

IMPROVING FOLLOW UP FOR POSTPARTUM WOMEN AT A RURAL CRITICAL
ACCESS HOSPITAL: A QUALITY IMPROVEMENT PROJECT

by

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CHAPTER ONE

REVIEW OF THE LITERATURE

Introduction

More than half of pregnancy-related deaths occur in the postpartum period (Murray et al., 2018). The weeks following birth are critical as women adapt to their new role and their bodies recover from delivery. The postpartum period is also a period of significant risk for postpartum complications including but not limited to breastfeeding problems, urinary incontinence, constipation, and sleep disorders to more life-threatening concerns including depression, hemorrhage, infection, and cardiovascular disease complications. The traditional 6-week postpartum visit is suboptimal and can lead to missed opportunities to catch complications that affect short and long-term health outcomes (Murray et al., 2018). The American College of Obstetricians and Gynecologists (ACOG) has called for restructuring of the postpartum visit, which includes individualized follow-up with the first patient contact being no later than three weeks postpartum (Lopez-Gonzalez & Kopparapu, 2022). However, ACOG's recommendation has not yet been fully recognized let alone implemented.

As many as 40% of women do not attend their postpartum healthcare visit (Yee et al., 2021). Women living in rural areas of the United States are at higher risk for maternal mortality than those in urban areas due to a lack of resources and access to care. Implementation of individualized follow-up in a primary care setting would not only have an effect nationally but could also potentially reduce health disparities in rural communities. The implementation of early postpartum contact within 72 hours and again 7 days after discharge has the potential to

improve follow-up rates while addressing postpartum health concerns. Follow-up via phone call in the early postpartum period is a way to provide comprehensive and holistic care. Early follow-up also ensures the health protection of mothers and newborns promoting individualized care and decreasing short and long-term healthcare expenses through early identification and intervention in high-risk conditions (Öztoprak & Erkaya, 2023). Contacting patients early after discharge not only improves systems of care, but has also been shown to improve patient satisfaction, improve patient retention rates, and promote more timely follow-ups on screening or diagnostic results (Hu et al., 2021).

Methods

A scoping literature review of databases, including PubMed, CINAHL, MEDLINE, Web of Science, and CatSearch, was performed to identify articles with targeted methods of improving postpartum follow-up. The research focused on intervention strategies and their effect on follow-up. Key search terms included phrases such as Improving systems of postpartum care, postpartum follow-up AND quality improvement AND intervention, postpartum AND early follow-up AND telephone, Interventions for increasing postpartum follow-up, and navigation programs AND postpartum. The identified articles were independently screened and refined by title and abstract in accordance with PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines (See Appendix A). All duplicate articles were identified and removed. Reference lists of included articles were reviewed for additional articles to be considered for inclusion. Exclusion criteria included: (1) published prior to 01/01/2018, (2) published in other languages other than English, (3) and if interventions were not applicable to the primary care setting.

Results

The initial search yielded 1044 articles. After duplicates were removed, a total of 1020 results remained. Articles were further screened following the discussed exclusion criteria. After review, 35 articles were considered, and, ultimately, 10 met the criteria for inclusion. The review of the literature includes qualitative studies with measured outcomes, quality improvement implementations, randomized controlled trials, and a mixed methods study. Articles meeting inclusion criteria support the implementation of early postpartum contact to improve follow-up.

Technology Systems for Screening. A common theme identified in postpartum intervention literature was the use of phone systems or text message reminders to facilitate communication and improve follow-up. The literature included in this review focused on telephone interviews and text message systems for intervention. Shorey et al. (2019) reported randomized controlled trials have begun adopting technology-based interventions as they are an ideal alternative to increase accessibility and improve maternal outcomes with the advantages of flexibility, individualized care, and privacy. One quality improvement initiative implemented a telephone interview survey that addressed symptoms of postpartum complications between one and three weeks postpartum. Findings from this study indicated 20% of the screened population (n=106) benefitted from the early screening as measured by survey results with positive screens for complications that required early follow-up (Diaz et al., 2022). Hirshberg et al. (2018) conducted research and reported improved outcomes in 77% of studies observed using text messaging with observed positive effects on medication treatment adherence, appointment attendance, and positive attitudes toward medication and treatment. The quality improvement

project described in this project implemented technology-based interventions to ensure early postpartum contact occurred and follow-up was scheduled.

Patient Navigation Programs/Protocols. Patient navigation is a service that helps people get the health care and other resources they need (CDC, 2022). The literature review completed here assessed interventions with patient navigation and the effect on postpartum follow-up. Patient navigation has been shown to positively affect the capability to perform self-care in the early postpartum period by supporting mothers through training, counseling, and providing guidance (Rowland & Kennedy, 2022). In one study included in this literature review, analysis of navigator logs revealed a high level of participant (n=50) need for services in the first month postpartum, with 165 interactions addressing patient needs recorded in the logs (Green et al., 2023). Supporting postpartum moms through navigation can promote self-awareness about health conditions and reduce complications that directly affect the quality of life. In rural settings, navigation can help reduce barriers to care. Patient navigation has proved beneficial among women with antenatal depressive symptoms by increasing follow-up rates, adding to the desirability of incorporating patient navigation in rural healthcare (Martinez et al., 2020). Implementing a navigation program or protocol needs to be tailored to the individual facility and community's needs but may include appointment management, care coordination, health education, and providing resources. This quality improvement project set out to use the clinic care manager and nursing staff to act as patient navigators and initiate early contact with postpartum patients to ensure postpartum follow-up occurred.

Discussion and Conclusions

The literature reviewed for this project suggested early postpartum contact can improve follow-up rates leading to improved postpartum outcomes. As the prevalence of healthcare provider shortages increases and access to care becomes harder, services such as early discharge phone calls, can effectively identify needs and assess for health concerns promoting improved outcomes for postpartum women. In rural areas, removing obstacles for postpartum women is essential for enhancing healthcare, and improving access and early patient contact may be the missing key to achieving this.

CHAPTER TWO

QUALITY IMPROVEMENT PROPOSAL

Introduction

Maternal mortality rates indicate nearly 800 women from around the world die daily, most of the deaths considered preventable (World Health Organization, 2023). Data from the past decade indicates a national shift in the timing of maternal mortality, with the preponderance of deaths occurring during the early postpartum period (Spelke & Werner, 2018). Montana has the 6th highest rate of maternal deaths in the U.S. with Montana rural critical access hospitals having a 9% greater probability of severe maternal morbidity and mortality (Woo & Glover, 2021). The statistics support the need for intervention to improve maternal outcomes and are in alignment with Healthy People 2030's objective to prevent pregnancy complications and maternal deaths (Healthy People 2030, 2023).

Problem Statement

In one rural Montana hospital, prenatal care is provided until the pregnant woman reaches 34 weeks gestation and then the care is transferred to an urban hospital for the remainder of the pregnancy and delivery. After delivery, the rural hospital's clinic care manager received notification of discharge from the urban hospital, and postpartum moms were called 72 hours after discharge for check-in. The clinic staff did not verify if the patient had scheduled an office visit with a provider for a 6-week postpartum check. As a result, patients had the potential to be lost to follow-up and/or unsure of where they should schedule follow-up services. Missed follow-up has the potential for delayed treatment of complications, which could in turn

contribute to overall maternal morbidity and mortality. The project proposal intended to implement two follow-up discharge calls, one at 72 hours and one at seven days after discharge, to check in with the new moms regarding their overall health and ensure they had appropriate follow-up in place with the goal that 100% of moms had postpartum follow-up scheduled by the second completed call. The stakeholders reached a consensus on the time frames for the phone calls during a meeting, concluding from research and experience that the first week is the most crucial period for postpartum complications. In the first week, women are at risk for severe hypertension, severe bleeding, and infection, which are the most common contributors to maternal death (Lopez-Gonzalez & Kopparapu, 2022).

Microsystem Assessment

No previous assessments or data collection had occurred specifically for postpartum women in the chosen rural Montana hospital, and no concrete data existed in relation to postpartum follow-up. Prior to implementation, the rural Montana hospital had the care manager document that 72-hour discharge calls occurred without differentiating types of patients, meaning the document did not show whether the call was to a postpartum mom or a patient with pneumonia. Due to this, there was no way to obtain previous data for postpartum women. During an interview with providers and the care manager, concern for women falling through the cracks in the transition of care between rural and urban hospitals was presented as a high priority to address. Specifically, the concern was sparked by a patient who brought their newborn into the rural clinic for a newborn weight check, and during a conversation with the mother, the provider incidentally found out that the mom was experiencing symptoms related to a postpartum emergency with no postpartum follow-up plan in place. This patient was evaluated and sent for

readmission to the urban hospital for treatment. The case was presented at the OB/Well Child Committee meeting, establishing a consensus on the existence of a care gap and the necessity for an intervention aimed at enhancing postpartum follow-up.

The rural hospital is located in south central Montana, belonging to a large network of rural hospitals across the U.S. designated as critical access hospitals. To be considered critical access, a hospital must be rural, located within a state participating in the Medicare Rural Hospital Flexibility Program, be more than a 35-mile drive from any other hospital, have 15 or fewer acute inpatient care beds or up to 25 beds if swing bed admission is offered, must offer 24-hour emergency services, and must be owned by the public or a non-profit entity (American Hospital Association, 2023). The non-profit hospital involved in this project serves a population of about 2,500 and the closest urban hospital is over 50 miles away. Services provided by the facility include 24-hour emergency care, 10 inpatient beds for acute, observation, and swing services, outpatient home care and hospice, rehabilitation services, laboratory services and diagnostic services, and a family practice clinic for primary care services.

Stakeholders involved in the quality improvement project included three clinic providers who provide prenatal care up to 34 weeks as well as newborn and postpartum care after delivery, the clinic care manager who initiates the initial contact 72 hours after discharge, the clinic manager who oversees clinic operations and clinic staff, the information technology (IT) manager who facilitates and supports the implementation of medical technologies to contribute to the transformation of healthcare services, and the clinic nursing staff who facilitate follow-up calls and navigate care for patients.

Quality Improvement Model

To guide the development, implementation, and evaluation of the practice change, use of the IOWA Model (Appendix B) for evidence-based practice served as the overall framework for the project, aiming to promote excellence in healthcare.

The IOWA Model starts by considering triggers that lead to the need for a practice change. The triggers for the project included the provider's concerns about care gaps resulting in patients with no postpartum follow-up in place and the desire to meet the objective of Healthy People 2030's to reduce severe maternal complications and maternal deaths (Healthy People 2030, 2023).

Step two in the IOWA model includes clearly stating the clinical problem to clarify the purpose of the project and to determine if the change is a priority for the organization. Population, Intervention, Comparison, Outcome (PICO) format provided a template to form the question: In postpartum patients, does contact 72 hours and 7 days after discharge to check in and schedule follow-up compared to one call 72 hours post-discharge improve postpartum follow-up rates? Follow-up rates for the project are defined as confirmed scheduled postpartum appointments after implementation. After considering the question, the stakeholders agreed a piloted project is necessary to determine if change will promote improvement in maternal health follow-up.

Step three calls for team formation. The team formed for the project included the DNP-s, three clinic providers, the clinic care manager, the clinic manager, IT, and clinic nursing staff. In step four, a systematic search for evidence was conducted and evidence was assembled, appraised, and synthesized, with an overall evaluation of whether evidence exists to support the

change. The evidence reviewed in Chapter One supports the use of technology and care navigation to improve postpartum follow-up rates.

Step five of the model involves piloting the practice change and includes patient engagement, evaluation of resources and constraints, developing an evaluation plan and implementation plan, preparing clinicians for the change, and then promoting adoption among the stakeholders and organization. Implementation began during the 3rd week of January 2024 and was piloted for 6 weeks. Data collection included patient initials, discharge phone calls completed at 72 hours and one week, as well as if follow-up appointments were in place. All data, including identifying data, was entered into a password-protected Excel sheet, and kept at the facility, to ensure patient privacy. At the end of the pilot period, patient initials were deleted from the document for analysis. The data determined if the change is appropriate for permanent integration.

Specific Aims and Purpose Statement

The purpose of this quality improvement project was to implement a postpartum follow-up process via phone at 72 hours and seven days post-discharge. The project confirmed a 6-week postpartum appointment had been scheduled. To guide the project, structured SMART goals were implemented (See Table 1). The short-term goal for the project was the design of a template agreed upon by stakeholders for nursing staff and the care manager to use during phone conversations by January 17th, 2024. The intermediate goal for the project was that 100% of postpartum moms in the piloted period between January 22nd and March 5th, 2024 receive calls at 72 hours and seven days after discharge. The long-term goal for the project was that 80% of women contacted at 72 hours post-discharge and 100% of women contacted at 7 days post-

discharge would have a scheduled postpartum follow-up appointment with the project site or their OB provider by March 5th, 2024. Further discussion related to goals is listed in Table 1.

Table 1. SMART Goals

Smart Goal #1: Design of a template agreed upon by stakeholders for nursing staff and the care manager to use during phone conversations by January 17th, 2024, and implement during the piloted period to assess effectiveness. • This goal was set to provide consistency during calls		
Description of strategies to be utilized to accomplish goal including any needed resources: • Key stakeholders meet and discuss key questions to include during call. • Key stakeholders approve questions for template. • DNP-S and Information Technology manager draft a template into EMR system		
Data to be collected:	Method of Collection and who is responsible:	Planned data analysis:
Template	Nursing will enter answers to template into EMR and schedule follow-up accordingly.	Calculate proportion number of patients who received calls using template vs. how many schedule follow-up.

Smart Goal #2: 100% of postpartum moms in the piloted period between January 22th-March 5th 2024 receive calls at 72 hours and seven days after discharge
Description of strategies to be utilized to accomplish goal including any needed resources: • Time for staff to make phone calls, answer questions, encourage follow-up.

Time for providers to collaborate with nurses to schedule care if patients are identified with urgent needs.		
Data to be collected:	Method of Collection and who is responsible:	Planned data analysis:
Number count of patients who received follow-up calls	Phone call: Care manager and Clinic nursing staff Record in Excel spread sheet	The proportion of number of patients who received follow-up calls versus number of patients who were not reachable and did not receive follow-up calls. Record proportions in Excel spreadsheet

Smart Goal #3: 80% of women contacted at 72 hours post-discharge and 100% of women contacted at 7 days post-discharge will have a scheduled postpartum follow-up appointment with the project site or their OB provider by March 5th, 2024.		
Description of strategies to be utilized to accomplish the goal including any needed resources: Nursing Staff education on correct documentation using the Excel Spreadsheet		
Data to be collected:	Method of Collection and who is responsible:	Planned data analysis:
Number count of patients who received follow-up calls and	Nursing Staff Record in Excel spreadsheet	Calculate the proportion number of patients who received calls vs

number of follow-up appointments in place		how many have follow-up in place Record in Excel spreadsheet
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Intervention and Implementation

At the rural hospital site, using the template approved by stakeholders, postpartum moms would receive a phone call 72 hours and seven days post-discharge as a check-in and to ensure a postpartum appointment was in place. Implementation of the calls began January 22nd, 2024 with the piloted period ending March 5th, 2024. Data analysis occurred between March 5th, 2024, through March 8th, 2024. Results identified if changes needed to occur with the process to improve follow-up rates or if the process can continue to be implemented.

The care manager conducted follow-up calls with patients approximately 72 hours after discharge. After the post-discharge phone call, the care manager sent the template as a timed message through the EMR to the clinic nursing pool message center to appear seven days after the initial call. The clinic nursing staff reached out to patients to ensure their continued well-being, let them know about the availability of newborn and postpartum care, and verify their scheduled follow-up appointments. The nurses used the template during the call, which guided the nurse to ask specific questions and aid in determining if an earlier follow-up was required. The goal for the project was that 80% of women contacted at 72 hours post-discharge and 100% of women contacted at 7 days post-discharge had a scheduled postpartum follow-up appointment with the project site or their OB provider. Anticipated barriers included adaptability of staff and technical problems. To address this, DNP-s encouraged staff throughout implementation and

reminded them of facility resources to utilize facility resources including IT if they ran into issues.

Evaluation and Analysis. Data Collection occurred with each phone call completed. Specifically, staff collected the patient's initials, documented each follow-up call that occurred, and if follow-up appointments were in place with each call. Staff used a cloud-shared Excel document, password protected, to enter data. Patient initials and dates of calls were recorded to allow nursing staff to link each phone call to the correct patient, however, identifying data was removed before the data was removed from the facility. See Appendix C for the Excel template to be used.

Descriptive statistics were used to summarize and describe the frequency of postpartum calls completed as well as the frequency of follow-up appointments in place. Quantitative data of follow-up in place at 72 hours and one-week post-discharge determined if the process improved follow-up rates or if modifications to the process for improvement needed to occur. The DNP-s reviewed findings with the stakeholders midway through implementation and at the completion of the piloted period to assess if adjustments needed to be made.

Safety and Confidentiality. Data confidentiality was a priority of the project. Minimal identifying data was collected. Data was stored on a password-protected document at the facility. After completion of the piloted period, the data was compiled and de-identified before being shared with the DNP-s for further analysis. Support of site stakeholders, the Institutional Review Board (IRB), Montana State University, and project committee approval was required for project implementation to ensure the ethical and legal compliance of project implementation. Approval was necessary to protect the rights, welfare, and well-being of the patients involved in the study

and help guarantee that the research design, methods, and protocols adhere to ethical standards, promoting the integrity and credibility of the findings. Before implementation, copies of a site representative form and documentation required from the IRB were submitted online to Montana State University's Office of Research and Compliance System for review and approval.

Conclusion

The intervention for the project was chosen to analyze whether postpartum contact improves follow-up rates leading to improved postpartum outcomes, as suggested in the literature review in chapter one. Analyzing collected data from the implementation results helped identify trends and patterns that can be used to improve postpartum follow-up rates. Specifically, by gathering the data we were able to identify areas that need improvement, identify patterns in the completion of calls that might indicate specific preferences or barriers for patients, and use data to assess whether any changes made led to improvements in follow-up rates. By using the data in these ways, we can modify the intervention to target effective strategies that can lead to improved postpartum follow-up rates and ultimately enhance the overall postpartum care for patients.

CHAPTER THREE

QUALITY IMPROVEMENT MANUSCRIPT

Contribution of Authors and Co-Authors

Manuscript in Chapters: 4

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Abstract

Background: Approximately 800 U.S. women die annually from pregnancy-related complications according to Croke (2019) and at least 60% of these deaths are considered preventable. Critical access hospitals and rural healthcare facilities are under-resourced causing healthcare disparities for rural populations. Closing the gap by initiating contact with postpartum women will help ensure postpartum appointments are made and patients do not slip through the cracks. In April 2018, The American College of Obstetrics and Gynecology (ACOG) recommended 12 weeks of support with the first postpartum evaluation within the first 3 weeks after delivery in-person or by phone with a comprehensive visit scheduled no later than 12 weeks (Lopez-Gonzalez & Kopparapu, 2022).

Local Problem: The United States has a maternal death rate higher than any other developed country. Montana has the 6th highest rate of maternal deaths in the U.S. (Glover, 2021). In critical access hospitals obstetric outcomes are worse than those at high-volume hospitals and rural populations have a 9% greater probability of severe maternal morbidity and mortality (Woo & Glover, 2021).

Methods: This quality improvement project will follow the Iowa model of evidence-based practice to promote excellence in healthcare.

Intervention: Two follow-up calls after discharge from delivery, one at 72 hours and one at 7 days post-discharge.

Results: The 72-hour call was completed 100% of the time, with all three women receiving the initial call. The seven-day call was completed 66% of the time, with only two women receiving the second call. Follow-up appointments were in place for each participant by the second discharge call, meeting the goal of 100%.

Conclusions: The results of this project aligned with the literature with improved patient and provider satisfaction, early identification of patient needs for follow-up, and the use of phone calls provided an ideal alternative to increase accessibility and improve maternal outcomes with the advantages of flexibility, individualized care, and privacy.

Key Words: *Postpartum care, postpartum follow-up, quality improvement, intervention, postpartum early follow-up, telephone, navigation programs, and postpartum.*

Clinical Problem

The U.S. has the highest maternal mortality rate among wealthy nations. In 2018, as the U.S. wrestled with escalating maternal health challenges, a significant milestone occurred when the “Preventing Maternal Deaths Act of 2018” was signed into law highlighting the urgency to focus on maternal health and mortality in the U.S., specifically related to postpartum care and follow-up (Jones et al., 2019). Montana ranks within the top 10 states with the highest maternal mortality rates in the U.S. Approximately 44% of Montanans live in a rural part of the state (Montana State Legislature, 2020). Postpartum care is especially challenging for rural communities with decreased access to obstetric services, putting rural populations at a greater risk for maternal morbidity and mortality.

The postpartum period represents a critical period to initiate targeted strategies to improve maternal health. ACOG recommends all women have tailored, personalized ongoing care with postpartum contact with their provider occurring within three weeks after delivery to improve maternal outcomes. By initiating postpartum contact via telephone within the first two weeks after delivery, healthcare providers can improve maternal health.

Review of the Literature

Researchers have demonstrated the effectiveness of early postpartum screening using technology to identify postpartum complications and patient navigation programs to improve postpartum follow-up attendance. Articles reviewed for the quality improvement project include qualitative studies with measured outcomes, quality improvement implementations, randomized controlled trials, and mixed methods studies. Articles that met the inclusion criteria provide support for implementing early postpartum contact to enhance follow-up, focusing on telephone

interviews and text message systems for intervention. Technology-based interventions are an ideal alternative to increase accessibility and improve maternal outcomes with the advantages of flexibility, individualized care, and privacy (Shorey et al., 2019). The literature review also assessed interventions with patient navigation and the effect on postpartum follow-up. Patient navigation is a service that helps people access health care and other resources they need (CDC, 2022). Patient navigation has been shown to positively affect the capability to perform self-care in the early postpartum period by supporting mothers through training, counseling, and providing guidance (Rowland & Kennedy, 2022). At one rural Montana hospital women receive prenatal care until 34 weeks gestation, transitioning to an urban hospital for delivery, and then may return to the rural hospital for care. With a gap in care and the rurality of the location, potential maternal risks were identified, and concern for maternal wellbeing fostered a desire for change. An evidence-based intervention was implemented to target early contact with postpartum moms at 72 hours and seven days post-discharge to check in with the patient, address their concerns, help navigate their care, and ensure follow-up was in place.

Conceptual Framework

The IOWA model served as the guiding framework for the project. The model focuses on the identification of the problem followed by guidance on achieving a solution through stating the purpose, team formation, appraisal, synthesis of evidence, designing and piloting the practice change, and assessing sustainability. In one rural hospital, improving postpartum care arose from the concern of postpartum women falling through the cracks while the transition from care between the rural and urban hospitals occurred. The OB/Well Child Committee deliberated a case that occurred at the clinical site, leading to the consensus on the existence of a care gap and

the imperative need for an intervention to improve postpartum care. Following the IOWA model, we decided the project was a priority for our patients and we formed a team. The team consists of three clinic providers who provide prenatal care up to 34 weeks as well as newborn and postpartum care after delivery, the clinic care manager who initiates the initial contact 72 hours after discharge, the clinic manager who oversees clinic operations and clinic staff, the information technology (IT) manager who facilitates and supports the implementation of medical technologies to contribute to the transformation of healthcare services, and the clinic nursing staff who facilitate follow-up calls and navigate care for patients. The next step in the framework involved synthesizing and appraising the evidence. The review of the literature identified sufficient evidence for process change and the project moved to the next step of developing and piloting the change. The team met and decided a phone call at 72 hours and seven days post-discharge from delivery to check in with moms would provide improved patient care based on the evidence, meeting ACOG's goal of postpartum contact within the first three weeks of discharge. After implementing the process for six weeks, data analysis occurred, and the team decided that the practice change was an appropriate and sustainable practice to continue to improve maternal outcomes.

Aim

The project aim was to improve patient outcomes for postpartum women in a rural Montana hospital through the implementation of a postpartum call process. The goal was initiating early postpartum contact would lead to improved postpartum follow-up rates and improved postpartum care, with the potential to reduce poor maternal outcomes.

Methods

Context. The clinical site for the quality improvement project is a designated critical access hospital in Montana. To be considered critical access, a hospital must be rural, located within a state participating in the Medicare Rural Hospital Flexibility Program, be more than a 35-mile drive from any other hospital, have 15 or fewer acute inpatient care beds or up to 25 beds if swing bed admission is offered, must offer 24-hour emergency services, and must be owned by the public or a non-profit entity (American Hospital Association, 2023). The project site serves a population of about 2,500 and the closest urban hospital is 60 miles away. Services provided by the facility include 24-hour emergency care, 10 inpatient beds for acute, observation, and swing services, outpatient home care and hospice, rehabilitation services, laboratory services and diagnostic services, and a family practice clinic for primary care services. The site stopped providing newborn delivery care over two decades ago due to the cost of anesthesia and the lack of providers willing to provide C-sections in a rural setting. After the termination of newborn delivery care, the clinical site moved to a model that provides prenatal care up to 34 weeks of pregnancy and then refers the patient to an urban hospital for the remainder of the pregnancy, having the patient transition back for postpartum care. Communication barriers between hospitals created inconsistency in the information the rural providers received while the patient was under the care of the urban hospital. Before the project, the rural providers typically did not see or communicate with the patient for postpartum care until around six weeks after delivery, widening the care gap.

Prior to this project's implementation, an interview with providers and the care manager highlighted a concern for women falling through the cracks in the transition of care between rural and urban hospitals and arose as a high priority to address. Specifically, the concern was

sparked by a patient who brought their newborn into the rural clinic for a newborn weight check, and during a conversation with the mother, the provider incidentally found the mom was experiencing symptoms related to a postpartum emergency with no postpartum follow-up plan in place. The patient was evaluated and urgently sent for readmission to the urban hospital for treatment. The case was presented at the OB/Well Child Committee meeting, establishing a consensus on the existence of a care gap and the necessity for an intervention aimed at enhancing postpartum follow-up.

Intervention. The project used evidenced-based research to implement two follow-up post-delivery discharge calls, one at 72 hours and one at seven days after discharge, to check in with the new moms regarding their overall health and ensure they had appropriate follow-up. The care manager initiated the first follow-up calls with patients approximately 72 hours after discharge. After the post-discharge phone call, the care manager sent a template as a timed message through the electronic medical record to the clinic nursing pool message center to appear seven days after the initial call. When the message appeared at the seven-day mark, the clinic nursing staff reached out to patients to ensure their continued well-being, let them know about the availability of newborn and postpartum care at the clinical site, and verified their scheduled follow-up appointments. The nurses used the template to guide their call to ask specific questions and aid in determining if an earlier follow-up was required.

Measures. Data collected for the project included patient initials, discharge phone calls completed at 72 hours and one week, as well as if follow-up appointments were in place. All data, including identifying data, were entered into a password-protected Excel sheet, and were kept at the facility, to ensure patient privacy. Data collected was used to assess project goal

achievement. The goals for the project included 80% of women contacted at 72 hours post-discharge and 100% of women contacted at 7 days post-discharge having a scheduled postpartum follow-up appointment with the project site or their urban OB provider.

Analysis. To analyze data for this project, the project data collected of postpartum follow-up discharge call rates obtained at 72 hours and seven days post-discharge and postpartum follow-up appointments scheduled rates were divided by their respective goal percentages, to assess the project success.

Results

In the six-week implementation period, three postpartum women participated in the project. The 72-hour call was completed 100% of the time, with all three women receiving the initial call. The seven-day call was completed 66% of the time, with only two women receiving the second call. This was due to a glitch with technology that will be discussed further in the limitations section. Follow-up appointments were in place for each participant by the second discharge call, meeting the goal of 100%. Qualitatively, the project yielded increased satisfaction. Providers in the clinic expressed increased satisfaction with the project, citing enhanced continuity of care as a key factor contributing to their positive experience. Nurses involved in the project observed a higher level of patient engagement and satisfaction, noting that the continuity of care approach resulted in more proactive management of postpartum concerns. Patient feedback indicated a strong appreciation for the check-in system, expressing gratitude for the personalized attention and support provided. Overall, the qualitative data revealed a positive reception to the project from both stakeholders and patients.

Discussion

The results of this project aligned with the literature with improved patient and provider satisfaction, early identification of patient needs for follow-up, and the use of phone calls provided an ideal alternative to increase accessibility and improve maternal outcomes with the advantages of flexibility, individualized care, and privacy.

Limitations. Barriers to implementation included staff participation, technology glitches, and a small population to capture data. In the week leading up to implementation, the staff was reluctant to meet to discuss the implementation process. It took persistence to ensure the meeting occurred for successful implementation. Technology also caused a bumpy start. When the first patient was called for the 72-hour check-in, the timed communicate was not sent properly through the system to the nursing pool due to a computer glitch. As a result, the first patient did not get a second call at seven days. Fortunately, the error was caught early enough that IT was able to troubleshoot with the care manager to ensure delivery for subsequent calls. The clinical site involved was a rural community with a large population of retirees. Young families are slowly trickling into the area but the small population led to a small potential pool of participants for the project.

Midway through the implementation of the project we recognized an additional barrier. The care manager is notified of patient discharge from the urban hospital only if one of the rural providers from the rural clinical site was listed as the patient's primary care provider. During the implementation, the team noticed there were a couple of women receiving prenatal care who did not have anyone listed as their primary care provider. We added a step in the final prenatal appointment occurring just prior to patient's transition of care to the urban center. The additional

step was designed to ensure the rural site's providers were listed as the patient's primary care provider.

Recommendations. Based on our findings, I would recommend all healthcare facilities, urban or rural, have a postpartum check-in process in place to meet ACOG's goal of the first patient contact being no later than three weeks postpartum. Although the project had a small number of patients, the project was deemed a success with observed increased provider satisfaction and feedback from patients who appreciated the continuity and individualized care.

Conclusion

Proactive care with early intervention in the postpartum period can lead to increased identification and early intervention in women at risk for immediate or long-term pregnancy complications. In addition, early contact with postpartum moms has the potential to substantially decrease maternal mortality, leading to improved population health in the future. Overall, the project found early contact in the postpartum was feasible and valuable to the organization and community it serves. Continued implementation of the interventions along with identifying trends and barriers has the potential to continue to improve postpartum follow-up and patient outcomes.

CHAPTER FOUR

ADVANCED NURSING ESSENTIALS REFLECTION

Introduction

Quality Improvement (QI) projects can lead to change, improve care, and transform services across healthcare systems. Montana State University (MSU) designed its Doctorate of Nurse Practitioner (DNP) program to prepare students for the highest level of leadership through QI. Students develop, plan, and implement QI projects following the eight core essentials created by The American Academy of Colleges of Nursing (AACN). The AACN created these essentials to ensure professional nurses who practice at the highest level receive the doctoral knowledge required for safe nursing practice and provide quality patient care delivery and outcomes (AACN, 2006). The chapter will reflect upon these essentials and discuss the experiences and growth opportunities that I have achieved throughout my experience in MSU's DNP educational program.

Essential I: Scientific Underpinnings for Practice

Scientific Underpinnings for Practice discusses knowledge that integrates nursing science with ethics and the biophysical, psychosocial, analytical, and organizational sciences. The knowledge prepares the DNP graduate to determine the nature and significance of health and healthcare delivery, improve systems, and evaluate outcomes. I met this essential during the DNP program at MSU in core classes including Evidenced-Based Practice (EBP) I and II, Nursing Leadership, Ethics, Law & Policy, Statistical Applications, Design of Healthcare Systems, Healthcare Informatics, Program Planning & Evaluation, and the DNP Scholarly project. These

courses were spread through the curriculum, allowing me to build on my knowledge, and prepared me to implement and complete a Quality improvement Scholarly Project. One specific example of this exemplar was the Implementation of the postpartum phone call intervention for my project gave me first-hand knowledge of the significance of improving systems in healthcare settings to improve patient outcomes. Although my project did have many postpartum calls, I was able to identify the impact of the change through the data that I collected and positive feedback from peers who made the phone calls to the postpartum patients and from the providers who felt that the process helped them stay better connected to the patient. As a DNP, I will use what I have learned to continue to use science to guide my practice and improve outcomes for my patients.

Essential II: Organizational and System Leadership for Quality Improvement and Systems Thinking

Essential II emphasizes the knowledge and skills important to eliminating health disparities through accountability, safety, communication, health policy, practice initiatives, financial initiatives, and research. I met this essential through the core classes of Program Planning & Evaluation, outcomes & Quality improvement as well as Financing and Budgeting of Healthcare systems. Both courses had students identify processes and improve them and lay foundational knowledge on how to use tools to improve systems. One tool I learned to use was a Value Stream Map. I created a Value Stream map to assess the process of bringing a portable chest X-ray to a patient in the ICU. Mapping out a process helped me analyze process waste and improve systems. I used this the knowledge I gained from the assignment to map out the process of postpartum follow-up in a rural hospital to identify areas to improve. I will continue to use this

knowledge in my future practice to evaluate processes, assess policies, and use evidence-based practice to improve systems, improving quality of care.

Essential III: Clinical Scholarship and Analytic Methods for Evidence-Based Practice

Essential III highlights scholarship and research, key essentials for doctoral education. This essential expands on Essential I, focusing on the translation of new science, its application, and evaluation. My Evidence-Based Research I and II class and Statistical analysis taught me how to successfully research literature and evaluate quality research. I was able to apply what I learned to perform a scoping literature review of databases and identify articles with targeted methods of improving postpartum follow-up to critically appraise and narrow down to use for my project. In my future practice, I will use this knowledge to find research to inform my practice.

Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care

Essential IV discusses the use of information/technology to support and improve patient care and healthcare systems through the design and evaluation of programs, the knowledge of technical skills to execute a plan and extract data, and the use of information to implement quality improvement initiatives and support practice administrative decision-making. In the MSU DNP Healthcare Informatics course I learned how to use technology to improve patient outcomes and make healthcare systems more efficient by optimizing healthcare delivery. I used what I learned to create timed messages through the EMR for each postpartum call so that the nurses call the patient back exactly one week after the initial call and organized the data through

a log on Excel to ensure follow-up calls occurred. In my future practice, I can use the skills I learned to streamline processes and manage data to improve my processes in my practice.

Essential V: Health Care Policy and Advocacy in Health Care

Healthcare policies are the backbone of change and can either facilitate or impede the delivery of care services. Policies establish guidelines for patients, healthcare organizations, and healthcare systems addressing health disparities, cultural sensitivity, ethics, access to care, quality of care, financing, and social justice in the delivery of healthcare. During the MSU DNP program, I took an Ethics, Law, & Policy course and I wrote an advocacy letter and reviewed ethical cases. I chose to write the advocacy letter to the Chief Executive Officer at a hospital I work for to advocate for a separate sick time off bank from Paid Time Off bank for staff and created a policy for her review. The course prepared me to have the confidence to advocate. For my project, I advocated for rural postpartum populations to create change. As a Nurse Practitioner, I will continue to be involved in healthcare policy and advocate for improvement in healthcare.

Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes

Essential VI focuses on collaborative team functioning and communication for effective team leadership to create change in complex healthcare systems. Delivery of healthcare takes a team. For my QI Project, I needed to involve nursing staff, information technology, care managers, and providers to make my project successful. During implementation, I had to organize meetings with the stakeholders to ensure an understanding of the new postpartum process and receive feedback to adjust to the needs of stakeholders and workflow. I faced

challenges including communication and scheduling barriers. Through the challenges, I learned the importance of communication and realized that to be a good leader I need to continue to address barriers to create change. In my future practice, I will use my knowledge and experiences from my project work to lead interprofessional teams to create changes in healthcare delivery systems.

Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health

Clinical Prevention and population health activities improve the health status of a population. In each course of the DNP program, individual, aggregate, or population health disparities were addressed through assignments and modules to address gaps in care. Integrating nursing science with knowledge from ethics, psychosocial, analytical, and organizational sciences, I was able to focus on a rural postpartum population in my community to reduce care gaps and promote health. Prior to the implementation of my project, women at one rural hospital saw their rural provider until 32-34 weeks gestation, then transitioned to an urban hospital for the remainder of the pregnancy and delivery, received one postpartum call at 72 hours by the rural hospital, and then had another care gap without check in until their six-week postpartum visit. The care gap concerned me with women living in rural areas of the United States at higher risk for maternal mortality than those in urban areas due to a lack of resources and access to care. Implementation of my project created individualized, earlier follow-up through the phone calls. Early follow-up ensures the health protection of mothers and newborns promoting individualized care and decreasing short and long-term healthcare expenses through early identification and intervention in high-risk conditions (Öztoprak & Erkaya, 2023).

Essential VIII: Advanced Nursing Practice

Advanced Nursing Practice involves the integration of didactic and clinical coursework to conduct assessments of health and illness, develop therapeutic relationships with patients and professionals, demonstrate advanced levels of clinical judgment, evaluate evidence-based care to improve outcomes, mentor and educate others, and create change through policy. Essential VIII was met through the completion of learning experiences in clinical rotations and foundational didactic coursework. I plan to use the knowledge I have learned through this essential to grow in my new role as an APRN by developing therapeutic relationships with my patients, using evidence-based practice to inform my practice, evaluating systems and processes to create change and improve outcomes, and stay involved in education to mentor future nurses or nurse practitioners to support the future of nursing.

Conclusion

Completing the DNP program has significantly elevated my proficiency across the eight essentials outlined by the AACN. Through rigorous academic and clinical experiences, I have honed my leadership, collaboration, and evidence-based practice skills, achieving a deeper understanding of healthcare and policy. MSU's DNP curriculum has provided me with a supportive pathway to meet these objectives and I can now confidently begin my journey as a well-prepared, competent nurse practitioner. I am committed to ongoing growth within these essentials, and I will continue to abide by them through the entirety of my career and continue to learn and grow as a nurse practitioner, contributing to the nursing profession.

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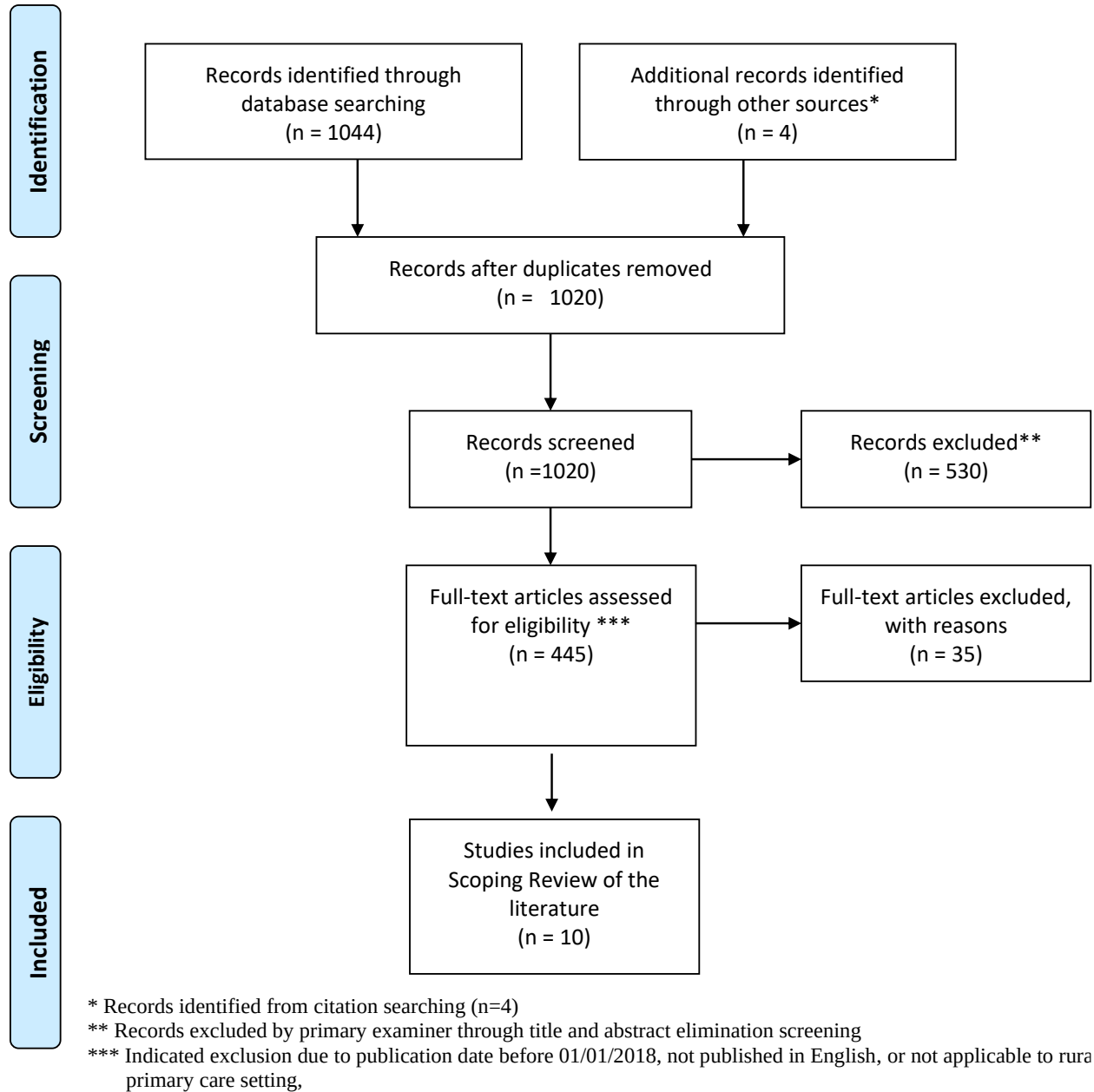
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APPENDICES

APPENDIX A

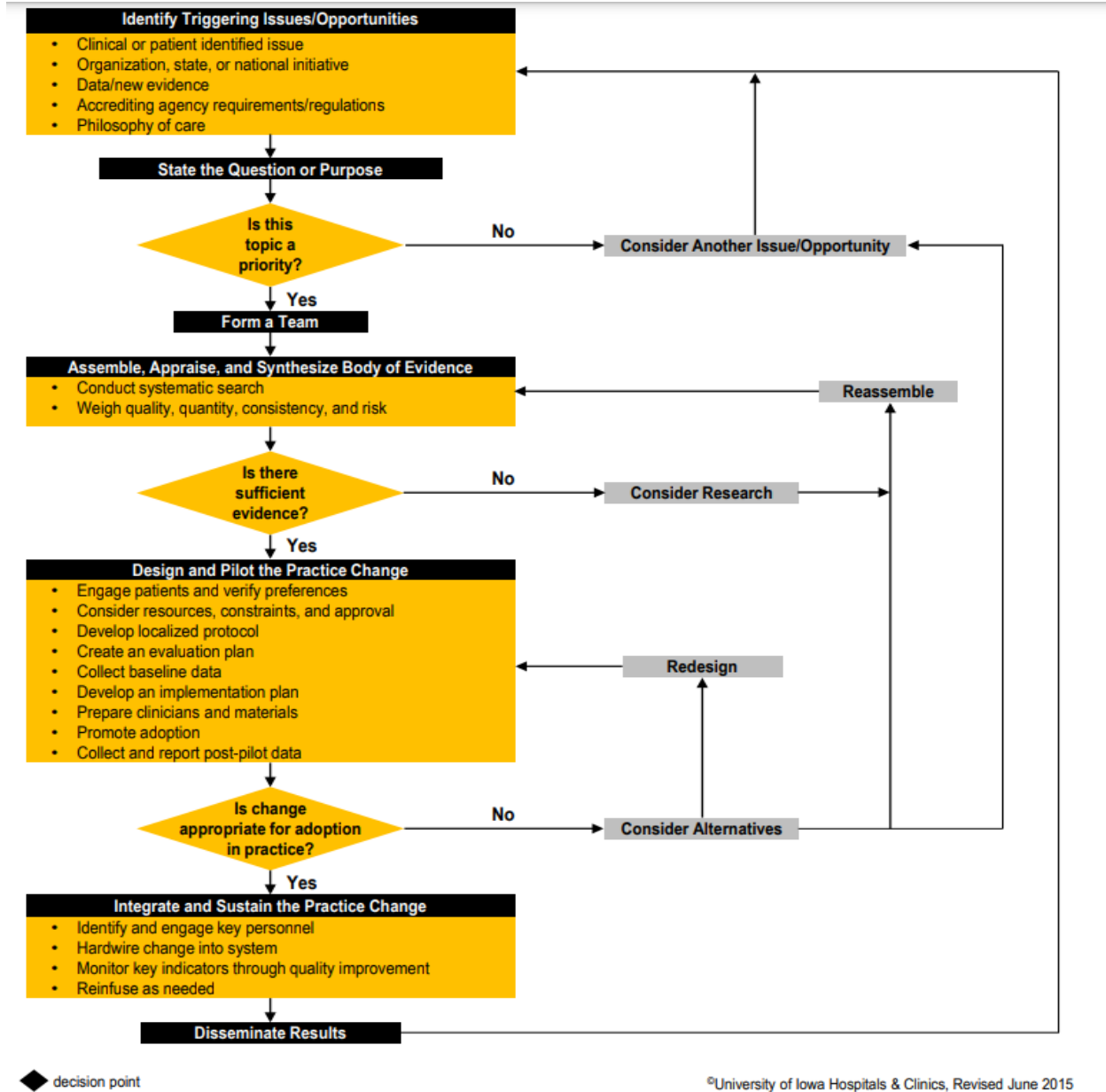
PRISMA DIAGRAM OF LITERATURE REVIEW



Appendix A. PRISMA diagram of Postpartum interventions to improve follow-up in a primary care setting.

APPENDIX B

IOWA MODEL OF EVIDENCE BASED PRACTICE



Reference

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APPENDIX C

EXCELL TEMPLATE FOR DATA COLLECTION

Patient Initials:	Postpartum Call: 72 Hours after discharge completion date:	Postpartum Call: seven-days after discharge completion date:	Postpartum Follow- up Appointment in Place: Yes/No