Lessons Learned from the Field

- Coders and clinical staff DO NOT have a shared understanding of PC-01 expectations:
  - Some coders only review provider documentation & others also review RN documentation in EHR
  - Providers DO NOT have a clear understanding of documentation requirements: using ACOG terminology but abstractors adhering to manual specifications= differing interpretations

Lessons Learned from the Field (Cont.)

- Very few hospitals have a **“hard-stop”** policy
- Team division:
  - Nursing taking the lead in accountability “enforcing” PC-01 resulting in “disharmony” with providers
  - Further divide between quality/coding teams and nursing/provider teams

Numerator and Denominator

Patients with cesarean sections

Nulliparous patients delivered of a live term singleton newborn in vertex presentation

Denominator Populations (Cont.)

- **Excluded Populations:**
  - Diagnosis Codes, for **multiple gestations and other presentations-** Appendix A, Table 11.09
  - < 8 years of age
  - >= to 65 years of age
  - LOS >120 days
  - Enrolled in clinical trials
  - Gestational Age < 37 weeks **or UTD**

Parity

- Vital records reports, **delivery logs or clinical information systems** acceptable data sources
- **Clarification added for conflicting documentation**
- Definition includes only previous live deliveries
- **Do not count current delivery in EHR**

How can we improve performance for PC-02?

- Reduce admissions in latent labor
- Eliminate elective labor induction before 41 weeks
- Improve diagnostic and treatment approaches for labor disorders (dystocia and failure to progress)

Improving Performance (Cont.)

- Standardize diagnosis and management of fetal heart rate abnormalities while in labor
- Reduce uterine hyper-stimulation associated with oxytocin
  - Follow oxytocin safety protocols

Improving Performance (Cont.)

- Encourage patience in the active phase of labor and in the second stage of labor (pushing)
- Encourage easy operative vaginal delivery as alternative to cesarean delivery in appropriate cases

PC-03

Antenatal Steroids

Original Performance Measure/Source Developer: Providence St Vincent's Hospital/Council of Women and Infant's Specialty Hospitals

Rationale

- National Institutes of Health 1994 recommendation
- Neuro protective benefits
- Reduces the risks of respiratory distress syndrome, prenatal mortality, and other morbidities

Numerator and Denominator

Patients with antenatal steroid therapy initiated prior to delivering preterm newborns

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Patients delivering live preterm newborns with =>24 and **<34** weeks gestation completed

Denominator Populations (Cont.)

- **Excluded Populations:**
  - < 8 years of age
  - >= to 65 years of age
  - LOS >120 days
  - Enrolled in clinical trials
  - Documented *Reason for Not Initiating Antenatal Steroid Therapy*
  - Principal or Other Diagnosis Codes for fetal demise- Appendix A, Table 11.09.1
  - *Gestational Age* < 24 or **>= 34 weeks or UTD**

Reason for Not Initiating Antenatal Steroid Therapy

- Documentation why therapy was not initiated
- Examples of implied reasons include:
  - Chorioamnionitis
  - Fetal anomalies incompatible with life
  - **Imminent delivery (within 2 hrs. after admission)**

PC-04

Health Care-Associated Bloodstream Infections in Newborns

Original Performance Measure/Source Developer: Agency for Healthcare Research and Quality

Rationale

- Rates range from 6% to 33%
- Increased mortality, length of stay & hospital costs
- Effective preventive measures available

Numerator and Denominator

Newborns with septicemia or bacteremia

Liveborn newborns

Birth Weight

- **If BOTH pounds & ounces AND grams recorded-use grams**
- Vital records reports, **delivery logs & clinical information systems** acceptable data sources

- **Admission weight if transfer ok**
- Data sources prioritized:
  - NICU Admission Assessment or Notes
  - Delivery and/or Operating Room Record

Bloodstream Infection Present on Admission

- Suspected or confirmed within 48 hrs.
- Positive or inconclusive blood cultures drawn within 48 hrs. **(Negative not included)**
- POA indicator present with codes for septicemia or bacteremia
- **R/O, work up or evaluate for sepsis not included**
- **Clinical signs & symptoms must be documented**

Bloodstream Infection Present on Admission (Cont.)

- Signs & symptoms:
  - body temperature changes
  - respiratory difficulty
  - diarrhea
  - hypoglycemia
  - reduced movements
  - reduced sucking
  - seizures
  - bradycardia
  - swollen/distended abdomen
  - vomiting and/or jaundice

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 & mother

Numerator and Denominator

Newborns that were fed breast milk only since birth

Single term newborns discharged alive from the hospital

Admission to NICU

- **Not defined by level designation or title**
- **AAP definition used**
- **Not necessary to look for "critical care services" provided**
- Excludes newborns admitted for observation/transitional care
- **Transitional care defined as LOS ≤ 4 hrs.**
- **If no order, look for supporting documentation**

Numerator Data Elements

- *Exclusive Breast Milk Feeding:*
  - **Drops of water or formula dribbled on breast to stimulate latching ok**

PC-05a

- Exclusive Breast Milk Feeding Considering Mother's Initial Feeding Plan

Numerator and Denominator

Newborns that were fed breast milk only since birth

Single term newborns discharged alive from the hospital excluding those whose mothers initial feeding plans were not to **exclusively** feed breast milk

Reason for Not Exclusively Feeding Breast Milk

- Allowable values (AVs):
  - 1.Maternal medical conditions
  - 2.Maternal initial feeding plan
  - 3.None of above or UTD

- Maternal conditions + formula must be clearly documented- do not assume
- Clarification added for “lactation consultant”: **IBCLC or CLC only; CLE not acceptable**

Reason for Not Exclusively Feeding Breast Milk (Cont.)

- Initial feeding plan discussion prior to first feeding must appear in newborn's record
- RN documentation requires additional validation- check box, standing orders NOT acceptable **alone** as validation
- Feeding "both" should be rare & requires education on risks
- Mother's record alone **cannot** be used if "linked" via EHRs

Reason for Not Exclusively Feeding Breast Milk (Cont.)

- "Bottle" cannot be used as "formula"
- Admission defined as birth
- Discussion prior to birth acceptable: must be timed and dated & must appear in newborn's record
- Mother changes to formula later: AV 3
- Newborn medical conditions: AV 3

How can we improve performance for PC-05 and PC-05a?

- Adopt a hospital wide feeding 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
- Share your mPINC scores with staff

FAQs

- What are the national rates for the PC measures?

The Joint Commission's Annual Report on Quality and Safety 2014

Measure Number	Measure Name	2013 Rate
Perinatal Care Composite		*74.1%*
PC-01	Elective Delivery	4.3%
PC-02	Cesarean Section*	25.9%
PC-03	Antenatal Steroids	89.7%
PC-04	Health Care-Associated Bloodstream Infections in Newborns*	2.5%
PC-05	Exclusive Breast Milk Feeding	53.6%
PC-05a	Exclusive Breast Milk Feeding Considering Mother's Initial Feeding Plan	69.2%

* Denotes outcome measure

The Joint Commission

View the manual and post questions at:

http://manual.jointcommission.org

The Joint Commission Disclaimer

- These slides are current as of (2/11/2015). The Joint Commission reserves the right to change the content of the information, as appropriate.