Postpartum Initiatives

Objective 1.1— By 2030, increase the postpartum visit attendance rate from 92.1% to 94.4%.

Optimizing Postpartum Care: The Title V Women/Maternal and Perinatal/Infant (P/I) Consultants will continue to add to the existing MCH Integration Toolkits and Action Alerts by creating additional resources to support local health agencies in educating women about the importance of the postpartum visit and comprehensive medical services available to them throughout the postpartum period, utilizing ACOG's Committee Opinion on Optimizing Postpartum Care as the basis of this work. The plan is to develop an algorithm and other graphic-based resources for integration into existing resources, including the Maternal Warning Signs (MWS) and Perinatal Hypertension (PHTN) Provider/Patient Education Guides. These resources will be integrated into existing Title V supported programs such as Home Visiting (HV), Becoming a Mom®/Comenzando bien® (BaM/Cb) prenatal education and Part C. Resources will also be disseminated through existing partnerships with Women, Infants and Children (WIC), the Kansas Perinatal Community Collaborative (KPQC), the state's Doula and midwife networks, as well as utilized by Kansas Perinatal Community Collaborative (KPCC) Regional Coordinators during their targeted outreach to outpatient clinical perinatal and family practice providers.

Expanding Postpartum Visit Options: The Screening and Surveillance Section within KDHE's BFH, which also houses Title V, is developing a pilot program that will use certified nurse midwives and/or registered nurse home visitors to redraw newborn screening samples for families with limited access to health care or have limited transportation. Ove the next year, the Title V leadership team will evaluate this program and the potential it may have for increasing the postpartum visit. The team will assess the feasibility of using mid-level providers for this service and if reimbursement is possible or how reimbursement strategies might have to be changed before this could happen. From there a decision will be made whether this is something that Title V should pilot.

AIM Patient Safety Bundles: In October 2021, the Kansas Perinatal Quality Collaborative (KPQC) enrolled as an AIM state implementing the Postpartum Discharge Transition (PPDT) patient safety bundle, known in Kansas as the Fourth Trimester Initiative (FTI). In December 2024, Kansas moved from the implementation phase of the FTI to sustaining which includes the following PPDT bundle components: postpartum visit scheduling prior to discharge from labor and delivery, chronic disease management and referral, behavioral health (including mental health and substance use disorder) screening and referral, breastfeeding, prevention of health disparities, care coordination and access to care.

Postpartum visit scheduling will continue as a core component of the Severe Hypertension in Pregnancy (SHTN) AIM bundle (See P/I plan for more details) for patients with a routine pregnancy/delivery course, and for those diagnosed with a hypertensive disorder of pregnancy/postpartum (HDP), including preeclampsia. Patients diagnosed with a HDP and/or preeclampsia will have a follow up appointment scheduled prior to hospital/clinic discharge following the American College of Obstetricians and Gynecologists (ACOG) Postpartum Surveillance algorithm.

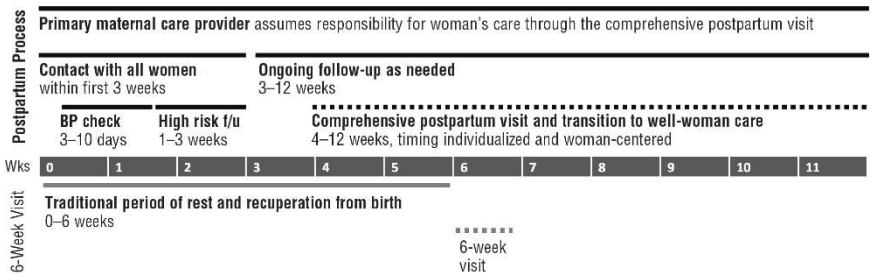


Figure 1. Proposed paradigm shift for postpartum visits. The American College of Obstetricians and Gynecologists' Presidential Task Force on Redefining the Postpartum Visit and the Committee on Obstetric Practice propose shifting the paradigm for postpartum care from a single 6-week visit (bottom) to a postpartum process (top). Abbreviations: BP, blood pressure; f/u, follow-up. ⇦

The W/M Consultant and P/I Consultant will continue to work closely with the KPQC Coordinator to support their efforts in sustaining the PPDT safety bundle and in the implementation of the SHTN safety bundle by sharing resources (such as those listed above under "Optimizing Postpartum Care") for use in the in-patient setting, as well as connecting efforts in the community setting through our Title V services and the KPCC led outreach to outpatient clinical perinatal and family practice providers. Additionally, consistent repeat messaging will be continued during training provided in both the clinical and community settings, where focus is placed on each organization and provider's role in educating, screening and connecting to services, as is outlined in the below flowcharts.

Goal: Clear, Consistent, Repeat Education and Messaging across all providers in the community on key Maternal Child Health topics.

Additionally, care coordination and warm connection to resources occurs across all perinatal periods.

KPCC Kansas Perinatal Community Collaboratives

FOURTH TRIMESTER INITIATIVE

KPCC Kansas Perinatal Community Collaboratives

(Prenatal)

- Prenatal Clinical Care
- Primary Care
- Group Prenatal Educ. (BaM)
- Home Visiting
- Community Health Worker
- Doula Support
- Peer Support
- WIC
- MCH (Title V)
- Family Planning (Title X)
- Behavioral Health

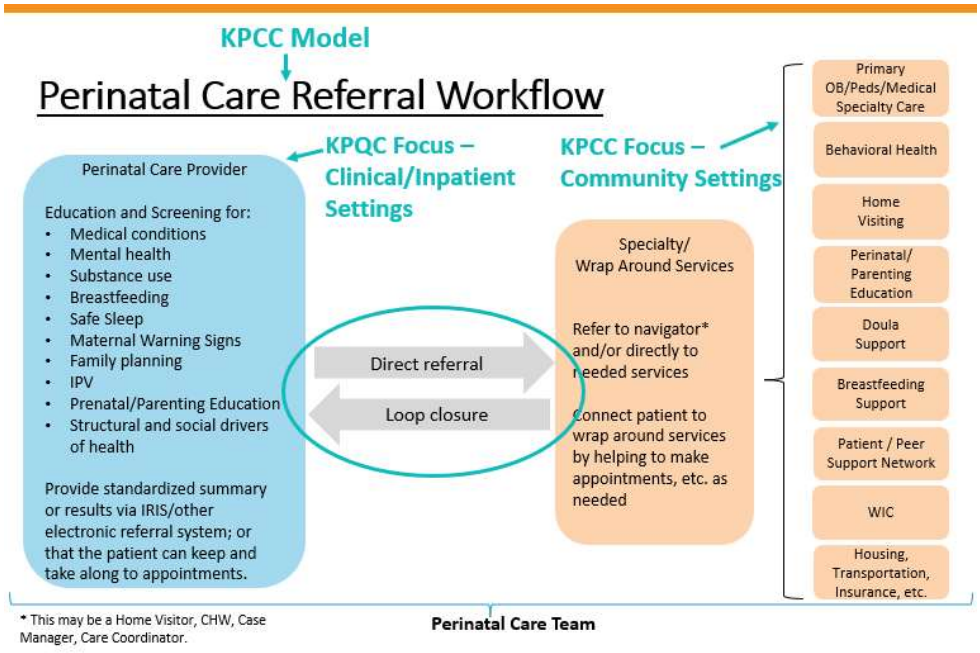
(Hospital)

Key Focus Areas:

- Perinatal Mood & Anxiety Disorders
- Substance Use
- Maternal Warning Signs
- Breastfeeding
- Safe Sleep
- Family Planning
- Intimate Partner Violence
- SDOH

(Postpartum)

- Postpartum Clinical Care
- Primary Care
- Early Childhood
- Home Visiting
- Community Health Worker
- Doula Support
- Peer Support
- WIC
- MCH (Title V)
- Family Planning (Title X)
- Behavioral Health


KPCC Model
Perinatal Care Referral Workflow
KPQC Focus – Clinical/Inpatient Settings
KPCC Focus – Community Settings
Perinatal Care Provider
Education and Screening for:
• Medical conditions
• Mental health
• Substance use
• Breastfeeding
• Safe Sleep
• Maternal Warning Signs
• Family planning
• IPV
• Prenatal/Parenting Education
• Structural and social drivers of health
Provide standardized summary or results via IRIS/other electronic referral system; or that the patient can keep and take along to appointments.
Direct referral
Loop closure
Specialty/ Wrap Around Services
Refer to navigator* and/or directly to needed services
Connect patient to wrap around services by helping to make appointments, etc. as needed
Primary OB/Peds/Medical Specialty Care
Behavioral Health
Home Visiting
Perinatal/ Parenting Education
Doula Support
Breastfeeding Support
Patient / Peer Support Network
WIC
Housing, Transportation, Insurance, etc.
* This may be a Home Visitor, CHW, Case Manager, Care Coordinator.
Perinatal Care Team