AIM

ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH

Postpartum Discharge Transition Patient Safety Bundle

Core Data Collection Plan

State Surveillance

Metric	Name	Description	Notes
SSI	Postpartum Readmissions within 42 Days	**Report N/D** **Denominator:** All documented birth hospitalizations **Numerator:** Among the denominator, readmissions at or within 42 days of discharge from birth hospitalization	Disaggregate by race/ ethnicity
SS2	Postpartum Pregnancy-Related Deaths	**Report N/D** **Denominator:** Live births among state residents **Numerator:** Pregnancy-related deaths between 7 and 365 days postpartum	Disaggregate by race/ ethnicity
SS3	Postpartum Visit Attendance	**Report N/D** **Denominator:** All documented birth hospitalizations **Numerator:** Birth hospitalizations in which patients had a postpartum visit at or within 7 to 84 days after discharge from birth hospitalization	Calculate using HEDIS measure specifications. Disaggregate by race/ ethnicity

Process

Metric	Name	Description	Notes
P1	Inpatient-Outpatient Care Provider Collaborative Education	**Report integers for each submeasure** A. At the end of this reporting period, **how many shared learning experiences** on issues related to pregnancy and the postpartum period that cross the continuum of care took place between inpatient and affiliated outpatient providers and nursing staff? B. At the end of this reporting period, **how many care settings*** were represented by attendees at all shared learning experiences?	*May include clinical and non-clinical care settings
P2	Provider and Nursing Education – Postpartum Concerns	**Report proportion completed (estimated in 10% increments-round up)** At the end of this reporting period, what cumulative proportion of inpatient clinical OB providers and nursing staff has received within the last 2 years an education program on **life-threatening postpartum concerns**?	
P3	Provider and Nursing Education – Respectful and Equitable Care	**Report proportion completed (estimated in 10% increments-round up)** At the end of this reporting period, what cumulative proportion of inpatient clinical OB providers and nursing staff has received within the last two years an education program on **respectful and equitable care**?	
P4	Postpartum Visit Scheduling	**Sample patient charts or report for all patients; report N/D** **Denominator:** All maternal discharges following a live birth, whether from sample or entire population **Numerator:** Among the denominator, those who had a postpartum visit scheduled before or within 24 hours of discharge from birth hospitalization	Disaggregate by race/ ethnicity

Metric	Name	Description	Notes
P5	Screening for Social and Structural Drivers of Health (SSDOH)	**Sample patient charts or report for all patients; report N/D** **Denominator:** All maternal discharges following a live birth, whether from sample or entire population **Numerator:** Among the denominator, those who were screened for SSDOH using a standardized, validated tool by the time of discharge from birth hospitalization*	*To be included in the numerator, patients had to have answered any question(s) from a validated SSDOH screening tool. Disaggregate by race/ ethnicity
P6	Patient Education on Life-Threatening Postpartum Concerns	**Sample patient charts or report for all patients; report N/D** **Denominator:** All maternal discharges following a live birth, whether from sample or entire population **Numerator:** Among the denominator, those who had documentation of verbal and written education on life-threatening postpartum concerns before discharge from birth hospitalization*	*To be included in the numerator, patient record needs to include documentation of verbal and written education.

Structure

Metric	Name	Description	Notes
S1	Inpatient-Outpatient Care Coordination Workgroup	**Report Start Date** Has your hospital established a **multidisciplinary workgroup of inpatient and outpatient providers** that meets regularly to identify and implement best practices on issues related to pregnancy and the postpartum period that cross the continuum of care?	This workgroup should help coordinate the completion of S2-S6.

Metric	Name	Description	Notes
S2	Resource Mapping/ Identification of Community Resources	**Report Initial Completion Date** Has your hospital created a **comprehensive list of community resources**, customized to include resources relevant for pregnant and postpartum people, that will be shared with all postpartum inpatient nursing units and outpatient OB sites?	• Resources list should be updated annually. • Resources list should include OUD/SUD treatment resources as well as mental health resources and allow for customization based on patient population (e.g. BIPOC).
S3	Shared Comprehensive Postpartum Visit Template	**Report Completion Date** Has your hospital shared with all its affiliated outpatient sites a **postpartum visit template** that includes at minimum all elements of a comprehensive postpartum visit as outlined in the AIM Postpartum Discharge Transition Bundle Implementation Details?	
S4	Emergency Department (ED) Screening for Current or Recent Pregnancy	**Report Start Date** Has your ED established or continued **standardized verbal screening for current pregnancy and pregnancy in the past year** as part of its triage process?	
S5	Patient Education Materials on Urgent Postpartum Warning Signs	**Report Completion Date** Has your department developed/curated **patient education materials on urgent postpartum warning signs** that align with culturally and linguistically appropriate standards?	
S6	Patient Event Debriefs	**Report Start Date** Has your department established a standardized process to conduct debriefs with patients after a severe event?	• Include patient support networks during patient event debriefs, as requested. • Severe events may include the TJC sentinel event definition, severe maternal morbidity, or fetal death.