



Care Coordination, Referral, and Collaboration With Hospitals and Health Care Systems

Background

Maternal morbidity and mortality are at their highest in 25 years. This health care crisis in the United States will require a multifaceted approach. A paradigm shift is needed to center postpartum care on the needs of women. Implementation will require coordination of current hospital and health system resources that become sustainable beyond a fixed visit or short-term peripartum period and lead to the creation of a health care medical home model.

Resources and Implementation Strategies

- The [American College of Obstetricians and Gynecologists' Postpartum Care Plan Form A](#) (*ACOG members only*) begins in the antepartum period, carries through peripartum and postpartum periods, and leads to ongoing care coordinated by a **health care navigator**.
- Care coordination using a patient-centered medical home care model will transform the episodic fragmented approach into a continuous comprehensive care model that is coordinated by a team leader or **health care navigator**.
- Implicit interpregnancy care proposed by family medicine interweaves ongoing maternal care into well baby visits. ([Implicit Network](#))
- Implementing team-based care can rely on novel telehealth and economic proposals. ([Collaboration in Practice: Implementing Team-Based Care](#), Task force report and executive summary p. 13–31).
- Patient safety bundles can guide care from birth to comprehensive postpartum health care. Patient bundles include a critical set of processes based on available guidance, tools, and resources that have been developed by trusted organizations. (www.safehealthcareforeverywoman.org)
- Association of Women's Health, Obstetric and Neonatal Nurses' postpartum discharge education plan targets major life-threatening complications and highlights that many are preventable, including severe hypertension, venous thromboembolism, infection, cardiac disease, and hemorrhage. Education regarding postbirth warning signs and use of checklists has the potential to be lifesaving. (<http://nwhjournal.org/cms/attachment/2075726627/2069832130/mmc1.pdf> [requires log in] and <https://www.perinatalqi.org/page/PPDischargeEdu>)
- Comprehensive postpartum care can facilitate the transition to well woman care as demonstrated by the Community Care initiative of North Carolina. Their novel approach to a pregnancy medical home care pathway serves as a model for best practice. It incorporates the following elements: postpartum depression screening, reproductive health planning, screening for chronic diseases, providing appropriate vaccinations, and promoting smoking cessation. (<https://www.communitycarenc.org/what-we-do/clinical-programs/pregnancy-medical-home/pmh-pathways/postpartum-care-and-transition-well-woman-care>)