Update on the Joint Commission’s Perinatal Care (PC) Core Measure Set

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These slides are current as of (2/18/2012). The Joint Commission reserves the right to change the content of the information, as appropriate.
Agenda

- Core Measures Overview
- PC Measures Overview
- PC Measures
  - PC-01
  - PC-02
  - PC-03
  - PC-04
  - PC-05
- FAQs & Resources
- Next Steps in the Timeline
Core Measure Set
Definition

A unique grouping of performance measures carefully selected to provide, when viewed together, a robust picture of the care provided.
Core Measure Attributes

- Standardized sets of performance measures
- Precisely defined specifications
- Can be uniformly embedded/adopted in extant systems
- Standardized data collection protocols
- Meet established evaluation criteria
Core Measure Set
(Includes 4-10 Well-Tested, Evidence-Based Measures)

A = Initial set
B = Initial set
C = Initial set
D = Initial set
E = Initial set
F = Future measure
G = Future measure
History of Core Measures

- In 2000, few measures, no national data collection and reporting
- By 2002, hospitals reporting on up to 19 measures with a composite rate of 81.8%
- By 2009, hospitals reporting on up to 30 measures with a composite rate of 95.4%
New Joint Commission Accountability Measures Framework

Accountability measures – quality measures that meet four criteria designed to identify measures that produce the greatest positive impact on patient outcomes when hospitals demonstrate improvement:

- **Research** - Strong evidence base demonstrating that given care processes leads to improved outcomes
- **Accuracy** - Measure accurately captures whether the evidence-based care process has been provided
- **Proximity** - Measure addresses a process that has very few intervening care processes that must occur before the improved outcome is realized
- **Adverse Effects** - Implementing the measure has little or no opportunity of inducing unintended adverse consequences
Accountability Measures — Using Measurement to Promote Quality Improvement

Mark R. Chassin, M.D., M.P.P., M.P.H., Jerod M. Loeb, Ph.D., Stephen P. Schmaltz, Ph.D., and Robert M. Wachter, M.D.

Measuring the quality of health care and using those measurements to promote improvements in the delivery of care, to influence payment for services, and to increase transparency are now commonplace. These activities, which now involve virtually all U.S. hospitals, are migrating to ambulatory and other care settings and are increasingly evident in health care systems worldwide. Many constituencies are pressing for continued expansion of programs that rely on quality measurement and reporting.
Goals of Core Measure Program

- Retire non-accountability measures
- Replace retired measures
- Performance on accountability measures integrated into standards beginning 2012
Detailed results for specific hospitals can be found at [www.qualitycheck.org](http://www.qualitycheck.org). Quality Check® is provided as a tool to help educate the public about the choices available to them.

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### Summary of Quality Information

**Accreditation Decision**
- Accredited.

**Decision Effective Date**
- January 15, 2009

**Accredited Programs**
- Hospital
- Laboratory
- Home Care

**Special Quality Awards**
- 2004 Hospital Quality Alliance Participation
- 2005 The Medal of Honor for Organ Donation

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#### Footnote Key

1. The Measure or Measure Set is not reported.
2. The Measure Set does not have an overall result.
3. The number of patients is not enough for comparison purposes.
4. The measure results are not displayed.
5. The organization scored above 90% but was below most other organizations.
6. The measure results are not statistically valid.
7. The measure results are based on a sample of patients.
8. The number of months with measure data is below the reporting requirement.

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#### National Patient Safety Goals:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Nationwide</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Quality Improvement Goals:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Attack Care</td>
<td>[✓]</td>
<td>[✓]</td>
</tr>
<tr>
<td>Heart Failure Care</td>
<td>[✓]</td>
<td>[✓]</td>
</tr>
<tr>
<td>Pneumonia Care</td>
<td>[✓]</td>
<td>[✓]</td>
</tr>
<tr>
<td>Surgical Infection Prevention Care (for all reported procedures)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Blood Vessel Surgery</td>
<td>[✓]</td>
<td>[✓]</td>
</tr>
<tr>
<td>- Colon or Large Intestinal Surgery</td>
<td>[✓]</td>
<td>[✓]</td>
</tr>
<tr>
<td>- Coronary Artery Bypass Graft</td>
<td>[✓]</td>
<td>[✓]</td>
</tr>
<tr>
<td>- Hip Joint Replacement Surgery</td>
<td>[✓]</td>
<td>[✓]</td>
</tr>
<tr>
<td>- Hysterectomy</td>
<td>[✓]</td>
<td>[✓]</td>
</tr>
<tr>
<td>- Knee Joint Replacement Surgery</td>
<td>[✓]</td>
<td>[✓]</td>
</tr>
<tr>
<td>- Open Heart Surgery</td>
<td>[✓]</td>
<td>[✓]</td>
</tr>
</tbody>
</table>

*State Results are not calculated for the National Patient Safety Goals.*
PC Measures Overview

- In November 2007, the Joint Commission’s Board of Commissioners recommended retiring the Pregnancy and Related Conditions Core Measure Set
- Recommendation to replace with an expanded set of measures based on current scientific evidence.
- National PC measures endorsed by NQF October 2008
- PC Technical Advisory Panel (TAP) appointed December 2008
- TAP meeting held February 2009
- Measure specifications work Feb-Oct 2009
PC Measures Overview (Cont.)

- Data collection: began with April 1, 2010 discharges
PC Core Measure Vision

- Identification and specification of an initial set of standardized PC core measures from existing National Quality Forum (NQF) endorsed evidence-based measures

- Over time identify future measurement needs and core measures that meet those needs
  - Add to existing set
  - Additional measure sets
PC Core Measures

- PC-01 Elective Delivery
- PC-02 Cesarean Section
- PC-03 Antenatal Steroids
- PC-04 Healthcare-Associated Bloodstream Infections in Newborns
- PC-05 Exclusive Breast Milk Feeding
PC Core Measure Set

- Two Distinct Populations:
  - Mothers
  - Newborns

- Consists of Five Measures Representing the Following Domains of Care:
  - Assessment/Screening
  - Prematurity Care
  - Infant Feeding
PC-01

Elective Delivery

Original Performance Measure/Source
Developer: Hospital Corporation of America- Women's and Children's Clinical Services
Rationale

- 39 completed weeks is the American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP) standard
- Significant short-term morbidity for the newborn
- Elective inductions result in more cesarean sections
Numerator and Denominator

Patients with elective deliveries

Patients delivering newborns with \( \geq 37 \) and \( < 39 \) weeks of gestation completed
Denominator Populations

Included Populations:

- *ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes* for planned cesarean section in labor as defined in Appendix A, Table 11.06.1
Denominator Populations (Cont.)

Excluded Populations:
- *ICD-9-CM Principal Diagnosis Code* or *ICD-9-CM Other Diagnosis Codes* for Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation as defined 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
- Prior uterine surgery
Denominator Data Elements

- Admission Date
- Birthdate
- Clinical Trial
- Discharge Date
- Gestational Age
- ICD-9-CM Other Diagnosis Codes
- ICD-9-CM Principal Diagnosis Code
- Prior Uterine Surgery

NEW!
Numerator Populations

- Included Populations: *ICD-9-CM Principal Procedure Code* or *ICD-9-CM Other Procedure Codes* for one or more of the following:
  - Medical induction of labor as defined in Appendix A, Table 11.05
  - Cesarean section as defined in Appendix A, Table 11.06 while not in *Active Labor* or experiencing *Spontaneous Rupture of Membranes*

- Excluded Populations: None
Numerator Data Elements

- Active Labor
- ICD-9-CM Other Procedure Codes
- ICD-9-CM Principal Procedure Code
- Spontaneous Rupture of Membranes
Gestational Age

Notes for Abstraction Updated:
- Gestational age calculation by ultrasound removed
- Guidance for gestational age calculation standardized
Appendix A

Table 11.06.1 Planned Cesarean Section in Labor
PC-02

Cesarean Section

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

- Skyrocketing increase in cesarean section (CS) rates
- Nulliparous women with term singleton baby in vertex position (NTSV) most variable portion of CS rate
- NTSV CS rates can be addressed through performance improvement activities
Numerator and Denominator

Patients with cesarean sections

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

**Included Populations:** Nulliparous patients with *ICD-9-CM Principal Diagnosis Code* or *ICD-9-CM Other Diagnosis Codes* for outcome of delivery as defined in Appendix A, Table 11.08 and with a delivery of a newborn with 37 weeks or more of gestation completed.
Excluded Populations: *ICD-9-CM Principal Diagnosis Code* or *ICD-9-CM Other Diagnosis Codes*, for contraindications to vaginal delivery as defined in Appendix A, Table 11.09

- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of Stay >120 days
- Enrolled in clinical trials
Denominator Data Elements

- Admission Date
- Birth Date
- Clinical Trial
- Discharge Date
- Gestational Age
- ICD-9-CM Other Diagnosis Codes
- ICD-9-CM Other Procedure Codes
- ICD-9-CM Principal Diagnosis Code
- ICD-9-CM Principal Procedure Code
- Parity
Numerator Populations

**Included Populations:** *ICD-9-CM Principal Procedure Code* or *ICD-9-CM Other Procedure Codes* for cesarean section as defined in Appendix A, Table 11.06

**Excluded Populations:** None
Numerator Data Elements

- ICD-9-CM Other Procedure Codes
- ICD-9-CM Principal Procedure Code
Risk Adjustment

Maternal Age
Stratification by Ages

- PC-02a Cesarean Section - Overall Rate
- PC-02b Cesarean Section - 8 through 14 years
- PC-02c Cesarean Section - 15 through 19 years
- PC-02d Cesarean Section - 20 through 24 years
- PC-02e Cesarean Section - 25 through 29 years
- PC-02f Cesarean Section - 30 through 34 years
- PC-02g Cesarean Section - 35 through 39 years
- PC-02h Cesarean Section - 40 through 44 years
- PC-02i Cesarean Section - 45 through 64 years
PC-03

Antenatal Steroids

Original Performance Measure/Source Developer: Providence St Vincent’s Hospital/Council of Women and Infant’s Specialty Hospitals
Rationale

- National Institutes of Health 1994 recommendation
- Reduces the risks of respiratory distress syndrome, prenatal mortality, and other morbidities
Numerator and Denominator

Patients with a full course of antenatal steroids completed prior to delivering preterm newborns

Patients delivering live preterm newborns with =>24 to <32 weeks gestation completed
Denominator Populations

Included Populations: NA
Denominator Populations (Cont.)

Excluded Populations:
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of Stay >120 days
- Enrolled in clinical trials
- Documented Reason for Not Administering Antenatal Steroid
- ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes for fetal demise as defined in Appendix A, Table 11.09.1
Denominator Data Elements

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

- ICD-9-CM Other Diagnosis Codes
- ICD-9-CM Principal Diagnosis Code
- Gestational Age
- Reason for Not Administering Antenatal Steroid
Numerator Populations

- **Included Populations**: Full course of antenatal steroids (refer to Appendix B, Table 11.0, antenatal steroid medications)

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

Antenatal Steroid Administered
Reason for Not Administering Antenatal Steroid

Notes for Abstraction Change:
- Implied reason, i.e., delivery prior to repeat dose, fetal anomalies
PC-04

Health Care-Associated Bloodstream Infections in Newborns

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

- Rates range from 6% to 33%
- Infections result in increased mortality, length of stay & hospital costs
- Effective preventive measures can be used to reduce infections
Numerator and Denominator

Newborns with septicemia or bacteremia

_____________________________________

Liveborn newborns
Denominator Populations

- **Included Populations:** *ICD-9-CM*
  *Other Diagnosis Codes* for birth weight between 500 and 1499g as defined in Appendix A, Table 11.12, 11.13, 11.13.1 or 11.14 OR *Birth Weight* between 500 and 1499g OR
ICD-9-CM Other Diagnosis Codes for birth weight > 1500g as defined in Appendix A, Table 11.15, 11.16, 11.16.1 or 11.17 OR Birth Weight > 1500g who experienced one or more of the following:

- Experienced death
- ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes for major surgery as defined in Appendix A, Table 11.18
- ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes for mechanical ventilation as defined in Appendix A, Table 11.19
- Transferred in from another acute care hospital within 2 days of birth
Excluded Populations:

- *ICD-9-CM Principal Diagnosis Code* for sepsis as defined in Appendix A, Table 11.10.2
- *ICD-9-CM Principal Diagnosis Code* for liveborn newborn as defined in Appendix A, Table 11.10.3 AND *ICD-9-CM Other Diagnosis Codes* for newborn septicemia or bacteremia as defined in Appendix A, Table 11.10
- *ICD-9-CM Other Diagnosis Codes* for birth weight < 500g as defined in Appendix A, Table 11.20 OR *Birth Weight* < 500g
- Length of Stay < 2 days OR > 120 days
- Enrolled in clinical trials
Denominator Data Elements

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

- Discharge Status
- ICD-9-CM Other Diagnosis Codes
- ICD-9-CM Other Procedure Codes
- ICD-9-CM Principal Diagnosis Code
- ICD-9-CM Principal Procedure Code
- Point of Origin for Admission or Visit
Numerator Populations

**Included Populations:**
- *ICD-9-CM Other Diagnosis Codes* for septicemias or bacteremias as defined in Appendix A, Table 11.10.2

**Excluded Populations:** None
Numerator Data Elements

ICD-9-CM Other Diagnosis Codes
Risk Adjustment

- Birth Weight: 3 birth weight categories (500-999, 1000-1249, 1250-2499 grams)
- Congenital Anomalies: 3 different types (gastrointestinal, cardiovascular, other specified) identified through ICD-9 codes
- Out-born birth
- Death or transfer out
PC-05

Exclusive Breast Milk Feeding

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

- Goal of World Health Organization (WHO), Department of Health and Human Services (DHHS), American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG)
- Numerous benefits for the newborn
Numerator and Denominator

Newborns that were fed breast milk only since birth

Single term newborns discharged from the hospital
Denominator Populations

**Included Populations:** Liveborn newborns with *ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes* for single liveborn newborn as defined in Appendix A, Table 11.20.1
Denominator Populations (Cont.)

**Excluded Populations:**
- Admitted to the Neonatal Intensive Care Unit (NICU) at this hospital during the hospitalization
- *ICD-9-CM Principal Diagnosis Code* or *ICD-9-CM Other Diagnosis Codes* for galactosemia as defined in Appendix A, Table 11.21
- *ICD-9-CM Principal Procedure Code* or *ICD-9-CM Other Procedure Codes* for parenteral infusion as defined in Appendix A, Table 11.22
- Experienced death
Excluded Populations (Cont.)

- Length of Stay >120 days
- Enrolled in clinical trials
- Documented *Reason for Not Exclusively Feeding Breast Milk*
- Patients transferred to another hospital
- *ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes* for premature newborns as defined in Appendix A, Table 11.23
Denominator Data Elements

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

- ICD-9-CM Other Diagnosis Codes
- ICD-9-CM Other Procedure Codes
- ICD-9-CM Principal Diagnosis Code
- ICD-9-CM Principal Procedure Code
- Point of Origin for Admission or Visit
- Reason for Not Exclusively Feeding Breast Milk
Numerator Populations

- Included Populations: NA
- Excluded Populations: None
Numerator Data Elements

Exclusive Breast Milk Feeding
Reason for Not Exclusively Feeding Breast Milk

- **Add** under the Inclusions:
  - Adoption or foster home placement of newborn
  - Previous breast surgery, i.e., bilateral mastectomy, bilateral breast reduction or augmentation where the mother is unable to produce breast milk
Current Joint Commission ORYX Requirements

Data collection required on 4 measures sets since 2008, some exceptions for small and specialty hospitals

Current standardized core measure sets
- Acute myocardial infarction
- Heart failure
- Pneumonia
- Surgical Care Improvement Project
- Perinatal care
- Children’s asthma care
- Hospital outpatient
- Hospital-based inpatient psychiatric services
- Venous thromboembolism
- Stroke

New Measure Sets for 2012
- Immunization
- Emergency department
- Tobacco treatment
- Substance abuse
PC ORYX Requirements

- Women’s Specialty Hospitals
  - Required if needed to meet ORYX requirement as a core set

- Acute-Care Hospitals serving this population
  - One of four sets of core measures or an additional set above the requirement
FAQs

What are the national benchmarks for the PC measures?
### Table 12: Perinatal care test measure results

<table>
<thead>
<tr>
<th>Performance measure</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perinatal care composite</strong></td>
<td>48.1%</td>
</tr>
<tr>
<td>Elective delivery</td>
<td>19.0%</td>
</tr>
<tr>
<td>Cesarean section</td>
<td>27.0%</td>
</tr>
<tr>
<td>Antenatal steroids</td>
<td>64.0%</td>
</tr>
<tr>
<td>Newborn bloodstream infections</td>
<td>0.3%</td>
</tr>
<tr>
<td>Exclusive breast milk feeding</td>
<td>40.5%</td>
</tr>
</tbody>
</table>

**NEW!**

Improving America’s Hospitals: The Joint Commission’s Annual Report on Quality and Safety 2011
FAQs

PC-01 Elective Delivery
How come some of ACOG’s approved justifications are not considered?

- Purpose is to enable hospitals to establish a baseline for performance to determine whether improvement efforts are effective over time

- Not every conceivable exclusion for the measure included in Table 11.07
How come some of ACOG’s approved justifications are not considered? (Cont.)

- Weighing the burden of data collection versus the frequency with which these conditions occur
- The value of including every conceivable justification outweighed by the additional time required to identify those cases via medical record review
FAQs

PC-02 Cesarean Section
Why are no other contraindications to vaginal deliveries considered such as maternal cardiac conditions or fetal distress?

- The measure is designed to measure complications that largely arise in labor and not exclude them.
- There are certainly good reasons to do a cesarean section that are captured in the measure.
- The premise is that medical practices during labor lead to the development of indications that were potentially avoidable.
FAQs

PC-05 Exclusive Breast Milk Feeding
How is exclusive breast milk feeding defined?

- A newborn receiving only breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals, or medicines
- If the newborn receives any other liquids including water during the entire hospitalization, select allowable value ‘No’
- Exclusive breast milk feeding includes the newborn receiving breast milk via a bottle or other means beside the breast
Why was Exclusive Breast Milk Feeding selected as a measure?

- The overall goal to improve exclusive breast milk feeding rates (estimated as low as 30% in some parts of the country)
- Supported by World Health Organization (WHO), Department of Health and Human Services (DHHS), American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG) & Healthy People 2010
- A number of evidence-based studies support the numerous benefits of exclusive breast milk feeding for both the mother and newborn
Why aren’t more newborn medical conditions excluded?

- Not all medical indications for formula supplementation in the first days of life are excluded from this measure.
- Many of these indications have a large variation in the definitions, thresholds and application of supplementation utilization.
- Rate of these complications should not vary greatly from hospital to hospital, though their severity can be driven by obstetric care.
Why is a mother's choice not to breast feed not considered?

- The Joint Commission recognizes and supports the right of a woman to refuse breast milk feeding
- A mother’s choice to breastfeed is a decision to be respected
- A number of educational programs based on scientific evidence have been successfully implemented by hospitals to increase the number of mothers that exclusively breast milk feed their newborns
- Cultural beliefs and values may influence the decision whether to exclusively breast milk feed or not
- Health care providers encouraged to integrate culturally sensitive information when promoting exclusive breast milk feeding as an option
Resources
March of Dimes Perinatal Care Resource

Toward Improving the Outcome of Pregnancy III (TIOP III)

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

NEW!
Resource for Elective Delivery

March Of Dimes (MOD)/California Maternal Quality Care Collaborative (CMQCC) <39wk Toolkit

Available at: marchofdimes.com or CMQCC.org to download your free copy of the toolkit.
Resources for Breast Milk Feeding Promotion

- The Centers for Disease Control and Prevention (CDC) has an excellent guide available at: [http://www.cdc.gov/breastfeeding/resources/guide.htm](http://www.cdc.gov/breastfeeding/resources/guide.htm).
- The Joint Commission’s Speak Up™ Campaign
The CDC Guide To Breastfeeding Interventions
- Released in 2005
- Provides Guidance in Selecting Promising Breastfeeding Promotion and Support Activities
- Two Categories of Interventions
Evidence-Based Interventions

- Maternity Care Practices
- Support for Breastfeeding in the Workplace
- Peer Support
- Educating Mothers
- Professional Support
- Media and Social Marketing
Interventions Whose Effectiveness Has Not Been Established

- Countermarketing and the World Health Organization (WHO) *International Code*
- Professional Education
- Public Acceptance
- Hotlines and Other Information Resources
ABM Clinical Protocols

- Hypoglycemia
- Going Home/Discharge
- Supplementation
- Mastitis
- Peripartum BF Management
- Cosleeping and Breastfeeding
ABM Clinical Protocols (Cont.)

- Model Hospital Policy
- Human Milk Storage
- Galactogogues
- Breastfeeding the Near-term Infant
- Contraception and Breastfeeding
The Breastfeeding-Friendly Physicians' Office Part 1: Optimizing Care for Infants and Children

Analgesia and Anesthesia for the Breastfeeding Mother

Breastfeeding the Hypotonic Infant
ABM Clinical Protocols (Cont.)

- Guidelines for Breastfeeding Infants with Cleft Lip, Cleft Palate, or Cleft Lip and Palate
- Use of Antidepressants in Nursing Mothers
- Breastfeeding Promotion in the Prenatal Setting
- Engorgement
ABM Clinical Protocols (Cont.)

- Breastfeeding and the Drug-Dependant Woman
- Jaundice
- Non-Pharmacologic Management of Procedure-Related Pain in the Breastfeeding Infant
- Allergic Proctocolitis in the Exclusively Breastfed Infant
The United States Breastfeeding Committee (USBC)

“All U.S. mothers should have the opportunity to breastfeed their infants and all infants should have the opportunity to be breastfed.”
USBC Toolkit for PC-05: Implementing The Joint Commission Perinatal Care Core Measure on Exclusive Breast Milk Feeding

Part 1 January 2010: The Guidelines for Data Collection

Part 2 December 2010: Implementing Practices That Improve Exclusive Breast Milk Feeding

The Joint Commission’s
Speak Up™ Campaign

August 2011
Speak Up™ Campaign

- The Joint Commission launched the Speak Up campaign on March 14, 2002

- Increase patient awareness and involvement

- Acknowledges that doctors, health care executives, nurses, and many health care technicians are already working to make health care safe
Joint Commission Standards

- Patient Rights – involve patients, inform them of outcomes, communicate, and inform them of rights and responsibilities
- Education – provide education for assessed needs, and educate patients to report perceived risk
- Leadership – give high priority to patient safety issues
- Performance Improvement – collect data on perceptions of risk and suggestions for improving safety
New Speak Up About Breastfeeding Campaign

- Released – August 1, 2011
- Coincided with World Breastfeeding Week
- Publicized through a national media campaign
Speak Up About Breastfeeding

Groups collaborating with The Joint Commission on the campaign:

- Academy of Breastfeeding Medicine
- American Academy of Pediatrics
- Association of Women's Health, Obstetric and Neonatal Nurses
- Baby-Friendly USA, Inc.
- Centers for Disease Control and Prevention
- March of Dimes
- United States Breastfeeding Committee
Brochures include a blank panel to allow for information about the organization, its commitment to patient safety, and the organization logo. Posters are available for some campaigns.
Speak Up Brochures

- All accredited health care organizations receive information about every new Speak Up campaign

- Organizations may order brochures, posters and buttons

- Church groups, advocacy groups and pharmaceutical companies print and distribute brochures

- Any group that wishes to use any of the campaigns are welcome to do so
Speak Up Brochures

- Written at a fifth grade reading level
- Available in English and Spanish
- Provide questions to ask and advice about what to expect in health care settings
- Brochures have a blank panel allowing health care organizations to add their own patient safety messages
Implementation of Speak Up in Field

HCOs are being very creative with the information:

- Pamphlets included in staff orientation, patient admission packets, patient education materials, distributed at health and education fairs, and public information booths
- Posters hung in public areas, patient rooms and waiting rooms
- Staff wearing Speak Up buttons
- Adapted into public service announcements
- Closed circuit television patient education programs
Implementation of Speak Up in Field (Cont.)

- Sent press releases which aired on local television and radio networks, and were printed in community magazines and newspapers
- Information included in newsletters to health care staff and the public
- Plaques created with Speak Up information
- Speak Up campaigns held
- Used as a kickoff for hospital week
- Established Speak Up Task Force
For more information

- **The Joint Commission website:**
  www.jointcommission.org/GeneralPublic/Speak-Up/

- **Joint Commission Resources:**
  www.jcrinc.com or 877.223.6866 (brochures and posters available for purchase)

- **YouTube:**
  http://www.youtube.com/user/TheJointCommission
Next Steps in the Timeline

- December 2008 PC TAP Members Appointed
- February 2009 TAP Meeting
- Feb-Oct 2009 Measure Specifications Development
- October 1, 2009 Manual Posting
- Data Collection began with April 1, 2010 Discharges
- 2011-2012 Reliability Testing
- Measure Specifications Post Testing
View the manual and post questions at: http://manual.jointcommission.org
Questions