Update on the Joint Commission’s Perinatal Care (PC) Core Measures: PC-01 Elective Delivery, PC-05 Exclusive Breast Milk Feeding and PC-05a Exclusive Breast Milk Feeding Considering a Mother’s Choice

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Perinatal Care (PC) Project

Overview

- 2007 Board of Commissioners recommendation
  - Use current evidence

- 2008 National Quality Forum project
  - Technical Advisory Panel (TAP) appointed

- 2009 TAP meeting
  - Measure specifications completed
  - Manual released

- 2010 Data Collection began
Current Joint Commission
ORYX Requirements

Data collection required on 4 measures sets since 2008, some exceptions for small and specialty hospitals

Current standardized core measure sets
- Acute myocardial infarction
- Heart failure
- Pneumonia
- Surgical Care Improvement Project
- Perinatal care
- Children’s asthma care
- Hospital outpatient
- Hospital-based inpatient psychiatric services
- Venous thromboembolism
- Stroke
- Immunization
- Emergency department
- Tobacco treatment
- Substance use
Current PC ORYX Requirements

- Women’s Specialty Hospitals
- Acute-Care Hospitals
Future ORYX Requirements

- Acute-care hospitals **SIX** core measure sets, effective with **January 1, 2014** discharges
- AMI, HF, Pneumonia and SCIP mandatory if those patient populations are served
- Perinatal care set mandatory for hospitals with 1,100 or more births per year (fifth mandatory measure set).
Joint Commission Accountability Measures Framework

- Research
- Accuracy
- Proximity
- Adverse Effects
Accountability Measures — Using Measurement to Promote Quality Improvement

Mark R. Chassin, M.D., M.P.P., M.P.H., Jerod M. Loeb, Ph.D., Stephen P. Schmaltz, Ph.D., and Robert M. Wachter, M.D.

Measuring the quality of health care and using those measurements to promote improvements in the delivery of care, to influence payment for services, and to increase transparency are now commonplace. These activities, which now involve virtually all U.S. hospitals, are migrating to ambulatory and other care settings and are increasingly evident in health care systems worldwide. Many constituencies are pressing for continued expansion of programs that rely on quality measurement and reporting.

Remarkably recent. In 1998, the Joint Commission launched its ORYX initiative, the first national program for the measurement of hospital quality, which initially required the reporting only of non-standardized data on performance measures. In 2002, accredited hospitals were required to collect and report data on performance for at least two of four core measure sets (acute myocardial infarction, heart failure, pneumonia, and pregnancy); these data were made publicly available by the Joint Commission in 2004.
PC-01 and PC-05a

- Accountability Measures
- Top Performer’s Program
- Standards Compliance
Use of Data for PC-01, PC-05 and PC-05a

- Publicly reported on Quality Check
- ORYX performance measurement report for surveyor use
- Priority Focus Process (PFP)
- Strategic Surveillance System™ (S3)
New Reporting Requirement for Centers for Medicare and Medicaid Services (CMS)

- Final Rule posted August 1, 2012
- PC-01: Elective Delivery included
- Data collection starts 1/1/13
- Payment Determination FY 2015
Proposed Rule: CMS Inpatient Prospective Payment System (IPPS)

- Posted in Federal Register
- Open for public comment until June 25, 2013
- Future requirement to collect via EHR:
  - PC-02 Cesarean Section
  - PC-05 Exclusive Breast Milk Feeding

**NEW!**
PC Core Measures

- PC-01 Elective Delivery
- PC-02 Cesarean Section
- PC-03 Antenatal Steroids
- PC-04 Healthcare-Associated Bloodstream Infections in Newborns
- PC-05 Exclusive Breast Milk Feeding
- PC-05a Exclusive Breast Milk Feeding Considering Mother’s Choice

NQF Endorsed
PC Core Measure Set

Two Distinct Populations:
- Mothers
- Newborns

Consists of Five Measures Representing the Following Domains of Care:
- Assessment/Screening
- Prematurity Care
- Infant Feeding
Maternal Initial Patient Population

- Patients admitted with ICD-9-CM Principal or Other Diagnosis Code as defined in Appendix A, Tables 11.01, 11.02, 11.03, or 11.04
- Patient Age (Admission Date – Birthdate) $\geq$ 8 years and $< 65$
- Length of Stay (Discharge Date - Admission Date) $\leq 120$ days.
Maternal Quarterly Sampling (Based on Initial Patient Population)

<table>
<thead>
<tr>
<th>Quarterly Discharges</th>
<th>Sample Size</th>
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<tr>
<td>&gt;=1501</td>
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<tr>
<td>376-1500</td>
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<td>75-375</td>
<td>75</td>
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<tr>
<td>&lt;75</td>
<td>100% (no sampling)</td>
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# Maternal Monthly Sampling (Based on Initial Patient Population)

<table>
<thead>
<tr>
<th>Monthly Discharges</th>
<th>Sample Size</th>
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<tbody>
<tr>
<td>&gt;=541</td>
<td>109</td>
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<tr>
<td>126-500</td>
<td>20%</td>
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<tr>
<td>25-125</td>
<td>25</td>
</tr>
<tr>
<td>&lt;25</td>
<td>100% (no sampling)</td>
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PC-01

Elective Delivery

Original Performance Measure/Source

Developer: Hospital Corporation of America-Women's and Children's Clinical Services
Rationale

- American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP) standard
- Significant short-term newborn morbidity
- Elective inductions result in more cesarean sections
Numerator and Denominator

Patients with elective deliveries

Patients delivering newborns with $\geq 37$ and $< 39$ weeks of gestation completed
Denominator Populations

Included Populations:

- Principal or Other Diagnosis Codes for planned cesarean section in labor as defined in Appendix A, Table 11.06.1
Excluded Populations:

- Principal or Other Diagnosis Codes for Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation as defined in Appendix A, Table 11.07
- < 8 years of age
- >= to 65 years of age
- LOS > 120 days
- Enrolled in clinical trials
- Prior uterine surgery
- Gestational Age < 37 or ≥ 39 weeks
Denominator Data Elements

- Admission Date
- Birthdate
- Clinical Trial
- Discharge Date
- Gestational Age
- ICD-9-CM Principal or Other Diagnosis Codes
- Prior Uterine Surgery

NEW!
Gestational Age

- Completed weeks of gestation
- Days \( \leq 6 \) are always rounded down
- Vital records reports a new data source
Prior Uterine Surgery

- Allowable Values changed
- Additional inclusions:
  - Prior classical cesarean section
  - Prior myomectomy
  - Prior surgery with perforation
  - History of uterine window
  - History of uterine rupture
Numerator Populations

- Included Populations: Principal or Other Procedure Codes for one or more of the following:
  - Medical induction of labor as defined in Appendix A, Table 11.05
  - Cesarean section as defined in Appendix A, Table 11.06 while not in Labor or experiencing Spontaneous Rupture of Membranes

- Excluded Populations: None
Numerator Data Elements

- ICD-9-CM Principal & Other Procedure Codes
- Labor
- Spontaneous Rupture of Membranes
Labor

- Data element re-named and simplified
- Documentation of contractions/cervical change removed
- List of clinicians defined

Guidelines for Abstraction Inclusion:
- Active Labor
- Spontaneous Labor
- Early Labor

Guidelines for Abstraction Exclusion:
- Prodromal Labor
- Latent Labor
FAQs

PC-01 Elective Delivery
How come some of ACOG’s approved justifications are not considered?

- Purpose is to enable hospitals to establish a baseline for performance to determine whether improvement efforts are effective over time.
- Not every conceivable exclusion for the measure included in Table 11.07.
How come some of ACOG’s approved justifications are not considered? (Cont.)

- Weighing the burden of data collection versus the frequency with which these conditions occur

- The value of including every conceivable justification outweighed by the additional time required to identify those cases via medical record review
Are all prior Cesarean Sections considered *Prior Uterine Surgery*?

- No, only a classical cesarean section is considered a prior uterine surgery which would exclude the case for PC-01.

- A prior low transverse cesarean section is not included.

- A prior cesarean section without the type noted is not included.
How can we improve performance for PC-01?

- Adopt a hospital wide policy establishing criteria for performing early term medical inductions or cesarean sections
- Require review of requests not meeting criteria
- Clear, concise documentation by clinicians
- Coder education as needed
PC-05

Exclusive Breast Milk Feeding

Original Performance Measure/Source
Developer: California Maternal Quality Care Collaborative
Rationale

- Goal of World Health Organization (WHO), Department of Health and Human Services (DHHS), American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG)
- Numerous benefits for the newborn
Numerator and Denominator

Newborns that were fed breast milk only since birth

Single term newborns discharged alive from the hospital
Denominator Populations

**Included Populations:** Principal Diagnosis Code for single liveborn newborn

- Derived from Table 11.20.1 in Appendix A
Excluded Populations:
– Admitted to the Neonatal Intensive Care Unit (NICU)
– Other Diagnosis Code for galactosemia
– Principal or Other Procedure Code for parenteral infusion
– Experienced death
Excluded Populations (Cont.)

- LOS >120 days
- Enrolled in clinical trials
- Documented Reason for Not Exclusively Feeding Breast Milk
- Patients transferred to another hospital
- Other Diagnosis Codes for premature newborns- Appendix A, Table 11.23
Exclusion of Newborn Transfers

- Likely to have feeding issues
- May be NPO or never received a feeding
Exclusion of Premature Newborns

- ICD-9-CM diagnosis codes used to identify pre-term newborns
- Documentation of medical problems related to prematurity important
Denominator Data Elements

- Admission Date
- Admission to NICU
- Birthdate
- Clinical Trial
- Discharge Date
- Discharge Disposition
Denominator Data Elements (Cont.)

- **ICD-9-CM Principal & Other Diagnosis Codes**
- **ICD-9-CM Principal & Other Procedure Codes**
- **Reason for Not Exclusively Feeding Breast Milk**
Admission to NICU

- Clarification of definition of NICU
- Defined by types of services provided, not by level designation
- Critical care services must be provided
- Observation/transitional care excluded
Additional Changes

- Remove *Discharge Status* and Replace with *Discharge Disposition*
Reason for Not Exclusively Feeding Breast Milk

- Only maternal medical conditions exclude cases for PC-05
- Newborn medical conditions not already mentioned do NOT exclude cases for PC-05
- Documentation ONLY from physician, APN, CNM or lactation consultant
Maternal Medical Conditions

- HIV infection
- Human t-lymphotrophic virus type I or II
- Substance abuse and/or alcohol abuse
- Active, untreated tuberculosis
- Taking certain medications, i.e., prescribed cancer chemotherapy, radioactive isotopes, antimetabolites, antiretroviral medications and other medications where the risk of morbidity outweighs the benefits of breast milk feeding
Maternal Medical Conditions (Cont.)

- Undergoing radiation therapy
- Active, untreated varicella
- Active herpes simplex virus with breast lesions
- Admission to Intensive Care Unit (ICU) post-partum
- Adoption or foster home placement of newborn
- Previous breast surgery, i.e., bilateral mastectomy, bilateral breast reduction or augmentation where the mother is unable to produce breast milk
Numerator Populations

- **Included Populations:** NA
- **Excluded Populations:** None
Numerator Data Elements

Exclusive Breast Milk Feeding
How is exclusive breast milk feeding defined?

- A newborn receiving only breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals, or medicines.

- If the newborn receives any other liquids including water during the entire hospitalization, select allowable value ‘No’.

- Exclusive breast milk feeding includes the newborn receiving breast milk via a bottle or other means beside the breast.
PC-05a

Exclusive Breast Milk Feeding Considering Mother’s Choice
Numerator and Denominator

Newborns that were fed breast milk only since birth

______________________________

Single term newborns discharged alive from the hospital excluding those whose mothers chose not to breast feed

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Reason for Not Exclusively Feeding Breast Milk

- Allowable values changed:
  1. Maternal medical conditions
  2. Maternal choice
  3. No reason documented

- Maternal medical conditions exclude cases for PC-05a

- Newborn medical conditions not already mentioned DO NOT exclude cases from PC-05a
Maternal Choice

- Mother’s choice at admission must be clearly documented
- Newborn’s medical record only
- Mentioned in the context of method of feeding
- In absence of documentation- do not assume
FAQs

PC-05 Exclusive Breast Milk Feeding
How are cases handled when mother chooses both breast milk and formula feeding?

- Clarify mother’s intent is for hospitalization only
- Opportunity to educate mother on benefits of exclusive breast milk feeding
- Select allowable value “2” if this choice confirmed
Why aren’t more newborn medical conditions excluded?

- Not all medical indications for formula supplementation in the first days of life are excluded from this measure.
- Many of these indications have a large variation in the definitions, thresholds and application of supplementation utilization.
- Rate of these complications should not vary greatly from hospital to hospital, though their severity can be driven by obstetric care.
How can we improve performance for PC-05 and PC-05a?

- Adopt a hospital wide policy promoting breast milk feeding as the default method of feeding
- Clear, concise documentation key to aid coders in identifying prematurity problems
- Make sure mother understands choice of feeding for hospitalization ONLY
Improving Performance (Cont.)

- Skin to skin contact immediately
- Rooming-in to recognize early feeding cues
- Utilize The Joint Commission’s Speak Up™ Campaign materials
  - Posters
  - Brochures
  - Buttons
Improving Performance (Cont.)

- Partnering with community maternal child health programs like WIC

Benefits:
- Offers evidence-based prenatal and postpartum education
- Nutrition support and monitoring
What are the national benchmarks for the PC measures?
The Joint Commission’s Annual Report on Quality and Safety 2012

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Name</th>
<th>2011 Rate</th>
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<tbody>
<tr>
<td>Perinatal Care Composite</td>
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<td>53.2%</td>
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<tr>
<td>PC-01</td>
<td>Elective Delivery</td>
<td>13.6%</td>
</tr>
<tr>
<td>PC-02</td>
<td>Cesarean Section*</td>
<td>26.3%</td>
</tr>
<tr>
<td>PC-03</td>
<td>Antenatal Steroids</td>
<td>73.6%</td>
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<td>PC-04</td>
<td>Health Care-Associated Bloodstream Infections in Newborns*</td>
<td>0.9%</td>
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<tr>
<td>PC-05</td>
<td>Exclusive Breast Milk Feeding</td>
<td>46.2%</td>
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* Outcome Measures
Resources
March of Dimes Perinatal Care Resource

Toward Improving the Outcome of Pregnancy III (TIOP III)

Available at:
http://www.marchofdimes.com/professionals/medicalresources_tiop.html
Resource for Elective Delivery

- March Of Dimes (MOD)/California Maternal Quality Care Collaborative (CMQCC) <39wk Toolkit

Available at: [marchofdimes.com](http://marchofdimes.com) or [CMQCC.org](http://CMQCC.org) to download your free copy of the toolkit.
Resources for Breast Milk Feeding Promotion


- The United States Breastfeeding Committee has a toolkit available at: http://www.usbreastfeeding.org/

- The Joint Commission’s Speak Up™ Campaign
View the manual and post questions at:
http://manual.jointcommission.org
These slides are current as of (5/14/2013). The Joint Commission reserves the right to change the content of the information, as appropriate.
Thank You