Improving Postpartum Access to Care (IPAC): Getting Started with the IPAC Toolkit and debrief from Face-to-Face Meeting

June 17, 2019
11:00 AM – 12:00 PM
Introductions

- Please enter for yourself and all those in the room with you viewing the webinar into the chat box your:
  - Name
  - Role
  - Institution
- If you are only on the phone line, please be sure to let us know so we can note your attendance

Please enter the name, role and institution of yourself and all those in the room viewing the webinar.
Overview

• Why IPAC & Initiative overview
• IPAC Aims and Measures
• IPAC Data Form
• IPAC Toolkit
• Takeaways from Face-to-Face and baseline evaluation
• Next Steps
Improving Postpartum Access to Care (IPAC)

WHY IPAC- INITIATIVE OVERVIEW
Redefining Postpartum Care

ACOG Committee Opinion #736:

• To **optimize** the health of women and infants, postpartum care should **become an ongoing process**, rather than a single encounter

• **All women** should ideally have contact with maternal care provider **within the first 3 weeks postpartum**
  - Blood pressure checks
  - Breastfeeding support
  - Mental health well-being
  - Contraception

• Initial assessment should be followed up with **ongoing care as needed**

• Conclude with a **comprehensive postpartum visit NO LATER than 12 after birth**
REVIEW OF MMRC REPORT
Key Recommendations from the MMRC report

• **For Providers:**
  • Providers should adopt the recent recommendation from the American College of Obstetricians and Gynecologists (ACOG) for early postpartum visit in addition to traditional 6 week visit

• **For Hospitals:**
  • Birthing hospitals should ensure that women are connected with a primary care or obstetrical provider and scheduled for a postpartum visit prior to hospital discharge

• **For Health Plans:**
  • Illinois should expand Medicaid eligibility for the postpartum period from 60 days to one year after delivery and health insurance plans should cover case management and outreach for postpartum high-risk women for up to one year after delivery
  • Health insurance plans should separate payment for visits in the postpartum period from labor and delivery (unbundle postpartum visit services from labor and delivery)

Maternal Morbidity in the Early Postpartum Period

- 50% of postpartum strokes occur within 10 days of discharge
- 20% of women discontinue breastfeeding before the first 6-weeks
- Up to 40% of women do not attend the 6-week postpartum visit
- As many as 1 in 5 women experience a postpartum mental health disorder
Components of the Early Postpartum Visit

Maternal Health Safety Check

- Blood pressure / preeclampsia symptoms check
- Wound/ perineum check
- Assess appropriate postpartum bleeding
- Mood check/depression screening
- Breastfeeding support
- Family planning/contraception options
- Linkage to health / community services (ie. WIC, breastfeeding support, home visits)
- Assess medical / pregnancy complications, including SUD/OUD risks and link to needed follow up care
- Review risk reduction strategies for future pregnancies
IPAC Clinical Leads

• Clinical Leads:
  – Michelle Bucciero, St. Anthony Hospital
  – Jeanne Goodman, Loyola University Medical Center
  – Kelli Lewis, Franciscan Health Olympia Fields
  – Lisa Masinter, Erie Health Center

• Clinical leads work with ILPQC to develop and refine data project aims/measures, data collection, scope, etc.
IPAC Teams to Date

1. AMITA Alexian Brothers Women’s & Children’s Hospital – Hoffman Estates
2. AMITA Alexian Brothers Hospital – Elk Grove Village
3. AMITA Resurrection Medical Center - Chicago
4. Loyola University Medical Center - Maywood
5. FHN Memorial Hospital - Rockford
6. Franciscan Health Olympia Fields - Olympia Fields
7. Touchette Regional Hospital – East St. Louis
8. SSM St. Mary’s – Centralia
9. St. Joseph Hospital – Chicago
10. Morris Hospital & Healthcare Centers – Morris
11. St. Margaret’s Health- Spring Valley
12. UI Health – Chicago
Improving Postpartum Access to Care (IPAC)

IPAC AIMS AND MEASURES
Setting IPAC Aim
Creating SMART AIMS

<table>
<thead>
<tr>
<th>S</th>
<th>Specific</th>
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<tbody>
<tr>
<td>M</td>
<td>Measureable</td>
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<tr>
<td>A</td>
<td>Attainable</td>
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<tr>
<td>R</td>
<td>Relevant</td>
</tr>
<tr>
<td>T</td>
<td>Time bound</td>
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- Within 11 months of initiative start, ≥80% of participating hospitals will implement universal early postpartum visits (within 2 weeks) and be able to facilitate scheduling prior to hospital discharge.
ILPQC Improving Postpartum Access to Care (IPAC) Initiative

**Aim:** Within 11 months of initiative start, ≥80% of participating hospitals will implement universal early postpartum visits (within 2 weeks) and be able to facilitate scheduling prior to hospital discharge

To **optimize** the health of women by increasing access to early postpartum care within the first two weeks postpartum to facilitate follow-up as an ongoing process, rather than a single 6-week encounter and provide an opportunity for a maternal health safety check and link women to appropriate services.

**Key Goals:**

- Increase % of women with an early postpartum visit scheduled with an OB provider within the first two weeks after delivery
- Increase % of women receiving focused postpartum education prior to discharge after delivery
- Increase % of providers / staff receiving education on optimizing early postpartum care
- Achieve GO LIVE goal to provide IPAC for ≥80% participating hospitals by May 2020
Within 11 months of initiative start, ≥80% of participating hospitals will implement universal early postpartum visits (within 2 weeks) and be able to facilitate scheduling prior to hospital discharge.

**AIM**

**Primary Key Drivers**

- Utilize provider outpatient packet to engage OB providers and outpatient care sites to help plan for early pp visit scheduling, obtain buy-in from providers, and share options for billing and coding.
- Implement process flow to facilitate universal scheduling of early pp visits prior to delivery discharge.
- Implement provider and nurse education on risks of the postpartum period, benefits of early pp visit, and key components of maternal health safety check.
- Standardize system to provide patient education prior to hospital discharge on the benefits of early pp visit, early pp warning signs, and benefits of pregnancy spacing and options for (outpatient) family planning.

**Secondary Key Drivers**

- Obtain buy-in from OB providers and outpatient care sites on national recommendations and benefits for an early pp visit within 2 weeks.
- Provide billing and coding information to OB providers and outpatient care sites for the early pp visit within 2 weeks.
- Create a hospital specific process flow to help facilitate scheduling of an early pp visit within 2 weeks prior to discharge.
- Revise policies and procedures to ensure scheduling for an early pp visit within 2 weeks.
- Develop strategy to educate inpatient and outpatient providers and staff using IPAC slide set, OB Provider Packet, and/or didactic education.
- Plan in place for ongoing and new hire education.
- Patient education materials selected: benefits of early pp visit/ components of maternal health safety check, early pp warning signs and how to seek care (AWHONN), benefits of healthy pregnancy spacing/(outpatient) family planning options.
- Implement system to provide and review IPAC patient education prior to hospital discharge.

**IPAC Key Driver Diagram**

**IL&PQC**

Illinois Perinatal Quality Collaborative
Establishing Measures
Types of Measures

**Structural**
- What system changes will you implement?
- Factors/Features of your system that will impact your providers implementation

**Process**
- How do you achieve your aim?
- Providers actions that will affect the outcomes

**Outcome**
- What are the results towards your aim?
- Patient’s experience and outcomes

**Balancing**
- Are there unintended consequences?
- Outcomes your system experiences from the changes
## Overall Initiative Aim

Within 11 months of initiative start, ≥80% of participating hospitals will implement universal early postpartum visits (within 2 weeks) and be able to facilitate scheduling prior to hospital discharge.

## Structure Measures

- IPAC protocol/process flow in place for facilitating scheduling of early postpartum visits with affiliated outpatient care sites and OB providers prior to discharge.
- Communicate recommendation/strategy for early postpartum visit and obtain buy-in with OB providers/outpatient care sites (ie, share ILPQC OB provider/outpatient care site packet).

## Process Measures

- Educate all providers and staff on optimizing early postpartum care including:
  - maternal safety risks in the postpartum period
  - benefits of early postpartum care/maternal health safety check
  - protocol for facilitating scheduling early postpartum visit prior to discharge
  - documentation and billing for early postpartum visit
  - components of early postpartum visits/maternal health safety check

## Outcome Measure

- Increase % of women with documentation of an early postpartum visit/maternal health safety check encounter scheduled within the first 2 weeks of delivery.
- Increase % of patients who receive standardized pp patient education prior to discharge.
Structure Measures

help you track your implementation of systems/capacity changes

• Communicate recommendation/strategy for early postpartum visit and obtain buy-in with OB providers/ outpatient care sites (ie. share ILPQC OB provider/outpatient care site packet)
• System in place for facilitating scheduling early postpartum visits with affiliated prenatal care sites before hospital discharge
• Patient education materials selected with system to provide/review with patients before hospital discharge

Reports will display your progress in red/yellow/green
(not started, started, completed)
Process Measures
help you track your implementation of clinical practices towards culture change

• % of Physician and midwife educated on IPAC
• % of Nurse, lactation consultant, and social worker educated on IPAC

Outcome Measures
help you track your progress towards changing the health status of patients

• # of deliveries for the month
• Random sample of 10 deliveries report
  – # early postpartum follow-up plan/counseling documented prior to hospital discharge
  – # early postpartum visits scheduled and documented prior to hospital discharge
  – # patient with documentation of standardized postpartum patient education prior to hospital discharge
Identifying Changes

PDSA Cycles

Sequential small tests of change
Utilize provider outpatient packet to engage OB providers and outpatient care sites to help plan for early pp visit scheduling, obtain buy-in from providers, and share options for billing and coding.

Implement process flow to facilitate universal scheduling and patient education, prior to hospital discharge, of early pp visits / maternal health safety check within 2 weeks.

Implement provider and nurse education on risks of the postpartum period, benefits of early pp visit, and key components of maternal health safety check.

Standardize system to provide patient education prior to hospital discharge on the benefits of early pp visit, early pp warning signs and how to seek care (ie AWHONN resource), and benefits of pregnancy spacing and options for (outpatient) family planning.
Getting started with your QI team

Fill out a 30/60/90 day form

• What are your goals?
• Where do you want to start?
• What would you like to accomplish in first 3 months of this initiative?

Include plan for **1st small test of change** (PDSA cycle)

— See IPAC launch slides for sample PDSA
Improving Postpartum Access to Care (IPAC)

DATA FORM
## ILPQC IPAC Data Collection Form

<table>
<thead>
<tr>
<th>Question</th>
<th>Answers/Format</th>
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</thead>
<tbody>
<tr>
<td>1. For which month are you reporting? [month]</td>
<td>Month/year: ________________________</td>
</tr>
<tr>
<td><strong>Structure Measures</strong></td>
<td></td>
</tr>
<tr>
<td>2. What stakeholders do you have on your hospital QI team to date?</td>
<td>1. Administration</td>
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<tr>
<td>(check all that apply)</td>
<td>2. Nursing</td>
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<tr>
<td></td>
<td>3. OB provider champion</td>
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<td></td>
<td>4. Postpartum care site liaison</td>
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<td></td>
<td>5. Social Work</td>
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<tr>
<td></td>
<td>6. Other: ________________________________________</td>
</tr>
<tr>
<td>3. Communicate recommendation/strategy for early postpartum visit</td>
<td>a. Have not started</td>
</tr>
<tr>
<td>and obtain buy-in with OB providers/outpatient care sites (e.g., share ILPQC OB provider/outpatient care site packet)</td>
<td>b. Working on it</td>
</tr>
<tr>
<td></td>
<td>c. In place</td>
</tr>
<tr>
<td>4. Does your team have a system in place to facilitate scheduling</td>
<td>a. Have not started</td>
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<tr>
<td>early postpartum visits with affiliated prenatal care sites prior to</td>
<td>b. Working on it</td>
</tr>
<tr>
<td>hospital discharge</td>
<td>c. In place</td>
</tr>
<tr>
<td>5. Does your team have patient education materials selected/created to</td>
<td>a. Have not started</td>
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<tr>
<td>disseminate to patients prior to hospital discharge?</td>
<td>b. Working on it</td>
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<tr>
<td></td>
<td>c. In place</td>
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<tr>
<td>a. Benefits of early postpartum care</td>
<td></td>
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<tr>
<td></td>
<td>a. Have not started</td>
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<tr>
<td></td>
<td>b. Working on it</td>
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<td></td>
<td>c. In place</td>
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<tr>
<td>b. Postpartum early warning signs and how to seek care</td>
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<tr>
<td></td>
<td>a. Have not started</td>
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<tr>
<td></td>
<td>b. Working on it</td>
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<tr>
<td></td>
<td>c. In place</td>
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<tr>
<td>c. Benefits of pregnancy spacing and options for outpatient family</td>
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<tr>
<td>planning</td>
<td>a. Have not started</td>
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<td></td>
<td>b. Working on it</td>
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<td></td>
<td>c. In place</td>
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<tr>
<td>6. Does your team have a system in place for educating inpatient</td>
<td>a. Have not started</td>
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<tr>
<td>providers and nurses on the benefits of early pp visit/maternal</td>
<td>b. Working on it</td>
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<td>health safety check and strategies to facilitate scheduling early pp</td>
<td>c. In place</td>
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<td>visit prior to hospital discharge?</td>
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<td></td>
<td>a. Have not started</td>
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<td></td>
<td>b. Working on it</td>
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<td></td>
<td>c. In place</td>
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<tr>
<td>7. Does your team have a system in place for communication with all</td>
<td>a. Have not started</td>
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<td>affiliated obstetric providers and outpatient care sites the benefits</td>
<td>b. Working on it</td>
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<td>of early pp visit, key components of the maternal health safety check</td>
<td>c. In place</td>
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<td>and education on billing and coding for this visit?</td>
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<td></td>
<td>a. 10%</td>
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<td></td>
<td>b. 20%</td>
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<td>c. 30%</td>
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<td>d. 40%</td>
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<td>e. 50%</td>
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<td>f. 60%</td>
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<td>g. 70%</td>
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<td></td>
<td>h. 80%</td>
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<tr>
<td></td>
<td>i. 90%</td>
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<td>j. 100%</td>
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<tr>
<td><strong>Process Measures</strong></td>
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<tr>
<td>8. % of providers educated on optimizing early postpartum care</td>
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</tbody>
</table>
Data Form Questions
Outcome measures

a) #___ patients with early postpartum follow-up plan / discussion documented prior to hospital discharge

b) #___ of patients with early postpartum visits scheduled prior to hospital discharge

Of patients who did not have an early postpartum visit scheduled prior to hospital discharge, what was the reason the early PP visit wasn’t scheduled?

i) #___ patient declined to schedule at this time
ii) #___ early PP visit discussion not documented
iii) #___ patient postpartum care site/provider not participating in early postpartum visits
iv) #___ other (write in) ______________

c) # ___ of patient who received standardized pp patient education prior to hospital discharge (benefits of early pp care visit, pp early warning signs, and benefits of pregnancy spacing).

i) #___ benefits of early pp care visit
ii) #___ pp early warning signs /how to seek care
iii) #___ benefits of pregnancy spacing
Steps for Data Form Implementation

1. Review IPAC data form with your team
2. Identify where data is available in EMR or chart review or track via bedside checklist
3. Identify data collection plan: who will collect, what data, and when to submit
4. Ensure all appropriate team members have access to REDCap
5. Plan to review data at monthly IPAC team meetings
ILPQC Data Entry

Collect data at your hospital

Enter data into RedCap data system

Review your team’s progress in web-based reports across time

Review your web-based reports across participating hospitals

Determine next steps and QI work → implement small changes
Improving Postpartum Access to Care (IPAC)

IPAC TOOLKIT UNPACKING
IPAC Toolkit

1. Introduction
2. Initiative Resources
3. Communicating and obtaining buy-in regarding need for early postpartum visit
4. Tools for implementing universal early postpartum visits scheduled prior to hospital discharge
5. Tools for outpatient providers to optimize early pp visit/maternal health safety check
6. Billing/coding strategies for reimbursement of IPAC
7. Resources for provider/nurse education
8. Resources for patient education regarding IPAC
Communication and obtaining provider buy-in

- OB Provider/Outpatient site letter
- IPAC Fact Sheet
- National and State Guidance documents
  - ACOG CO #736
  - AIM Postpartum Care Safety Bundle
  - MMRC
Implementing universal early postpartum visits scheduled prior to hospital discharge

- Sample process flow
- Sample protocols
- Postpartum visit timeline tool
- Patient referral checklist
Tools for outpatient providers to optimize early pp visit maternal health safety check

- Maternal health safety checklist
- ACOG Sample of postpartum comprehensive follow-up
- ACOG Reproductive Life Planning, Contraception and Sexual Health pp toolkit
Billing/coding strategies for reimbursement

- ILPQC Coding for early pp visit
- ACOG Guidance on billing and reimbursement (ACOG pp toolkit)
- ACOG Guidance on Coding PP Service (ACOG PP toolkit)
- Coding for Specific pp services
  - Ex: Breastfeeding, Chronic disease follow-up, PPD, newborn care
Resources for provider & nurse education

- AWHONN Post-birth warning signs education program
- Grand Rounds Slide Set from St. Anthony’s Hospital
- Improving pp care fact sheet
- IPAC Slide set: risks of pp period, benefits of early pp visit and components of maternal health safety check
Resources for Postpartum Patient Education

**Benefits of early pp visit (coming soon!)**

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**How long should you wait before getting pregnant again?**

For most women, it's best to wait at least 18 months between giving birth and getting pregnant again. This means your baby will be at least 1½ years old before you get pregnant.

Too little time between pregnancies increases your risk of premature birth. Premature birth is when your baby is born too soon. Premature babies are more likely to have health problems than babies born on time. The shorter the time between pregnancies, the higher your risk for premature birth.

Your body needs more time to fully recover from your last pregnancy before it's ready for your next pregnancy. Waiting at least 6 months between pregnancies may help reduce your risk for premature birth in your next pregnancy. Use this time to talk to your healthcare provider about things you can do to help reduce your risk. To learn more, go to marchofdimes.org/prematurebirth.

**What you can do:**
- Wait 18 months or more after having a baby before getting pregnant again.
- If you're older than 35 or had a miscarriage or stillbirth, talk to your provider about how long to wait.
- Use effective birth control until you're ready to get pregnant.
- Talk to your health care provider about birth control options.

Waiting at least 18 months doesn't mean for sure that your next baby will be born on time. But it can help.

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**Get your 16 months.**

Fill this out with your provider so you know when you can start trying to get pregnant again:

**Example:**
- Date your baby was born: May 16, 2017
- Add 1 year and 6 months
- Now you try:
- Date your baby was born: Nov 18, 2018
- Add 1 year and 6 months

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**Watch a video**

marchofdimes.org/videos

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**Get Care for These POST-BIRTH Warning Signs**

Most women who give birth recover without problems. But some women can have complications after giving birth. Learning to recognize these POST-BIRTH warning signs and knowing what to do can save your life.

**Call 911 if you have:**
- **Bleeding, soaking through one pad/hour, or blood clots, the size of an egg or bigger**
- **Infection that is not healing**
- **Red or swollen leg, that is painful or warm to touch**
- **Temperature of 100.4°F or higher**
- **Headache that does not get better, even after taking medicine, or bad headache with vision changes**

**Call your healthcare provider if you have:**
- **If you can't reach your healthcare provider, call 911 or go to an emergency room**

**Tell 911 or your healthcare provider:**

“I gave birth on ______ and I am having ______.”

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**Your postpartum checkups are very important.**

- A postpartum checkup is a medical checkup after the baby is born. It's important to make sure you're recovering well from labor and birth.
- It's important to check if you're still getting enough breast milk. It's also important to check if you're ready for another pregnancy.
- Most women who give birth need a 6-week checkup. This is when you can discuss your postpartum recovery and any other health concerns you may have.

Postpartum care is important for women who have any health concerns, including:
- Maternal health issues. This includes breast and pelvic pain.
- Postpartum depression. This is when a baby dies in the first few weeks to a month or two.
- Obesity. This can cause stress and pain.
- Other health concerns. This includes diabetes, high blood pressure, or other health conditions.

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**How to get your postpartum checkup:**

- Contact your healthcare provider to schedule your postpartum checkup.
- If you're having trouble getting care, contact your local health department or a community-based organization.
- If you're in poverty or uninsured, contact a local family planning clinic for help.
- If you're in a hospital, talk to your doctor or nurse about your postpartum care.

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**Get help:**

My Healthcare Provider/Client: ______
Hospital/Other: ______
Improving Postpartum Access to Care (IPAC)

TAKE-AWAYS FROM FACE-TO-FACE MEETING AND BASELINE EVALUATION
ILPQC OB Face-to-Face Meeting Numbers

• 263 physicians, nurses, and public health professionals attended OB Meeting

• 204 attended the neonatal meeting on 5/31 with over 100 attendees present at both
Materials distributed

- IPAC and IPLARC binders distributed to teams with a submitted roster
- Patient education materials distributed included:
  - Postpartum Birth Control, Postpartum LARC, Postpartum Implant and Postpartum IUD pads
  - Pregnancy spacing/planning tear pads
  - SBIRT pocket cards
• Some providers are already routinely seeing most patients for an early postpartum visit
• Most hospitals are able to help facilitate scheduling postpartum visits before delivery discharge
Current strategies for patient education

Display of education poster regarding importance of birth spacing in post partum hall, waiting rooms throughout the hospital (Emergency department and labor and delivery waiting room). Discuss birth spacing during postpartum education.

Our institutions instructs all patients on care of self and newborn as well as signs and symptoms of early warning signs of abnormalities. Each patients receives instructions for quick reference.

Current strategies for scheduling

Nursing staff contact the providers office and schedule appointments prior to discharge. When patients are discharged on weekends the patient is educated to contact the providers office on the next business day to schedule appointment. The appointment is documented in the patients discharge instructions and education is given prior to discharge.
<table>
<thead>
<tr>
<th>Barriers</th>
<th>Opportunity</th>
<th>Other</th>
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<tbody>
<tr>
<td>Patient No Show at Appt.</td>
<td>Cluster care as much as possible PP Visit with Ped Visit</td>
<td>Look at bigger scope of why &quot;No Show&quot; transportation, babysitting. Mothers are more inclined to care for their infants than themselves. Need to educate moms on why this is important</td>
</tr>
<tr>
<td></td>
<td>Educate on warning signs consistently in hospital and need for IPAC prior to D/C. Create a process flow so every patient gets this info</td>
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</tr>
<tr>
<td>Transportation to visit</td>
<td>Look to develop alternative means of transportation (Utilize: Security, Van, etc) RN home visits to screen patients and trigger contact with OB if abnormal findings</td>
<td>Cluster care as much as possible. Look into dual appointment opportunities. Look to develop relationships and coordination with health dept.</td>
</tr>
<tr>
<td>Provider Buy-In</td>
<td>Educate, Present Data, Refer to ACOG/ILPQC outpatient packet Provide billable codes found in toolkit Newsletter with Recommendation for IPAC and provide case study of good catches with early visit. Share the near misses.</td>
<td>6wk. PP code can only be billed once. Use other codes such as family planning, hypertension, wound check, depression screen etc. for early visit. Provide billing document to OB providers from ILPQC</td>
</tr>
<tr>
<td>Need Billing</td>
<td></td>
<td>Can consider a grand round or mail chimp to target providers and circulate close calls.</td>
</tr>
<tr>
<td>OB Schedule load for an additional early visit</td>
<td>Schedule early visit when scheduling IOL or C/S. Schedule prior to discharge look for ways to automate process as much as possible</td>
<td>Dr. schedules appt. with office on discharge rounds in M/B Access to Office schedule for hospital staff to schedule prior to D/C Provider has block times for Early PP visit that staff can just assign to patients prior to D/C</td>
</tr>
<tr>
<td>Setting appointment</td>
<td>Utilize Telehealth in rural areas</td>
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Other takeaways from F2F?
Improving Postpartum Access to Care (IPAC)

NEXT STEPS
Next Steps to move forward

- **Finalize your IPAC Team** and establish a time for at least **monthly IPAC meetings**

- Complete team baseline evaluation if not already completed (email [info@ilpqc.org](mailto:info@ilpqc.org) for access)

- Use your teams baseline evaluation, review Key Driver Diagram/Toolkit and develop a **30/60/90 day work plan** for success (email [info@ilpqc.org](mailto:info@ilpqc.org) for a copy)

- **Review data form, strategize plan** for data collection

- Invite team members **join monthly IPAC webinars** 3rd Monday of the month 11am-12, starting in June
How will ILPQC help?

• IPAC Toolkit available.
  – Please reach out to info@ilpqc.org if you did not get a toolkit at the Face-to-Face Meeting

• Monthly team webinars with education, data review and Team Talks to learn from other teams and discuss issues & strategies across hospitals

• ILPQC Data System each team will have secure access to the REDCap portal and live reports that can be shared at your hospital to support your teams efforts

• QI support coaching calls to teams to problem solve
# IPAC Calls

- **THIRD MONDAY OF THE MONTH**

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
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<tbody>
<tr>
<td>June 17</td>
<td>Getting started with the IPAC Toolkit and debrief from Face-to-Face</td>
</tr>
<tr>
<td>July 15</td>
<td>Obtaining OB Provider / Outpatient site IPAC buy-in and engagement</td>
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<tr>
<td>August 19</td>
<td>Creating IPAC process flow and system changes to facilitate universal scheduling prior to hospital discharge</td>
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<tr>
<td>September 16</td>
<td>Strategies to launch IPAC provider and nurse education</td>
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<tr>
<td>October 21</td>
<td>Implement IPAC process flow and system changes to provide patient education prior to hospital discharge</td>
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Contact

- Email info@ilpqc.org
- Visit us at www.ilpqc.org