Perinatal Care Measures 101

Candy Walk RN, BC
Quality Measures Project Manager
April 8, 2015

https://manual.jointcommission.org
Reporting Requirements

Effective with January 1, 2014 discharges, Joint Commission Perinatal Care measures reporting is required for hospitals with 1100 or more births per year.
## Perinatal Care Measures

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure Short Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC-01</td>
<td>Elective Delivery</td>
</tr>
<tr>
<td>PC-02</td>
<td>Cesarean Section</td>
</tr>
<tr>
<td>PC-03</td>
<td>Antenatal Steroids</td>
</tr>
<tr>
<td>PC-04</td>
<td>Health Care-Associated Bloodstream Infections in Newborns</td>
</tr>
<tr>
<td>PC-05</td>
<td>Exclusive Breast Milk Feeding</td>
</tr>
</tbody>
</table>
PC-Mother Measures

Population of PC-Mother measures (PC-01, 02, and 03) are identified using 4 data elements:

- Admission Date
- Birthdate
- Discharge Date
- ICD-9 Principal or Other Diagnosis Code
PC-Mother Measures

PC Mother Initial sampling group:

• ICD-9 Principal or Other Diagnosis Code 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
PC-Newborn Measures

Population of the PC-Newborn measures (PC-04 and 05) use 5 data elements:

- Admission Date
- Birthdate
- Discharge Date (PC-05 only)
- ICD-9-CM Principal or Other Diagnosis Code
- ICD-9-CM Principal or Other Procedure Code
## Monthly PC-Mothers Sampling

<table>
<thead>
<tr>
<th>Monthly Sample Group</th>
<th>Minimum Required Sampling</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;=501</td>
<td>101</td>
</tr>
<tr>
<td>126 - 500</td>
<td>20% of Initial Patient Population</td>
</tr>
<tr>
<td>25 - 125</td>
<td>25</td>
</tr>
<tr>
<td>&lt;25</td>
<td>No sampling; 100% Population required</td>
</tr>
</tbody>
</table>
# Monthly PC-Newborns-Breast Feeding Sampling

<table>
<thead>
<tr>
<th>Monthly Sample Group</th>
<th>Minimum Required Sampling</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;=181</td>
<td>37</td>
</tr>
<tr>
<td>46 - 180</td>
<td>20% of Initial Patient Population</td>
</tr>
<tr>
<td>9 - 45</td>
<td>9</td>
</tr>
<tr>
<td>&lt;9</td>
<td>No sampling; 100% Population required</td>
</tr>
</tbody>
</table>
PC-Newborn BSI Sampling

- Newborns with BSI population are not eligible for sampling
- Use the entire Newborns with BSI Initial Patient sampling group for reporting
PC-01 Elective Delivery
PC-01 Elective Delivery

Numerator: Patients with elective deliveries

Included Populations:
ICD-9 Principal or Other 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 not in Labor and no history of Prior Uterine Surgery
PC-01 Elective Delivery

Denominator: Patients delivering newborns with ≥37 and <39 weeks of gestation

Included Populations:

• ICD-9 Principal or Other Dx Codes for pregnancy in Appendix A Tables 11.01 - 11.04

• ICD-9 Principal or Other Dx Codes for planned c-section in labor in Appendix A, Table 11.06.1
PC-01 Elective Delivery

Excluded Populations:

- ICD-9 Principal or Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks in Appendix A, Table 11.07
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of stay >120 days
- Enrolled in clinical trials
- Gestational Age <37 or >=39 weeks
Data Elements
Shared Data Elements

TJC has aligned some of the data elements in their manual with the Inpatient CMS manual:

• Admission Date
• Birth date
• Clinical Trial
• Discharge Date
• Discharge Disposition
Clinical Trial

Allowable Values:

Y (Yes) Patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (PC)

N (No) No clinical trial for PC or unable to determine (UTD)
Clinical Trial

Broader definition than for the Inpatient Measures:

• Must be a signed consent form for experimental (not observational) study
• Captures any clinical trials for pregnant patients or newborns
• For PC measures only - Vendor tool may default to “No” - need to abstract/chang if the actual value is “Yes”
Gestational Age

• Round off gestational age to the nearest completed week...

• Review:
  ➢ Delivery or OR record first - If not recorded, then continue to review sources in the following order:
  ➢ H & P, prenatal forms, clinician admission progress note and D/C summary until a positive finding is found
  ➢ If conflicting data, gestational age in first document listed should be used - "estimated gestational age" is acceptable
Gestational Age

• If no prenatal care, select UTD (previously stated to use EGA)
• When admission date is different from delivery date, use gestational age documented closest to delivery
• Gestational age should be a value between 1-50 - the clinician, not the abstractor, should perform the calculation based on first day of the last menstrual period (not presumed time of conception) and the date of delivery
Gestational Age

- If gestational age in the first document listed is obviously in error but is a valid number and the correct number can be supported with other acceptable sources, the correct number may be entered.
- Documentation may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN).
Gestational Age

Acceptable to use data derived from:

- Vital records reports received from state or local departments of public health
- Delivery logs or clinical information systems (new)

May be used in lieu of the hierarchy of Acceptable Sources
Gestational Age

ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE:

- Delivery room record
- Operating room record
- History and physical
- Prenatal forms
- Admission clinician progress notes
- Discharge summary
Labor

Yes - Documentation by the clinician that the patient was in labor

No - No documentation by the clinician that the patient was in labor OR UTD
A clinician is defined as a physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN)

Abstract Labor at face value - no descriptors needed

**Documentation of regular contractions or cervical change without mention of labor cannot be used to answer “Yes”**
Labor

Inclusion (Acceptable Descriptors):

- Active
- Early
- Spontaneous

Exclusion:

- Prodromal
- Latent
Spontaneous Rupture

• Data element “Spontaneous Rupture of Membranes” or SROM has been removed for 2015

• This is now captured using ICD-9 diagnosis codes on Table 11.07

• This will exclude the case for conditions justifying elective delivery
Prior Uterine Surgery

Allowable Values:

Yes - Documentation that the patient had undergone prior uterine surgery

No - No documentation that the patient had undergone a prior uterine surgery OR UTD
Prior Uterine Surgery

Only prior uterine surgeries accepted are:

• Prior classical cesarean section (vertical incision into upper uterine segment)
• Prior myomectomy
• Prior uterine surgery resulting in a perforation of the uterus due to an accidental injury
• History of a uterine window or thinning of wall noted during prior uterine surgery or during ultrasound
• Hx of uterine rupture requiring surgical repair
• **History of a cornual ectopic pregnancy
Prior Uterine Surgery

Exclusions:

• Prior low transverse cesarean section
• Prior cesarean section without specifying prior classical cesarean section
PC-02 Cesarean Section
PC-02 Cesarean Section

Numerator
Patients with cesarean sections

Included Populations
ICD-9 Principal or Other Procedure Codes for cesarean section in Appendix A, Table 11.06
PC-02 Cesarean Section

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

Included Populations:
• *ICD-9 Principal or Other Diagnosis Codes* for pregnancy in Appendix A, Tables 11.01 - 11.04
• Nulliparous patients with *ICD-9-CM Principal or Other Dx Codes* for delivery in Appendix A, Table 11.08 and with a delivery of a newborn ≥37 weeks gestation
Data Elements
Parity

• Review:
  - Delivery or OR record first - If not recorded, then continue to review sources in the following order:
  - H & P, prenatal forms, clinician admission progress note and D/C summary until a positive finding is found
  - If conflicting data, parity in first document listed should be used
Parity

- If parity is not documented and GTPAL terminology is documented where G= Gravida, T= Term, P= Preterm, A= Abortions and L= Living, all previous term and preterm deliveries should be added together to determine parity.
- If parity is not documented and gravidity is one, parity should be considered zero.
- Previous delivery of twins or any multiple gestation is considered one parous event.
Parity

- Documentation may be written by: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN)
- If number for parity includes delivery for the current hospitalization, parity should be answered as one number less than the number documented
- If primagravida is documented select zero for parity
Parity

Acceptable to use data derived from:

• Vital records reports received from state or local departments of public health
• Delivery logs or clinical information systems (new)

May be used in lieu of the hierarchy of Acceptable Sources
Parity

ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE:

• Delivery room record
• Operating room record
• History and physical
• Prenatal forms
• Admission clinician progress notes
• Discharge summary
Parity

Inclusion:

• **Para

The following descriptor must precede the number when determining parity:
• Parity
• P

Examples: parity=2 or g3p2a1
Parity

Exclusion:
A string of three or more numbers without the alpha designation of "p" preceding the second number can not be used to determine parity
Example: 321

When GTPAL terminology is documented, G= Gravida, T= Term, P= Preterm, A= Abortions, L= Living, P does not equal parity
PC-03 Antenatal Steroids
PC-03 Antenatal Steroids

Numerator:
Patients with antenatal steroid therapy initiated prior to delivering preterm newborns

Included Populations:
Antenatal steroid therapy initiated (refer to Appendix C (B in 2014 manual), Table 11.0, antenatal steroid medications)
PC-03 Antenatal Steroids

Denominator:
Patients delivering live preterm newborns with >=24 and <34 (changed from 32 in 2014) weeks gestation completed

Included Populations:
*ICD-9-CM Principal or Other Dx Codes for pregnancy in Appendix A, Tables 11.01 - 11.04*
PC-03 Antenatal Steroids

Excluded Populations:

• *ICD-9 Principal or Other Dx Codes* for fetal demise in Appendix A, Table 11.09.1

• *Gestational Age* < 24 or >= 34 weeks

• Documented *Reason for Not Initiating Antenatal Steroid Therapy*
Data Elements
Antenatal Steroid Initiated

- Initial antenatal steroid therapy is 12 mg betamethasone IM or 6 mg dexamethasone IM
- If antenatal steroid therapy was initiated prior to current hospitalization in another setting, i.e., doctor's office, clinic, birthing center, hospital before delivery, select “Yes”
- If antenatal steroid therapy was initiated in the hospital, the name of the medication must be documented in order to select “Yes”
Reason for Not Initiating Antenatal Steroid Therapy

• Reasons must be explicitly documented:
  ➢ “patient had an adverse reaction to the medication in the past - unable to initiate antenatal steroid therapy”
  ➢ or clearly implied (**documentation of an imminent delivery which occurs within 2 hours after admission, there is documentation the fetus has anomalies which are not compatible with life, or there is documentation that the patient has chorioamnionitis)
• **Removed for 2015: “If reasons are not mentioned in the context of antenatal steroid administration, do not make inferences.”
PC-04  Health Care-Associated Bloodstream Infections in Newborns
Bloodstream Infections in Newborns

Numerator: Newborns with septicemia or bacteremia

Included Populations:

*ICD-9 Other Diagnosis Codes* for newborn septicemia or bacteremia in Appendix A, Table 11.10

OR

*ICD-9 Other Diagnosis Codes* for sepsis in Appendix A, Table 11.10.1
Bloodstream Infections in Newborns

Denominator: Liveborn newborns

Included Populations:

ICD-9 Other Diagnosis Codes for birth weight between 500 and 1499g in Appendix A, Tables 11.12 - 11.14

OR Birth Weight between 500 and 1499g

OR
Included Populations (cont.)

ICD-9 Other Diagnosis Codes for birth weight ≥ 1500g as defined in Appendix A, Tables 11.15 -11.17

OR Birth Weight ≥ 1500g who experienced one or more of the following:

- Experienced death
- *ICD-9 Principal or Other Procedure Codes* for major surgery in Appendix A, Table 11.18
- *ICD-9 Principal or Other Procedure Codes* for mechanical ventilation in Appendix A, Table 11.19
- Transferred in from another acute care hospital or health care setting within 2 days of birth
Data Elements
Admission Date

For newborns that are born within this hospital, the admission date is the date the baby was born.
Birth Weight

453.5 grams = 1 pound
28.35 grams = 1 ounce
All birth weights must be converted to grams

• When converting from pounds and ounces to grams, do not round to the nearest pound before converting the weight to grams - round to the nearest whole number after the conversion to grams

• Newborns with birth weights <150 grams and >8165 grams need to be verified for data quality
Birth Weight

• If birth weight is unable to be determined from documentation, enter "UTD"

• NICU admission assessment or notes should be reviewed first for the birth weight - In the absence of admission to the NICU, the delivery record or OR record should be reviewed next

• In cases with conflicting data - use documented birth weight closest to time of delivery
Birth Weight

Acceptable to use data derived from:

- Vital records reports received from state or local departments of public health
- Delivery logs or clinical information systems (new)

May be used in lieu of the hierarchy of Acceptable Sources
Birth Weight

• For newborns received as a transfer, the admission birth weight may be used if the original birth weight is not available.

• If birth weight is recorded in pounds and ounces and also in grams, abstract the value for grams.
Birth Weight

Suggested Data Sources In Order of Priority:

- NICU admission assessment or notes
- Delivery record
- Operating room record
- History and physical
- Nursing notes
- Nursery record
- Physician progress notes
Bloodstream Infection Present on Admission

Allowable Values:

Yes; Documentation within the first 48 hours that patient had a bloodstream infection present on admission or is receiving treatment for a suspected bloodstream infection or septicemia on admission

No; No documentation within the first 48 hours that the patient had a bloodstream infection present on admission or is receiving treatment for a suspected bloodstream infection or septicemia present on admission or UTD
Bloodstream Infection Present on Admission

• Admission assessment and NICU admission assessment **or NICU notes should be reviewed first for suspected or confirmed bloodstream infection present on admission **or within the first 48 hours after admission

• Documentation of the suspected bloodstream infection being present on admission should be taken at face value regardless of the blood culture results

• If the present on admission (POA) indicator is present with the diagnosis code for septicemia or bacteremia, answer “Yes”
Bloodstream Infection on Admission

- Routine work up for sepsis should not be considered a suspected bloodstream infection in the absence of positive blood culture results.
- There must be documentation specifically stating that the newborn appeared septic or was showing S & S of sepsis in order to answer “Yes”.
- Results of initial blood cultures drawn within the first 48 hours which are reported after the first 48 hours may be used to determine if the bloodstream infection was present on admission.
Inclusions

- Suspected bloodstream infection
- Positive blood culture
- Inconclusive blood culture under treatment
- Staphylococcal septicemia
- Staphylococcal bacteremia
- Gram negative septicemia
- Gram negative bacteremia
Exclusions (new)

- Rule out sepsis
- R/O sepsis
- Work up for sepsis
- Negative blood culture under treatment
- Evaluation for sepsis
PC-05 Exclusive Breast Milk Feeding Considering Mother’s Initial Feeding Plan
PC-05 Exclusive Breast Milk Feeding

Description:
PC-05 Exclusive breast milk feeding during the newborn's entire hospitalization
PC-05a Exclusive breast milk feeding during the newborn’s entire hospitalization considering mother’s **initial feeding plan
PC-05 Exclusive Breast Milk Feeding

Numerator:
PC-05/05a Newborns that were fed breast milk only since birth

Included Populations:
Not applicable
PC-05 Exclusive Breast Milk Feeding

Denominator:
PC-05 Single term newborns discharged alive from the hospital
PC-05a Single term newborns discharged alive from the hospital excluding those whose mothers **initial feeding plans were not to exclusively feed breast milk

Included Populations:
Liveborn newborns with *ICD-9 Principal Dx Code* for single liveborn newborn in Appendix A, Table 11.20.1
Exclusions

- Admitted to NICU during the hospitalization
- *ICD-9 Other Dx Codes* for galactosemia App A, Table 11.21
- *ICD-9 Principal or Other Procedure Codes* for parenteral infusion in Appendix A, Table 11.22
- Experienced death
- Length of Stay >120 days
- Enrolled in clinical trials
- *Reason for Not Exclusively Feeding Breast Milk*
- Patients transferred to another hospital
- *ICD-9 Other Dx Codes* for premature newborns as defined in Appendix A, Table 11.23
Data Elements
Admission to NICU

Allowable Values:

Y (Yes) Newborn was admitted to the NICU at this hospital at any time

N (No) No documentation that newborn was admitted to the NICU at this hospital at any time during the hospitalization or UTD
Admission to NICU

- Defined as a unit providing critical care services with personnel/equipment to provide continuous life support and comprehensive care for extremely high-risk newborn infants and those with complex and critical illness.

- **Names of NICUs may vary from hospital to hospital - level designation and capabilities also vary from region to region and cannot be used alone to determine if nursery is a NICU**
Admission to NICU

• If the newborn is admitted to the NICU for observation or transitional care following a c-section, select “No” - **Transitional care is defined as a stay of 4 hours or less in the NICU

• **If no order to admit to NICU, must have supporting documentation indicating that newborn received critical care services in the NICU to answer “Yes” (NICU admission assessment or flow sheet)
Exclusive Breast Milk Feeding

- Yes/No - Determine what infant consumed
- If the newborn receives any other liquids including water during the entire hospitalization, select allowable value "No"
- Exclusive breast milk feeding includes breast milk via a bottle or other means (EBM)
- Sweet-Ease® or a similar 24% sucrose and water solution given for reducing discomfort during a painful procedure is classified as a medication and is not considered a supplemental feeding
Exclusive Breast Milk Feeding

Select “Yes”:

- Newborn receives donor breast milk
- Breast milk fortifier is added to breast milk
- ** Newborn received drops of water or formula dribbled onto the mother’s breast to stimulate latching and not an actual feeding

Select “No”:

- If conflicting documentation and both exclusive breast milk feeding and formula supplementation is documented
Reason for Not Exclusively Feeding Breast Milk

Allowable Values:
1.) Documentation by
   • physician/APN/PA/certified nurse midwife (CNM)
   • **international board certified lactation consultant (IBCLC)**
   • **certified lactation consultant (CLC)**

Due to a maternal medical condition with which breast milk feeding should be avoided
Reason for Not Exclusively Feeding Breast Milk

2.) There is documentation by physician/APN/PA/CNM/**IBCLC/CLC/RN that the newborn’s mother’s **initial feeding plan for the hospitalization included formula upon admission of the newborn

3.) None of the above or unable to determine (UTD) from medical record documentation (Was; There is no documentation by the physician....)
Reason for Not Exclusively Feeding Breast Milk

• Admission is defined as birth of the newborn
• Mother's initial feeding plan must be documented in the newborn's record prior to the first feeding
• If discussion of the mother's feeding plan occurred prior to the birth, this may be used provided the date/time of the discussion appears in the newborn's record - and is prior to the date/time of the first feeding
Reason for Not Exclusively Feeding Breast Milk

Example:

- Initial feeding plan in mother's record on 6/1 at 10:00
- Baby was born (admitted) on 6/1 at 13:00
- First feeding 6/1 at 13:30 in newborn’s record
- NB record should show discussion of initial feeding plan that took place with the mother, content of the discussion and mother’s decision for feeding plan along with date/time of discussion (6/1 at 10:00)

- If date/time in NB record does not match that of original discussion in mother's record and it turns out to be another discussion and feeding plan taking place after the first feeding, this documentation cannot be used, e.g., discussion at 6/1 at 14:00
Reason for Not Exclusively Feeding Breast Milk

• Reasons must be explicitly documented:
  ➢ “mother is HIV positive - newborn will not be breast fed”
  ➢ or clearly implied ("mother is currently abusing alcohol - newborn will be fed formula")
  ➢ if reasons are not mentioned in the context of newborn feeding, do not make inferences (do not assume the newborn is not receiving breast milk because of medications the mother is taking)

• RN or certified lactation educator documentation is not acceptable for maternal medical conditions
Reason for Not Exclusively Feeding Breast Milk

• If newborn medical conditions, i.e., hypoglycemia, weight loss, hyperbilirubinemia, etc. are documented as a reason, select “3” None of the Above or UTD

• A mother’s feeding plan that includes formula feeding must be clearly documented in the newborn’s record in the context of substance fed in order to select allowable value “2”

• Do not assume that the newborn was not exclusively fed breast milk due to the mother’s initial feeding plan in the absence of such documentation
Reason for Not Exclusively Feeding Breast Milk

• No evidence to support feeding both breast milk and formula, so discussion of the mother’s feeding plan should focus on benefits of exclusive breast milk feeding and the risks of adding formula.

• If there is documentation in the newborn’s record of the discussion and the mother's feeding plan, and the mother still elected to feed both, select “2” (plan included formula).

• If mother’s feeding plan was to exclusively feed breast milk, and the mother’s plan changed later in the hospitalization to include formula select allowable value “3” (None of Above or UTD).
Reason for Not Exclusively Feeding Breast Milk

• Standing orders and check boxes listing the method of feeding to include formula cannot be used alone to select “2” - there must be additional supporting documentation by the physician…. that the feeding plan was discussed with the mother

• RN documentation of the discussion and the mother’s feeding plan to include formula discussed upon admission is acceptable ONLY if there is supporting documentation by the physician... at some point during the hospitalization to corroborate the RN’s discussion

• If the mother decides to feed formula prior to the supporting documentation, only the initial feeding plan can be used
Reason for Not Exclusively Feeding Breast Milk

- Mother’s record cannot be used to determine the initial feeding plan
- Documentation must appear in the newborn’s record without using the mother’s record to perform the abstraction
  - Even if there is a link between the mother and newborn records in the EHR
- Bottle is a method of feeding and is not the same as formula
- Bottle cannot be used interchangeably for formula, since breast milk can also be fed via a bottle
Inclusions

These are the only acceptable maternal medical conditions for which breast milk feeding should be avoided which includes one or more of the following medical conditions:

• Human t-lymphotrophic virus type I or II
• HIV infection
• Substance abuse and/or alcohol abuse
• Active, untreated tuberculosis
Inclusions

- 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
- Undergoing radiation therapy
- Active, untreated varicella
- Active herpes simplex virus with breast lesions
- Admission to Intensive Care Unit (ICU) post-partum
Inclusions

• **Newborn and mother will be separated after discharge from the hospital, and the mother will not be providing care for the newborn after the hospitalization. Examples include, but are not limited to: adoption, foster home placement, surrogate delivery, incarceration of the mother**

• Previous breast surgery, i.e., bilateral mastectomy, bilateral breast reduction or augmentation where the mother is unable to produce breast milk

• Breast abnormality, i.e., hypoplasia, tumor, etc. where the mother is unable to produce breast milk
Abstraction Services

Primaris provides

- Short-term, long-term and interim core measures and registry abstraction
- Retrospective quality measures validation audits
- Quality measures education and training
- Performance and clinical documentation improvement consulting and training

As required and optional measures continue to increase, Primaris has the flexibility to absorb your hospital’s changing needs.