Pioneers in Quality Expert to Expert Series: 2025 Reporting Year Annual Updates for PC-02 and PC-07

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Good afternoon and welcome to our Expert to Expert webinar: Annual Updates for PC-02 and PC-07 eCQMs for 2025 Implementation. I'm Susan Funk, an Associate Project Director with The Joint Commission's Engagement and Quality Improvement team, and today I'll be serving as this webinar's facilitator. Thank you for joining us.

To start off, here we have a few comments about today's webinar platform. Use your computer speakers or headphones to listen. There are no dial-in lines. Participants are connected in listen-only mode. Feedback or dropped audio are common for live streaming events. Refresh your screen or rejoin the event if this occurs. We will not be recognizing the Raise a Hand or the Chat features. To ask a question, click on the Question Mark icon on the audience toolbar on the left side of your screen. A panel will open for you to type your question and submit. The slides are designed to follow Americans with Disability Act rules.

Before we get started covering today's electronic clinical quality measure content, we do want to explain that this webinar is highly technical and requires a baseline understanding of eCQM logic and concepts. Participant feedback from previous webinars indicated that the content is often too technical for individuals that are new to eCQMs to comprehend. We recommend that anyone new to eCQMs visit the eCQI Resource Center at the hyperlink provided on this slide. You will find a collection of resources to help you get started with eCQMs.

The slides are available now within the viewing platform. On the left side of the screen... On the left side of your navigation pane, select the document icon. A new pop-up window will open, and you can select the name of the file. A new browser window will open, and, from it, you can download or print the PDF of the slides. The slides will be posted at the link at the bottom of this screen within two weeks following this broadcast. One last note about the slides. The links are not clickable on screen within this viewing platform. However, if you download the slides, all of the links provided during the webinar are functional.

This webinar is approved for 1.5 continuing education credits or Qualifying Education Hours for the following organizations: the Accreditation Council for Continuing Medical Education, American Nurses Credentialing Center, American College of Healthcare Executives, and the California Board of Registered Nursing. Participants receive a certificate after completing the webinar and survey. Although we've listed the organizations that accredit Joint Commission to provide CEs, many other professional societies and state boards that are not listed accept credits or will match credit from Joint Commission's educational courses.

To earn CE credit, participants must individually register for this broadcast webinar, participate for the entire webinar, and complete a post-program evaluation and attestation survey. For more information on the Joint Commission's continuing education policies, visit the link at the bottom of this slide.

Just a few words about how to navigate to the CE survey and obtain your certificate. You will receive the CE survey link two ways. On the last slide, we've included a QR code accessible via most mobile devices. If you miss the QR code, you will also receive an automated email that includes the survey link.

After you submit the online evaluation survey, you will be redirected to a link from which you can print or download and save a CE certificate. In case you miss the popup screen with a certificate, an automated email will also deliver the certificate link. Complete the certificate by adding your own name and credentials.

The participant learning objectives for this webinar are: Locate measure specifications, value sets, Measure flow Diagrams and technical release notes on the eCQI Resource Center. Facilitate your organization's implementation of the PC-02 and PC-07 eCQM annual updates for the 2025 calendar year. And utilize answers regarding common issues and questions regarding the PC-02 and PC-07 eCQMs to inform 2025 eCQM use and implementation.

This webinar does not cover these topics: basic eCQM concepts, topics related to chart abstracted measures, process improvement efforts related to this measure, and eCQM validation. All staff and speakers have disclosed that they do not have any conflicts of interest.

For example, financial arrangements, affiliations with, or ownership of organizations that provide grants, consultancies, honoraria, travel, or other benefits that would impact the presentation of today's webinar content.

Myself, Susan Funk, Melissa Breth, Raquel Belarmino, Kelley Franklin, and Valery Danilack.

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The agenda for today's discussion follows. Highlight how to access eCQM resources on the eCQI Resource Center, review the PC-02 and PC-07 eCQM annual updates for reporting year 2025, review the measure flow and algorithm, review Frequently Asked Questions, and then we'll have a live facilitated audience Q&A segment during which we will reply to questions submitted during the broadcast.

We will now highlight how to access the CMS eCQI Resource Center. The eCQI Resource Center provides a centralized location for news, information, tools, and standards related to eCQMs. The majority of the tools and resources referenced within the eCQI Resource Center are openly available for stakeholder use and provide a foundation for the development, testing, certification, implementation, reporting, and continuous evaluation of eCQMs.

Raquel, when you have your screen up and ready, please go ahead and start your part of the presentation.

Okay, thank you, Susan. Hello, everyone. I am Raquel Belarmino, Associate Project Director for Clinical Quality Informatics. For the measure specifications and other helpful documents, navigate to the eCQI Resource Center website at https://ecqi.healthit.gov. Click on the second orange rectangle labeled Eligible Hospital/Critical Access Hospital eCQMs, which leads to a new webpage where you can download specifications or click on the hyperlink title of the desired measure and access and readily view the specifications and data elements.

Available documents include HTML version of the Human Readable measure specifications, value sets, data elements, the eCQM Flow, technical release notes of all changes for this year, and even link out to view Jira tickets submitted for the selected measure. The eCQM Flow document depicts the process flow diagrams that some may refer to as algorithms. They walk through the steps to take to calculate an eCQM. Value sets links out to the Value Set Authority Center, VSAC, where one will find all the terms and associated codes contained within each value set.

Note that a login is required, but anyone can request a UMLS account, and it's free. For more details, view the eCQI Resource Center Navigation video short. I now turn it over to Kelley to discuss ePC-02.

Thank you, Raquel. I'm Kelley Franklin. I am an Associate Project Director for Clinical Quality Measures, and I am the Clinical Lead for Perinatal Measures. We will now discuss ePC-02 in detail.

Next slide please.

The cesarean birth measure looks at Nulliparous Term Singleton Vertex Cesarean Rates, which is the primary cesarean of first births, Nulliparous, with term Singleton pregnancies in a head-down position. It's an important population to focus on because Nulliparous patients have four to six times the cesarean birth rate than multiparous patients, and therefore the NTSV population is the largest driver of the primary cesarean birth rate. In addition, a reduction in primary cesarean births will reduce the number of birthing persons having repeat cesarean sections, as almost 90% of those who have a primary C-section will have subsequent cesarean birth.

Next slide.

Although cesarean delivery can be lifesaving for the fetus, the mother, or both in certain cases, the rapid increase in the rate of cesarean births without evidence of decreases in maternal or neonatal morbidity and mortality raises significant concern that cesarean deliveries are overused.

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Studies have shown an increased risk of severe maternal morbidities, or SMM, for cesarean delivery compared to vaginal deliveries. Many studies have shown that physician factors rather than patient characteristics or obstetric diagnoses are the major driver for the differences in cesarean rates within the hospital. First-birth labor inductions and early labor admissions can also cause variations in the rates among hospitals. Main et al in 2012 found that over 60% of the variation in cesarean rates among hospitals can be attributed to first-birth labor induction rates and first-birth early labor admission rates. The results showed, if labor was forced when the cervix was not ready, the outcomes were poorer. The cesarean birth measure can assist organizations in monitoring their quality improvement efforts to reduce the NTSV cesarean rate. Cesarean birth rates have improved, however, there are still hospitals with rates that are over 30%.

The PC-02 measure, which earned endorsement from the National Quality Forum, or NQF, in 2022 is now endorsed by the Consensus-Based Entity, or CBE. As per the American College of Obstetricians and Gynecologists, or ACOG recommendations, cesarean delivery is indicated for patients with active genital lesions, genital herpes, or prodromal symptoms that may indicate viral shredding. Shedding, sorry. Therefore, the measure will exclude encounters with a diagnosis of active genital herpes. The accepted treatment for placenta accreta spectrum disorders, including placenta increta, percreta, and accreta, placenta previa, and vasa previa is cesarean delivery. So, placenta accreta spectrum was added to qualifying measure Exclusions as well.

To reiterate, the measure description for PC-02 is Nulliparous patients with a term, Singleton baby in a head-down or vertex position who are delivered by cesarean section. The Initial Population is inpatient hospitalizations for patients age greater than or equal to eight years and less than 65, admitted to the hospital for inpatient acute care who undergo a delivery procedure with a discharge date that ends during the measurement period.

The Denominator is inpatient hospitalizations for Nulliparous patients delivering a live term, single newborn greater than or equal to 37 weeks of gestation completed. The measure defines Nulliparous as a patient with gravida equal to 1 or parity equal to 0 or preterm and term births equal to 0. Denominator Exclusions are inpatient hospitalizations with abnormal presentation or placenta previa, placenta accreta spectrum disorders, vasa previa, or active genital herpes during the encounter. Please note that, throughout this presentation, underline is indicative of a change made during the most recent annual update cycle.

The Numerator is inpatient hospitalizations delivered by cesarean section. Please note, ePC-02 is an inverse measure and therefore, generally speaking, lower scores are better. The Joint Commission does not want to encourage inappropriately low cesarean rates that may be unsafe to patients. Acceptable PC-02 rates are 30% or lower, however, there's not an established threshold for what rate may be too low. PC-06 serves as a balancing measure for PC-02 to guard against any unanticipated or unintended consequences and to identify unforeseen complications that may arise. I will now turn it over to Raquel who will present the technical aspects for this measure.

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Thanks, Kelley. This table lists some of the technical changes to the measure. To clearly distinguish libraries used for measures based on the Quality Data Model, QDM, from those using the Fast Healthcare Interoperability Resources, FHIR information model, the MATGlobalCommonFunctions QDM and PCMaternalQDM libraries have been updated to include the letters QDM. Value set Payor was renamed to Payor Type to more accurately reflect the contents and intent of the value set.

As mentioned earlier by Kelley, placenta accreta spectrum includes placenta increta, percreta, and accreta, and the accepted treatment of the placenta accreta spectrum, placenta previa, and vasa previa is cesarean delivery. So, the value set Placenta Previa or Accreta or Vasa Previa was renamed to Placenta Accreta Spectrum Previa or Vasa Previa. Plus, the value set Genital Herpes was added based on ACOG recommendations since cesarean delivery is indicated for patients with active genital lesions, genital herpes, or prodromal symptoms that may indicate viral shedding. There were multiple values set changes made for reporting year 2025 with addition and/or deletion of codes due to terminology updates. Please see the VSAC for value sets and technical release notes accessible through the eCQI Resource Center for more details. The LastEstimatedGestationalAge function was captured by an assessment performed 24 hours or less before or on the last time of delivery.

This year, notice the timing has changed, with the EGATiming same day as logic that was added to the LastEstimatedGestationalAge function. This should account for events of precipitous deliveries. So, the EGA may now be captured from 24 hours before the encounter through, not just the time of the last time of delivery, but the same day as logic extends that time to the end of the day of delivery before midnight.

Since the Length of Stay requirement was removed from the Global Common Library, the Global.Inpatient Encounter definition was added to better align with measure intent and logic. This table presents how it is now utilized in the PCMaternal.Encounter with Age Range definition for this reporting year. In addition, day of timing was removed from the Initial Population to align datetime precision of Numerator and Denominator, which fixed a known technical issue of including a delivery procedure that unlikely occurred on the first or last day but not during the delivery encounter.

There were a couple modifications made to the Encounter with Abnormal Presentation definition this year. It was updated to specify that the delivery encounter includes the full hospitalization encounter to better align with measure intent. Plus, the definition was modified to improve readability. We will go into more of those details when we walk through the logic.

Next, we will review the Measure flow Diagram. Measure flow Diagrams provide a high-level overview of the steps to calculate the measures. The measure specifications are the source of truth, but the Measure flow Diagrams are like algorithms that can clarify the main concepts.

The Initial Population main definition for eP-02 is Delivery Encounter with Age Range. Three conditions must be met to qualify for this definition. An inpatient encounter must be present, the patient must be greater or equal to eight and less than sixty-five years of age, and there must be a procedure code from the Delivery Procedure value set with a start date during the hospitalization encounter.

If the criteria is met, the patient is in the Initial Population. If not, the patient is not in the Initial Population and processing ends.

The Denominator flow diagram is a little bit more complex and will be covered on the next two slides. The main definition is Singleton Delivery Encounters at 37 Plus Weeks Gravida 1, Parity 0, No Previous Births. To start, one of three definitions must be met to determine that Gestational Age is greater or equal to 37 weeks. The first is the calculated Gestational Age greater or equal to 37 weeks. The calculated Gestational Age is based on ACOG's revitalized definition and is the preferred method of determining Gestational Age. The second is the estimated Gestational Age. If the calculated Gestational Age is null, the estimated gestational is the next preferred method to determine Gestational Age.

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The third and last way to determine Gestational Age is based on ICD-10 or SNOMED codes. This is the lowest in the hierarchy. Calculated and estimated Gestational Age must be null to invoke this logic. If one of these definitions are met, they must now intersect with the Encounter with Singleton Delivery definition, as the measure only includes single births. If the criteria is not met, processing ends. If the criteria is met, the measure flow continues on the next page.

We continue to determine if the Denominator is met by determining if gravidity is one or the parity equals 0 or both preterm and term births are equal 0. If just one of these conditions are met, the patient will be in the Denominator. If not, processing ends. Note the a1, a2, a3 notations in the small diamonds. We will refer back to these notations when we get to the sample calculations.

Now that we have our Denominator cases, we need to determine if any should be excluded. There are two definitions that could be met. The first is if there is an encounter with abnormal presentation, and the second is if the encounter has genital herpes or placenta accreta spectrum or vasa previa. If either is met, the patient meets the Denominator Exclusion. If not met, the patient continues on through the algorithm to be considered if the Numerator is met. Again, note the b1, b2 in the small diamonds to be used later in the sample calculation.

Our Numerator is fairly straightforward. Did the patient have a cesarean birth during the encounter? No? The patient is not in the Numerator. Yes? the patient is in the Numerator. And, again, note the c notation in the small diamond. At the bottom, the sample calculation is available. Now that the Numerator, Denominator, and Denominator Exclusions are defined, we can plug the quantities into the calculation formula. Note the diamond notations referenced from the previous slides.

So now that you have a high-level overview of the logic flow, we will dive into the specifics of the logic. The main Initial Population definition is Delivery Encounter with Age Range, which is stored in the PCMaternal Library. The PCMaternal Library stores definitions and functions which are used by both maternal measures in the CMS program, i.e., PC-02 and PC-07, as well as PC-01 in The Joint Commission ORYX program. This definition identifies patients that had a qualifying delivery procedure during this hospitalization. Recall that hospitalization function returns the total interval from the start of any immediately prior emergency department visit or OB triage visit, through the observation visit, to the discharge of the given encounter.

If you would like more information about this concept, please review the Hospitalization with Observation video short listed on the Resources slide at the end of this presentation. Note that day of has been removed to align datetime precision of Numerator and Denominator, which fixes a known issue.

This definition calls the definition titled Encounter with Age Range, which is also stored in the PCMaternal QDM Library. Since the Length of Stay requirement was removed from the Global Common Library, the Global.Inpatient Encounter definition that specifies the EncounterInpatient.relevantPeriod ends during day of measurement period has been inserted here.

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The Denominator definition is Singleton Delivery Encounters at 37 Plus Weeks Gravida 1, Parity 0, No Previous Births. We will look at each line of this logic in detail.

Let's start with the Delivery Encounter with Gestational Age Greater Than or Equal to 37 Weeks definition. Redefinitions are unioned here to reflect the three approaches to determining Gestational Age.

The first definition in the union statement is Delivery Encounter with Calculated Gestational Age Greater or Equal to 37 Weeks. The initial patient population, Delivery Encounter with Age Range, is our starting point. Then the CalculatedGestationalAge function is used to narrow the population. This function is stored in the PCMaternal Library. It calculates the Gestational Age based on ACOG's revitalized definition. The function calculates the difference in days between the LastTimeOfDelivery and LastEstimatedDeliveryDate, then subtracts that from 280 and divides by seven. We will discuss these functions in greater detail on the next few slides.

Let's discuss the PCMaternal.LastTimeOfDelivery function. This function's purpose is to gather all assessments that document delivery datetime, sort these items by the relevant datetime that the assessment was performed, and identify the last assessment. It then stores a result of that assessment as the last time of delivery. There are no changes to this function this year. If you'd like to learn more about the EarliestOf function, please go to the eCQI Resource Center Teach Me CQL video series. The link is provided on the Resources page at the end of this presentation.

Let's review a related Frequently Asked Question. "The LastTimeOfDelivery function uses the EarliestOf function. Why is this when we are trying to identify the last time of delivery documented?"

The answer. The last and EarliestOf operators may seem contradictory in this logic. The EarliestOf operator evaluates if relevant time is specified, which returns the relevant time. If the relevant period has a starting boundary specified, it returns the starting point of the period, otherwise returns the ending point of the period. If both are present, we choose the earliest of the relevant datetime or the relevant start period of the assessment. Then all of the earliest updates are sorted, and the last one is chosen.

Next, let us discuss the PCMaternal.LastEstimatedDeliveryDate function. This function identifies the last time the estimated delivery date or due date was assessed 42 weeks or less prior to or on delivery and stores a result of that assessment.

Now that we have defined the LastTimeOf Delivery and the LastEstimatedDeliveryDate, we can plug those values into the equation to arrive at the calculated Gestational Age. Then the logic determines if the calculated Gestational Age is greater or equal to 37 weeks.

Let's turn our attention to the second definition of the union statement for the first line of the Denominator definition, Delivery Encounter with Estimated Gestational Age Greater or Equal to 37 Weeks. This definition calls the CalculatedGestationalAge function that we just covered to determine if the CGA is null. If CGA is null, it calls the LastEstimatedGestationalAge function from the PCMaternal Library. Let's discuss the LastEstimatedGestationalAge function in more detail on the next slide. The LastEstimatedGestationalAge function is constructed similarly to the LastEDD and the LastTimeOfDelivery functions that we just covered. This function's purpose is to gather all assessments that document the patient's estimated Gestational Age 24 hours or less before or on the last time of delivery. Also includes those performed on the same day as the last time of delivery up until just before midnight. Then sort these items by the relevant datetime that the assessment was performed and identify the last assessment. It then stores the result of that assessment as a quantity representing estimated weeks gestation. Note that this function now aims to also capture instances where documentation was updated after a rapid delivery.

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So now that we have the LastEstimatedGestationalAge, we go back to the higher level definition. If the calculated Gestational Age is null and the estimated Gestational Age is greater or equal to 37 weeks, the definition is met. Next, let's turn our attention to the third definition of the union statement, Delivery Encounter with Gestational Age Greater than or Equal to 37 Weeks Based on Coding. If the calculate Gestational Age is null and the estimate Gestational Age is null, then the diagnosis codes are evaluated.

To recap, let's circle back to the highest level definition. We unioned the calculated Gestational Age, the estimated Gestational Age, and the Gestational Age based on coding definitions to identify delivery encounters greater or equal to 37 weeks.

Let's go back to our main Denominator definition. The last eleven slides covered the first definition of Delivery Encounter with Gestational Age Greater or Equal to 37 Weeks. The next definition, Encounter with Singleton Delivery, looks for an encounter diagnosis which represents a Singleton delivery.

Moving down to the where clause of the main definition, we call four functions and qualify the results. We are looking for patients who are gravida 1, parity 0, or preterm and term births both equal 0. The four functions starting with the word last are all structured similarly. Let's look at LastGravida as an example. The LastGravida function's intent is to look at all assessments of gravidity where the relevant datetime is 42 weeks or less before delivery, sort these assessments by the relevant datetime, and then store the result from the last assessment as the gravida to be used to determine if the patient is in the Denominator. Similarly, LastHistoryPretermBirth, LastHistoryTermBirth, and LastParity have the EarliestOf function and the relevantPeriod attribute.

In summary, we are looking for delivery encounters with Gestational Age greater or equal to 37 weeks that also had the delivery of a single baby where the LastGravida equals 1 or the LastParity equals 0 or the LastHistoryPretermBirth and the LastHistoryOfTermBirth are both 0.

Raquel, I have a question. "Can nursing documentation address the elements gravida, parity, preterm, and term live birth?"

Great question, Kelley. There is an FAQ related to that topic. And here it is. Are nurses considered clinicians for documentation purposes concerning the elements gravida, parity, preterm, and term live births? The answer is yes. Nurses are considered clinicians and are authorized to document elements such as gravida, parity, preterm, and term live births. This means they can accurately record these details in the patient's electronic health record, EHR. However, to ensure that the documentation is correctly captured and reflected in the system's reports, it is important to verify with your IT department and EHR vendor.

Okay, next we will evaluate Denominator Exclusions which consist of two definitions, one, Encounter with Abnormal Presentation and, second, Encounter with Genital Herpes, Placenta Previa, Vasa Previa, or Placenta Accreta Spectrum. Note the additions of genital herpes and placenta accreta changed to placenta accreta spectrum.

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Starting with the Encounter with Abnormal Presentation definition. We call the Denominator population Singleton Delivery Encounters at 37 Plus Weeks Gravida 1 Parity 0, No Previous Births. The alias, QualifyingEncounter, was modified to ThirtysevenWeeksPlusEncounter for the alias to be more descriptive and align with the CQL Style Guide. We give organizations two options to evaluate abnormal presentation. First, we look to see if an assessment is performed during the encounter that indicates the fetus is in an abnormal presentation. This logic defines a variable of LastAbnormalPresentation where an assessment is performed before or on the delivery date that indicates abnormal presentation. And this assessment of abnormal presentation occurs during the full hospitalization encounter. Then we look for a diagnosis of abnormal presentation. The portion of the logic for a diagnosis was moved this year to the end of the definition to improve readability.

Raquel, I have another question. Yes. "When would we need to assess abnormal presentation to meet the Denominator Exclusion for qualifying encounter?"

What a great segue to this Frequently Asked Question of, "When and where must the assessment of abnormal presentation be performed to meet the Denominator Exclusion for a qualifying encounter?"

The answer is that the assessment of abnormal presentation must occur during qualifying encounters such as an emergency department, ED visit, OB triage visit, observation visit, or inpatient admission either before or at the time of delivery. The function, PCMaternal.HospitalizationWithEDOBTriage, includes the entire interval from the start of any prior visit to the discharge, meeting the criteria for Denominator Exclusion. Oh, makes sense, thank you. Sure, you're welcome, thank you.

Moving on to the Encounter with Genital Herpes, Placenta Previa, Vasa Previa, Placenta Accreta Spectrum definition. If the patient has a diagnosis code within the genital herpes or the placenta accreta spectrum previa or vasa previa value sets on the encounter, the definition will be satisfied. Note that the alias names have been updated to improve clarity. The value set names was revised to reflect the additional conditions of placenta accreta and placenta percreta.

Since placenta accreta spectrum refers to placenta increta, percreta, and accreta, the value set name is now placenta accreta spectrum previa or vasa previa.

Also note that the Denominator Exclusion was expanded to include active lesions of genital herpes.

Lastly, we move on to the Numerator, inpatient hospitalizations for cesarean births. The logic looks for a procedure of cesarean birth performed during the delivery encounter, hospitalization. And this wraps up our presentation for ePC-02 logic. Now we will discuss ePC-07 in detail.

Next slide.

The Joint Commission developed ePC-07 in collaboration with Yale New Haven Health Services Corporation Center for Outcome Research and Evaluation, or Yale CORE and our expert advisor, Dr. Elliott Main, who is the former Medical Director for the California Maternal Quality Care Collaborative and the Executive Committee Chair. And he is also a professor at the University of Stanford School of Medicine. This is a risk-adjusted outcome measure.

Severe maternal morbidity poses serious health threats to pregnant patients in the United States where rates have been on the rise compared to other developed nations. Severe maternal morbidity is defined as unexpected outcomes of labor and delivery that result in significant short or long-term consequences to a woman's health. These high rates in the United States present unique opportunities for large-scale quality measurement and improvement activities. Statistics on preventability vary but suggest that a considerable proportion of maternal morbidity and mortality events can be prevented.

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A report in 2019 from 14 maternal mortality review committees that conducted a thorough review of pregnancy-related deaths determined that 65.8% of them were preventable. Although there are limited measures to assess variability among hospitals, using the CDC definition of severe maternal morbidity, or SMM, the US median rate was 1.4% and the highest hospital rate was 12.2%. Studies also show that non-Hispanic Black women are three to four times more likely to die from pregnancy-related causes than non-Hispanic white women. SMM impacts the mother's health, increasing medical costs and hospital lengths of stay. One report found that women with SMM delivering vaginally have hospital stays that are 70% longer than women with vaginal deliveries experiencing no SMM and costs that are almost 80% higher. SMM is defined as unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health, per ACOG and the Society for Maternal Fetal Medicine. The CDC specifically defines SMM by 21 indicators, defined by International Classification of Diseases Tenth Revision, or ICD-10 diagnoses and procedure codes. Some SMM examples include acute renal failure, acute respiratory distress, and blood transfusion. More on this later.

An important distinction compared to the CDC model is that our measure uses Present on Admission, or POA codes to distinguish SMM that may be present on arrival.

The goal of ePC-07 is to assess prevalence of SMM and mortality. Specifications are modeled after a modified version of the CDC's SMM indicators, with the addition of maternal mortality. At times, we may refer to the CDC indicators of morbidity as SMM, but the outcome of the measure, which includes morbidity and mortality, is referred to as severe obstetric complications, or SOC. Now Valery Danilack from Yale CORE will explain the risk adjustment model for PC-07.

The goal of a measure score is to isolate the assessment of quality of care. Risk adjustment enables this goal by accounting for patient characteristics and/or comorbidities that are associated with the measure outcome but are reasonably beyond the control of the hospital, such as those Present on Admission when the patient arrives at the hospital. Risk adjustment accounts for case mix differences between hospitals and levels the playing field, so to speak, allowing for better comparisons between hospitals on the care patients receive at that given hospital. Risk adjustment is achieved through the development of a risk model or models which are typically multivariable regression models that include risk factors as covariates. We identify candidate risk variables predictive of severe obstetric complications for consideration in the measure risk adjustment model by utilizing literature and research findings and reviewing the list of hospital core clinical data elements. We also sought input from clinical expert consultants and members of a technical expert panel, which included patients. Only conditions or comorbidities that were Present on Admission were included in risk adjustment.

Following the identification of risk adjustment variables, a risk model was developed for severe obstetric complications, and separately the severe obstetric complications excluding blood transfusion-only encounters outcomes. Due to very low prevalence of a few risk variables, human immunodeficiency virus was combined with autoimmune disease, and obstetric venous thromboembolism was combined with long-term anticoagulant medication use. This was done for the model of severe obstetric complications excluding transfusion-only encounters only in initial measure of development and will be implemented as necessary when the measure scores are reported. Otherwise, the same risk variables are included in the risk models for severe obstetric complications and severe surgical complications excluding blood transfusion-only encounters.

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Social risk factors were considered dependent on the availability of information in the EHR. Economic/housing instability was chosen for inclusion in the model due to support in research literature and availability in the EHR. The Severe Obstetric Complications Risk Adjustment Methodology Report is available on the eCQI Resource Center. Race/ethnicity and insurance type were not considered for risk adjustment. Instead, they were planned for stratification of the measure scores. This is to illuminate outcome disparities by race and ethnicity and insurance type rather than adjust the outcomes by these factors, which would be most informative and impactful in improving maternal care. Back to you, Kelley.

Thank you, Valery. ePC-07 uses value sets to group each category of SMM diagnosis codes. When hospitals are reviewing their Numerator cases, these categories can be used to identify potential areas for quality improvement as well as opportunities to improve coding documentation. It is also important to understand that the conditions which are used in the risk adjustment model adjust the rate to account for the severity of cases Present on Admission. They are not excluded from the measure. The Denominator Exclusion criteria for this measure will be discussed in an upcoming slide. Also, when looking at ePC-07 rates, they will be reported per 10,000 delivery hospitalizations.

To reiterate, the measure description for PC-07 is patients with severe obstetric complications which occurred during the inpatient delivery hospitalization. You may recall Stratum 1 as a subset of the Numerator, and now that calculation has been fully separated, so there are two measure calculations. With that said, there are now two Numerators for the measure which will be explained in the next few slides, but the specifications on this slide are the same for both outcomes. We will take a close look at how ePC-07 populations are defined. The initial patient population is defined as inpatient hospitalizations for patients age greater than or equal to eight years and less than 65 admitted to the hospital for inpatient acute care who undergo a delivery procedure with a discharge date that ends during the measurement period. The Denominator is inpatient hospitalizations for patients delivering stillborn or live birth with greater than or equal to 20 weeks gestation completed. Denominator Exclusions are patients with confirmed diagnosis of COVID with a COVID-related respiratory condition or patients with confirmed diagnosis of COVID with a COVID-related respiratory procedure.

Numerator 1 is inpatient hospitalizations for patients with severe obstetric complications. Numerator 1 includes transfusions. You may recall from earlier in the presentation we mentioned CDC's SMM indicators. Here are those indicators that are used to define the Numerator in addition to a discharge disposition of expired. One, Severe Maternal Morbidity diagnoses which must be coded as not Present on Admission to get into the Numerator.

Two, Severe Maternal Morbidity procedures. And three, a Discharge Disposition Equals Expired. Please note, again, throughout this presentation that the star in a circle icon will denote new content along with underlined text, while stricken text denotes removed content.

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Numerator 2 addresses the second measure calculation, inpatient hospitalizations for patients with severe obstetric complications, excluding cases where blood transfusion was the only SOC. One, Severe Maternal Morbidity diagnoses which must be coded as not Present on Admission to get into the Numerator. Two, Severe Maternal Morbidity procedures. And three, Discharge Disposition Equals Expired.

This year, there is a Numerator exclusion for both Numerators. Cases that are excluded are those in which the only complication was a transfusion or a hysterectomy and the patient had a diagnosis of placenta percreta or increta. Per the American College of Obstetricians and Gynecologists, the most generally accepted approach to placenta accreta spectrum is cesarean hysterectomy, with the placenta left in situ after delivery of the fetus due to the risk of severe hemorrhage with removal or manipulation of the placenta after delivery.

This measure is risk adjusted using the preexisting conditions listed here. Present on Admission codes are used to determine if any of the conditions are preexisting. Additional variables used for risk adjustment are heart rate, systolic blood pressure, white blood cell count, and hematocrit. The first resulted values, from 24 hours prior to the start of the encounter through before time of delivery, are used for the vital signs and laboratory tests.

Now we will summarize the major measure changes for 2025. Remember that the star in the circle icon will denote changes, along with underlined text for new content, and stricken text, which denotes removed content. For reporting year 2025, all references from NQF have been changed to CBE to identify the Consensus-Based Entity role. This measure has been endorsed for trial use, and we will submit for full endorsement when due. We've clarified that anemia includes sickle cell disease within the Risk Adjustment section of the Measure Specifications header, and housing instability is now economic housing instability based on support in research literature and availability in the EHR, as mentioned earlier by Valery. I will now turn it over to Raquel to cover.

some of the technical changes. Thanks, Kelley.

To clearly distinguish the libraries used for the measures based on the Quality Data Model from those using the Fast Healthcare Interoperability Resource information model, the MATGlobalCommonFunctions QDM and PCMaternal QDM libraries have been updated to include the letters QDM. Value set Payer was renamed to Payer Type to more accurately reflect the contents and intent of the value set. There were multiple value sets with code additions/deletions due to terminology updates. Review the technical release notes in the eCQI Resource Center and value sets in the VSAC for more details. Since the Length of Stay requirement was removed from the Global Common Library to align better with the measure intent and logic, the Global.Inpatient Encounter definition is now utilized within the Initial Population. Its modifications are best seen within the Encounter with Age Range definition in the PCMaternal Library.

This year, risk assessment variable logic was added for maternal age so that age is automatically calculated and stored, alleviating confusion, and clarifying measure logic. Lab.result is null, is not null, and Exam.result is not null were added to FirstLabTestWithEncounterId and FirstPhysicalExamWithoutEncounterId, respectively, to check and confirm that relevant lab and physical exam values are captured and null results are ignored. We will review this logic in more detail towards the end of this presentation. As mentioned earlier at PC-02, the EGATiming variable was added with same day as logic to capture the estimated Gestational Age assessment from 24 hours before or on last time of delivery to the same day as delivery until before midnight.

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The Present on Admission function, POAIsNoOrUTD, was added to simplify SMM diagnosis and procedures logic, while the Present on Admission function, POAIsYesOrExempt, was added to simplify risk adjustment logic. Logic was added to flag which diagnosis and/or procedures qualify patients for Numerator inclusion to assist with data analysis. Take note. Implementers do not need to do anything additional or submit additional data for this.

The most significant change this year is the change in structure of measure from having one measure calculation with the one stratum, a subset of the Numerator, to having two Numerators, two measure calculations. We will review this in more detail next as we walk through the measure flow and, again, we discuss the logic. And, last but not least, Numerator Exclusions were added based on the recommendations of the technical advisory panel for blood transfusion or hysterectomy with a diagnosis of placenta percreta or placenta increta. Numerator Exclusions are applied to each Numerator population, which we will discuss through the measure flow and then in the discussion of the logic.

Next, we will review the measure flow. The measure flows provide a high-level overview of the steps to calculate the measure and can be found on the eCQI Resource Center. Remember that there are two measure calculations for this measure. The Initial Population is the same for both measure calculations and is identical to ePC-02's Initial Population, which was described earlier in the presentation.

Like PC-02's Denominator, the Denominators for both PC-07's measure calculations have three different approaches to evaluate the Gestational Age. The first is the calculated Gestational Age greater or equal to 20 weeks. The calculated Gestational Age is based on ACOG's revitalized definition and is the preferred method of determining Gestational Age. The second is the estimated Gestational Age. If the calculate Gestational Age is null, the estimated gestational is the next preferred method in the hierarchy to determine Gestational Age. The third and last way to determine Gestational Age is based on ICD-10 or SNOMED codes. This is the lowest in the hierarchy. Calculated and estimated Gestational Age must be null to invoke this logic. If the criteria is not met, processing ends, and the case is not in the measure. If the criteria is met, the case is in the Denominator. And just as you saw in the PC-02 Measure flow Diagram, the a1, a2, a3 notations in the small diamonds will be used in the calculation.

Moving on to the Denominator Exclusions, a patient must have a COVID diagnosis and a respiratory condition related to COVID or a respiratory support procedure such as ventilation performed during the encounter. If the criteria is met, the patient will be excluded from the Denominator. If not met, the patient moves on to determine if the Numerator is met.

A case qualifies for the Numerator if one of the three definitions are met. One, delivery encounters with severe obstetric complications or severe obstetric procedure, excluding blood transfusion. Expirations. Blood transfusion was performed during the encounter. If the criteria is not met, processing ends and the case is not in the Numerator. If one of the three definitions is met, the case is then evaluated for the Numerator Exclusions.

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The Numerator Exclusion looks for delivery encounters with the severe obstetric complications, with a blood transfusion or hysterectomy, with a diagnosis of placenta increta or placenta percreta and no other severe obstetric complications, or, in other words, except if the delivery encounter has other severe maternal morbidity diagnosis whose Present on Admission indicator is no or unable to determine or the delivery encounter also has procedures of cardiac conversion, tracheostomy, or ventilation or the patient expired. A sample calculation to determine the measure's rate is provided below.

To identify the second measure calculation Numerator, overlap delivery encounters with severe obstetric complications with delivery encounters with SOC diagnosis or procedure, excluding blood transfusions and expirations. If the criteria is not met, processing ends, and the case is not in the Numerator. If criteria is met, the case is then evaluated for Numerator Exclusions. The Numerator Exclusion looks for delivery encounters with severe obstetric complications except where blood transfusions were the only SOC, with a blood transfusion or hysterectomy, and a diagnosis of placenta increta or placenta percreta, except if the delivery encounter has other severe maternal morbidity diagnosis whose Present on Admission indicator's no or unable to determine or the delivery encounter also has procedure of cardiac conversion, tracheostomy, or ventilation or the patient expired. And a sample calculation to determine a measure's rate is provided below.

Now we will study the measure logic in detail. Both measure calculations share the Initial Population definition, which is Delivery Encounter with Age Range. It is stored in the PCMaternal Library and is identical to ePC-02's Initial Population, which we have already covered.

Moving on to the Denominator. We're now looking for patients who deliver a stillborn or live birth at greater or equal to 20 weeks. Similar to ePC-02, the Denominator definition, Delivery Encounters at Greater than or Equal to 20 Weeks Gestation, unions three definitions, one that reports the calculated Gestational Age, one that reports the estimated Gestational Age, and one to identify patients with Gestational Age greater than or equal to 20 weeks based on coding. The Denominator logic is the same as ePC-02, with exception with ePC-07 is looking for Gestational Age greater or equal to 20 weeks. So we will not repeat the common logic here.

Next, we move on to our Denominator Exclusions for both measure calculations, which are patients with confirmed diagnosis of COVID with COVID-related respiratory condition, or patients with confirmed diagnosis of COVID with COVID-related respiratory procedure. We start with our Denominator definition of Delivery Encounters Greater or Equal to 20 Weeks Gestation. Then we add on a qualification of a confirmed COVID diagnosis and a diagnosis of COVID-related respiratory conditions or COVID-19-related respiratory procedure where the procedure starts during the hospitalization encounter.

PC-07 Numerator reads, inpatient hospitalizations for patients with severe obstetric complications, including the following: Severe Maternal Morbidity Diagnosis, Severe Maternal Morbidity Procedures, Discharge Disposition Equal Expired. Please note, PC-07 is an inverse measure. In other words, a lower calculated performance rate indicates better clinical care. So, the less patients in the Numerator, the better the performance rate. The main definition calls three additional definitions, Severe Obstetric Complication Diagnosis or Procedures Excluding Blood Transfusions, Expirations, and Blood transfusions.

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While the blood transfusion is a severe obstetric complication procedure, these procedures are kept separate for purposes of distinguishing between the two Numerators. Let's start with the first definition in the union statement,

Delivery Encounters with Severe Obstetric Complication Diagnosis or Procedure Excluding Blood Transfusion. We start with the Denominator definition and then look for SMM where the diagnosis must not be Present on Admission or unable to determine. Notice that the Present on Admission is no or unable to determine logic has been changed to the POAIsNoOrUTD function, to simplify measure logic. Moving on with the definition, or exists looks for a procedure of SMM where the procedure starts during the hospitalization encounter.

Next, let's look at the second definition of the Numerator statement, Delivery Encounters with Expiration. This is a simple definition that looks at the Denominator cases with the discharge disposition of expired. Now let's look at the third definition of the Numerator statement, Delivery Encounters with Blood Transfusion.

Again, we start with the Denominator definition. Look for a procedure of blood transfusion and the transfusion starts during the hospitalization encounter. So, putting all three definitions together with union statements. If any of the conditions of: delivery encounters with severe obstetric complications diagnosis or procedure excluding blood transfusion, delivery encounters with expiration, or delivery encounters with blood transfusions are met, the patient will be in the Numerator.

From Numerator 1, we move on to Numerator Exclusions 1. Numerator Exclusion 1 looks for cases in the Numerator, delivery encounters with severe obstetric complications that have a blood transfusion or hysterectomy and a diagnosis of placenta increta or placenta percreta. The rest of the logic in the definition keeps the encounter in the Numerator if there is an additional SOC besides blood transfusion or hysterectomy. There's quite a bit to unpack here, so let's dig in.

For reference, on the left-hand side of the screen, you will find the Numerator Exclusions 1 definition again, which looks at the encounters in Numerator 1 that have a diagnosis of placenta increta or placenta percreta and a blood transfusion or hysterectomy.

Now, the latter portion of the definition keeps the encounter in the Numerator if there are any other SOCs by looking at the Numerator 1 encounters with SMM diagnosis where POA is no or unable to determine, or cardiac conversion, tracheostomy, or ventilation procedures were performed, or encounters with expiration. This completes the first measure calculation.

Since the two measure calculations have identical Initial Populations, Denominators, and Denominator Exclusions, we will jump to the Numerator of population… We will jump to the Numerator Population Criteria 2, referenced from this point as Numerator 2. The main definition is, Delivery Encounters with Severe Obstetric Complications Including Blood Transfusions Only. It calls the definition of the first Numerator, Delivery Encounters with Severe Obstetric Complications and intersects with the Delivery Encounters with Severe Obstetric Complication and Excluding Blood Transfusions. The operator, intersects, looks for encounters or cases that qualify for one definition and the other definition. Let's compare the first definition next to the second definition to see how they overlap.

All these definitions have been addressed earlier in this presentation. In the side-by-side comparison, we see that Delivery Encounters with Blood Transfusion is not included in both. Therefore, Numerator 2 includes delivery encounters with SOC, excluding encounters where blood transfusions was the only SOC.

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Lastly, from Numerator 2, we move on to evaluate Numerator Exclusions 2. Numerator Exclusions 2 looks for cases in the Numerator, Delivery Encounters with Severe Obstetric Complications Excluding Blood Transfusions Only, that have a blood transfusion or hysterectomy and a diagnosis of placenta increta or placenta percreta. The rest of the logic in this definition keeps the encounter in the Numerator if there is an additional SOC besides blood transfusion or hysterectomy.

Next, we will review risk adjustment logic. But, first, let's review a Frequently Asked Question.

I understand PC-07 is a risk-adjusted measure. Is a patient with preexisting conditions listed on a risk variable list excluded from the measure?

The answer is risk adjustments does not exclude cases. The Denominator Exclusions are inpatient hospitalizations for patients with confirmed diagnosis of COVID with COVID-related respiratory conditions, or patients with confirmed diagnosis of COVID with COVID-related respiratory procedure, and the Numerator Exclusions address blood transfusions or hysterectomy with a diagnosis of placenta increta or placenta percreta. Conditions that are defined as risk variables will be reflected in the risk-adjusted performance rates.

ePC-07 is risk-adjusted using one of the preexisting conditions, lab results, or vital signs that we covered earlier in this presentation. We will start with the preexisting conditions, using anemia as one example. Our risk variable anemia definition starts with encounters that qualify for the Denominator and then looks for a diagnosis code from the anemia value set that must have a Present on Admission code of yes or exempt.

This has been updated this year with POA function to simplify measure logic. Two of the preexisting conditions are handled differently.

They are maternal age and preterm birth. Maternal age, based on mother's date of birth, is straightforward. Let's talk about preterm birth. The first part of the definition uses the CalculatedGestationalAge function to determine if the mother is preterm. In other words, is she greater or equal to 20 weeks and less than or equal to 37 weeks gestation? If CalculatedGestationalAge is null, then EstimatedGestationalAge is used.

The second half of the logic is applied if CalculatedGestationalAge and EstimatedGestationalAge are both null. Then we look for a diagnosis code in the preterm birth value set that is Present on Admission or exempt.

Next, we review the lab results that are considered for risk adjustment. We look for the first resulted hematocrit or white blood cell count 24 hours prior to the start of the encounter and before the time of delivery. A function is used to gather this data, and the function is called FirstLabTestWithEncounterId. We start with our Denominator definition, then we express a let statement to define the first lab from a specified lab list. The lab result is not null, and the result datetime must be during the interval of the start of hospitalization encounter, minus 1,440 minutes, which is 24 hours, up to the time of delivery. Then we sort all those results by the result datetime so that the first result can be used. The function returns the first lab's EncounterId, the result in the lab result, datetime.

Similar to the lab result logic, we look for the first resulted heart rate or blood pressure 24 hours prior to the start of the encounter and before the time of delivery. A function is used to gather this data. It's called FirstPhysicalExamWithEncounterId. We start with our Denominator definition. Then we express a let statement to define the first exam from a specified exam list. The exam result is not null, and the result datetime must be during the interval of the start of the hospitalization encounter, minus 1,440 minutes, which is 24 hours, up to the time of delivery. Then sort those results by the result datetime so that the first result can be used. The function returns the FirstPhysicalExamWithEncounterId result and the relevant datetime of the exam.

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Lastly, we share with you the Risk Variable Lab and Physical Exam Results definition, which pulls together the first vital signs and lab values that we just discussed. You see the FirstPhysicalExamWithEncounterId and FirstLabTestWithEncounterId functions that we just covered on the previous slides highlighted here. The function calls the respective vital sign and lab test value sets. The comments provide guidance on the units to be used when submitting data, for the vital signs heart rate should be reported as beats per minute and systolic blood pressure as millimeters of mercury. For the lab test, hematocrit is to be reported as a percentage and WBCs as thousands per microliter.

We have an FAQ about risk variables for this measure. "There are a lot of risk variables associated with ePC-07. Do we need to map each one of these individually in our QRDA submission?"

The answer is the risk variable definitions are included in these specifications and should be sent with eCQM data in the QRDA1 file. Specific risk variable templates are not needed in QRDA1 files, and therefore there is no additional submission process for risk variables as compared with other data elements. If risk variable data is not provided, then your performance rate will not be risk-adjusted.

Raquel, that's good to know. What about the FDE or supplemental data elements details?

Yes. Our next FAQ is about the SDE SOC diagnosis details and SDE SOC procedure details. Is your question about these? Yes, like the question says, do we need to map those SOC diagnoses and procedure details in the QRDA? No, there's no need to submit the actual SOC diagnosed category and SOC procedure category in the QRDA file. These can be calculated from diagnosis and encounter data provided in QRDA1 on the receiving end.

Thanks, Raquel.

Sure thing. And this wraps up our PC-07 presentation.

Back to you, Susan.

Wow, you guys presented so much content. So, if you can go to the next slide. We're just going to share a few of the resources we've got available. We have a couple slides here.

We've provided links to direct you to the eCQI Resource Center, CMS Eligible Hospitals Measure page and Get Started with eCQM links, the Teach Me Clinical Quality Language, or CQL, video series landing page, as well as the video shorts on hospitalization with observation and what is a value set. And on the next slide we have... We're continuing on with resource links. We've provided a link to the Value Set Authority Center, or VSAC support, the Pioneers in Quality landing page on The Joint Commission's website, the Expert to Expert webinar series landing page, and finally the ASTP/ONC Issue Tracking System. And that's where clinical and technical questions about these eCQMs should be submitted. The next slide.

Real quick, I'll go through directions for anyone that hasn't submitted a question that would still like to. Please submit your questions via the question pane. Click the question mark icon in the audience toolbar, and a panel will open for you to type and submit your question. Please indicate to which eCQM your question pertains. All questions not answered during the live event will be addressed within a written follow-up Q&A document that will be posted on The Joint Commission website within several weeks of the live event. So, with that, I'm going to turn things over to Melissa and Susan. And while I take over the screen sharing, why don't you please both go ahead and start with whatever questions are in the queue?

Sure, thanks, Susan. This is Melissa Breth, Associate Project Director for the Clinical Quality Informatics. And our first question actually came in from a participant that was registering before the webinar.

And the question is, "Can we discuss the role of provider documentation and coding in PC-07?"

Documentation by providers can be used for PC-07 eCQM if data are pulled from codified, discrete fields. We recognize that SNOMED is typically tied to provider documentation, yet it is not used due to the required POA, or Present on Admission indication, within the measure. Measure testing and SME, subject matter expert feedback, confirmed that POA was not consistently included within written documentation but was accurately captured within billing.

(01:20:59)

Hi, this is Susan Yendro, and I'm an Associate, or I'm, yeah, Associate Director with The Joint Commission. The next question that I'm going to read off is, "How can hospitals better address eCQM submission when documentation in multiple EMR systems?"

So, we recommend that you work with your IT department, quality team, hospital leadership, and your EMR vendors to improve interoperability amongst all the EMR systems that you use.

Next question. "For PC-07, are there recommended coding definitions for sepsis and acute kidney injury that hospitals should use for this measure?"

Please use the VSAC, Value Set Authority Center website, at https://vsac.nlm.nih.gov/ to review the terminology for acute renal failure. And contained within is the OID, or the Object Identifier and sepsis. And, again, here's the Object Identifier, or OID, which is also listed in the measure specifications. You can search by that to find the value sets. Note that the value sets are measure-specific for CMS 1028 PC-07.

Okay, the next question is regarding PC-02. "We are seeing very different PC-02 rates compared to when we chart abstracted this measure. Is that consistent with what other sites are seeing?"

So, when we've looked at the national rates, we are seeing that the performance rates are becoming fairly aligned, within two percentage points actually, between the Chart Abstracted and the eCQM versions of CMS 334 versus the current PC-02 measure.

Okay. "Why are there no neonatal conditions that warrant a cesarean delivery, such as severe bradycardia, decreased fetal heart tones?"

A recent TAP, or Technical Advisory Panel convened to look at possible Exclusions, which would be indications for cesarean birth able to be identified in coding and are not a potential reflection of labor management or variation in interpretation or severity of conditions. Often, fetal bradycardia or fetal heart rate variations can be a result of labor management or have varied interpretation and severity. These conditions can often be resolved through intervention, and not all require a cesarean delivery.

Okay, another question about cesarean sections is, "Why isn't placental abruption a condition?"

And the answer is that the cesarean birth measure PC-02 focuses on mothers having their first birth who are at the highest risk of primary cesarean birth when compared to mothers who have experienced a previous vaginal birth. Extensive testing indicated no need to exclude for all known indicators for performing C-sections, since these types of medical conditions are less common and would not significantly increase the hospital's adjusted cesarean rate. So, our Technical advisory panel convened and also discussed this issue, and the TAP felt that it's too difficult to define with ranges from spotting to full on abruption, so therefore it was not added to the list of Exclusions.

Okay. Also, for PC-02. "Will the PC-02 recommended rate threshold be decreased?"

There are currently no thresholds for PC-02 in accreditation. Acceptable PC-02 rates are 30% or lower. However, there is not an established threshold for what rate may be too low. The goal is for hospitals to understand their baseline rate of performance for each measure in order to determine if performance improvement efforts are effective over time when their baseline is higher than the national performance.

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Okay. So, this next question is kind of more general eCQM question. "Will there be an opportunity to manually adjust data for charts that are pulled into the eCQM by error on reports?"

The answer is that, while data cannot be manually adjusted, again, we recommend working with your IT department, your quality department, hospital leadership, to improve documentation, terminology mapping, and coding practices for more accurate reports.

Okay. "For PC-07, would it be possible to remove transfusion from PC-07? Transfusing patients who have experienced hemorrhage is improving mortality."

The TAP, a different TAP, discussed the removal of transfusion-only cases from the measure. The TAP, which was comprised of OB, MFM, neonatologists, nurses, and midwives voted unanimously to keep both transfusion and non-transfusion rates. Hospitals can use the transfusion-only cases to identify disparities in care and work to decrease them.

Okay. Back to another cesarean birth measure question. "Has there been any discussion of excluding mothers with seizures, drug use, or gestational diabetes? And what about mothers who refuse to give birth vaginally?"

So only diagnosis codes that are listed on Table 11.09 can be used to exclude cases from the measure. You may find the following information helpful. The cesarean birth measure is designed to measure the rates of cesarean births among the subset of the general obstetric population of women while also keeping the burden of data collection to a minimum. The measure focuses on mothers having their first birth who are at the highest risk of primary cesarean birth when compared to mothers experienced previously vaginal births. Extensive testing, again, we'd like to point out it was done, and including comprehensive set of maternal medical exclusions would add data collection burden without commensurate benefit Okay.

This is for PC-02. "Are gravida 2 para 0 patients not included in this measure, only gravida 1 para 0?"

The PC-02 measure focuses on Nulliparous women with a term Singleton baby in vertex position delivered by cesarean birth. And the Denominator population is defined as Singleton Delivery Encounters at 37 Plus Weeks Gravida 1 Parity 0, No Previous Births.

Ooh, we've had such great questions. I've noticed that we are at time. So, I'm going to pass it back over to Susan Funk to close out for today.

Oh, great, thanks so much. And just a reminder to the audience that all of the questions that were asked today will be documented. The ones that we didn't get to, responses will be written, and all of those will be posted. And that's a great segue to tell you where you'll be able to find the webinar recording links, slides, transcripts, and, when they're available, the Q&A documents. And that's all on this Expert to Expert landing page. We've provided the link here. Just a reminder that we included as one of the handouts the registration links for all of the Expert to Expert webinars in the series that are currently open for registration. So, this is your go-to spot for all of the information regarding upcoming webinars and then to also get the follow-up documents that are posted after a webinar. So just bookmark this link, and you can stay in the loop.

So, real quick, I mentioned some of these details earlier regarding the evaluation survey. We use your feedback to determine education gaps and your organization's needs, inform future content, and assess the quality of our educational programs. The QR code is on the next slide. If you choose to take the CE survey later, a link is delivered in an automated email. And then, finally, to get your CE certificate, after you click Submit when you take the survey, a popup window will show up with a certificate. If you don't download it then, you will also get an email that delivers a link to that certificate. And then just one final reminder. You add your own name and credentials. We capture registration information so, if we are ever audited, we will know who attended. So, the certificate is for your own records. And, with that, we are on our final slide.

(01:30:27)

We will pause here for several moments to permit anyone that wishes to use the QR code. You can just scan it with your mobile device. Very quickly, thank you to Melissa, Raquel, Valery, and Kelley for all of the work you did to develop and present today's content. Thanks to Melissa and Susan for facilitating the Q&A segment and especially to the staff in the background that typed all of the responses to the questions as they were being submitted. Finally, thanks to everyone in the audience that attended today. Thank you so much for your continued participation and have a great day.