



BACKGROUND

Maternal Health Crisis: In the United States, inequitable obstetric care leads to a staggering maternal mortality ratio of 18.6 deaths per 100,000 live births. This crisis carries a heavy financial burden, costing \$32.3 billion in 2019 and continues to rise.

Comprehensive approach: The program addresses both clinical and social needs to improve overall maternal health outcomes.

Purpose: This quality improvement project aims to analyze the impact of the Transition of Care (TOC) bundle of interventions on postpartum readmissions, and identify critical interventions effective in addressing gaps in care.

METHODS

Setting: Eight acute care hospitals at a large hospital-network (NJ)

Population: Discharged Postpartum patients

Design: Retrospective data review

Program Process: A nurse-led TOC team trained to review Epic for eligible patients for program enrollment. A face-to-face screening takes place using the approved tools for SDOH, depression, and substance use. The team develops a patient-centered care plan and communicates the information to the rest of the multidisciplinary team and community partners.

STAFFING MODEL

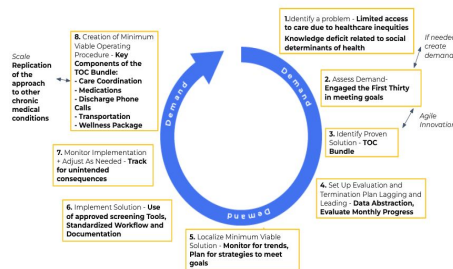
Corporate:
SVP Associate Chief Quality Officer
VP of Women & Community Quality Improvement
Director of Community Health Quality
Data Quality & Operations Manager
Project Managers
Research Nurse Coordinator
Administrative Assistant

Regional:
Regional Managers

TOC Team:
Nurse Navigators
Navigators
Transitions Assistants
Care Coordinator

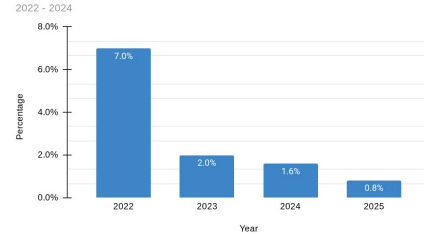
RESULTS

Agile Methodology



This patient-centered program significantly lowered hospital readmissions for maternal health patients from 7% in 2022 to 1.6% in 2024. These efforts resulted in 100% appointment scheduling and a 73% attendance rate among the program's participants, with 77% of enrolled patients attending appointments.

QIP Maternal Health 30 Day Re-admissions



TOC Interventions	Number of Services
Meds-to-Beds	1,880
Food insecurity services	948
Transportation Assistance	702
Postpartum visits	3,244
Incision checks	1,286
Blood pressure monitoring appointments	672
Follow-up phone calls	15,140

TOC INTERVENTIONS

- Care Coordination**
Postpartum follow-up with PCPs & Other Specialists
- Medications**
Free of any cost and co-pay assistance, 30-day supply before discharged
- Discharge Phone Calls**
Risk stratified calls (High, Med, & Low)
- Transportation**
To all f/u appointments; SDOH needs
- Wellness Package**
Blood pressure monitors, food insecurity gift card, etc.

DMAIC PROCESS IMPROVEMENT MODEL

- Define**
Volume of birthing patients attending post-discharge appointments and hospital readmissions
- Measure**
Collected patient readmission data
- Analyze**
Fishbone diagram identified causes of readmissions and opportunities for improvement
- Improve**
Implemented interventions to reduce readmissions and provide additional training
- Control**
Track metrics, continue to educate/train team members, and conduct clinical/leadership rounds



Scan the QR code and see the impact The First Thirty (QIP-NJ) program has on the lives of maternal health patients!

METRICS

- MH1 Severe Maternal Morbidity
- MH2 Cesarean Birth
- MH3 Postpartum Depression Screening
- MH4 Postpartum Care
- MH5 Initiation & Engagement of ETOH & Other Drug use or Dependence Treatment in Pregnant Women
- MH6 Timely Transmission of EHR
- MH7 Treatment of SHTN
- MH8 3-Item Care Transitions Measure (CTM-3)
- MH9 SDOH Screening

CONCLUSIONS

- Patient-centered care** focusing on social determinants of health (SDoH) improved maternal health outcomes.
- Agile and DMAIC** methodologies effectively reduced readmissions, enhanced care coordination, and boosted patient engagement.
- Further research is needed to assess long-term effects and scalability.