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Memo

November 17, 2020

To: Consensus Standards Approval Committee (CSAC)

From: Perinatal and Women's Health Project Team

Re: Perinatal and Women's Health Spring 2020 Cycle[a]

CSAC Action Required

The CSAC will review recommendations from the Spring 2020 Perinatal and Women's Health project at its November 17, 2020, meeting and vote on whether to uphold the recommendations from the Committee.

This memo includes a summary of the project, measure recommendations, themes identified, responses to the public and member comments, and the results from the NQF member expression of support. The following documents accompany this memo:

1. **Perinatal and Women's Health Spring 2020 Draft Report**. The draft report has been updated to reflect the changes made following the Standing Committee's discussion of public and member comments. The complete draft report and supplemental materials are available on the project webpage.
2. **Comment Table**. Staff has identified themes within the comments received. This table lists two comments received during the post-meeting comment period and the NQF/Standing Committee responses.

Background

The National Quality Forum's portfolio of measures for Perinatal and Women's Health includes measures for reproductive health; pregnancy, labor and delivery; high-risk pregnancy; newborn, premature, or low birthweight newborns; and postpartum patients. Some measures for other aspects women's health are reviewed by other Committees, e.g., a perinatal vaccination measure is in the Prevention and Population Health Standing Committee portfolio.

For the spring 2020 cycle, the NQF Perinatal and Women's Health project focused on measures related to care delivered immediately before and after birth—this included labor and delivery care, practices to promote positive health outcomes for mothers and infants, and unexpected negative infant health outcomes.

Regarding care delivered immediately before birth, roughly one in three women in the United States give birth by cesarean delivery. The American College of Obstetrics and Gynecology guidelines advise that providers promote vaginal delivery unless otherwise indicated or requested by the patient. Each subsequent cesarean delivery can increase the risk of negative health outcomes to the mother. An

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additional concern with the frequency of cesareans in the United States is its potential overuse, which results in higher costs to patients and to society. Regarding care delivered immediately after birth, the World Health Organization advises exclusive breast milk feeding for the first six months of life. Encouragement and education around exclusive breast milk feeding during a hospitalization can help to improve rates.

Draft Report

The Perinatal and Women's Health Spring 2020 draft report presents the results of the evaluation of six measures considered under the Consensus Development Process (CDP). All six measures are recommended for endorsement.

The measures were evaluated against the 2019 version of the measure evaluation criteria.

	Maintenance	New	Total
Measures under consideration	6	0	6
Measures recommended for endorsement	6	0	6

CSAC Action Required

Pursuant to the CDP, the CSAC is asked to consider endorsement of six candidate consensus measures.

Measures Recommended for Endorsement

- **NQF 0469** PC-01 Elective Delivery (The Joint Commission)

  Overall Suitability for Endorsement: Yes-17; No-0

- **NQF 0469e** PC-01 Elective Delivery e (The Joint Commission)

  Overall Suitability for Endorsement: Yes-16; No-0

- **NQF 0480** PC-05 Exclusive Breast Milk Feeding (The Joint Commission)

  Overall Suitability for Endorsement: Yes-15; No-1

- **NQF 0480e** PC-05 Exclusive Breast Milk Feeding e (The Joint Commission)

  Overall Suitability for Endorsement: Yes-15; No-2

- **NQF 0471** PC-02 Cesarean birth (The Joint Commission)

  Overall Suitability for Endorsement: Yes-16; No-0

- **NQF 0716** Unexpected Complications in Term Newborns (California Maternal Quality Care Collaborative)

  Overall Suitability for Endorsement: Yes-16; No-1

Comments and Their Disposition

NQF received one comment on the draft report from an NQF member organization and one comment from a member of the public during the 30-day commenting period.

A table of comments submitted during the comment period, with the responses to each comment and the actions taken by the Standing Committee and measure developers, is posted to the Perinatal and Women's Health Spring 2020 project webpage.

Comment Themes and Committee Responses

Comments about specific measure specifications and rationale were forwarded to the developers, who were invited to respond.

The Standing Committee reviewed all submitted comments (general and measure specific) and developer responses. Committee members focused their discussion on measures or topic areas with the most significant and recurring issues.

Themed Comments

Consistency of the Consensus Development Process

One commenter expressed concern that the evidence votes for 0471: PC-02 Cesarean Birth and 0716: Unexpected Complications in Term Newborns was not consistent with the CDP. Specifically, the commenter noted that these measures have votes of "Yes/No" while the remaining Spring 2020 measures have votes of "High", "Moderate", "Low", or "Insufficient". The commenter requested clarification on whether the CDP was followed for each of the measures reviewed by this Committee, given the difference in the measure evaluation votes.

> **NQF Staff Response:**
> Thank you for your comment. Pursuant to the NQF measure evaluation guidance (page 15), outcome measures are evaluated based on a "pass" or "no pass" basis (i.e., yes or no). Both 0471: PC-02 Cesarean Birth and 0716: Unexpected Complications in Term Newborns are outcome measures and therefore were voted on in accordance with this protocol and received a "pass" or "no pass" rating.

> **Committee Response:**
> Thank you for your comment. Since 0471: PC-02 Cesarean Birth and 0716: Unexpected Complications in Term Newborns are both outcome measures, the Committee evaluated the evidence using a "pass" or "no pass" rating, as described on page 15 of the NQF measure evaluation guidance.

During the post-comment meeting, Co-Chair Kim Gregory stated that the Committee followed the agreed-upon CDP during the measure evaluation meeting on June 26, 2020 and that the Committee is not charged with changing the criteria. The Committee expressed continued support for all three measures that received comments after discussing the comments and themes.

Measure-Specific Comments

0480: PC-05 Exclusive Breast Milk Feeding

One commenter suggested additional exclusions, such as diagnosis of hypoglycemia requiring treatment, mother transferred or admitted to the Intensive Care Unit and unable to breastfeed/pump, and newborn admission to an Intermediate Care Nursery.

> **Measure Steward/Developer Response:**
> A number of infant medical problems are iatrogenic, and most are often avoided by early and frequent breast milk feedings. It appears for many of these indications, i.e., hypoglycemia; there is large variation in the definitions, thresholds and application of supplementation utilization. The rate of these complications should not vary greatly from hospital to hospital, though their severity can be driven by obstetric care. For example, the better the maternal blood sugar

control, the lower the rate of newborn hypoglycemia. Chertok et al (2009) looked at infant glucose levels of term infants born to mothers with gestational diabetes who were breastfeed immediately following delivery compared to infants with delayed breastfeeding. They found that infants who breastfed right after delivery had significantly higher mean blood glucose levels compared to those infants with delayed feedings.
The situations you cite have been discussed extensively with our perinatal care technical advisory panel and the CDC. Legitimate reasons for supplementation can be case-specific—even if a particular condition does not generally require supplementation, it might in specific circumstances. For example, delayed lactogenesis and hyperbilirubinemia might not individually be adequate reasons for supplementation, the combination of the two could be. For that very reason, we have chosen to NOT exclude these cases where there can be a wide variation in practice.
PC-05 no longer excludes maternal medical conditions effective with 10/1/15 discharges. This change was made because these conditions are unusual (~2% of patients), and they cannot be modeled in the electronic Clinical Quality Measure (eCQM) version of PC-05. The removal of measure exclusions will also significantly reduce the burden of data abstraction. In addition, PC-05a: Exclusive Breast Milk Feeding Considering Mother's Initial Feeding Plan was retired effective with 10/1/15 discharges. As a result of some mothers declining exclusive breast milk feeding and by removing exclusions, The Joint Commission does not anticipate or expect that measure rates for PC-05 will reach near 100% as has been the case for many other measures. Available evidence suggests that a 70% threshold may be a more reasonable target for many organizations.

During the spring 2020 post-comment meeting, Co-Chair Carol Sakala reminded the Committee that it supported the measure with consideration of the potential for exclusions, but that the Committee can suggest future improvements to the measure through exclusions. In its response, the developer noted that the situation was discussed extensively during measure development, and the decision was made not to exclude cases of donor milk use because of a wide variation in practice. The Committee did not raise concerns regarding the developer's response to the comments but did encourage the developer to continue to monitor this issue.

The Committee did request updates from the developer regarding a discussion during the June 26, 2020, measure evaluation call, specifically the concern that donor milk may be used to improve performance on the measure. The developer informed the Committee that it explored the issue with an expert responsible for running a donor milk bank, and it supported the inclusion of donor milk in the measure. The expert also noted that some milk banks have begun to screen breastmilk for protein content so that premature infants receive milk with higher protein content and term newborns receive other milk. The developer stated that it further anticipates some updates to guidelines on the use of donor milk in term newborns as well. The developer noted that it will continue to monitor this issue and will update the measure if the guidelines are updated. Finally, the developer noted that it believes there is little incentive to game the measure as facilities are not expected to achieve 100% breastmilk feeding rates. These rates are not yet reported by CMS since the measure is not used in a value-based purchasing program.

One Committee member asked whether certain exclusions such as HIV or cardiac medications were considered. The developer response noted 100% attainment on the measure is not expected, and those mothers whose medications contraindicate breastfeeding are expected to fall in that 30% where a mother is not expected to breastfeed. The Committee ultimately agreed not to recommend the developer adopt the commenters' suggested exclusions.

The Committee questioned the developer's contention that a 70% threshold diminishes the likelihood

that facilities are using donor milk to improve their reporting due to the fact that it is natural for providers and facilities to want to improve their rates as much as possible, no matter what a threshold is. The Committee strongly recommended that, in the future, the developer assesses the use of the donor milk and mother's milk within the measure.

Appendix A: CSAC Checklist

The table below lists the key considerations to inform the CSAC's review of the measures submitted for endorsement consideration.

Key Consideration	Yes/No	Notes
Were there any process concerns raised during the CDP project? If so, briefly explain.	Yes	Concerns were raised regarding whether 0471 and 0716 were evaluated according to the NQF evaluation guidance. However, because outcome measures are evaluated based on a "pass" or "no pass" basis, NQF confirmed at the post-comment meeting that both 0471 and 0716 were evaluated according to NQF evaluation guidance. See NQF measure evaluation guidance page 15 for this process.
Did the Standing Committee receive requests for reconsideration? If so, briefly explain.	No	
Did the Standing Committee overturn any of the Scientific Methods Panel's ratings of Scientific Acceptability? If so, state the measure and why the measure was overturned.	No	
If a recommended measure is a related and/or competing measure, was a rationale provided for the Standing Committee's recommendation? If not, briefly explain.	N/A	
Were any measurement gap areas addressed? If so, identify the areas.	No	
Are there additional concerns that require CSAC discussion? If so, briefly explain.	No	

Appendix B: Appendix B: Measures Not Recommended for Endorsement

All measures in the Perinatal and Women's Health spring 2020 measure evaluation cycle were recommended for endorsement.

Appendix C: NQF Member Expression of Support Results

No NQF members provided their expression of support or non-support.

Appendix D: Details of Measure Evaluation

Measures Recommended

0469 PC-01 Elective Delivery

Submission

Description: This measure assesses patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed

Numerator Statement: Patients with elective deliveries with ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for one or more of the following: Medical induction of labor as defined in Appendix A, Table 11.05 of the measure submission, while not in Labor prior to the procedure, Cesarean birth as defined in Appendix A, Table 11.06 of the measure submission and all of the following: not in Labor, no history of a Prior Uterine Surgery

Denominator Statement: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed with ICD-10-PCS Principal or Other Procedure Codes for delivery as defined in Appendix A, Table 11.01.1 of the measure submission and with ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for planned cesarean birth in labor as defined in Appendix A, Table 11.06.1 of the measure submission

Exclusions: ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07 of the measure submission include the following: History of prior stillbirth, Less than 8 years of age, Greater than or equal to 65 years of age, Length of Stay >120 days, Gestational Age < 37 or >= 39 weeks or UTD

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility, Other

Setting of Care: Inpatient/Hospital

Type of Measure: Process

Data Source: Electronic Health Records, Other, Paper Medical Records

Measure Steward: The Joint Commission

STANDING COMMITTEE MEETING [06/26/2020]

1. Importance to Measure and Report: The measure meets the importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-9; M-8; L-0; I-0**; 1b. Performance Gap: **H-5; M-12; L-0; I-0**;

Rationale:

- The Committee noted that evidence presented by the developer suggests a need to measure the rate of elective deliveries prior to 39 weeks gestation, as there are multiple guidelines that require 39 weeks gestation prior to an elective delivery.
- For performance gap, the Committee noted that 9% of hospitals report rates higher than the goal of 5% elective delivery rates. Although this is a relatively small gap, the Committee agreed that without a measure of elective delivery, rates could drift, and elective deliveries could increase.
- The Committee also noted significant disparities in elective deliveries by age.

2. Scientific Acceptability of Measure Properties: The measure meets the scientific acceptability criteria

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **H-5; M-12; L-0; I-0**; 2b. Validity: **H-3; M-13; L-1; I-0**

Rationale:

- The Committee noted that the rate of medically indicated deliveries has changed over time and that this could be due to certain conditions being poorly coded; this may have had an effect on both the measure's the measure's validity.
- The Committee expressed a desire to see analyses from the developer regarding the effects of implicit

0469 PC-01 Elective Delivery
bias and institutional racism, which could support a risk adjustment model to account for significant disparities in the measure. For example, patients with no prenatal care might be excluded from the measure. However, no risk adjustment was supplied for the Committee's consideration this cycle. • The Committee agreed that the measure is significantly associated with Neonatal Intensive Care Unit (NICU) admissions and harm to newborns, and its validity is demonstrated by that correlation.
3. Feasibility: H-5; M-12; L-0; I-0 *(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)* Rationale: • The Committee did not have any significant concerns about feasibility of the measure.
4. Usability and Use: The maintenance measure meets the use subcriterion *(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)* 4a. Use**: Pass-17; No Pass-0**; 4b. Usability: **H-8; M-9; L-0; I-0** Rationale: • This measure is publicly reported and used in the Hospital Inpatient Quality Reporting accountability program. • The Committee noted that the developer has reported that modifications to the measure have been made in response to feedback from measure users over the years. • The Committee had some concern that hospitals with higher risk patient populations may appear to have higher rates of elective delivery, when in fact quality care is being provided. It was noted, however, these hospitals likely have large denominators so that the effect on the measure is minimal. The Committee agreed this was not a significant enough concern for the usability of the measure.
5. Related and Competing Measures No related or competing measures noted.
Standing Committee Recommendation for Endorsement: Yes-17; No-0
6. Public and Member Comment • No measure-specific comments were submitted for this measure
7. Consensus Standards Approval Committee (CSAC) Endorsement Decision
8. Appeals

0469e PC-01 Elective Delivery e
Submission
Description: This measure assesses patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed. *PC-01: Elective Delivery* has been re-engineered as an eCQM **Numerator Statement**: Inpatient hospitalizations for patients with elective deliveries by either: - Medical induction of labor while not in labor prior to the procedure - Cesarean birth while not in labor and with no history of a prior uterine surgery **Denominator Statement**: Inpatient hospitalizations for patients delivering newborns with >= 37 and < 39 weeks of gestation completed **Exclusions**: Inpatient hospitalizations for patients with conditions possibly justifying elective delivery prior to 39 weeks gestation

0469e PC-01 Elective Delivery e

Adjustment/Stratification: No risk adjustment or risk stratification
Level of Analysis: Facility, Other
Setting of Care: Inpatient/Hospital
Type of Measure: Process
Data Source: Electronic Health Data, Electronic Health Records, Other
Measure Steward: The Joint Commission

STANDING COMMITTEE MEETING [06/26/2020]

1. Importance to Measure and Report: <u>The measure meets the importance criteria</u>
(1a. Evidence, 1b. Performance Gap)
1a. Evidence: **H-3; M-13; L-0; I-0**; 1b. Performance Gap: **H-9; M-7; L-0; I-0**;
<u>Rationale</u>:

- Although the evidence presented for #0469 is the same as the evidence presented for #0469e, the Committee could not carryover the evidence vote to #0469e, as quorum was not achieved during the evaluation of #0469. Therefore, a survey was distributed to gather quorum votes for #0469.
- The Committee noted that evidence presented by the developer suggests a continued need to measure the rate of elective deliveries prior to 39 weeks gestation, as there are multiple guidelines that require 39 weeks gestation prior to an elective delivery.
- For performance gap, this measure showed a significant and wide variation in performance by age and race.
- The mean gap is much larger for this measure (17.6%) compared to the "paper" version of the measure (1.7%). It was noted, however, that this large difference could reflect an issue with coding exclusions as well.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the scientific acceptability criteria</u>
(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)
2a. Reliability: **H-1; M-10; L-4; I-2**; 2b. Validity: **H-2; M-12; L-2; I-0**
<u>Rationale</u>:

- The Committee had some concerns about the validity of the measure. First, it was not clear that the coding for exclusions was uniform across measured entities, which meant this could affect the apparent gap in performance between this measure and the "paper" version. Second, three of the six data elements had good agreement, as shown through their Kappa scores, but the other three data elements had poor Kappa scores.
- The concern about coding was not significant enough to vote the measure down, but the Committee stressed that when the measure comes back for maintenance, the developer should perform an analysis to see whether data extraction for exclusions has improved over time.
- The Committee's concern about the data element agreement also was not significant enough to vote the measure down. Although two of the data elements were viewed as critical, one (prior uterine surgery) was not viewed as vital for the calculation of the measure.
- The Committee also had concerns about specific capture of the estimated gestational age data element, but the developer explained how this information is captured and calculated automatically and assuaged the Committee's concerns on this matter.
- For validity of the measure, the Committee expressed concern about the lack of correlation with the "paper" version of the measure but was satisfied with the developer's response that this was due to small numerator sizes in the calculation of the correlation.

0469e PC-01 Elective Delivery e

3. Feasibility: H-9; M-7; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The Committee had no concerns about the feasibility of this measure, as all data elements are in a defined field in Electronic Health Records (EHRs).
- The Committee decided that although there are some discrepancies between this measure and its "paper" version, the feasibility of this eCQM is high.

4. Usability and Use: The maintenance measure meets the use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-16; No Pass-0**; 4b. Usability: **H-2; M-10; L-3; I-2**

Rationale:

- This measure is not yet publicly reported, but is used in an accountability program, namely CMS's Hospital Inpatient Quality Reporting program.
- The Committee had some concerns about the lack of public reporting, and the developer explained that this is one of several eCQMs in a pool that hospitals may choose to report.
- The developer noted that the lack of public reporting has made it difficult to show whether there has been significant improvement in performance over time. However, the Committee decided that the small demonstration of improvement that the developer provided was sufficient to pass the measure on usability.

5. Related and Competing Measures

No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Yes-16; No-0

6. Public and Member Comment

- No measure-specific comments were submitted for this measure

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision

8. Appeals

0480 PC-05 Exclusive Breast Milk Feeding

Submission

Description: This measure assesses the rate of newborns exclusively fed breast milk during the newborn´s entire hospitalization

Numerator Statement: Newborns that were fed breast milk only since birth

Denominator Statement: Single term liveborn newborns discharged alive from the hospital with ICD-10-CM Principal Diagnosis Code for single liveborn newborn as defined in Appendix A, Table 11.20.1 of the measure submission

Single term newborns discharged alive from the hospital
Liveborn newborns with ICD-10-CM Principal Diagnosis Code for single liveborn newborn as defined in Appendix A, Table 11.20.1 of the measure submission

Exclusions:

• Admitted to the NICU at this hospital during the hospitalization

0480 PC-05 Exclusive Breast Milk Feeding
• ICD-10-CM Other Diagnosis Codes for galactosemia as defined in Appendix A, Table 11.21 of the measure submission • ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for parenteral infusion as defined in Appendix A, Table 11.22 of the measure submission • Experienced death • Length of Stay >120 days • Patients transferred to another hospital • Patients who are not term or with < 37 weeks gestation completed **Adjustment/Stratification**: No risk adjustment or risk stratification **Level of Analysis:** Facility, Other **Setting of Care:** Inpatient/Hospital **Type of Measure**: Process **Data Source**: Electronic Health Records, Other, Paper Medical Records **Measure Steward**: The Joint Commission
STANDING COMMITTEE MEETING [06/26/2020] **1. Importance to Measure and Report: <u>The measure meets the importance criteria</u>** (1a. Evidence, 1b. Performance Gap) 1a. Evidence: **H-1; M-14; L-2; I-0**; 1b. Performance Gap: **H-8; M-8; L-0; I-0**; <u>Rationale</u>: • The Committee agreed to carry-over the results from #0480e, as the evidence is the same.
2. Scientific Acceptability of Measure Properties: <u>The measure meets the scientific acceptability criteria</u> (2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity) 2a. Reliability: **H-7; M-8; L-1; I-0**; 2b. Validity: **H-5; M-8; L-3; I-0** <u>Rationale</u>: • The Committee raised concern over the terminology of the exclusion and whether it was appropriate to exclude term newborns when this measure could apply to all infants. The Committee agreed that it was appropriate to use "term," since preterm infants have a distinct set of issues compared to term infants.
3. Feasibility: H-1; M-14; L-1; I-0 *(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)* <u>Rationale</u>: • The Committee noted that this measure is more burdensome than the eCQM version, but it agreed that the lack of exclusions helped to reduce the burden of reporting for this measure. • The Committee raised concerns that this measure was difficult to abstract, since each feeding must be reviewed. • The Committee also noted it would be possible to automate this measure in an electronic medical record, but this would be highly dependent on the electronic medical record being used.
4. Usability and Use: <u>The maintenance measure meets the use subcriterion</u> *(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)* 4a. Use**: Pass-16; No Pass-0**; 4b. Usability: **H-0; M-15; L-1; I-0** <u>Rationale</u>: • The Committee noted that this measure has shown little improvement since 2015, but that it may be due low breastfeeding rates being a systemic problem. The Committee also agreed that this measure

0480 PC-05 Exclusive Breast Milk Feeding
will improve over time and believed this measure does indicate a need for improvement. • The Committee raised concerns around a potential unintended consequence of this measure: Specifically, a provider could unknowingly recommend breastfeeding in those medically unable to do so. The Committee acknowledged that while this is a concern, the benefits of this measure outweigh the potential unintended consequences.
5. Related and Competing Measures No related or competing measures noted.
Standing Committee Recommendation for Endorsement: Yes-15; No-1
6. Public and Member Comment • One commenter suggested additional exclusions, such as diagnosis of hypoglycemia requiring treatment, mother transferred or admitted to the Intensive Care Unit and unable to breastfeed/pump, and newborn admission to an Intermediate Care Nursery. • The developer response noted 100% attainment on the measure is not expected, and those mothers whose medications contraindicate breastfeeding are expected to fall in that 30% where a mother is not expected to breastfeed. • The Committee ultimately agreed not to recommend the developer adopt the commenters' suggested exclusions.
7. Consensus Standards Approval Committee (CSAC) Endorsement Decision
8. Appeals

0480e PC-05 Exclusive Breast Milk Feeding e
Submission
Description: This measure assesses the rate of newborns exclusively fed breast milk during the newborn´s entire hospitalization. *PC-05: Exclusive Breast Milk Feeding* has been re-engineered as an eCQM **Numerator Statement**: Inpatient hospitalization for newborns that were fed breast milk only since birth **Denominator Statement**: Inpatient hospitalization for single newborns with an estimated gestational age at birth of >=37 weeks who are born in the hospital and who did not have a diagnosis of galactosemia, were not subject to parenteral nutrition, and had a length of stay of less than or equal to 120 days that ends during the measurement period **Exclusions**: - Inpatient hospitalization for newborns who were admitted to the Neonatal Intensive Care Unit (NICU) - Inpatient hospitalization for newborns who were transferred to an acute care facility - Inpatient hospitalization for newborns who were transferred to other health care facility - Inpatient hospitalization for newborns who expired during the hospitalization **Adjustment/Stratification**: No risk adjustment or risk stratification **Level of Analysis:** Facility, Other **Setting of Care:** Inpatient/Hospital **Type of Measure**: Process **Data Source**: Electronic Health Data, Electronic Health Records, Other **Measure Steward**: The Joint Commission
STANDING COMMITTEE MEETING [06/26/2020] **1. Importance to Measure and Report: <u>The measure meets the importance criteria</u>** (1a. Evidence, 1b. Performance Gap)

0480e PC-05 Exclusive Breast Milk Feeding e

1a. Evidence: **H-1; M-14; L-2; I-0**; 1b. Performance Gap: **H-9; M-7; L-0; I-0**;
Rationale:

- The Committee noted that the evidence has not changed since the last submission of this measure and is still strong.
- The Committee raised concerns regarding the lack of exclusions related to the mother's choice and autonomy but acknowledged that the goal for this measure is 70%, mentioning that it may be burdensome to include maternal conditions, which may exclude a mother from this measure.
- The Committee also raised concerns over whether the 70% target would be achievable for hospitals that care for patients with higher rates of exclusive breast milk feeding contraindications.
- The Committee raised concerns that this measure does not specify that the milk should come from the infant's mother and could potentially result in donor milk being given to term infants rather than preterm infants who would benefit the most from it. The Committee also noted that this issue would disproportionately affect women of color due to the frequency of preterm births.
- The Committee noted that there may be an educational opportunity to inform hospitals that they will not improve their rates on this measure by giving donor milk to preterm infants.

2. Scientific Acceptability of Measure Properties: The measure meets the scientific acceptability criteria
(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)
2a. Reliability: **H-0; M-15; L-1; I-1**; 2b. Validity: **H-3; M-10; L-3; I-1**
Rationale:

- The Committee raised concerns that some data elements were not able to be assessed for accuracy.
- The Committee acknowledged that since the measure was submitted in 2016, some data elements have been updated.
- The Committee further noted that this measure is strongly correlated with the "paper" measure, #0480, and the concern about the data element testing was not significant enough to vote the measure down.

3. Feasibility: H-7; M-9; L-1; I-0
(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)
Rationale:

- The Committee did not express concerns around feasibility.

4. Usability and Use: The maintenance measure meets the use subcriterion
(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)
4a. Use**: Pass-17; No Pass-1**; 4b. Usability: **H-2; M-14; L-2; I-0**
Rationale:

- For usability, the Committee's major concerns included medical need for supplementation and donor milk, which were noted during the evidence criterion and did not warrant additional discussion here.
- The Committee also raised concerns around racial and ethnic disparities and whether hospitals have reduced disparities. The developer explained that with targeted programs, some hospitals have seen improvement in this regard.

5. Related and Competing Measures
No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Yes-15; No-2

0480e PC-05 Exclusive Breast Milk Feeding e

6. Public and Member Comment

- No measure-specific comments were submitted for this measure

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision

8. Appeals

0471 PC-02 Cesarean birth

Submission

Description: This measure assesses the rate of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth
Numerator Statement: Patients with cesarean births with ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for cesarean birth as defined in Appendix A, Table 11.06 of the measure submission
Denominator Statement: The outcome target population being measured is: Nulliparous patients with an ICD-10-CM Principal or Other Diagnosis Code for outcome of delivery as defined in Appendix A, Table 11.08 of the measure submission and with a delivery of a newborn with 37 weeks or more gestation completed or with an ICD-10-PCS Principal or Other Procedure Codes for delivery as defined in Appendix A, Tables 11.01.1 of the measure submission.
Exclusions:
• ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for multiple gestations and other presentations as defined in Appendix A, Table 11.09 of the measure submission
• Less than 8 years of age
• Greater than or equal to 65 years of age
• Length of Stay >120 days
• Gestational Age < 37 weeks or UTD
Adjustment/Stratification: No risk adjustment or risk stratification
Level of Analysis: Facility, Other
Setting of Care: Inpatient/Hospital
Type of Measure: Outcome
Data Source: Electronic Health Records, Other, Paper Medical Records
Measure Steward: The Joint Commission

STANDING COMMITTEE MEETING [06/26/2020]
1. Importance to Measure and Report: The measure meets the importance criteria
(1a. Evidence, 1b. Performance Gap)
1a. Evidence: **Y-16; N-0**; 1b. Performance Gap: **H-9; M-7; L-0; I-0**;
Rationale:

- The Committee agreed that the evidence supplied in the measure submission supported the measures continued importance. Of particular interest was the evidence that labor and delivery guidelines have an impact on delivery outcomes, and that a reduction in cesarean sections was not associated with an increase in negative health outcomes.
- The Committee sought clarification from the developer on the way in which the measure will be reported. The developer confirmed that the measure will report whether an organization is at or below a threshold of 30 percent. If it is above this threshold, then the actual rate of cesarean sections will be reported.
- The Committee noted that there is considerable variability among reporting organizations and that more than half of the hospitals have not yet met the Healthy People 2020 goal of 23.9%.

0471 PC-02 Cesarean birth

2. Scientific Acceptability of Measure Properties: <u>The measure meets the scientific acceptability criteria</u>
(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)
2a. Reliability: **H-4; M-12; L-0; I-0**; 2b. Validity: **H-4; M-12; L-0; I-0**
<u>Rationale</u>:

- The Committee had no concerns about the reliability of the measure.
- The Committee noted the measure is not risk adjusted, and further that there has been debate on whether this measure should be risk adjusted. Ultimately, the Committee agreed that increased transparency of data reporting might help resolve this issue.
- The Committee did not express concerns about the validity of the measure and agreed that the construct validity testing of the measure, which examined correlations between this measure and other Joint Commission measures, was sufficient to support the measure's validity.

3. Feasibility: H-2 M-14; L-0; I-0
(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)
<u>Rationale</u>:

- The Committee agreed that while reporting the measure is sometimes burdensome, it does not present a large enough problem to warrant significant concerns about the measure's feasibility.
- The developer noted that an eCQM version of this measure is being developed.

4. Usability and Use: <u>The maintenance measure meets the use subcriterion</u>
(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)
4a. Use**: Pass-16; No Pass-0**; 4b. Usability: **H-0; M-15; L-1; I-0**
<u>Rationale</u>:

- The Committee noted that the measure will begin public reporting in July 2020 as part of the Joint Commission's Quality Check program; it also will be included in the 2020 Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP and the Medicaid Child Core set.
- The Committee noted that queries regarding implementation of this measure have decreased since its initial endorsement, signifying better usability of the measure.
- The Committee stressed there is still a great deal of room for improvement on this measure, as performance has not changed significantly since 2015.

5. Related and Competing Measures
No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Yes-16; No-0

6. Public and Member Comment

- One commenter expressed concern that the evidence vote was not consistent with the CDP. Specifically, the commenter noted that these measures have votes of "Yes/No" while the remaining Spring 2020 measures have votes of "High", "Moderate", "Low", or "Insufficient".
- The Committee agreed that they followed the CDP during the measure evaluation meeting on June 26, 2020 and that the Committee is not charged with changing the criteria.

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision

8. Appeals

0716 Unexpected Complications in Term Newborns

Submission

Description: This is a hospital level performance score reported as the percent of infants with Unexpected Newborn Complications among full term newborns with no preexisting conditions, typically calculated per year.

Numerator Statement: The numerator is divided into two categories: Severe complications and moderate complications.

Severe complications include neonatal death, transfer to another hospital for higher level of care, severe birth injuries such as intracranial hemorrhage or nerve injury, neurologic damage, severe respiratory and infectious complications such as sepsis. Parents of such babies may often worry about short- or long-term infant outcomes.

Moderate complications include diagnoses or procedures that raise concern but at a lower level than the list for severe (e.g. use of CPAP or bone fracture). For inclusion in the numerator, most require an infant length of stay that exceeds that of the mother, validating that these are indeed significant complications. Examples include less severe respiratory complications (e.g. Transient Tachypnea of the Newborn), or infections with a longer length of stay not including sepsis. As a "safety net" to capture cases who were under-coded, the numerator also includes infants who have a prolonged length of stay of over 5 days to capture the "seemingly normal" infants with neither any form of jaundice nor a social reason for staying in the hospital (e.g. family disruption or adoption).

Denominator Statement: The denominator is comprised of singleton, live born babies who are at least 37.0 weeks of gestation, and over 2500g in birth weight. The denominator excludes most serious fetal conditions that are "preexisting" (present before labor), including prematurity, multiple gestations, poor fetal growth, congenital malformations, genetic disorders, other specified fetal and maternal conditions and infants exposed to maternal drug use in-utero. The final denominator population consists of babies who are expected to do well following labor and delivery and go home routinely with their mothers.

Exclusions:

a) Babies not born in hospitals are excluded as this is a hospital quality performance measure

b) Babies who are part of multiple gestation pregnancies are excluded.

c) Premature infants (babies born before 37 weeks gestational age) are excluded

d) Low birth weight babies (<=2500g) are excluded

e) Babies with congenital malformations and genetic diseases are excluded

f) Babies with pre-existing fetal conditions such as IUGR are excluded

g) Babies who were exposed to maternal drug use in-utero are excluded

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility, Integrated Delivery System, Population, Regional and State

Setting of Care: Inpatient/Hospital

Type of Measure: Outcome

Data Source: Claims

Measure Steward: California Maternal Quality Care Collaborative

STANDING COMMITTEE MEETING [06/26/2020]

1. Importance to Measure and Report: The measure meets the importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Y-15; N-2**; 1b. Performance Gap: **H-5; M-11; L-1; I-0**;

Rationale:

- The Committee reviewed the evidence submitted, in which the developer noted five studies that have used unexpected newborn complications as either a key outcome or important balancing measure during studies focused on improving obstetric practice and offer comparisons to other simultaneously collected neonatal outcome measures.
- The Committee agreed that the evidence supplied in the measure submission supported the measures

0716 Unexpected Complications in Term Newborns
continued importance. • The Committee reviewed the distribution of the rates of unexpected newborn complications from 0.21 to 11.21, noting that a gap in care remains.
2. Scientific Acceptability of Measure Properties: <u>The measure meets the scientific acceptability criteria</u> (2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity) 2a. Reliability: **H-5; M-3; L-0; I-1**; 2b. Validity: **H-3; M-4; L-1; I-1** <u>Rationale</u>: • This measure was evaluated by the SMP. After a brief discussion, the Committee had no concerns and voted to accept the SMP's vote for reliability and validity. The votes above reflect the SMP members' vote. The Committee voted to accept the SMP's vote 15 for yes and 1 for no.
3. Feasibility: H-1; M-15; L-1; I-0 *(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)* <u>Rationale</u>: • The Committee had no concerns around feasibility.
4. Usability and Use: <u>The maintenance measure meets the Use subcriterion</u> *(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)* 4a. Use**: Pass-16; No Pass-0**; 4b. Usability: **H-6; M-10; L-1; I-0** <u>Rationale</u>: • The Committee noted that the measure is not publicly reported but is in use in the California Maternal Quality Care Collaborative and Blue Cross Blue Shield accountability programs. • The Committee felt that the number of exclusions may present a challenge for hospitals to set this measure up for themselves, but the developer noted that the Joint Commission's third-party intermediary could be used to set up the algorithm for those hospitals.
5. Related and Competing Measures No related or competing measures noted.
Standing Committee Recommendation for Endorsement: Yes-16; No-1
6. Public and Member Comment • One commenter expressed concern that the evidence vote was not consistent with the CDP. Specifically, the commenter noted that these measures have votes of "Yes/No" while the remaining Spring 2020 measures have votes of "High", "Moderate", "Low", or "Insufficient". • The Committee agreed that they followed the CDP during the measure evaluation meeting on June 26, 2020 and that the Committee is not charged with changing the criteria.
7. Consensus Standards Approval Committee (CSAC) Endorsement Decision
8. Appeals

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Perinatal and Women's Health Spring 2020 Review Cycle

CSAC Review and Endorsement

November 17, 2020

Funded by the Centers for Medicare and Medicaid Services under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001.

NATIONAL QUALITY FORUM

Standing Committee Recommendations

- Six measures reviewed for Spring 2020
  - One measures reviewed by the Scientific Methods Panel
- Six measures recommended for endorsement
  - **NQF 0469** PC-01 Elective Delivery (Maintenance Measure)
  - **NQF 0469e** PC-01 Elective Delivery e (Maintenance Measure)
  - **NQF 0480** PC-05 Exclusive Breast Milk Feeding (Maintenance Measure)
  - **NQF 0480e** PC-05 Exclusive Breast Milk Feeding e (Maintenance Measure)
  - **NQF 0471** PC-02 Cesarean birth (Maintenance Measure)
  - **NQF 0716** Unexpected Complications in Term Newborns (Maintenance Measure)

Public and Member Comment and Member Expressions of Support

- Two comments received
- No NQF member of expressions of support or non-support received

Questions?

- Project team:
  - Matthew Pickering, PharmD
  - Chelsea Lynch, MPH, MSN, RN, CIC
  - Yemsrach Kidane, PMP
  - Erin Buchanan, MPH
  - Hannah Ingber, MPH
  - Robyn Y. Nishimi, PhD
- Project webpage: https://www.qualityforum.org/Perinatal_and_Womens_Health.aspx
- Project email address: perinatal@qualityforum.org

THANK YOU.

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Perinatal and Women's Health, Spring 2020 Cycle: CDP Report

DRAFT REPORT FOR CSAC REVIEW
NOVEMBER 17, 2020

This report is funded by the Centers for Medicare and Medicaid Services under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001

http://www.qualityforum.org

Contents

Executive Summary

Maternal and child health is a public health priority, as pregnancy and childbirth are some of the leading causes of hospitalization for women. Additionally, compared to other countries in the World Health Organization's (WHO) latest maternal mortality ranking, the United States ranked 55th, just behind Russia (17 per 100,000) and just ahead of Ukraine (19 per 100,000).[1]

Measures of care surrounding the time of labor and delivery focus attention on an acute care moment when maternal morbidity can be avoided through better quality care. Additionally, care during labor and delivery has implications for reducing maternal morbidities after pregnancy and poor infant outcomes.[2–4] Measures of infant health can help prevent significant negative health outcomes later in life and incentivize quality care during pregnancy.

The National Quality Forum's (NQF) portfolio of measures for perinatal and women's health includes quality measures for reproductive health; pregnancy, labor and delivery; high-risk pregnancy; newborn, premature, or low birthweight newborns; and postpartum patients. Some measures for other aspects of women's health are reviewed by other committees, e.g., a perinatal vaccination measure is in the Prevention and Population Health Standing Committee portfolio.

For this project, the Standing Committee evaluated and recommended six measures undergoing maintenance review against NQF's standard evaluation criteria:

- **NQF 0469** PC-01 Elective Delivery (The Joint Commission)
- **NQF 0469e** PC-01 Elective Delivery e (The Joint Commission)
- **NQF 0480** PC-05 Exclusive Breast Milk Feeding (The Joint Commission)
- **NQF 0480e** PC-05 Exclusive Breast Milk Feeding e (The Joint Commission)
- **NQF 0471** PC-02 Cesarean birth (The Joint Commission)
- **NQF 0716** Unexpected Complications in Term Newborns (California Maternal Quality Care Collaborative)

Brief summaries of the measures currently under review are included in the body of the report; detailed summaries of the Committee's discussion and ratings of the criteria for each measure are in Appendix A.

Introduction

Maternal and child health is a public health priority, as pregnancy and childbirth are some of the leading causes of hospitalization for women. Additionally, compared to other countries in the World Health Organization's (WHO) latest maternal mortality ranking, the United States ranked 55th, just behind Russia (17 per 100,000) and just ahead of Ukraine (19 per 100,000).[1] Moreover, birth-related events are considered to be among the best measures for assessing healthcare quality. For women of reproductive age in the United States, access to high-quality care before and between pregnancies can reduce the risk of pregnancy-related complications, including maternal and infant mortality.[5] The infant mortality rate in 2018 was 5.7 deaths per 1,000 live births and the top five leading causes of death for infants were birth defects, maternal pregnancy complications, sudden infant death syndrome, injuries, and preterm birth and low birth weight.[6] In 2018 the rate of low birth weight births (infants born at less than 2,500 grams) was 8.28%.[7]

For the spring 2020 cycle, the NQF Perinatal and Women's Health project focused on measures related to care delivered immediately before and after birth. This included labor and delivery care, practices to promote positive health outcomes for mothers and infants, and unexpected negative infant health outcomes. Regarding care delivered immediately before birth, roughly one in three women in the United States give birth by cesarean delivery.[8,9] The American College of Obstetrics and Gynecology (ACOG) guidelines advise that providers promote vaginal delivery unless otherwise indicated or requested by the patient.[10] Each subsequent cesarean delivery can increase the risk of negative health outcomes. An additional concern with the frequency of cesareans in the United States is its potential overuse, which results in higher costs to patients and to society.[11] Regarding care delivered immediately after birth, the WHO advises exclusive breast milk feeding for the first six months of life.[12] Encouragement and education around exclusive breast milk feeding during a hospitalization can help to improve rates.

NQF Portfolio of Performance Measures for Perinatal and Women's Health Conditions

The Perinatal and Women's Health Standing Committee (Appendix C) oversees NQF's portfolio of perinatal and women's health measures (Appendix B) that include measures for reproductive health; pregnancy, labor and delivery; high-risk pregnancy; newborn, premature, or low birthweight newborns; and postpartum patients. The Committee's portfolio contains 16 measures: eight process measures and eight outcome and resource use measures (see Table 1 below).

Table 1. NQF Perinatal and Women's Health Portfolio of Measures

	Process	Outcome/Resource Use
Preconception	1	3
Birth	6	1
Newborns	1	4
Total	8	8

Additional measures related to perinatal and women's health have been assigned to other portfolios. These include various complications and outcomes measures (Surgery), perinatal immunization (Prevention and Population Health), and routine breast cancer screening (Prevention and Population Health).

Perinatal and Women's Health Measure Evaluation

On June 26, 2020, the Perinatal and Women's Health Standing Committee evaluated six measures undergoing maintenance review against NQF's standard measure evaluation criteria (Table 2).

Table 2. Perinatal and Women's Health Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	6	0	6
Measures recommended for endorsement	6	0	6

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on May 1, 2020, and will close on September 3, 2020. As of June 15, 2020, one comment was submitted and shared with the Committee prior to the measure evaluation meeting(s) (Appendix F).

Comments Received After Committee Evaluation

The continuous 16-week public commenting period with NQF member support closed on May 24, 2020. Following the Committee's evaluation of the measures under consideration, NQF received a comment on the draft report from one NQF member organization and one member of the public during the 30-day commenting period. All comments for each measure under consideration have been summarized in Appendix A.

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. No NQF members provided their expression of support or not support.

Summary of Measure Evaluations

The following brief summaries of the measure evaluation highlight the major issues that the Committee considered. Details of the Committee's discussion and ratings of the criteria for each measure are included in Appendix A.

0469 PC-01 Elective Delivery (The Joint Commission): Recommended

Description: This measure assesses patients with elective vaginal deliveries or elective cesarean births at >=37 and <39 weeks of gestation completed; **Measure Type**: Process; **Level of Analysis**: Facility, Other; **Setting of Care**: Inpatient/Hospital; **Data Source**: Electronic Health Records, Other, Paper Medical Records.

The Standing Committee recommended the measure for continued endorsement. Committee members agreed this is an important area of measurement due to the negative impacts of elective deliveries when they are not medically indicated. The Committee determined that the evidence submitted supports the measure and demonstrates that elective deliveries prior to 39 weeks gestation without medical indication are not beneficial. The Committee suggested that evidence from the ARRIVE trial be included in the evidence section because it points to the safety of induction after 39 weeks gestation. With respect to performance gap, the Committee expressed some concerns that measure performance may be topped out. Ultimately, Committee members agreed that although the performance gap is narrowing, there is still utility in continuing to report results from this measure, especially given all facilities do not have capacity to report the matching electronic clinical quality measure (eCQM) NQF #0469e. Committee members were satisfied with the reliability testing for the measure. Regarding validity testing, the Committee agreed that the magnitude and direction of the construct validity testing was acceptable. The measure was regarded as feasible by Committee members, and they did not express concerns with use and usability. The Committee observed that there are no related and competing measures to discuss for this measure, but the measure is aligned with NQF #0469e.

0469e PC-01 Elective Delivery e (The Joint Commission): Recommended

Description: This measure assesses patients with elective vaginal deliveries or elective cesarean births at >=37 and <39 weeks of gestation completed. *PC-01: Elective Delivery* has been re-engineered as an eCQM; **Measure Type**: Process; **Level of Analysis**: Facility, Other; **Setting of Care**: Inpatient/Hospital; **Data Source**: Electronic Health Data, Electronic Health Records, Other.

The Standing Committee recommended the measure for continued endorsement. The Committee agreed this is an important area of measurement and there is a performance gap. It discussed concerns about all necessary electronic data elements being accurately captured by the measure but noted that the data elements in question did not appear to be critical. The Committee passed the measure on scientific acceptability, including reliability and validity. The measure was regarded as feasible with no concerns expressed. In its discussions related to usability and use, the Committee noted that the measure is not yet publicly reported. The Committee also noted improvement over time, with no significant unintended consequences, and passed the measure on use and usability. The Committee observed that there are no related and competing measures to discuss for this measure, but the measure is aligned with the “paper” version of this measure, NQF #0469.

0480e PC-05 Exclusive Breast Milk Feeding e (The Joint Commission): Recommended

Description: This measure assesses the rate of newborns exclusively fed breast milk during the newborn´s entire hospitalization. *PC-05: Exclusive Breast Milk Feeding* has been re-engineered as an eCQM; **Measure Type**: Process; **Level of Analysis**: Facility, Other; **Setting of Care**: Inpatient/Hospital; **Data Source**: Electronic Health Data, Electronic Health Records, Other.

The Standing Committee recommended the measure for continued endorsement. The Committee agreed that this is an important area of measurement and discussed that facilities are not expected to achieve 100% as a maximum value. Per the developer, facilities are expected to achieve a 70% rate, as this accounts for individuals who do not wish to exclusively breastfeed or who are unable to do so. The Committee agreed that the evidence supports the benefits of exclusive breastmilk feeding. The Committee noted, however, that the measure specifications do not distinguish between mother's breast milk and donor breast milk. Given this, the Committee expressed concerns that the measure may incentivize the use of donor breastmilk for healthy infants and thereby reduce the availability of donor breastmilk for vulnerable populations. One Committee member cited a publication in this regard. The Committee noted that while there is evidence for the use of donor breast milk in preterm infants, there has been no evidence of benefits of donor breast milk in term infants. It asked the developer to further examine this issue for the next review. With respect to performance gap, the Committee observed that there is a performance gap that warrants continued endorsement. Regarding validity and reliability, the developer conducted validity testing at the data element level. Per NQF guidelines, this approach may be used to demonstrate reliability. The Committee voted to pass the measure on validity, and accordingly, the measure passed on reliability. The measure was regarded as feasible by Committee members, although some stated they have found it relatively burdensome. In their discussions related to usability and use, Committee members noted that the measure is publicly reported. Although some concerns were expressed about unintended harms to patient autonomy and donor breast milk reserves, the Committee agreed these harms require more investigation by the developer to identify their impact on the measure specifications. It passed the measure on use and usability. The Committee noted there are no related and competing measures to discuss for this measure, but the measure is aligned with the "paper" version of this measure, NQF #0480.

0480 PC-05 Exclusive Breast Milk Feeding (The Joint Commission): Recommended

Description: This measure assesses the rate of newborns exclusively fed breast milk during the newborn´s entire hospitalization; **Measure Type**: Process; **Level of Analysis**: Facility, Other; **Setting of Care**: Inpatient/Hospital; **Data Source**: Electronic Health Records, Other, Paper Medical Records.

The Standing Committee recommended the measure for continued endorsement. This measure also concerns exclusive breastmilk feeding of infants in a facility and so Committee concerns related to patient autonomy and donor milk brought up during the discussion of NQF #0480e also apply. The Committee agreed that this is an important area of measurement. The Committee determined that the vote from the prior measure could carry over, given that the submitted evidence is the same. It observed that a performance gap exists and did not express any concerns. The Committee also expressed no concerns related to reliability and validity but did discuss whether the term of the newborn should be included in the denominator. The Committee agreed that only term newborns should be included in the denominator to avoid variability due to neonatal intensive care unit admissions or other complications that prevent oral intake of nutrition. The measure was regarded as feasible with no concerns. In its discussions related to usability and use, the Committee noted that the measure is publicly reported as part of the Joint Commission's Accreditation Program and the CMS Hospital Inpatient Quality Reporting Program. The Committee also noted improvement over time and no significant unintended consequences. It passed the measure on use and usability. The Committee

observed that there are no related and competing measures to discuss for this measure, but the measure is aligned with the electronic version of this measure, NQF #0480e.

0471 PC-02 Cesarean birth (The Joint Commission): Recommended

Description: This measure assesses the rate of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth; **Measure Type**: Outcome; **Level of Analysis**: Facility, Other; **Setting of Care**: Inpatient/Hospital; **Data Source**: Electronic Health Records, Other, Paper Medical Records.

The Standing Committee recommended the measure for continued endorsement. The Committee agreed that this is an important area of measurement. It determined there continues to be evidence to support the measure. The Committee observed that there is a performance gap and did not express any concerns. The Committee did not express any concerns related to reliability and validity. However, one Committee member noted that occasionally this measure will capture some effects of care provided outside of a hospital when home births end up being sent to a hospital during labor due to an issue prior to admission. The measure was regarded as feasible with no concerns expressed. In discussions related to usability and use, the Committee recognized that the measure will be publicly reported in The Joint Commission's Quality Check program in January 2021—with the delay due to COVID-19. The Committee also noted that the developer is hoping to include this measure in future continuing customer engagement endeavors to improve usability. The Committee observed that there are no related and competing measures to discuss for this measure.

0716 Unexpected Complications in Term Newborns (California Maternal Quality Care Collaborative): Recommended

Description: This is a hospital level performance score reported as the percent of infants with unexpected newborn complications among full term newborns with no preexisting conditions, typically calculated per year. The Unexpected Complications in Term Newborns metric measures adverse outcomes resulting in severe or moderate morbidity in otherwise healthy term infants without preexisting conditions; **Measure Type**: Outcome; **Level of Analysis**: Facility, Integrated Delivery System, Population : Regional and State; **Setting of Care**: Inpatient/Hospital; **Data Source**: Claims.

The Standing Committee recommended the measure for continued endorsement. The Committee agreed that this is an important area of measurement and serves as a balancing measure for NQF #0471, *PC-02 Cesarean birth*. The Committee determined that there continue to be actions providers can take to influence outcomes and improve performance on this measure. The Committee observed that there is a performance gap and did not express any concerns. Regarding scientific acceptability, it expressed some concern related to the accuracy of the length of stay, given that some healthy term newborns may have an increased stay due to their mother's illness, rather than their own complications. The Committee decided that the measure's separation into moderate and severe newborn complications addresses this issue by ensuring that only major neonatal complications are captured. After some discussion, the Committee agreed the measure was reliable and valid and accepted the Scientific Methods Panel's (SMP) rating of high and moderate, respectively for both criteria. The measure was regarded as feasible with no concerns expressed. In its discussions related to usability and use, the Committee noted that there have been improvements in care that impact the measure score. The

Committee noted improvement over time in performance and no significant unintended consequences. The Committee also observed that there are no related and competing measures to discuss for this measure.

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Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Measures Recommended

0469 PC-01 Elective Delivery

Submission | Specifications

Description: This measure assesses patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed

Numerator Statement: Patients with elective deliveries with ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for one or more of the following: Medical induction of labor as defined in Appendix A, Table 11.05 of the measure submission, while not in Labor prior to the procedure, Cesarean birth as defined in Appendix A, Table 11.06 of the measure submission and all of the following: not in Labor, no history of a Prior Uterine Surgery

Denominator Statement: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed with ICD-10-PCS Principal or Other Procedure Codes for delivery as defined in Appendix A, Table 11.01.1 of the measure submission and with ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for planned cesarean birth in labor as defined in Appendix A, Table 11.06.1 of the measure submission

Exclusions: ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07 of the measure submission include the following: History of prior stillbirth, Less than 8 years of age, Greater than or equal to 65 years of age, Length of Stay >120 days, Gestational Age < 37 or >= 39 weeks or UTD

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility, Other

Setting of Care: Inpatient/Hospital

Type of Measure: Process

Data Source: Electronic Health Records, Other, Paper Medical Records

Measure Steward: The Joint Commission

STANDING COMMITTEE MEETING [06/26/2020]

1. Importance to Measure and Report: The measure meets the importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-9; M-8; L-0; I-0**; 1b. Performance Gap: **H-5; M-12; L-0; I-0**;

Rationale:

- The Committee noted that evidence presented by the developer suggests a need to measure the rate of elective deliveries prior to 39 weeks gestation, as there are multiple guidelines that require 39 weeks gestation prior to an elective delivery.
- For performance gap, the Committee noted that 9% of hospitals report rates higher than the goal of 5% elective delivery rates. Although this is a relatively small gap, the Committee agreed that without a measure of elective delivery, rates could drift, and elective deliveries could increase.
- The Committee also noted significant disparities in elective deliveries by age.

2. Scientific Acceptability of Measure Properties: The measure meets the scientific acceptability criteria

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **H-5; M-12; L-0; I-0**; 2b. Validity: **H-3; M-13; L-1; I-0**

Rationale:

- The Committee noted that the rate of medically indicated deliveries has changed over time and that this could be due to certain conditions being poorly coded; this may have had an effect on both the measure's the measure's validity.

0469 PC-01 Elective Delivery

- The Committee expressed a desire to see analyses from the developer regarding the effects of implicit bias and institutional racism, which could support a risk adjustment model to account for significant disparities in the measure. For example, patients with no prenatal care might be excluded from the measure. However, no risk adjustment was supplied for the Committee's consideration this cycle.
- The Committee agreed that the measure is significantly associated with Neonatal Intensive Care Unit (NICU) admissions and harm to newborns, and its validity is demonstrated by that correlation.

3. Feasibility: H-5; M-12; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The Committee did not have any significant concerns about feasibility of the measure.

4. Usability and Use: The maintenance measure meets the use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-17; No Pass-0**; 4b. Usability: **H-8; M-9; L-0; I-0**

Rationale:

- This measure is publicly reported and used in the Hospital Inpatient Quality Reporting accountability program.
- The Committee noted that the developer has reported that modifications to the measure have been made in response to feedback from measure users over the years.
- The Committee had some concern that hospitals with higher risk patient populations may appear to have higher rates of elective delivery, when in fact quality care is being provided. It was noted, however, these hospitals likely have large denominators so that the effect on the measure is minimal. The Committee agreed this was not a significant enough concern for the usability of the measure.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Yes-17; No-0

6. Public and Member Comment

- No measure-specific comments were submitted for this measure

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision

8. Appeals

0469e PC-01 Elective Delivery e

Submission | Specifications

Description: This measure assesses patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed. *PC-01: Elective Delivery* has been re-engineered as an eCQM
Numerator Statement: Inpatient hospitalizations for patients with elective deliveries by either:
- Medical induction of labor while not in labor prior to the procedure
- Cesarean birth while not in labor and with no history of a prior uterine surgery
Denominator Statement: Inpatient hospitalizations for patients delivering newborns with >= 37 and < 39 weeks of gestation completed
Exclusions: Inpatient hospitalizations for patients with conditions possibly justifying elective delivery prior to 39 weeks gestation
Adjustment/Stratification: No risk adjustment or risk stratification
Level of Analysis: Facility, Other
Setting of Care: Inpatient/Hospital

0469e PC-01 Elective Delivery e

Type of Measure: Process
Data Source: Electronic Health Data, Electronic Health Records, Other
Measure Steward: The Joint Commission

STANDING COMMITTEE MEETING [06/26/2020]

1. Importance to Measure and Report: <u>The measure meets the importance criteria</u>

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-3; M-13; L-0; I-0**; 1b. Performance Gap: **H-9; M-7; L-0; I-0**;

<u>Rationale</u>:

- Although the evidence presented for #0469 is the same as the evidence presented for #0469e, the Committee could not carryover the evidence vote to #0469e, as quorum was not achieved during the evaluation of #0469. Therefore, a survey was distributed to gather quorum votes for #0469.
- The Committee noted that evidence presented by the developer suggests a continued need to measure the rate of elective deliveries prior to 39 weeks gestation, as there are multiple guidelines that require 39 weeks gestation prior to an elective delivery.
- For performance gap, this measure showed a significant and wide variation in performance by age and race.
- The mean gap is much larger for this measure (17.6%) compared to the "paper" version of the measure (1.7%). It was noted, however, that this large difference could reflect an issue with coding exclusions as well.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the scientific acceptability criteria</u>

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **H-1; M-10; L-4; I-2**; 2b. Validity: **H-2; M-12; L-2; I-0**

<u>Rationale</u>:

- The Committee had some concerns about the validity of the measure. First, it was not clear that the coding for exclusions was uniform across measured entities, which meant this could affect the apparent gap in performance between this measure and the "paper" version. Second, three of the six data elements had good agreement, as shown through their Kappa scores, but the other three data elements had poor Kappa scores.
- The concern about coding was not significant enough to vote the measure down, but the Committee stressed that when the measure comes back for maintenance, the developer should perform an analysis to see whether data extraction for exclusions has improved over time.
- The Committee's concern about the data element agreement also was not significant enough to vote the measure down. Although two of the data elements were viewed as critical, one (prior uterine surgery) was not viewed as vital for the calculation of the measure.
- The Committee also had concerns about specific capture of the estimated gestational age data element, but the developer explained how this information is captured and calculated automatically and assuaged the Committee's concerns on this matter.
- For validity of the measure, the Committee expressed concern about the lack of correlation with the "paper" version of the measure but was satisfied with the developer's response that this was due to small numerator sizes in the calculation of the correlation.

3. Feasibility: H-9; M-7; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Committee had no concerns about the feasibility of this measure, as all data elements are in a defined field in Electronic Health Records (EHRs).
- The Committee decided that although there are some discrepancies between this measure and its "paper" version, the feasibility of this eCQM is high.

4. Usability and Use: <u>The maintenance measure meets the use subcriterion</u>

0469e PC-01 Elective Delivery e

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-16; No Pass-0**; 4b. Usability: **H-2; M-10; L-3; I-2**

Rationale:

- This measure is not yet publicly reported, but is used in an accountability program, namely CMS's Hospital Inpatient Quality Reporting program.
- The Committee had some concerns about the lack of public reporting, and the developer explained that this is one of several eCQMs in a pool that hospitals may choose to report.
- The developer noted that the lack of public reporting has made it difficult to show whether there has been significant improvement in performance over time. However, the Committee decided that the small demonstration of improvement that the developer provided was sufficient to pass the measure on usability.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Yes-16; No-0

6. Public and Member Comment

- No measure-specific comments were submitted for this measure

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision

8. Appeals

0480 PC-05 Exclusive Breast Milk Feeding

Submission | Specifications

Description: This measure assesses the rate of newborns exclusively fed breast milk during the newborn´s entire hospitalization
Numerator Statement: Newborns that were fed breast milk only since birth
Denominator Statement: Single term liveborn newborns discharged alive from the hospital with ICD-10-CM Principal Diagnosis Code for single liveborn newborn as defined in Appendix A, Table 11.20.1 of the measure submission
Single term newborns discharged alive from the hospital
Liveborn newborns with ICD-10-CM Principal Diagnosis Code for single liveborn newborn as defined in Appendix A, Table 11.20.1 of the measure submission
Exclusions:
• Admitted to the NICU at this hospital during the hospitalization
• ICD-10-CM Other Diagnosis Codes for galactosemia as defined in Appendix A, Table 11.21 of the measure submission
• ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for parenteral infusion as defined in Appendix A, Table 11.22 of the measure submission
• Experienced death
• Length of Stay >120 days
• Patients transferred to another hospital
• Patients who are not term or with < 37 weeks gestation completed
Adjustment/Stratification: No risk adjustment or risk stratification
Level of Analysis: Facility, Other
Setting of Care: Inpatient/Hospital
Type of Measure: Process
Data Source: Electronic Health Records, Other, Paper Medical Records
Measure Steward: The Joint Commission

0480 PC-05 Exclusive Breast Milk Feeding

STANDING COMMITTEE MEETING [06/26/2020]

1. Importance to Measure and Report: <u>The measure meets the importance criteria</u>

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-1; M-14; L-2; I-0**; 1b. Performance Gap: **H-8; M-8; L-0; I-0**;

<u>Rationale</u>:

- The Committee agreed to carry-over the results from #0480e, as the evidence is the same.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the scientific acceptability criteria</u>

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **H-7; M-8; L-1; I-0**; 2b. Validity: **H-5; M-8; L-3; I-0**

<u>Rationale</u>:

- The Committee raised concern over the terminology of the exclusion and whether it was appropriate to exclude term newborns when this measure could apply to all infants. The Committee agreed that it was appropriate to use "term," since preterm infants have a distinct set of issues compared to term infants.

3. Feasibility: H-1; M-14; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Committee noted that this measure is more burdensome than the eCQM version, but it agreed that the lack of exclusions helped to reduce the burden of reporting for this measure.
- The Committee raised concerns that this measure was difficult to abstract, since each feeding must be reviewed.
- The Committee also noted it would be possible to automate this measure in an electronic medical record, but this would be highly dependent on the electronic medical record being used.

4. Usability and Use: <u>The maintenance measure meets the use subcriterion</u>

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-16; No Pass-0**; 4b. Usability: **H-0; M-15; L-1; I-0**

<u>Rationale</u>:

- The Committee noted that this measure has shown little improvement since 2015, but that it may be due low breastfeeding rates being a systemic problem. The Committee also agreed that this measure will improve over time and believed this measure does indicate a need for improvement.
- The Committee raised concerns around a potential unintended consequence of this measure: Specifically, a provider could unknowingly recommend breastfeeding in those medically unable to do so. The Committee acknowledged that while this is a concern, the benefits of this measure outweigh the potential unintended consequences.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Yes-15; No-1

6. Public and Member Comment

- One commenter suggested additional exclusions, such as diagnosis of hypoglycemia requiring treatment, mother transferred or admitted to the Intensive Care Unit and unable to breastfeed/pump, and newborn admission to an Intermediate Care Nursery.
- The developer response noted 100% attainment on the measure is not expected, and those mothers whose medications contraindicate breastfeeding are expected to fall in that 30% where a mother is not expected to breastfeed.

0480 PC-05 Exclusive Breast Milk Feeding

- The Committee ultimately agreed not to recommend the developer adopt the commenters' suggested exclusions.

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision

8. Appeals

0480e PC-05 Exclusive Breast Milk Feeding e

Submission | Specifications

Description: This measure assesses the rate of newborns exclusively fed breast milk during the newborn´s entire hospitalization. *PC-05: Exclusive Breast Milk Feeding* has been re-engineered as an eCQM
Numerator Statement: Inpatient hospitalization for newborns that were fed breast milk only since birth
Denominator Statement: Inpatient hospitalization for single newborns with an estimated gestational age at birth of >=37 weeks who are born in the hospital and who did not have a diagnosis of galactosemia, were not subject to parenteral nutrition, and had a length of stay of less than or equal to 120 days that ends during the measurement period
Exclusions:
- Inpatient hospitalization for newborns who were admitted to the Neonatal Intensive Care Unit (NICU)
- Inpatient hospitalization for newborns who were transferred to an acute care facility
- Inpatient hospitalization for newborns who were transferred to other health care facility
- Inpatient hospitalization for newborns who expired during the hospitalization

Adjustment/Stratification: No risk adjustment or risk stratification
Level of Analysis: Facility, Other
Setting of Care: Inpatient/Hospital
Type of Measure: Process
Data Source: Electronic Health Data, Electronic Health Records, Other
Measure Steward: The Joint Commission

STANDING COMMITTEE MEETING [06/26/2020]

1. Importance to Measure and Report: The measure meets the importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-1; M-14; L-2; I-0**; 1b. Performance Gap: **H-9; M-7; L-0; I-0**;

Rationale:

- The Committee noted that the evidence has not changed since the last submission of this measure and is still strong.
- The Committee raised concerns regarding the lack of exclusions related to the mother's choice and autonomy but acknowledged that the goal for this measure is 70%, mentioning that it may be burdensome to include maternal conditions, which may exclude a mother from this measure.
- The Committee also raised concerns over whether the 70% target would be achievable for hospitals that care for patients with higher rates of exclusive breast milk feeding contraindications.
- The Committee raised concerns that this measure does not specify that the milk should come from the infant's mother and could potentially result in donor milk being given to term infants rather than preterm infants who would benefit the most from it. The Committee also noted that this issue would disproportionately affect women of color due to the frequency of preterm births.
- The Committee noted that there may be an educational opportunity to inform hospitals that they will not improve their rates on this measure by giving donor milk to preterm infants.

2. Scientific Acceptability of Measure Properties: The measure meets the scientific acceptability criteria

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **H-0; M-15; L-1; I-1**; 2b. Validity: **H-3; M-10; L-3; I-1**

Rationale:

0480e PC-05 Exclusive Breast Milk Feeding e

- The Committee raised concerns that some data elements were not able to be assessed for accuracy.
- The Committee acknowledged that since the measure was submitted in 2016, some data elements have been updated.
- The Committee further noted that this measure is strongly correlated with the "paper" measure, #0480, and the concern about the data element testing was not significant enough to vote the measure down.

3. Feasibility: H-7; M-9; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The Committee did not express concerns around feasibility.

4. Usability and Use: The maintenance measure meets the use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-17; No Pass-1**; 4b. Usability: **H-2; M-14; L-2; I-0**

Rationale:

- For usability, the Committee's major concerns included medical need for supplementation and donor milk, which were noted during the evidence criterion and did not warrant additional discussion here.
- The Committee also raised concerns around racial and ethnic disparities and whether hospitals have reduced disparities. The developer explained that with targeted programs, some hospitals have seen improvement in this regard.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Yes-15; No-2

6. Public and Member Comment

- No measure-specific comments were submitted for this measure

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision

8. Appeals

0471 PC-02 Cesarean birth

Submission | Specifications

Description: This measure assesses the rate of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth
Numerator Statement: Patients with cesarean births with ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for cesarean birth as defined in Appendix A, Table 11.06 of the measure submission
Denominator Statement: The outcome target population being measured is: Nulliparous patients with an ICD-10-CM Principal or Other Diagnosis Code for outcome of delivery as defined in Appendix A, Table 11.08 of the measure submission and with a delivery of a newborn with 37 weeks or more gestation completed or with an ICD-10-PCS Principal or Other Procedure Codes for delivery as defined in Appendix A, Tables 11.01.1 of the measure submission.
Exclusions:
• ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for multiple gestations and other presentations as defined in Appendix A, Table 11.09 of the measure submission
• Less than 8 years of age
• Greater than or equal to 65 years of age
• Length of Stay >120 days

0471 PC-02 Cesarean birth

• Gestational Age < 37 weeks or UTD
Adjustment/Stratification: No risk adjustment or risk stratification
Level of Analysis: Facility, Other
Setting of Care: Inpatient/Hospital
Type of Measure: Outcome
Data Source: Electronic Health Records, Other, Paper Medical Records
Measure Steward: The Joint Commission

STANDING COMMITTEE MEETING [06/26/2020]

1. Importance to Measure and Report: The measure meets the importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Y-16; N-0**; 1b. Performance Gap: **H-9; M-7; L-0; I-0**;

Rationale:

- The Committee agreed that the evidence supplied in the measure submission supported the measures continued importance. Of particular interest was the evidence that labor and delivery guidelines have an impact on delivery outcomes, and that a reduction in cesarean sections was not associated with an increase in negative health outcomes.
- The Committee sought clarification from the developer on the way in which the measure will be reported. The developer confirmed that the measure will report whether an organization is at or below a threshold of 30 percent. If it is above this threshold, then the actual rate of cesarean sections will be reported.
- The Committee noted that there is considerable variability among reporting organizations and that more than half of the hospitals have not yet met the Healthy People 2020 goal of 23.9%.

2. Scientific Acceptability of Measure Properties: The measure meets the scientific acceptability criteria

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **H-4; M-12; L-0; I-0**; 2b. Validity: **H-4; M-12; L-0; I-0**

Rationale:

- The Committee had no concerns about the reliability of the measure.
- The Committee noted the measure is not risk adjusted, and further that there has been debate on whether this measure should be risk adjusted. Ultimately, the Committee agreed that increased transparency of data reporting might help resolve this issue.
- The Committee did not express concerns about the validity of the measure and agreed that the construct validity testing of the measure, which examined correlations between this measure and other Joint Commission measures, was sufficient to support the measure's validity.

3. Feasibility: H-2 M-14; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The Committee agreed that while reporting the measure is sometimes burdensome, it does not present a large enough problem to warrant significant concerns about the measure's feasibility.
- The developer noted that an eCQM version of this measure is being developed.

4. Usability and Use: The maintenance measure meets the use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-16; No Pass-0**; 4b. Usability: **H-0; M-15; L-1; I-0**

Rationale:

- The Committee noted that the measure will begin public reporting in July 2020 as part of the Joint Commission's Quality Check program; it also will be included in the 2020 Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP and the Medicaid Child Core set.

0471 PC-02 Cesarean birth

- The Committee noted that queries regarding implementation of this measure have decreased since its initial endorsement, signifying better usability of the measure.
- The Committee stressed there is still a great deal of room for improvement on this measure, as performance has not changed significantly since 2015.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Yes-16; No-0

6. Public and Member Comment

- One commenter expressed concern that the evidence vote was not consistent with the CDP. Specifically, the commenter noted that these measures have votes of "Yes/No" while the remaining spring 2020 measures have votes of "High", "Moderate", "Low", or "Insufficient".
- The Committee agreed that they followed the CDP during the measure evaluation meeting on June 26, 2020 and that the Committee is not charged with changing the criteria.

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision

8. Appeals

0716 Unexpected Complications in Term Newborns

Submission | Specifications

Description: This is a hospital level performance score reported as the percent of infants with Unexpected Newborn Complications among full term newborns with no preexisting conditions, typically calculated per year.
Numerator Statement: The numerator is divided into two categories: Severe complications and moderate complications.
Severe complications include neonatal death, transfer to another hospital for higher level of care, severe birth injuries such as intracranial hemorrhage or nerve injury, neurologic damage, severe respiratory and infectious complications such as sepsis. Parents of such babies may often worry about short- or long-term infant outcomes.
Moderate complications include diagnoses or procedures that raise concern but at a lower level than the list for severe (e.g. use of CPAP or bone fracture). For inclusion in the numerator, most require an infant length of stay that exceeds that of the mother, validating that these are indeed significant complications. Examples include less severe respiratory complications (e.g. Transient Tachypnea of the Newborn), or infections with a longer length of stay not including sepsis. As a "safety net" to capture cases who were under-coded, the numerator also includes infants who have a prolonged length of stay of over 5 days to capture the "seemingly normal" infants with neither any form of jaundice nor a social reason for staying in the hospital (e.g. family disruption or adoption).
Denominator Statement: The denominator is comprised of singleton, live born babies who are at least 37.0 weeks of gestation, and over 2500g in birth weight. The denominator excludes most serious fetal conditions that are "preexisting" (present before labor), including prematurity, multiple gestations, poor fetal growth, congenital malformations, genetic disorders, other specified fetal and maternal conditions and infants exposed to maternal drug use in-utero. The final denominator population consists of babies who are expected to do well following labor and delivery and go home routinely with their mothers.
Exclusions:
a) Babies not born in hospitals are excluded as this is a hospital quality performance measure
b) Babies who are part of multiple gestation pregnancies are excluded.
c) Premature infants (babies born before 37 weeks gestational age) are excluded
d) Low birth weight babies (<=2500g) are excluded
e) Babies with congenital malformations and genetic diseases are excluded
f) Babies with pre-existing fetal conditions such as IUGR are excluded
g) Babies who were exposed to maternal drug use in-utero are excluded

0716 Unexpected Complications in Term Newborns

Adjustment/Stratification: No risk adjustment or risk stratification
Level of Analysis: Facility, Integrated Delivery System, Population, Regional and State
Setting of Care: Inpatient/Hospital
Type of Measure: Outcome
Data Source: Claims
Measure Steward: California Maternal Quality Care Collaborative

STANDING COMMITTEE MEETING [06/26/2020]

1. Importance to Measure and Report: The measure meets the importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Y-15; N-2**; 1b. Performance Gap: **H-5; M-11; L-1; I-0**;

Rationale:

- The Committee reviewed the evidence submitted, in which the developer noted five studies that have used unexpected newborn complications as either a key outcome or important balancing measure during studies focused on improving obstetric practice and offer comparisons to other simultaneously collected neonatal outcome measures.
- The Committee agreed that the evidence supplied in the measure submission supported the measures continued importance.
- The Committee reviewed the distribution of the rates of unexpected newborn complications from 0.21 to 11.21, noting that a gap in care remains.

2. Scientific Acceptability of Measure Properties: The measure meets the scientific acceptability criteria

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **H-5; M-3; L-0; I-1**; 2b. Validity: **H-3; M-4; L-1; I-1**

Rationale:

- This measure was evaluated by the SMP. After a brief discussion, the Committee had no concerns and voted to accept the SMP's vote for reliability and validity. The votes above reflect the SMP members' vote. The Committee voted to accept the SMP's vote 15 for yes and 1 for no.

3. Feasibility: H-1; M-15; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The Committee had no concerns around feasibility.

4. Usability and Use: The maintenance measure meets the Use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-16; No Pass-0**; 4b. Usability: **H-6; M-10; L-1; I-0**

Rationale:

- The Committee noted that the measure is not publicly reported but is in use in the California Maternal Quality Care Collaborative and Blue Cross Blue Shield accountability programs.
- The Committee felt that the number of exclusions may present a challenge for hospitals to set this measure up for themselves, but the developer noted that the Joint Commission's third-party intermediary could be used to set up the algorithm for those hospitals.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Yes-16; No-1

6. Public and Member Comment

0716 Unexpected Complications in Term Newborns
• One commenter expressed concern that the evidence vote was not consistent with the CDP. Specifically, the commenter noted that these measures have votes of "Yes/No" while the remaining spring 2020 measures have votes of "High", "Moderate", "Low", or "Insufficient". • The Committee agreed that they followed the CDP during the measure evaluation meeting on June 26, 2020 and that the Committee is not charged with changing the criteria.
7. Consensus Standards Approval Committee (CSAC) Endorsement Decision
8. Appeals

Appendix B: Perinatal and Women's Health Portfolio—Use in Federal Programs

NQF #	Title	Federal Programs: Finalized or Implemented as of July 1, 2020
0033	Chlamydia Screening in Women (CHL)	Merit-Based Incentive Payment System (MIPS) Program (Implemented); Medicaid (Implemented); Marketplace Quality Rating System (QRS) (Implemented)
0304	Late Sepsis or meningitis in Very Low Birth Weight (VLBW) neonates (risk-adjusted)	None
0470	Incidence of Episiotomy	None
0476	PC-03 Antenatal Steroids	None
0478	Neonatal Blood Stream Infection Rate (NQI 03)	None
0483	Proportion of infants 22 to 29 weeks gestation screened for retinopathy of prematurity.	None
1382	Percentage of low birthweight births	Medicaid (Implemented)
1731	PC-04 Health Care-Associated Bloodstream Infections in Newborns	None
2902	Contraceptive Care - Postpartum	Medicaid (Implemented)
2903	Contraceptive Care – Most & Moderately Effective Methods	Medicaid (Implemented)
2904	Contraceptive Care - Access to LARC	Merit-Based Incentive Payment System (MIPS) Program (Implemented)

Appendix C: Perinatal and Women's Health Standing Committee and NQF Staff

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Appendix D: Measure Specifications

	0469 PC-01 Elective Delivery: Specifications
Steward	The Joint Commission
Description	This measure assesses patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed. This measure is part of a set of four nationally implemented measures that address perinatal care (PC-01: Elective Delivery, ePC-01: Elective Delivery; PC-02: Cesarean Birth, ePC-02: Cesarean Birth will be added as an eCQM 1/1/2020; PC-05: Exclusive Breast Milk Feeding, ePC-05: Exclusive Breast Milk Feeding; PC-06 Unexpected Complications in Term Newborns was added 1/1/2019). PC-01: Elective Delivery is one of three measures in this set that have been re-engineered as eCQMs (ePC-01 Elective Delivery, ePC-02 Cesarean Birth and ePC-05 Exclusive Breast Milk Feeding). A reduction in the number of non-medically indicated elective deliveries at >=37 to <39 weeks gestation results in a substantial decrease in neonatal morbidity and mortality, as well as a significant savings in health care costs. In addition, the rate of cesarean sections should decrease with fewer elective inductions resulting in decreased length of stay and health care costs (AAFP, 2000). The measure will assist health care organizations (HCOs) to track non-medically indicated early term elective deliveries and reduce the occurrence. American Academy of Family Physicians. (2000). Tips from Other Journals: Elective induction doubles cesarean delivery rate, 61, 4.Retrieved December 29, 2008 at: http://www.aafp.org/afp/20000215/tips/39.html.
Type	Process
Data Source	Electronic Health Records, Other, Paper Medical Records
Level	Facility, Other
Setting	Inpatient/Hospital
Numerator Statement	Patients with elective deliveries with ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for one or more of the following: Medical induction of labor as defined in Appendix A, Table 11.05 while not in Labor prior to the procedure, Cesarean birth as defined in Appendix A, Table 11.06 and all of the following: not in Labor, no history of a Prior Uterine Surgery.
Numerator Details	Four data elements are used to calculate the numerator: 1. ICD-10-PCS Other Procedure Codes - The International Classification of Diseases, Tenth Revision, Procedure Coding System code that identifies significant procedures performed other than the principal procedure during this hospitalization. 2. ICD-10-PCS Principal Procedure Code - The International Classification of Diseases, Tenth Revision, Procedure Coding System code that identifies the principal procedure performed during this hospitalization. The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication. 3. Labor- Documentation that the patient was in labor prior to induction and/or cesarean birth. Allowable values: Yes or No/UTD. 4. Prior Uterine Surgery- Documentation that the patient had undergone prior uterine surgery which includes: a prior classical cesarean birth defined as a vertical incision into the upper uterine segment, a prior myomectomy, a prior uterine surgery resulting in a perforation of the uterus due to an accidental injury, a 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, a history of uterine rupture requiring surgical repair, a history of a

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	cornual ectopic pregnancy, a history of a transabdominal cerclage, or a history of metroplasty and/or prior removal of vestigial horn with entry into the uterine cavity. Allowable Values: Yes or No/UTD Patients are eligible for the numerator population with ICD-10-PCS Other Procedure Codes or ICD-10-PCS Principal Procedure Code for medical induction or with ICD-10-PCS Other Procedure Codes or ICD-10-PCS Principal Procedure Code for cesarean birth when the allowable value equals "no" for the data elements Labor and Prior Uterine Surgery.
Denominator Statement	Patients delivering newborns with >= 37 and < 39 weeks of gestation completed with ICD-10-PCS Principal or Other Procedure Codes for delivery as defined in Appendix A, Table 11.01.1 and with ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for planned cesarean birth in labor as defined in Appendix A, Table 11.06.1.
Denominator Details	Seven data elements are used to calculate the denominator: 1. Admission Date – The month, day, and year of admission to acute inpatient care. 2. Birthdate - The month, day, and year the patient was born. 3. Discharge Date – The month, day, and year the patient was discharged from acute care, left against medical advice, or expired during the stay. 4. Gestational Age – Documentation of the weeks of gestation completed at the time of delivery. Allowable Values: 1-50 or UTD. 5. History of Stillbirth – Documentation that the patient had prior history of stillbirth. Allowable Values: Yes or No/UTD 6. ICD-10-CM Other Diagnosis Codes - The International Classification of Diseases, Tenth Revision, Clinical Modification codes associated with the other or secondary diagnoses for this hospitalization. 7. ICD-10-CM Principal Diagnosis Code - The International Classification of Diseases, Tenth Revision, Clinical Modification diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.
Exclusions	ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07 include the following: History of prior stillbirth, Less than 8 years of age, Greater than or equal to 65 years of age, Length of Stay >120 days, Gestational Age < 37 or >= 39 weeks or UTD
Exclusion details	Patients with ICD-10-CM Principal Diagnosis Code or Other Diagnosis Codes for conditions for possibly justifying elective delivery are excluded. The patient age in years is equal to the Admission Date minus the Birthdate. Patients less than 8 years of age or greater or equal to 65 years of age are excluded. Length of stay (LOS) in days is equal to the Discharge Date minus the Admission Date. If the LOS is greater than 120 days, the patient is excluded. Patients with a Gestational Age less than 37 weeks or equal to or greater than 39 weeks or UTD are excluded from the measure. Patients with a prior history of stillbirth are excluded from the measure.
Risk Adjustment	No risk adjustment
Stratification	No risk stratification
Type Score	Rate/proportion
Algorithm	1. Start processing. Run cases that are included in the PC-Mother Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure. 2. Check ICD-10-CM Principal or Other Diagnosis Codes

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	a) If at least one of the ICD-10-CM Principal or Other Diagnosis Codes is on Table 11.07, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing. b) If none of the ICD-10-CM Principal or Other Diagnosis Code is on Table 11.07, continue processing and proceed to Gestational Age. 3. Check Gestational Age a) If Gestational Age is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop Processing. b) If Gestational Age is less than 37 or greater than or equal to 39 or equal to a Not Unable to Determine Value, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop Processing. c) If Gestational Age is greater than or equal to 37 and less than 39, continue processing and proceed to Check History of Stillbirth. 4. Recheck ICD-10-CM Principal or Other Diagnosis Codes a) If at least one of the ICD-10-CM Principal or Other Diagnosis Code is on Table 11.06.1, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing. b) If none of the ICD-10-CM Principal or Other Diagnosis Code is on Table 11.06.1, continue processing and proceed to ICD-10-CM Principal or Other Procedure Codes. 5. Check ICD-10-PCS Principal or Other Procedure Codes a) If at least one of the ICD-10-PCS Principal or Other Procedure Codes is on Table 11.05, continue processing and proceed to Labor b) If Labor is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop Processing. c) If Labor equals No, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop Processing. d) If none of the ICD-10-CM Principal Procedure Codes is on Table 11.05, continue processing and proceed to recheck ICD- 10-PCS Principal or Other Procedure Codes. 6. Recheck ICD-10-PCS Principal or Other Procedure Codes a) If none of the ICD-10-PCS Principal or Other Procedure Code is on Table 11.06, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop Processing. b) If at least one of the ICD-10-PCS Principal or Other Procedure Code is on Table 11.06, continue processing and proceed to Labor. 7. Check Labor a) If Labor is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop Processing. b) If Labor equals Yes, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing. c) If Labor equals No, continue processing and proceed to Prior Uterine Surgery. 8. Check Prior Uterine Surgery a) If Prior Uterine Surgery is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop Processing. b) If Prior Uterine Surgery equals Yes, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing. c) If Prior Uterine Surgery equals No, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop Processing. Gestational Age. 9. Check History of Stillbirth (as of 1/1/2019 this check moves to last position)

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	a) If History of Stillbirth is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop Processing. b) If History of Stillbirth is Yes, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop Processing. c) If History of Stillbirth is No, continue processing and proceed to recheck ICD-10-CM Principal Procedure or Other Diagnosis Codes.Gestational Age. 4. Check Gestational Age a. If Gestational Age is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop Processing. b. If Gestational Age is less than 37 or greater than or equal to 39 or equal to a Not Unable to Determine Value, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop Processing. c. If Gestational Age is greater than or equal to 37 and less than 39, continue processing and proceed to recheck ICD-10-CM Principal Procedure or Other Diagnosis Codes. 5. Recheck ICD-10-CM Principal or Other Diagnosis Codes a. If at least one of the ICD-10-CM Principal or Other Diagnosis Code is on Table 11.06.1, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing. b. If none of the ICD-10-CM Principal or Other Diagnosis Code is on Table 11.06.1, continue processing and proceed to ICD-10-CM Principal or Other Procedure Codes. 6. Check ICD-10-PCS Principal or Other Procedure Codes a. If all of the ICD-10-PCS Principal or Other Procedure Codes are missing, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop Processing. b. If at least one of the ICD-10-PCS Principal or Other Procedure Codes is on Table 11.05, continue processing and proceed to Labor i. If Labor is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop Processing. ii. If Clinical Trial equals Yes, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop Processing. iii. If Labor equals No, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop Processing. c. If none of the ICD-9-CM Principal Procedure Codes is on Table 11.05, continue processing and proceed to recheck ICD-10-PCS Principal or Other Procedure Codes. 7. Recheck ICD-10-PCS Principal or Other Procedure Codes a. If none of the ICD-10-PCS Principal or Other Procedure Code is on Table 11.06, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop Processing. b. If at least one of the ICD-10-PCS Principal or Other Procedure Code is on Table 11.06, continue processing and proceed to Labor. 8. Check Labor a. If Labor is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop Processing. b. If Labor equals Yes, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing. c. If Labor equals No, continue processing and proceed to Spontaneous Rupture of Membranes. 9. Check Prior Uterine Surgery

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	a. If Prior Uterine Surgery is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop Processing. b. If Prior Uterine Surgery equals Yes, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing. c. If Prior Uterine Surgery equals No, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop Processing.
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	0469e PC-01 Elective Delivery e: Specifications
Steward	The Joint Commission
Description	This measure assesses patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed. This measure is part of a set of four nationally implemented measures that address perinatal care (PC-01: Elective Delivery, ePC-01: Elective Delivery; PC-02: Cesarean Birth, ePC-02: Cesarean Birth will be added as an eCQM 1/1/2020; PC-05: Exclusive Breast Milk Feeding, ePC-05: Exclusive Breast Milk Feeding; PC-06 Unexpected Complications in Term Newborns was added 1/1/2019). PC-01: Elective Delivery is one of three measures in this set that have been re-engineered as eCQMs (ePC-01 elective Delivery, ePC-05 Exclusive Breast Milk Feeding and ePC-02 Cesarean Birth). A reduction in the number of non-medically indicated elective deliveries at >=37 to <39 weeks gestation will result in a substantial decrease in neonatal morbidity and mortality, as well as a significant savings in health care costs. In addition, the rate of cesarean deliveries should decrease with fewer elective inductions resulting in decreased length of stay and health care costs (AAFP, 2000). The measure will assist health care organizations (HCOs) to track non-medically indicated early term elective deliveries and reduce the occurrence. American Academy of Family Physicians. (2000). Tips from Other Journals: Elective induction doubles cesarean delivery rate, 61, 4.Retrieved December 29, 2008 at: http://www.aafp.org/afp/20000215/tips/39.html.
Type	Process
Data Source	Electronic Health Records, Other, Paper Medical Records
Level	Facility, Other
Setting	Inpatient/Hospital
Numerator Statement	Inpatient hospitalizations for patients with elective deliveries by either: - Medical induction of labor while not in labor prior to the procedure - Cesarean birth while not in labor and with no history of a prior uterine surgery
Numerator Details	The numerator includes the following two key items to calculate the cases from the target population. -The 'Medical Induction' of labor should occur 24 hours or less before labor and is represented as a code from one of the following value sets and the associated QDM datatype:

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	o Procedure, Performed: Medical Induction of Labor (OID 2.16.840.1.113883.3.117.1.7.1.288) o Procedure, Performed: Artificial Rupture of Membranes (OID 2.16.840.1.113762.1.4.1045.57) o Medication, Administered: Oxytocin (OID 2.16.840.1.113762.1.4.1045.55) o Medication, Administered: Dinoprostone (OID 2.16.840.1.113762.1.4.1045.56) -The 'Labor' should occur during the delivery encounter and is represented with the QDM datatype and value set of Assessment, Performed: Labor (OID 2.16.840.1.113883.3.117.1.7.1.281) - The 'Cesarean Birth' should start during the delivery encounter and is represented with the QDM data type and value set of "Procedure, Performed: Cesarean Birth (OID 2.16.840.1.113883.3.117.1.7.1.282) - The history of 'Prior Uterine Surgery' should start before the start of the delivery encounter and is represented as a code from one of the following value sets and the associated QDM datatype: o Diagnosis: Perforation of Uterus (OID 2.16.840.1.113762.1.4.1110.14) o Diagnosis: Uterine Window (OID 2.16.840.1.113883.3.117.1.7.1.137) o Diagnosis: Uterine Rupture (OID 2.16.840.1.113762.1.4.1110.16) o Diagnosis: Cornual Ectopic Pregnancy (OID 2.16.840.1.113762.1.4.1110.12) o Procedure, Performed: Classical Cesarean Birth (OID 2.16.840.1.113883.3.117.1.7.1.421) o Procedure, Performed: Myomectomy (OID 2.16.840.1.113883.3.117.1.7.1.422) o Procedure, Performed: Transabdominal Cerclage (OID 2.16.840.1.113762.1.4.1110.18) o Procedure, Performed: Metroplasty (OID 2.16.840.1.113762.1.4.1110.25) o Procedure, Performed: Uterine Horn (OID 2.16.840.1.113762.1.4.1110.24) To access the value sets for the measure, please visit the Value Set Authority Center (VSAC), sponsored by the National Library of Medicine at this link: https://vsac.nlm.nih.gov/.
Denominator Statement	Inpatient hospitalizations for patients delivering newborns with >= 37 and < 39 weeks of gestation completed.
Denominator Details	The denominator includes the following key elements: - The delivery encounter must be less than or equal to 120 days during the measurement period and is represented with the QDM datatype and value set of Encounter, Performed: Encounter Inpatient (2.16.840.1.113883.3.666.5.307) - The patient must be between the ages of 8 years and less than 65 years at the start of the delivery encounter and is represented with the QDM datatype and direct reference code of Patient Characteristic Birthdate: Birth date (LOINC Code 21112-8) - The 'Delivery Procedure' should start during the delivery encounter and is represented with the QDM datatype and value set of Procedure, Performed: Delivery Procedures (OID:2.16.840.1.113762.1.4.1045.59) - The 'Estimated Gestational Age' should be the last assessment within 1 day or less prior to or at the same time as the delivery and be greater than or equal to 37 weeks and less than 39 weeks and is represented with the QDM datatype and value set of Assessment, Performed: Estimated Gestational Age at Delivery (OID: 2.16.840.1.113762.1.4.1045.26) - The 'Time of Delivery' should occur during the delivery encounter and is represented with the QDM datatype and value set of Assessment, Performed: Time of Delivery (OID: 2.16.840.1.113762.1.4.1045.28) - The 'Time of Delivery' should occur during the delivery encounter and is represented with the QDM datatype and value set of Assessment, Performed: Time of Delivery (OID: 2.16.840.1.113762.1.4.1045.28)

	0469e PC-01 Elective Delivery e: Specifications
Exclusions	Inpatient hospitalizations for patients with conditions possibly justifying elective delivery prior to 39 weeks gestation.
Exclusion details	- The 'Conditions Possibly Justifying Elective Delivery' should be present during the delivery encounter and are represented with the QDM datatype, attribute and value set: Diagnosis: Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation using Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation Grouping Value Set (2.16.840.1.113883.3.117.1.7.1.286) Encounter diagnoses: Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation using Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation Grouping Value Set (2.16.840.1.113883.3.117.1.7.1.286)
Risk Adjustment	No risk adjustment
Stratification	No risk stratification
Type Score	Rate/proportion
Algorithm	See attached HQMF file
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	0480 PC-05 Exclusive Breast Milk Feeding: Specifications
Steward	The Joint Commission
Description	PC-05 assesses the rate of newborns exclusively fed breast milk during the newborn´s entire hospitalization. This measure is part of a set of four nationally implemented measures that address perinatal care (PC-01: Elective Delivery, ePC-01: Elective Delivery; PC-02: Cesarean Birth, ePC-02: Cesarean Birth will be added as an eCQM 1/1/2020; PC-05: Exclusive Breast Milk Feeding, ePC-05: Exclusive Breast Milk Feeding; PC-06 Unexpected Complications in Term Newborns was added 1/1/2019). PC-05: Exclusive Breast Milk Feeding is one of three measures in this set that have been re-engineered as eCQMs (ePC-01 Elective Delivery, ePC-02 Cesarean Birth, and ePC-05 Exclusive Breast Milk Feeding). Increasing the number of newborns who are exclusively fed breast milk for the first six months of life remains a major goal of the WHO, DHHS, AAP and ACOG. Guidelines for the promotion of breast milk feeding are available from the CDC to assist hospitals in establishing successful interventions to improve exclusive breast milk feeding rates in newborns. Breast milk feeding results in numerous health benefits for both mother and newborn. Breastfeeding is associated with decreased risk for many early-life diseases and conditions, including otitis media, respiratory tract infections, atopic dermatitis, gastroenteritis, type 2 diabetes, sudden infant death syndrome, and obesity. Breastfeeding also is associated with health benefits to women, including decreased risk for type 2 diabetes, ovarian cancer, and breast cancer. The measure will assist health care organizations (HCOs) to track evidence of an increase in the number of newborns who were exclusively fed breast milk during the birth hospitalization.
Type	Process

	0480 PC-05 Exclusive Breast Milk Feeding: Specifications
Data Source	Electronic Health Records, Other, Paper Medical Records
Level	Facility, Other
Setting	Inpatient/Hospital
Numerator Statement	Newborns that were fed breast milk only since birth
Numerator Details	One data element is used to calculate the numerator: 1. Exclusive Breast Milk Feeding - Documentation that the newborn was exclusively fed breast milk during the entire hospitalization. Allowable Values: Yes or No/UTD. Cases are eligible for the numerator when allowable value = yes.
Denominator Statement	Single term liveborn newborns discharged alive from the hospital with ICD-10-CM Principal Diagnosis Code for single liveborn newborn as defined in Appendix A, Table 11.20.1. Single term newborns discharged alive from the hospital Liveborn newborns with ICD-10-CM Principal Diagnosis Code for single liveborn newborn as defined in Appendix A, Table 11.20.1
Denominator Details	Ten data elements are used to calculate the denominator: 1. Admission Date – The month, day, and year of admission to acute inpatient care. 2. Admission to NICU - Documentation that the newborn was admitted to the Neonatal Intensive Care Unit (NICU) at this hospital any time during the hospitalization. Allowable values: Yes or No/UTD 3. Birthdate - The month, day, and year the patient was born. 4. Discharge Date – The month, day, and year the patient was discharged from acute care, left against medical advice, or expired during the stay. 5. Discharge Disposition - The place or setting to which the patient was discharged. (On the day of discharge) 6. ICD-10-CM Other Diagnosis Codes - The International Classification of Diseases, Tenth Revision, Clinical Modification codes associated with the other or secondary diagnoses for this hospitalization. 7. ICD-10-PCS Other Procedure Codes - The International Classification of Diseases, Tenth Revision, Procedure Coding System code that identifies significant procedures performed other than the principal procedure during this hospitalization. 8. ICD-10-CM Principal Diagnosis Code - The International Classification of Diseases, Tenth Revision, Clinical Modification code associated with the diagnosis that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization. 9. ICD-10-CM Principal Procedure Code - The International Classification of Diseases, Tenth Revision, Procedure Coding System code that identifies the principal procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication. 10. Term Newborn - Documentation that the newborn was at term or >= 37 completed weeks of gestation at the time of birth. 1. Yes, there is documentation that the newborn was at term or >= 37 completed weeks of gestation at the time of birth. 2. No, there is documentation that the newborn was not at term or >= 37 completed weeks of gestation at the time of birth. 3. UTD, unable to determine from medical record documentation.
Exclusions	• Admitted to the Neonatal Intensive Care Unit (NICU) at this hospital during the hospitalization

	0480 PC-05 Exclusive Breast Milk Feeding: Specifications
	• ICD-10-CM Other Diagnosis Codes for galactosemia as defined in Appendix A, Table 11.21 • ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for parenteral infusion as defined in Appendix A, Table 11.22 • Experienced death • Length of Stay >120 days • Patients transferred to another hospital • Patients who are not term or with < 37 weeks gestation completed
Exclusion details	• The data element Admission to NICU is used to determine if the patient was admitted to the NICU. • Patients with ICD-10-CM Other Diagnosis Codes for galactosemia are excluded. • Patients with ICD-10-PCS Principal Procedure Code or ICD-10-PMS Other Procedure Codes for parenteral infusion are excluded. • Length of stay (LOS) in days is equal to the Discharge Date minus the Admission Date. If the LOS is greater than 120 days, the patient is excluded. • The data element Discharge Disposition is used to determine if the patient was transferred to another hospital or expired. • The data element Term Newborn is used to determine if the patient was not term or < 37 completed weeks of gestation.
Risk Adjustment	No risk adjustment
Stratification	No risk stratification
Type Score	Rate/proportion
Algorithm	1. Start processing. Run cases that are included in the PC-Newborn Initial Patient Newborns with Breast Feeding and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure. 2. Check Discharge Disposition a) If Discharge Status is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing. b) If Discharge Status equals 4,5, 6, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop processing. c) If Discharge Status equals 1, 2, 3, 7, 8, continue processing and proceed to Term Newborn. 3. Check Term Newborn a) If Term Newborn is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing. b) If Term Newborn =1 the case will proceed to a Measure Category Assignment of E and will be in the Numerator population. Stop processing. c) If Term Newborn =2 or 3, the case will proceed to a Measure Category Assignment of B and Not in the Measure Population. Stop processing. 4. Check Admission to NICU a) If Admission to NICU is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing. b) If Admission to NICU equals Yes, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop processing. c) If Admission to NICU equals No, continue processing and proceed to Exclusive Breast Milk Feeding. 5. Check Exclusive Breast Milk Feeding

	0480 PC-05 Exclusive Breast Milk Feeding: Specifications
	a) If Exclusive Breast Milk Feeding is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing. b) If Exclusive Breast Milk Feeding equals Yes, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop processing. c) If Exclusive Breast Milk Feeding equals No, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.
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	0480e PC-05 Exclusive Breast Milk Feeding e: Specifications
Steward	The Joint Commission
Description	PC-05 assesses the rate of newborns exclusively fed breast milk during the newborn´s entire hospitalization. This measure is a part of a set of four nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, ePC-02 Cesarean Birth will be added as an eCQM 1/1/2020, PC-06 Unexpected Complications in Term Newborns was added as a chart-based measure on 1/1/2019). ePC-05: Exclusive Breast Milk Feeding, is one of three measures in this set that has been reengineered as eCQMs and is included in the Hospital Inpatient Quality Reporting (IQR) Program and the Medicare and Medicaid Promoting Interoperability programs. Increasing the number of newborns who are exclusively fed breast milk for the first six months of life remains a major goal of the WHO, DHHS, AAP and ACOG. Guidelines for the promotion of breast milk feeding are available from the CDC to assist hospitals in establishing successful interventions to improve exclusive breast milk feeding rates in newborns. Breast milk feeding results in numerous health benefits for both mother and newborn. Breastfeeding is associated with decreased risk for many early-life diseases and conditions, including otitis media, respiratory tract infections, atopic dermatitis, gastroenteritis, type 2 diabetes, sudden infant death syndrome, and obesity. Breastfeeding also is associated with health benefits to women, including decreased risk for type 2 diabetes, ovarian cancer, and breast cancer. The measure assists health care organizations (HCOs) to track evidence of increases in the number of newborns who were exclusively fed breast milk during the birth hospitalization.
Type	Process
Data Source	Electronic Health Records, Other, Paper Medical Records
Level	Facility, Other
Setting	Inpatient/Hospital
Numerator Statement	Inpatient hospitalization for newborns that were fed breast milk only since birth
Numerator Details	The following items are used to calculate the cases from the target population: - Administration of breast milk is represented with the QDM datatype and value set of Substance, Administered: Breast Milk (OID: 2.16.840.1.113883.3.117.1.7.1.30)

	0480e PC-05 Exclusive Breast Milk Feeding e: Specifications
	- Administration of other dietary intake is represented with Substance, Administered: Dietary Intake Other than Breast Milk (OID: 2.16.840.1.113883.3.117.1.7.1.27) To access the value sets for the measure, please visit the Value Set Authority Center (VSAC), sponsored by the National Library of Medicine, at this link: https://vsac.nlm.nih.gov/
Denominator Statement	Inpatient hospitalization for single newborns with an estimated gestational age at birth of >=37 weeks who are born in the hospital and who did not have a diagnosis of galactosemia, were not subject to parenteral nutrition, and had a length of stay of less than or equal to 120 days that ends during the measurement period.
Denominator Details	The following items are used to calculate the cases from the target population/denominator: Inpatient Encounters are represented using the QDM datatype and value set of Encounter, Performed: Encounter Inpatient (OID: 2.16.840.1.113883.3.666.5.307). Length of stay is calculated within the measurement period based on inpatient encounter start and end dates. Single term newborns are represented by the following QDM datatypes, attributes and value sets: o Assessment, Performed: Gestational age at birth (Result>=37 weeks) using Gestational age at birth LOINC code 76516-4 o Encounter, Performed attribute diagnoses, Single Live Born Newborn Born in Hospital using Single Live Born Newborn Born in Hospital Grouping Value Set (2.16.840.1.113883.3.117.1.7.1.26) - Galactosemia is represented using the QDM datatype Encounter Performed attribute diagnoses and value set of Galactosemia (OID: 2.16.840.1.113883.3.117.1.7.1.35) - Parenteral Nutrition is represented using the QDM datatype and value set of Procedure, Performed: Parenteral Nutrition (OID: 2.16.840.1.113883.3.117.1.7.1.38)
Exclusions	- Inpatient hospitalization for newborns who were admitted to the Neonatal Intensive Care Unit (NICU) - Inpatient hospitalization for newborns who were transferred to an acute care facility - Inpatient hospitalization for newborns who were transferred to other health care facility - Inpatient hospitalization for newborns who expired during the hospitalization
Exclusion details	NICU admissions, transfers to another facility, and patient expiration are all represented in QDM as attributes of the inpatient encounter. o facility location: Neonatal Intensive Care Unit(NICU) (OID:2.16.840.1.113883.3.117.1.7.1.75) o discharge disposition: Patient Expired (OID:2.16.840.1.113883.3.117.1.7.1.309) o discharge disposition: Discharge to Acute Care Facility (OID:2.16.840.1.113883.3.117.1.7.1.87) o discharge disposition: Other Health Care Facility (OID: 2.16.840.1.113762.1.4.1029.67)
Risk Adjustment	No risk adjustment
Stratification	No risk stratification
Type Score	Rate/proportion
Algorithm	See attached HQMF file
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	0480e PC-05 Exclusive Breast Milk Feeding e: Specifications
	These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. The measures and specifications are provided without warranty.

	0471 PC-02 Cesarean birth: Specifications
Steward	The Joint Commission
Description	This measure assesses the rate of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. This measure is part of a set of four nationally implemented measures that address perinatal care (PC-01: Elective Delivery, ePC-01: Elective Delivery; PC-02: Cesarean Birth, ePC-02: Cesarean Birth will be added as an eCQM 1/1/2020; PC-05: Exclusive Breast Milk Feeding, ePC-05: Exclusive Breast Milk Feeding; PC-06 Unexpected Complications in Term Newborns was added 1/1/2019). PC-02: Cesarean Birth is one of three measures in this set that have been re-engineered as eCQMs (ePC-01 Elective Delivery, ePC-02 Cesarean Birth, and ePC-05 Exclusive Breast Milk Feeding). A reduction in the number of nulliparous patients with live term singleton newborns in vertex position (NTSV) delivering by cesarean birth will result in increased patient safety, a substantial decrease in maternal and neonatal morbidity and substantial savings in health care costs, Main et al. (2011). Successful quality improvement efforts incorporate audit and feedback strategies combined with provider and nurse education, guidelines and peer review. The measure will assist health care organizations (HCOs) to track nulliparous patients with live term singleton newborns in vertex position delivering by cesarean birth to reduce the occurrence. Nulliparous women have 4-6 times the cesarean birth rate than multiparous women; thus, the NTSV population is the largest driver of primary cesarean birth rate. Furthermore, nulliparity varies greatly among hospitals (20% to 60%) making it the most important risk factor for stratification or adjustment, Main et al. (2006). NTSV has the large variation among facilities, thus identifying an important population on which to focus quality improvement efforts. In addition, a reduction in primary cesarean births will reduce the number of women having repeat cesarean births (currently >90% of mothers who have a primary cesarean birth will have a Cesarean for all her subsequent births). Thus, improvement in the rates of cesarean birth for the first birth will reduce the morbidity of all future births and avoid all the controversies with trial of labor after cesarean/elective repeat cesareans. Main, E.K., Moore, D., Farrell, B., Schimmel, L.D., Altman, R.J., Abrahams, C., et al., (2006). Is there a useful cesarean birth measure? Assessment of the nulliparous term singleton vertex cesarean birth rate as a tool for obstetric quality improvement. Am J Obstet Gynecol. 194:1644-51. Main, E.K., Morton, C.H., Hopkins, D., Giuliani, G., Melsop, K. and Gould, J.B. (2011). Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality. Palo Alto, CA: CMQCC.
Type	Process
Data Source	Electronic Health Records, Other, Paper Medical Records
Level	Facility, Other
Setting	Inpatient/Hospital
Numerator Statement	Patients with cesarean births with ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for cesarean birth as defined in Appendix A, Table 11.06.

	0471 PC-02 Cesarean birth: Specifications
Numerator Details	Two data elements are used for the observed outcome and to calculate the numerator: 1. ICD-10-PCS Other Procedure Codes - The International Classification of Diseases, Tenth Revision, Procedure Coding System code that identifies significant procedures performed other than the principal procedure during this hospitalization. 2. ICD-10-PCS Principal Procedure Code - The International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) code that identifies the principal procedure performed during this hospitalization. The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.
Denominator Statement	The outcome target population being measured is: Nulliparous patients with an ICD-10-CM Principal or Other Diagnosis Code for outcome of delivery as defined in Appendix A, Table 11.08 and with a delivery of a newborn with 37 weeks or more gestation completed or with an ICD-10-PCS Principal or Other Procedure Codes for delivery as defined in Appendix A, Tables 11.01.1.
Denominator Details	Seven data elements are used to identify the outcome target population and to calculate the denominator: 1. Admission Date – The month, day, and year of admission to acute inpatient care. 2. Birthdate - The month, day, and year the patient was born. 3. Discharge Date – The month, day, and year the patient was discharged from acute care, left against medical advice, or expired during the stay. 4. Gestational Age – Documentation of the weeks of gestation completed at the time of delivery. Allowable Values: 1-50 or UTD. 5. ICD-10-CM Other Diagnosis Codes - The International Classification of Diseases, Tenth Revision, Clinical Modification codes associated with the other or secondary diagnoses for this hospitalization. 6. ICD-10-CM Principal Diagnosis Code - The International Classification of Diseases, Tenth Revision, Clinical Modification diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization. 7. Number of Previous Live Births - The number of deliveries resulting in a live birth the patient experienced prior to current hospitalization. Allowable Values: 0-50 or UTD (as of 1/1/2019 Previous Live Births - Documentation that the patient experienced a live birth prior to the current hospitalization. Allowable values: Yes or No/UTD.)
Exclusions	• ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for multiple gestations and other presentations as defined in Appendix A, Table 11.09 • Less than 8 years of age • Greater than or equal to 65 years of age • Length of Stay >120 days • Gestational Age < 37 weeks or UTD
Exclusion details	• Patients with ICD-10-CM Principal Diagnosis Code or Other Diagnosis Codes for multiple gestations and other presentations are excluded. Appendix A, Table 11.09 • The patient age in years is equal to the Admission Date minus the Birthdate. Patients less than 8 years of age or greater or equal to 65 years of age are excluded. • Length of stay (LOS) in days is equal to the Discharge Date minus the Admission Date. If the LOS is greater than 120 days, the patient is excluded. • Patients with a Gestational Age less than 37 weeks or UTD are excluded from the measure.
Risk Adjustment	No risk adjustment

	0471 PC-02 Cesarean birth: Specifications
Stratification	No risk stratification
Type Score	Rate/proportion
Algorithm	1. Start processing. Run cases that are included in the PC-Mother Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure. 2. Check ICD-10-CM Principal or Other Diagnosis Codes a) If at least one of the ICD-10-CM Principal or Other Diagnosis Code is on Table 11.09, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop processing. b) If none of the ICD-10-CM Principal or Other Diagnosis Code is on Table 11.09, continue processing and proceed to recheck ICD-10-CM Principal or Other Diagnosis Codes. 3. Recheck ICD-10-CM Principal or Other Diagnosis Codes a) If none of the ICD-10-CM Principal or Other Diagnosis Codes is on Table 11.08, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop processing. b) If at least one of the ICD-10-CM Principal or Other Diagnosis Codes is on Table 11.08, continue processing and proceed to Gestational Age. 4. Check Gestational Age a) If Gestational Age is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing. b) If Gestational Age is less than 37 or equal to an Unable to Determine Value, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop processing. c) If Gestational Age is greater than or equal to 37, continue processing and proceed to Number of Previous Live Births. 5. Check Previous Live Births a) If Previous Live Births is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop Processing. b) If Previous Live Births is Yes, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop Processing. c) If Previous Live Births is No, continue processing and proceed to recheck ICD-10-CM Principal Procedure or Other Diagnosis Codes. 6. Check ICD-10-PCS Principal or Other Procedure Codes a) If all of the ICD-10-PCS Principal or Other Procedure Codes are missing or none of the ICD-10-PCS Principal or Other Procedure Codes is on Table 11.06, the case will proceed to a Measure Category Assignment of D and will be in the measure population. Stop processing. b) If at least one of the ICD-10-PCS Principal or Other Procedure Code is on Table 11.06, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop processing.
Copyright / Disclaimer	No royalty or use fee is required for copying or reprinting this manual, but the following are required as a condition of usage: 1) disclosure that the Specifications Manual is periodically updated, and that the version being copied or reprinted may not be up-to-date when used unless the copier or printer has verified the version to be up-to-date and affirms that, and 2) users participating in Joint Commission accreditation, including vendors, are required to update their software and associated documentation based on the published manual production timelines.

	0716 Unexpected Complications in Term Newborns: Specifications
Steward	California Maternal Quality Care Collaborative
Description	This is a hospital level performance score reported as the percent of infants with Unexpected Newborn Complications among full term newborns with no preexisting conditions, typically calculated per year.
Type	Outcome
Data Source	Claims
Level	Facility, Integrated Delivery System, Population
Setting	Inpatient/Hospital
Numerator Statement	Numerator: The numerator is divided into two categories: Severe complications and moderate complications. Severe complications include neonatal death, transfer to another hospital for higher level of care, , severe birth injuries such as intracranial hemorrhage or nerve injury, neurologic damage, severe respiratory and infectious complications such as sepsis. Parents of such babies may often worry about short or long term infant outcomes. Moderate complications include diagnoses or procedures that raise concern but at a lower level than the list for severe (e.g. use of CPAP or bone fracture). For inclusion in the numerator, most require an infant length of stay that exceeds that of the mother, validating that these are indeed significant complications. Examples include less severe respiratory complications (e.g. Transient Tachypnea of the Newborn), or infections with a longer length of stay not including sepsis. As a "safety net" to capture cases who were under-coded, the numerator also includes infants who have a prolonged length of stay of over 5 days to capture the "seemingly normal" infants with neither any form of jaundice nor a social reason for staying in the hospital (e.g. family disruption or adoption).
Numerator Details	In the full term neonatal population that excluded premature infants, low birth weight babies, infants with congenital malformations, fetuses with pre-existing conditions such as IUGR and babies exposed to maternal drug use, babies were selected for inclusion in the numerator in a hierarchical manner as follows: PART A: Severe Complications: Identify and include the following in a hierarchical manner: a) Neonatal Deaths (Use patient discharge diagnosis data, specifically the disposition code for death) b) Neonatal Transfers (Use patient discharge diagnosis data, specifically the disposition code for transfer to a higher level of care) c) Severe Morbidities: (Use patient discharge diagnosis data, examining both primary and other diagnosis and procedure fields for ICD-10 Codes defining an array of specific severe complications. Please refer to Tables 11.36 thru 11.45 (Appendix 3, Groups 3A through 3I) with the specific ICD10 codes and descriptors listed in excel document in S.2b above and on our website. d) Sepsis with a neonatal Length of Stay that exceeds 4 days (Use patient discharge diagnosis data, examining both primary and other diagnosis fields for the specific ICD-9 code defining sepsis. Note that neonatal stay is defined as the date of discharge minus the date of birth). The neonates identified in Part A make up the "Severe Complications" component of the numerator. In the remaining infants (those without severe morbidities), identify and include the following PART B: Moderate Complications: Identify and include the following in a hierarchical manner:

	0716 Unexpected Complications in Term Newborns: Specifications
	a) Moderate complications not requiring a specific length of stay: Identify babies with moderate complications that do not require a specific length of stay for inclusion (Use Patient discharge Diagnosis data, examining both primary and other diagnosis and procedure fields for ICD-10 codes identifying specific moderate complications (see Table 11.46 thru Table 11.53 for the specific ICD10 codes and descriptors listed in excel document in S.2b above and on our website b) Specific Prolonged neonatal length of Stay stratified by method of delivery. Among babies who were delivered vaginally, identify those who have a length of stay of over 2 days. Among babies delivered via Cesarean Section, identify those who have a length of stay of over 4 days. (Use Z38.00 to identify vaginal births, and Z38.01 to identify Cesarean births. Z-codes are found in patient discharge data. Neonatal length of stay is defined as the date of discharge minus the date of birth). c) Moderate complications requiring a prolonged length of stay: Among the infants identified in step b, identify those with moderate complications (Use Patient discharge Diagnosis data, examining both primary and other diagnosis and procedure fields for ICD-10 codes identifying specific moderate complications that require a prolonged length of stay for inclusion in the numerator. See Table 11.46 thru Table 11.53) d) Prolonged neonatal Length of Stay that Exceeds 5 days: In the remaining population, identify babies who have a prolonged length of stay that exceeds 5 days. (Use Patient Discharge Diagnosis Data to determine Length of Stay. Neonatal length of stay is defined as the date of discharge minus the date of birth). e) Exclude infants with jaundice or social indications: Among babies identified as having a length of stay that exceeds 5 days, exclude those who have jaundice or are in hospital for social indications such as adoption or foster care. (See Table 11.33 thru Table 11.35 in the excel spread sheet in S.2b for jaundice and social exclusion codes)
Denominator Statement	The denominator is comprised of singleton, live born babies who are at least 37.0 weeks of gestation, and over 2500g in birth weight. The denominator excludes most serious fetal conditions that are “preexisting” (present before labor), including prematurity, multiple gestations, poor fetal growth, congenital malformations, genetic disorders, other specified fetal and maternal conditions and infants exposed to maternal drug use in-utero. The final denominator population consists of babies who are expected to do well following labor and delivery and go home routinely with their mothers.
Denominator Details	Step 1: Identify and include singleton, inborn, live births (Use Patient discharge Diagnosis data, specifically diagnosis Codes Z38.00 or Z38.01). Step 2: Identify and include babies with birth weight >= 2500g. (Use ICD10 codes for low birth weight, birth certificate or EMR). Step 3: Identify and include full term babies, >=37 weeks gestation (Use ICD10 codes or birth certificate variable called best obstetric estimate of gestational age or EMR data). Step 4: In less than 1% of cases, the best obstetric estimate of gestation age is missing. In these cases, use LMP-based gestational age to identify full term infants. (Use birth certificate or Patient Discharge data). Step 5: If both sources of gestational age are missing, include only infants who are over 3000g, as they are more likely to be full term. **Note: List of ICD-10 codes with individual descriptors is available in the Measure Specifications in S2b above and on our web-page as an excel file
Exclusions	a) Babies not born in hospitals are excluded as this is a hospital quality performance measure b) Babies who are part of multiple gestation pregnancies are excluded. c) Premature infants (babies born before 37 weeks gestational age) are excluded

	0716 Unexpected Complications in Term Newborns: Specifications
	d) Low birth weight babies (<=2500g) are excluded e) Babies with congenital malformations and genetic diseases are excluded f) Babies with pre-existing fetal conditions such as IUGR are excluded g) Babies who were exposed to maternal drug use in-utero are excluded
Exclusion details	a)Babies not born in hospitals are excluded as this is a hospital quality performance measure (Exclude all other live birth codes other than Z38.00 and Z38.01) b)Babies who are part of multiple gestation pregnancies are excluded. c)Premature infants (babies born before 37 weeks gestational age) are excluded (use best obstetric estimate of gestational age found in the birth certificate to exclude all infants born before 37 weeks. If best obstetric of gestational age is missing, use the LMP gestational age variable instead to identify infants under 37 weeks) d)Low birth weight babies (<=2500g) are excluded (Use birth certificate birth weight variable to identify infants under 2500g) e)Babies with congenital malformations and genetic diseases are excluded (Use ICD-10 codes listed in Table 11.30 to exclude infants with these conditions) f)Babies with pre-existing fetal conditions such as IUGR are excluded (Use ICD-10 codes listed in Table 31 to exclude infants with these conditions) g)Babies who were exposed to maternal drug use in-utero are excluded (Use ICD-10 codes listed in Table 32 to exclude infants with these conditions) The excel document is found in S2b above and on our website.
Risk Adjustment	No risk adjustment
Stratification	No risk stratification
Type Score	Rate/proportion
Algorithm	STEP 1: Calculate Denominator Inclusions a)Identify and include singleton, inborn, live births (Use Patient discharge Diagnosis data, specifically diagnosis Codes V30.00 or V30.01 listed in Appendix 1). b)Next, identify and include babies with birth weight >= 2500g. (Use birth certificate or Patient Discharge data). c)Next, identify and include full term babies, >=37 weeks gestation (Use birth certificate variable called best obstetric estimate of gestational age). In less than 1% of cases, the best obstetric estimate of gestation age is missing. In these cases, use LMP-based gestational age to identify full term infants. (Use birth certificate or Patient Discharge data). d)If both sources of gestational age are missing, include only infants who are over 3000g, as they are more likely to be full term. (Use the birth certificate variable for birth weight). STEP 2: Calculate Denominator Exclusions a)In the singleton, full term, population of neonates obtained in Step 1, identify and exclude babies with all congenital malformations and genetic disorders (Use codes listed in Appendix 2, Group A to exclude infants) b)After congenital malformations and genetic disorders are excluded, further exclude babies with fetal conditions such as IUGR (Use codes listed in Appendix 2, Group B to exclude infants) c)After babies with congenital malformations, genetic disorders and fetal conditions are excluded, further exclude infants who were exposed to maternal drug use in-utero. (Use codes listed in Appendix 2, Group C to exclude infants). d)This is the measure's final denominator population Step 3: Numerator Inclusions: PART A: SEVERE COMPLICATIONS

	0716 Unexpected Complications in Term Newborns: Specifications
	a)Identify and include Neonatal Deaths (Using patient discharge diagnosis data, specifically the disposition code for death) b)Identify and include neonatal transfers (Using patient discharge diagnosis data, specifically the disposition code for transfer to a higher level of care) c)Identify and include babies with "Apgar at 5 minutes" OR "Apgar at 10 minutes" scores of less than 4 (Use Birth certificate or medical record to obtain Apgar scores) d)Identify and include babies with Severe Morbidities (Use patient discharge diagnosis data, examining both primary and other diagnosis and procedure fields for specific ICD-9 Codes defining an array of specific severe complications. Please refer to Appendix 3, Groups 3A through 3I as the codes are too numerous to include here) e)Identify and include babies with a Sepsis code and a length of stay that exceeds 4 days (Use patient discharge diagnosis data, examining both primary and other diagnosis fields for the specific ICD-9 code defining sepsis but also requiring a neonatal length of stay of over 4 days. Note that neonatal stay is defined as the date of discharge minus the date of birth). The neonates identified in Step 3 comprise the "Severe Complications" component of the numerator. Step 4: Numerator Inclusions: PART B: MODERATE COMPLICATIONS In the remaining infants (those without severe morbidities), identify and include the following a)Identify babies with moderate complications that do not require a specific length of stay for inclusion (Use Patient discharge Diagnosis data, examining both primary and other diagnosis and procedure fields for specific ICD-9 codes identifying specific moderate complications (see Appendix 4, Groups A though C) b)Identify babies with a specified prolonged length of stay stratified by method of delivery. In the population of babies who were delivered vaginally, identify those who have a length of stay of over 2 days. Among babies delivered via Cesarean Section, identify those who have a length of stay of over 4 days. c)Among babies identified as having a prolonged length of stay (stratified by method of delivery), identify and include those who have moderate complications (Use Patient discharge Diagnosis data, examining both primary and other diagnosis and procedure fields for specific ICD-9 codes identifying specific moderate complications. See Appendix 4, Groups D through H) d)In the remaining population, identify babies who have a prolonged length of stay that exceeds 5 days. Use Patient Discharge Diagnosis Data to determine Length of Stay e)Among babies identified as having a length of stay that exceeds 5 days, exclude those who have jaundice or are in hospital for social indications such as adoption or foster care (See Appendix 5 for jaundice and social exclusion codes) Step 5: Calculation of Unexpected Complications in Term Newborns measure: Unexpected Newborn Complications (Total): Rate per 100 live births. (Severe Complications + Moderate Complications/ Final Denominator) x100
Copyright / Disclaimer	This measure will be in the public domain.

Appendix E: Related and Competing Measures

No related or competing measures were identified for all measures under review.

Appendix F: Pre-Evaluation Comments

Comments received as of June 15, 2020.

Topic	Commenter	Comment
0469e PC-01 Elective Delivery e (The Joint Commission)	Submitted by Federation of American Hospitals	The Federation of American Hospitals (FAH) appreciates the opportunity to comment on measure #469e *PC-01 Elective Delivery*, prior to the Standing Committee's evaluation. Specifically, the FAH asks the committee to discuss potential concerns with the validity of this electronic clinical quality measure (eCQM) in light of the kappa scores for two of the data elements (medical induction of labor and active labor). Because these data elements are integral to calculating the performance of the eCQM, the FAH does not believe that this measure meets the validity subcriterion and thus may not be appropriate for accountability uses at this time.

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