“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
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

NQF Endorsed
Current ORYX Requirements

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

<table>
<thead>
<tr>
<th>WHAT</th>
<th>Strong focus on improving quality of care for normal physiologic birth through use of standards, clinical practice guidelines, and performance measures</th>
</tr>
</thead>
</table>
| 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                                                                                     |
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
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:

- 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
Excluded Populations:

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

- Admission Date
- Birthdate
- Clinical Trial
- Discharge Date
- Gestational Age
- Principal or Other Diagnosis Codes
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
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
Numerator Data Elements

- Principal & Other Procedure Codes
- Labor
- Prior Uterine Surgery
- Spontaneous Rupture of Membranes

has been removed

NEW!
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
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

NEW!
Prior Uterine Surgery (Cont.)

Exclusions:

- Prior cesarean section without specifying type
- Prior low-transverse cesarean section
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
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
PC-02

Cesarean Section

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

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

Patients with cesarean sections

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

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

NEW!
Numerator Populations

**Included Populations:** Principal or Other Procedure Codes for cesarean section- Appendix A, Table 11.06

**Excluded Populations:** None
Numerator Data Elements

- *Principal or Other Procedure Codes*
Direct Standardization (Risk Adjustment)

Maternal Age Bands
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
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

Patients delivering live preterm newborns with $\geq 24$ and $<34$ weeks gestation completed

NEW!
Denominator Populations

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

NEW!
Denominator Data Elements

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

- Principal or Other Diagnosis Codes
- Gestational Age
- Reason for Not Initiating Antenatal Steroid Therapy
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)
Numerator Populations

- **Included Populations:** Antenatal steroid therapy initiated- *Appendix C, Table 11.0*

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

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

- Only initiation versus full course
- Initiation prior to hospitalization acceptable
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
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
Other Diagnosis Codes for birth weight $\geq 1500\text{g}$ - Appendix A, Table 11.15, 11.16, 11.16.1 & 11.17 OR *Birth Weight $\geq 1500\text{g}$* 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
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
Denominator Data Elements

- Admission Date
- Birthdate
- Birth Weight
- Bloodstream Infection Present on Admission
- Clinical Trial
Denominator Data Elements (Cont.)

- Discharge Date
- Discharge Disposition
- Principal or Other Diagnosis Codes
- Principal or Other Procedure Codes
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 *NEW!*
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
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
Numerator Data Elements

Other Diagnosis Codes
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
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
Denominator Populations

**Included Populations:** Principal Diagnosis Code for single liveborn newborn
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
Denominator Data Elements

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

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

- Included Populations: NA
- Excluded Populations: None
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
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?
<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Name</th>
<th>2013 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perinatal Care Composite</strong></td>
<td></td>
<td>74.1%</td>
</tr>
<tr>
<td>PC-01</td>
<td>Elective Delivery</td>
<td>4.3%</td>
</tr>
<tr>
<td>PC-02</td>
<td>Cesarean Section*</td>
<td>25.9%</td>
</tr>
<tr>
<td>PC-03</td>
<td>Antenatal Steroids</td>
<td>89.7%</td>
</tr>
<tr>
<td>PC-04</td>
<td>Health Care-Associated Bloodstream Infections in Newborns*</td>
<td>2.5%</td>
</tr>
<tr>
<td>PC-05</td>
<td>Exclusive Breast Milk Feeding</td>
<td>53.6%</td>
</tr>
<tr>
<td>PC-05a</td>
<td>Exclusive Breast Milk Feeding Considering Mother’s Initial Feeding Plan</td>
<td>69.2%</td>
</tr>
</tbody>
</table>

* Denotes outcome measure
Resources
March of Dimes Perinatal Care Resource

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

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 or CMQCC.org to download your free copy of the toolkit.
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
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
Resources for Antenatal Steroids

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

- March of Dimes Preterm Labor Assessment Toolkit:
Resources for Preventing Bloodstream Infections


NEW!
Resources for Breast Milk Feeding Promotion

- The Joint Commission’s Speak Up™ Campaign: [http://www.jointcommission.org/speakup.aspx](http://www.jointcommission.org/speakup.aspx)
View the manual and post questions at:
http://manual.jointcommission.org
These slides are current as of (2/11/2015). The Joint Commission reserves the right to change the content of the information, as appropriate.