# IT-8.6: Cesarean Rate for Nulliparous Singleton Vertex

| **Measure Title** | **PC-02 Cesarean Section** | | |
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| **Description** | This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section. This measure is part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding). | | |
| **NQF Number** | 0471 | | |
| **Measure Steward** | The Joint Commission | | |
| **Link to measure citation** | <https://www.qualityforum.org/QPS/0471> | | |
| **Measure type** | Non Stand-Alone (NSA) | | |
| **Measure status** | P4P | | |
| **DSRIP-specific modifications to Measure Steward’s specification** | The Measure Steward’s specification has been modified as follows:   * Revised the numerator to match NQF measure specification * Removed reference to table not included in the document | | |
| **Denominator Description** | Nulliparous patients delivered of a live term singleton newborn in vertex presentation | | |
| **Denominator Inclusions** | The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description. | | |
| **Denominator Exclusions** | • ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes for contraindications to vaginal delivery  • Less than 8 years of age  • Greater than or equal to 65 years of age  • Length of Stay >120 days  • Enrolled in clinical trials • Gestational Age < 37 weeks | | |
| **Denominator Size** | Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)   * For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. * For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. * For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases. | | |
| **Numerator Description** | Patients with cesarean sections with ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes for cesarean section as defined in Appendix A, Table 11.06 available at: <http://manual.jointcommission.org> | | |
| **Numerator Inclusions** | The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description. | | |
| **Numerator Exclusions** | The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description. | | |
| **Setting** | Inpatient | | |
| **Data Source** | Administrative/Clinical data sources | | |
| **Denominator Sub-set Definition (Optional)** | Providers have the option to further narrow the denominator population for this measure across one or more of the following domains. If providers wish to use this option, they must indicate their preference to HHSC through the measure selection process.  **Payer:** Providers may define the denominator population such that it is limited to one of the following options:   1. Medicaid 2. Uninsured/Indigent 3. Both: Medicaid and Uninsured/Indigent   **Gender:** Providers may define the denominator population such that it is limited to one of the following options:   1. Male 2. Female   **Ethnicity:** Providers may define the denominator population such that it is limited to one of the following options:   1. White/Caucasian 2. Black/African American 3. Latino/Hispanic 4. Asian 5. American Indian/Alaskan Native 6. Native Hawaiian/Other Pacific Islander   **Age:** Providers may define the denominator population such that it is limited to an age range:  Lower Bound: \_\_\_\_ (Provider defined)  Upper Bound: \_\_\_\_ (Provider defined)  **Comorbid Condition:** Providers may define the denominator population such that it is limited to individuals with one or more comorbid conditions:  Comorbid condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Provider defined)  **Setting/Location:** Providers may define the denominator population such that it is limited to individuals receiving services in a specific setting or service delivery location(s).  Service Setting/Delivery Location(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Provider defined) | | |
| **Demonstration Years** | **DY3**  **10/01/13 – 09/30/14** | **DY4**  **10/01/14 – 09/30/15** | **DY5**  **10/01/15 – 09/30/16** |
| **Measurement Periods**  *(Note: For P4P measures, DY3 Measurement Period is equivalent to the Baseline Period for purposes of measuring improvement.)* | **Providers must report data for one of the following DY, SFY, or CY time periods:**  12 Month Period:   1. 10/01/13 – 09/30/14, or 2. 09/01/13 – 08/31/14, or 3. 01/01/13 – 12/31/13, or 4. 10/01/12 – 09/30/13, or 5. 09/01/12 – 08/31/13   6 Month Period:   1. 04/01/14 – 09/30/14, or 2. 03/01/13 – 08/31/14, or 3. 01/01/13 – 06/30/13, or 4. 07/01/13 – 12/31/13   Other: Providers specify/propose an alternative 6 or 12 month time period to be reviewed and approved by HHSC. | **Providers must report data across a 12-month time period that meets the following parameters:**  1. Start date: The start date for the reporting period must occur after the provider’s DY3 Measurement Period.  2. End date: The end date for the reporting period must occur on or before 09/30/15. | **Providers must report data across a 12-month time period that meets the following parameters:**  1. Start date: The start date for the reporting period must occur after the provider’s DY4 Measurement Period.  2. End date: The end date for the reporting period must occur on or before 09/30/16. |
| **Reporting Opportunities to HHSC** | 10/31/2014 | 4/30/2015  10/31/2015 | 4/30/2016  10/31/2016 |
| **Pay for Performance Target Methodology**  *(Note: See DSRIP Category 3 Companion Document for detailed P4P target methodology descriptions pertaining to (1) QISMC methodology, and (2) Improvement Over Self methodology.)* | Not Applicable | QISMC | QISMC |
| **Pay for Performance QISMC Benchmark Definition** | Not Applicable | TBD | TBD |
| **Pay for Performance QISMC Benchmark Source** | Not Applicable | TBD | TBD |
| **Pay for Performance QISMC High Performance Level Definition** | Not Applicable | TBD | TBD |
| **Pay for Performance QISMC High Performance Level Value** | Not Applicable | TBD | TBD |
| **Pay for Performance QISMC Minimum Performance Level Definition** | Not Applicable | TBD | TBD |
| **Pay for Performance QISMC Minimum Performance Level Value** | Not Applicable | TBD | TBD |