Kickoff:
Postpartum Discharge Transition

MDPQC Maternal Office Hours

July 7, 2026

Optimizing Post-Partum Care: The AIM Postpartum Discharge Transition Bundle

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St. Louis, Mo

Speaker

Susan Kendig, JD, WHNP-BC, FAANP, is a board-certified women's health nurse practitioner and attorney with over four decades of experience as a healthcare provider, educator, and strategist. Her work is grounded in a strong background at the intersection of clinical practice, policy, and public health. Currently, Sue is a Women's Health Integration Specialist and Co-PI of the Missouri Collaboration for Clinical Community Integration in Maternal Health (MO C3), with SSM Health Women's Services, St. Louis, MO, and is an adjunct professor in the Saint Louis University, School of Public Health, and Social Justice, Center of Excellence in Maternal and Child Health Education, Science and Practice. Prior to joining SSM Health, Sue was a teaching professor at the University of Missouri-St. Louis, where she led the Women's Health Nurse Practitioner program for almost two decades. She served as a member of the Women's Preventive Services (WPSI) Advisory Panel, which guided a HRSA funded collaborative interdisciplinary effort to develop, review, and disseminate recommendations for women's preventive health care services.

Active with the Alliance for Innovation in Maternal Health (AIM) national team, she co-led development of maternal safety bundles related to mental health, postpartum and women's health. At home in Missouri, she served as Chair of the Mo DHSS Women's Health Council, and as a gubernatorial appointee to the Missouri Patient Safety Commission and the Missouri Task Force on Prematurity and Infant Mortality. Sue has been part of the Missouri LAN core advisory panel since its inception. She is committed to the concept of clinical and community integration as a tool to improve health outcomes, and to optimize quality in health care service delivery. To this end, she has provided technical assistance to integrated primary care medical home/behavioral health home and other value-based care initiatives, and collective impact maternal and infant mortality reduction efforts in urban and rural communities.

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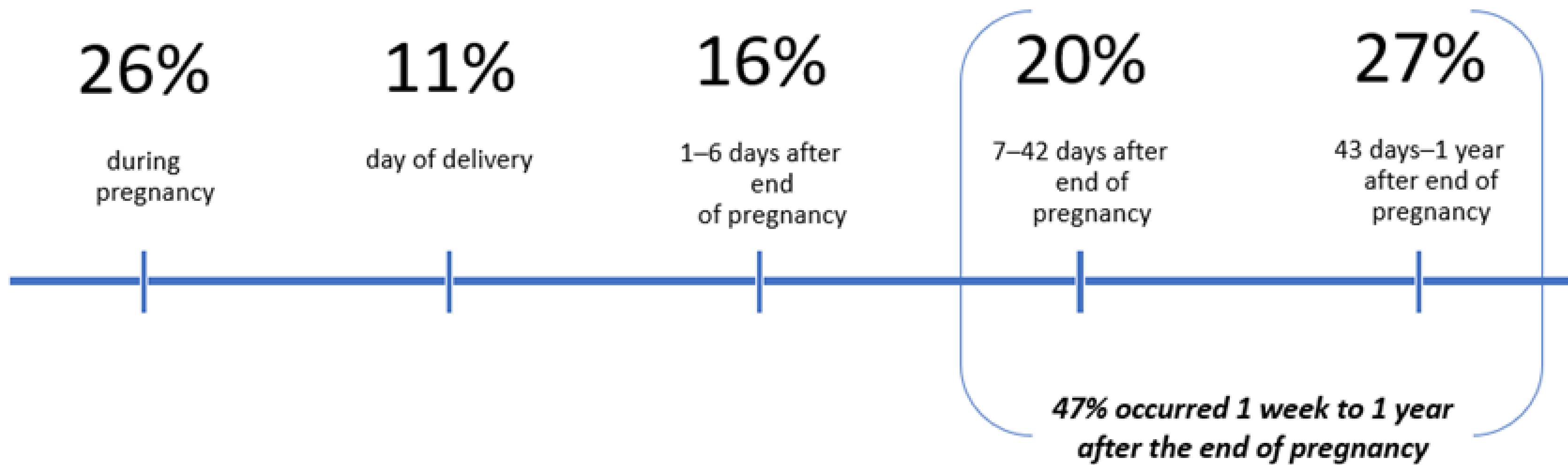
Objectives

This presentation is designed to:

- Describe the importance of supporting birthing persons during the postpartum period to improve maternal health.
- Introduce the AIM Postpartum Discharge Transition bundle elements.
- Discuss strategies to support element application in practice
- Describe a minimum of two resources to support bundle implementation

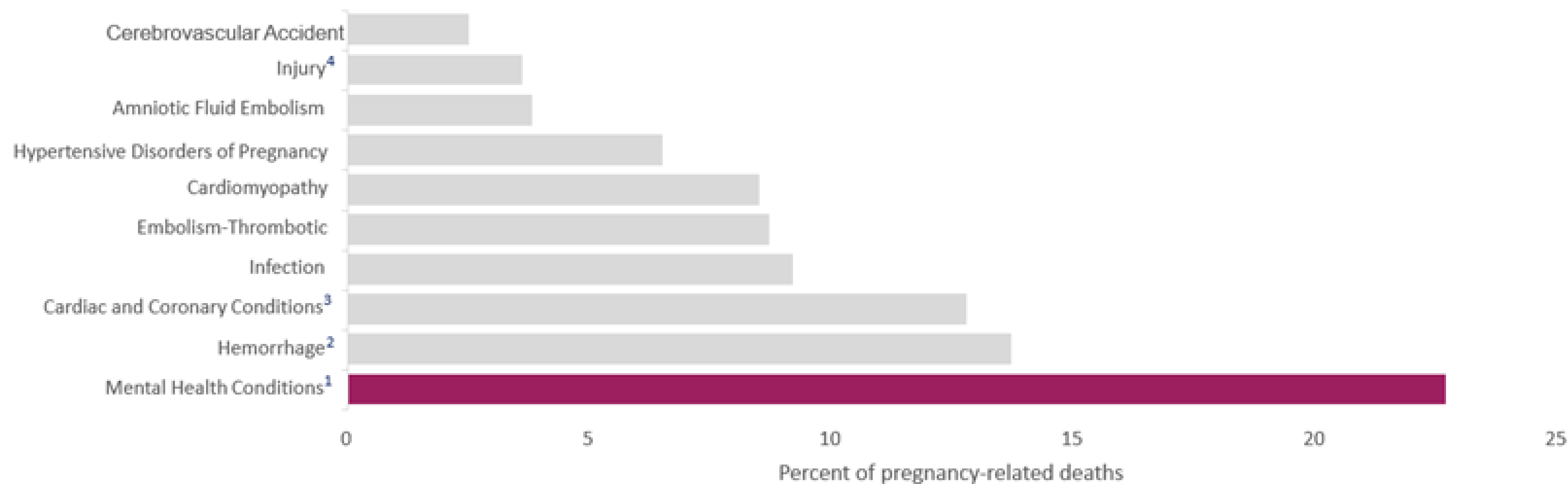
WHY DO WE NEED TO FOCUS ON POSTPARTUM TRANSITIONS?

Maternal Mortality Review Committees in 38 U.S. States, 2020: Timing of pregnancy-related deaths



Timing was missing (n=2) or unknown (n=14) for 16 (1.6%) pregnancy-related deaths.
https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html

Most Frequent Underlying Causes of Pregnancy-Related Deaths*



*Only 10 most frequent underlying causes of death are shown; underlying cause of death was missing (n=10) or unknown (n=21) for 31 (3.0%) pregnancy-related deaths.

1. Mental health conditions include deaths to suicide, unintentional or unknown intent overdose/poisoning related to substance use disorder, and other deaths determined by the MMRC to be related to a mental health condition, including substance use disorder
2. Excludes aneurysms or cerebrovascular accident (CVA)
3. Cardiac and coronary conditions include deaths to coronary artery disease, pulmonary hypertension, acquired and congenital valvular heart disease, vascular aneurysm, hypertensive cardiovascular disease, Marfan Syndrome, conduction defects, vascular malformations, and other cardiovascular disease; and excludes cardiomyopathy and hypertensive disorders of pregnancy.
4. Injury includes intentional injury (homicide), unintentional injury, including overdose/poisoning deaths not related to substance use disorder, and injury of unknown intent or not otherwise specified.

But What About those who Live? Severe Maternal Morbidities (SMM)

- The rate of severe maternal morbidities has risen commensurate with the increase in pregnancy-related deaths and demonstrates similar characteristics. (ACOG, SMFM, 2021)
- An analysis of 20 indicators of SMM from 2012 to 2019 concluded that morbidity rates increased from 69.5 per 10,000 delivery hospitalizations in 2012 to 79.7 per 10,000 in 2019. (Hirai et al, 2022)
- The prevalence of SMM increased between 2008 and 2021 and was estimated to be 163.3 per 10,000 discharges.
- The highest SMM was in 2021 with 206.1 per 10,000 discharges. (Fink, 2023)

What We Do Here Today ...
and Every Day ...
Matters More Than We Know

Adverse pregnancy outcomes and CVD Risk

Pregnancy Outcome/ Reproductive Risk Factors	Outcome Association	Evidence Strength
Hypertensive disorders of pregnancy (preeclampsia, gestational hypertension)	▯ Atherosclerotic CVD	A
	▯ Hemorrhagic stroke	B
	▯ Heart failure	B
Gestational diabetes	▯ Atherosclerotic CVD	A
Preterm birth	▯ Atherosclerotic CVD	A
Small for gestational age	▯ Atherosclerotic CVD	A
Large for gestational age	▯ Atherosclerotic CVD	B
Placental abruption	▯ Atherosclerotic CVD	A
Miscarriages/stillbirths	▯ Atherosclerotic CVD	A

Parikh NI, et al. *Circulation*. 2021;143(18):e902-e916.

Impact of Chronic Conditions

- Overall women's health status may contribute to rising maternal mortality and morbidity
  - Pre-pregnancy obesity
  - Pre-existing chronic medical conditions
  - Conditions identified in pregnancy
- Obesity is the most common medical condition in reproductive age women/birthing people, contributing to short term and long-term sequelae, such as glucose intolerance in pregnancy, VTE, and future cardiometabolic risks (Catalano, PM, & Shankar, K. (2017). BMJ)
- Congenital malformations and perinatal mortality rates remain severalfold higher in pregnant women with type 1 diabetes (McCance, DR & Casey, C. 2019. Endocrinol Metab Clin North Am)
- Overall 30% increase in rate of GDM between 2016 – 2020, with larger annual percent change between 2019 – 2020 (Gregory, ECW & Ely, DM.(2022). National Vital Statistics Report)
- 15 yr. follow up study of women with GDM
  - Increased incidence of diagnosed diabetes
  - Significantly shorter median time for developing diabetes (Minooee, S, Ramezahni, T, Rahmati, M, et al (2017) Diab Res Clin Prac.)
- Meta-analysis of 22 studies found preeclampsia associated with a 4-fold increase in future incident heart failure and a 2-fold increased risk in coronary heart disease, stroke, and death because of coronary heart or cardiovascular disease. (Wu, P, Haththotuwa,R, Kwok, CS, et al. (2017).Circ Cardiovasc Qual Outcomes)

READINESS – EVERY UNIT

AIM Postpartum Discharge Transition Bundle. Available at: https://saferbirth.org/psbs/postpartum-discharge-transition/

Readiness – Every Unit

- Develop and maintain a set of referral resources and communication pathways between obstetric providers, CBOs and state and public health agencies to enhance services and supports for pregnant and postpartum families.

Finding and Utilizing Community Resources

- Identify existing community-based resources
  - Maternal mental health providers
  - Home visiting services
  - Support groups
  - Wrap-around services
- Maintain updated information about resources
  - Key staff contacts
  - Contact/access information
  - Requirements
- Consider distance mediated resources

Readiness – Every Unit

- Establish a multidisciplinary care team to design coordinated clinical pathways for patient discharge and a standardized discharge summary form to give to all patients prior to discharge
  - Provide multidisciplinary staff education to clinicians and office staff on optimizing PP care, including why and how to screen for life-threatening PP 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 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.

Growing Your Team

- Representation from both inpatient and outpatient areas
- Consider:
  - Physicians
  - Nurses
  - Social work
  - Pharmacy
  - Mental Health/SUD clinicians
  - Doulas/CHWs
  - Community partners
  - Others

Graphic from: McMorrow, K, Williams, N, Winner, L. et al. Improving the quality of discharge instructions for obstetric & postpartum patients leveraging the EMR. https://nursing.jhu.edu/wp-content/uploads/2011/05/Williams_Fuld_Poster_Final.pdf

"…design coordinated clinical pathways for patient discharge and a standardized discharge summary form…"

- Patient information
- Pregnancy and birth history
- Relevant diagnoses
- Provider contact information:
  - Obstetric care provider
  - Mental health and SUD provider
  - Specialty and subspecialty providers
  - Primary care provider
- Where to call/go in case of emergency
- Community support person (Care coordinator, CHW, doula, etc.)
- Upcoming appointments
- Medication list
- Postpartum labs
- Suggested community resources

RECOGNITION & PREVENTION – EVERY PATIENT

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Recognition & Prevention: Every Patient

- Establish a system for scheduling the PP care visit and needed immediate specialty care visit or contact (virtual or in-person visit) prior to discharge or within 24 hrs. of discharge.
- Screen each patient for PP risk factors and provide linkage to community services/resources prior to discharge.

Establish a system for scheduling the PP visit ….

Simply prescheduling a postpartum visit prior to the due date, followed by targeted messaging and reminders as to the upcoming appointment and importance of the postpartum visit and primary care follow up increased completion of the visit within four months postpartum by 40% (Clapp et al., JAMA Network Open)

Maternal Mental Health Considerations

- Perinatal mental health conditions affect more than one in five people and are among the most common complications of pregnancy and postpartum.)
- Suicide and overdose/poisoning are the most common causes of pregnancy associated maternal mortality
- Maternal mortality secondary to mental health conditions is preventable.
- Perinatal depression affects approximately 1 in 7 women.
- Perinatal anxiety strongly predictors perinatal depression.
- Bipolar disorder affects approximately 2% - 8% of the perinatal population.
- Maternal mental health conditions are associated with adverse obstetric, fetal, neonatal and infant outcomes, including stillbirth, preterm birth, SGA, and other concerns.

As cited in ACOG Clinical Practice Guideline No.4. (2023) Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum.

Does Screening for the "Big 5" Tell the Whole Story?

The "Big 5": Food insecurity, unstable housing, transportation, utility difficulties, interpersonal violence

- Experience of living with low income and material hardship influences parental stress and mental illness. (Gershoff et al., 2007, Child Development)
- Food insufficiency was shown to increase risk for depression in poor Black women, even after adjusting for unemployment, unstable housing, childcare availability, transportation and discrimination. (Seifert, et al., 2007, Am J Orthopsychiatry)
- Mothers experiencing diaper need exhibited higher depression scores than those with food insecurity. (Austin, A & Smith, 2017, Health Equity; Smith, MV et al, 2013, Pediatrics.

SDoH and Maternal Health: Additional Considerations

- Link between adverse childhood events and chronic health problems.
- Preliminary evidence shows potential relationship between maternal mortality and morbidity and “neighborhood deprivation”.
- National study of data from 2007-2015 found a 9% higher probability of severe maternal mortality and morbidity among rural residents as compared to urban residents.
  - Lower initiation of first trimester prenatal care
  - Less than ½ live within 30 min. drive to perinatal center
  - Report highest rates of no or delayed care due to cost

Recognition & Prevention – Every Patient

- In all care environments assess and document if a patient is currently 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 safer therapeutic regimens.
  - Facilitate and assure linkage to relevant services in outpatient settings for care identified for PP risk factors.

Assess Pregnancy Status

Assess all reproductive capable people presenting for care if they are/or have been pregnant within the past year.

Are you currently pregnant, or have you been pregnant, in the last twelve months?

Why is Pregnancy Status Within the Last Year Important?

Case example1: Patient presented to a walk in clinic, complaining of respiratory symptoms. Treated for URI. Was not asked this one crucial question. In reality, patient was 2 mo. PP, breastfeeding and had mastitis.

Case example 2: Patient presents complaining of extreme fatigue, shortness of breath when going up stairs, etc. “Not sure why I am so tired all of the time. Without asking this crucial question, would not know patient was 6 mo. PP and experiencing cardiac symptoms.

Case Example 3: 23 y.o presents for urgent care services. BP 146/94. Without asking this crucial question, would not know patient was 6 weeks PP, and had experienced pregnancy induced hypertension, placing her at increased risk for future cardiac events, and in need of follow-up.

RESPONSE – EVERY EVENT

AIM Postpartum Discharge Transition Bundle. Available at: https://saferbirth.org/psbs/postpartum-discharge-transition/

Response: Every Event

- Provide patient education prior to discharge that includes life-threatening PP complications and early warning signs, including mental health conditions, in addition to patient specific conditions, risks and how to seek care.
- Provide each PP patient with a standardized discharge summary form that details key information from pregnancy and birth.

Considerations in Planning Education Targeting Maternal Mortality

Patient education to enhance risk awareness, activate health promoting behaviors and improve communication with clinicians are common strategies to improve maternal outcomes.

Birthing people's health related decisions are affected by perceptions of respectful care, health literacy, personal health risk, and cultural or community differences in lived experience.

Patient and Family Education

- Include information about postpartum physical, mental and social health with postpartum education
- Provide education about warning signs, “red flags”, recognition of risk and signs of recurrence
- Provide resource information and discuss where to go for help
  - Who to call
  - How to access services
- Assess reports from family members and support persons

Review Warning Signs at Each Touch Point

CDC Centers for Disease Control and Prevention

HEAR HER™ Campaign

Español (Spanish) | Print

Learn the Warning Signs
It could help save a life
Learn More

HEAR™
HEAR HER concerns

Pregnant & Postpartum People

Partners, Friends & Family

Healthcare Professionals

Pregnant now or within the last year?
Get medical care right away if you experience any of the following symptoms:

Headache that won't go away or gets worse over time
Dizziness or fainting
Changes in your vision
Fever of 100.4˚F or higher
Extreme swelling of your hands or face
Thoughts of harming yourself or your baby
Trouble breathing
Chest pain or fast beating heart
Severe nausea and throwing up
Severe belly pain that doesn't go away
Baby's movement stopping or slowing during pregnancy
Severe swelling, redness or pain of your leg or arm
Vaginal bleeding or fluid leaking during pregnancy
Heavy vaginal bleeding or discharge after pregnancy
Overwhelming tiredness

These could be signs of very serious complications. If you can't reach a healthcare provider, go to the emergency room. Be sure to tell them you are pregnant or were pregnant within the last year.

Learn more at

HEAR

https://www.cdc.gov/hearher/index.html

You're not alone

Pregnant or just had a baby? The National Maternal Mental Health Hotline is free, confidential, and here to help, 24/7.

1-833-TLC-MAMA

Text

Call

Graphic from: McMorrow, K, Williams, N, Winner, L. et al. Improving the quality of discharge instructions for obstetric & postpartum patients leveraging the EMR. https://nursing.jhu.edu/wp-content/uploads/2011/05/Williams_Fuld_Poster_Final.pdf

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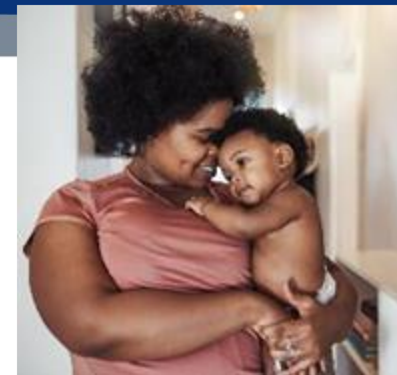
Postpartum Glucose Screening

Lack of screening follow up for Gestational Diabetes

- ACOG recommends screening women with GDM 4-12 week postpartum for diabetes and pre-diabetes in line with postpartum visit
- OGTT 4-12 weeks postpartum rather than A1c (ADA)
- 447,556 women across 50 states (59% white) 7.2% had GDM and 75% no f/u screen within 1 year (Eggleston et al. Obstet Gynecol 2016;128:159)
- Women with GDM only 23.4 % received any kind of glucose test by 6 months postpartum (McCloskey et al. J Wom Health 2014;23:327)

Women's Preventive Services Initiative's (WPSI)Recommendation: Diabetes Screening After Pregnancy



Screening for type 2 diabetes in women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes.

- Initial testing should ideally occur within the first year postpartum and can be conducted as early as 4–6 weeks postpartum.
- Women who were not screened in the first year postpartum or those with a negative initial postpartum screening test result should be screened at least every 3 years for a minimum of 10 years after pregnancy.
- For those with a positive screening test result in the early postpartum period, testing should be repeated at least 6 months postpartum to confirm the diagnosis of diabetes regardless of the type of initial test (eg, fasting plasma glucose, hemoglobin A1C, oral glucose tolerance test).
- Repeat testing is also indicated for women screened with hemoglobin A1C in the first 6 months postpartum regardless of whether the test results are positive or negative because the hemoglobin A1C test is less accurate during the first 6 months postpartum.

https://www.womenspreventivehealth.org/recommendations/diabetes-after-pregnancy/

Response – Every Event

- Conduct a comprehensive PP visit.
  - Encourage 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 PP patient around elements of PP self care prior to discharge.
  - Implement a multidisciplinary discharge process to provide a coordinated pathway for clinical PP discharge, which may include multidisciplinary rounding.

Attendance at the Postpartum Visit

Up to 40% of birthing people do not attend a routine postpartum visit, and few receive all recommended elements of postpartum care.

Predictors of attendance at PP visit

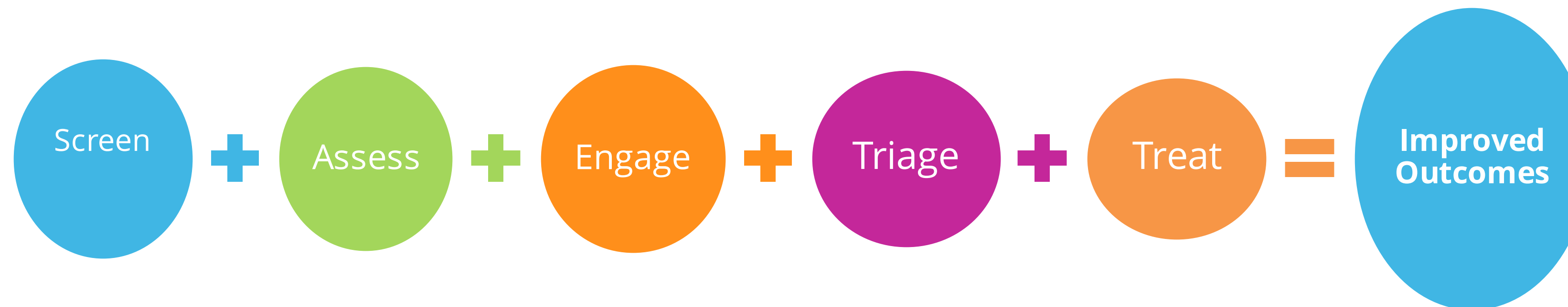
Gemkow, et al. 2022. A. Jnl. Prev. Care)

Access to health insurance	Completed medical visit within year before pregnancy	Attendance at a first trimester visit. (

Facilitate Transitions in Care Across Outpatient and Community Touchpoints

- Schedule risk appropriate PP appointments and touchpoints
- Coordinate care between obstetric care, mental health, primary and specialty care providers, CHWs and doulas during the prenatal and postpartum period
- Establish a plan for care beyond the postpartum period
  - Women's Health Care
  - Mental Health Care
  - Primary and Specialty Care
  - Social and Material Supports
- Assure required consents are in place

The Continuum of Care: The Warm Handoff



Gilbody, S, Sheldon, T, & House, A. (2008). CMAJ, 178(8), 997-1003; Yonkers, K, Smith, M, Lin, H. Howell, H, Shao, L, & Rosenhack, R. (2009). Psychiatric Services, 60 (3), 322-328

REPORTING AND SYSTEM LEARNING - EVERY UNIT

AIM Postpartum Discharge Transition Bundle. Available at: https://saferbirth.org/psbs/postpartum-discharge-transition/

Reporting and 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 PP period, including emergency and urgent care clinicians and staff.
- Consider a multidisciplinary huddle for PP patients identified as higher risk for complications to identify potential gaps or adjustments to the standardized discharge process.

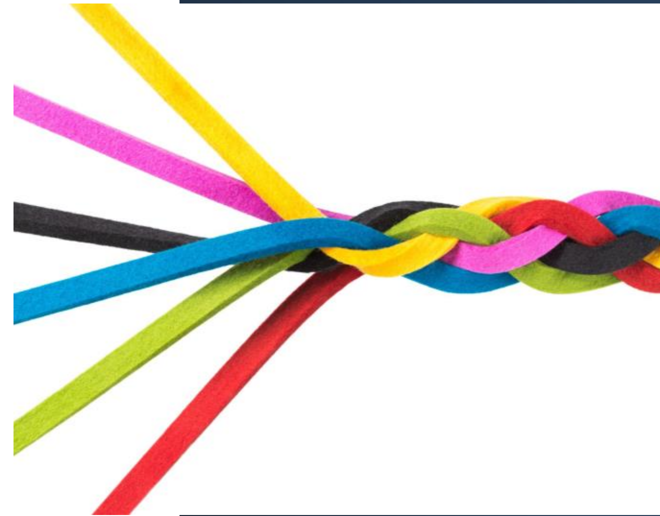
Create a Culture of Safety

A culture of safety - one where people are encouraged to work toward change and take action to make change happen

- Non-judgmental
- Emphasizes teamwork
- Considers processes

Inpatient and Outpatient Team Communications

- Identify key metrics to monitor care coordination and referrals.
- Develop an integrated, shared data plan.
- Create a mechanism to monitor and address gaps in care.



Reporting and Systems Learning – Every Unit

- Develop and systematically utilize a standard comprehensive PP visit template.
  - Identify and monitor PP quality measures in all care settings.
  - Monitor data related to completed PP comprehensive visits in each office, with disaggregation by race and ethnicity at a minimum, to evaluate disparities in rate of follow-up visit completion

RESPECTFUL, EQUITABLE AND SUPPORTIVE CARE – EVERY UNIT/ PROVIDER/TEAM MEMBER

AIM Postpartum Discharge Transition Bundle. Available at: https://saferbirth.org/psbs/postpartum-discharge-transition/

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

- Include each PP 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 PP people and their identified support network to understand the diagnoses, options and treatment plans.

Communication, Engagement and Shared Decision-Making

"Motivational interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."

(Miller & Rolnick, 2013)

Additional Resources

- FIGO Pregnancy Passport
- ACOG My Postpartum Care Checklist
- AIM Postpartum Transition Bundle and Resources

Questions/Comments

Next Steps:

1. Review Postpartum Discharge Transition Data Reporting Slides & Recording
2. Complete the Pre-Assessment HEART
3. Register here for office hours on August 4th
4. Submit Q2 data by July 31st (AIM data + Hemorrhage Rate data)

MDPQC

Open Discussion

Please complete the evaluation poll before you go.

Next Session

Postpartum Discharge Transition Kick-Off

August 4, 2026

Register Now

12pm – 1pm

MDPQC

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