NPIC

National Perinatal Information Center

CONTINUING EDUCATION

Perinatal Care (PC) Core Measures: Updates for 2022

Chris Walas, MSN, RN
Managing Project Director, Clinical
Department of Quality Measurement, The Joint Commission

Kelley Franklin, MSN, RN
Associate Project Director
Department of Quality Measurement, The Joint Commission

EMPOWERED by Data. CONNECTED by Purpose.

NPIC.ORG

Learner Outcome & Contact Hour

Purpose/Goal(s) of this Education Activity

The purpose/goal(s) of this activity is for participants to be able to verbalize changes and updates to Joint Commission Perinatal Care core measures, standards, reporting and documentation.

1.5 Contact Hour(s)

This nursing continuing professional development activity has been approved by the Northeast Multistate Division Continuing Education Unit, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Disclosures & Successful Completion

- There is no commercial support being received for this activity.
- No individuals in a position to control content for this activity has any relevant financial relationships to declare.
- There will be no discussion of off-label usage of any products.
- To successfully complete this activity and receive 1.5 Contact Hour(s)/1.0 *AMA PRA Category 1 Credit™* you must attend/watch the program and submit the completed post-test/evaluation to NPIC.

Continuing Medical Education (CME)

1.0 *AMA PRA Category 1 Credit™*

CME credit is provided for select programs through a partnership with Women & Infants Hospital of Rhode Island (WIHRI).

This activity fulfills core competencies for Continuing Medical Education credit.

Accreditation: Women & Infants Hospital is accredited by the Massachusetts Medical Society to sponsor intrastate continuing education for physicians. Women & Infants Hospital designates this online educational activity for a maximum of 1.0 *AMA PRA Category 1 Credit™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This activity qualifies for 1.0 Risk Management Credit.

Thank You For Attending

REMINDER:
DO NOT CLOSE YOUR BROWSER WINDOW

- You will be redirected to the post-test and evaluation once the webinar has ended
- Certificates of attendance and completion will be sent to the email address provided at registration within 14 business days following post-test/evaluation submission to NPIC

Chris Walas, MSN, RN, Managing Project Director
Department of Quality Measurement The Joint Commission

Kelley Franklin MSN, RN, Associate Project Director Department of Quality Measurement The Joint Commission

The Joint Commission Perinatal Care (PC) Measures Updates 2022

National Perinatal Information Center Webinar

December 7, 2022

The Joint Commission

The Joint Commission Disclaimer

- These slides are current as of 11/14/2022. The Joint Commission reserves the right to change the content of the information, as appropriate.

Objectives

- Discuss the Perinatal Care (PC) measures updates
- Review PC measures reporting requirements
- Describe the Perinatal Care (PC) measures, key data elements and recent revisions to the measures
- Discuss ePC07 measure and key data elements
- Identify some of the resources available for improving perinatal care

Introduction

The Joint Commission

An independent, not-for-profit organization founded in 1951

NOT a “regulatory agency”

The nation's oldest and largest standards-setting and accrediting body in health care

Certifies and accredits over 22,000 health care organizations and programs in the United States

Joint Commission International is in > 100 countries worldwide

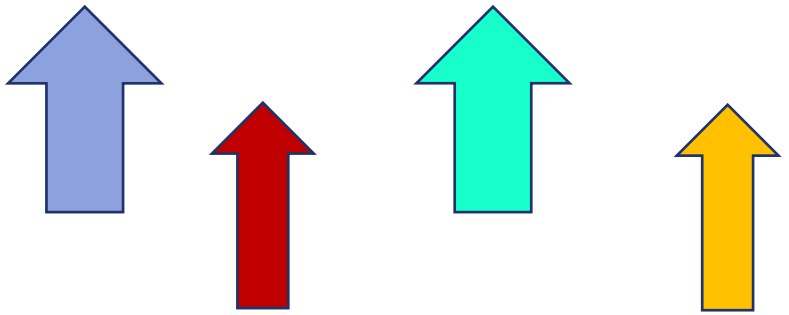
Mission and Vision

- Mission: To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.
- Vision: All people always experience the safest, highest quality, best-value health care across all settings.

We have accreditation programs for hospitals, nursing care centers, home care, behavioral health, ambulatory care, laboratories, and office-based surgery

Our Levers to Improve Care

- Standards
  - Assess during on-site survey
- Performance Measures
- Share leading practices, including high reliability solutions
- Publications: Sentinel Event Alert, Quick Safety, Joint Commission Journal on Quality and Patient Safety



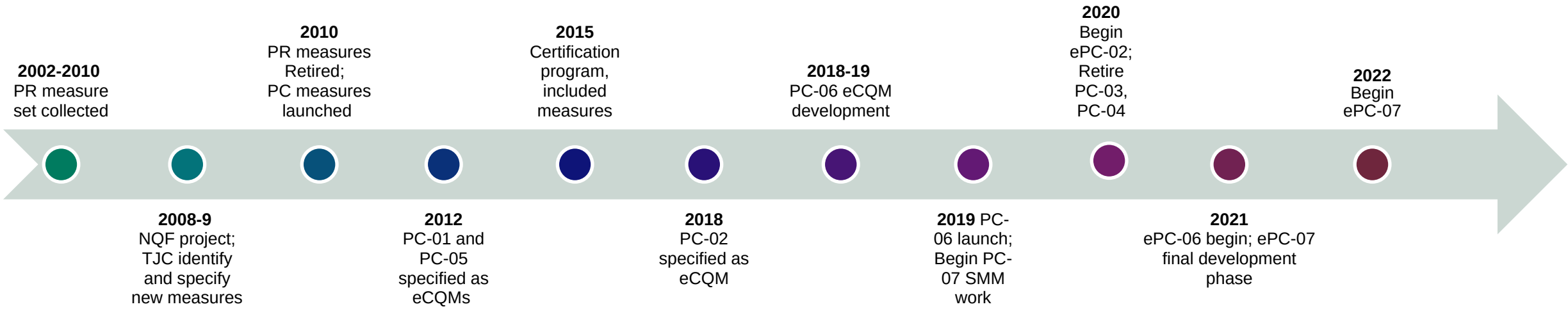
The Joint Commission

Certification

- Deeper look at quality and safety for a specific condition or procedure than what is done during accreditation
- Addresses the questions, I know the (health care organization) is safe because it is accredited, but:
  - How well does this doctor/center care for people with my condition? (measures)
  - How well does this doctor/center perform the surgery/procedure I need? (measures)
  - Do they have all the essential resources to care for me in any eventuality? (standards)

Perinatal Measures Project

Perinatal Care Measures Project History



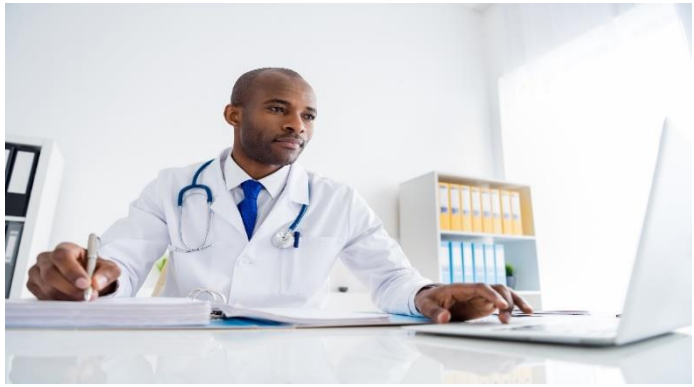
Perinatal Care (PC) Measures – Chart Based

- **PC-01** Elective Delivery
- **PC-02** Cesarean Birth
- **PC-05** Exclusive Breast Milk Feeding
- **PC-06** Unexpected Complications in Term Newborns

The Joint Commission

Electronic Perinatal Care Measures (ePC)

- ePC-01 Elective Delivery
- ePC-02 Cesarean Birth
- ePC-05 Exclusive Breast Milk Feeding
- ePC-06 Unexpected Complications in Term Newborns
- ePC-07 Severe Obstetric Complications



Key Measure Activity

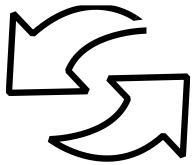
National Quality Forum (NQF) measure endorsement:

- NQF endorsed
  - PC-01 Elective Delivery
  - ePC-01 Elective Delivery
  - PC-05 Exclusive Breast Milk Feeding
  - ePC-05 Exclusive Breast Milk Feeding
  - PC-02 Cesarean birth
  - PC-06 Unexpected Complications in Term Newborns (CMQCC steward)
- Pending NQF endorsement 2022
  - ePC-02 Cesarean Birth
  - ePC-07 Severe Obstetric Complications

Advanced Certification in Perinatal Care (ACPC)

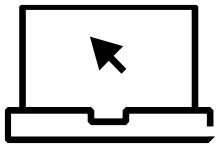
- Developed in collaboration with ACOG
- Launch date January 1st, 2023
- Available for pre-application currently
- Supports the enhancement of integrated, coordinated and patient-centered care that begins with prenatal care and continues through postpartum care
- Components include:
  - Benchmarks for performance
  - Conducting tracer activities during on-site review
  - Evaluating consistent communication and collaboration among all healthcare professionals involved in caring for pregnant, postpartum, and newborn patients
  - Demonstrating application of and compliance with clinical practice guidelines or evidence-based practices
  - Collecting data on Perinatal Care program measures

ACPC Eligibility Requirements - Measures



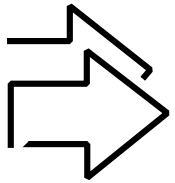
Volume

- Minimum of 40 deliveries per year
- Minimum of 30 total denominator cases for calculating aggregate performance rates for threshold requirements



Data Collection

- All chart-abstracted Perinatal Care Core Measures (PC-01, PC-02, PC-05, PC-06)
- 4 months of data at initial certification review
- 24 months of data at recertification



Threshold Requirements

- PC-02 aggregate performance rate 30% or less
- PC-06 Severe Rate less than 50/1000 live births

ACPC Measure Reports

- Trend Reports in CMIP provide organizations with their numerator and denominator cases
- Future Development
  - PC Dashboard in JC Extranet Site
  - Accelerate PI reports will provide aggregate rates for rolling 12 months of data
  - Additional visual graphs/charts for PC data
  - Comparison data when enough data available

Maternal Levels of Care (MLC): General Program Overview

The voluntary MLC product has been developed in collaboration with ACOG, utilizing the Levels of Maternal Care (LoMC) Obstetric Care Consensus from 2019.

- Level I (basic care)
- Level II (specialty care)
- Level III (subspecialty care)
- Level IV (regional perinatal health care centers)

**Each level builds upon the previous level requiring organizations to demonstrate a higher level of capability.

The Joint Commission will conduct on-site surveys every 3 years. The program is designed to verify organizational services, skills and capabilities.

MLC is open to any acute care hospital and critical access hospital who is otherwise in compliance with CoPs and federal laws.

The purpose of MLC is to establish a complete and integrated system of perinatal regionalization and risk-appropriate maternal care using a classification system for the purposes of reducing maternal morbidity and mortality.

Requirements

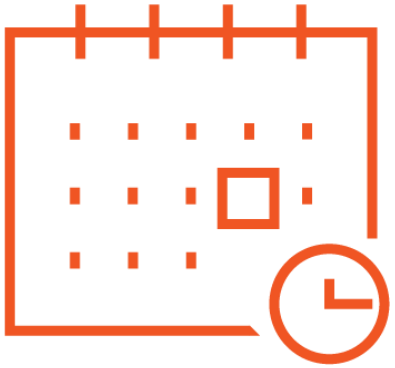
Performance Measurement: Accreditation

- The Joint Commission's ORYX® initiative integrates performance measurement data into the accreditation process.
- ORYX measurement requirements support Joint Commission-accredited organizations in their quality improvement efforts.
- The Joint Commission continues to align measures as closely as possible with the Centers for Medicare & Medicaid Services (CMS).

Direct Data Submission Platform (DDSP)

- A new Joint Commission DDSP was built and went live in the second half of 2022. This platform is used for accreditation data.
- Certification data is reported in the CMIP tool.

2022 ORYX® Performance Measurement Timeline



- December 31, 2022 DDSP closes for all remaining quarters of 2021 chart-abstracted entries
- January 2, 2023 DDSP opens for CY2022 chart-abstracted entry for all 4 quarters
- April 30, 2023 DDSP closes for chart-abstracted entry for CY2022
- May 1, 2023 DDSP opens for chart-abstracted entry of CY2023 1Q2023 (Jan, Feb, March)

The Joint Commission

2023 ORYX® Requirements Document

	ORYX OVERVIEW: HAP & CAH FACILITIES ORYX DATA SUBMISSION REQUIREMENTS			
# (Link)	**HAP & CAH: Facility Size/Type**	**Chart-abstracted Measure Requirements**	**Electronic Clinical Quality Measure (eCQM) Requirements**	**Notes**
1	Hospitals (HAP) with ≥26 Licensed beds ***OR*** ≥50,000 Outpatient visits *AND:*		Select a minimum of four (4) eCQMs, reporting the same eCQMs for all (4) four quarters as applicable to patient population/ services offered.[3] There are 16 available eCQMs for CY2023.	- Additional measures are available for submission based on patient population/services offered. - [1]HCOs can submit associated eCQMs instead of chart-abstracted Measures to meet their PC measure requirements. - [2]HCOs that do not provide Obstetrical Services are not required to submit alternate chart-abstracted measures but may do so if they wish. - [3]If unable to submit eCQMs, HCOs must request an extenuating circumstance exemption from TJC and will be required to submit three (3) chart-abstracted measures for all four (4) quarters of CY2023.
	• 300+ live births annually	PC-01, PC-02, PC-05, PC-06[1]		
	• 1-299 live births annually	PC-01[1]		
	• Do not provide Obstetrical Services	None[2]		
2	Hospitals (HAP) with <26 Licensed beds **AND** <50,000 Outpatient visits (Small Hospitals)	Submit any combination of three (3): - chart-abstracted measures for all four (4) quarters - and/or eCQMs for all (4) four quarters as applicable to patient population/services offered		- May elect to submit additional measures based on patient population/services offered.
3	Critical Access Hospitals (CAH)	Submit any combination of three (3): - chart-abstracted measures for all four (4) quarters - and/or eCQMs for all (4) four quarters as applicable to patient population/services offered		- May elect to submit additional measures based on patient population/services offered.
4	Freestanding Psychiatric Hospitals (HAP)	HBIPS-2, HBIPS-3, HBIPS-5	N/A	- IMM-2, TOB-2, TOB-3, SUB-2, SUB-3 are available as additional chart-abstracted measures
5	Free-standing Children's Hospitals	ORYX Performance Measurement reporting requirements are suspended for these Hospital Accreditation Programs.		
	Long Term Acute Care Hospitals (LTACHs)			
	Inpatient Rehabilitation Facilities (IRFs)			
	HCOs in PPS-Exempt-Cancer Hospital Quality Reporting (PCHQR) Program			

Resources

a. Joint Commission Website - Measurement: https://www.jointcommission.org/measurement/reporting/accreditation-oryx/
b. Joint Commission Measure Specifications (both eCQM and chart-abstracted): https://www.jointcommission.org/measurement/specification-manuals
c. Joint Commission Measure Data Submission Timeline: https://www.jointcommission.org/measurement/resources *(under supporting materials)*

Specifications, Updates and Key Elements

Chart Abstracted Measure Manual

Updated twice per year

- Posted around Feb 1st and Aug 1st
- Effective for discharges July 1st or Jan 1st

Complete Measure Manual and Release Notes are available at:
https://manual.jointcommission.org

Initial Patient Population: 2 Subpopulations

Mothers

- PC-01 Elective Delivery
- PC-02 Cesarean Birth
- PC-07 Severe Obstetric Complications

Newborns

- PC-05 Exclusive Breast Milk Feeding
- PC-06 Unexpected Complications in Term Newborn

Sampling

Sampling allowed

- PC-01 Elective Delivery
- PC-02 Cesarean Birth
- PC-05 Exclusive Breast Milk Feeding

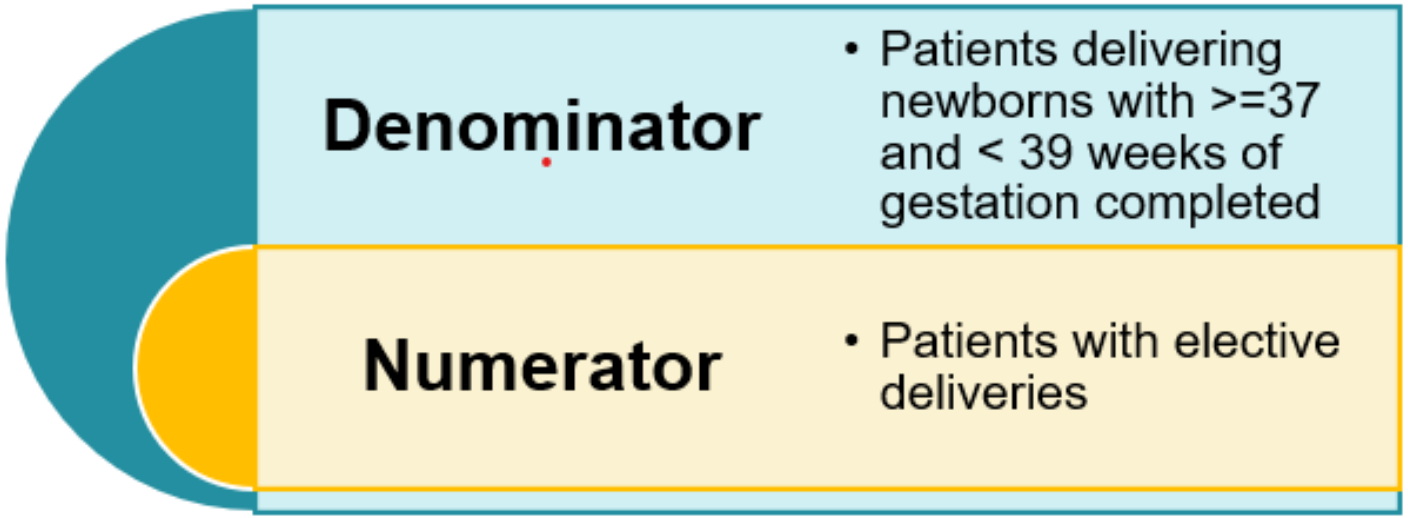
No Sampling

- PC-06 Unexpected Complications in Term Newborn
- ePC-07 Severe Obstetric Complications*

*Sampling is not allowed for any eCQM

PC-01 Elective Delivery

Description: Elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed



Denominator Population

Included Population:
• Procedure Codes for Delivery- Appendix A, Table 11.01.1
• Diagnosis Codes for Planned Cesarean Birth in Labor- Appendix A, Table 11.06.1
Excluded Population:
• Diagnosis Codes for Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation- Appendix A, Table 11.07
• < 8 years of age
• >= to 65 years of age
• LOS >120 days
• Gestational Age < 37 or ≥ 39 weeks or UTD
• History of prior stillbirth

Numerator Population

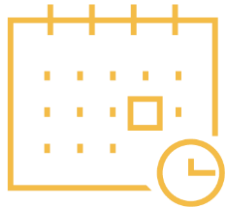
Included Population:
• Procedure Codes for Medical Induction of Labor- Appendix A, Table 11.05 while not in *Labor*
• Cesarean Birth- Appendix A, Table 11.06 and all of the following: not in *Labor* and no history of *Prior Uterine Surgery*
Excluded Population:
• None

The Joint Commission

Table Number 11.07:
Conditions Possibly Justifying Elective Delivery

- Codes for PC-01 are guided by the ACOG Committee Opinion for Medically Indicated Late-Preterm and Early-Term Deliveries.
- Because medical conditions are varied and some conditions are uncommon or rare, it is impossible to enumerate 100% of the potential circumstances that could justify an early term delivery.
- This guidance supports the rationale for not expecting this measure to consistently reach 0% elective deliveries

Gestational Age (PC-01, 02)



- Defined as best obstetrical estimate (OE) which includes:
  - All perinatal factors & assessments
  - Ultrasound (earlier better)
- Completed weeks of gestation, days < 6 are rounded down
- UTD should be selected if no GA documented e.g. patient had no prenatal care
- Document closest to or at the time of delivery
- Calculated and documented by the clinician, not abstractor
- Vital records reports, delivery logs or clinical information systems acceptable data sources

Gestational Age Clarification

Review First: delivery **OR** operating room record (document closest to delivery)

Documentation of a valid number should be abstracted.

If the gestational age in the delivery or operating room record is

- missing
- obviously incorrect (in error, e.g., 3.6)
- or there is conflicting data within the same document

Then continue to review the following data sources, starting with the document completed closest to or at the time of the delivery until a positive finding for gestational age is found:

- History and physical
- Clinician admission progress note
- Prenatal forms

Gestational age documented closest to or at the time of the delivery (not including the newborn exam) should be abstracted.

Labor (PC-01)

- Checked for BOTH “induction” & cesarean birth
- Documentation of labor or **regular** contractions w/ or w/o cervical change
- Methods of induction may include: Oxytocin, AROM, cervical dilation, ripening agents, membrane stripping
  - Descriptors not required to be present, may include: active, spontaneous, early, latent. Prodromal labor is not considered yes for Labor.

Documentation

Labor and PROM

- Labor is determined by the Labor data element not by a code set
- ICD-10-CM diagnosis codes on Table 11.07 should be used for premature rupture of membranes (PROM) which is a spontaneous rupture of membranes before the start of labor
    - Codes O42.011, O42.012, O42.013, O42.02, are used when onset of labor is within 24 hours of spontaneous rupture
    - Codes O42.911, O42.912, O42.913 and O42.92 are for when there is an unspecified length of time between spontaneous rupture and onset of labor, for example no labor documented so unable to specify the amount of time between spontaneous rupture and labor
    - Codes O42.111, O42.112, O42.113 and O42.12 are for when onset of labor is more than 24 hours following spontaneous rupture
- Membrane rupture that occurs before 37 weeks of gestation is referred to as preterm PROM
- Membrane rupture that occurs at 37 weeks of gestation or later is referred to as full-term PROM
- Coding guidance should be followed to determine applicable codes

Prior Uterine Surgery (PC-01)

The only prior uterine surgeries considered for the purposes of the measure are:

- Prior classical cesarean birth which is defined as a vertical incision into the upper uterine segment
- Prior myomectomy
- Prior uterine surgery resulting in a perforation of the uterus due to an accidental injury
- History of a uterine window or thinning or defect of the uterine wall noted during prior uterine surgery or during a past or current ultrasound
- History of uterine rupture requiring surgical repair
- History of a cornual ectopic pregnancy
- History of transabdominal cerclage
- History of metroplasty and/or prior removal of vestigial horn with entry into the uterine cavity
- Prior uterine incision with descriptors including "high" or "vertical" or "mid" or "active segment" or "classical".

Prior Uterine Surgery (cont.)

Exclusions from data element:

- Prior cesarean birth without specifying type
- Prior low-transverse cesarean birth
- Hx of an ectopic pregnancy w/o specifying cornual
- Hx of a cerclage w/o specifying transabdominal

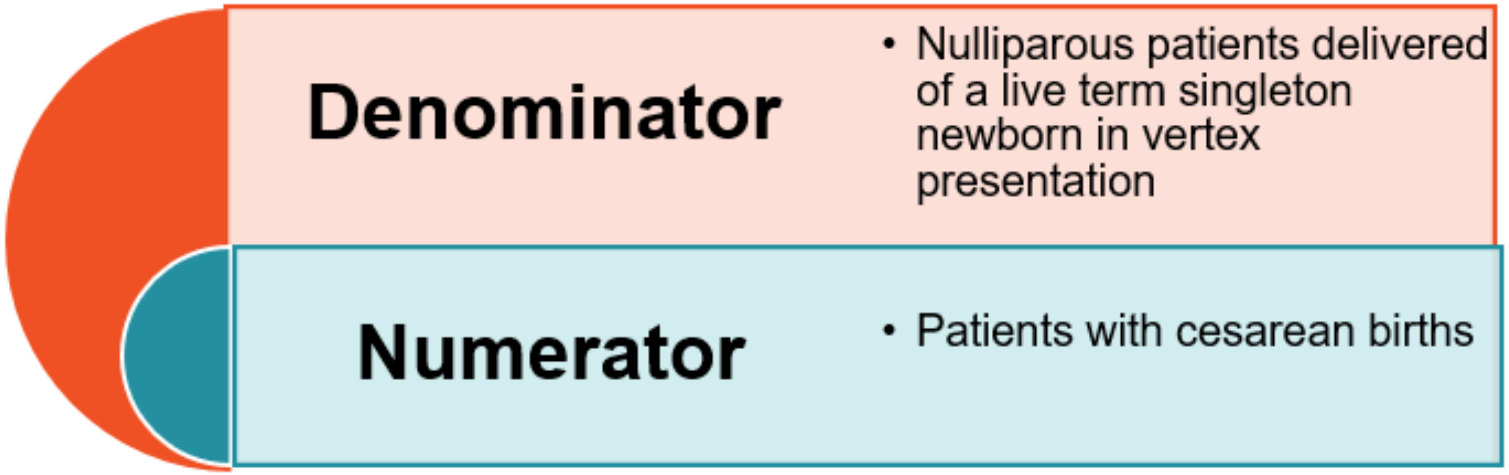
PC-01 Updates

- v2022A1 Discharges 01-01-22 (1Q22) through 06-30-22 (2Q22)
  - Added Respiratory Codes to Table 11.07 Conditions Possibly Justifying Elective Delivery

- v2022B Discharges 07-01-22 (3Q22) through 12-31-22 (4Q22)
  - Updated reference: Kilpatrick, S. J., Papile, L.-A., & Macones, G. A. (Eds.). (2017). Guidelines for perinatal care (8th ed.). American Academy of Pediatrics.
  - Labor data element changing preterm to premature rupture of membranes.

PC-02 Cesarean Birth

Description: Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth



The Joint Commission

Denominator Population

Included Population:
• Procedure Codes for Delivery- Appendix A, Table 11.01.1
• Nulliparous patients
• With Principal or 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 Population:
• Diagnosis Codes for Multiple Gestations and Other Presentations- Appendix A, Table 11.09
• < 8 years of age
• >= to 65 years of age
• LOS >120 days
• Gestational Age < 37 wks or UTD

The Joint Commission

Numerator Population

Included Population:

- Principal or Other Procedure Codes for Cesarean Birth- Appendix A, Table 11.06

Excluded Population:

- None

The Joint Commission

Table Number 11.09:
Multiple Gestations and Other Presentations

- The ICD-10 codes for the exclusion criteria were chosen to ensure that the target population would be women with nulliparous, term, singleton, vertex (NTSV) pregnancies
- PC-02 is Cesarean Birth however some refer to it as “low-risk”
- The code table does not include codes to exclude high risk conditions

Documentation

- Confusion between PC01 code Table 11.07 and PC-02 code Table 11.09
- Criteria and measure intent are different for these tables
- Table 11.07 Conditions Possibly Justifying Elective Delivery include codes for maternal health conditions
- Table 11.09 Multiple Gestations and Other Presentations includes codes which target the NTSV population
  - Nulliparous
    - Term
    - Singleton
    - Vertex Position

PC-02 Cesarean Birth Public Reporting

- Public reporting on Quality Check began January 2021
- Three criteria used to determine PC-02 rating:
  1. ≥ 30 cases reported in both years
  2. PC-02 rate >30% for the current year
  3. Overall 24-month aggregate PC-02 rate >30%
- Hospitals will be identified with either a plus (+) or minus (-) symbol
  - Plus (+) symbol signifies a hospital has an acceptable rate.
  - A minus (-) symbol signifies the hospital's rate is consistently high, and large enough sample size

The Joint Commission

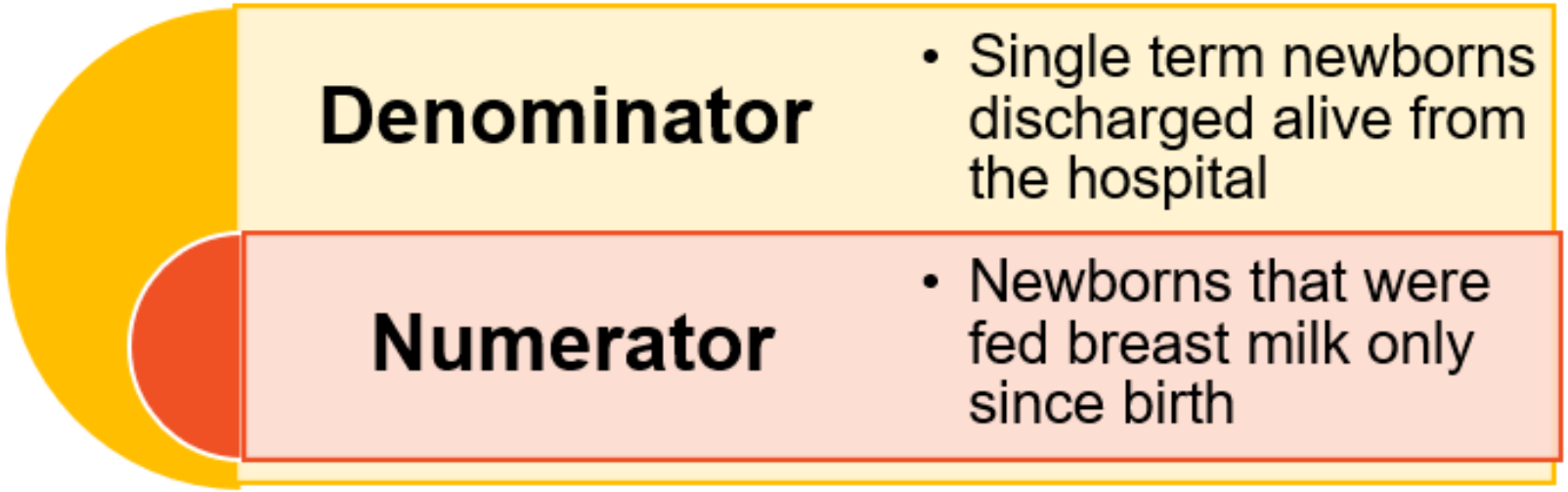
PC-02 Updates

v2022B Discharges 07-01-22 (3Q22) through 12-31-22 (4Q22)

- Improvement noted as:
  - Change from “decrease in the rate” to “Within optimal range”
- Measure analysis suggestions:
  - Updated to “The Joint Commission does not want to encourage inappropriately low Cesarean rates that may be unsafe to patients. Acceptable PC-02 rates are 30% or lower, however there is not an established threshold for what rate may be too low. PC-06 serves as a balancing measure for PC-02 to guard against any unanticipated or unintended consequences and to identify unforeseen complications that might arise as a result of quality improvement activities and efforts for this measure. In order to identify areas for improvement, hospitals may want to review results based on specific ICD-10 codes or patient populations. Data could then be analyzed further determine specific patterns or trends to help reduce cesarean births.”

PC-05 Exclusive Breast Milk Feeding

Description: Exclusive breast milk feeding during the newborn's entire hospitalization



The Joint Commission

Denominator Population

Included Population:
• Principal Diagnosis Code for Single Liveborn Newborn-Appendix A, Table 11.20.1
Excluded Population:
• Admitted to the Neonatal Intensive Care Unit (NICU)
• Other Diagnosis Code for Galactosemia-Appendix A, Table 11.21
• Principal or Other Procedure Code for Parenteral Nutrition-Appendix A, Table 11.22
• Experienced death
• LOS >120 days
• Patients transferred to another hospital
• Patients not term or < 37 wks. gestation

The Joint Commission

Numerator Population

Included Population:
• Not applicable
Excluded Population:
• None

The Joint Commission

Table 11.21 Galactosemia and Table 11.22 Parenteral Nutrition

- There are no maternal conditions for exclusion criteria
- Exclusions for newborns are codes from Table 11.21 Galactosemia and Table 11.22 Parenteral Nutrition
- Data elements are used for other exclusions:
    - newborns admitted to NICU
    - preterm infants <37 weeks
    - newborns with discharge disposition of death
    - transferred to another hospital or whose length of stay is >120 days

Admission to NICU (PC-05)

- Not defined by level designation or title
- AAP definition used
    - Provide critical care services, personnel and equipment to provide continuous life support, comprehensive care for extremely high-risk newborns with complex, critical illness
- Excludes newborns admitted for observation/transitional care; transitional care defined as LOS < 4 hrs; no time period for observation
- If no order for NICU admit, must be supporting documentation critical care was received in the NICU, e.g. NICU admit assessment, NICU flowsheet

Term Newborn (PC-05, 06)

- A range for gestational age is acceptable, e.g., 37-38 weeks
- For conflicting documentation gestational age takes precedence: e.g., both term & 36 weeks documented, use gestational age & select “no”
- The mother's medical record alone cannot be used to determine the newborn's gestational age
- Use documentation based on dates over newborn exam
- Vital records reports, delivery logs or clinical information systems acceptable data sources

Exclusive Breast Milk Feeding (PC-05)

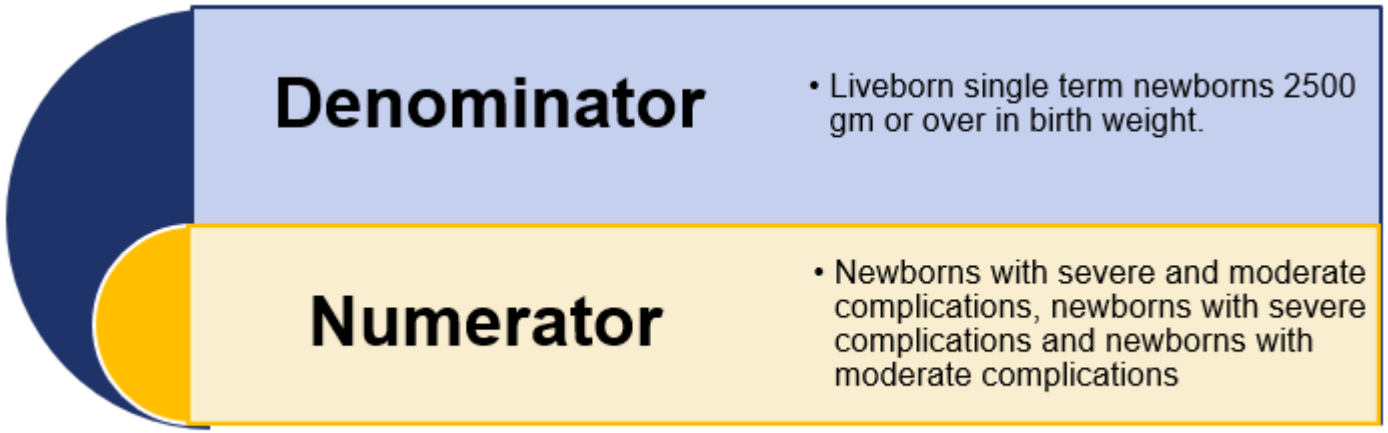
- **ANY** other liquids fed, select **No**
- IV fluids are a medication
- The use of dextrose or glucose 40% gel is considered a medication, not a feeding.
  - This should be reflected in the documentation.
- Review for actual feedings, not “plans”
  - EBM or donor milk can be fed in bottle or syringe and still answer **YES**
  - Drops of EBM or formula can be used to assist with latching is not an actual feed, so ok to say **YES** to exclusive BF.
- **ONLY** acceptable data sources:
  - Diet flow sheets
  - Feeding flow sheets
  - Intake and output sheets

Documentation

- The Exclusive Breastmilk Feeding data element requires documentation of actual feedings from the following acceptable sources:
    - Diet flow sheets
    - Feeding flow sheets
    - Intake and output sheets
- Documentation of nutrition type is the biggest obstacle for determining if a newborn was exclusively fed breast milk because the field is often left blank on the acceptable sources.
- Exclusive breast milk feeding includes the newborn receiving breast milk via a bottle or other means beside the breast which is why Nutrition Type is important in documentation.

PC-06 Unexpected Complications in Term Newborns

Description: The percent of infants with unexpected newborn complications among full term newborns with no preexisting conditions.



Clinical Intent and Guidance

- This metric focuses on term newborns who otherwise would be expected to be healthy. As such, the following exclusions are made from this newborn population: preterm, small for dates, multiple gestations, congenital malformations, fetal diagnoses and exposure to maternal drug use.
- Focus should be on the Severe Rate
- Each code is vetted through our Perinatal Technical Advisory Panel (TAP) and not every conceivable code could be added to the table, as these conditions are rare.
- If a case falls into more than one complication bucket, there is an assignment hierarchy to prevent double counting. Also note that groupings into complication buckets are only used internally for hospital QI purposes.

Denominator Population

Included Population:
• Single liveborn newborns-Appendix A, Table 11.20.1
Excluded Population:
• Patients who are not born in the hospital-Appendix A, Table 11.20.1
• Part of multiple gestation pregnancies
• Birth weight < 2500g
• Not term or with < 37 weeks gestation completed
• Congenital malformations
• Genetic diseases
• Pre-existing fetal conditions
• Maternal drug use exposure in-utero

Exclusion Tables

- Table 11.30 Congenital Malformations
- Table 11.31 Fetal Conditions
- Table 11.32 Maternal Drug Use

- The exclusion criteria for the anomaly are applied first.
- Therefore, newborns with any known anomalies, fetal conditions or maternal drug use are excluded before being considered for the numerator.

Numerator Population: Severe Complications

Included Population:
• Death
• Transfer to another acute care facility for higher level of care

• Diagnosis Code or Procedure Codes for Severe Morbidities
  ○ Severe Birth Trauma
  ○ Severe Hypoxia/Asphyxia
  ○ Severe Shock and Resuscitation
  ○ Severe Respiratory Complications
  ○ Severe Infection
  ○ Severe Neurological Complications

• Length of Stay greater than 4 days AND Sepsis
Excluded Population:
• None

The Joint Commission

Severe Complication Rate Tables

- 11.36 Severe Birth Trauma
- 11.37 Severe Hypoxia/Asphyxia
- 11.38 Severe Shock and Resuscitation
- 11.39 Neonatal Severe Respiratory Complications
- 11.40 Neonatal Severe Infection
- 11.41 Neonatal Severe Neurological Complications
- 11.42 Severe Shock and Resuscitation Procedures
- 11.43 Neonatal Severe Respiratory Procedures
- 11.44 Neonatal Severe Neurological Procedures
- Patients with Length of Stay greater than 4 days AND a code on Table 11.45 Neonatal Severe Septicemia

Severe Complication Rates cont.

- There are overlapping codes on tables 11.45 Neonatal Severe Septicemia and 11.53 Moderate Infection with LOS.
- Those codes are listed in both tables because of the clinical intent of the table.
- When you follow the algorithm, you would get to a severe complication before you would have to account for the table 11.53 moderate complication code. This case would therefore be in the severe complication category.

Numerator Population: Moderate Complications

Included Population:

• Diagnosis or Procedure Codes for moderate complications:
  ○ Moderate Birth Trauma
  ○ Moderate Respiratory Complications

• Patients with Length of Stay greater than 5 days and NO jaundice or social indications
• Vaginal delivery AND Length of Stay greater than 2 days **OR** • Cesarean delivery AND Length of Stay greater than 4 days

The Joint Commission

Numerator Population: Moderate Complications (cont.)

Included Population:

AND ANY

- Diagnosis Code or Other Procedure Codes for moderate complications:
  - Moderate Birth Trauma with LOS
  - Moderate Respiratory Complications with LOS
  - Moderate Neurological Complications with LOS
  - Moderate Infection with LOS

Excluded Population:

- None

Moderate Complication Rates

- 11.46 Moderate Birth Trauma
- 11.47 Moderate Respiratory Complications
- 11.48 Moderate Respiratory Complications Procedures

LOS>2 days for vaginal delivery or LOS >4 days for cesarean delivery

- 11.49 Moderate Birth Trauma with LOS
- 11.50 Moderate Respiratory Complications with LOS
- 11.51 Moderate Neurological Complications with LOS Procedures
- 11.52 Moderate Respiratory Complications with LOS Procedures
- 11.53 Moderate Infection with LOS

Moderate Complication Rate cont.

Patients with length of stay >5 day and NO codes on the following tables will be counted as a moderate complication:

- 11.33 Neonatal Jaundice
- 11.34 Phototherapy
- 11.35 Social Indications

Documentation

- Transfer to NICU alone is not a complication unless the NICU is not located in the delivery hospital.
- Transfers to NICU within the same 4 walls of the hospital but owned by different entities do not count as a transfer HOWEVER the delivering hospital must coordinate and track the ICD-10 codes and discharge dates for these newborns.
- Transfers to locations outside of the hospital separate moms and newborns and results in a disruption to the family
- The transfer will not count as a complication if the case was already excluded with a code from an exclusion table

Documentation cont.

- CPAP use for newborns may be a few minutes to a few days.
- CPAP use is only a fall out if the LOS criteria is also met for the measure
- Coding guidelines can help determine when the code is appropriate to use

PC-06 Code Updates

v2022A1 Discharges 01-01-22 (1Q22) through 06-30-22 (2Q22)

Table 11.31 Fetal Conditions-Hemophilia Codes Added:

- D66 Hereditary factor VIII deficiency
- D67 Hereditary factor IX deficiency
- D681 Hereditary factor XI deficiency
- D682 Hereditary deficiency of other clotting factors

v2022B Discharges 07-01-22 (3Q22) through 12-31-22 (4Q22)

11.35 Social Indications:

- *Z76.2 Encounter for health supervision and care of other healthy infant and child to table 11.35 Social Indications*

11.31 Fetal Conditions:

- *I47.1 – Supraventricular tachycardia*

11.30 Congenital Malformations:

- Multiple Z87 codes for corrected malformation conditions

The Joint Commission

Code Updates 2022 Manuals cont.

v2022B2 Discharges 12-31-22 (4Q22)

Table 11.31 Fetal Conditions-Codes Removed:

- P558 Other hemolytic diseases of newborn
- P559 Hemolytic disease of newborn, unspecified

Table 11.33 Neonatal Jaundice-Codes Added:

- P558 Other hemolytic diseases of newborn
- P559 Hemolytic disease of newborn, unspecified

PC-06 Rates

- Data is reported as an aggregate rate generated from count data reported as a rate **per 1000 livebirths**.
- There are 3 numerators, but the denominator remains the same for all sub-measures
- 3 Rates will be reported:

Set Measure ID	Performance Measure Name
PC-06.0	Unexpected Complications in Term Newborns - Overall Rate
PC-06.1	Unexpected Complications in Term Newborns - Severe Rate
PC-06.2	Unexpected Complications in Term Newborns - Moderate Rate

PC-06 Unexpected Complications in Term Newborns Public Reporting

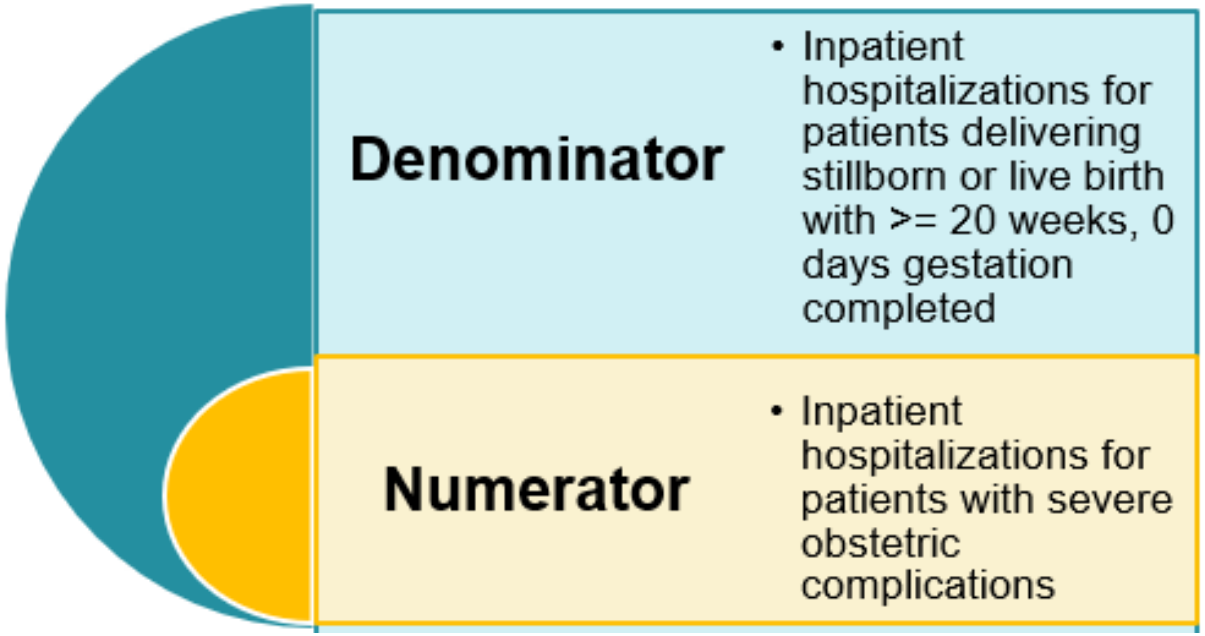
- Beginning with 2022 submissions, only the severe rates will be publicly reported. All three rates will still be provided to individual hospitals.
- There is no target rate for PC-06 Unexpected Newborn Complications at this time.
- The goal is to monitor your own hospital's rate over time and be alert to substantive increases. However, a rate above 50 per 1000 live births should lead to immediate review of all numerator cases to identify improvement opportunities for both clinical and coding practices.

ePC-07 Severe Obstetric Complications

The Joint Commission

ePC-07 Severe Obstetric Complications

Description: Patients with severe obstetric complications which occur during the inpatient delivery hospitalization.



The Joint Commission

Denominator Exclusions

Inpatient hospitalizations with:

Confirmed Covid-19 Diagnosis

AND

A Covid-related respiratory condition

OR

Confirmed Covid-19 Diagnosis

AND

Covid-related respiratory procedure

The Joint Commission

ePC-07 Numerator: SMM Diagnoses

Cardiac
- Acute heart failure*
- Acute myocardial infarction
- Aortic aneurysm
- Cardiac arrest/ventricular fibrillation
- Heart failure/arrest during procedure or surgery

Hemorrhage
- Disseminated intravascular coagulation
- Shock

Renal
- Acute renal failure

Respiratory
- Adult respiratory distress syndrome
- Pulmonary edema*

Sepsis

Other OB
- Air and thrombotic embolism
- Amniotic fluid embolism
- Eclampsia
- Severe anesthesia complications

Other Medical
- Puerperal cerebrovascular disorder
- Sickle cell disease with crisis

The Joint Commission

Numerator: SMM Procedures & Discharge Disposition

SMM Procedures

- Blood transfusion
- Conversion of cardiac rhythm
- Hysterectomy
- Temporary tracheostomy
- Ventilation

Discharge Disposition

- Discharge disposition of Expired

Stratification and Rate Aggregation

- Nontransfusion only severe obstetric complications *(excluding cases where transfusion was the only severe obstetric complication)*
- Stratification by race and ethnicity *(still under development)*

Hospital-level measure scores

- Calculated as a risk-adjusted proportion
- Reported as a rate per 10,000 delivery hospitalizations.

Risk Adjustment

Risk Adjustment		
	• Anemia • Asthma • Autoimmune Disease • Bariatric Surgery • Bleeding disorder • BMI • Cardiac Disease • Gastrointestinal Disease • Gestational Diabetes • HIV • Housing Instability • Hypertension • Maternal Age • Mental Health Disorder • Multiple Pregnancy	• Neuromuscular Disease • Other Pre-eclampsia • Placenta Previa • Placental Abruption • Placental Accreta Spectrum • Pre-existing Diabetes • Preterm Birth • Previous Cesarean • Pulmonary Hypertension • Renal Disease • Severe Pre-eclampsia • Substance Abuse • Thyrotoxicosis • Long-term Anticoagulant Use • Obstetric VTE

Risk Adjustment (cont.)

Risk Adjustment

First resulted value 24 hours prior to start of encounter and before time of delivery:

- Heart Rate
- Systolic Blood Pressure
- White Blood Cell Count
- Hematocrit

The Joint Commission

ePC-07 Reporting Requirements

- Optional Joint Commission eCQM measure for 2022/2023* reporting years

CMS

- Self-select to report for CY 2023 reporting period/FY 2025 payment determination
- Mandatory beginning with CY 2024 reporting period/FY 2026 payment determination

Resources for PC Measures

The Joint Commission Measurement Resources

- The Joint Commission website: https://www.jointcommission.org/measurement/
- Measure specific resources: PC Measures Resource Links
- The Joint Commission R3 Report| Requirement, Rationale, Reference: https://www.jointcommission.org/standards/r3-report/r3-report-issue-24-pc-standards-for-maternal-safety/

Sign up for e-Alerts on the Joint Commission website.

Questions