POSTPARTUM ACCESS & CONTINUITY OF CARE (PACC) MEASUREMENT GRID

The PACC Initiative's purpose is to work with providers, hospitals, and other partners to improve maternal health through a hospital-facilitated continuum of postpartum care by arranging and providing respectful, timely, and risk-appropriate, coordinated care and services.

The measures listed in this document will be calculated and reported monthly to participating hospitals in a quality improvement data report so that facilities can track their progress. These measures may be subject to change during the initiative with prior approvals.

For process and outcome measures, hospitals will report data on 20 systematically selected discharged deliveries per month.

Selection process:

- If your hospital has 40 births per month or more:

Start by dividing the total number of delivery discharges that occurred at your facility in a given month by 20. Then select every nth chart where n is the result of that division.

e.g. Your hospital had 105 discharged deliveries in June. Divide 105 by 20, which equals 5.25. 5 is your nth for June. Report data on every 5th chart.

e.g. Your hospital had 119 discharged deliveries in June. Divide 119 by 20, which equals 5.95. 5 is your nth for June. Report data on every 5th chart.

The above examples are exemplifying the importance of rounding down to the nearest whole number. This is needed to ensure that each hospital will have the correct amount of total delivery charts per month. Rounding up will result in an inadequate amount of delivery charts abstracted.

- If your hospital has less than 40 births per month, submit the first 10 delivery charts per month.

Patients need to meet the following criteria:

Inclusion criteria (qualifying patients): include women admitted for delivery who are discharged home, regardless of infant outcome.

Exclude: pregnant women who are in observation status or seen in the ED; pregnant women not admitted for delivery; women admitted for delivery who die prior to discharge or are transferred to other hospitals.

#	Outcome Measures	Description	Reported	Source
O1	Early postpartum visit/encounter (Post-Birth Health Check) scheduled within 2 weeks after birth	Numerator: # of qualifying women with documented early postpartum visit/encounter scheduled within 2 weeks after birth regardless of medical/social risk Denominator: # qualifying women **NOTE:** Appointment needs to be scheduled and documented prior to patient discharge	Monthly Disaggregate by race-ethnicity, insurance type, and risk	Abstracted from medical chart

02	Patient PP education	Numerator: # of qualifying women verbally educated and to whom written materials have been provided for the following postpartum education topics: 1. Benefits of early risk-appropriate PP visits/encounters (Post-Birth Health Check), 2. PP warning signs and 3. Benefits of and options for pregnancy spacing, family planning, and contraceptive choice. Denominator: # qualifying women	Monthly Disaggregate by race-ethnicity, insurance type, and risk	Abstracted from medical chart
Secondary outcome	The Agency for Health Care Administration (AHCA) could report rates on emergency room utilization, hospital readmissions, and postpartum visit attendance as the data becomes available. The data has a delay of 6-9 months.		Periodically by AHCA	Medicaid Claims data
#	Process Measures	Description	Reported	Source
P1	Schedule/arrange risk-appropriate PP care including obstetrical, specialty, and other community services prior to discharge	Numerator: # of women for whom risk-appropriate PP care* including obstetrical, specialty, and other community services prior to discharge have been scheduled/arranged Denominator: # qualifying women *Refer to the Maternal Discharge Risk Assessment for guidance **NOTE:** Appointments need to be scheduled and documented prior to patient discharge.	Quarterly	Abstracted from medical chart
P2	Conduct a Maternal Discharge Risk Assessment	The Maternal Discharge Risk Assessment determines the need of the mother for additional services during the PP period. It should be conducted early in the delivery admission. It is included in the PACC toolkit. Numerator: # of women with a documented Maternal Discharge Risk Assessment Denominator: # qualifying women	Monthly	Abstracted from medical chart

P3	Conduct a PP Discharge Assessment just prior to discharge	The PP Discharge Assessment (vital signs and appropriate response) should be done just prior to discharge to make sure the mother is stable and medically ready to leave the hospital. Numerator: # of women with a documented maternal safety check prior to discharge Denominator: # qualifying women	Monthly	Abstracted from medical chart
P4	Educate patients on the benefits of early risk-appropriate PP visits/encounters (Post-Birth Health Check)	Numerator: # of women verbally educated and to whom written materials have been provided on the benefits of early risk-appropriate PP visits/encounters Denominator: # qualifying women	Monthly	Abstracted from medical chart
P5	Educate all patient on PP Warning Signs and provide written and verbal education and materials	Numerator: # of women verbally educated and to whom written materials have been provided on PP Warning Signs Denominator: # qualifying women	Monthly	Abstracted from medical chart
P6	Educate patients on the benefits of and options for pregnancy spacing, family planning and contraceptive choice	Numerator: # of women verbally educated and to whom written materials have been provided on the benefits of and options for pregnancy spacing, family planning and contraceptive choice Denominator: # qualifying women	Monthly	Abstracted from medical chart
P7	Educate inpatient and outpatient providers and staff using initiative promotional and education materials	Training bundle includes 1. Benefits of early risk-appropriate PP care, 2. Process, guideline, or protocol for facilitating scheduling the early PP visit prior to discharge, 3. Documentation and billing for the early PP visit and 4. Components of the early risk-appropriate PP visit/encounter (Post-Birth Health Check - "Follow the B's!") **Nurses:** Numerator: # of nurses who received education on EACH topic of the PACC education bundle to date Denominator: Total # of L&D nurses **Providers:** Numerator: # of advanced practice nurses (ARNPs, PAs), midwives, and physicians who received education on EACH topic of the PACC education bundle to date Denominator: Total # of L&D providers **Report:** 0%; 1-25%; 26-50%; 51-75%; 76-100%	Quarterly	Varies by hospital

Hospitals need to implement and/or reinforce key processes, guidelines, policies, and resources to support PACC. Hospitals will report structural measures until they have them fully implemented. Report as follows:

- **Not started**
- **Planning**
- **Started Implementing** - started implementation in the last 3 months
- **Implemented** - less than 80% compliance after at least 3 months of Implementation (Not routine practice)
- **Fully Implemented** - at least 80% compliance after at least 3 months of Implementation (Routine practice)

#	Structural Measure	Description	Frequency
S1	A. Develop a process flow to schedule early risk-appropriate PP visits/encounters prior to discharge B. Align policies, guidelines, and procedures to support risk-appropriate PP visits/encounters prior to discharge	Numerator: # of hospitals that have developed a process flow to schedule early risk-appropriate PP visits/encounters prior to discharge and aligned policies and procedures accordingly Denominator: # of participating hospitals	Quarterly
S2	Implement universal Maternal Discharge Risk Assessment	Numerator: # of hospitals that have implemented a universal Maternal Discharge Risk Assessment Denominator: # of participating hospitals	Quarterly
S3	Establish a system to ensure that all patients receive recommended and documented PP education and discharge information	Numerator: # of hospitals that have established a system to ensure that all patients receive recommended and documented PP education and discharge information Denominator: # of participating hospitals	Quarterly
S4	Develop a strategy to engage and educate inpatient and outpatient providers and staff using initiative promotional and educational materials	Numerator: # of hospitals that have developed a strategy to engage and educate inpatient and outpatient providers and staff using initiative promotional and education materials Denominator: # of participating hospitals	Quarterly

S5	Implement periodic education and engagement of new hires using initiative promotional and education materials	Numerator: # of hospitals that have a plan in place to continue to engage and educate new hires using initiative promotional and education materials Denominator: # of participating hospitals	Quarterly
S6	Implement periodic education and engagement for ER physicians & staff about pregnancy/PP care including PP screening & care practices	Numerator: # of hospitals that have developed a strategy to engage and educate ER physicians & staff about pregnancy/PP care including PP screening & care practices Denominator: # of participating hospitals	Quarterly
S7	ER established standardized verbal screening for pregnancy now and during the past year as part of its triage or initial assessment process	Numerator: # of hospitals that have established a standardized ER verbal screening for pregnancy now and during the past year as part of its triage or initial assessment process Denominator: # of participating hospitals	Quarterly

Questions? Please contact FPQC@usf.edu