Impact of TJC New Perinatal Care Core Measure: Supporting Exclusive Breastfeeding in the Hospital

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Faculty Disclosure Information

In the past 12 months, I have not had a significant financial interest or other relationship with the manufacturer(s) of the product(s) or provider(s) of the service(s) that will be discussed in my presentation.

This presentation will not include discussion of pharmaceuticals or devices that have not been approved by the FDA and I will not be discussing unapproved or “off-label” uses of pharmaceuticals or devices.

Kathleen A. Marinelli MD, IBCLC, FABM, FAAP
Objectives

Following this discussion you will be able to:

- Describe the **new mandate** for The Joint Commission Perinatal Care Core Measures effective January 1, 2014;
- Relate in detail the specific key points concerning exclusive breast milk feeding (PC-05 and PC-05a);
- Identify strategies to improve compliance with exclusive breast milk feeding core measures;
- List resources available to help achieve compliance.
Thank you to

- Celeste G. Milton, MPH, BSN, RN
  Associate Project Director
  Center for Performance Measurement
  The Joint Commission
- United States Breastfeeding Committee
  For the generous use of slides from TJC and USBC Perinatal Core Set presentations
The Joint Commission (TJC)

- An independent, non-profit organization
- Accredits and certifies more than 20,000 health care organizations and programs in the US
- 47 states require TJC accreditation for hospital licensure and Medicaid reimbursement
- Ensures a standard of quality
Joint Commission Accreditation

- Hospital is surveyed once every 3 years
- Surveyors can appear with little warning
- Review many aspects of hospital operations
  - TJC measures hospital’s improvement over time
  - Compares one hospital to similar hospitals
- Private companies may publicly report hospital comparisons
The Joint Commission's Core Measures

• Serve as a national, standardized performance measurement system
  • Provide assessments of care delivered in given focus areas

• Factors causing varying compliance with core measures
  • Lack of awareness of the evidence connecting processes of care to improved outcomes
  • Hospitals should plan to use their data to drive quality improvements in evidence-based care
  • Help track progress from year to year
Why Do Core Measures Matter?

- Health care delivery is shifting to value-based care and core measures will be tied to reimbursement
- IOM calling for health care delivery to become STEEEP-safe, timely, effective, efficient, equitable, and patient-centered
- QI is the methodology used for Core Measures implementation
Perinatal Core Measures Overview

- Nov 2007, TJC Board of Commissioners recommended retiring Pregnancy and Related Conditions Core Measure Set, in use since 2002
  - Retired March 31, 2010
- Recommended replacement with expanded measure set based on current evidence-based science
- Endorsed by National Quality Forum October 2008
  - The Joint Commission selected 5 of the 17 NQF perinatal measures for the Core Measure Set
- Available for selection by hospitals beginning April 1, 2010 discharges
  - Revised Dec 2010
PC Core Measures*

- PC-01 Elective Delivery
- PC-02 Cesarean Section
- PC-03 Antenatal Steroids
- PC-04 Health Care-Associated Bloodstream Infections in Newborns
- PC-05 Exclusive Breast Milk Feeding
- PC-05a Exclusive Breast Milk Feeding Considering Mother’s Choice (new!!)

*Hospitals who pick PC set must do all 5 above

http://www.jointcommission.org/core_measure_sets.aspx
The New Mandate

- Beginning January 1, 2014
- Maternity hospitals delivering ≥ 1,100 infants annually
- Must report on PC-05, PC-05a
- Hospital readiness
  - EHR’s as a component of meaningful use
  - USBC expert panel developing guidelines
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HOSPITAL REPUTATION
- **External** – Recruiting physicians and patients, payer association, watchdog websites, RHIO / HIE / ACOs
- **Internal** – physician reputation, employee satisfaction, performance

FINANCIAL RETURNS
- **Reimbursement** – higher levels from higher quality of care
- **Avoided Costs** – high compliance reduces costs from avoidable errors
- **Avoid Non-Payment** for mistakes

PATIENT SATISFACTION
- **Shorter recovery** / less frustration
- Establish **trust** with clinicians
- Word of mouth advertising; **positive brand** within healthcare
- **Improved outcomes** post-discharge

QUALITY OF CARE
- **Evidence-based**, best practice care
- **Lower rate**: mortality, complication, co-morbidities, infections, re-admits
- Improved outcomes, **shorter LOS**
- **Enhanced patient experience**

**Benefits of High Core Measure Compliance**
Current Joint Commission ORYX Requirements

- 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
- Immunization
- Emergency department
- Tobacco treatment
- Substance use

Data collection required on 4 measures sets since 2008, some exceptions for small and specialty hospitals
Up-Coming ORYX Requirements

- Acute-care hospitals will be required to choose SIX core measure sets, effective with January 1, 2014 discharges
- AMI, HF, Pneumonia and SCIP mandatory if those patient populations are served
- Perinatal Care set mandatory for hospitals with 1,100 or more births per year (fifth mandatory measure set)
- Have to achieve sustained quality in a measure set to discontinue it
PC-01 Elective Delivery

- Definition: Delivery of a newborn(s) when mother was not in active labor or presented with SROM prior to medical induction and/or c-section
- 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 $\geq 37$ and $< 39$ weeks of gestation completed

**Lower rate is noted for improvement**
PC-02 Cesarean Section

- 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 (≥ 37 weeks of gestation completed) in vertex presentation

**Lower rate is noted for improvement**
PC-03 Antenatal Steroids

- Full course of antenatal steroids consists of two doses of 12mg bethamethasone IM 24 hours apart
  OR four doses of 6 mg dexamethasone IM every 12 hours prior to delivery
- 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 0/7-32 0/7 weeks gestation completed

**Higher rate noted for improvement**
PC-04 Health Care-Associated Bloodstream Infections in Newborns

- **Health care-associated infection**: localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s).
  - There must be no evidence that the infection was present or incubating at the time of admission to the care setting.
- Rates range 6% - 33%; occur in first 48 hrs
- 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

Live born newborns

**Lower rate noted for improvement**
PC-05 Exclusive Breast Milk Feeding

© K Marinelli MD IBCLC
PC-05 and PC-05a

- TJC defines exclusive breast milk feeding as newborn receiving only breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, mineral, or medicines.
- Breast milk feeding includes expressed mother’s milk as well as donor human milk, both of which may be fed to the infant by means other than suckling at the breast.
US breastfeeding rates, 1985-2009
Percent of U.S. breastfed children supplemented with infant formula

Goal 14.2%

25% and rising

http://cdc.gov/breastfeeding/data/NIS_data/index.htm
PC: 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, infant has not been exclusively breastfed
  
  • Exclusive breast milk feeding includes the newborn receiving breast milk via a bottle or other means beside the breast (includes mother’s own milk and donor milk)
Why was Exclusive Breast Milk Feeding selected as a measure?

- The overall goal is 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
- All the data concerning “Just one bottle (of formula)...
Numerator and Denominator PC-05

Newborns that were fed breast milk only since birth

Single term newborns discharged alive from the hospital

** Higher rate noted for improvement
Denominator Populations

**Included Populations:**
- Live born single newborns

**Excluded Populations:**
- Admitted to the NICU during the hospitalization
- Galactosemia
- Parenteral infusion
- Experienced death
- Length of Stay >120 days
- Enrolled in clinical trials that affect infant feeding
- Documented *Reason for Not Exclusively Feeding Breast Milk*
- Patients transferred to another hospital
- Premature newborns
Admission to NICU

- Not defined by level designation
- Includes only newborns with critical care services provided
- Excludes newborns admitted for observation/transitional care
TJC describes the only acceptable maternal reasons for which breast milk feeding should be avoided as:

- HIV infection
- Human t-lymphotrophic virus type I or II
- Substance abuse and/or alcohol abuse
- Active, untreated tuberculosis
- Taking certain medications, i.e., prescribed cancer chemotherapy, radioactive isotopes, antimetabolites, antiretroviral medications, and other medications where the risk of morbidity outweighs the benefits of breast milk feeding.
TJC describes the only acceptable maternal reasons for which breast milk feeding should be avoided as:

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

*must be documented in medical record*
Reason for Not Exclusively Feeding Breast Milk

- Who can document this data?
  - RN documentation requires additional validation
  - Physician/Advanced Practice Nurse/Certified Nurse Midwife/ Lactation Consultant Documentation Only

- Inclusion:
  - Maternal admission to Intensive Care Unit (ICU) post-partum
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.
  - e.g. The better maternal blood sugar control, the lower the rate of newborn hypoglycemia.
PC-05a Exclusive Breast Milk Feeding Considering Mother’s Choice

“only those newborns that were exclusively fed breast milk during the entire hospitalization excluding those whose mothers chose not to breast feed.

- In absence of documentation- do not assume
- Must be documented before first feed
- If RN documents, also need documentation by advanced practice/MD in progress notes
- Make clear to mother only relates to her plan for her time in the hospital

Beginning with January 1, 2013 discharges
Numerator and Denominator

Newborns that were fed breast milk only since birth

Single term newborns discharged alive from the hospital excluding those whose mothers chose not to breastfeed

** Higher rate noted for improvement
"All U.S. mothers should have the opportunity to breastfeed their infants and all infants should have the opportunity to be breastfed."

The United States Breastfeeding Committee (USBC)

http://www.usbreastfeeding.org/
http://www.usbreastfeeding.org/HealthCare/HospitalMaternityCenterPractices/
ToolkitImplementingTJCCoreMeasure/tabid/184/Default.aspx
USBC Toolkit

- Addresses the exclusive breast milk feeding CM
- Part 1, Guidelines for Data Collection
  - originally released January 2010
  - Designed to aid hospitals and maternity facilities in accurate collection of the data to comply with PC-05
  - re-released with addition of Part 2 December 2010
  - Revised 2013
- Part 2, Implementing Practices That Improve Exclusive Breast Milk Feeding
  - focuses on improving adherence to evidence-based best practices
  - ultimately reflected in rates of exclusive breast milk feeding
What is exclusive breast milk feeding?

- Feeding at the breast (breastfeeding!)
- Feeding expressed mother’s own milk or donor milk by means other than suckling at the breast
- While breastfeeding is the goal for optimal health, it is recognized that human milk provided indirectly is still superior to alternatives
What About Sugar Solutions?

- **Sweet-Ease (24 % sucrose)**
  - solution given for analgesia
  - classified as a medication

- **Glucose water (5% glucose)**
  - There is no medical reason for a hospital to stock glucose water
  - Classified by TJC as a supplement
• The measure does not examine medically acceptable reasons to supplement a breastfed infant,
  
  *but* . . .

• Hospitals that implement the Ten Steps to Successful Breastfeeding are likely to have fewer infants who require supplementation for medical reasons like dehydration.

• Thus, this is an outcome measure that reflects use of other best practices (e.g. Ten Steps)
So what does TJC want to know (PC-05)?

**Numerator**
# of term singleton newborns that were fed only breast milk since birth

**Denominator**
# term singleton newborns discharged from the hospital (of non-excluded categories)
Acceptable exclusions from the denominator

- Mother taking certain medications where the risk of morbidity outweighs the benefits of breast milk feeding
  - prescribed cancer chemotherapy
  - radioactive isotopes
  - anti-metabolites
  - antiretroviral medications, and other medications
In some of these cases,

- Infant can and should be exclusively fed breast milk or donor human milk
  - even though TJC allows these infants to be excluded from the denominator
  - mother with herpetic lesions on one breast can still feed from the other breast
  - mother with active untreated tuberculosis can have someone else feed her infant her own expressed milk
    - feeding at the breast is not recommended due to droplet precautions
    - mother in clinical trial may breastfeed if trial allows

- But you don’t get any TJC credit for these!
Important to note

- that the “reasons for not exclusively feeding breast milk” listed by The Joint Commission are not indications for supplementation in a breastfed infant.

- Many of these exclusions concern breastfeeding initiation
Not acceptable exclusions for PC-05

- Mother’s choice to give formula
- Medical reason for supplementation
  - excessive weight loss
  - hypoglycemia
Important note on exclusive breastfeeding

- Health outcomes in most studies on breastfeeding based on mother/child dyad breastfeeding, i.e., feeding at the breast
- WHO and CDC now define breastfeeding to include feeding expressed milk
  - Only in recent years, and predominantly in the US, studies have begun to include expressed milk as part of the definition of breastfeeding
  - Further research is necessary to assess whether health impact of breastfeeding for mother and child is also present with the feeding of expressed milk
Important note on non-exclusive breast milk feeding

• TJC does not require documentation of medical indications for supplementing a breastfed infant
• If supplement consists of expressed HM or DM infants can still be counted as exclusively breast milk-fed
• Medical reasons for supplementation are not reasons for excluding infants from the denominator
  • Indications for supplementing a breastfed infant should be documented for purposes of patient care
  • “Supplements” may consist of expressed or DM or formula
  • Hospitals seeking Baby-Friendly designation are required to document medical reasons for supplementation, as well as the route and type of supplementation (not required by TJC)
Practice Implementation

- Ten Steps to Successful Breastfeeding
  - set of evidence-based policy and practice steps has been demonstrated to improve breastfeeding outcomes
  - additive effect of the implementation of the Ten Steps
  - first-time mothers intending to breastfeed exclusively who gave birth in facilities where most of the Ten Steps were in practice were 6 times more likely to achieve exclusive breastfeeding (Declercq E, Labbok MH, Sakala C, O'Hara M. Am J Public Health 2009;99:929-35)
  - Baby-Friendly® designation consists of the Ten Steps plus the additional step of compliance with the WHO International Code of Marketing of Breast-milk Substitutes
  - Keeping mothers and babies together offers the most significant opportunity for improvement of exclusive breastfeeding (skin to skin, rooming in)
### Table 1. WHO/UNICEF Ten Steps to Successful Breastfeeding
(as adopted for the United States by Baby-Friendly USA, Inc.)

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practice “rooming in”—allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.
Recommendations for Evidence-Based Best Practices

- Labor and Delivery Care
  - Initial skin-to-skin contact
  - Initial breastfeeding opportunity
  - Routine procedures performed skin-to-skin

- Postpartum Care
  - Feeding of Breastfed Infants
    - Initial feeding received after birth
    - Supplementary feedings
  - Breastfeeding Assistance
    - Documentation of feeding decision
    - Breastfeeding advice and counseling
    - Assessment and observation of breastfeeding
    - Pacifier use
Recommendations for Evidence-Based Best Practices

- Postpartum Care
  - Contact Between Mother and Infant
    - Separation of mother and newborn during transition to receiving patient care units
    - Patient rooming-in
    - Instances of mother infant separation throughout the intrapartum stay

- Facility Discharge Care
  - Assurance of ambulatory breastfeeding support
  - Distribution of “discharge packs” containing infant formula

- Staff Training
  - Preparation of new staff
  - Continuing education
  - Competency assessment
Recommendations for Evidence-Based Best Practices

- Structural and Organizational Aspects of Care Delivery
  - Infant feeding policy
  - Communication of infant feeding policy
  - Employee breastfeeding support
  - Procurement of infant formula and feeding supplies
  - Prenatal breastfeeding instruction
  - Coordination of lactation care
Examples

• 36 week infant not in NICU
Examples

- 36 week infant not in NICU
  - excluded (preterm)
Examples

- 36 week infant not in NICU
  - excluded (preterm)
- Healthy term infant dehydrated from poor milk transfer
Examples

- 36 week infant not in NICU
  - excluded (preterm)
- Healthy term infant dehydrated from poor milk transfer
  - not excluded
Examples

- 36 week infant not in NICU
  - excluded (preterm)
- Healthy term infant dehydrated from poor milk transfer
  - not excluded
- Mom who is only formula feeding
Examples

- 36 week infant not in NICU
  - excluded (preterm)
- Healthy term infant dehydrated from poor milk transfer
  - not excluded
- Mom who is only formula feeding
  - not excluded
Examples

- 36 week infant not in NICU
  - excluded (preterm)
- Healthy term infant dehydrated from poor milk transfer
  - not excluded
- Mom who is only formula feeding
  - not excluded
- Baby supplemented with expressed milk or donor milk
Examples

- 36 week infant not in NICU
  - excluded (preterm)
- Healthy term infant dehydrated from poor milk transfer
  - not excluded
- Mom who is only formula feeding
  - not excluded
- Baby supplemented with expressed milk or donor milk
  - counts as exclusively breast milk fed
Examples

- 36 week infant not in NICU
  - excluded (preterm)
- Healthy term infant dehydrated from poor milk transfer
  - not excluded
- Mom who is only formula feeding
  - not excluded
- Baby supplemented with expressed milk or donor milk
  - counts as exclusively breast milk fed
- Given 5 cc formula
Examples

- 36 week infant not in NICU
  - excluded (preterm)
- Healthy term infant dehydrated from poor milk transfer
  - not excluded
- Mom who is only formula feeding
  - not excluded
- Baby supplemented with expressed milk or donor milk
  - counts as exclusively breast milk fed
- Given 5 cc formula
  - doesn’t count as exclusively fed
Examples

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  - doesn’t count as exclusively fed
- Mom wants to formula feed—stated in the written record
Examples

- 36 week infant not in NICU
  - excluded (preterm)
- Healthy term infant dehydrated from poor milk transfer
  - not excluded
- Mom who is only formula feeding
  - not excluded
- Baby supplemented with expressed milk or donor milk
  - counts as exclusively breast milk fed
- Given 5 cc formula
  - doesn’t count as exclusively fed
- Mom wants to breast and formula feed starting in the hospital—stated in the written record
  - Included in PC-05; excluded from PC-05a
TJC data sources for collecting exclusive breast milk feeding data:

- Discharge summary
- Feeding flow sheets*
- Individual treatment plans
- Intake and output sheets*
- Nursing notes
- Physician progress notes

* Direct documentation
USBC suggests

- Modify existing charting to support appropriate data collection and easy extraction with chart audits
  - Avoid using the word “bottle” as a synonym for formula
  - Encourage provider orders that state “exclusive breastfeeding” or “breastfeeding contraindicated due to __________.”
  - special charting section on supplementation
    - Expressed MOM/DHM/formula
  - Consider creating a check-off list that includes approved reasons for not exclusively feeding breast milk
USBC suggests

- Key information should be aggregated and summarized
- A hospital may use a feeding flow sheet or intake/output sheet as a central source of final documentation for all feeding information
- Universal data collection on all infants will support consistent practices and is preferable to sampling (although TJC allows sampling size)
- Point-of-use inventory management can support documentation of feeding practices
Charting Tip

- Avoid using the word “bottle” as synonym for formula
Toolkit: Implementing TJC Perinatal Care Core Measure on Exclusive Breast Milk Feeding

On March 31, 2010, The Joint Commission’s Pregnancy and Related Conditions core measure set was retired and replaced with the new Perinatal Care core measure set. The new Perinatal Care core measure set became available for selection by hospitals beginning with April 1, 2010 discharges.

*NEW*: On November 30, 2012, The Joint Commission announced that the Perinatal Care core measure set would become mandatory for all hospitals with 1,100 or more births per year, effective January 1, 2014.

The USBC toolkit, Implementing The Joint Commission Perinatal Care Core Measure on Exclusive Breast Milk Feeding, addresses the exclusive breast milk feeding core measure.

Download the Toolkit (revised 2013)

Resources for Hospitals/Maternity Centers

Skin to skin contact including C-sections

Skin-to-skin contact during cesarean birth:

Photo courtesy of Cindy Curtis
Do not remove infant from mother’s body before first breastfeed (WHO)
Routine procedures performed skin to skin

- APGARS, heel sticks, painful procedures
Include ventral positioning as an option in charting
Develop policy/procedure for expressed MOM and DHM if don’t have one
Eliminate All Formula Company Discharge Bags

Ban the Bags
www.banthebags.org
Toolkit

- Exclusive Breast Milk Feeding likely will require changes in most hospitals’ current documentation practices
- EBMF rates will improve as hospitals move toward implementing Baby-Friendly practices
- Use the Toolkit as a resource and blueprint
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

• The Academy of Breastfeeding Medicine (ABM) has protocols available at: http://www.bfmed.org/Resources/Protocols.aspx

• The United States Breastfeeding Committee has a toolkit available at: http://www.usbreastfeeding.org/

• The Joint Commission’s Speak Up™ Campaign

http://www.jointcommission.org/speakup_breastfeeding/
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
As a mother, one of the most important things you will decide is how to feed your baby. The many health benefits of breastfeeding include:

- Natural source of the nutrients your baby needs
- Less risk of Sudden Infant Death Syndrome (SIDS)
- Fewer ear and respiratory infections for your baby
- Enhances newborn brain development
- Less risk your baby will be overweight
- Less risk of diabetes for your baby and you
- Less risk of postpartum depression for you
- Less risk of breast and ovarian cancer for you
- Faster recovery for you

Breastfeeding is natural for you and your baby, but it is a skill that needs to be learned. Speak up and ask questions about breastfeeding before your baby is born and while you are in the hospital. This will help you continue to breastfeed after you go home. This brochure provides information to help you breastfeed your baby. Remember, you should always talk to your doctor or nurse about any tips or advice given to you about your health.
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
- Organizations may order brochures, posters and buttons
- Can print and distribute brochures
- Any group that wishes to use any of the campaigns are welcome to do so
Resources for Hospitals/Maternity Centers

Below is a list of selected resources, some of which are available at no cost, and some of which are available for purchase. This list is by no means exhaustive and may be periodically updated. The United States Breastfeeding Committee has no financial interest in the sale or use of any of these resources.

California Department of Public Health: Examples of consents to supplement
- Includes two model consent forms in English and one in Spanish
- Includes model policy (from Kaiser) for supplementation

Academy of Breastfeeding Medicine: Clinical protocols
- See especially Protocol #3 (Supplementation) and Protocol #7 (Model Hospital Policy)

Lamaze International: Healthy birth practices
- Includes care practice papers such as Keep Mother and Baby Together—It’s Best for Mother, Baby, and Breastfeeding

Health Education Associates: Resources on skin-to-skin contact
- Skin to Skin in the First Hour After Birth: Practical Advice for Staff after Vaginal and Cesarean Birth: three-part video to aid in training hospital staff about the importance of skin-to-skin and examples of the baby’s stages during the first hour; practical advice for staff after a vaginal birth; and practical advice for staff after a cesarean birth
- "The First Hour After Birth: A Baby’s 9 Intrinsic Stages": tear-off pad which clearly explains the nine observable newborn stages that occur when a baby is in skin-to-skin contact after birth

JSI Maternal and Infant Health Project: "The Warm Chain"
- Ten-minute online video demonstrating the World Health Organization’s recommendations on skin-to-skin contact and other measures for preventing neonatal hypothermia

California Department of Public Health: Birth and Beyond California: hospital breastfeeding quality improvement and staff training demonstration project
- Utilizes Quality Improvement (QI) methods and training to implement evidence-based policies and practices that support breastfeeding within the maternity care setting

Breastfeeding Friendly Consortium: Online provider training module
- Provides up to 30 hours of credit, designed for physicians, nurses, educators, and health care professionals

Association of Women’s Health, Obstetric and Neonatal Nurses: Guidelines for Professional Registered Nurse Staffing for Perinatal Units
- Provides staffing recommendations for nurses as well as for lactation consultants

U.S. Lactation Consultant Association: International Board Certified Lactation Consultant Staffing Recommendations for the Inpatient Setting
- Provides staffing recommendations for lactation consultants in various hospital settings

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
View TJC manual and post questions at:
http://manual.jointcommission.org
Breastfeeding is nature’s universal health care plan.