MDPQC Office Hours

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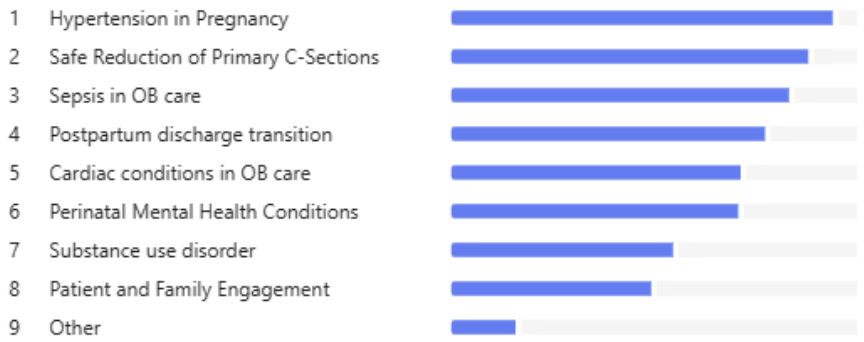
Maryland
DEPARTMENT OF HEALTH

Pushing for Progress: Birthing the Next Initiative
February 3, 2026

Next Steps Hospital Assessment

Please rank which maternal topic areas you would be most interested in working on:



Rank	Options	First choice ● ● ● ● ● ● ● ● ● Last choice
1	Hypertension in Pregnancy	
2	Safe Reduction of Primary C-Sections	
3	Sepsis in OB care	
4	Postpartum discharge transition	
5	Cardiac conditions in OB care	
6	Perinatal Mental Health Conditions	
7	Substance use disorder	
8	Patient and Family Engagement	
9	Other	

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Safe Reduction of Primary Cesarean Birth Patient Safety Bundle

https://saferbirth.org/psbs/safe-reduction-of-cesarean-birth/

Readiness – Every Unit

- Develop provider, patient community and unit culture that values, promotes, and supports spontaneous onset and progress of labor and vaginal birth and understands the risks for current and future pregnancies of cesarean birth without medical indication.
- Provide education to pregnant people and families related to their options for labor and birth throughout the perinatal care cycle, with an emphasis on informed consent, and shared decision-making.
- Facilitate multidisciplinary education to healthcare team members on approaches which maximize the likelihood of vaginal birth, including assessment of labor, methods to promote labor progress, labor support, coping mechanisms, and pain management (both pharmacologic and non-pharmacologic), and shared decision-making to all providers and staff that provide care to pregnant and postpartum people.
- Training on trauma-informed care and health care team member biases to enhance high-quality, equitable outcomes.

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Recognition & Prevention – Every Patient

- Implement standardized admission criteria, triage management, education, and support for people presenting in spontaneous labor.
- Ensure availability and offer a range of standard techniques of pain management and comfort measures that promote labor progress and prevent dysfunctional labor.
- Utilize standardized methods in the assessment of the fetal heart rate status, including interpretation and documentation and encourage evidence-based positioning and patient movement in labor.
- Implement protocols for timely identification of specific conditions, such as active herpes and breech presentation, for patients who can benefit from proactive intervention before labor to reduce the risk for cesarean birth.
- Implement standardized approaches to promote evidence-based interventions for conditions such as macrosomia, low-lying placenta, and oligohydramnios.

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Response – Every Event

- Ensure availability of clinicians, staff, and resources to maintain appropriate ongoing labor assessment and support and respond to labor process disruptions and emergencies.
- Uphold comprehensive standardized induction scheduling with shared decision-making, planning, and preparation of patients undergoing induction.
- Utilize standardized evidence-based labor algorithms, policies, and techniques, which allow for prompt recognition and treatment of dystocia and are consistent with the diagnosis of labor dystocia criteria.
- Adopt policies that outline standard responses to abnormal fetal heart rate patterns and uterine activity to avoid unnecessary intervention and maintain high-quality neonatal outcomes.
- Provide via clinician training, skill development, or referral expertise and techniques to lessen the need for abdominal delivery, such as breech version, instrumented delivery, and twin delivery protocols.

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Reporting & Systems Learning – Every Unit

- Perform regular multidisciplinary reviews of indications for cesarean births to determine alignment with established standards to identify systems issues and variations in provider performance.
- Monitor appropriate metrics and balancing measures, including maternal and newborn outcomes resulting from changes in labor management strategies, with disaggregation by race and ethnicity due to known disparities in rates of cesarean delivery.
- Establish a culture of multidisciplinary planning, huddles, and post-event debriefs for unplanned cesarean births, which identify success, opportunities for improvement, and action planning for future events.

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Respectful, Equitable, Supportive Care – Every Unit/Provider/Team Member

- Include each pregnant or postpartum person and their identified support network as respected members of and contributors to the multidisciplinary care team.
- Engage in open, transparent, and empathetic communication with pregnant and postpartum people and their identified support network to respond to their concerns.

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Safe Reduction of Primary C-Section Measures

	PROCESS MEASURES	STRUCTURE MEASURES
Reported by:	**Hospitals** to AIM Data Center	**Hospitals** to AIM Data Center
Reporting Frequency:	Quarterly	Quarterly – Likert scale
Measures:	1. Cesarean Bundle Adherence Rate 1. Dystocia/Arrest of Labor 2. Failed Induction of Labor 3. Abnormal or Indeterminate Fetal Heart Rate Pattern 2. OB Provider Education a) Safe Support of Labor & Vaginal Births b) Respectful & Equitable Care 3. OB Nursing Education a) Safe Support of Labor & Vaginal Births b) Respectful & Equitable Care	1. Patient and Support Network Review of Cesarean Birth 2. Patient and Support Network Support After an Unexpected or Traumatic Cesarean Birth 3. Labor Management Huddles 4. Unit Policies & Procedures for Labor Support 5. Unit Policies & Procedures for Prioritizing Scheduled Inductions of Labor 6. Multidisciplinary Case Reviews for C/S Bundle

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Process Measure P1

Cesarean Bundle Adherence Rate: Select one or more of these sub-measures for ongoing monitoring and review of indications for Cesarean births

- *Sample patient charts or report for all patients*

Measure Description	Notes
CS P1A: Dystocia/Arrest of Labor in the Active Phase Denominator: All NTSV Cesarean births for dystocia or arrest of labor in the active phase Numerator: Among the denominator, those who met criteria	For CS P1A, the following criteria should be present to be included in the numerator: • Cervix 6 cm or greater at time of Cesarean • Membranes ruptured and no cervical change X 4 hours with adequate uterine activity (or 6 hours with oxytocin)
CS P1B: Failed Induction of Labor Denominator: All NTSV Cesarean births with an induction of labor, inclusive of cervical ripening, for dystocia or arrest of labor before 6cm dilation Numerator: Among the denominator, those who met criteria	For CS P1B, the following criteria should be present to be included in the numerator: • Oxytocin used for a minimum of 12-18 hours after ruptured membranes before declaring arrest
CS P1C: Abnormal or Indeterminate Fetal Heart Rate Pattern Denominator: All NTSV Cesarean births for an abnormal or indeterminate fetal heart rate pattern Numerator: Among the denominator, those who met established unit-standard criteria	For CS P1C, facilities should use their unit-standard criteria for managing Category II FHR tracings to determine numerator inclusion.

Safe Reduction of Primary Cesarean Births

Pros

- Maryland NTSV rate is above national average, and continues to climb
- C-sections are driving hemorrhage rates

Cons

- Requires heavy provider engagement
- Other states implementing this bundle have failed to see improvement

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Postpartum Discharge Transition Bundle

To address the immediate postpartum period, specifically hospital discharge to outpatient obstetrical care, ongoing specialist care, and community supports and services.
While ideally all elements of a patient safety bundle would be implemented in all relevant settings, this may be aspirational for some settings based on capacity and resources. For this reason, elements that are considered foundational to addressing morbidity and mortality in the postpartum period are bolded below.

https://saferbirth.org/psbs/postpartum-discharge-transition/

Readiness – Every Unit

- **Develop and maintain a set of referral resources and communication pathways between obstetric providers, community-based organizations, and state and public health agencies to enhance services and supports for pregnant and postpartum families.**
- **Establish a multidisciplinary care team to design coordinated clinical pathways for patient discharge and a standardized discharge summary form to give to all postpartum patients prior to discharge.**
- Provide multidisciplinary staff education to clinicians and office staff on optimizing postpartum care, including why and how to screen for life-threatening postpartum complications.
- Develop trauma-informed protocols and trainings to address health care team member biases to enhance quality of care.
- Educate outpatient care setting staff on how to use a standardized discharge summary form to review patient data and ensure that recommendations made for outpatient follow-up and community services/resources have been carried out.

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Recognition & Prevention – Every Patient

- **Establish a system for scheduling the postpartum care visit and needed immediate specialty care visit or contact (virtual or in-person visit) prior to discharge or within 24 hours of discharge.**
- **Screen each patient for postpartum risk factors and provide linkage to community services/ resources prior to discharge.**
- **In all care environments assess and document if a patient presenting is pregnant or has been pregnant within the past year.**
- Offer reproductive life planning discussions and resources, including access to a full range of contraceptive options in accordance with safe therapeutic regimens.
- Facilitate and assure linkage to relevant services in outpatient settings for care identified for postpartum risk factors.

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Response – Every Event

- **Provide patient education prior to discharge that includes life-threatening postpartum complications and early warning signs, including mental health conditions, in addition to individual patient-specific conditions, risks, and how to seek care.**
- **Provide each postpartum patient with a standardized discharge summary form that details key information from pregnancy and birth.**
- **Conduct a comprehensive postpartum visit.**
- Encourage the presence of a designated support person during all instances of care as desired, and particularly when teaching or education occurs.
- Engage in dialogue with the postpartum patient around elements of postpartum self-care prior to discharge.
- Implement a multidisciplinary discharge process to provide a coordinated pathway for clinical postpartum discharge, which may include multidisciplinary rounding.

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Reporting & Systems Learning – Every Unit

- **Convene inpatient and outpatient providers in an ongoing way to share successful strategies and identify opportunities for prevention of undesired outcomes in the postpartum period, including emergency and urgent care clinicians and staff.**
- **Consider a multidisciplinary huddle for postpartum patients identified as higher-risk for complications to identify potential gaps or adjustments to the standardized discharge process.**
- **Develop and systematically utilize a standard comprehensive postpartum visit template.**
- Identify and monitor postpartum quality measures in all care settings.
- Monitor data related to completed postpartum comprehensive visits in each office, with disaggregation by race and ethnicity at a minimum, to evaluate disparities in rate of follow-up visit completion.

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Respectful, Equitable, Supportive Care – Every Unit/Provider/Team Member

- **Include each pregnant or postpartum person and their identified support network as respected members of and contributors to the multidisciplinary care team.**
- Engage in open, transparent, and empathetic communication with pregnant and postpartum people and their identified support network to understand diagnoses, options, and treatment plans.

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Postpartum Discharge Transition Measures

	PROCESS MEASURES	STRUCTURE MEASURES
Reported by:	**Hospitals** to AIM Data Center	**Hospitals** to AIM Data Center
Reporting Frequency:	Quarterly	Quarterly – Likert scale
Measures:	1. OB Provider Education a) Life-Threatening Postpartum Concerns b) Respectful & Equitable Care 2. OB Nursing Education a) Life-Threatening Postpartum Concerns b) Respectful & Equitable Care 3. Inpatient-Outpatient Care Provider Collaborative Education 4. Postpartum Visit Scheduling 5. Screening for Social and Structural Drivers of Health (SSDOH) 6. Patient Education on Life-Threatening Postpartum Conditions	1. Patient Event Debriefs 2. Patient Education Materials on Urgent Postpartum Warning Signs 3. Emergency Department Screening for Current or Recent Pregnancy 4. Inpatient-Outpatient Care Coordination Workgroup 5. Resource Mapping/Identification of Community Resources 6. Shared Comprehensive Postpartum Visit Template

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Process Measures P2-P5

Measure	Description	Notes
Inpatient-Outpatient Care Provider Collaborative Education	PPDT P2A: At the end of this reporting period, how many shared learning experiences on issues related to pregnancy and the postpartum period that cross the continuum of care took place between inpatient and affiliated outpatient providers and nursing staff? PPDT P2B. At the end of this reporting period, how many care settings were represented by attendees at all shared learning experiences?	May include clinical and non-clinical care settings
Postpartum Visit Scheduling	Denominator: All maternal discharges following a live birth Numerator: Among the denominator, those who had a postpartum visit scheduled before or within 24 hours of discharge from birth hospitalization	Disaggregated by race/ethnicity
Screening for SSDOH	Denominator: All maternal discharges following a live birth Numerator: Among the denominator, those who were screened for SSDOH using a standardized, validated tool by the time of discharge from birth hospitalization	Disaggregated by race/ethnicity. To be included in the numerator, patients had to have answered any question(s) from a validated SSDOH screening tool.
Patient Education on Life-Threatening Postpartum Concerns	Denominator: All maternal discharges following a live birth Numerator: Among the denominator, those who had documentation of verbal and written education on life-threatening postpartum concerns before discharge from birth hospitalization	To be included in the numerator, patient record needs to include documentation of verbal and written education.

Postpartum Discharge Transition

Pros

- Broad-reaching across conditions
- Postpartum readmissions have been a state priority
- Creates an opportunity to increase referral and communication pathways

Cons

- Requires follow-up actions beyond L&D/mother-baby units and hospital walls
- Does not address prevention or management prior to giving birth
- Tracking impact may be a challenge

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Open Discussion

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Decision Time

Cast your vote here!

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Reminders

- Q4-2025 data is past due!
  - AIM Data Center
  - Hemorrhage Rate Submission Form

- Register for March Maternal Health Office Hours:
  - Tuesday, March 3rd, 12pm-1pm
    Register here

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Open Discussion

Please complete the evaluation poll before you go!

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Contact Us

For more information

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