teams to level 4
YES!
NO
GAP between science + practice?
EXAMPLES of great practice?
Strong business case?
WEEK 8
12-15 THINKERS & DOERS
MEET THE EXPERTS
SPOT THE TALENT
RECRUIT THE DREAM TEAM
Faculty
I.A.
Director
Chair
PMO
= 1WTE
CO-CREATION
CHANGE PACKAGE
Ideas with a pedigree
LAUNCH
CHARTER
•Vision
•Goals
•Expectations
RECRUITMENT
MEASUREMENT STRATEGY
•What?
•Define
•Collection
LAUNCH
PROCESS precedes OUTCOME
WILL
IDEAS
EXECUTION
MARKETING
SELECTION
WEEK 16
WEEK 20
WHO'S IN?
20–100 TEAMS
ME!
WE!
ME!
WE!
ME!
WE!
Testing the will
PREWORK

Key Driver basic concepts



Postpartum Access & Continuity of Care (PACC)

Global AIM: Improve maternal health through hospital-facilitated continuum of postpartum (PP) care by coordinating and providing respectful, timely, and risk-appropriate coordinated care and services.

AIM	Primary Key Drivers	Secondary Key Drivers
By 6/2024, FPQC participating hospitals will: • Increase % of patients with a 2-week PP visit scheduled prior to discharge by 20%* • Increase patient PP education~ by 20%*	Process for Maternal Discharge Risk Assessment & Arranging Early PP Visits	Develop a process flow to schedule early risk-appropriate PP visits/encounters prior to discharge and align policies and procedures accordingly
		Conduct a PP Discharge Assessment prior to discharge
		Implement universal Maternal Discharge Risk Assessment & schedule/arrange risk-appropriate PP care including obstetrical, specialty & community services before discharge
	Comprehensive PP Patient Discharge Education	Verbally educate patients on the benefits of early risk-appropriate PP visits/encounters (Post-Birth Health Check) and provide written materials
		Verbally educate all patient on PP Warning Signs and provide written materials
		Verbally educate patients on the benefits of and options for pregnancy spacing, family planning and contraceptive choice and provide written materials
		Establish a system to ensure that all patients receive recommended and documented PP education and discharge information
	Clinician PP Engagement and Education	Develop a strategy to engage and educate inpatient and outpatient providers and staff using initiative promotional and education materials
		Plan in place to continue to engage and educate new hires
		Develop a strategy to engage and educate ER physicians & staff about pregnancy/PP care including PP screening & care practices.

Respectful care is a universal component of every driver and activity

~ Includes benefits of early PP visits, warning signs, and family planning
* Baseline will be established with the first quarter of hospital data

AIM

Outcome Measures

By 6/2024, FPQC participating hospitals will:

1. Increase % of patients with a 2-week PP visit scheduled prior to discharge by 20%*

2. Increase patient PP education by 20%*

Includes benefits of early PP visits, warning signs, and family planning

* Baseline will be established with the first quarter of hospital data

OUTCOME MEASURES

"Provide feedback on whether changes are having the desired impact on patient outcomes."

Secondary Outcome Measures

The Agency for Health Care Administration could report rates on:

- Emergency room utilization (60-day rate)
- Hospital readmissions (60-day rate)
- Postpartum visit attendance (<21 days; <84 days)

Hypertension
Cardiovascular Disease
Infection
Hemorrhage
Thromboembolism
Substance Use Disorder

The data has a delay of 6-9 months

AIM

QI Outcome Measures

By 6/2024, FPQC participating hospitals will:

1. Increase % of patients with a 2-week PP visit scheduled prior to discharge by 20%*

2. Increase patient PP education by 20%*

Includes benefits of early PP visits, warning signs, and family planning

* Baseline will be established with the first quarter of hospital data

AIM

Primary Key Drivers

By 6/2024, FPQC participating hospitals will:

- Increase % of patients with a 2-week PP visit scheduled prior to discharge by 20%*
- Increase patient PP education~ by 20%*

Respectful care is a universal component of every driver and activity

Process for Maternal Discharge Risk Assessment & Arranging Early PP Visits

Comprehensive PP Patient Discharge Education

Clinician PP Engagement and Education

PROCESS MEASURES

Indicate what a provider does to maintain or improve health

“Are the parts/steps in the system performing as planned?”

STRUCTURAL MEASURES

"Assesses features of a healthcare organization or clinician relevant to its capacity (infrastructure) to provide healthcare."

Policies / Processes / Guidelines

Primary Key Driver	Secondary Drivers
Process for Maternal Discharge Risk Assessment & Arranging Early Postpartum Visits	Develop a process flow to schedule early risk-appropriate PP visits/encounters prior to discharge and align policies and procedures accordingly
	% of patients…
	Conduct a PP Discharge Assessment prior to discharge
	Conduct Maternal Discharge Risk Assessment for PP care & schedule/arrange risk-appropriate PP care including obstetrical, specialty, & community services before discharge

Primary Key Driver	Secondary Drivers
	% of patients…
Comprehensive Postpartum Patient Discharge Education	Verbally educate patients on the benefits of early risk-appropriate PP visits/encounters (Post-Birth Health Checks)
	Verbally educate all patient on PP Warning Signs and provide written materials
	Verbally educate patients on the benefits of and options for pregnancy spacing, family planning and contraceptive choice and provide written materials
	Establish a system to ensure that all patients receive recommended and documented PP education and discharge information

Primary Key Driver	Secondary Drivers
Clinician Postpartum Engagement and Education	Develop a strategy to engage and educate inpatient and outpatient providers and staff using initiative promotional and education materials
	% of providers who have received PACC education?
	Plan in place to continue to engage and educate new hires
	Develop a strategy to engage and educate ER physicians & staff about pregnancy/PP care including PP screening & care practices

POSTPARTUM ACCESS & CONTINUITY OF CARE (PACC)
Hospital-Level Data Collection Form

Guidelines, Policies, and/or Processes					
1- Not Started 2- Planning 3 -Started Implementing – Started implementation in the last 3 months 4- Implemented – Less than 80% compliance after at least 3 months of Implementation (Not routine practice) 5- Fully Implemented – At least 80% compliance after at least 3 months of Implementation (Routine practice)					
To what extent has your hospital:	Not started 1	Planning 2	Started to implement 3	Implemented 4	Fully implemented 5
Developed a process flow to schedule early risk-appropriate PP visits/encounters prior to discharge	☐	☐	☐	☐	☐
Aligned policies, guidelines, and/or procedures to support risk-appropriate PP visits/encounters prior to discharge	☐	☐	☐	☐	☐
Implemented universal Maternal Discharge Risk Assessment	☐	☐	☐	☐	☐
Established a system to ensure that all patients receive recommended and documented PP education and discharge information	☐	☐	☐	☐	☐
Developed a strategy to engage and educate inpatient providers and staff using initiative promotional and educational materials	☐	☐	☐	☐	☐
Developed a strategy to engage outpatient providers using initiative promotional materials and educate them on billing and coding for early PP visits	☐	☐	☐	☐	☐
Implemented periodic education and engagement of new hires	☐	☐	☐	☐	☐
Implemented periodic education and engagement for ER physicians & staff about pregnancy/PP care including PP screening & care practices	☐	☐	☐	☐	☐
ER established standardized verbal screening for pregnancy now and during the past year as part of its triage or initial assessment process	☐	☐	☐	☐	☐

Staff Education		
Please report the cumulative percentage of staff and providers who received education on each of the following topics:		
Has your Staff received education on:	Nurses	OB doctors and providers
The benefits of the early risk-appropriate PP visit/Post-Birth Health Check	________%	________%
The process, guideline, and/or protocol for facilitating scheduling the early postpartum visit prior to discharge	________%	________%
The documentation of scheduled postpartum visit(s)	________%	________%
The components of the Post-Birth Health Check	________%	________%

Questions? Please contact FPQC@usf.edu

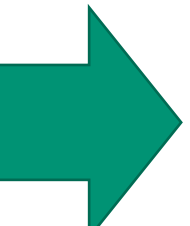
10/18/2022

HOSPITAL-LEVEL DATA

- ❑ Not started
- ❑ Planning
- ❑ Started to implement

- ❑ Implemented

- ❑ Fully Implemented



Cumulative Percent

Complete for 20 systematically selected postpartum (PP) women (sampling method on the back) admitted to your hospital for delivery regardless of infant outcome

STUDY ID # __________

DEMOGRAPHICS		
Delivery Month _______ Year ________	Saturday/Sunday/Holiday discharge ☐ Yes ☐ No	Maternal age ________
Type of insurance: ☐ Medicaid/Medicaid plans ☐ Private ☐ Self-pay ☐ Other_______ ☐ Unknown	Mother's Race (check all that apply): ☐ White ☐ Black ☐ Asian ☐ Other: ____________ ☐ Unknown	Mother's Ethnicity: ☐ Hispanic ☐ Haitian ☐ Non-Hispanic/Non-Haitian ☐ Unknown
Prenatal care started in: ☐ I / II trimester ☐ III trimester ☐ No prenatal care ☐ Unknown	Mother's Preferred Language: ☐ English ☐ Spanish ☐ Creole ☐ Other: ____________ ☐ Unknown	Route of Delivery: ☐ Vaginal ☐ Cesarean

POSTPARTUM CARE	Yes	No
Was a Maternal Discharge Risk Assessment performed?	☐	☐
Was the patient (pt.) verbally instructed on the benefits of early risk-appropriate PP visits/Post-Birth Health Check and given written materials?	☐	☐
Was the pt. verbally instructed about PP Warning Signs and given PP warning signs written materials?	☐	☐
Was the pt. verbally instructed about the benefits of and options for pregnancy spacing, family planning, and contraceptive choice and given written materials?	☐	☐
Was a PP Discharge Assessment (vital signs and response) conducted just prior to discharge?	☐	☐

POSTPARTUM VISITS	
How many days after delivery were Postpartum Visits scheduled prior to discharge (check all that apply)?	☐ <7 days ☐ 7-14 days ☐ 15 - 21 days ☐ > 21 days ☐ Not scheduled/mother instructed

PP High risk? ☐ Yes → check condition(s) below ☐ No	Referrals scheduled and medications provided prior to discharge (check all that apply)	
☐ Chronic HTN, gestational HTN, pre-eclampsia, eclampsia, maternal heart disease, or related conditions		
☐ Hx of venous thromboembolism (DVT or pulmonary embolism) /on anticoagulation	Specialty appointment	☐
☐ C-section or 3rd or 4th degree vaginal laceration	Mental/Behavioral Health appointment	☐
☐ Positive screen for Substance Use Disorder	Healthy Start/home visiting	☐
☐ Feeling unsafe at home / Positive for Intimate Partner Violence	Medicaid Case Manager	☐
☐ Positive Edinburgh Postnatal Depression Scale	Hospital financial counselor	☐
☐ Requested/required additional community resources	Appropriate medication	☐
☐ Other ____________________	Naloxone kit/Rx	☐

PATIENT-LEVEL DATA

Report on up to 20 women per month

Disaggregate by race, ethnicity, insurance type, risk

QI MONTHLY CYCLE

Identify opportunities *PDSA*

Coaching Call

Submit Data

Review Data Report

Discuss and Disseminate Data Report

QI REPORTS

- Aim
- Run Charts
- Tracks Process, Structural and Outcome Measures
- Add your PDSAs

Important requests

- ❑ Track completion of your hospital's Data Use Agreement
- ❑ Let us know of any changes in your PACC team: Data Lead resources
- ❑ Attend the data webinar
- ❑ Submit your Hospital-Level Data by December
- ❑ Patient-level data collection starts in January

PACC DATA WEBINAR

Date: Thursday, November 10, 2022
12:00 PM – 01:00 PM EDT

- **Importance of data for the PACC initiative**
- **Data definitions, inclusion criteria**
- **Data tools - data collection sheets**
- **Processes to submit data**
- **Review of a sample report**
- **Using your report to guide improvement**

What questions do you have?

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www.fpqc.org

"To improve the health and health care of all Florida mothers & babies"

Stump the PACC Advisors

FPQC

Evaluations & Thank You

Adjourn

FPQC