WHM 1 PERFORMANCE MEASURE **Goal: Prenatal Care** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/or facilitating timely prenatal care.
GOAL	To ensure supportive programming for prenatal care.
MEASURE	The percent of MCHB funded projects addressing prenatal care. The percent of pregnant program participants who receive prenatal care beginning in the first trimester.
DEFINITION	**Tier 1**: Are you addressing prenatal care in your program? ☐ Yes ☐ No **Tier 2**: Through what processes/ mechanisms are you addressing prenatal care? ☐ Technical Assistance ☐ Training ☐ Product Development ☐ Research/ Peer-reviewed publications ☐ Outreach/ Information Dissemination/ Education ☐ Tracking/ Surveillance ☐ Screening/ Assessment ☐ Referral/ care coordination ☐ Direct Service ☐ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes? % of pregnant women who receive prenatal care beginning in the first trimester **Numerator:** Pregnant program participants who began prenatal care in the first trimester of pregnancy. **Denominator**: Pregnant program participants who were enrolled prenatally, prior to their second trimester of pregnancy.
BENCHMARK DATA SOURCES	Related to MICH Objective #10: Increase the proportion of pregnant women who receive prenatal care beginning in the first trimester (Baseline: 70.8% in 2007, Target: 77.9%)
GRANTEE DATA SOURCES	Title V Ntnl Outcome Measure #1, Healthy People 2020 MICH-10
SIGNIFICANCE	Entry of prenatal care during the first trimester is important to ensuring a healthy pregnancy. Women who receive delayed

WHM 1 PERFORMANCE MEASURE **Goal: Prenatal Care** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/or facilitating timely prenatal care.
	prenatal care (entry after the first 12 weeks) are at risk for having undetected complications in pregnancy that can result in undesirable consequences for both mother and baby.

WHM 2 PERFORMANCE MEASURE **Goal: Perinatal/ Postpartum Care** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/or facilitating timely postpartum care.
GOAL	To ensure supportive programming for postpartum care.
MEASURE	The percent of MCHB funded projects addressing perinatal and postpartum care. The percent of pregnant women with a postpartum visit within 4-6 weeks of delivery
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating timely postpartum care in your program? ☐ Yes ☐ No **Tier 2**: Through what processes/ mechanisms are you promoting and/ or facilitating perinatal and postpartum care? ☐ Technical Assistance ☐ Training ☐ Product Development ☐ Research/ Peer-reviewed publications ☐ Outreach/ Information Dissemination/ Education ☐ Tracking/ Surveillance ☐ Screening/ Assessment ☐ Referral/ care coordination ☐ Direct Service ☐ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of pregnant women with a postpartum visit within 4 to 6 weeks after delivery[1] **Numerator:** Women program participants who enrolled prenatally or within 30 days after delivery and received a postpartum visit within 4-6 weeks after delivery[2] **Denominator:** Women program participants who enrolled prenatally or within 30 days after delivery during the reporting period **Definition:** ACOG recommends that the postpartum visit occur between 4-6 weeks after delivery. ACOG suggests a 7-14 day postpartum visit for high-risk

[1] Consistent with Healthy Start Benchmark 3: The percent of Healthy Start women participants who receive a postpartum visit.
[2] PRAMS measures 4-6 weeks, a visit between 28-42 days of delivery.

WHM 2 PERFORMANCE MEASURE **Goal: Perinatal/ Postpartum Care** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/or facilitating timely postpartum care.
	women.[3] A participant who has a visit prior to 4-6 weeks must still have a visit between 4-6 weeks to meet the standard and be included in the numerator.
BENCHMARK DATA SOURCES	Related to Healthy People 2020 MICH- 19: Increase the proportion of women giving birth who attend a postpartum care visit with a health worker. Pregnancy Risk Assessment Monitoring System (PRAMS) (91% in 14 states with no timing restriction, 2011); Healthcare Effectiveness Data and Information Set (HEDIS) – (61.8% Medicaid HMO, 2014)
GRANTEE DATA SOURCES	Grantee Data System; Pregnancy Risk Assessment Monitoring System
SIGNIFICANCE	Since the period immediately following birth is a time of many physical and emotional adjustments, the postpartum visit is important for educating new mothers on what to expect during this period and address any concerns which may arise. Additional issues include any health complications the mother may have and the health benefits of breastfeeding for the mother and baby. [4]ACOG Committee on Obstetric Practice. Guidelines for Perinatal Care (7th Edition, p. 207) state that 4 to 6 weeks after delivery, women should have a postpartum visit with her doctor.

[3] Note: ACOG suggests a 7-14 day postpartum visit for high-risk women.
[4] http://www.aafp.org/afp/2005/1215/p2491.html

WMH 3 PERFORMANCE MEASURE **Goal: Well Woman Visit/ Preventive Health Care** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/ or facilitating well woman visits/ preventive health care.
GOAL	To ensure supportive programming for well woman visits/ preventive health care.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating well woman visits/ preventive health care and through what processes.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating well woman visits/ preventive health care in your program? ☐ Yes ☐ No **Tier 2**: Through what activities are you promoting and/ or facilitating well woman visits/ preventive health care? ☐ Technical Assistance ☐ Training ☐ Product Development ☐ Research/ Peer-reviewed publications ☐ Outreach/ Information Dissemination/ Education ☐ Tracking/ Surveillance ☐ Screening/ Assessment ☐ Referral/ care coordination ☐ Direct Service ☐ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of women with a well woman/ preventative visit in the past year.[5] **Numerator:** Women program participants who received a well-woman or preventive visit (including prenatal or postpartum visit) in the past 12 months prior to last assessment within the reporting period. **Denominator:** Women program participants during the reporting period **Definition:** A participant is considered to have a well-woman or preventive visit and included in the numerator if she has a documented health assessment visit where she obtained recommended preventive services that are age and developmentally appropriate

[5] Consistent with Healthy Start Benchmark 5: The percent of Healthy Start women participants who have a well-woman visit.

WMH 3 PERFORMANCE MEASURE **Goal: Well Woman Visit/ Preventive Health Care** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/ or facilitating well woman visits/ preventive health care.
	within twelve months of her last contact with the Program in the reporting year. For purposes of reporting, a prenatal visit or postpartum visit during the twelve month period would meet the standard.
BENCHMARK DATA SOURCES	BRFSS (Women 18-44 with a past-year preventive visit: 65.2%, 2013); Vital Statistics (any prenatal care: 98.4%, 2014); PRAMS (postpartum visit: 91%, 2011)
GRANTEE DATA SOURCES	Grantee Data Systems
SIGNIFICANCE	A number of illnesses that affect women can be prevented when proper well-woman care is a priority and even illnesses that can't be prevented have a much better prognosis when detected early during a regular well-woman care exam. ACOG recommends annual assessments to counsel patients about preventive care and to provide or refer for recommended services. These assessments should include screening, evaluation and counseling, and immunizations based on age and risk factors.[6]

[6] http://www.acog.org/About-ACOG/ACOG-Departments/Annual-Womens-Health-Care/Well-Woman-Recommendations

WMH 4 PERFORMANCE MEASURE **Goal: Depression Screening** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/ or facilitating depression screening.
GOAL	To ensure supportive programming for depression screening.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating depression screening and through what processes.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating depression screening in your program? ☐ Yes ☐ No **Tier 2**: Through what activities are you promoting and/ or facilitating depression screening? ☐ Technical Assistance ☐ Training ☐ Product Development ☐ Research/ Peer-reviewed publications ☐ Outreach/ Information Dissemination/ Education ☐ Tracking/ Surveillance ☐ Screening/ Assessment ☐ Referral/ care coordination ☐ Direct Service ☐ Quality improvement initiatives **Tier 3**: How many are reached through those activities? (*Report in Table 1: Activity Data Collection Form*) # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of women screened for depression using a validated tool[7] **Numerator:** Number of women program participants who were screened for depression with a validated tool during the reporting period. **Denominator:** Number of women program participants in the reporting period. **Definition:** A participant is considered to have been screened and included in the numerator if a standardized screening tool which is appropriately validated for her circumstances is used. Several screening instruments have been validated for use to

[7] Consistent with Healthy Start Benchmark 12a and 12b: Percent of Healthy Start women participants who receive depression screening and referral.

WMH 4 PERFORMANCE MEASURE **Goal: Depression Screening** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/ or facilitating depression screening.
	assist with systematically identifying patients with depression.[8] % of women who screened positive for depression who receive a referral for services **Numerator:** Number of women participants who screened positive for depression during the reporting period and received a subsequent referral for follow-up services. **Denominator:** Number of HS women participants who screened positive for depression during the reporting period. **Definitions:** A participant is considered to have been referred for follow-up services and included in the numerator if she is referred to a qualified practitioner for further assessment for depression. Referral can be to either an internal or external provider depending on availability and staffing model.
BENCHMARK DATA SOURCES	Related to Healthy People 2020 MICH #34 Objective: (Developmental) Decrease the proportion of women delivering a live birth who experience postpartum depressive symptoms. PRAMS (depression screening)
GRANTEE DATA SOURCES	Grantee Data Systems
SIGNIFICANCE	Perinatal depression is one of the most common medical complications during pregnancy and may include major and minor depressive episodes. It is important to identify women with depression because when untreated, mood disorders can have adverse effects on women, infants, and families. Often, perinatal depression goes unrecognized because the changes are often attributed to normal pregnancy, such as changes in sleep and appetite. Therefore, it is important and recommended that clinicians screen patients at least once during the perinatal period for depression. Although screening is important for detecting perinatal depression, screening by itself is insufficient to improve clinical outcomes and must be paired with appropriate follow-up and treatment when indicated.[9]

[8] http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression
[9] http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression