Inpatient Quality Reporting Program

Support Contractor

2015 Updates to Perinatal Care (PC) Core Measure: PC-01 Elective Delivery and Structural Measures and Data Accuracy and Completeness Acknowledgement (DACA)

Moderator:
Candace Jackson, RN
IQR Support Contractor Team Lead, HSAG

Speaker(s):
Celeste Milton, MPH, BSN, RN
Associate Project Director, Division of Healthcare Quality Evaluation, Company

Candace Jackson, RN
IQR Support Contractor Team Lead, HSAG

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Katie McDonald: Hello and thank you for joining us today. My name is Katie McDonald and I'll be your host for today's call. Before we get started, I want to cover a few items so that you know how to interact with the presenters and get the audio for today.

So, today, the audio will be provided via internet streaming. You do not need [a telephone line] audio is delivered online. So just make sure your headphones or speakers are plugged in and turned up.

To ask questions today, we will be using the “Chat with the Presenter” section located in the bottom left-hand side of the screen. You can type your questions in here and we'll get back to you with the answers as fast as we can.

So, we'll get started now. I'll turn this over to Candace.

Candace Jackson: Thank you. Hello and welcome to our Inpatient Quality Reporting monthly webinar. My name is Candace Jackson, and I, too, will be

your host for today's event. Before we begin, I'd like to make a few announcements.

This program is being recorded. A transcript of the presentation along with the Qs&As will be posted to our Inpatient website at www.qualityreportingcenter.com within two days and will be posted to *QualityNet* at a later date.

If you're registered for this event, a reminder email, as well as the slides, were sent out approximately one hour ago to your email. If you did not receive the email, you can download the slides at our Inpatient website, and again that is www.qualityreportingcenter.com.

Next slide please.

The purpose of today's presentation is to provide information and updates regarding the structural measures and the Data Accuracy and Completeness Acknowledgement, also known as the DACA, and to provide updates and revisions to the PC-01 measure, Elective Delivery for 2015.

Next slide please.

At the end of today's presentation, you will be able to discuss the PC-01 measure and recent revisions to the measure, along with resources that are available for improving perinatal care. In addition, you will be able to define what a structural measure is and will be able to submit the structural measures and DACA to meet the IQR program requirement.

Next slide please.

This slide, 2015 update structural measures and DACA; for the first part of our presentation, we will be providing an update on the 2015 structural measures and the Data Accuracy and Completeness, excuse me, Acknowledgement.

Next slide please.

A structural measure reflects the environment in which providers care for patients. Structural measures assess characteristics linked to the capacity of the provider to deliver quality health care. CMS believes requesting structural measure information will encourage facilities to increase the use of tools, ultimately improving the quality of care provider to Medicare beneficiary.

Next slide please.

This slide is labeled fiscal year 2016 structural measures. For fiscal year 2016 payment, which is January 1st, 2014 through December 31, 2014 discharges; there are four structural measures that will be required: One) participation in systemic database for cardiac surgery; two) participation in a systemic clinical database for nursing-sensitive care; three) participation in a systemic clinical database registry for general surgery; and four) use of a safe surgery checklist.

Next slide.

We receive frequent questions from providers asking if a certain entity or entities are considered a registry. At this time, CMS does not provide a listing of entities that are considered a registry. For the Inpatient Prospective Payment System (IPPS) final rule, CMS defines a registry as a collection of clinical data for purposes of assessing clinical performance, quality of care, and opportunities for quality improvement.

When answering the structural measures question, you will also want to keep in mind the definition of “participation” and “qualified.” “Participation” is the same as submitting standardized data elements applicable to at least two National Quality Forum-(NQF-) endorsed measures related to the topic measured by the registry and reporting on all patients eligible for the measures.

And “qualified” is defined as receiving data from more than five hospitals and providing calculated measures, results, benchmarks, and quality improvement information to the participants and to designated third parties.

As a provider, you will need to make the determination if you are submitting data to a registry or not. If you are submitting data to an entity that meets the definition as outlined, then you would be able to select yes, that you are submitting data to a registry.

Next slide please.

We are now on a slide labeled registry requirements for structural measures. Hospitals are not required to participate in a registry, only to answer the questions regarding participation. Hospitals will not be penalized for non-participation in a registry. A hospital's annual payment update or APU is affected only when the hospital does not answer all the required questions indicating participation or non-participation.

So, just to emphasize, to meet the reporting requirements for the structural measures, hospitals only have to answer “yes” or “no” to the questions about whether they participate or not.

Next slide please.

Hospitals electronically acknowledge on an annual basis that all information submitted for the hospital Inpatient Quality Reporting (IQR) program is complete and accurate to the best of their knowledge at the time of submission. This acknowledgement covers all hospital IQR information reported by the hospital and any data or survey vendors acting on behalf of the hospital to CMS.

When signing the DACA, the hospital is acknowledging that, to the best of their knowledge at the time of submission, that all data

or information was collected in accordance with all applicable requirements. In addition, you are also acknowledging that you understand that this information is used as the basis for public reporting of quality care and patient assessment of care.

For the DACA, CMS recommends a hospital CEO who's ultimately responsible, or an authorized representative with the proper role, complete this requirement.

Next slide please.

When signing the DACA, the information that you are acknowledging is complete and accurate, includes the chart of extracted measure sets, initial patient population and sample counts, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data, and the Healthcare-Associated Infection (HAI) measures reported to National Healthcare Safety Network (NHSN). In addition, it includes that you are a current – that you have a current notice of participation (NoP) and at least one *QualityNet* administrator.

Next slide please.

As mentioned previously, structural measures and the DACA are reported annually. For fiscal year 2016 payments, the structural measures and DACA references participation and submission from January 1, 2014 through December 31, 2014. The submission deadline to complete the structural measures and DACA is from April 1, 2015 through May 15, 2015.

Next slide please.

And now we should be on a slide that is labeled Structural Measure and DACA Submission. Access to the IQR structural measures is available through the *QualityNet Secure Portal*. From the Quality Programs tab on the *Secure Portal* landing

page, click the Hospital Quality Reporting, IQR, OQR, ASCQR, IPFQR, PCHQR link. The “My Task” page, as shown in the slide, will appear. Select the “Manage Measures” link name, View/ Edit Structural/Web-Based Measures/DACA.

Next slide please.

Depending on your hospital structure, you may have additional choices from this screen in addition to the Inpatient Structural Measures/DACA. For example, the Outpatient Structural Measures may appear as a selection choice, depending on your assigned role. Select the Inpatient Structural Measures/ DACA link. This will take [you] to the Inpatient Structural Measures/DACA screen for payment year selection.

Next slide please.

And the slide we are on is entitled Payment Year Selection. On the Payment Year Selection screen, identify the one year for which you want to enter or view data. For data entry for this submission period, you would select 2016. Click continue.

Next slide please.

If you are a hospital user and have access only to your hospital data, you will be presented immediately with a summary screen displaying the completion status of structural measures and DACA. If you are a user representing an organization having access to multiple providers, you will be presented with a provider selection page.

On this summary page, the measures and DACA will be marked as either “Complete” or “Incomplete” once the submission period has started. At this time, since the submission period does not begin until April 1st, 2015, the measures and DACA are marked as “Not Available.”

To enter the data, click the link name or DACA which is in dark blue and bolded to proceed to the associated data entry screen. And notice that you can return to the payment year selection page if necessary, by clicking the payment year selection button.

Next slide please.

Once you have selected one of the structural measures, that question will display on the screen. As we talked about earlier, you only have to answer “Yes” or ”No.” There is no right or wrong answer. The Safe Surgery Checklist Use measure has a single ”Yes/No” question. The other three measures have multiple questions and only “Yes” answers will bring up the next question. So, if you answer “Yes,” then a free-text field will display for you to enter the registry name.

Next slide please.

And the title of this slide is DACA Statement. As we have talked about, IQR providers must attest to the accuracy and completeness of the data entered via the DACA form. The DACA, like the individual structural measures, is completed during a submission period. You will access the DACA as you do the other measures through the link on the summary page.

Next slide please.

At the bottom of the DACA, click on the ”Yes, I Acknowledge” button, enter a description of your position, and click “Submit” to save. You can click “Return to Summary” to go back to the measure summary screen. Once completed, the data entered will display at the bottom of the DACA, as shown in the slide.

Next slide please.

Once the structural data and DACA is entered, the summary page will show that the tasks were completed.

And next slide please.

We are now on the slide that says 2015 update Perinatal Care (PC) Core Measures. And now I would like to introduce our guest speaker, Celeste Milton. So, Celeste is an associate project director in a quality measurement department at The Joint Commission, and is a subject matter expert for the Perinatal Care Measure Set and PC-01.

So, Celeste, the floor is yours.

Celeste Milton: Hi. Thank you, Candace. Thank you everyone for being on this call later this afternoon or morning, depending on where you're located. We're going to talk a little bit about some of the updates that have taken place for PC-01 here beginning with January 1, 2015 discharges.

So, I'm sure that you're on the call or you're staying around on the call because you probably have questions, but we'll see if we can answer those with these next few slides.

Okay, the next slide here should say Perinatal Care Project Overview. Just for those of you that are new to this, just to give you some background information on the perinatal care core measure set: back in 2007 The Joint Commission's Board of Commissioners recommended at that time that we replace the parent set which was known as Pregnancy-Related Conditions with a new set based on evidence.

So, in 2008, the National Quality Forum convened a project looking at perinatal care measures. During this project, a total of 17 measures received endorsement. At the end of 2008, when this happened and the Joint Commission formed a Technical Advisory Panel (TAP) comprised of perinatal care experts, we took the 17 measures and brought the panel together in early 2009 to review those measures and determine which measures

should comprise a new set. A total of five measures were selected, and measure specifications were completed in 2009, and a manual was posted the 1st of October, 2009 with the first data collection beginning April 1 of 2010.

So, we're almost up to about five years. It doesn't seem like it's been that long, but in about another month, well, we have been doing this for five years.

For those of you that are Joint Commission accredited, we have what we call ORYX requirements, and that's our performance measurement requirements as a part of accreditation. So, if you're a hospital that has 1,100 births or more annually per year, this has become a fifth mandatory measure set. So, some of you were probably doing it both for CMS, the PC-01 measure, and you might be doing it also for Joint Commission, especially if you have the higher number of births.

This next slide talks a little bit about the reporting requirement for CMS. The Final Rule, which was posted in August of last year, indicated that you should continue to collect [and] report PC-01, the elective delivery measure. It further stated that for fiscal year (FY) 2017, this will be one of three proposed process measures that will be used in a value-based purchasing program. So this is something that both The Joint Commission and CMS considered to be an important measure.

One little thing that's going on at Joint Commission that I just wanted to make people aware of related to perinatal care is that we are in the process of finalizing development of our perinatal care certification program. This program would be available to organizations that want to become certified in perinatal care, and it's going to be focusing on looking at the normal physiologic birth and this is going to be accomplished by the use of standards,

clinical practice guidelines, and then of course, our performance measures.

We're anticipating, about the middle of this year, that we will begin to take applications for certification. And if you have further questions, I can include it in email address here where you can pose those questions.

Now, I had mentioned that PC-01 is part of the perinatal care core measure set, so I just wanted to give you a slide here that shows the five measures that do comprise this current measure set. All of these are National Quality Forum-endorsed.

So, when we talk about the perinatal care core measure sets, there are two distinct populations. Of course, the measure that we'll be talking about today looks at the mothers. We have three measures that looked at the mothers and then the last two measures look at the newborns. All of our measures, though, represent domains of care. And in this case, we'll be talking a little bit about assessment and screening when we talk about PC-01.

Okay, the next slide is titled Maternal Initial Patient Population. If you're a hospital that's not doing this for [The] Joint Commission, and you're not working with a vendor, then you're charged with the responsibility of identifying those patients for this measure. That's accomplished via ICD-9-CM principle and other diagnosis codes. Those can be found in Appendix A of our manual and there are four tables that are basically the universe of pregnancy that resulted in a delivery during that hospitalization. So you have tables 11.01, 11.02, 11.03, or 11.04. For [a] patient that has a code on any one of those tables, they would then be eligible as part of the initial patient population for this measure.

In addition, we've set other criteria, and that would be patient age. So that would be your admission date minus the birth date. It has

to be greater than or equal to eight years of age but less than 65. We actually have – here's the sweet spot on that ... We ran some numbers just to see if there were any cases that were excluded that were either younger or older, and there were none. So we believe that we've got the wide range that we would need for this. Also, the length of stay, it has to be equal to or less than 120 days, and you would determine that by a discharge date minus the admission date.

In addition to that, on this next slide, we talk about sampling. As I go through the specifications, I'm going to discourage sampling because there are other ways that you can actually identify all of your cases. But if you do choose to sample on a quarterly basis, it's going to be according to the discharge that you have for the quarter.

So, if you have equal to or greater than 1,501 quarterly discharges, your minimum sample size would be at 301 medical records for that order, and your next cut point would be 20 percent, and then 75 to 375 would be at least 75, and if you have less than 75, then you are required to review all of the records for that order.

The next slide shows the maternal monthly sampling, and it's going to be very similar to quarterly sampling concepts. If you got – excuse me, 541 or more discharges, your minimum sample would be 109, your next cut point is 20 percent, and then it goes down to 25, and then finally 100 percent, if you have less than 25 discharges for a month.

Okay, our next slide is PC-01, Elective Delivery. The original measure developer was the Hospital Corporation of America (HCA), the Women's and Children's Clinical Services division. This is a process measure. The numerator is a subset of the denominator. Improvement is noted as a decrease in rate. And

as I indicated, the domain that's represented here is Assessment and Screening.

So our next slide discusses why this is an important measure. The American College of Obstetricians and Gynecologists and the American Academy of Pediatrics have had a standard in place for decades that you really should not be performing an early term elective delivery without a true medical indication. We know that even a couple of extra days can make a big difference in outcomes for the newborns, [and] can lessen the likelihood of a NICU admission and other short-term morbidities. We also know that if a mother is induced and the cervix is not favorable, it can almost double the cesarean rates.

Now the next slide talks about the populations that are actually measured. So this is our numerator and denominator. Please draw your attention to the bottom of the slide. This is our denominator, which is our larger population. Of these, we'd be looking those mothers that had delivered newborns where they have reached 37 weeks, completed gestation, so that's 37 and zero all the way up to 37 [weeks] and six days all the way up to less than 39 weeks. So the top would be 38 weeks and six days. You always round down because you have not completed and actually entered that 39th week until the clock turns to that seventh day.

Now, looking at the – I need to go back, sorry. Looking at the numerator, then, would be only those patients with elective deliveries. So remember, the goal here is a lower rate for noted improvement. So you really don't want to be in the numerator for this measure.

Now, as we talk about denominator populations in the next slide, we have the included population which I've already mentioned.

They were part of the initial patient population. So, again, in appendix A, you have those four tables.

We also have another table, table 11.06.1 that looks at if a diagnosis code has been assigned for a planned cesarean section when the patient actually comes to the hospital in labor. There are two codes on this table. So if your coders apply this, then basically you don't have to look for evidence of labor. You're basically done abstracting at that time once you've determined that they're in the measure via gestational age, and then this code would actually put them into the measure – into the denominator which is where you want to be.

Now, the next slide is going to be a continuation of denominator populations. We're going to be looking at excluded populations. We do have table 11.07 in appendix A, and these are diagnosis codes for conditions possibly justifying an elective delivery prior to 39 weeks gestation. Again, just to reiterate, if they're under eight years of age or they're equal to or greater than 65 years of age, they're not included, or a length of stay greater than 120 days. If the patient is enrolled in a clinical trial, this would have to be directly related to the laboring process. In other words, you're going to be doing something different as a result of them coming in labor and delivering. And also, we are excluding cases if they're less than 37 weeks or equal to or greater than 39 weeks. And the new thing here is, if you're unable to determine. So let's talk here in our next slide about some of the denominator data elements and I'll get into more details here with gestational age on this slide after this.

Our admission date and birth date are necessary in order to determine the patient age. Admission date and the discharge date are necessary to determine length of stay. We've talked a little bit about what clinical trial is. I will talk a little bit about gestational age here in just a second. Then we did talk about

those diagnosis codes that identify those patients that had a planned cesarean when they show up to the hospital in labor.

Let's talk about gestational age. If you're doing the entire measure set, it applies to the three maternal measures, which I've indicated on this slide. Again, that's got to be completed weeks of gestation. So if its six days or less, you probably round it down. You never round it up because you haven't completed that week. So 37 [weeks] and six [days] is – you're still in 37 [because] you haven't completed that week until it reaches that seventh day, and then it becomes 38.

Also, UTD should be documented. This is effective the beginning of this year if the patient shows up and has not received perinatal care. We receive feedback from the field throughout 2014 that this is primarily happening when a patient has not received perinatal care and they're not exactly sure what their gestational age is. In [the] past, you're advised to put an estimated gestational age. That's no longer required. If you're not sure, they should be just putting down that they can't determine that, and then the case would be completely removed from the measure.

We've also had a clarification about conflicting documentation, and it appears, in some case, that you had equivalent documents like the delivery record and delivery summary and you have conflicting gestational ages. So, in those cases, you're going to have to look at other sources to see what – or ponder at evidences as far as the correct gestational age. Also, you should be looking at the document that is completed closest to the time of delivery. Don't be relying on your perinatal forms to be giving you an accurate gestational age, especially if they're a couple of days older or a week or two old. You have to extract that at face value, and if it's only listed in the perinatal form and it's not listed anywhere in the medical record, that's obviously going to skew

the data, but you have to go, again, with what's there at face value.

Over the past year, we did allow the use of vital record reports which are actually data that you have within the hospital via your birth certificate data. In some states, you have the ability to electronically clear your vital records report from your State Department of Health and actually get that information back. So this is useful for determining gestational age so that you can look at only those cases where they've reached 37 and 38 weeks gestation and do [a] 100 percent review. We've now allowed the use of delivery logs or other clinical information systems that contain this information.

It is to your advantage not to sample and to live with all of your 37- and 38-week gestation cases if it all possible because this will increase your denominator size. So, if you do happen to have fallout or two, your rate won't look this severe if you have a larger denominator population. So, again, this is something that's new. Please be taking advantage of that–that you aren't sampling, if it all possible.

Now, on the next slide, we're going to discuss numerator populations. You would be included if you had a procedure code for one or more of the following: and the first thing that is looked at is whether you have a medical induction of labor code that's found on table 11.05 in appendix A. And at that point, [the] case would flow to the numerator. Now, if there wasn't an induction and there was a cesarean section code found on table 11.06 in Appendix A, you would have had all of the following: they would have not been in labor and they would have had no history of a prior uterine surgery. I'll be getting into more detail on those two data elements here in a second.

There are no additional exclusions at this level that we haven't already discussed at the denominator level. And you'll note that we did remove the requirement to review Spontaneous Rupture of Membrane (SROM), and I'll be talking about that too.

Under our numerator data elements then, we do a different – one of the procedure codes which you saw on the previous slide. We use labor of course, Spontaneous Rupture of – excuse me, Prior Uterine Surgery, however Spontaneous Rupture of Membrane has been removed. The reason that this has been removed is because this is redundant based on the ICD-9 codes that are present in table 11.07, 658, 1165821, Premature Rupture of Membranes and Prolonged Rupture of Membranes. That actually is what should've been taking place all along.

Premature Rupture of Membranes is equivalent to Pre-Labor Rupture of Membranes according to American Congress of Obstetricians and Gynecologists (ACOG) who recently visited this in their revitalize campaign. It has nothing to do with gestational age or the application related to gestational age. It just simply means that the membrane is ruptured and labor did not commence.

So, in cases where the labor had not commenced as a result of SROM, they should be coded with the codes accordingly; that's been greater than 24 hours than the prolonged rupture code would apply.

Let's talk about labor. If they say they're in labor, they're in labor. There's no requirement, at least in this version of the manual. It should be taken at face value. If they're being admitted for labor or they're in labor or they're reviewing their labor, there's no requirement for the descriptor to be present. It is strictly a descriptor. So if you have Active, Spontaneous, or Early, those are acceptable. That means the patient was in labor. Again, it's

not required, but if it's there, you can use it. However, if they describe it as prodromal-related labor, then it is not considered labor for the purposes of this measure, and you would not count that as the labor at that point.

Now, Prior Uterine Surgery is the title of this slide, and we do have inclusions. We've added a new one, but let's review what we'd had on there in the past. In prior classical, which means that there was a vertical incision into the upper part of the uterus ... Remember, you don't want these patients to go on to labor if they've had a previous vertical incision because they're at increased risk for rupture. Same is true with the prior myomectomy of any type as long as it's documented. In prior surgery that resulted in a perforation, it means that there was an accidental injury that they had to – so that – back up. That means the wall now is weakened and you wouldn't want that patient to go into labor.

And so, if they had, let's say, [a] low transverse cesarean, that alone wouldn't be it, but if the result with perforation that occurred then is as documented, and that would be considered prior uterine surgery. Also, the history of the uterine window, and that would be either about – because of a prior surgery that they've noted that's – or via ultrasound that could be either a current or a past ultrasound, as long it's documented that there's a thinning, a defect, that the wall is weak, that you wouldn't want that patient to go into surgery –into labor rather.

Also, a history of uterine rupture that required repair, you absolutely wouldn't want them to again labor. And then, we've recently added the history of cornual ectopic pregnancy. That means basically that the pregnancy took place outside of uterine wall. You have a weakened wall as a result of that. So those patients should also not go into labor.

Now, in the slide about prior uterine surgery we talk about exclusions. I think I've already alluded to this, that if [there was a] prior low transverse cesarean section, it's not a reason to take a patient into early term elective delivery. A prior cesarean section where they don't specify the type isn't that, [as] well. You have no way [of] knowing whether that's [a] classical incision or not. So unless it's documented as such, you can't count that.

Now let's talk a little bit about lessons learn from the field. Part of this, we receive actually through the Medicare program that was looking at the hospital engagement networks and it was I believe, it was called Strong Start or Strong Beginnings, for they were looking to reduce early-term elective deliveries. We received this feedback from some of the hospitals. We've worked a lot with the HEN providers in past years, educating and doing outreach to their hospitals. And they [have] been kind enough to share some information they received. And I think that's important for everyone that's doing this, to kind of understand that the shared understanding – they're differing depending on who you are in the hospital.

You have some coders that are only going to review just the clinician's or the provider's documentation, and you're going to have others that would review the registered nurses' documentation. So I think it's important that they take the entire picture in and that everybody is like, looking at this same way. Also, your clinicians, your providers don't have a clear understanding of the documentation requirements. They might be using a ACOG terminology that the abstractors are adhering to, manual specifications; so there's different interpretations. This requires education on both parts. You're not going to get a clinician to write Premature Ruptured Membrane, but you could get them to write if the patient had Spontaneous Ruptured Membranes and labor did not ensue. Therefore, this would be the

reason to go for the cesarean section or for the induction of labor, depending on what the circumstances are.

So I think that describing something, as its defined, is just as important that you have clear concise documentation. It's not always going to be what they have in their coding manual.

We also have learned – continuing on the next slide – that very few hospitals have a “hard-stop” policy, and there was a recent study put out by HCA. They looked at three different ways of approaching this. The first was looking at putting a “hard-stop” policy in place. If I was in the room right now, I'd have people raise their hands to see how many have “hard-stop” policies.

Currently, when the hospital engagement networks met, very few of them had “hard-stop” policies. I think a lot of them have worked to put those in place. But it really does put people into an accountability position where you have to say, it's on their list of accepted reason that they're actually saying, "Why it should be done and going to go to another level of review?" Also, they noted that there's division between the team's nursing, which typically does this, takes lead and accountability. So they really [are] quote, unquote "enforcing this." And sometimes this does result in a little disharmony with providers. So, getting everybody kind of on the same page about what the requirements are. It shouldn't be [a] treasure hunt to find most current gestational age.

When we went out to do medical record reviews when we were testing these for reliability testing, I was amazed at how many times I couldn't find gestational age documented closer to the time of delivery. This – at this point especially with everybody looking at this measure should be an absolute no-brainer. It ought to be there. It should be there in every delivery record, period. And there shouldn't be conflicting data. Everybody should be on the same page.

We also know that there's a divide between the Quality and the Coding teams, you know, whether strictly adhering to – it has to be worded this way rather than it's defined in the medical record, the way that it's worded. So, really, getting everybody to kind of work together, and then get your nursing and provider teams working together. It's going to require education and everybody reaching out.

So, how can we improve performance for PC-01? And I think I've already alluded to this: adopting a hospital-wide policy is really important once you get [the] criteria in place. So, it's very easy if someone calls and they want to schedule an induction or a cesarean section, that you can go through a list and see if it meets these criteria. And if it doesn't, then it goes to a different level of review. And there are going to be cases where you can't possibly get every single case excluded due to specific criteria. And sometimes it's going to be based on the maternal fetal medicine recommendation, so that you really need to be able to look at the entire picture and get enough involvement so that you can say, "Yes, this does meet the criteria."

Getting your clinicians to really document is going to important. It's got to be clear and concise so that it – and it's unequivocal and they can use this especially when it's going to aid them in applying codes correctly to either include or exclude case and either level of the measure. And then again, coder education and outreach is needed to make sure this coding is taking place.

Now, as far as frequently asked questions, I think I've already kind of touched on this one, and this has to do with how come some of ACOG's approved justifications are not considered.

If there was a way to get every conceivable possible reason identified, we would have done it by now, but it's not possible. So the purpose of this measure, when this was first tested and

developed, is just to help hospitals establish a baseline so you know what your performance is, where you [are] at when you start measuring this, are you within where your peers are, are you much higher, are you lower? And then determine whether improvement efforts are effective over a period of time.

You're going to be getting this information, at least if you were a Joint Commission. On a quarterly basis, you're going to receive an ORYX Performance Measurement Report. It's going to tell you how you look against your peers. We take the mean and we plot that on a graph with two standard deviations above and below that mean. And your rate would be plotted against that. You kind of have an idea of where you're at, where your baseline is, and how you're doing. In addition to that, you'll receive control charts and comparison charts. So you'll be able to tell how you've been doing from quarter to quarter. And you could go again, this comparison that I just told you about, comparing yourself to that target range. That target range will vary from quarter to quarter, and we've seen dramatic results.

I'll be showing you a slide here in a second that talks a little bit about how people are doing with all the of the PC measures.

And again I can't stress enough that there's no way that we can exclude every possible justified reason. One example would be a patient that has grand mal seizures that are uncontrolled. There is no ICD-9 code that recognizes that. There's a code for epilepsy, but [for] epilepsy that's well-controlled, there's not a reason to do an early-term elective delivery.

You also have other cases that are rather rare. You're going to have certain types of cancers where delivery is imminent so they can start the mother on chemotherapy. They've been in an automobile accident. There's going to always [be] different circumstances, but there's no way that we can identify all of those

reasons and exclude those cases because. If we do it for one hospital, it has to be uniform across country: we'd have to create a special data element. For example, we'd have to create a data element for uncontrolled grand mal seizure, a data element of chemotherapy for stage four breast cancer, a data element for automobile accident resulting in abdominal pain. It would be virtually impossible.

We did do a review of our codes on table 11.07. Actually, the Hospital Corporation of America did. They did publish an article approximately a year or two back, and it looked at what was happening within their system of over 100 hospitals. What they determined was, 98 percent of the time, those justifications appear on the codes on table 11.07.

So the [there is a] very small number that is justified that are not codable. So, we do take this seriously. We looked at this. We discuss it every time we bring our technical advisory panel together, if we hear of a different code or something that might be a reason. And every now and then, we do make modifications to the table. But basically, the table has stayed fairly unchanged since the actual testing phase, because they found that that typically captured most of those reasons.

Now, I'll move down to the next slide here. Again, I think I've already touched on the burden of the data abstraction that this would require, and the fact that it's virtually impossible to get all of those justifications. So, another common question that we get is "What are the national benchmarks for the PC measures?"

Well, The Joint Commission doesn't set any kind of benchmarks for any of their measures, but we do provide you with information in our *Annual Report on Quality and Safety* that was published in the Fall of 2014. That comes out every year. The information

that you're seeing on the slide is based on our 2013 data. The first level there is looking at the “Perinatal Care Composite.”

The composite is comprised of the process measures which are PC-01, PC-03, 5, and 5A. You're taking all of your numerator cases and dividing them by all of your denominator cases. So it's not just adding them up and dividing them by three or four. In this case, there's a 5A, so there'd be four.

You're going to have a larger number of numerator cases for 5 and 5A then you would for 1 and you would for 3. So it's all relative to the number of cases for all of them and then to divide. And that's how we're coming up with this composite of a little over 74 percent.

We have made progress. We've been doing this, as I alluded, since 2010. So we don't have 2014 yet, but we'll have that in – at the end of April. And then, we'll be able to take a better look and know how you finished out.

So we're working on of our most current data here. Now, if you'll note for PC-01, which is what we're talking about today, the elective delivery rate actually fell to 4.3 percent for 2013. When we started back in 2010 it was 19 percent. So this tells us that what gets measured gets managed. We have seen an impact here just by evaluating the practice and monitoring it. We have seen some noted changes, and then you can see what the rest of these measures – as we made progress in all of them. Cesarean section has remained about that point over the past few years, but that's not what our discussion is today.

Now, as far as resources, there are number of resources that are available out there that will help you with perinatal care. This first one is an excellent resource. This is an overarching resource for perinatal care. It's "Toward Improving the Outcome of Pregnancy III." It was published by the March of Dimes. It's available to be

downloaded for free from their website. It talks about the whole phase of a woman from after conception to the perinatal period to the labor and delivery to the post-perinatal and on, with all sorts of information about the types of programs you can have in place to be monitoring their quality and different things that are evidence-based related to this practice. I highly encourage you to go and download this if you haven't done this yet.

The other resource which is specific to this measure is the resource that was developed by the March of Dimes, "The California Maternal Quality Care Collaborative." They put a toolkit together here that takes a look at reducing early-term elective deliveries. You can download this in either one of their websites again, for free. This is a really good toolkit. It has a whole evidence-based [section] that discusses why this is important. It has [a] case study that shows how they actually made improvements in different parts of the country. There's a model policy that your hospital can adopt. There are model PowerPoint slides that you can do presentations as far as doing education with your staff. So I really encourage that you avail yourself to this because it's free for the asking and it really will help you if you haven't gotten the program in place yet.

Now, as far as where the manual is located, here is your web link for that. We do request [that] if you're working with a performance measurement system vendor, even it's for CMS, that you talk to them first because they are educated by The Joint Commission directly and they are updated periodically, and they'll have the answers. They – if they see a trend, though, then they'll let us know, and it just makes it a little bit easier to determine [if we] have gotten several questions from one vendor about the same thing, then we know that we might need to do some revisions to make it a little bit easier.

However, you can post questions. If it's for Joint Commission purposes [let's} address [them] right now. If you're doing it for CMS purposes, that's where you should be posting those questions, either on specifications or on data submission. There are actually two modules that are available and right now for that.

[These] slides are current as of today, but like the weather that might change overnight. But we don't anticipate any dramatic changes on what I've told you today. We are in the process, though, of revising measures specifications. So just be aware that, starting with actual – with first discharges, provide the ICD-10 code go through this year. We'll have a new manual that will actually be posted somewhere around the first of May that will talk about some of the revisions, and some of the revisions to this measure are going to be necessary because of the ICD-10 code and either the specificity or lack of specificity. We'll be making some enhancements to the perinatal care measures as a result of that.

So, at this point I am up to questions and I want to turn it back to Candace.

Candace Jackson: Thank you so, Celeste. I would like to thank Celeste for the information she shared with us today. It was very beneficial and valuable and informative. Before we read questions that were sent in, I want to remind you that today's –

Next slide, please.

I want to remind you that today's webinar has been approved for one continuing education credit by the boards listed on the slide.

Next slide please.

So what is the C.E. credit process? Well, we now have an online C.E. certificate process – excuse me. If you have registered for

this webinar through ReadyTalk©, a survey will automatically pop up when that webinar encloses. After you've completed the survey, a page will display to register as either a new user or if you have attended any of our webinars as an existing user.

A onetime registration is required. Your complete email address is your user I.D. If you do not receive the survey, please don't worry, we will be sending out the survey link and then email to all participants within the next 48 hours. It will not arrive today, though. If there are others listening to this event but are not registered in ReadyTalk©, please pass the survey to them.

And now I'm going to open your line to Celeste and our subject matter expert for the Q&A, as we have time that will allow. And I am going to start up with a couple of Qs&As that we have received and some frequently asked questions. One of them, "If we have already done the structural measure and DACA, do we have to do it again? And the simple answer is, yes. The structural measure and DACA are done annually. They do not carry over. You do need to do that submission each year.

And "Do critical access hospitals have to do the structural measures and DACA?" And that is, no. The critical access hospitals are not required to submit structural measures or the DACA, as they are not part of the Inpatient Quality Reporting program. They can be submitted voluntarily, though, by the critical access hospitals.

We do have questions asking, "What are the IQR requirements for PC-01? I know Celeste gave us a lot of information for The Joint Commission and how to abstract. So for CMS, hospitals are required to submit the aggregate data for PC-01 through the web-based tool in [the] *Secure Portal*. Hospitals are required to submit the total of mother patients, population size, the sample size, the

numerator and denominator, and the number of cases for each of the exclusions.

Another frequently asked question is, “What if our facility does not have an OB unit or [offer] treatment [for] OB patients?” For CMS, you are still required to enter the aggregate data, and, in this case, if you do not treat OB patients or do not have an OB unit, you would need to enter zeros into each of the data fields.

And now I've got some questions that I will present to Celeste.

Celeste, “If the MD documents Prior Classical Concern and/or Prior T-incision on Uterus, would this be an inclusion for Prior Uterine Surgery?”

Celeste Milton: Yes, T-incision would be that there's a vertical incision in the upper part, and then the bottom of the T would be the where the transverse – low transverse section took place. So, since it has extended up into the upper uterus, then that would be the same as – just as [if] it was just a vertical incision. So that would be counted. That's a yes.

Candace Jackson: Thank you, Celeste. Okay, next question. “On slide 37 for gestational age, it says to take documentation closest to time of delivery – vital record reports, delivery logs or clinical information system. The dictionary says something slightly different. What priority should I go with?”

Celeste Milton: Okay, when you look at the data in [the] dictionary and you look at the data elements form for this, it's, once again, the use of the vital record reports for the delivery log or the clinical information systems are to identify those cases that are 37 and 38 weeks of gestation, because what's what you reported on the birth certificate, which should be accurate. Hospitals should also be monitoring to make sure that reports they get back or that they find are as accurate as what they look at in the medical record.

But you know, once you confirmed that, then you would look at this document closer to the time of delivery. That would be how they got this information for the birth certificate data.

So, the reason for the vital record reports and the delivery logs and the clinical information systems is to identify all of your cases which you don't have to sample. You still have to open up the record and look at it because there's going to be certain things that you want to – you just want to validate that yes, the gestational age is 37, just as the report told me, because that's – what's in the medical record is what happened. And again, if you've got discrepancies, then you should find out why you're reporting something different to your state, or putting something different in your delivery log. So that's what that direction is about in the data element form.

Candace Jackson: Thank you, Celeste.

Next question, "Will the Joint Commission PC Certification be done through electronic measures, or only through chart-abstracted measures?

Celeste Milton: Well, currently we do have two of our PC measures available in eMeasure specification. This happens to be one of them. The other one is PC-05, our breast feeding measure, which is – you can use for voluntary EHR reporting under the – your Inpatient Prospective Payment System (IPPS) program.

We are in the process of – we have done some specifications on PC-02, and those have not been used by CMS to date, but those will have been completed. They're not out there for public yet. We have not begun re-specifying three or four yet. That'll come eventually, but that's in the immediate queue for re-specifying. We're working on a number of our paper-based measures and a number of our core set. But that will happen eventually.

The requirements for ORYX, when you look at the reporting, changed this year. You could do all paper-based, a hybrid of paper-based and eMeasures, or all eMeasures. But once again, not all sets are completely specified, in this case, the PC set.

So to answer your question for the certification program, at this point in time, we would just be looking at the paper-based abstracted measures. And if you're doing it with a vendor now, we're working on a way so that that measure information can seamlessly go over into the database for the certification programs. We, basically, are collecting and reporting at once, and it'll be used for two purposes: for accreditation and for certification.

Candace Jackson: Thank you. "If your hospital has less than 250 births per year, are you required to report P.C. core measures, or is it optional?"

Celeste Milton: For Joint Commission purposes, it's optional. We're looking at a minimum of 1,100 births annually, and that's based on your two previous years of delivery to come up – or of births to come up with that number, whether you're at that baseline. So, if you have 250 births annually, it's not required. But you certainly can use that to meet your requirement for Joint Commission purposes. You could report that fact. That could be one that you couldn't select.

Candace Jackson: And just to add, for CMS, there is no number of births where you would not be able to report. So if you have one birth in a quarter, we would still expect to see data from that one birth. So that is a little bit different than some of The Joint Commission.

Next question is, "Why do you discourage sampling? And if we are a large birthing hospital, how would you suggest we handle volume?"

Celeste Milton: Okay, well, I think I just alluded to that for this measure. For PC-01 and actually for PC-02, you would basically – if you have vital record report, you would query all of your cases that are for measure one, that are 37 or 38 weeks of gestation. So even if you're a really large hospital, we've done an analysis of gestational ages and measures that were reported from the entire set. That comprises about 20 percent of all deliveries. So if you look at sampling, you're roughly right on that same range. But the difference is, you're looking at every single record that was 37 and 38, and you're not opening up one that was 40 or one that was 36, and closing it. And you can't count it. It's not a part of your initial patient population that's going to, you know, basically be excluded from that measure. So it decreases your denominators size if you're sampling.

Sampling is basically – is a statistical estimate that's trying to say, "Well, if I look at this number of record, it'll probably be the same as if I look at all of them." But what we have found, especially in hospitals that have a smaller number of discharges, if you're not looking at all of them, and you're counting on occasional fallouts for those very reasons that I discussed as far as not being able to take them out with a specific ICD-9 code. You reviewed them, and yes, it really was a reason to do it, then you're getting a higher rate than what you would anticipate. And I field these questions literally, every single week, and almost every day, from hospitals that don't understand that. That's why we're encouraging you not to sample. If you can find all of those cases, do not sample. Look at all of them that are 37 and 38. I think you'll be far more satisfied if you have [an] occasional case that ends up in the numerator even if it had a valid reason or not, as far as giving you a more accurate reflection of what your true rate is.

Candace Jackson: Next question, "When will ICD-10 codes be available for these?"

Celeste Milton: Okay, well, I kind of alluded to that. We think they're going to be available the 1st of October. Actually, if you go to the current manual right now, in Appendix P, as in Paul of the manual, there is a previous section that shows you what we envision the ICD-10 codes to be. We also have another section that shows crosswalk from ICD-9 and ICD-10. That's actually been up there for quite some time. We put it up last year.

So this will give you an idea, but unless the government changes its mind, and they pass another law, we expect that it's going to take place the 1st of October. And therefore, the manual that we're currently working on, which will be available around the 1st of May, will show you then what those ICD-10 codes are.

Just kind of give you a preview, right now, you have four code tables that identify pregnancies that resulted in the delivery. The new ICD-10 codes don't have any codes that relate to whether they had a delivery or not. So we're actually going to a new table – procedure code – that will take a look at the types of delivery to identify patients. So in other words, the patient had a vaginal delivery, had a cesarean birth, vacuum, et cetera, et cetera. Those will all be coded. And if you've got a code for that during in-hospitalization that tells us there was a delivery, so that makes the patient eligible.

So there are going to be some changes and we expect that that will be in the next manual.

Candace Jackson: Thank you, Celeste. The next question,– we got several questions in regards to this. “I do not understand what is meant by ‘hard-stop’ policy.”

Celeste Milton: Okay, a “hard-stop” policy basically would be – let's say that you have a clinician that says I'm on a schedule on induction that you actually have a policy in place that says if they're calling to schedule in induction or any of these conditions present, and you

go to the ACOG guidelines on labor induction. They're very clear about what types of cases do merit an early-term elective induction, where you could say that the patient has this condition, that condition, or the other condition, and so forth. I'm not going to get in to all the different conditions, but basically, if it's not on your list, then the schedule will or would say that this needs to go to a higher level of review. And that's exactly what it would do, whether it would be a committee review or a chairman of the department – that someone else would be looking at this to say that even though it doesn't have – meet the criteria that we'd set forth, it does meet criteria as I alluded to when I was saying how come we couldn't capture all of the reasons.

We have a patient that has a stage four tumor that needs to have the cesarean so they can start the patient on the chemotherapy. Well, that's not going to be on your list of criteria for scheduling an elective induction. It's just [a] non-common thing – thank goodness – if this not a common thing where it's happening all the time, so it will go to another level of review, and they would say, "Yes, this is the reason that you should be doing this." They would concur with that. And you'll find that you have fewer of these cases where it's a little muddy, like there's impending macrosomia – that's a favorite one.

Well, impending macrosomia means that it might be a high birth weight. Well, if you look at table 11.07, there are no codes at all for macrosomia on there because it's very subjective. So there is going to be times where they might want to schedule something that doesn't have a really true reason, and that's where it would go to another level of review.

There is an article that came out in the OB Green Journal, like I said, last year. Dr. Clark was one of the principal authors on this. If you do a query on it, he basically talks about – that they've looked at The Joint Commission measures, and that we've got the

majority of the reasons on our table. So, I'm going to kind of refer you back, you know, to looking at the evidence that's out there.

Candace Jackson: And I'm afraid we are about to the top of hour. We do not have time for any more questions at this time. Again, I'd like to thank Celeste for being a guest speaker today. And we'd like to thank everyone participating in our webinar, and hope that you learned something new, something beneficial, and something that was of a good resource to you. And please, enjoy the rest of your day. Thank you.

END

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