“Perinatal Care (PC) Core Measures: Updates for 2015”

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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

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PC Core Measures

- PC-01 Elective Delivery
- PC-02 Cesarean Section
- PC-03 Antenatal Steroids
- PC-04 Health Care-Associated Bloodstream Infections in Newborns
- PC-05 Exclusive Breast Milk Feeding
- PC-05a Exclusive Breast Milk Feeding Considering Mother's Initial Feeding Plan

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Current ORYX Requirements

- Perinatal Care set mandatory for hospitals with 1,100 or more births per year (fifth mandatory measure set)

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Reporting Requirement for Centers for Medicare and Medicaid Services (CMS)

- IPPS Final Rule posted August 2014
- Continue collecting & reporting PC-01: Elective Delivery
  - FY 2017 to be used in Value Based Purchasing Program 1 of 3 proposed process measures:
    - MRSA Bacteremia
    - C. difficile infection
    - **PC-01 Elective delivery**

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Additional EHR Based Measures Hospital IQR Program

- **FY 2017 Electronic Health Record (EHR) Based (voluntary reporting)**
  - Hearing Screening Prior to Hospital Discharge
  - **PC-05 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother's Choice**
  - CAC-3 (Children's Asthma Care-3) Home Management Plan of Care (HMPC) document given to patient/caregiver
  - Healthy Term Newborn

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FY 2015 Proposed IPPS Rule Hospital IQR Program

- Future Electronic Clinical Quality Measures for FY 2018 payment determination:
  - Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge NQF #0475
  - **PC-02 Cesarean Section NQF #0471**
  - Adverse Drug Events – Hyperglycemia
  - Adverse Drug Events – Hypoglycemia

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In Development: Perinatal Care Certification

WHAT	Strong focus on improving quality of care for normal physiologic birth through use of standards, clinical practice guidelines, and performance measures
WHEN	Timeline under review Current projection: Mid 2015
PROCESS POINT	Standards and onsite review process currently in development and pilot testing
QUESTIONS?	Contact us at dscinfo@jointcommission.org

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PC Core Measure Set

- 1385 hospitals reported for 2014
- Two Distinct Populations:
  - Mothers
  - Newborns
- Consists of Five Measures Representing the Following Domains of Care:
  - Assessment/Screening
  - Prematurity Care
  - Infant Feeding

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PC-01

Elective Delivery

Original Performance Measure/Source

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

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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

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Numerator and Denominator

Patients with elective deliveries

Patients delivering newborns with >=37 and < 39 weeks of gestation completed

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Denominator Populations

- Included Populations:
  - Diagnosis Codes for pregnancy- Appendix A, Tables 11.01, 11.02, 11.03, 11.04
  - Diagnosis Codes for planned cesarean section in labor- Appendix A, Table 11.06.1

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Denominator Populations (Cont.)

- Excluded Populations:
  - Diagnosis Codes for Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation- Appendix A, Table11.07
  - < 8 years of age
  - >= to 65 years of age
  - LOS >120 days
  - Enrolled in clinical trials
  - Gestational Age < 37 or ≥ 39 weeks **or UTD**

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Denominator Data Elements

- *Admission Date*
- *Birthdate*
- *Clinical Trial*
- *Discharge Date*
- *Gestational Age*
- *Principal or Other Diagnosis Codes*

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Gestational Age (PC-01, 02 & 03)

- Completed weeks of gestation
- Days ≤ 6 are always rounded down
- **UTD should be documented if no prenatal care** (effective 1/1/15)
- **Clarification added for conflicting documentation**

- Document closest to time of delivery
- Vital records reports, **delivery logs or clinical information systems** acceptable data sources

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Numerator Populations

- Included Populations: Procedure Codes for one or more of the following:
  - Medical induction of labor- Appendix A, Table 11.05
  - Cesarean section- Appendix A, Table 11.06 and all of the following: not in *Labor* and no history of *Prior Uterine Surgery*
- Excluded Populations: None

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Numerator Data Elements

- *Principal & Other Procedure Codes*
- *Labor*
- *Prior Uterine Surgery*
- ***Spontaneous Rupture of Membranes*** **has been removed**

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Labor

- Documentation taken at face value
- **Descriptors not required to be present**

- Descriptive Inclusions:
  - Active Labor
  - Spontaneous Labor
  - Early Labor
- Descriptive Exclusions:
  - Prodromal Labor
  - Latent Labor

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Prior Uterine Surgery

- Inclusions:
  - Prior classical cesarean section (vertical incision into upper uterine segment)
  - Prior myomectomy
  - Prior surgery with perforation (result of accidental injury)
  - Hx of uterine window (prior surgery or via ultrasound)
  - Hx of uterine rupture
  - **Hx of a cornual ectopic pregnancy**

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Prior Uterine Surgery (Cont.)

- Exclusions:
  - Prior cesarean section without specifying type
  - Prior low-transverse cesarean section

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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

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How can we improve performance for PC-01?

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

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PC-02

Cesarean Section

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

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Rationale

- Skyrocketing increase in rates
- Most variable portion of a **primary** CS rate
- Performance improvement opportunity

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Why are there no exclusions to the measure such as maternal cardiac conditions, fetal distress, etc.?

- **Variation of a primary CS rate which does not allow for exclusions**
- Designed to measure complications that largely arise in labor and not exclude them
- Some medical practices during labor lead to the development of indications that were potentially avoidable

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Numerator and Denominator

Patients with cesarean sections

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

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Denominator Populations

- **Included Populations:**
  - Diagnosis Codes for pregnancy- Appendix A, Tables 11.01, 11.02, 11.03, 11.04
  - Nulliparous patients
  - With Principal or Other Diagnosis Codes for outcome of delivery as defined in Appendix A, Table 11.08
  - And with a delivery of a newborn with 37 weeks or more of gestation completed

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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**

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Denominator Data Elements

- *Admission Date*
- *Birth Date*
- *Clinical Trial*
- *Discharge Date*
- *Gestational Age*
- *Principal* or *Other Diagnosis Codes*
- *Principal* or *Other Procedure Codes*
- *Parity*

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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**

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Numerator Populations

- **Included Populations:** Principal or Other Procedure Codes for cesarean section- Appendix A, Table 11.06
- **Excluded Populations:** None

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Numerator Data Elements

- *Principal* or *Other Procedure Codes*

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Direct Standardization (Risk Adjustment)

- Maternal Age Bands

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Stratification by Ages

- PC-02a Cesarean Section - Overall Rate
- PC-02b Cesarean Section - 8 through 14 years
- PC-02c Cesarean Section - 15 through 19 years
- PC-02d Cesarean Section - 20 through 24 years
- PC-02e Cesarean Section - 25 through 29 years
- PC-02f Cesarean Section - 30 through 34 years
- PC-02g Cesarean Section - 35 through 39 years
- PC-02h Cesarean Section - 40 through 44 years
- PC-02i Cesarean Section - 45 through 64 years

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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)

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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

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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

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Rationale

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

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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

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Denominator Populations

- **Included Populations:** Diagnosis Codes for pregnancy- Appendix A, Tables 11.01, 11.02, 11.03, 11.04

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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**

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Denominator Data Elements

- *Admission Date*
- *Birthdate*
- *Clinical Trial*
- *Discharge Date*

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Denominator Data Elements (Cont.)

- *Principal* or *Other Diagnosis Codes*
- *Gestational Age*
- *Reason for Not Initiating Antenatal Steroid Therapy*

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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)**

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Numerator Populations

- **Included Populations:** Antenatal steroid therapy initiated- **Appendix C**, Table 11.0
- **Excluded Populations:** None

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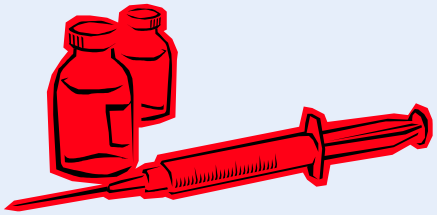
Numerator Data Elements

- *Antenatal Steroid Therapy Initiated:*
  - 12 mg betamethasone IM or 6mg dexamethasone IM



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Antenatal Steroid Therapy Initiated

- Only initiation versus full course
- Initiation prior to hospitalization acceptable

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PC-04

Health Care-Associated Bloodstream Infections in Newborns

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

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Rationale

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

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Numerator and Denominator

Newborns with septicemia or bacteremia

Liveborn newborns

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Denominator Populations

- **Included Populations:** Other Diagnosis Codes for birth weight between 500 and 1499g- Appendix A, Table 11.12, 11.13, 11.13.1 or 11.14 OR *Birth Weight* between 500 and 1499g

OR

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Denominator Populations (Cont.)

- Other Diagnosis Codes for birth weight ≥ 1500g- Appendix A, Table 11.15, 11.16, 11.16.1 & 11.17 OR *Birth Weight* ≥ 1500g who experienced one or more of the following:
  - Experienced death
  - Principal or Other Procedure Codes for major surgery- Appendix A, Table 11.18
  - Principal or Other Procedure Codes for mechanical ventilation- Appendix A, Table 11.19
  - Transferred in from another acute care hospital within 2 days of birth

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Denominator Populations (Cont.)

Excluded Populations:

- Principal Diagnosis Code for septicemias or bacteremias- Appendix A, Table 11.10.2
- Other Diagnosis Code for septicemias or bacteremias- Appendix A, Table 11.10.2 OR Principal or Other Diagnosis Codes for newborn septicemia or bacteremia- Appendix A, Table 11.10 with *Bloodstream Infection Present on Admission*
- Other Diagnosis Codes for birth weight < 500g- Appendix A, Table 11.20 OR *Birth Weight* < 500g
- LOS < 2 days
- Enrolled in clinical trials

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Denominator Data Elements

- *Admission Date*
- *Birthdate*
- *Birth Weight*
- *Bloodstream Infection Present on Admission*
- *Clinical Trial*

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Denominator Data Elements (Cont.)

- *Discharge Date*
- *Discharge Disposition*
- *Principal* or *Other Diagnosis Codes*
- *Principal* or *Other Procedure Codes*

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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

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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**

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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

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Numerator Populations

- **Included Populations:**
  - Other Diagnosis Codes for newborn septicemia or bacteremia- Appendix A, Table 11.10

    OR

  - Other Diagnosis Codes for sepsis- Appendix A, Table 11.10.1
- **Excluded Populations:** None

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Numerator Data Elements

- *Other Diagnosis Codes*

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Risk Adjustment

- Birth Weight: 3 birth weight categories (500-999, 1000-1249, 1250-2499 grams)
- Congenital Anomalies: 3 different types (gastrointestinal, cardiovascular, other specified) identified through diagnosis codes
- Out-born birth
- Death or transfer out

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PC-05

Exclusive Breast Milk Feeding

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

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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

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Numerator and Denominator

Newborns that were fed breast milk only since birth

Single term newborns discharged alive from the hospital

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Denominator Populations

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

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Denominator Populations (Cont.)

- **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

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Denominator Populations (Cont.)

- **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

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Denominator Data Elements

- *Admission Date*
- *Admission to NICU*
- *Birthdate*
- *Clinical Trial*
- *Discharge Date*
- *Discharge Disposition*

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Denominator Data Elements (Cont.)

- *Principal & Other Diagnosis Codes*
- *Principal & Other Procedure Codes*
- *Reason for Not Exclusively Feeding Breast Milk*

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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**

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Numerator Populations

- **Included Populations:** NA
- **Excluded Populations:** None

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Numerator Data Elements

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

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PC-05a

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

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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

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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**

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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

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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

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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

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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

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FAQs

- What are the national rates for the PC measures?

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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

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Resources

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March of Dimes Perinatal Care Resource

- **Toward Improving the Outcome of Pregnancy III (TIOP III):**

http://www.marchofdimes.com/professionals/medicalresources_tiop.html

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Resource for Elective Delivery

- March Of Dimes (MOD)/California Maternal Quality Care Collaborative (CMQCC) <39wk Toolkit
- Available at: marchofdimes.com or CMQCC.org to download your **free copy of the toolkit.**

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Resources for Cesarean Section

- California Maternal Quality Care Collaborative white paper: “Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality”:

http://www.cmqcc.org/resources/2079/download

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Resources for Cesarean Section (Cont.)

- ACOG Obstetric Care Consensus #1: Safe Prevention of the Primary Cesarean Delivery

http://www.acog.org/Resources_And_Publications/Obstetric_Care_Consensus_Series/Safe_Prevention_of_the_Primary_Cesarean_Delivery

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Resources for Antenatal Steroids

- ACOG clinical-practice guideline, *Management of Pre-Term Labor* :

http://www.guideline.gov/content.aspx?id=38621&search=antenatal+steroids

- March of Dimes Preterm Labor Assessment Toolkit:

http://www.marchofdimes.com/professionals/preterm-labor-assessment-toolkit.aspx#

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Resources for Preventing Bloodstream Infections

- CDC guideline for the prevention of intravascular catheter-related infection:

http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf

- Joint Commission CLABSI Toolkit:

http://www.jointcommission.org/Topics/Clabsi_toolkit.aspx

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Resources for Breast Milk Feeding Promotion

- The Centers for Disease Control and Prevention (CDC) guide: http://www.cdc.gov/breastfeeding/resources/guide.htm.
- The Academy of Breastfeeding Medicine (ABM) protocols: http://www.bfmed.org/Resources/Protocols.aspx .
- The United States Breastfeeding Committee toolkit: http://www.usbreastfeeding.org/
- The Joint Commission's Speak Up™ Campaign:

http://www.jointcommission.org/speakup.aspx

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View the manual and post questions at:

http://manual.jointcommission.org

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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.

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