

# Benchmark

## Improving Performance on Perinatal Care Measures

Quality improvements in essential areas of patient safety, including perinatal care, rely on the performance of specific tasks. To help assess the effectiveness of patient care, The Joint Commission requires hospitals to submit data reports based on measures that meet certain criteria. These accountability measures are organized into “measure sets,” which are a unique group of action items specifically selected to optimize the care provided in each area.

Currently, general medical/surgical hospitals are required to submit data for a minimum of 4 measure sets (out of 14) via a vendor that has been evaluated and listed by The Joint Commission. This will change, however, in 2014. Beginning January 1, hospitals must submit data for 6 measure sets. According to the new guidelines, some of these sets will be mandatory for hospitals. Others will be discretionary. A number of health care organizations that are involved in perinatal care supported adoption of the measure (*see* the box on page 18).

Perinatal care will fall under the mandatory column for hospitals with 1,100 or more births annually. The Joint Commission will monitor this threshold over the first four to eight quarters of data collection and then reassess the number with an expectation that it will be modified over time to include more hospitals. Celeste G. Milton, MPH, BSN, RN, associate project director for the Division of Healthcare Quality Evaluation at The Joint Commission, says the decision to make the perinatal care measures mandatory was “based on overwhelming feedback The Joint Commission received from the perinatal care organizations across the country.”

The Perinatal Care Measure Set (PC) includes the following measures:

- PC-01 Elective delivery
- PC-02 Cesarean section



*Beginning January 1, 2014, hospitals that see more than 1,100 births annually will be required to submit data on the Perinatal Care Measure Set.*

- 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 choice

Milton, who is the clinical lead for the perinatal care core measures, says the Perinatal Care Technical Advisory Panel, which is comprised of perinatal care experts, recommended these evidence-based measures to help provide a robust picture of perinatal care provided during hospitalization. “The goal is to improve the quality and safety of care for both mothers and newborns,” Milton says. “Collecting and reporting the data will enable hospitals to establish a baseline for their performance, which in turn serves as a determinant of whether there are gaps in care and whether improvement efforts are effective over time,” she says.

Closing the gaps in care through measure sets is the prime directive of Performance Improvement (PI) Standard

PI.02.01.03, which requires accredited hospitals to achieve a composite performance rate of at least 85% on the ORYX® accountability measures transmitted to The Joint Commission.<sup>1</sup> (ORYX is The Joint Commission's performance measurement and improvement initiative which integrates outcomes and other performance measurement data into the accreditation process.<sup>2</sup>)

Typical data for measures includes the following:

- Admission date
- Birth date
- Clinical trial
- Discharge date
- Gestational age
- Diagnosis and procedure codes specific to the measure

This performance data is submitted every quarter.

Current measure specifications for perinatal care, available in the *Specifications Manual for Joint Commission National Quality Core Measures*, indicate the types of data elements that should be recorded. To access the specifications manual, visit [http://www.jointcommission.org/specifications\\_manual\\_joint\\_commission\\_national\\_quality\\_core\\_measures.aspx](http://www.jointcommission.org/specifications_manual_joint_commission_national_quality_core_measures.aspx).

Sending data to The Joint Commission involves working with performance measurement systems vendors who act as intermediaries between The Joint Commission and the hospitals. Milton says that “[Performance measurement system] vendors will provide the hospitals with a data collection tool to collect the required data based on Joint Commission measure specifications,” and then transmit that data for analysis and future public reporting.

## Strategies for Improvement

In order to provide the best care and identify opportunities for improvement, accredited hospitals should adopt policies and procedures that can bolster their achievement. For that reason, The Joint Commission strongly encourages hospitals to adopt the PC measure set before it goes into effect the first of the year. Fortunately, a variety of resources are available to help tackle the new PC measures now and help hospitals better protect new mothers and their babies.

Below are recommendations for improving performance on each of the measures in the PC set.

**STRATEGY PC-01 Elective delivery:** Milton says many hospitals are adopting policies to reduce early-term elective deliveries that can result in health complications (for an example see the article “Spotlight on Success: Addressing Early Effective Deliveries,” in the February 2013 issue of this newsletter). The American College of Obstetricians and Gynecologists (ACOG) and the American

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Academy of Pediatrics (AAP) have a three-decade-old standard in place that requires 39 completed weeks' gestation prior to elective delivery. However, a 2007 survey of almost 20,000 births by the March of Dimes and ACOG revealed that almost one third of all babies delivered in the United States are electively delivered and 5% do not adhere to that guideline. The survey found that most of these deliveries were made out of convenience, and resulted in significant short-term neonatal morbidity.<sup>3</sup>

To help prevent these problems, Milton recommends downloading the *Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age* toolkit, developed by the March of Dimes and the California Maternal Quality Care Collaborative at [http://www.marchofdimes.com/professionals/medicalresources\\_39weeks.html](http://www.marchofdimes.com/professionals/medicalresources_39weeks.html). The toolkit is designed to prevent elective deliveries prior to 39 weeks' gestation and contains a comprehensive literature review about the importance of eliminating elective deliveries before 39 weeks, a step-by-step guide to help hospital leaders implement improvements, a guide for measuring and tracking quality improvement effectiveness over time, as well as educational tools for clinicians, staff, and patients.<sup>4</sup>

**STRATEGY PC-02 Cesarean section:** This Joint Commission measure is designed to help reduce the number of cesarean sections, which can potentially cause health concerns for babies and mothers, such as significantly higher rates of respiratory complications and morbidity, compared to vaginal births.<sup>5</sup> The measure applies specifically to first-time mothers with a single baby and vertex presentation. PC-02 requires a multifaceted approach to improve performance for cesarean sections, according to Milton. She recommends a white paper published by the California Maternal Quality Care Collaborative, “Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality,” available at <http://www.cmqcc.org/resources/2079/download>.

The paper discusses a number of clinical improvement strategies, including the following<sup>5</sup>:

- Reduce admissions in early labor (during the latent phase)

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- Eliminate *elective* labor induction before 41 weeks, especially in first births with an unfavorable cervix
- Improve diagnostic and treatment approaches for labor disorders (such as dystocia and failure to progress)
- Standardize diagnosis and management of fetal heart rate abnormalities while in labor
- Reduce uterine hyper-stimulation associated with oxytocin (by using oxytocin safety protocols)
- 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

**Strategy PC-03 Antenatal steroids:** The National Institutes of Health recommends a full course of corticosteroids to all pregnant women between 24 weeks and 34 weeks of gestation who are at risk of preterm delivery. Repeated courses, however, may result in decreased brain size, decreased birth weight, and adrenal insufficiency in newborns exposed to repeated doses.<sup>6</sup> Milton suggests reviewing the ACOG clinical practice guideline, *Management of Preterm Labor* (available at <http://www.guideline.gov/content.aspx?id=38621&search=antenatal+steroids>), which includes administration of antenatal steroids. Major recommendations by ACOG include the following:

- The evidence supports the use of first-line tocolytic treatment with beta-adrenergic agonist therapy, calcium channel blockers, or non-steroidal anti-inflammatory drugs (NSAIDs) for short-term prolongation of pregnancy (up to 48 hours) to allow for the administration of antenatal steroids.
- A single course of repeat antenatal corticosteroids should be considered in women whose prior course of antenatal corticosteroids was administered at least 7 days previously and who remain at risk of preterm birth before 34 weeks of gestation.

**Strategy PC-04 Health care–associated bloodstream infections in newborns:** Health care–associated bacteremia is a significant problem for infants admitted into neonatal intensive care units (NICUs) and other hospital units. Preventive measures can include hand hygiene protocols, closed medication delivery systems, or more elaborate, multidisciplinary quality improvement plans.<sup>8</sup> The Centers for Disease Control and Prevention (CDC) offers guidelines for the prevention of intravascular catheter-related infection, which is the most common cause of bloodstream infections, at <http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf>.<sup>9</sup>

## Baby Brigade

A significant factor in the decision to make the perinatal care measures mandatory was the overwhelmingly positive feedback from many organizations that are involved or concerned with perinatal care that supported the change. Some of those organizations include the following:

- American College of Obstetricians and Gynecologists (ACOG)
- American Academy of Pediatrics (AAP)
- Society for Maternal-Fetal Medicine (SMFM)
- Association of Women’s Health, Obstetric & Neonatal Nurses (AWHONN)
- American College of Nurse Midwives (ACNM)
- Centers for Disease Control and Prevention (CDC)
- National Perinatal Information Center (NPIC)
- Hospital Corporation of America (HCA)
- California Maternal Quality Care Collaborative (CMQCC)

## Strategy PC-05 Exclusive breast milk feeding / PC-05a Exclusive breast milk feeding considering mother’s choice:

“Exclusive breast milk feeding evaluated in PC-05 and PC-05a can be improved by adopting a policy promoting breast milk as the default method of feeding,” Milton says. According to the Academy of Breastfeeding Medicine, exclusive breast milk feeding for the first six months of neonatal life is an important behavior in decreasing infant death and illness worldwide.<sup>10</sup> Breastfeeding has also been championed by the World Health Organization (WHO), US Department of Health and Human Services (DHHS), American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG).<sup>11</sup>

An evidence-based model policy developed by the Academy of Breastfeeding Medicine and available at <http://www.bfmed.org/Resources/Protocols.aspx> offers clinical protocols for the care of breastfeeding mothers and infants.<sup>12</sup> Milton recommends the United States Breastfeeding Committee Toolkit: *Implementing TJC Perinatal Care Core Measure on Exclusive Breast Milk Feeding*, which was specifically designed to aid hospitals and maternity facilities in accurate collection of the data needed to comply with The Joint Commission’s PC-05 and PC-05a measures (available at <http://www.usbreastfeeding.org/HealthCare/HospitalMaternityCenterPractices/ToolkitImplementingTJCCoreMeasure/tabid/184/Default.aspx>). The toolkit also

offers strategies for improving adherence to evidence-based best practices related to exclusive breast milk feeding.<sup>13</sup>

Hospitals with 1,100 or more births annually have an opportunity to get a jumpstart on the mandatory PC measure set. By using the many resources available to improve perinatal care procedures, they can not only work toward achieving a high performance rating, but ensure that every baby “is a finer one than the last” by directly impacting what matters most—the care and protection of newborns and their mothers. “The evidence base supporting the PC measures shows that improvement in the measures results in shorter hospitalizations, lower morbidity and mortality, and decreased costs to the patients and hospitals,” Milton says. “These measures will ensure that the patients receive quality and safe care.” 

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