Postpartum Discharge Transition Bundle

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To address the postpartum period, specifically focusing on key transition periods, such as hospital discharge to outpatient obstetrical care and ongoing specialist care as needed.

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.

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.

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.

*See **Postpartum Discharge Element Implementation Details**

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.

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 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.

*See **Postpartum Discharge Element Implementation Details**

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Respecful, Equitable, and Supportive Care — Every Unit/Provider/Team Member

Include each 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.

*See **Postpartum Discharge Element Implementation Details**

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