March 26, 2014

Celeste Pierre
The Joint Commission
Standards and Survey Methods
New Perinatal Care Certification Program
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
Letter via email to: cpierre@jointcommission.org

Re: Proposed Perinatal Care Certification Requirements

Dear Ms. Pierre:

On behalf of the Coalition for Quality Maternity Care (CQMC), a group of national professional, consumer, and human rights organizations that promote high-quality maternity care for all women and newborns, we appreciate the opportunity to provide comments on The Joint Commission's "Proposed Perinatal Care Certification Requirements," (hereinafter "Certification Requirements) released for public comment on February 12, 2014. We hope that you find our comments helpful and look forward to your response in the final version of the Certification Requirements.

General Comments

The members of the CQMC are pleased that The Joint Commission is developing a certification program for the care of the great majority of childbearing women and newborns who have been found to be at low risk for adverse events. In terms of the number of hospital discharges, childbirth and care of newborns constitute the most common reason for use of hospital services, and facility costs alone for childbirth and newborn care run into the tens of billions of dollars each year. Further, these services impact the entire population during the most vulnerable period at the beginning of life and also impact about 85% of women who experience this full episode of care once or more during their lifetime. It is therefore appropriate to provide hospitals with a way to demonstrate to the public and the various stakeholders that they have met a high standard with regard to their ability to care for this population of women and newborns. We support this effort.

Below we provide a table with specific recommendations. In addition, we wish to share several overall concerns:

- Many elements of the certification program are better suited to a higher risk population and the draft standards omit many opportunities to expressly meet the needs of the focal population of the program, women and newborns with uncomplicated pregnancies. This population requires an approach that is closely aligned with its needs. The CQMC recommends that the Certification Requirements be revised to emphasize more directly the need for system leaders and clinical teams to reduce overuse and misuse of interventions and to actively address underuse of beneficial practices that support physiologic labor and birth as the standard of care for those without a need for intervention. Data clearly show that quality and safety issues facing perinatal services include excess risk of harm from overuse of interventions such as non-medically indicated inductions of labor and cesareans. We strongly recommend that in finalizing the Certification Requirements, The Joint Commission work with provider groups that specialize in supporting normal physiologic childbearing to identify practices that foster physiologic childbearing, and safely limit the use of common interventions. These approaches should be foundational within its Certification Requirements.

  We encourage The Joint Commission to use this opportunity to create a certification program that drives quality improvement for low-risk women and newborns and recognizes facilities that focus on normal physiologic birth. Many facilities likely already meet the bulk of the standards articulated in this document. Women need a way to identify those facilities that are best able to support and foster their own physiologic capacities without inappropriately interfering with what is a normal process, not an illness.

- Throughout the document there are references to 24-hour availability of various services. In rural areas or in smaller hospitals, this may not always be possible. As a result, these facilities may not be able to qualify for the certification. As rural and smaller hospitals provide care to many low-risk women and newborns, we recommend that The Joint Commission consider how to enable such hospitals to qualify for certification. The general principle should be one of inclusion.

- We recommend avoiding the designation "patient" when referring to healthy childbearing women and newborns. In our comments, below, we refer to "women" and "newborns," and we encourage The Joint Commission to edit the Certification Requirements to reference these groups in a similar manner.

Specific Comments

Standard and Element Number (Line Number)	Recommended Change	Rationale
PNPM 1 New Element	We recommend that a new element be included that emphasizes the need for the organization's Board of Directors	The Institute for Healthcare Improvement, an organization that has looked closely at improving perinatal care, has emphasized the need to have the institution's Board of Directors closely involved in quality efforts. See here for

	to directly support the care, treatment, and services.	details.
PNPM.1 Element 6 Line 12	We recommend adding the underlined text to this element. "….and how staff and leaders can support the program, ensure consistency in standards of care across services, and refer patients to…"	Perinatal services currently often function in a silo within the hospital organization. For example, improvement programs, staffing patterns, and standards of care in the main operating room are not always implemented or consistently applied in an obstetric operating room.
PNPM 2 Element 2 Line 21	We recommend adding the following text to element 2: "In cases where Certified Nurse-Midwives (CNMs) or Certified Midwives (CMs) provide care in the hospital, a CNM or CM must be identified to be jointly responsible with the identified obstetrician or family practice physician for the management of the program. They must both be jointly included in senior management decisions regarding the perinatal program."	ACOG and ACNM have both endorsed a position statement on collaborative practice based on mutual respect. It is important that perinatal programs recognize and support both types of providers in their respective realms of expertise so that the hospital can offer the best of both available skill sets to women and newborns. See: "Joint Statement of Practice Relations between Obstetrician Gynecologists and Certified Nurse-Midwives /Certified Midwives," available here.
PNPM 2 Element 4 Lines 25-26	We recommend that this element be revised to read: "A board-certified or -eligible anesthesiologist, or certified registered nurse anesthetist, is responsible for program management of obstetrical anesthesia services."	CRNAs commonly provide anesthesia and leadership in obstetrical units. Furthermore, under Medicare's supervision requirements, physician supervision in non-opt out states does not have to come from an anesthesiologist, but can come from the operative physician (42 CFR 416.42). Many hospitals may not have an anesthesiologist on staff and may instead rely wholly upon CRNAs for provision of anesthesia services, including leadership and management in obstetric anesthesia services. In such cases, meeting this element, as drafted, may not be possible. CRNA's have a proven track record of providing safe and effective care. Restricting CRNAs from serving as program managers of obstetrical anesthesia services may raise the cost of health care, decrease access to quality health care, and significantly restrict innovation in health care delivery models.
PNPM 2 Element 8 Lines 32-33	We recommend that this element be revised to read: "The program leaders make certain that practitioners practice at the maximum level of their scope of licensure, certification, training, and current competency."	The IOM and FTC have both recognized the value of full practice authority for advanced practice registered nurses and other independent providers. Both have strongly endorsed this position. Programs should be required to make effective and efficient use of their providers in accordance with the recommendations from these bodies. These recommendations are based on solid evidence of the safety and efficacy of care provided by this group or practitioners.
PNPM 2 New Element	We recommend inserting the following new element: "A nursing leader with expertise in perinatal care is responsible for the perinatal nursing care."	CQMC members have received reports that there are leaders of women's health services who do not have expertise in perinatal nursing care. Their lack of familiarity and expertise in this area affects their ability to adequately lead and guide the perinatal nursing care services. As nurses do not report to physicians, having physicians with perinatal expertise is not adequate.
PNPM 3 Element 4 Line 42	We recommend revising this element by adding the underlined text. "…to provide fetal monitoring using continuous cardiotocography, intermittent auscultation, and telemetry." We note as well, that similar	Access to safe alternatives to continuous electronic fetal monitoring (see http://www.ncbi.nlm.nih.gov/pubmed/23728657) will ensure that women can make informed choices about fetal monitoring, and have options for freedom of movement and use of tubs and showers, and reduce the likelihood of operative birth (see http://www.ncbi.nlm.nih.gov/pubmed/23959763).

	requirements for fetal monitoring appear elsewhere in the document. We recommend that conforming edits be made at these points in the documents. See lines 145 and 157.	
PNPM 3 New Element	We recommend inserting the following new element: "The program provides women with continuous labor support, specifically doula care when possible."	Continuous labor support has been shown to reduce cesareans and confer many other benefits. Continuous support can be provided by a nurse, a doula, a family member. See: Hodnett ED, Gates S, Hofmeyr GJ, Sakala C, Continuous support for women during childbirth (Review), The Cochrane Collaboration, The Cochrane Library, 2012, Issue 10, available at: http://www.ncbi.nlm.nih.gov/pubmed/23857334. See also: #3: Continuous Labor Support, Lamaze International Education Council, Barbara Hotelling, BSN, CD (DONA), LCCE, FACCE, and Carol Sakala, PhD, MSP, See http://www.lamazeinternational.org/p/cm/ld/fid=214
PNPM 3 After Element 5 Line 44 New Element	We recommend inserting the following new element: "The program has a registered nurse staffing plan, including an "on-call" or back-up staffing plan, to respond to fluctuations in the volume of women and nurse absenteeism and assure adequate levels of nursing care consistent with national staffing recommendations. The nurse staffing in relation to the number of women receiving care is assessed at regular intervals within a 24 hour period."	See: Guidelines for Professional Registered Nurse Staffing for Perinatal Units, from the Association of Women's Health, Obstetric and Neonatal Nurses, 2010.
PNPM 3 Element 11 Lines 59-61	We recommend editing this item to read: "The program has and follows written policies that support an integrated system of care that provides seamless consultation, collaborative practice, transfer, and transport for both women who need the level of care at the organization and women who need a higher level of care than the organization can provide." The organization's responsibility for care of both incoming and outgoing women and newborns should be integrated throughout the Certification Requirements (e.g., also at PNPM 4, EP 1, line 75 and elsewhere)	An integrated maternity care system is safest for women and newborns. This must address needed care that is beyond the scope of services at the organization as well as needed care that is within the scope of services of the organization and of value to women and newborns whose care originated elsewhere.
PNPM 4 Lines 65-66	We recommend that the introductory text under this Standard be revised to read: "The program uses clinical practices originating from up-to-date systematic reviews and evidence-based national guidelines ~~or expert consensus~~ to deliver or facilitate the delivery of clinical care, treatment, and	"Expert consensus" is not a reliable barometer of the safest, highest quality care, and is often considered to be the lowest level of evidence. Further, current guidelines in the United States often fall short of the standards in the Institute of Medicine report, *Clinical Practice Guidelines We Can Trust.* The abundance of systematic reviews that have assessed the weight of better quality evidence for pregnancy and childbirth care are especially reliable sources about the effects of specific practices. Those that have not been incorporated into clinical practice guidelines should nonetheless be used as resources to

	services. <u>These clinical practices are continually reviewed and updated in written form consistent with best current evidence. Guidelines should be obtained from applicable national professional organizations, including ACOG, SMFM, AAFP, ACNM and AWHONN.</u> Note that a conforming change should be made in PNPM 4, Element 4, line 102 where another reference to "expert consensus" appears.	educate maternity care providers and inform protocols. The various professional groups have different foci of expertise and thus, these programs should draw guidelines from them all.
PNPM 4 Element 1 Line 71	We recommend revising the item on line 71 within this element by adding the underlined text. "The care of mothers and newborns who have been assessed as clinically uncomplicated<u>, including practices which support physiologic labor and birth, breastfeeding and newborn transition.</u>"	70-80% of pregnant women are healthy. Physiologic labor and birth includes practices that support spontaneous labor and birth. Increasing the clinician's appreciation of the complex hormonal cascade of pregnancy and birth and encouraging a philosophical shift or change in paradigm from an illness model toward a prevention and wellness model is important to emphasize in this certification program.
PNPM 4 Element 1 Line 86	We recommend adding the following policies to the existing list under Element 1: -Bereavement Support -Screening and referral for domestic violence -Screening and referral for mental health -Screening and treatment for women and newborns with substance abuse -Triage - Appropriate length of first (both latent and active phase), second, and third stages of labor -Pushing -Non medically indicated elective induction -Initiation of and support for breastfeeding	Each of these additional elements are known to improve outcomes, but are not consistently available to women in the United States. These elements also are more prevention and wellness focused and would help provide balance to the standards.
PNPM 4 Element 3 Lines 94-100	We recommend revising the introductory text of this element to read: "<u>If a normal woman/fetus/baby's risk status increases,</u> the program uses evidence-based protocols for managing conditions that may occur. This includes:"	The proposed Certification Program is focused on "mothers and newborns who have been assessed as clinically uncomplicated." Consequently, it should focus on fostering normal physiologic birth and should specify when other approaches to care are needed.
PNPM 5 New Element After Element 2 Line 114	We recommend inserting the following new element: "The program has an emergency preparedness plan that accommodates the needs of pregnant, laboring, and postpartum women and newborns."	

PNPM 5 Element 5 Lines 126-128	We recommend adding “cervical ripening agents” to the list of pharmaceuticals for which medication management is needed.	See: Hofmeyr GJ, Gülmezoglu AM, Pileggi C., “Vaginal misoprostol for cervical ripening and induction of labour.” Cochrane Database Systematic Review, Oct. 6, 2010.
PNPM 6 New Element	We recommend the following new element: “The program fosters critical appraisal skills and supports clinicians in understanding and valuing better-quality evidence, gaining access to it, and prioritizing its use in clinical care. This includes making good use of the abundant better-quality systematic reviews about effects of pregnancy and birth care practices.”	We encourage The Joint Commission to incorporate into PNPM 6 the spirit and principles of The Sicily Statement on Evidence-Based Practice, available here. The Institute of Medicine has identified systematic reviews as the best way of *Finding What Works in Health Care*.
PNPM 6 Element 4 Line 145	We recommend adding the following critical competencies to the list under element 4: -Care practices that support and sustain physiologic labor and birth and newborn transition -Clinical drills to help staff prepare for high risk events with a low rate of occurrence - Clinical drill debriefings to evaluate team performance and identify areas for improvement. See also PNPM 3, element 4, line 42 to address appropriate options for fetal monitoring in this population.	Supports a shift toward preventing harms to mothers and infants and processes to enhance learning and identify areas for improvement based on drills and emergencies.
PNPM 6 Element 6 Line 152	We recommend adding the following critical competencies to the list under element 6: -Care practices that support and sustain physiologic labor and birth and newborn transition	
PNPM 6 Element 6 Lines 153 and 161	The items in Element 6 on lines 153 and 161 refer to “high risk” events. We recommend revising this language to substitute “unexpected” for the term “high risk.” Careful consideration should be given to the use of the term “high risk” throughout the document to ensure that the focus of the Certification Program on normal pregnancy is not lost. A review of the document, looking for this term and revising it appropriately is recommended.	These Certification Requirements are meant to focus on uncomplicated births, which should be at the core of these Requirements.
PNPM 6 Element 6 Lines 156-157	We recommend inserting the underlined text: “-The use of reVITALize and other standardized ….”	For more about reVITALize, see here.
PNPM 6	We recommend specifying that	Drills are one of many possible approaches to safety and

Element 6 Lines 161-162	the program routinely engages in safety practices such as simulation, medication safety systems, team building and facilitation (including encouraging all staff to speak up to improve quality and safety), safety and emergency preparedness courses, and analysis of adverse events and liability claims.	readiness for unexpected situations. For an inventory of quality improvement and safety practices that have been used in maternity care, see http://transform.childbirthconnection.org/wp-content/uploads/2013/01/CC_Table_MaternityCareQuality.pdf See also: Audrey Lyndon, et. al., “Predictors of likelihood of speaking up about safety concerns in labour and delivery,” *BMJ Quality & Safety,* 22 (2): 182.
PNPM 6 New Element	To foster normal physiologic birth, we recommend that a new element be added, that reads thus: “Program leaders should ensure that providers possess, retain, and make available essential skills and knowledge for supporting normal physiologic birth.. These should include: 1. External cephalic version 2. Skilled assisted vaginal birth (forceps and vacuum) 3. Vaginal birth after cesarean 4. Vaginal breech birth 5. Vaginal twin births 6. Intermittent auscultation 7. Non-pharmacologic comfort measures 8. Labor progress measures	These evidence-based practices foster safety when they avoid the need for surgery and enable care providers to respond competently to unexpected situations. They are a hallmark of woman- and family-centered care as they enable women to make informed choices among evidence-based care options. This is an example of a way that the planned certification can help women and the public to identify an exemplary service.
PNPM 7 Element 2 Line 191	We recommend listing licensed social workers and nurse case managers on separate lines. We further recommend that behavioral health/mental health professionals be added to the list on a distinct line.	LCSWs and RNs perform distinct functions. It is important to disaggregate them to reinforce the idea that the program makes provision for the distinct services these two types of providers supply. With regard to behavioral health/mental health, postpartum depression and other mental health conditions are serious issues. It is important for perinatal care programs to be able access the services of these professionals.
PNPM 7 Element 2 Line 198	We recommend editing the item on line 198 thus: “Nurse(s) <u>or other licensed independent practitioners</u> with appropriate training or experience in perinatal care to conduct staff education and development.”	Certified Midwives are not technically nurses, though they obtain the same midwifery education and certification as do Certified Nurse-Midwives. There may also be other practitioners who could appropriately provide education to a perinatal team. The specific language of this item limits who can provide such education to nurse(s).
PNPC 1 Element 7 Lines 235-236	We recommend adding examples of community services: “, including mental health breastfeeding, food assistance, social work, and support for women facing domestic violence.	These address common experiences. Helping women access and use these services would be an essential component of an exemplary perinatal care organization.
PNPC 2 Element 1 Line 242	We recommend inserting the underlined words: “The program discusses with <u>women</u> how they want to receive information, including the type and extent of information, <u>their preferred communication method</u>	

	(including personal health record, phone call, email, paper-based/written), and their preferred language. We recommend adding the following sentence to this element: "The program ensures that non-English speakers and hearing impaired women have access to language services, including a language line."	
PNPC 2 Element 5 Lines 249-251	We recommend editing this element to read: "The program regularly engages women (and family members, as appropriate) in shared decision making processes that: provide better-quality information about care options and the possible benefits and harms of each (including the option of watchful waiting), help women consider their values and preferences relative to the care options; and support women's informed personalized care decisions. This applies to **all** decisions about their care and the care of their newborns." In addition, we recommend that this element require that the program has a written protocol and SOP for women who disagree with medical advice after proper informed consent and be required to continue caring for such women with compassion and respect regardless of their decisions.	Shared decision making is increasing recognized as the optimal way to engage women in their care decisions. These processes and use of available high-quality decision aids and related tools would be a hallmark of a high-performing program.
PNPC 3 Element 1 Line 260	We recommend insertion of the underlined words: "The documented plan of care is developed together with the woman and her family, based on their assessed …."	For a consumer perspective on care plans that has been endorsed by 20 organizations, please see http://www.nationalpartnership.org/research-library/health-care/HIT/consumer-principles-for-1.pdf. We encourage The Joint Commission to draw on these principles.
PNPC 3 Element 3 Lines 263-264	We recommend the following underlined edits: "The program provides care, treatment, and services in a manner that meets the woman's communication needs. This includes recognizing and addressing her language preferences, and level of understanding and knowledge."	Proposed edits use more woman-friendly designation that reflects the health status of most childbearing women and those that this certification programs addresses and add the importance of access in her preferred language.
PNPC 3 Element 5 Line 278	We recommend this element be reworded to focus on actual implementation of the woman's plan of care. It should read thus: "The program makes specific efforts to accommodate the woman's cultural and	See: Halfon, N., et. al., "Lifecourse health development: past, present and future," in *Maternal Child Health Journal*, vol. 18, no. 2, February 2014, pp. 344-65. See also: "Rethinking MCH: The Life Course Model as an Organizing Framework," Concept Paper, U.S. Department of Health and Human Services, Health Resources and Services

	reproductive preferences and birth plan while providing care, treatment, and services from a life course perspective."	Administration, Maternal and Child Health Bureau, November, 2010, Version 1.1
PNPC 3 New Element	We recommend inserting a new element under this standard. "The program has equipment, trained staff and policies and procedures that support women who opt for normal physiologic birth, without labor augmentation, pain medications, and related interventions."	Since the Certification Program focuses on uncomplicated pregnancies, its focus should be on fostering normal physiologic birth.
PNPC 3 New Element	We recommend that, whether the program has a Baby-Friendly designation or not, the program consistently demonstrates the ten Baby-Friendly Hospital Initiative steps.	This is another important way that programs with the Certification can signal to women and the public that they are providing exemplary care.
PNPC 4 New Element	We recommend adding: "The interdisciplinary program team obtains social assessment information and environmental barriers relevant to the woman's ability to achieve her individualized plan of care."	This is an important prerequisite for assisting women in accessing community resources, per line 235 in PNPC 1.
PNPC 5 Element 1 Lines 317-318	We recommend that the following be added to the language of this element: "Care plans should be developed in cooperation with the woman. The program should ensure that the woman has access to clinical evidence related to the potential benefits and harms of the various possible interventions and that she takes this into account when developing her care plan.	Many women are not aware of the known potential harms of the various interventions they may experience. Without access to appropriate information to inform her choices, a woman may inadvertently accept interventions that she would otherwise decline.
PNPC 5 Element 2 Line 319	We recommend that the language of this element be revised thus: "The program implements interventions based on priority and risk, <u>in accord with evidence-based criteria.</u>	
PNPC 5 Element 5 Line 346	We recommend revising this element by adding the underlined text. "…transfer of medical information <u>before and after transfer</u>."	The mother may not have been transferred with the baby. The clinical teams will benefit from hearing periodic updates about the mother and baby who are transferred and get feedback on their outcomes.
PNPC 5 New Element	We recommend inserting a parallel element to #5 to enable the program to be on the receiving end of women and babies who need a higher level of care.	A fully integrated system is safest for women and babies and respectful of women's care choices. The program should be able to offer consultation, collaborative care, transfer of care, and transport in from lower level hospitals, birth centers, and planned home births. Just as the program needs places to help women and babies whose situation falls outside of its scope of care, so do others have need for the program's scope of care.
PNPC 5 Element 7 Lines 348-353	We recommend that the following item be added to those appearing under Element 7: - An established referral system is in place for follow up by mental	

	health professionals, and women are provided with written referrals with specific details to ensure timely follow up if need be.	
PNPC 5 Element 9 Lines 355-362	We recommend that the reference to financial counseling be revised to read thus: "Financial counseling, including assistance in understanding their insurance policy terms and responsibilities." We recommend adding a new item: "Community resources and supports (e.g., transportation, interpretation, child care, and health education)	
PNPC 5 Element 10 Line 363	We recommend that the text of this element be revised to read thus: "The program provides evidence-based education, training, and support to the woman in a manner that is comprehensible and fosters health literacy."	It is important that women be provided with evidence based education, rather than simple guidance about the program's protocols and practices. This enables women to make informed choices about their care.
PNPC 6 Element 1 Line 376	We recommend inserting the underlined word: "The program implements its process of electronically exchanging …." We also propose inserting a cross-reference to the new proposed element in PNIM 2 for using electronic health records and meeting Meaningful Use requirements.	This is the standard of care and a core element of national health care policy. This makes clinical information available at multiple sites of care (which is highly relevant to this population), helps measure performance, and facilitates communicate with members of the team including women themselves.
PNPC 7 Line 403	We recommend that the text of this line be revised to state that with discharge a comprehensive perinatal care center should include contraception decision making and counseling about birth spacing, which may involve provision of contraception prior to discharge or follow up plans or appointments to address contraception.	
PNIM 2 New Element	We recommend adding: "Facilities of programs use certified electronic health records and meet requirements for meaningful use of electronic health records."	This is the standard of care and a core element of national health care policy. This makes clinical information available at multiple sites of care (which is highly relevant to this population), helps measure performance, and facilitates communicate with members of the team including women themselves. Ultimately, facilities should meet requirements of Meaningful Use Stage 3. Initially, they should meet a high bar that applies to the present environment.
PNIM 2 Element 3 Line 461	We recommend inserting at the end of this element: "and language preferences."	
PNIM 2	We recommend that a new	Birth certificates are used to describe the population of

New Element	element to this standard be added thus: "The program ensures that the birth certificate accurately reflects the medical record, including proper identification of the rendering provider."	childbearing women and newborns, their care, and trends over time. They are used for research, and they shape policies. Validation studies identify errors on birth certificates, including undercounting of many elements. An exemplary perinatal care program will have explicit procedures to foster accurate recording of birth certificates.
PNIM 3 New Element	We recommend that perinatal care programs have health information capabilities to have bidirectional communication with county/local, state, and national data sets, where keepers of such data sets are capable of such bidirectional communication. This will foster not only for continuity of care, but also benchmarking and continuous checks and balances.	
PNIM 3 Element 4 Lines 474-478	We recommend that this element include a requirement that the program communicate to both the woman's and the newborn's primary care provider or clinic a summary statement about the full episode of perinatal care and condition after the birth. Optimally, this is included within their continuing electronic health records.	The reference to "the physician's office has access to the postpartum patient information" is vague. If, as we believe, this is with reference to the primary care provider or site of the woman and the baby, then our proposed language is more precise and also more encompassing of primary care that may be provided by others, such as a nurse-practitioners.
PNIM 3 New Element	We recommend adding: "Women are given online access to their own health information and that of their newborn.	This is the standard of care and a core element of national health care policy. It is crucial that a high-quality program facilitates safe and secure sharing of information, not just between providers, but with women and families. Women value and are highly likely to use this capability, and it adds transparency to the system. It offers the ability to identify and correct errors, provide more complete information in the record, better understand health conditions, keep up with medications, and strengthen relationships with care providers.
PNIM 5	We recommend clarifying that this standard is with reference to information needs of health professionals, if this is the intention.	
PNPI 1 Element 5 Lines 502-503	We recommend that the data related to the performance improvement plan be communicated to organizational leaders quarterly.	More frequent review is likely to result in course corrections more quickly.
PNPI 1 Element 8 Line 507	We recommend the language of this element be revised thus: "Women have a defined role in the evaluation of the provision of care, treatment and services. Women's input is provided in real time or other frequent basis."	
PNPI 1 New Element	We recommend that a new element be added to this standard requiring programs to have in place mechanisms to identify and curb incidence of overuse and unwarranted practice variation.	It has long been recognized that many interventions used during the perinatal period occur at varying rates, depending on geography, facility and individual provider practice patterns. (See, for example, "Kozhimannil, Law and Virnig, "Cesarean delivery rates vary ten fold among hospitals; Reducing variations may address quality and cost issues, in

		Health Affairs, vol. 32, no. 3, March 2013, pp. 527-35). See also, data on early elective deliveries provided by the Leapfrog group at: http://www.leapfroggroup.org/tooearlydeliveries
PNPI 2 Element 1 Line 527	We recommend adding the following item to the list under Element 1: -Severe maternal and neonatal morbidity	Morbidity is also important to measure, especially given how rare maternal mortality is.
PNPI 2 Element 2 Lines 528-536	We recommend that the program be required not only to collect data with regard to The Joint Commission's Perinatal Care core performance measures, but also be required to set specific performance goals related to those measures and document improvement as an element of retaining certification.	Data gathering is the first step in quality improvement. It is necessary to act on those data to improve care. As these nationally standardized measures will now be collected and reported in all areas of the country by most US hospitals with maternity units, it is very important to use them to drive improvement. The Perinatal Care Certification program provides an important opportunity to leverage such improvement.
PNPI 2 Element 2 Lines 528-536	We recommend that The Joint Commission also include the NQF-endorsed Healthy Term Newborn measure in the list of performance measures for which the program collects data. Note that this measure is being improved and renamed as Unexpected Newborn Complications.	This measure examines the percent of term singleton live births (excluding those with diagnoses originating in the fetal period) who DO NOT have significant complications during birth or the nursery care. It is a useful measure for evaluating how well the hospital is performing with regard to the quality of its perinatal services. (The revised version conversely identifies the proportion of low-risk newborns that experience complications during or shortly after birth.)
PNPI 2 Element 6 Line 540	We recommend that this be edited to change "patient satisfaction" to "the woman's experience of her own and her newborn's care".	There is now consensus that the broader concept of the "experience" of people receiving care supersedes prior focus on "satisfaction." That is the focus of the CAHPS surveys, which are integrated into national health policy. Unfortunately, the CAHPS facility, provider, and health plan surveys either fail to capture the experiences of this population or do not adequately do so. There is a need for Maternity CAHPS adaptations of the generic facility, provider, and health plan surveys. In the meantime, the CAHPS supplemental item sets offer perinatal services an opportunity to measure care from such perspectives as health literacy, health information technology, and cultural competence.
PNPI 3 New Element	We recommend the following new element: "The program stratifies data by disparity variables (e.g., race/ethnicity, language, socioeconomic status, disability status, sexual orientation, and gender identity) to identify and address any health disparities present in the population receiving care."	A high-performing program will actively work to recognize, measure, and reduce disparities. Certified programs should meet this standard.
PNPI 5 Element 1 Line 565	Access to appropriate levels of care and scope of services is bidirectional. This is an essential responsibility of a Perinatal Care program that is certified as meeting high standards of care.	Please see previous comments, e.g., at PNPC 5 New Element, and PNPM 3 Element 11, PNPI 2 Element 6.
PNPI 6 Line 587 New Elements	We recommend that two new elements be included thus: 1. Programs should have a mechanism and protocol for	Many major professional associations, including ACOG and AAFP, have identified disclosure to the harmed person and family as the standard of care.

	reporting sentinel events to affected women and families. 2. Patients should have a written protocol for grievance/complaints, including corporate compliance processes.	

Again, thank you for providing us with this opportunity to comment on this very important document, which has the potential to improve birth for the majority of women, who have uncomplicated pregnancies and deliveries. Should you have any questions, please feel free to contact me at jbushman@acnm.org or 240-485-1843.

Signatory Organizations
American Association of Birth Centers
American College of Nurse Midwives
Association of Women's Health, Obstetric and Neonatal Nurses
Centering Healthcare Institute
International Center for Traditional Childbearing
Lamaze International
National Association of Certified Professional Midwives
National Partnership for Women & Families
United States Breastfeeding Committee