MDPQC Office Hours

August 11, 2026

Agenda

1. Associated Black Charities
2. Guided Discussion
3. Open Q&A
4. Next Steps

Associated Black Charities

Maryland Postpartum Discharge Transition Bundle

Respectful Patient Care Capacity Building Project

Hospital & Community Partnership Kickoff Meetings

August 11, 2026
Team bi-weekly check-in meeting

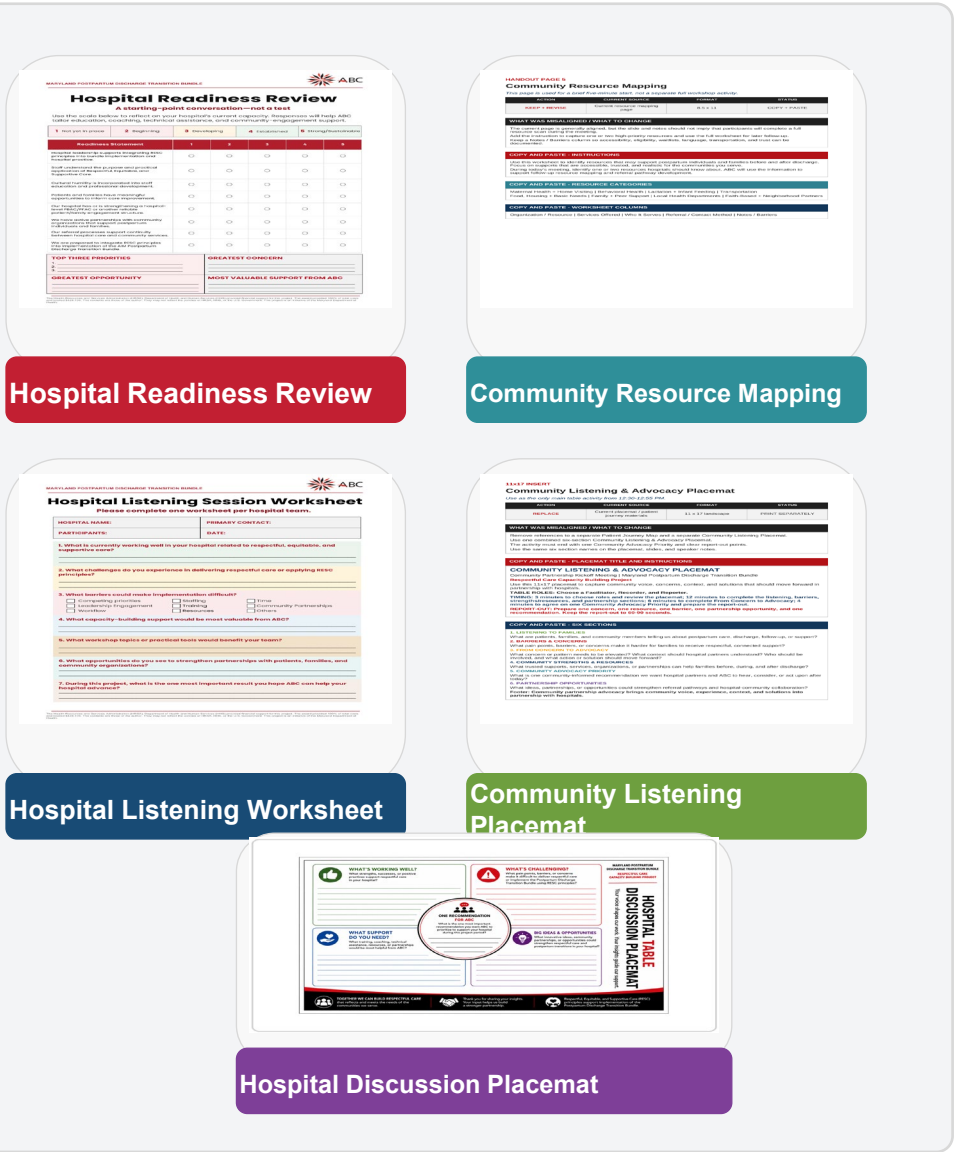
What We Heard

Hospital and Community Partnership Kickoff Meetings

Briefing for MDH and MDPQC Members

Purpose:

- **Share key themes**
- **Implementation implications where ABC needs partnership support as we move from kickoff feedback to action.**
- **Next Steps**



Who Participated

Feedback was gathered through two kickoff sessions and multiple structured tools.

55
total attendance entries across both kickoff sessions

25
Hospital Partnership Kickoff attendance

30
Community Partnership Kickoff attendance entries

14
identified hospitals represented at the hospital session

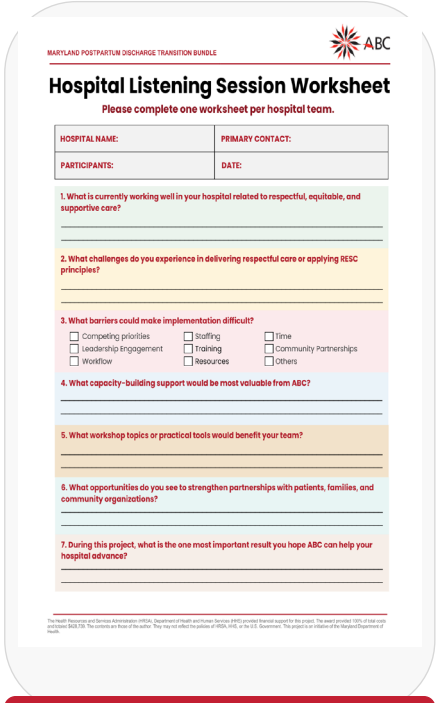
18
named community, health, academic, advocacy, and maternal health organizations

How feedback was gathered

- Kickoff discussions
- Hospital listening worksheet
- Hospital readiness review
- Community Listening & Advocacy Placemat
- Resource mapping + referral pathway tools
- Participant evaluations and report-outs

Why it matters: ABC intentionally created separate spaces so hospital teams and community partners could speak openly from their own roles, experiences, and needs.

Tools Used to Listen and Organize Feedback



MARYLAND POSTPARTUM DISCHARGE TRANSITION BUNDLE

Hospital Listening Session Worksheet

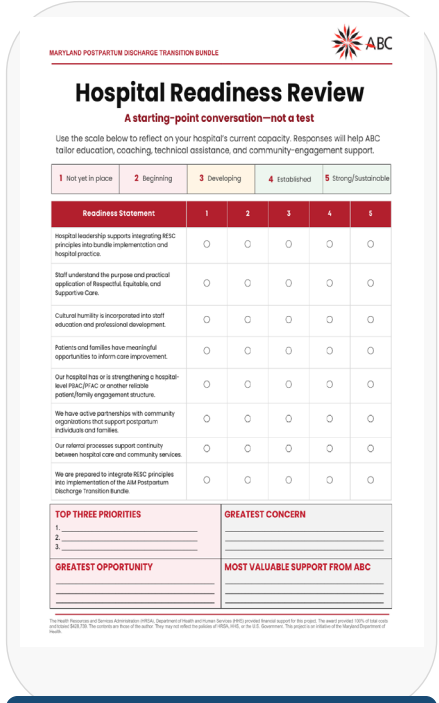
Please complete one worksheet per hospital team.

HOSPITAL NAME:	PRIMARY CONTACT:
PARTICIPANTS:	DATE:

1. What is currently working well in your hospital related to respectful, equitable, and supportive care?
2. What challenges do you experience in delivering respectful care or applying RESC principles?
3. What barriers could make implementation difficult?
   - ☐ Competing priorities ☐ Staffing ☐ Time
   - ☐ Leadership Engagement ☐ Training ☐ Community Partnerships
   - ☐ Workflow ☐ Resources ☐ Others
4. What capacity-building support would be most valuable from ABC?
5. What workshop topics or practical tools would benefit your team?
6. What opportunities do you see to strengthen partnerships with patients, families, and community organizations?
7. During this project, what is the one most important result you hope ABC can help your hospital advance?

The Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS) provided financial support for this project. The award provided 100% of total costs and totals $628,739. The contents are those of the author. They may not reflect the policies of HRSA, HHS, or the U.S. Government. This project is an initiative of the Maryland Department of Health.

Hospital Listening Session Worksheet



MARYLAND POSTPARTUM DISCHARGE TRANSITION BUNDLE

Hospital Readiness Review

A starting-point conversation—not a test

Use the scale below to reflect on your hospital's current capacity. Responses will help ABC tailor education, coaching, technical assistance, and community-engagement support.

1 Not yet in place | 2 Beginning | 3 Developing | 4 Established | 5 Strong/Sustainable

Readiness Statement	1	2	3	4	5
Hospital leadership supports integrating RESC principles into bundle implementation and hospital practice.	○	○	○	○	○
Staff understand the purpose and practical application of Respectful, Equitable, and Supportive Care.	○	○	○	○	○
Cultural humility is incorporated into staff education and professional development.	○	○	○	○	○
Patients and families have meaningful opportunities to inform care improvement.	○	○	○	○	○
Our hospital has or is strengthening a hospital-level PSAC/PFAC or another reliable patient/family engagement structure.	○	○	○	○	○
We have active partnerships with community organizations that support postpartum individuals and families.	○	○	○	○	○
Our referral processes support continuity between hospital care and community services.	○	○	○	○	○
We are prepared to integrate RESC principles into implementation of the JIM Postpartum Discharge Transition Bundle.	○	○	○	○	○

TOP THREE PRIORITIES	GREATEST CONCERN
1. 2. 3.	
GREATEST OPPORTUNITY	**MOST VALUABLE SUPPORT FROM ABC**

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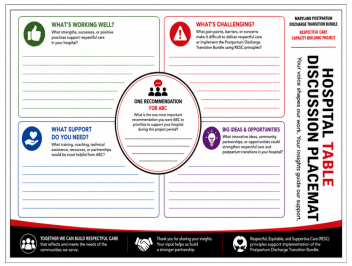
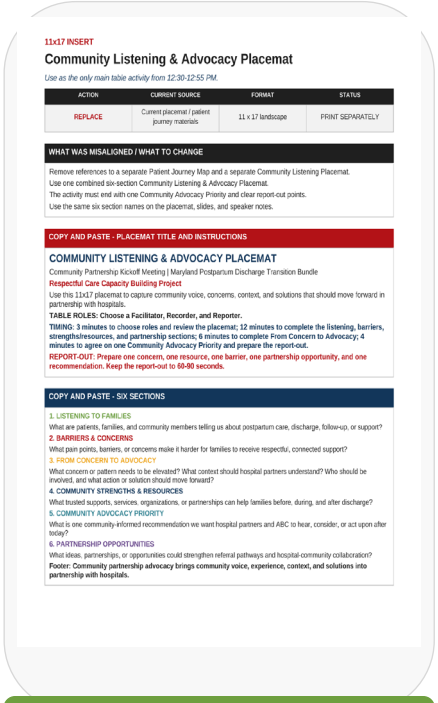
Hospital Readiness Review



Hospital Discussion Placemat



11x17 INSERT

Community Listening & Advocacy Placemat

Use as the only main table activity from 12:30-12:55 PM.

ACTION	CURRENT SOURCE	FORMAT	STATUS
REPLACE	Current placemat / patient journey materials	11 x 17 landscape	PRINT SEPARATELY

WHAT WAS MISALIGNED / WHAT TO CHANGE

Remove references to a separate Patient Journey Map and a separate Community Listening Placemat.
Use one combined six-section Community Listening & Advocacy Placemat.
The activity must end with one Community Advocacy Priority and clear report-out points.
Use the same six section names on the placemat, slides, and speaker notes.

COPY AND PASTE - PLACEMAT TITLE AND INSTRUCTIONS

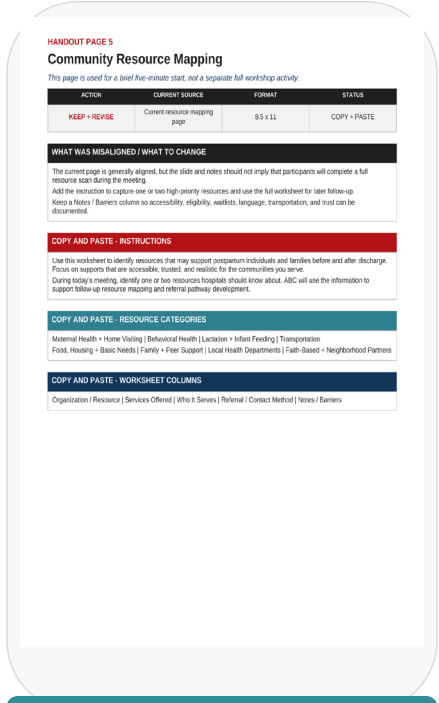
COMMUNITY LISTENING & ADVOCACY PLACEMAT

Community Partnership Kickoff Meeting | Maryland Postpartum Discharge Transition Bundle
Respectful Care Capacity Building Project
Use this 11x17 placemat to capture community voice, concerns, context, and solutions that should move forward in partnership with hospitals.
TABLE ROLES: Choose a Facilitator, Recorder, and Reporter.
TIMING: 3 minutes to choose roles and review the placemat; 12 minutes to complete the listening, barriers, strengths/resources, and partnership sections; 6 minutes to complete From Concern to Advocacy; 4 minutes to agree on one Community Advocacy Priority and prepare the report-out.
REPORT-OUT: Prepare one concern, one resource, one barrier, one partnership opportunity, and one recommendation. Keep the report-out to 60-90 seconds.

COPY AND PASTE - SIX SECTIONS

1. LISTENING TO FAMILIES
What are patients, families, and community members telling us about postpartum care, discharge, follow-up, or support?
2. BARRIERS & CONCERNS
What pain points, barriers, or concerns make it harder for families to receive respectful, connected support?
3. FROM CONCERN TO ADVOCACY
What concern or pattern needs to be elevated? What context should hospital partners understand? Who should be involved, and what action or solution should move forward?
4. COMMUNITY STRENGTHS & RESOURCES
What trusted supports, services, organizations, or partnerships can help families before, during, and after discharge?
5. COMMUNITY ADVOCACY PRIORITY
What is one community-informed recommendation we want hospital partners and ABC to hear, consider, or act upon after today?
6. PARTNERSHIP OPPORTUNITIES
What ideas, partnerships, or opportunities could strengthen referral pathways and hospital-community collaboration?
Footer: Community partnership advocacy brings community voice, experience, context, and solutions into partnership with hospitals.

Community Listening & Advocacy Placemat



HANDOUT PAGE 5

Community Resource Mapping

This page is used for a brief five-minute start, not a separate full workshop activity.

ACTION	CURRENT SOURCE	FORMAT	STATUS
KEEP + REVISE	Current resource mapping page	8.5 x 11	COPY + PASTE

WHAT WAS MISALIGNED / WHAT TO CHANGE

The current page is generally aligned, but the slide and notes should not imply that participants will complete a full resource scan during the meeting.
Add the instruction to capture one or two high-priority resources and use the full worksheet for later follow-up.
Keep a Notes / Barriers column so accessibility, eligibility, waitlists, language, transportation, and trust can be documented.

COPY AND PASTE - INSTRUCTIONS

Use this worksheet to identify resources that may support postpartum individuals and families before and after discharge. Focus on supports that are accessible, trusted, and realistic for the communities you serve.
During today's meeting, identify one or two resources hospitals should know about. ABC will use the information to support follow-up resource mapping and referral pathway development.

COPY AND PASTE - RESOURCE CATEGORIES

Maternal Health + Home Visiting | Behavioral Health | Lactation + Infant Feeding | Transportation
Food, Housing + Basic Needs | Family + Peer Support | Local Health Departments | Faith-Based + Neighborhood Partners

COPY AND PASTE - WORKSHEET COLUMNS

Organization / Resource | Services Offered | Who It Serves | Referral / Contact Method | Notes / Barriers

Community Resource Mapping

These tools shaped the feedback themes: readiness, barriers, community resources, referral pathways, advocacy priorities, and support needed from ABC.

What We Heard from Hospitals

Hospitals have commitment and existing practices, but asked ABC to help "connect the dots."

Strong foundation already exists

Discharge education, BP monitoring, home-visiting referrals, care navigators, safe-sleep education, and respectful-care trainings are already in motion.

Resource navigation is fragmented

Hospitals reported difficulty identifying county-specific resources, referral options, points of contact, and community partners.

Implementation needs to be practical

Hospitals requested action-oriented learning, case examples, communication strategies, tools, videos, and onboarding resources.

Readiness varies across hospitals

Leadership buy-in, staff time, workflows, community partnerships, and patient/family engagement structures differ across sites.

Consistent hospital request: help us connect systems, partners, practices, and resources in a way teams can actually use.

What We Heard from Community Partners

Community partners emphasized voice, trust, whole-family support, and a connected system.

Community message:

Families need a connected system—not disconnected services.

Discharge should be understood as the start of an ongoing support journey, not the end of care.

Key themes from the community session

Voice at the table must be meaningful	Community partners want to be heard, valued, represented, and engaged before decisions are final.
Families need better navigation	Patients may not know rights, resources, next steps, or who to call after discharge.
Trust and relationships matter	Respectful care requires listening, responsiveness, consistent communication, and follow-through.
Whole-family support is essential	Partners named fathers, caregivers, behavioral health, transportation, housing, safety, legal, and faith supports.

Where Hospital and Community Feedback Converged

Different starting points, closely aligned priorities.

Hospitals

Need support integrating respectful care into workflows, building buy-in, and navigating resources.

Shared Priorities

- ✓ Stronger hospital-community relationships
- ✓ Clear resource and referral pathways
- ✓ Warm handoffs and follow-through
- ✓ Patient, family, and community voice
- ✓ Practical tools, examples, and coaching
- ✓ Sustainable implementation supports

Community Partners

Need authentic partnership, warm handoffs, clear pathways, and family-centered support after discharge.

The bridge is the work: connecting care, community, communication, and accountability.

How ABC Will Use the Feedback

The feedback will shape individualized Respectful Care capacity-building support.

1 Listen

Review kickoff themes and hospital-specific priorities.

2 Map

Identify community resources, gaps, and referral pathways.

3 Connect

Facilitate hospital-community introductions and structured conversations.

4 Build

Deliver workshops, coaching, tools, examples, and TA.

5 Sustain

Support hospital-level PBAC/PFAC engagement and workflow integration.

Respectful Care capacity-building activities

- Respectful Care Learning Series
- Coaching and technical assistance
- Community resource mapping
- Referral pathway and warm-handoff support
- Hospital-level PBAC/PFAC support where appropriate
- Evaluation, shared learning, and sustainability planning

Design principle

Standardized statewide approach with flexibility for hospital readiness, community context, geography, and existing partnerships.

Hospital Cohort Structure

1 BALTIMORE METRO

11 HOSPITALS

Core Baltimore-area hospitals with established urban and metropolitan referral relationships.

HOSPITAL MEMBERSHIP

- Ascension St. Agnes Hospital
- Johns Hopkins Bayview Medical Center
- Johns Hopkins Hospital
- LifeBridge Sinai Hospital
- MedStar Franklin Square Medical Center
- MedStar Harbor Hospital
- Mercy Medical Center
- University of Maryland Medical Center
- Greater Baltimore Medical Center
- University of Maryland St. Joseph Medical Center
- Howard County Medical Center

2 MONTGOMERY, CAPITAL REGION & SOUTHERN MARYLAND

10 HOSPITALS

Montgomery and Prince George's County hospitals aligned with Southern Maryland referral patterns and the broader capital-region service area.

HOSPITAL MEMBERSHIP

- Holy Cross Hospital
- Holy Cross Germantown Hospital
- Adventist HealthCare Shady Grove Medical Center
- Adventist HealthCare White Oak Medical Center
- MedStar Montgomery Medical Center
- University of Maryland Capital Region Medical Center
- MedStar Southern Maryland Hospital Center
- University of Maryland Charles Regional Medical Center
- MedStar St. Mary's Hospital
- CalvertHealth Medical Center

3 CHESAPEAKE BAY, ANNE ARUNDEL & EASTERN SHORE

5 HOSPITALS

Hospitals connected through Chesapeake Bay referral and service relationships, including Anne Arundel and Eastern Shore access pathways.

HOSPITAL MEMBERSHIP

- Luminis Health Anne Arundel Medical Center
- University of Maryland Baltimore Washington Medical Center
- University of Maryland Upper Chesapeake Medical Center
- University of Maryland Shore Regional Health
- TidalHealth Peninsula Regional

4 WESTERN & RURAL MARYLAND

5 HOSPITALS

Hospitals serving rural and geographically dispersed communities in Western and north-central Maryland.

HOSPITAL MEMBERSHIP

- Carroll Hospital
- Frederick Health Hospital
- Meritus Medical Center
- UPMC Western Maryland
- Garrett Regional Medical Center

Hospital's Maternal Health Levels

Cohort structure for implementation of Respectful Care capacity-building support.

Maternal Level 1

- Calvert Health Medical Center
- Garrett Regional Medical Center
- MedStar St. Mary's Hospital
- University of Maryland Charles Regional Medical Center
- University of Maryland Shore Medical Center at Easton

Maternal Level 2

- Adventist Health Care White Oak Medical Center
- Carroll Hospital Center
- Holy Cross Germantown Hospital
- MedStar Harbor Hospital
- MedStar Montgomery Medical Center
- MedStar Southern Maryland Hospital Center
- Meritus Medical Center
- Tidal Health Peninsula Regional Medical Center
- University of Maryland Baltimore Medical Center
- University of Maryland Upper Chesapeake Medical Center
- UPMC Western Maryland

Maternal Level 3

- Adventist HealthCare Shady Grove Medical Center
- Ascension Saint Agnes Hospital
- Frederick Health Hospital
- Greater Baltimore Medical Center
- Holy Cross Hospital
- Johns Hopkins Bayview Medical Center
- Johns Hopkins Howard County Medical Center
- LifeBridge Health Sinai Hospital
- Luminis Health Anne Arundel Medical Center
- MedStar Franklin Square Medical Center
- Mercy Medical Center
- University of Maryland Capital Region Medical Center
- University of Maryland St. Joseph Medical Center

Maternal Level 4

- The Johns Hopkins Hospital
- University of Maryland Medical Center

Clarify from MDH and MDPQC Members

A clear partnership ask will help move from feedback to implementation.

From MDH

Role clarity and messaging	Reinforce the aligned MDH/HQI/ABC language so hospitals understand where to turn.
Support coordinated follow-up	Provide visibility and urgency as ABC schedules readiness sessions and follow-up.
Reduce duplication	Identify related efforts, state resources, and communication channels ABC should align with.
Lift barriers early	Resolve statewide or policy-level issues that surface across hospitals and regions.

From MDPQC Members

Hospital connections	Encourage hospital teams to identify leads, complete readiness conversations, and engage in TA.
QI and data alignment	Connect ABC feedback themes to implementation learning and improvement priorities.
Community-informed pathways	Share local knowledge about resources, gaps, referrals, and community partnerships.
Learning loop	Surface lessons, promising practices, and concerns that should inform coaching and shared learning.

The ask: Help ABC turn what we heard into coordinated, credible, and actionable support for hospitals and communities.

Immediate Next Steps

Moving from kickoff feedback to implementation support.

1 Finalize summaries

Share hospital and community feedback summaries as follow-up attachments.

2 Schedule readiness sessions

Hold individualized conversations with participating hospitals.

3 Map resources

Begin county and regional community resource and referral mapping.

4 Connect partners

Identify aligned hospital-community partnership opportunities.

5 Launch supports

Begin Respectful Care learning, coaching, TA, and shared learning activities.

Call To Action

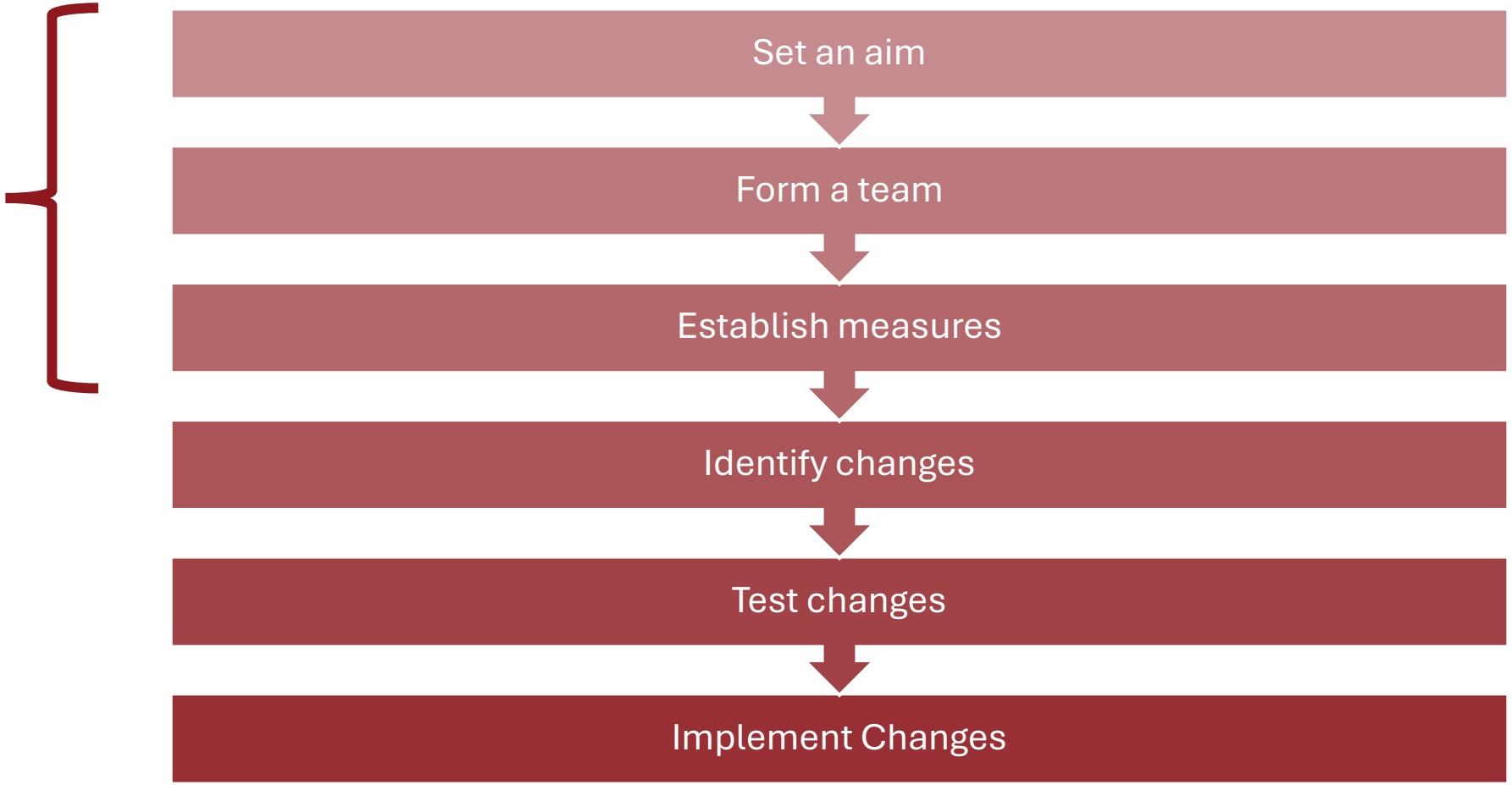
1. Register for the next in-person session on August 26, 2026
2. Sign Up for your Readiness Call

Hospitals and community partners are ready to work together. They need clear pathways, trusted relationships, practical tools, and sustained support.

Guided Discussion on Getting Started

The Quality Improvement Process

Steps for an improvement team in a clinical setting:



The Quality Improvement Process

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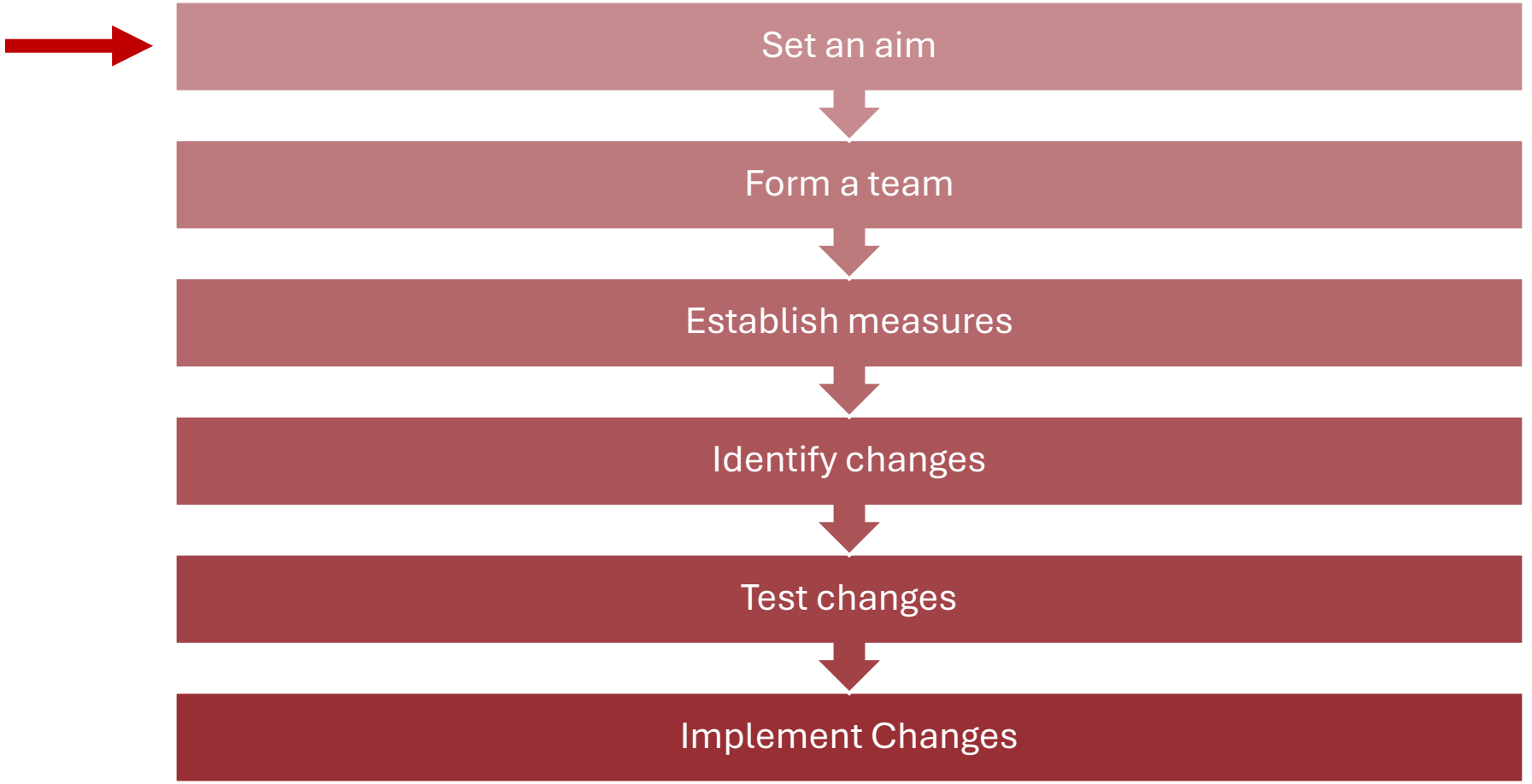


MDPQC Goals

Postpartum Discharge Transition

- Implement the AIM Postpartum Discharge Transition Patient Safety Bundle in all Maryland hospitals
- Improve quality of care and outcomes during a critical period in which patients are at risk for morbidity and mortality
- Support relationships between hospitals and community stakeholders
- Promote equitable care for all patients

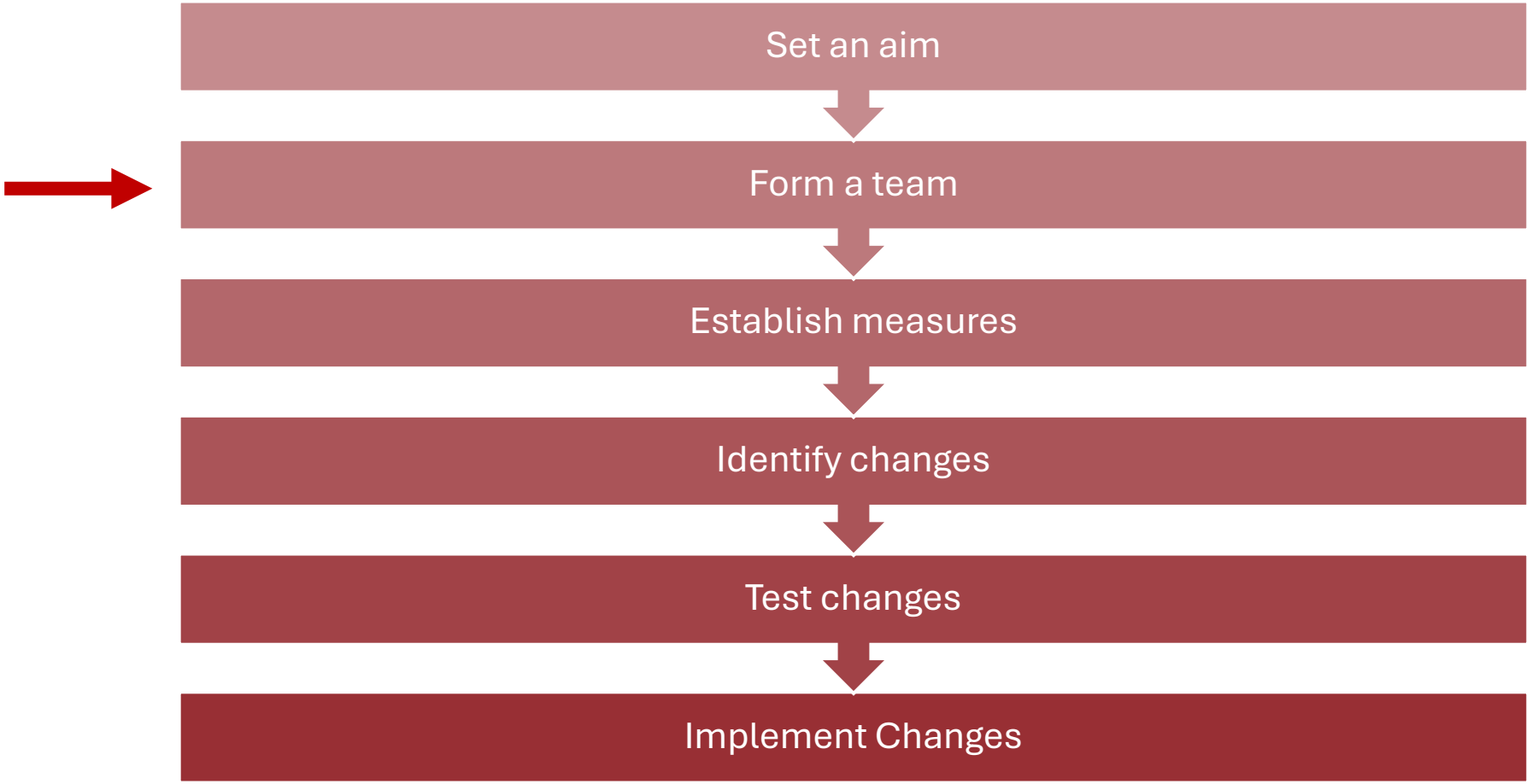
What are you hoping to accomplish in your facility?

Substance Exposed Newborns

- Standardize substance use screening for mothers at L&D intake.
- Improve identification of and care for Substance Exposed Newborns and their families.
- Decrease the length of stay for substance exposed newborns.
- Connect families impacted by substance use to appropriate follow-up services and community-based supports prior to discharge.
- Empower parents and caregivers to care for infants with in-utero substance exposure.
- Support hospitals to implement Eat-Sleep-Console methodology.

The Quality Improvement Process

Steps for an improvement team in a clinical setting:



Forming Your QI Team

Team Members

- L&D, Mother-Baby, NICU/SCN
- Nurses
- Physicians
- Midwives
- Doulas
- Quality
- Social Work
- Lactation
- Navigators
- Lab
- ED
- OR
- IT/EMR

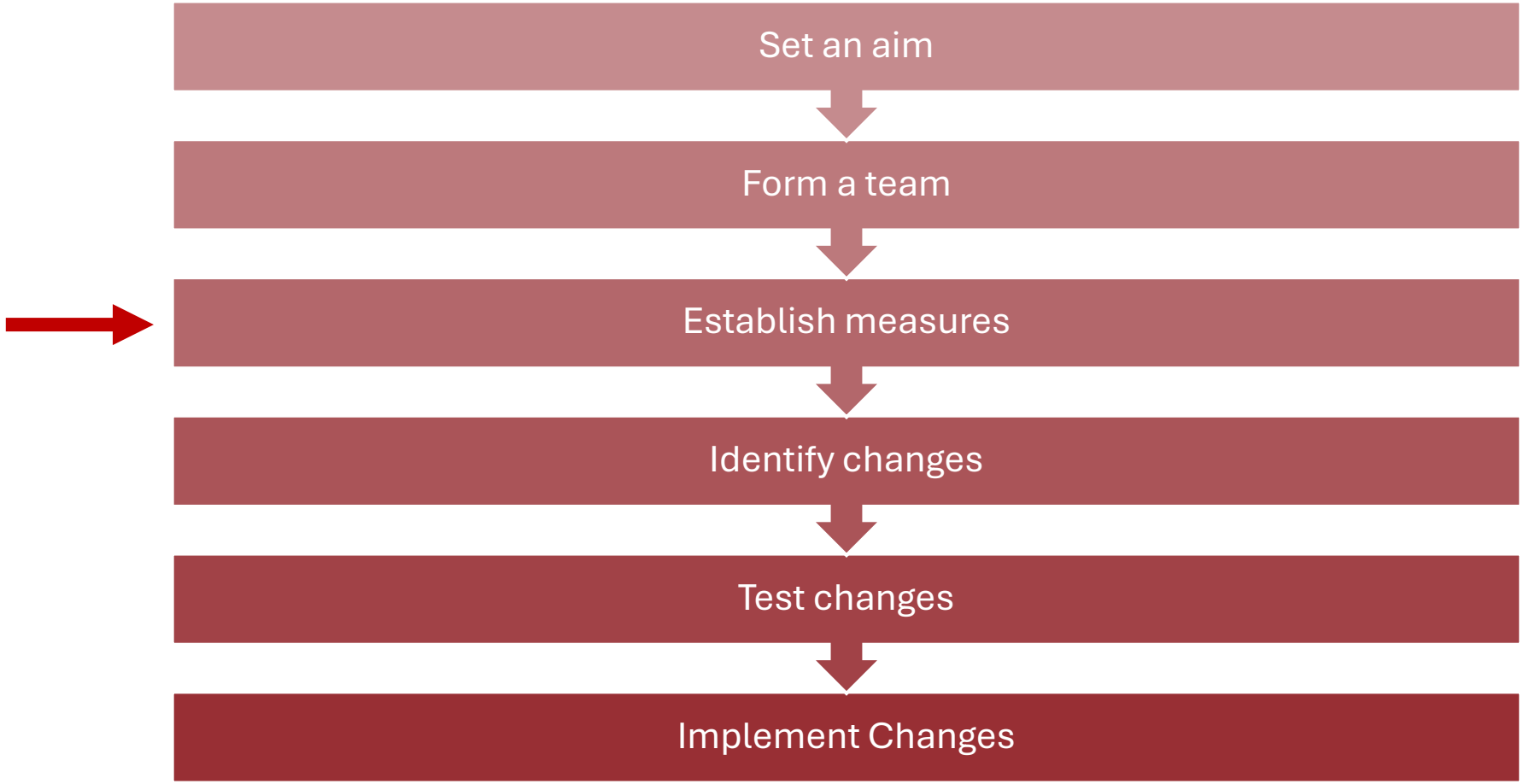
Who else is on your team?

Team Activities

- Regular meetings
- Data collection and review
- Identify opportunities for improvement
- Plan QI activities
- Protocol/policy review/development

The Quality Improvement Process

Steps for an improvement team in a clinical setting:



Postpartum Discharge Transition Measures

	PROCESS MEASURES	STRUCTURE MEASURES
PDT 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
Sustainability Measures:	1. Timely Treatment for Severe Hypertension 2. Number of Drills 3. Hemorrhage Rate (via separate MS Form)	

Full Data Collection Plan Available Here

Reported as: Yes/No/In Development

Full measures available in June office hours slides

SEN Structure Measures

Measure
Hospital provides standardized staff education on compassionate, non-judgmental screening, patient education, and support
Hospital uses standardized definitions of SEN/NAS
Hospital uses a standardized screening protocol for maternal substance use at L&D intake, reviewed and updated based on legal requirements and best practices.
Hospital uses a standardized protocol for referral to Child Protective Services related to in-utero substance use, reviewed and updated based on legal requirements and best practices.
Hospital has established non-pharmacologic treatment protocols
Hospital uses Eat-Sleep-Console in the Nursery / Hospital uses Eat-Sleep-Console in the SCN/NICU
Hospital has created or procured a comprehensive list of community resources, customized to include resources relevant for pregnant and postpartum people, that will be shared with all postpartum inpatient nursing units, the SCN/NICU, and outpatient pediatricians.
Hospital has created a standardized Plan of Safe Care template and protocol for families being discharged
Hospital has established a mechanism of obtaining feedback from parents and caregivers about their care experience and regularly reviews this feedback.
Hospital provides additional safe sleep education specifically tailored to substance exposed newborn populations, above and beyond standard practice for a typical discharge.

Data Reporting

- **What questions do you have?**
- **Where are your challenges within the measures?**
- **What are your barriers to reporting?**
- **Is anyone building a report?**


Q
&
A

Open Discussion

Please complete the evaluation poll before you go.

Next Session

MDPQC Annual Meeting

September 22, 2026

Register Now

9am – 3pm

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