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# PHLC Postpartum Care Measure

## User Story - Aliyah Jackson



- Age: 22
- Health Concerns: Preeclampsia, history of depression and anxiety
- Social Needs: Low income, low health literacy, experience in foster care
- Location: Redding, Shasta County
- Occupation: Part-time in Retail
- Insurance: Partnership Health Plan
- Pronouns: she/her

### Introduction

The purpose of this user story is to walk through how data flows in the health and social care systems as Aliyah navigates her postpartum care journey.

**Current & Future State:** The user story contains use cases that illustrate the current state and future state. The current state, in black, is what currently happens in the system of care. The future state, in blue, contains feasible, suggested improvements to the current state that would help streamline workflows and improve coordination of postpartum care, all with the goal of improving performance on the PPC EPT measure. Some organizations and practices already perform certain future state workflow steps, while others have the capability to do so but have not yet implemented the necessary technology or workflows.

**System Interaction Diagrams:** The system interaction diagrams are visual representations of the step-by-step use cases. To support future implementation work, the blue arrows in the diagrams represent the suggested future state steps.



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## **User Story Overview:**

This user story provides a narrative walkthrough of Aliyah's postpartum care journey. It includes her delivery in the hospital, her hospital admission for preeclampsia, and her 1-week postpartum care visit. This user story focuses on data exchange and workflow solutions to:

- Improve timeliness and quality of postpartum care, specifically for preeclampsia, lactation support, and mental health screening.
- Coordinate dyadic care so both birthing person and newborn can attend a contiguous postpartum/newborn visit.
- Improve care coordination for high-risk postpartum individuals, specifically for those qualifying for enhanced care management.
- Correctly bill postpartum care so practices and health plans receive EPT credit for the PPC measure.

## **About Aliyah:**

- Aliyah is 22 years old, was in the foster care system as a kid, and currently lives in Redding with her aunt.
- She was working part-time in retail until giving birth to her baby, Cora, and needs to figure out child care so she can start working again.
- She has a history of depression and anxiety, and has been experiencing more anxiety and depression since giving birth to her baby.

## **Aliyah's Challenges, Goals, and Expectations from the CA Health and Social Care System:**

- She did not receive prenatal care because she realized she was pregnant late and it was hard to schedule around work.
- Her boyfriend broke up with her when he found out she was pregnant. She has little support with her baby.
- She was diagnosed with preeclampsia during the delivery.
- She has a history of anxiety and depression.
- She needs timely and accurate transfer of medical records from the hospital where she delivered to her primary care provider who does not have prenatal records for her.
- She needs consistent check-ups for her preeclampsia and needs a mental health screening.



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- She needs to be connected to resources for stable housing and child care.
- She needs accessible educational materials about preeclampsia, breastfeeding, and caring for herself and baby more generally.

### **Aliyah's Pain Points:**

- Unstable living situation for her and her baby.
- Needs to find child care so she can find a job.
- Difficulty scheduling postpartum appointments around work.
- Difficulty bonding with baby and feeling increasingly depressed and anxious, but doesn't have anyone to talk to about this.
- Has a low health literacy level and doesn't know what hypertension is
- Does not have any education on breastfeeding, or know what resources are available for her or her baby.
- She has some tentativeness about going to the doctor due to previous visits where she experienced discrimination.

### **Aliyah's Typical Routines & Interactions:**

- Was working ~24 hours a week at her retail job before having her baby.
- Socially isolated from her friends which contributes to her depression and anxiety.
- She hasn't had any contact with her ex-boyfriend since he found out she was pregnant.
- Mainly interacts with her aunt, who she is currently living with, but needs to find a different living situation soon.
- Used to like to paint and write poetry but doesn't feel like she has the time or energy for that anymore.

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## **Use Case 1: Hospital Admission for Preeclampsia, Assignment of MCP Care Manager, Scheduling Postpartum Follow-up Visit, and Referral for ECM**

### **1A: Hospital Admission for Preeclampsia**

Aliyah goes into labor with her daughter Cora (without having received prenatal care) and is admitted to the hospital.

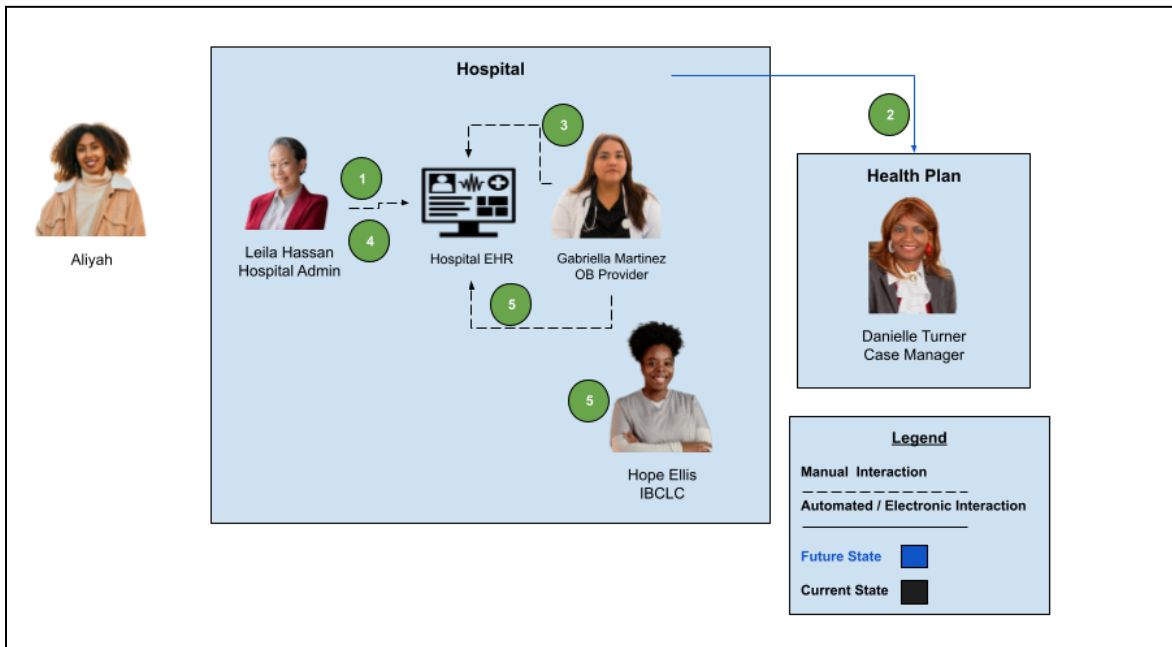
Step	Current State	Future State
1A.1	<b>Leila Hassan, the Hospital Admin</b> , creates a record for Aliyah in the hospital EHR.	No change.
1A.2	The hospital sends an admission notification to Aliyah's health plan.	The hospital sends an admission notification to Aliyah's health plan indicating that she is there for a birth. Since the health plan was previously unaware that she was pregnant, Aliyah is flagged for high intensity transitional care services (TCS). <sup>1</sup> Aliyah is assigned to <b>Danielle Turner, a MCP care manager</b> , to monitor her case.
1A.3	During the delivery of her daughter, <b>Gabriella Martinez, the OB</b> diagnoses Aliyah with preeclampsia. She did not get diagnosed earlier because she did not receive prenatal care. <b>Dr. Martinez</b> documents the details of the delivery and the complication due to preeclampsia in the delivery summary in the EHR.	No change.
1A.4	Due to her preeclampsia, Aliyah is transferred to the postpartum unit for further monitoring. <b>Leila Hassan</b>	No change.

<sup>1</sup> <https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf>



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	documents this status in Aliyah's record.	
1A.5	<b>Dr. Martinez</b> submits a request in the EHR for Aliyah and her daughter to receive a lactation consultation with <b>Hope Ellis, the hospital IBCLC</b> .	No change



Use Case Scene 1A: Hospital Admission for Preeclampsia

**1B: Scheduling Postpartum Follow-up Visit**

Dr. Gabriella Martinez, the OB provider, reviews Aliyah's progress and determines that Aliyah is ready for discharge after 2 days in the postpartum unit.

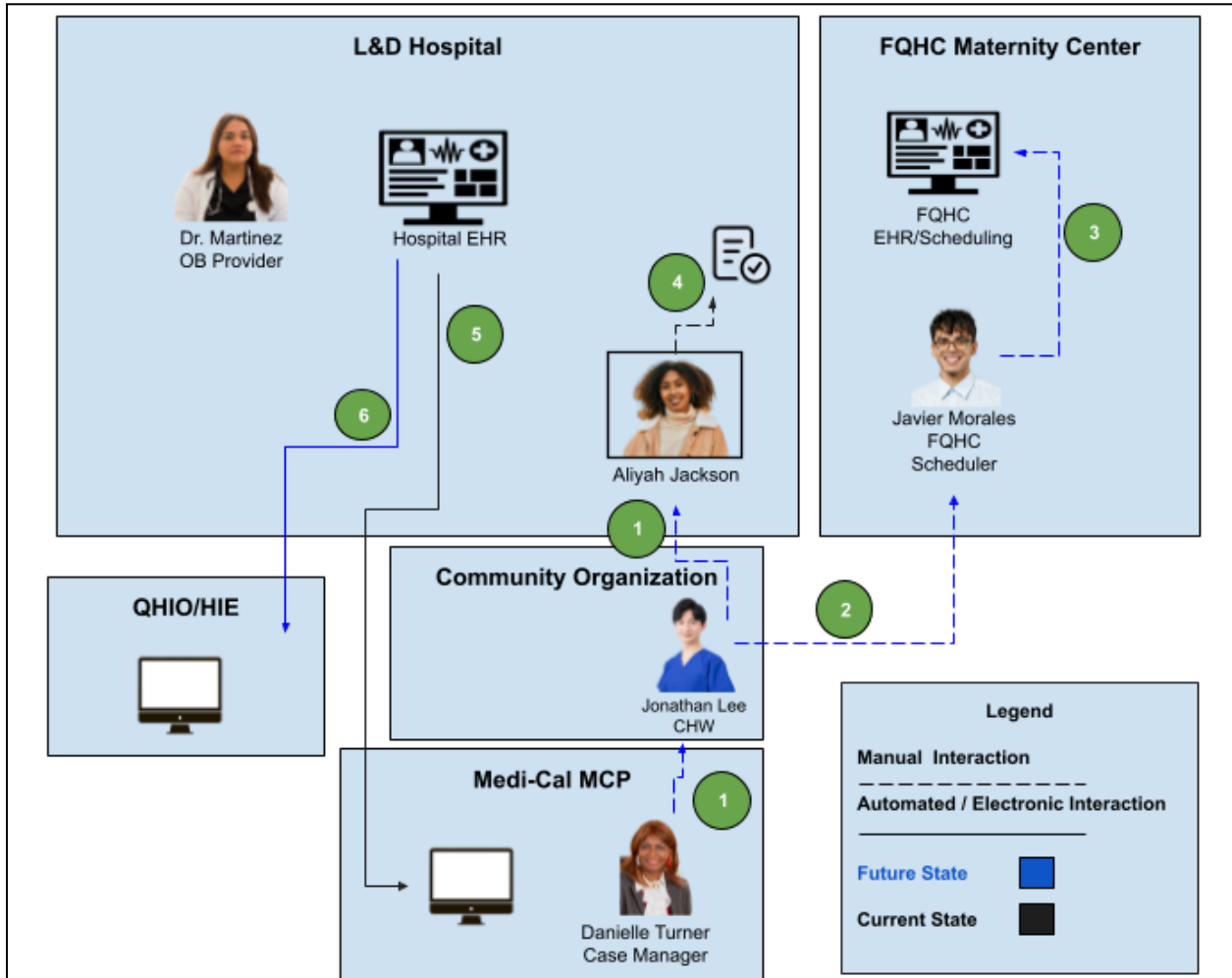
Step	Current State	Future State
1B.1	<b>Leila Hassan, the Hospital Admin</b> faxes a referral order to the FQHC Maternity Center, indicating that Aliyah should be seen within a week after discharge.	<b>Danielle Turner, the MCP care manager</b> arranges for <b>Jonathan Lee, a CHW from a community organization that contracts with the MCP</b> , to visit Aliyah in-person before discharge to schedule her



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		follow-up appointment at FQHC Maternity Center.
1B.2	<b>Joshua Reyes, the postpartum nurse,</b> reviews the discharge instructions with Aliyah, including how to schedule the OB follow-up appointment, and documents this education in the EHR.	During the visit with <b>Jonathan,</b> Aliyah expresses that she needs more support with breastfeeding. <b>Jonathan</b> calls <b>Javier Morales, the FQHC Scheduler</b> to schedule a contiguous postpartum appointment for Aliyah and newborn appointment for her daughter, as well as a 60-minute lactation consultation with the staff IBCLC.
1B.3	<b>Aliyah</b> calls <b>Javier Morales, the FQHC Scheduler</b> to schedule her postpartum follow-up appointment.	<b>Javier</b> views both the Maternity schedule and Pediatrics schedule to schedule both appointments contiguously, and also schedules the lactation consultation with the IBCLC on staff.
1B.4	<b>Aliyah</b> signs a consent form to allow the hospital to share her medical records for her follow-up visit.	No change.
1B.5	The hospital sends a discharge notification to the MCP when Aliyah is discharged.	No change.
1B.6	Not commonly implemented	The hospital EHR sends a copy of Aliyah’s discharge summary to the QHIO.

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Use Case Scene 1B: Scheduling Postpartum Follow-up Visit

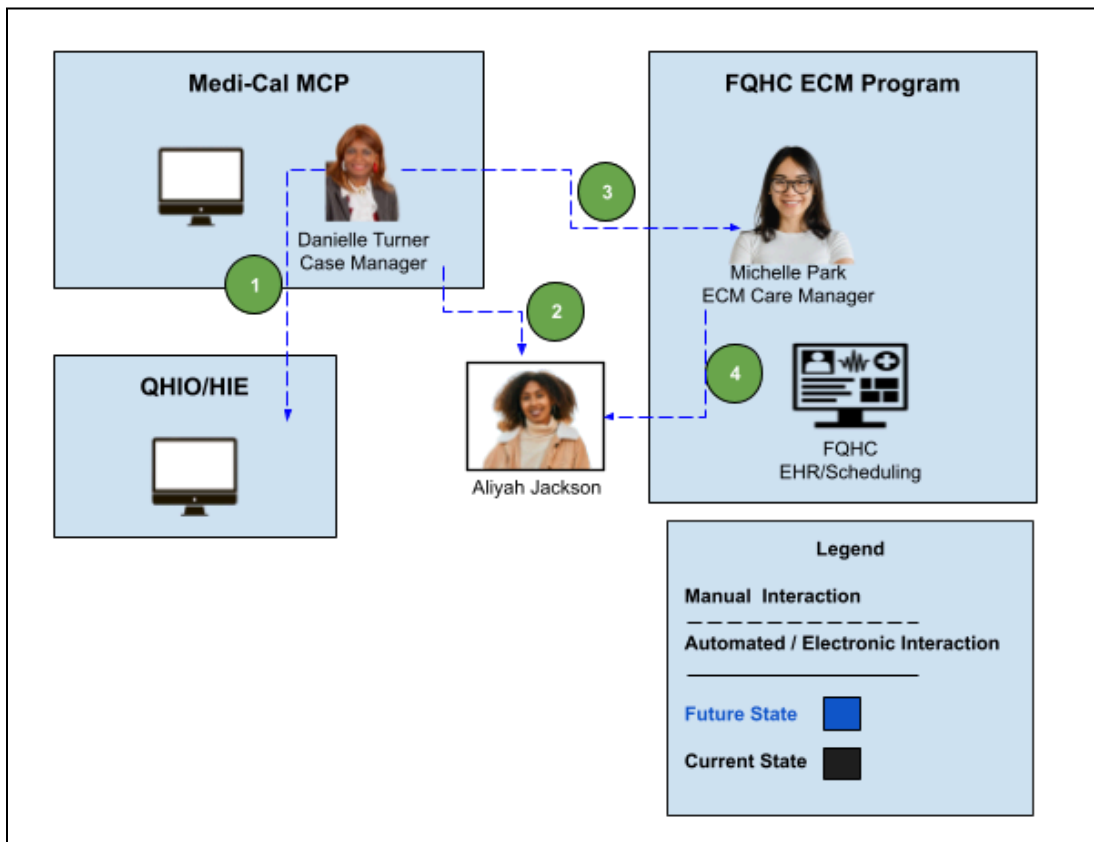
**1C: Post-Discharge Follow-up & Referral for ECM**

Step	Current State	Future State
1C.1	Not commonly implemented	<b>Danielle Turner</b> , the MCP care manager, queries the QHIO for a copy of Aliyah's discharge summary.
1C.2	Aliyah is flagged by the MCP as qualifying for ECM under the birth equity population of focus. Aliyah is	Aliyah is flagged by the MCP as qualifying for ECM under the birth equity population of focus. <b>Danielle Turner, the MCP care</b>



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	included in a member information file (MIF) sent to an ECM provider in Redding.	<b>manager</b> , calls Aliyah after discharge to check in on how she's doing and let her know about the benefits of ECM.
1C.3	Not currently implemented	<b>Danielle</b> calls the FQHC ECM provider to refer her directly to the FQHC for ECM.
1C.4	The ECM provider in Redding receives the MIF and calls Aliyah to schedule an ECM assessment.	<b>The FQHC ECM care manager, Michelle Park</b> , calls Aliyah to schedule an ECM assessment. <b>Michelle</b> arranges for the ECM assessment to occur at the FQHC during Aliyah's postpartum follow-up visit.



Use Case 1C: Post-Discharge Follow-up & Referral for ECM

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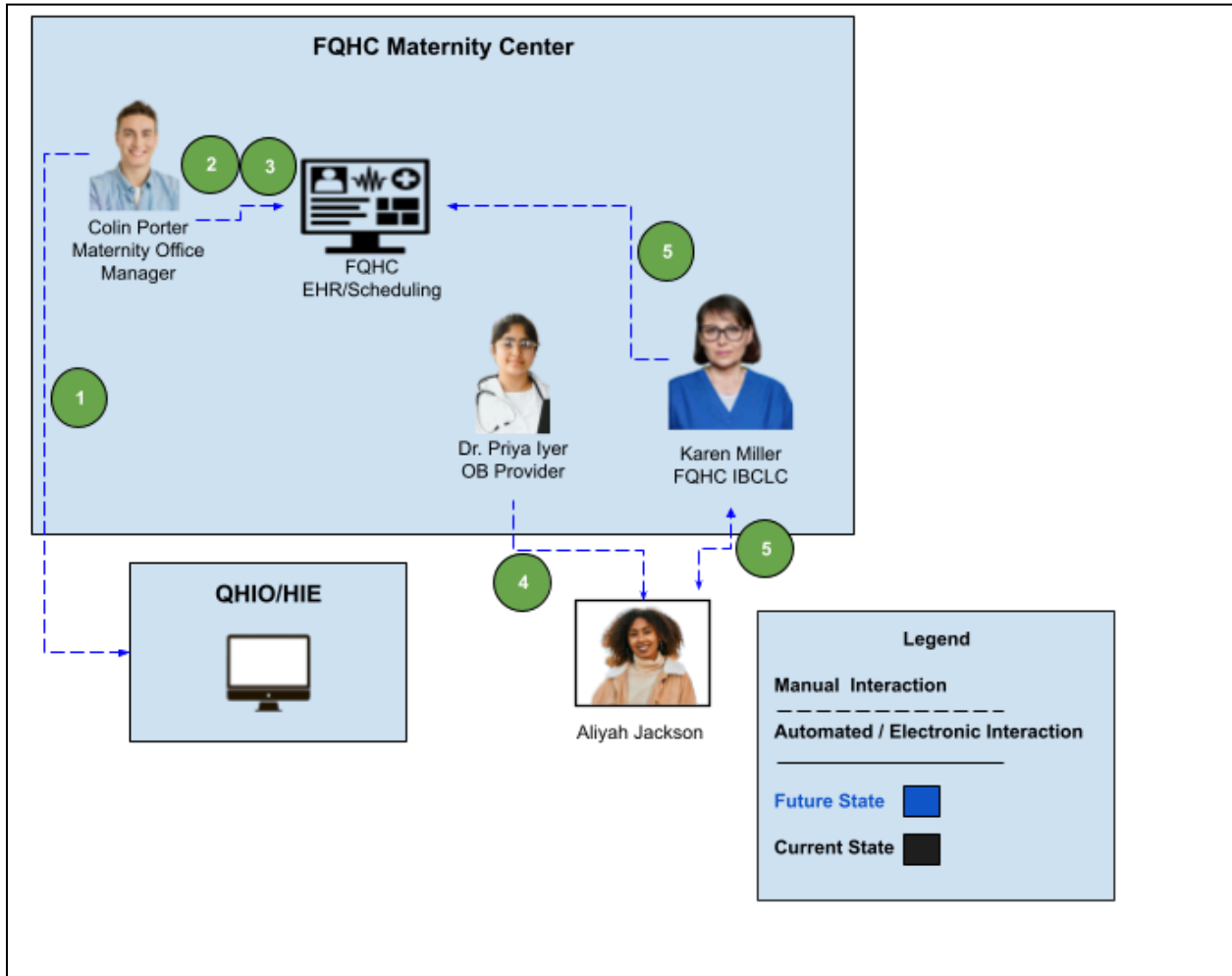
## **Use Case 2: 1-week Postpartum Visit with FQHC Maternity, Breastfeeding Support, Mental Health Screening, and ECM Assessment**

### **2A: Follow-up for Preeclampsia with FQHC Maternity & Lactation Consultation**

Step	Current State	Future / Ideal State
2A.1	Before Aliyah's follow-up visit, <b>Colin Porter, the FQHC Maternity Office Manager</b> , calls the hospital to request her discharge summary, and <b>Leila Hassan, the hospital admin</b> , faxes it over.	<b>Colin</b> queries the QHIO/HIE for Aliyah's discharge summary.
2A.2	<b>Colin</b> creates a record for Aliyah in the FQHC EHR and scans the discharge summary into her record, including the preeclampsia diagnosis.	<b>Colin</b> creates a record for Aliyah in the FQHC EHR and imports the discharge summary from the QHIO into the EHR.
2A.3	Not commonly implemented	<b>Colin</b> links Aliyah's record to her baby's record in the FQHC EHR.
2A.4	One week after her hospital admission, Aliyah attends her postpartum follow-up appointment at the FQHC Maternity Center. Her attendance means that the practice will receive EPT credit for her postpartum visit. <b>Dr. Priya Iyer, the OB provider</b> , conducts a postpartum check and adjusts her blood pressure medications as needed.	Aliyah and her baby attend their combined postpartum/newborn visit, and lactation consultation, and Aliyah completes her initial assessment for ECM. Her attendance means that the practice will receive EPT credit for her postpartum visit. <b>Dr. Priya Iyer, the OB provider</b> , conducts a postpartum check and adjusts her blood pressure medications as needed.
2A.5	Not commonly implemented	Aliyah and her daughter have a lactation consultation with <b>Karen Miller, the FQHC Staff IBCLC</b> . During the consultation, Karen is able to seamlessly view both Aliyah and her baby's records since they are linked in the EHR. <b>Karen</b> documents

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the encounter in Aliyah's record.



Use Case Scene 2A: Follow-up for Preeclampsia with FQHC Maternity & Lactation Consultation

**2B: PMAD Screening, ECM Assessment, & Visit Documentation**

Step	Current State	Future State
2B.1	During the postpartum visit, <b>Luca Bianchi, the medical assistant</b> screens Aliyah for Perinatal Mood and Anxiety	No change.



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	<p>Disorder (PMAD) with the Edinburgh Postnatal Depression Scale. <b>Luca</b> verbally asks her the questions and inputs her answers into the EHR. The questionnaire is automatically scored within the EHR. Aliyah scores ‘17’ on the screening, indicating that she has moderate depression.</p>	
<p><b>2B.2</b></p>	<p><b>Dr. Priya Iyer, the OB provider,</b> includes instructions in the after-visit summary for Aliyah to find and schedule an appointment with a mental health provider.</p>	<p><b>Dr. Iyer</b> submits an internal referral for Aliyah to see a mental health provider at the FQHC.</p>
<p><b>2B.3</b></p>	<p>Not commonly implemented</p>	<p>After the postpartum visit, <b>Michelle Park, the FQHC ECM care manager,</b> conducts the initial assessment with Aliyah, and saves this assessment in Aliyah’s record. Based on the assessment, <b>Michelle</b> refers Aliyah to community resources to address social determinants of health, including housing and childcare.</p>
<p><b>2B.4</b></p>	<p>Not commonly implemented</p>	<p><b>Michelle</b> sees in Aliyah’s record that she has a referral to see a mental health provider and checks in to make sure she knows next steps for scheduling the appointment.</p>
<p><b>2B.5</b></p>	<p>At the end of the visit, <b>Colin, the FQHC Maternity Office Manager</b> documents that Aliyah has had a postpartum care visit, including the general postpartum</p>	<p>At the end of the visit, <b>Colin, the FQHC Maternity Office Manager</b> documents that Aliyah has had a postpartum care visit, including the general postpartum</p>

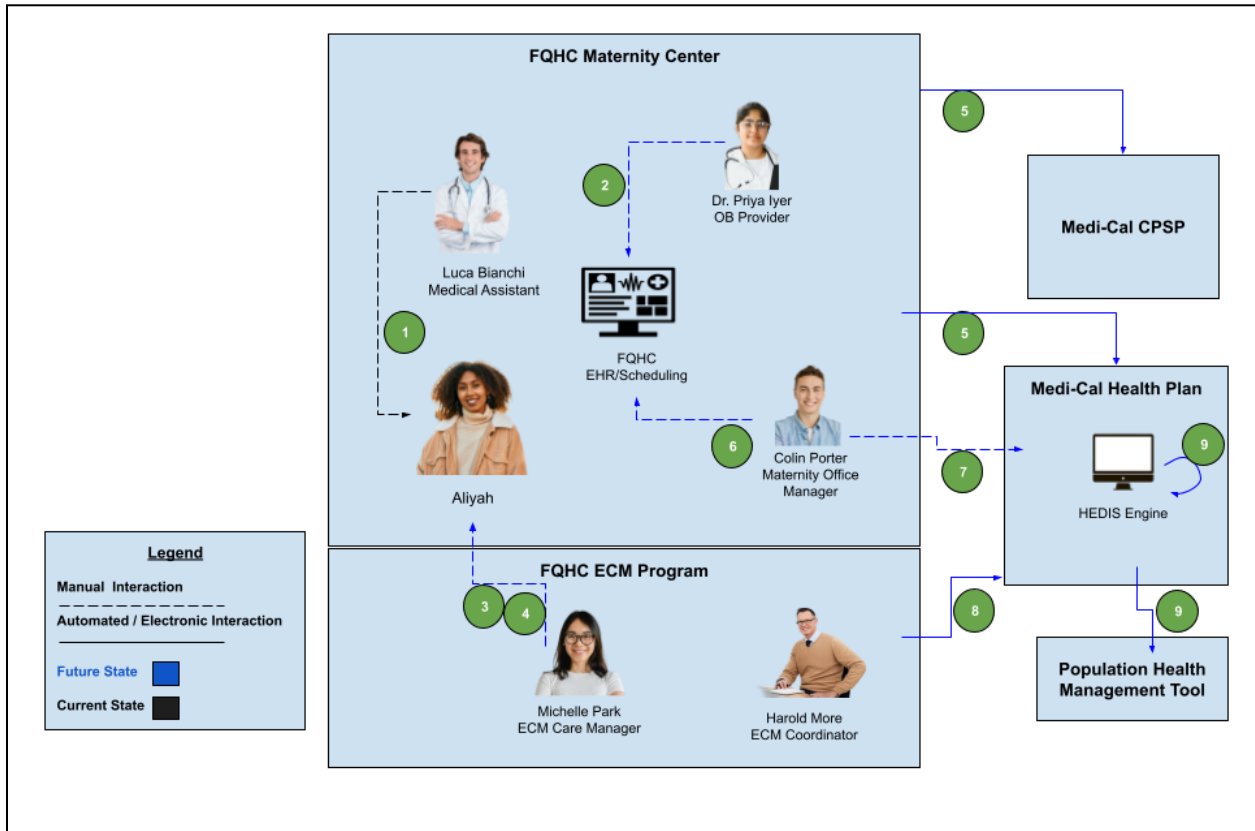


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	check, mental health screening and breastfeeding support, and submits this claim to the health plan to get credit for the PPC measure.	check, mental health screening and breastfeeding support, and submits this claim to the health plan to get credit for the PPC measure. He submits a claim for the lactation consultation to Medi-Cal CPSP.
2B.6	Not commonly implemented	<b>Colin</b> runs a report in his EHR to create a standard supplemental data file containing all the depression screenings and results completed in the last 30 days. Aliyah's screening is included in that data set (Edinburgh Postnatal Depression Scale (EPDS)) = 99046-5, 17)
2B.7	Not commonly implemented	<b>Colin</b> uploads the supplemental data file to the MCP shared drive.
2B.8	Not applicable	<b>Harold More, the ECM Coordinator</b> , documents Aliyah’s ECM visit and submits the claim to the health plan.
2B.9	The claims data is automatically uploaded into the <b>MCP HEDIS engine</b> and the <b>Population Health Management tool</b> to update all the measures and close outstanding gaps where appropriate.	The claims and supplemental data is automatically uploaded into the <b>MCP HEDIS engine</b> and the <b>Population Health Management tool</b> to update all the measures and close outstanding gaps where appropriate.



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2B: PMAD Screening, ECM Assessment, & Visit Documentation






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### Personas referenced in this document:

Name	Photo	Human Actor	Business Actor	System Actor
Aliyah Jackson		Persona	N/A	N/A
Gabriella Martinez		L&D Hospital OB Provider	Hospital	Hospital EHR
Leila Hassan		L&D Hospital Admin	Hospital	Hospital EHR
Joshua Reyes		Postpartum Nurse	Hospital	Hospital EHR
Hope Ellis		Hospital IBCLC	Hospital	Hospital EHR
Colin Porter		FQHC Maternity Office Manager	FQHC	FQHC EHR



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Priya Iyer		FQHC OB Provider	FQHC	FQHC EHR
Javier Morales		FQHC Scheduler	FQHC	FQHC EHR
Karen Miller		FQHC IBCLC	FQHC	FQHC EHR
Michelle Park		FQHC ECM Care Manager	FQHC	FQHC EHR
Luca Bianchi		FQHC Maternity Medical Assistant	FQHC	FQHC EHR
Harold More		FQHC ECM Coordinator	FQHC	FQHC EHR
Danielle Turner		MCP Care Manager	MCP	Population Health Management Tool and HEDIS engine



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Jonathan Lee		Community Health Worker	Community Organization	Case Management System
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