OHIC Measure Alignment Work Group
2021 Annual Review of the Maternity Care Aligned Measure Set
Measure Specifications

Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH) - Maternal Care

NQF Endorsement Status	Not Endorsed
NQF ID	9999
Measure Type	Patient-Reported Outcome-Based Performance Measure (PRO-PM)
Measure Content Last Updated	2021-02-01
Info As Of	Not Available

Properties

Description	Percentage of women, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: depression screening, alcohol use screening, tobacco use screening, drug use screening (illicit and prescription, over the counter), and intimate partner violence screening.
Numerator	Patients who received the following behavioral health screening risk assessments at the first prenatal visit. Depression screening, Alcohol Use screening, Drug Use and Intimate Partner Violence
Denominator	All patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care.
Denominator Exclusions	None
Rationale	Not Available
Evidence	Not Available

Developer/Steward

Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Contact	Not Available

Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH) - Maternal Care

Measure Developer	Not Available
Development Stage	Fully Developed

Characteristics

Measure Type	Patient-Reported Outcome-Based Performance Measure (PRO-PM)
Meaningful Measure Area	Not Available
Healthcare Priority	Person- and Family-Centered Care
eCQM Spec Available	Not Available
NQF Endorsement Status	Not Endorsed
NQF ID	9999
Last NQF Update	Not Available
Target Population Age	0+
Target Population Age (High)	Not Available
Target Population Age (Low)	0
Reporting Level	Clinician/Group
Conditions	Behavioral/Mental Health; Pregnancy
Subconditions	Not Available
Care Settings	Ambulatory Care: Clinican Office

Groups

Core Measure Set	Medicaid Child Core Set

Measure Group	Group Identifier

Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH) - Maternal Care

Measure Group	Group Identifier
Child Core Set	
MC	03
CHIP Child Core Measure Set	
BHRA	CH
Medicaid Child Core Measures	

Measure Links

Measure Program: Medicaid

Info As Of	Not Available
Program / Model Notes	
Data Sources	Electronic Clinical Data (non-EHR)
Purposes	Not Available
Quality Domain	Maternal and Perinatal Health
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Inactive
Data Reporting Begin Date	Not Available
Data Reporting End Date	2018-10-01

Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH) - Maternal Care

Measure Program Links

https://www.medicaid.gov/

****NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE****

Measure Information Form

Measure Set: Perinatal Care (PC)

Set Measure ID: PC-02

Performance Measure Name: Cesarean Birth

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

Rationale: The removal of any pressure to not perform a cesarean birth has led to a skyrocketing of hospital, state and national cesarean birth (CB) rates. Some hospitals now have CB rates over 50%. Hospitals with CB rates at 15-20% have infant outcomes that are just as good and better maternal outcomes (Gould et al., 2004). There are no data that higher rates improve any outcomes, yet the CB rates continue to rise. This measure seeks to focus attention on the most variable portion of the CB epidemic, the term labor CB in nulliparous women. This population segment accounts for the large majority of the variable portion of the CB rate, and is the area most affected by subjectivity.

As compared to other CB measures, what is different about NTSV CB rate (Low-risk Primary CB in first births) is that there are clear cut quality improvement activities that can be done to address the differences. Main et al. (2006) found that over 60% of the variation 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. Alfirevic et al. (2004) also showed that labor and delivery guidelines can make a difference in labor outcomes. Many authors have shown that physician factors, rather than patient characteristics or obstetric diagnoses are the major driver for the difference in rates within a hospital (Berkowitz, et al., 1989; Goyert et al., 1989; Luthy et al., 2003). The dramatic variation in NTSV rates seen in all populations studied is striking according to Menacker (2006). Hospitals within a state (Coonrod et al., 2008; California Office of Statewide Hospital Planning and Development [OSHPD], 2007) and physicians within a hospital (Main, 1999) have rates with a 3-5 fold variation.

Type Of Measure: Outcome

Improvement Noted As: Decrease in the rate

Numerator Statement: Patients with cesarean births

> **Included Populations:** *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for cesarean birth as defined in Appendix A, Table 11.06
>
> **Excluded Populations:** None
>
> **Data Elements:**
>
> - *ICD-10-PCS Other Procedure Codes*

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- *ICD-10-PCS Principal Procedure Code*

Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation

Included Populations:

- *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1
- Nulliparous patients with *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for outcome of delivery as defined in Appendix A, Table 11.08 and with a delivery of a newborn with 37 weeks or more of gestation completed

Excluded Populations:

- *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

Data Elements:

- *Admission Date*
- *Birthdate*
- *Discharge Date*
- *Gestational Age*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *Previous Live Births*

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: In order to identify areas for improvement, hospitals may want to review results based on specific ICD-10 codes or patient populations. Data could then be analyzed further determine specific patterns or trends to help reduce cesarean births.

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

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Selected References:

- Agency for Healthcare Research and Quality. (2002). *AHRQ Quality Indicators Guide to Inpatient Quality Indicators: Quality of Care in Hospitals Volume, Mortality, and Utilization*. Revision 4 (December 22, 2004). AHRQ Pub. No. 02-RO204.
- Alfirevic, Z., Edwards, G., & Platt, M.J. (2004). The impact of delivery suite guidelines on intrapartum care in "standard primigravida." *Eur J Obstet Gynecol Reprod Biol*.115:28-31.
- American College of Obstetricians and Gynecologists. (2000). *Task Force on Cesarean Delivery Rates. Evaluation of Cesarean Delivery*. (Developed under the direction of the Task Force on Cesarean Delivery Rates, Roger K. Freeman, MD, Chair, Arnold W. Cohen, MD, Richard Depp III, MD, Fredric D. Frigoletto Jr, MD, Gary D.V. Hankins, MD, Ellice Lieberman, MD, DrPH, M. Kathryn Menard, MD, David A. Nagey, MD, Carol W. Saffold, MD, Lisa Sams, RNC, MSN and ACOG Staff: Stanley Zinberg, MD, MS, Debra A. Hawks, MPH, and Elizabeth Steele).
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- DiGiuseppe, D.L., Aron, D.C., Payne, S.M., Snow, R.J., Dieker, L., & Rosenthal, G.E. (2001). Risk adjusting cesarean delivery rates: a comparison of hospital profiles based on medical record and birth certificate data. *Health Serv Res*.36:959-77.
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- Goyert, G.L., Bottoms, F.S., Treadwell, M.C., et al. (1989). The physician factor in cesarean birth rates. *N Engl J Med*.320:706-9.
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Original Performance Measure Source / Developer:
California Maternal Quality Care Collaborative

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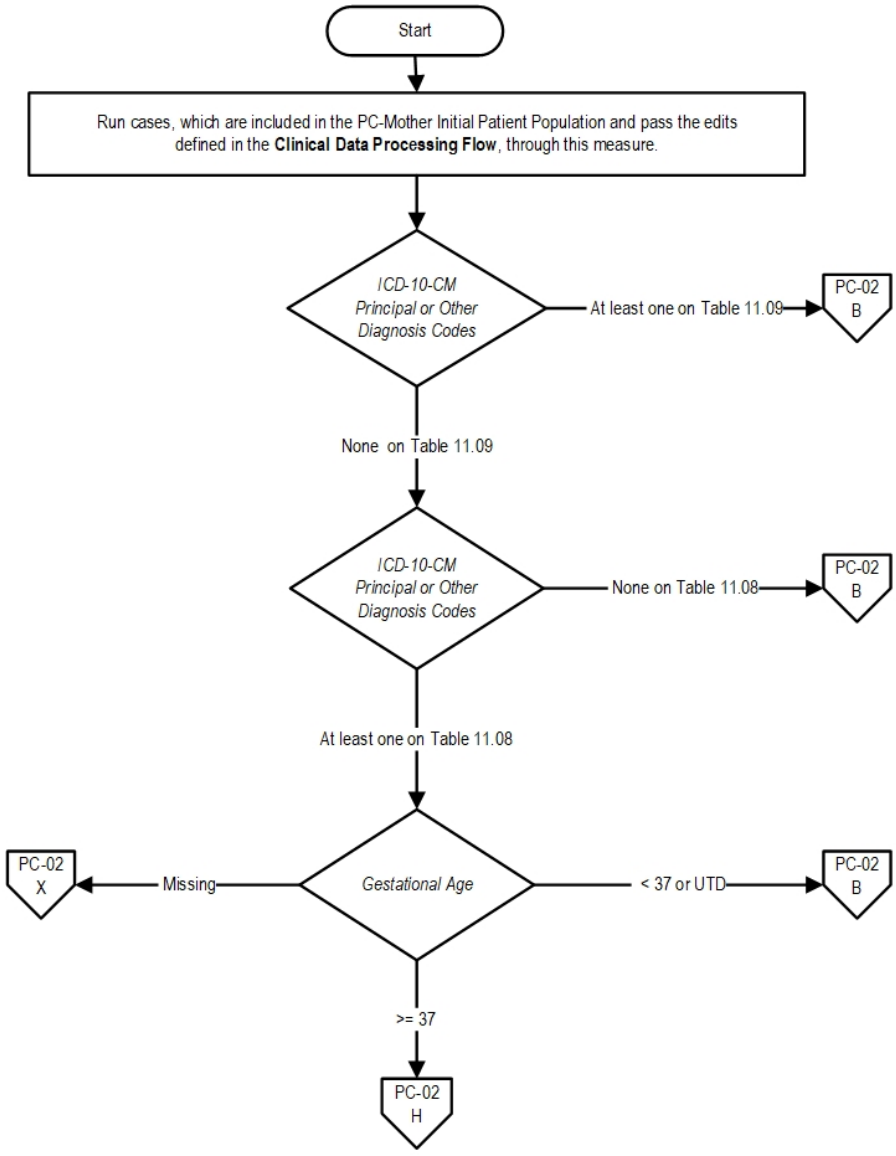
Measure Algorithm:

PC-02: Cesarean Birth

Numerator: Patients with cesarean births

Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation



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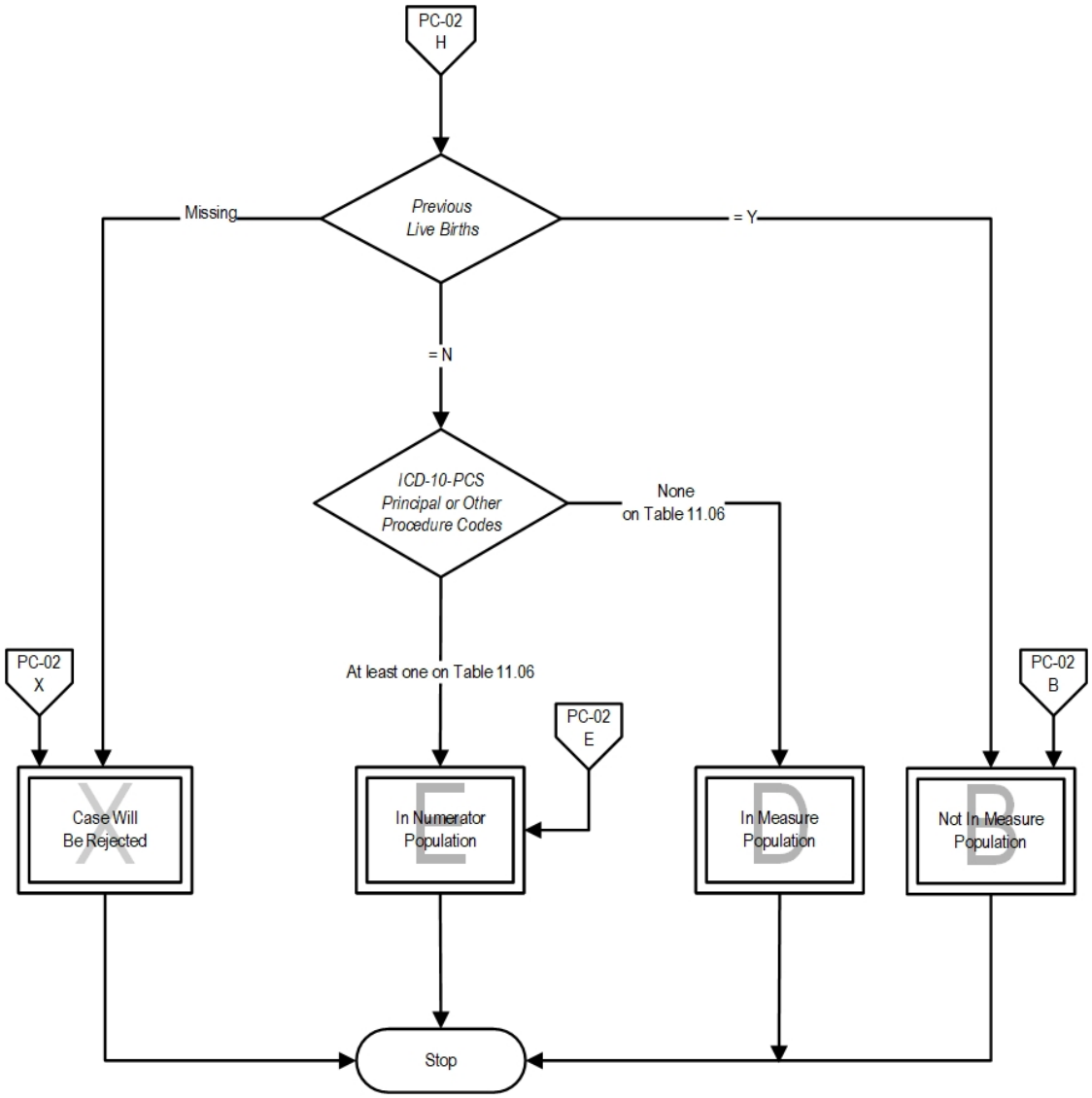

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****NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE****

Measure Information Form

Measure Set: Perinatal Care (PC)

Set Measure ID: PC-01

Performance Measure Name: Elective Delivery

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

Rationale: For almost 3 decades, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) have had in place a standard requiring 39 completed weeks gestation prior to ELECTIVE delivery, either vaginal or operative (ACOG, 1996). A survey conducted in 2007 of almost 20,000 births in HCA hospitals throughout the U.S. carried out in conjunction with the March of Dimes at the request of ACOG revealed that almost 1/3 of all babies delivered in the United States are electively delivered with 5% of all deliveries in the U.S. delivered in a manner violating ACOG/AAP guidelines. Most of these are for convenience, and result in significant short term neonatal morbidity (neonatal intensive care unit admission rates of 13- 21%) (Clark et al., 2009).

According to Glantz (2005), compared to spontaneous labor, elective inductions result in more cesarean births and longer maternal length of stay. The American Academy of Family Physicians (2000) also notes that elective induction doubles the cesarean delivery rate. Repeat elective cesarean births before 39 weeks gestation also result in higher rates of adverse respiratory outcomes, mechanical ventilation, sepsis and hypoglycemia for the newborns (Tita et al., 2009).

Type Of Measure: Process

Improvement Noted As: Decrease in the rate

Numerator Statement: Patients with elective deliveries

> **Included Populations:** *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*
>
> **Excluded Populations:** None
>
> **Data Elements:**

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- *ICD-10-PCS Other Procedure Codes*
- *ICD-10-PCS Principal Procedure Code*
- *Labor*
- *Prior Uterine Surgery*

Denominator Statement: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed

Included Populations:

- *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1

- *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

Excluded Populations:

- *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
- 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

Data Elements:

- *Admission Date*
- *Birthdate*
- *Discharge Date*
- *Gestational Age*
- *History of Stillbirth*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: In order to identify areas for improvement, hospitals may want to review results based on specific ICD-10 codes or patient populations. Data could be analyzed further to determine specific patterns or trends to help reduce elective deliveries.

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Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

- 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.
- American College of Obstetricians and Gynecologists. (November 1996). ACOG Educational Bulletin.
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Original Performance Measure Source / Developer:
Hospital Corporation of America-Women's and Children's Clinical Services

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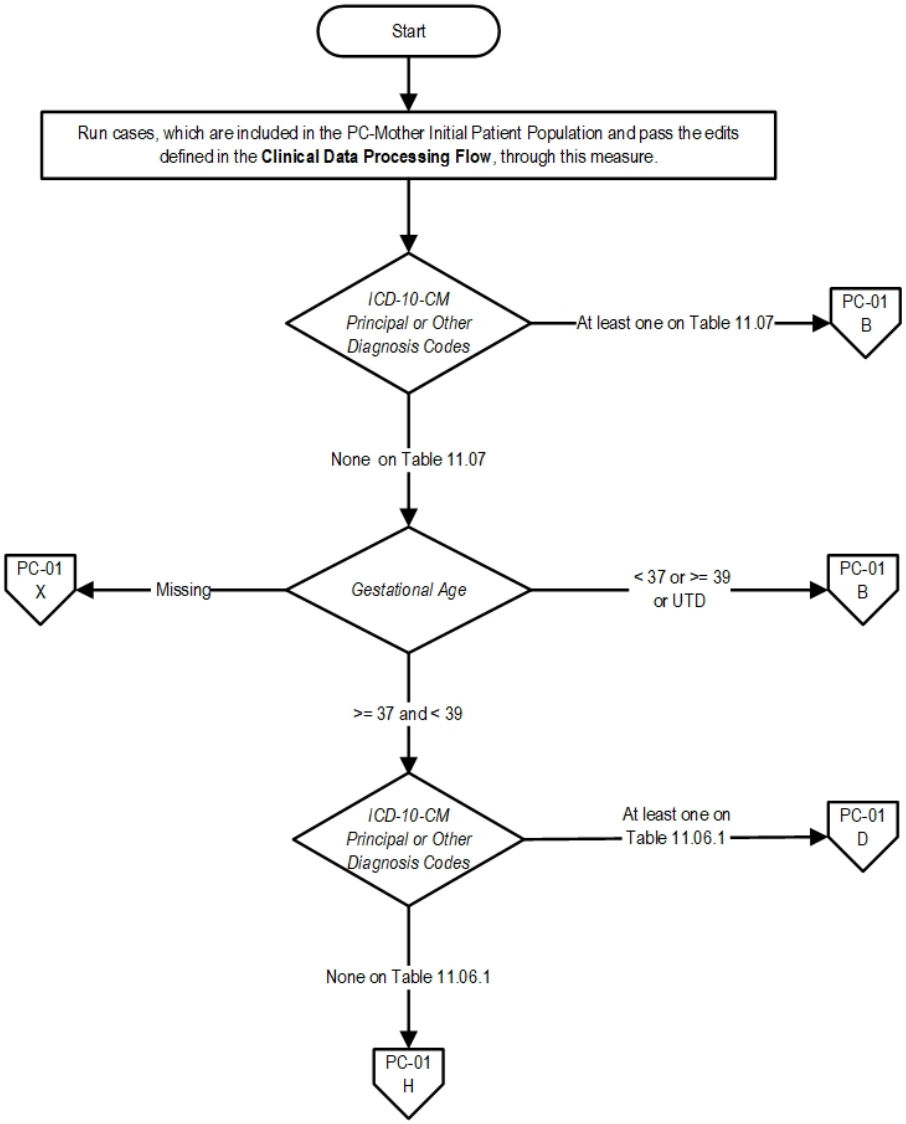
Measure Algorithm:

PC-01: Elective Delivery

Numerator: Patients with elective deliveries

Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed



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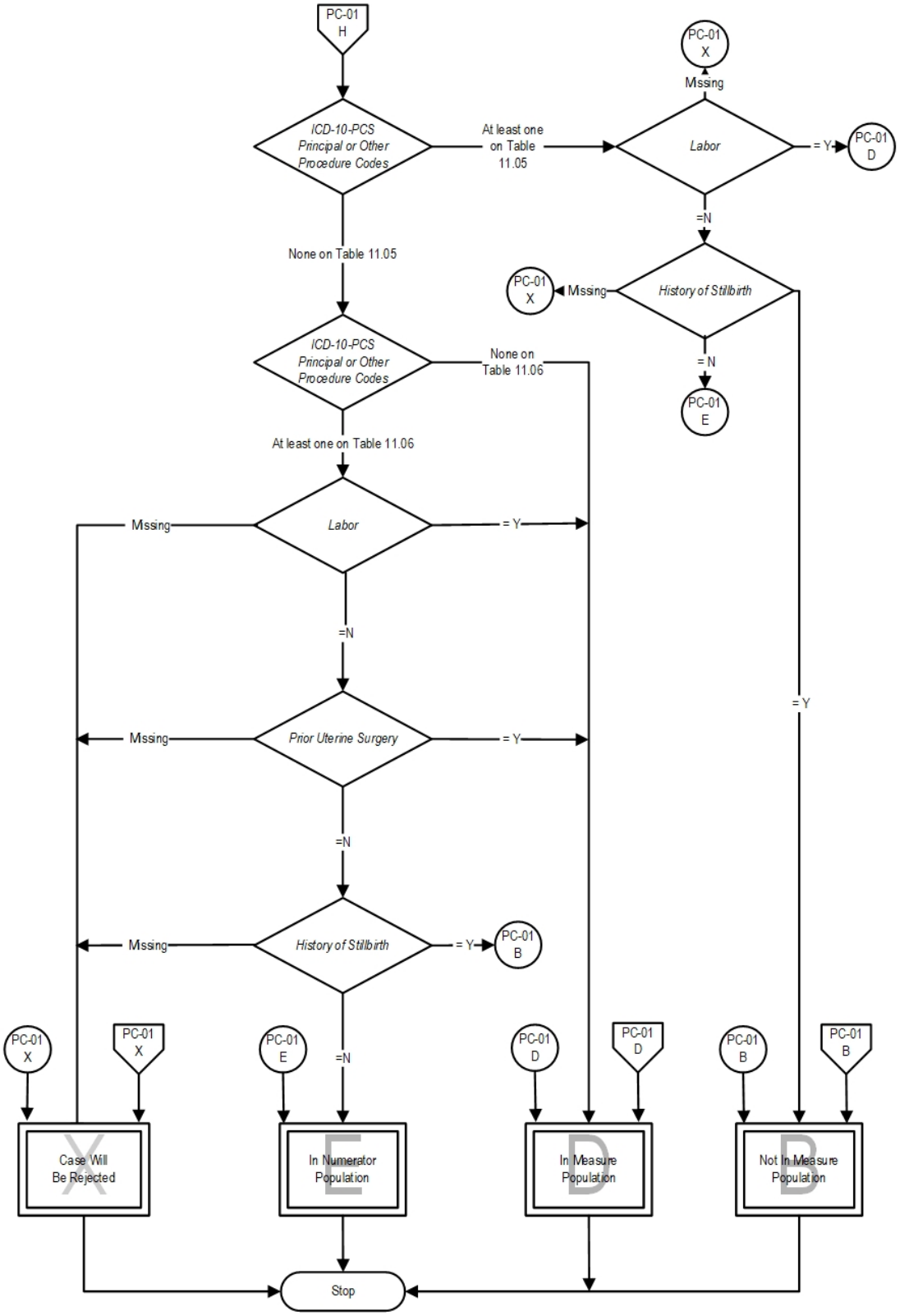

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****NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE****

Measure Information Form

Measure Set: Perinatal Care (PC)

Set Measure ID: PC-05

Performance Measure Name: Exclusive Breast Milk Feeding

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

The measure is reported as an overall rate which includes all newborns that were exclusively fed breast milk during the entire hospitalization.

Rationale: Exclusive breast milk feeding for the first 6 months of neonatal life has long been the expressed goal of World Health Organization (WHO), Department of Health and Human Services (DHHS), American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG). ACOG has recently reiterated its position (ACOG, 2007). A recent Cochrane review substantiates the benefits (Kramer et al., 2002). Much evidence has now focused on the prenatal and intrapartum period as critical for the success of exclusive (or any) BF (Centers for Disease Control and Prevention [CDC], 2007; Petrova et al., 2007; Shealy et al., 2005; Taveras et al., 2004). Exclusive breast milk feeding rate during birth hospital stay has been calculated by the California Department of Public Health for the last several years using newborn genetic disease testing data. Healthy People 2010 and the CDC have also been active in promoting this goal.

Type Of Measure: Process

Improvement Noted As: Increase in the rate

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

> **Included Populations:** Not applicable
>
> **Excluded Populations:** None
>
> **Data Elements:**
>
> - *Exclusive Breast Milk Feeding*

Denominator Statement: Single term newborns discharged alive from the hospital

> **Included Populations:** Liveborn newborns with *ICD-10-CM Principal Diagnosis Code* for single liveborn newborn as defined in Appendix A, Table 11.20.1
>
> **Excluded Populations:**

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- Admitted to the Neonatal Intensive Care Unit (NICU) at this hospital during the hospitalization
- *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 nutrition 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

Data Elements:

- *Admission Date*
- *Admission to NICU*
- *Birthdate*
- *Discharge Date*
- *Discharge Disposition*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *ICD-10-PCS Other Procedure Codes*
- *ICD-10-PCS Principal Procedure Code*
- *Term Newborn*

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: In order to identify areas for improvement in breast milk feeding rates, hospitals may wish to review documentation for reasons. Education efforts can be targeted based on the specific reasons identified.

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

- American Academy of Pediatrics. Section on Breastfeeding. Policy Statement. Breastfeeding and the Use of Human Milk. *Pediatrics* 2012 Mar; 129 (3): e827-841.
- American College of Obstetricians and Gynecologists. (Feb. 2007). Committee on Obstetric Practice and Committee on Health Care for Underserved Women.Breastfeeding: Maternal and Infant Aspects. ACOG Committee Opinion 361.

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- California Department of Public Health. (2017). Division of Maternal, Child and Adolescent Health, Breastfeeding Initiative, In-Hospital Breastfeeding Initiation Data, Hospital of Occurrence: Available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/Breastfeeding/Pages/In-Hospital-Breastfeeding-Initiation-Data.aspx
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Original Performance Measure Source / Developer:
California Maternal Quality Care Collaborative

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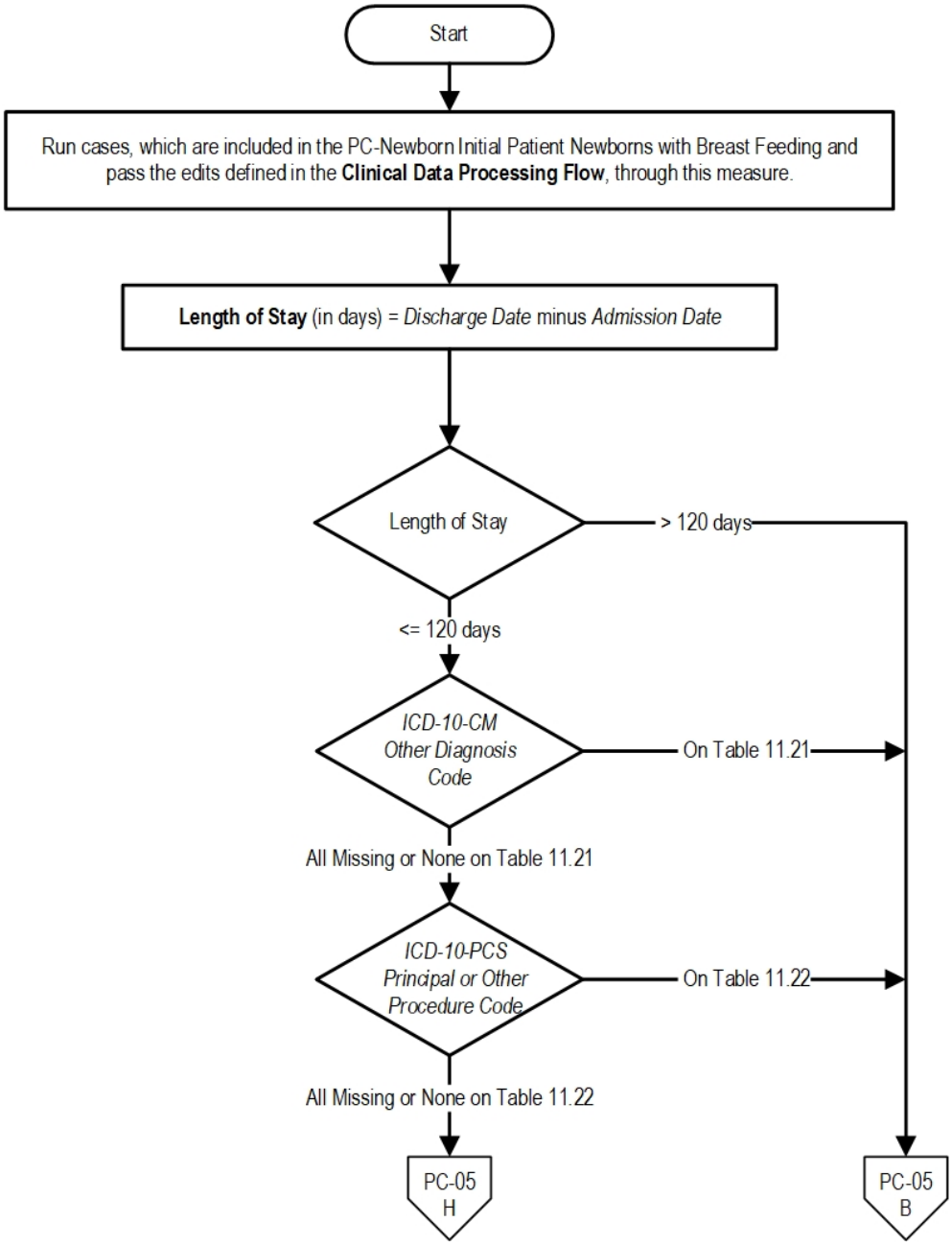
Measure Algorithm:

PC-05: Exclusive Breast Milk Feeding

Numerator: Newborns that were fed breast milk only since birth

Denominator: Single term newborns discharged alive from the hospital



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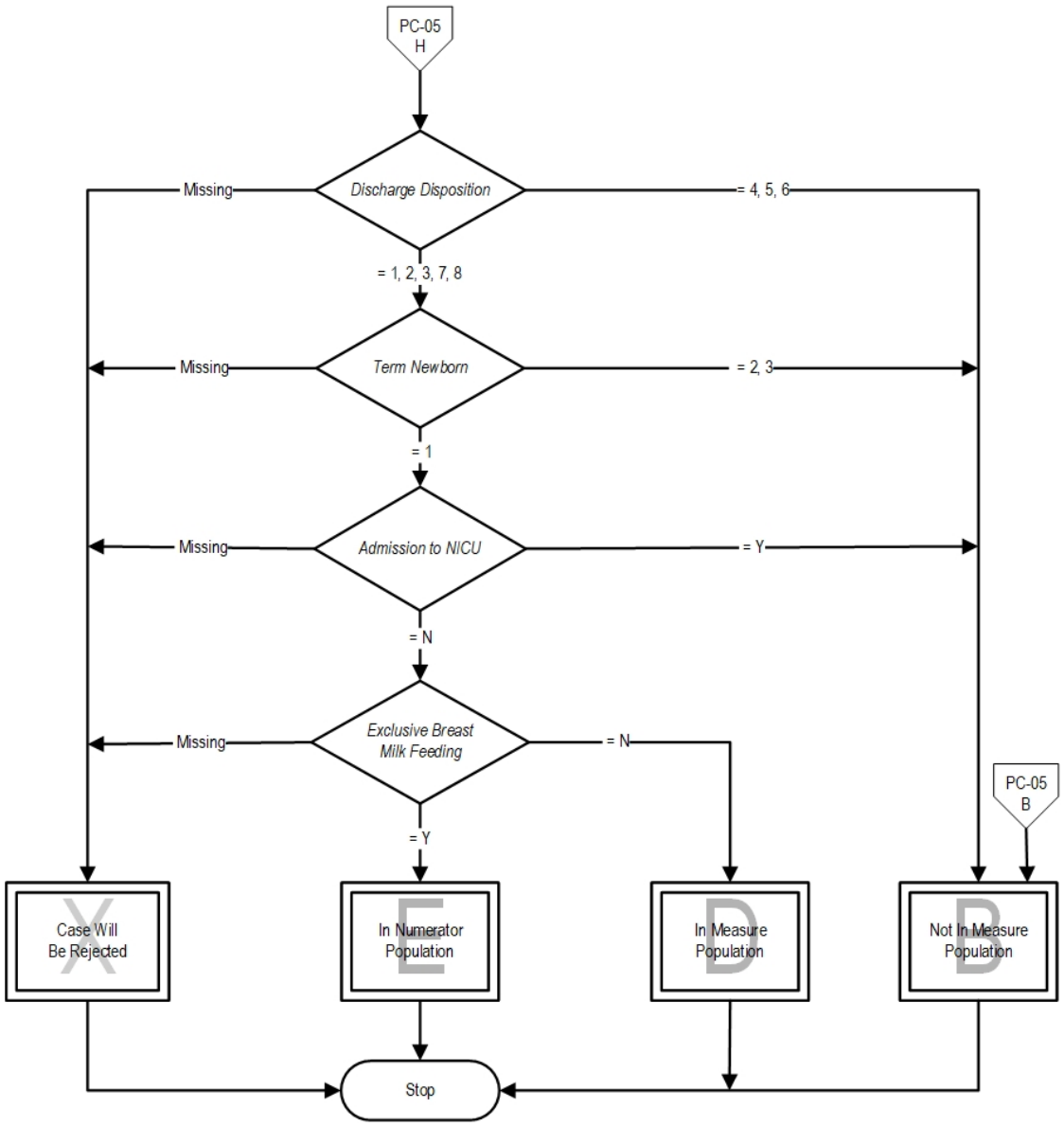

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Quality ID #336: Maternity Care: Postpartum Follow-up and Care Coordination
– National Quality Strategy Domain: Communication and Care Coordination
– Meaningful Measure Area: Prevention, Treatment, and Management of Mental Health

2021 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for postpartum care before or at 8 weeks of giving birth and received the following at a postpartum visit: breast-feeding evaluation and education, postpartum depression screening, postpartum glucose screening for gestational diabetes patients, family and contraceptive planning counseling, tobacco use screening and cessation education, healthy lifestyle behavioral advice, and an immunization review and update

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for all patients seen for postpartum care before or at 8 weeks of giving birth during the performance period. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third-party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality-data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third-party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third-party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
All patients, regardless of age, who gave birth during a 12-month period and were seen for postpartum care at a visit before or at 8 weeks of giving birth

Denominator Criteria (Eligible Cases):
All patients, regardless of age
AND
Patient procedure during performance period (CPT): 59400, 59410, 59430, 59510, 59515, 59610, 59614, 59618, 59622
AND
Postpartum care visit before or at 8 weeks post-delivery

NUMERATOR:
Patients receiving the following at a postpartum visit:

- Breast-feeding evaluation and education, including patient-reported breast-feeding
- Postpartum depression screening
- Postpartum glucose screening for gestational diabetes patients
- Family and contraceptive planning counseling
- Tobacco use screening and cessation education
- Healthy lifestyle behavioral advice
- Immunization review and update

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Definitions:

Breast-Feeding Evaluation and Education – Patients who were evaluated for and educated about breast-feeding before or at 8 weeks postpartum.

Postpartum Depression Screening – Patients who were screened for postpartum depression before or at 8 weeks postpartum. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer-administered questionnaires, and results should be documented in the medical record. Depression screening should include a self-reported validated depression screening tool (e.g., PHQ-2, Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression Scale (EPDS)).

Postpartum Glucose Screening for Gestational Diabetes – Patients who were diagnosed with gestational diabetes during pregnancy who were screened with a glucose screen before or at 8 weeks postpartum.

Family and Contraceptive Planning Counseling – Patients who were provided family and contraceptive planning counseling (*including contraception, if necessary*) before or at 8 weeks postpartum.

Tobacco Use Screening and Cessation Education – Patients who were screened for tobacco use before or at 8 weeks postpartum. Patients who used any type of tobacco who were given brief counseling (3 minutes or less) and/or pharmacotherapy.

Healthy Lifestyle Behavioral Advice – Clinicians should use discretion to determine which patients they deem appropriate for healthy lifestyle counseling. Clinicians may take into account the number of weeks that have passed since childbirth, whether the mother is breast-feeding, the degree to which the mother's body mass index (BMI) exceeds the normal range, whether postpartum depression is present, and the mother's own feelings and perceptions of her body weight. Counseling should include suggestions around healthy eating and staying active.

If deemed necessary by the clinician, the conversation about healthy lifestyle choices could include a follow-up plan, including a referral to a specialist such as a registered dietitian nutritionist, primary care provider, or mental health professional for lifestyle/behavioral therapy, pharmacological interventions, dietary supplements, exercise counseling or nutrition counseling.

Immunization Review and Update – Patients whose immunization records were reviewed and who were provided with indicated immunizations, including completing series initiated antepartum or postpartum, at or before 8 weeks postpartum.

Numerator Instruction:

To satisfactorily meet the numerator ALL components (breast-feeding evaluation and education, postpartum depression screening, postpartum glucose screening for patients with gestational diabetes, family and contraceptive planning counseling, tobacco use screening and cessation education, healthy lifestyle behavioral advice, and immunization review and update) must be performed according to the definitions provided above.

NUMERATOR OPTIONS:

Performance Met:	Postpartum screenings, evaluations, and education performed **(G9357)**
OR	
Performance Not Met:	Postpartum screenings, evaluations and education, not performed **(G9358)**

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RATIONALE:

Managing and ensuring concrete postpartum follow-up after delivery is a critical challenge to the health care system impacting the quality of care mothers receive. The American College of Obstetricians and Gynecologists (ACOG) sees the weeks following birth as a critical period for a woman and her child that sets the stage for long-term health and well-being. As such, this "fourth trimester" should include a comprehensive postpartum visit with a full assessment of physical, social, and psychological well-being.

Postpartum follow-up for depression screening, breast-feeding evaluation and education, family and contraceptive planning counseling, glucose screening for gestational diabetes, tobacco use screening and cessation education, healthy lifestyle behavioral advice, and immunization review and update are important risk factors to evaluate after childbirth. Maternal depression is one of the most common perinatal complications; however, the disorder remains under recognized, underdiagnosed, and undertreated. The various maternal depression disorders are defined by the severity of the depression and the timing and length of the episode. Studies report that 3 to 25 percent of women experience major depression during the year following childbirth.

Establishing the diagnosis of gestational diabetes mellitus offers an opportunity not only to improve pregnancy outcomes, but also to decrease risk factors associated with the subsequent development of type 2 diabetes. The ACOG Committee on Obstetric Practice recommends that all women with gestational diabetes mellitus be screened at 6–12 weeks postpartum and managed appropriately.

Tobacco and nicotine use is still a major contributor to morbidity and mortality in women and men. Women who stop using tobacco and nicotine receive an immediate health and financial benefit.

ACOG acknowledges that unintended pregnancies are common and that pregnancy spacing is important for healthy families. In addition, the greatest risk of low birth weight and preterm birth occurs when the interconception interval is less than 6 months. The ACOG sees the weeks following birth as a critical period for a woman and her child that set the stage for long-term health and well-being.

The ACOG 2018 Postpartum Toolkit states that immunization in the postpartum period is a simple and effective way to protect the woman and her child from certain infections, particularly when the woman was not immunized during pregnancy. Although obstetrician–gynecologists encourage women of childbearing age to be current with their immunizations before the peripartum period, postpartum maternal immunization can prevent acute maternal infection and potential spread of illness from the woman to her newborn. Infants of breast-feeding women acquire maternal antibodies through breast milk.

This measure is a measure of the adequacy of the care provided for those that come for postpartum care, as patients who do not have postpartum visits are excluded from this measure.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted from the referenced clinical guidelines.

ACOG Committee Opinion No. 736: Optimizing Postpartum Care (2018):
The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains:

- Mood and emotional well-being
- Infant care and feeding
- Sexuality, contraception, and birth spacing
- Sleep and fatigue
- Physical recovery from birth
- Chronic disease management
- Health maintenance

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Breast-Feeding Evaluation and Education
The USPSTF recommends interventions during pregnancy and after birth to promote and support breast-feeding.

This recommendation applies to pregnant women, new mothers, and young children. In rare circumstances involving health issues in mothers or infants, such as human immunodeficiency virus (HIV) infection or galactosemia, breast-feeding may be contraindicated, and interventions to promote breast-feeding may not be appropriate.

Interventions to promote and support breast-feeding may also involve a woman's partner, other family members, and friends.

Postpartum Depression Screening
The VA/DoD Clinical Practice Guideline for the Management of Pregnancy Version 3.0 (2018) and ACOG Committee Opinion No. 757: Screening for Perinatal Depression (2018) state that a screening for postpartum depression should be included in the postpartum visit. Both resources reference the 10-question Edinburgh Postnatal Depression Scale (EPDS), which is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool. Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week. In doubtful cases it may be useful to repeat the tool after 2 weeks.

Postpartum Glucose Screening for Gestational Diabetes Patients
The ACOG Tool for Postpartum Gestational Diabetes Mellitus (GDM) Follow-up states that up to one-third of women who experienced GDM will have impaired glucose metabolism postpartum and 15% to 50% of women will develop type 2 diabetes within the decades following the affected pregnancy. Postpartum follow-up with treatment has been proven to postpone or prevent this occurrence. The VA/DoD Clinical Practice Guideline for the Management of Pregnancy Version 3.0 (2018) concurs that glucose testing should be included in the postpartum visit for patients who had pregnancies complicated by gestational diabetes. The ACOG Committee Opinion No. 736: Optimizing Postpartum Care (2018) recommends either a 75g, 2-hour oral glucose tolerance test, or a fasting plasma glucose test. Refer to the VA/DoD Clinical Practice Guideline for the Management of Diabetes Mellitus in Primary Care (2017) for more information regarding glucose screening techniques.

Family and Contraceptive Planning Counseling
The ACOG Committee Opinion No. 666: Optimizing Postpartum Care (2016) states that the optimal interval between delivery and subsequent pregnancy is 18 months to 5 years. The VA/DoD Clinical Practice Guideline for the Management of Pregnancy Version 3.0 (2018) states that family planning and contraception should be discussed at the postpartum visit.

Further, the ACOG Committee Opinion No. 736: Optimizing Postpartum Care (2018) states that a woman's future pregnancy intentions provide a context for shared decision making regarding contraceptive options. Shared decision making brings two experts to the table: the patient and the health care provider. The health care provider is an expert in the clinical evidence, and the patient is an expert in her experiences and values. As affirmed by the World Health Organization (WHO), when making choices regarding the timing of the next pregnancy, "Individuals and couples should consider health risks and benefits along with other circumstances such as their age, fecundity, fertility aspirations, access to health services, child-rearing support, social and economic circumstances, and personal preferences." Given the complex history of sterilization abuse and fertility control among marginalized women, care should be taken to ensure that every woman is provided information on the full range of contraceptive options so that she can select the method best suited to her needs.

Tobacco Screening and Cessation Education
The ACOG Committee Opinion No. 736: Optimizing Postpartum Care (2018) recommends that one component of postpartum care be assessing mood and emotional well-being, which includes screening for tobacco use and counseling regarding relapse risk in the postpartum period. An ACOG Work Group created a Tobacco and Nicotine

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Cessation Toolkit to support clinicians in discussing tobacco and smoking cessation with patients.

Healthy Lifestyle Behavioral Advice
The ACOG 2018 Postpartum Toolkit states that approximately 65% of reproductive-aged women are overweight or obese at the time of pregnancy and are at risk of postpartum weight retention and chronic obesity.

Risk factors for being overweight or obese include a sedentary lifestyle, high caloric dietary intake, family history, genetics, and individual metabolism. Regular physical activity during an uncomplicated pregnancy and the postpartum period can improve cardiorespiratory fitness and reduce the risk and downstream health consequences (e.g., heart disease, diabetes) of being overweight or obese. According to ACOG, postpartum women should follow the national guidelines for physical activity, which is 150 minutes of moderate exercise each week. Recommendations include a target of 20–30 minutes of exercise on most days of the week. In its Postpartum Toolkit: Achieving a Healthy Weight in the Postpartum Patient, ACOG identifies that providing lifestyle recommendations to promote maternal health for long-term reduction in the risk of chronic obesity and its downstream sequelae of diabetes and cardiovascular disease is a key objective of the postpartum visit. Such recommendations will also result in improved health in the interpregnancy period, if further childbearing is desired.

Immunization Review and Update
The ACOG Committee Opinion No. 736: Optimizing Postpartum Care (2018) states that one component of postpartum care includes reviewing vaccination history and providing indicated immunizations, including completing series initiated antepartum or postpartum. The VA/DoD Clinical Practice Guideline for the Management of Pregnancy Version 3.0 (2018) states that the postpartum visit should include a review of current vaccination status in accordance with CDC Pregnancy and Maternal Vacciation guidance, including a review of immunization status against pertussis, influenza, varicella, and rubella. The ACOG Committee Opinion No. 732: Influenza Vaccination During Pregnancy (2018) states that the influenza vaccine is an essential element of pre-pregnancy, prenatal, and postpartum care since influenza can result in serious illness, and has a higher chance of progressing to pneumonia when it occurs during the antepartum or postpartum period. Likewise, the ACOG Committee Opinion No. 753: Assessment and Treatment of Pregnant Women With Suspected or Confirmed Influenza (2018) notes that postpartum women are at high risk of serious complications of seasonal and pandemic influenza infection.

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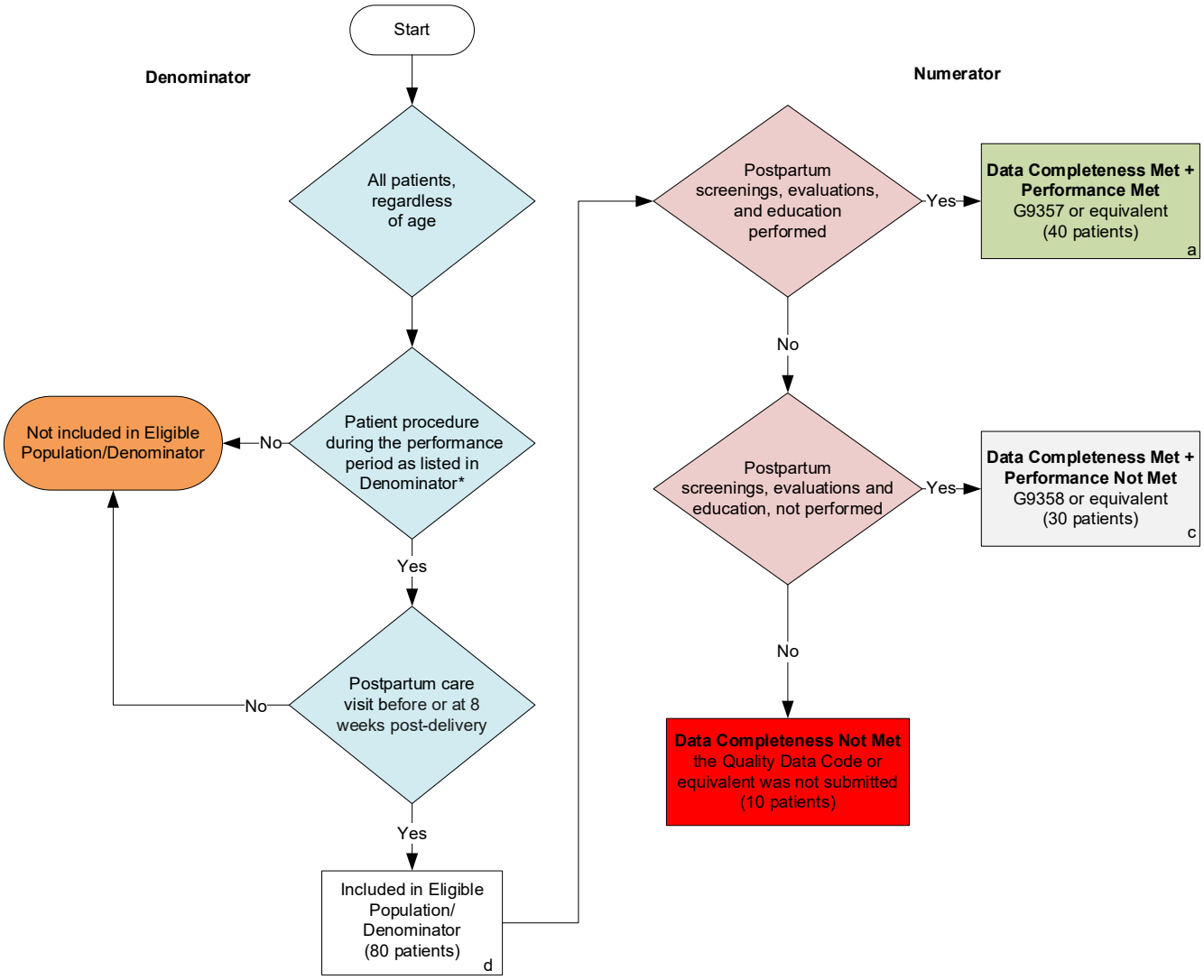
2021 Clinical Quality Measure Flow for Quality ID #336: Maternity Care: Postpartum Follow-up and Care Coordination

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=
Performance Met (a=40 patients) + Performance Not Met (c=30 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=
Performance Met (a=40 patients) = 40 patients = **57.14%**
Data Completeness Numerator (70 patients) = 70 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Process

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2021 Clinical Quality Measure Flow Narrative for Quality ID #336: Maternity Care: Postpartum Follow-up and Care Coordination

***Disclaimer**: Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator.
2. All patients, regardless of age.
3. Check *Patient procedure during the performance period as listed in Denominator**:
    a. If *Patient procedure during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient procedure during the performance period as listed in Denominator** equals Yes, proceed to check *Postpartum care visit before or at 8 weeks post-delivery*.
4. Check *Postpartum care visit before or at 8 weeks post-delivery*:
    a. If *Postpartum care visit before or at 8 weeks post-delivery* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Postpartum care visit before or at 8 weeks post-delivery* equals Yes, include in *Eligible Population/Denominator.*
5. Denominator Population:
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
6. Start Numerator
7. Check *Postpartum screenings, evaluations, and education performed*:
    a. If *Postpartum screenings, evaluations, and education performed* equals Yes, include in *Data Completeness Met and Performance Met.*
        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 patients in the Sample Calculation.
    b. If *Postpartum screenings, evaluations, and education performed* equals No, proceed to *Postpartum screenings, evaluations, and education not performed*.
8. Check *Postpartum screenings, evaluations, and education not performed*:
    a. If *Postpartum screenings, evaluations, and education not performed* equals Yes, include in *Data Completeness Met and Performance Not Met.*
        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 patients in the Sample Calculation.
    b. If *Postpartum screenings, evaluations, and education not performed* equals No, proceed to check *Data Completeness Not Met.*

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9. Check *Data Completeness Not Met*:
    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from Data Completeness Numerator in the Sample Calculation.

Sample Calculations:

Data Completeness equals Performance Met (a equals 40 patients) plus Performance Not Met (c equals 30 patients) divided by Eligible Population / Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

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Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Revised the definition of last enrollment segment.
- Clarified that visits that occur prior to the enrollment start date (during the pregnancy) meet criteria.
- Added telephone visits (Telephone Visits Value Set) e-visits and virtual check-ins (Online Assessments Value Set) to the Timeliness of Prenatal Care rate (administrative specification) and clarified in the *Notes* that services provided via telephone, e-visit or virtual check-in are eligible for use in reporting both rates.
- Updated the Hybrid specification to indicate that sample size reduction is allowed using only the current year's administrative rate for MY 2020; for MY 2021, organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate.
- Added examples of "pregnancy diagnosis" in the Hybrid specification of the Timeliness of Prenatal Care indicator.

Description

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
- *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Definitions

First trimester	280–176 days prior to delivery (or EDD).
Last enrollment segment	The period of continuous enrollment (with no gaps in enrollment) during the pregnancy with the start date that is closest to the delivery date. Use guideline "Members Who Switch Products/Product Lines" in the *General Guidelines for Data Collection and Reporting* to determine continuous enrollment.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 17: Members in Hospice.*

Product lines	Commercial, Medicaid (report each product line separately).
Age	None specified.
Continuous enrollment	43 days prior to delivery through 60 days after delivery.

Allowable gap No allowable gap during the continuous enrollment period.

Anchor date Date of delivery.

Benefit Medical.

Event/diagnosis *Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.* Include women who delivered in any setting.

Multiple births. Women who had two separate deliveries (different dates of service) between October 8 of the year prior to the measurement year and October 7 of the measurement year count twice. Women who had multiple live births during one pregnancy count once.

Follow the steps below to identify the eligible population, which is the denominator for both rates.

Step 1 Identify deliveries. Identify all women with a delivery (Deliveries Value Set) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.

Note: *The intent is to identify the date of delivery (the date of the "procedure"). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge.*

Step 2 Exclude non-live births (Non-live Births Value Set).

Step 3 Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps.

Administrative Specification

Denominator The eligible population.

Numerator

Timeliness of Prenatal Care A prenatal visit during the required timeframe. Follow the steps below to identify numerator compliance.

Step 1 Identify women whose last enrollment segment started before, on or between 280 and 219 days before delivery (or EDD).

These women must have a prenatal visit during the first trimester.

Step 2 Identify women whose last enrollment segment started less than 219 days before delivery (or EDD).

These women must have a prenatal visit any time during the period that begins 280 days prior to delivery and ends 42 days after enrollment start date.

Do not count visits that occur on or after the date of delivery. Visits that occur prior to the woman's enrollment start date during the pregnancy meet criteria.

Step 3 Identify prenatal visits that occurred during the required timeframe (the time frame identified in step 1 or 2). Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria for a prenatal visit:

- A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set).
- A prenatal visit (Prenatal Visits Value Set; Telephone Visits Value Set; Online Assessments Value Set) ***with*** a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).

Postpartum Care A postpartum visit on or between 7 and 84 days after delivery. Any of the following meet criteria:

- A postpartum visit (Postpartum Visits Value Set).
- Cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set).
- A bundled service (Postpartum Bundled Services Value Set) where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).

Exclude services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set).

Note: *The practitioner requirement only applies to the Hybrid Specification. The organization is not required to identify practitioner type in administrative data.*

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for each product line.

For MY 2020 reporting, the organization may reduce the sample size using the current year's administrative rate. The prior year's reported rate may not be used when reducing the sample size for MY 2020 reporting.

For MY 2021 reporting, organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate.

Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Numerator

Timeliness of Prenatal Care A prenatal visit during the required timeframe. Refer to the Administrative Specification to identify the required timeframe for each woman based on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from the administrative data.

Medical record

Prenatal care visit to an OB/GYN or other prenatal care practitioner, or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of *one* of the following.

- Documentation indicating the woman is pregnant or references to the pregnancy; for example:
  - Documentation in a standardized prenatal flow sheet, ***or***
  - Documentation of LMP, EDD or gestational age, ***or***
  - A positive pregnancy test result, ***or***
  - Documentation of gravidity and parity, ***or***
  - Documentation of complete obstetrical history, ***or***
  - Documentation of prenatal risk assessment and counseling/education.
- A basic physical obstetrical examination that includes auscultation for fetal heart tone, ***or*** pelvic exam with obstetric observations, ***or*** measurement of fundus height (a standardized prenatal flow sheet may be used).
- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), ***or***
  - TORCH antibody panel alone, ***or***
  - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, ***or***
  - Ultrasound of a pregnant uterus.

Postpartum Care

A postpartum visit on or between 7 and 84 days after delivery, as documented through either administrative data or medical record review.

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from the administrative data.

Medical record

Postpartum visit to an OB/GYN or other prenatal care practitioner, or PCP on or between 7 and 84 days after delivery. Do not include postpartum care provided in an acute inpatient setting.

Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and *one* of the following.

- Pelvic exam.
- Evaluation of weight, BP, breasts and abdomen.
  - Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component.
- Notation of postpartum care, including, but not limited to:
  - Notation of “postpartum care,” “PP care,” “PP check,” “6-week check.”
  - A preprinted “Postpartum Care” form in which information was documented during the visit.
- Perineal or cesarean incision/wound check.
- Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders.

- Glucose screening for women with gestational diabetes.
- Documentation of any of the following topics:
  - Infant care or breastfeeding.
  - Resumption of intercourse, birth spacing or family planning.
  - Sleep/fatigue.
  - Resumption of physical activity.
  - Attainment of healthy weight.

Note

- *Criteria for identifying prenatal care for women who were not continuously enrolled during the first trimester allow more flexibility than criteria for women who were continuously enrolled.*
  - *For women whose last enrollment segment started before, on or between 280 and 219 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.*
  - *For women whose last enrollment segment started less than 219 days before delivery, the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment.*
- *Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure.*
- *For each member, the organization must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently. If the organization elects to use EDD, and the EDD is not on or between October 8 of the year prior to the measurement year and October 7 of the measurement year, the member is excluded as a valid data error and replaced by the next member of the oversample. The LMP may not be used to determine the first trimester.*
- *The organization may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate.*
- *A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.*
- *The intent is that a prenatal visit is with a PCP or OB/GYN or other prenatal care practitioner. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type.*
- *The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.*
- *Refer to Appendix 3 for the definition of* PCP *and* OB/GYN and other prenatal care practitioner.
- *For both rates, services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table PPC-1/2: Data Elements for Prenatal and Postpartum Care

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	*For each of the 2 rates*	*For each of the 2 rates*
Eligible population	*For each of the 2 rates*	*For each of the 2 rates*
Number of numerator events by administrative data in eligible population (before exclusions)		*For each of the 2 rates*
Current year's administrative rate (before exclusions)		*For each of the 2 rates*
Minimum required sample size (MRSS)		*For each of the 2 rates*
Oversampling rate		*For each of the 2 rates*
Number of oversample records		*For each of the 2 rates*
Number of medical records excluded because of valid data errors		*For each of the 2 rates*
Number of employee/dependent medical records excluded		*For each of the 2 rates*
Records added from the oversample list		*For each of the 2 rates*
Denominator		*For each of the 2 rates*
Numerator events by administrative data	*For each of the 2 rates*	*For each of the 2 rates*
Numerator events by medical records		*For each of the 2 rates*
Reported rate	*For each of the 2 rates*	*For each of the 2 rates*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Prenatal and Postpartum Care

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	NA	There are no ages specified in this measure.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events that contain (or map to) codes in the value sets may be used to identify visits. The value sets and logic may not be changed. Organizations may not change the logic but may change the delivery date and account for the impact on other date-dependent events. ***Note:*** *Organizations may assess at the member level (vs. discharge level) by applying measure logic appropriately (i.e., percentage of members with deliveries).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Timeliness of Prenatal Care • Postpartum Care	No	Value sets and logic may not be changed. If the delivery-date range is changed, all numerator events must be measured in relation to the new range.

Measure Information Form

Measure Set: Perinatal Care (PC)

Set Measure ID: PC-06

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

Performance Measure Name: Unexpected Complications in Term Newborns

Description: Unexpected complications among full term newborns with no preexisting conditions.

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.

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. Examples include less severe respiratory complications e.g. Transient Tachypnea of the Newborn, or infections with a longer length of stay not including sepsis, infants who have a prolonged length of stay of over 5 days.

Rationale: The most important childbirth outcome for families is bringing home a healthy baby. While there have been measures developed to assess clinical practices and outcomes in preterm infants, there is a lack of metrics that assess the health outcomes of term infants who represent over 90% of all births. This measure addresses this gap and gauges adverse outcomes resulting in severe or moderate morbidity in otherwise healthy term infants without preexisting conditions. This measure also uses length of stay (LOS) modifiers to guard against overcoding and undercoding of diagnoses. Importantly, this metric also serves as a balancing measure for other maternal measures such as NTSV Cesarean rates and early elective delivery rates. The purpose of a balancing measure is to guard against any unanticipated or unintended consequences of quality improvement activities for these measures.

Type Of Measure: Outcome

Improvement Noted As: Decrease in the rate

Numerator Statement:
PC-06.0 Newborns with severe complications and moderate complications.
PC-06.1 Newborns with severe complications.
PC-06.2 Newborns with moderate complications.

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Included Populations:
Severe Complications:

- Death
- Transfer to another acute care facility for higher level of care
- *ICD-10-CM Principal Diagnosis Code*, *ICD-10-CM Other Diagnosis Codes*, *ICD-10-PCS Principal Procedure Code* or *ICD-10-PCS Other Procedure Codes* for Severe Morbidities as defined in Appendix A, Tables:
    - 11.36 Severe Birth Trauma
    - 11.37 Severe Hypoxia/Asphyxia
    - 11.38 Severe Shock and Resuscitation
    - 11.39 Neonatal Severe Respiratory Complications
    - 11.40 Neonatal Severe Infection
    - 11.41 Neonatal Severe Neurological Complications
    - 11.42 Severe Shock and Resuscitation Procedures
    - 11.43 Neonatal Severe Respiratory Procedures
    - 11.44 Neonatal Severe Neurological Procedures
- Patients with Length of Stay greater than 4 days AND an *ICD-10-CM Principal Diagnosis Code* or *ICD-10-CM Other Diagnosis Codes* for Sepsis as defined in Appendix A, Table 11.45 Neonatal Severe Septicemia

Moderate Complications:

- *ICD-10-CM Principal Diagnosis Code*, *ICD-10-CM Other Diagnosis Codes*, *ICD-10-PCS Principal Procedure Code* or *ICD-10-PCS Other Procedure Codes* for moderate complications as defined in Appendix A, Tables:
    - 11.46 Moderate Birth Trauma
    - 11.47 Moderate Respiratory Complications
    - 11.48 Moderate Respiratory Complications Procedures
- *ICD-10-CM Principal Diagnosis Code* for single liveborn newborn as defined in Appendix A, Table 11.20.2 Single Liveborn Newborn-Vaginal AND Length of Stay greater than 2 days
  OR
  ICD-10-CM Principal Diagnosis Code for single liveborn newborn as defined in Appendix A, Table 11.20.3 Single Liveborn Newborn-Cesarean AND Length of Stay greater than 4 days
  AND ANY
  ICD-10-CM Principal Diagnosis Code, *ICD-10-CM Other Diagnosis Codes*, *ICD-10-PCS Principal Procedure Code* or *ICD-10-PCS Other Procedure Codes* for moderate complications as defined in Appendix A, Tables:
    - 11.49 Moderate Birth Trauma with LOS
    - 11.50 Moderate Respiratory Complications with LOS
    - 11.51 Moderate Neurological Complications with LOS Procedures
    - 11.52 Moderate Respiratory Complications with LOS Procedures
    - 11.53 Moderate Infection with LOS
- Patients with Length of Stay greater than 5 days and NO *ICD-10-CM Principal Diagnosis Code*, *ICD-10-CM Other Diagnosis Codes*, *ICD-10-PCS Principal Procedure Code* or *ICD-10-PCS Other Procedure Codes* for jaundice or social indications as defined in Appendix A, Tables:

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- 11.33 Neonatal Jaundice
- 11.34 Phototherapy
- 11.35 Social Indications

Excluded Populations: None

Data Elements:

- *Admission Date*
- *Discharge Date*
- *Discharge Disposition*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *ICD-10-PCS Other Procedure Codes*
- *ICD-10-PCS Principal Procedure Code*

Denominator Statement: Liveborn single term newborns 2500 gm or over in birth weight.

Included Populations: Single liveborn newborns with *ICD-10-CM Principal Diagnosis Code* for single liveborn newborn as defined in Appendix A, Table Number 11.20.1: Single Liveborn Newborn

Excluded Populations:

- Patients who are not born in the hospital or are part of multiple gestation pregnancies, with no *ICD-10-CM Principal Diagnosis Code* for single liveborn newborn as defined in Appendix A, Table Number 11.20.1: Single Liveborn Newborn
- *Birth Weight* < 2500 gm
- Patients who are not term or with < 37 weeks gestation completed
- Patients whose term status or gestational age is missing and birthweight < 3000 gm
- *ICD-10-CM Principal Diagnosis Code* or *ICD-10-CM Other Diagnosis Codes* for congenital malformations and genetic diseases as defined in Appendix A, Table 11.30 Congenital Malformations
- *ICD-10-CM Principal Diagnosis Code* or *ICD-10-CM Other Diagnosis Codes* for pre-existing fetal conditions as defined in Appendix A, Table 11.31 Fetal Conditions
- *ICD-10-CM Principal Diagnosis Code* or *ICD-10-CM Other Diagnosis Codes* for maternal drug use exposure in-utero as defined in Appendix A, Table 11.32 Maternal Drug Use

Data Elements:

- *Birth Weight*
- *Birthdate*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *ICD-10-PCS Other Procedure Codes*
- *ICD-10-PCS Principal Procedure Code*
- *Term Newborn*

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Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: In order to identify areas for improvement, hospitals may want to review results based on specific ICD-10 codes or patient populations. Data could then be analyzed further to determine specific patterns or trends to help reduce unexpected newborn complications.

Sampling: No.

Data Reported As: Aggregate rate generated from count data reported as a rate per 1000 livebirths.
Note:
All 3 sub-measures will have the same Final Denominator.
Final Denominator = Number of patients in Overall Numerator (PC-06.0=category E) + Number of cases in Overall Denominator (PC-06.0= category of D)

Rate Calculation:
PC-06.0: Overall rate = ((Number of patients with Severe Complications + Number of patients with Moderate Complications) / Final Denominator) * 1000
PC-06.1: Severe rate = (Number of patients with Severe Complications / Final Denominator) * 1000
PC-06.2: Moderate rate = (Number of patients with Moderate Complications / Final Denominator) * 1000

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Original Performance Measure Source / Developer:
California Maternal Quality Care Collaborative

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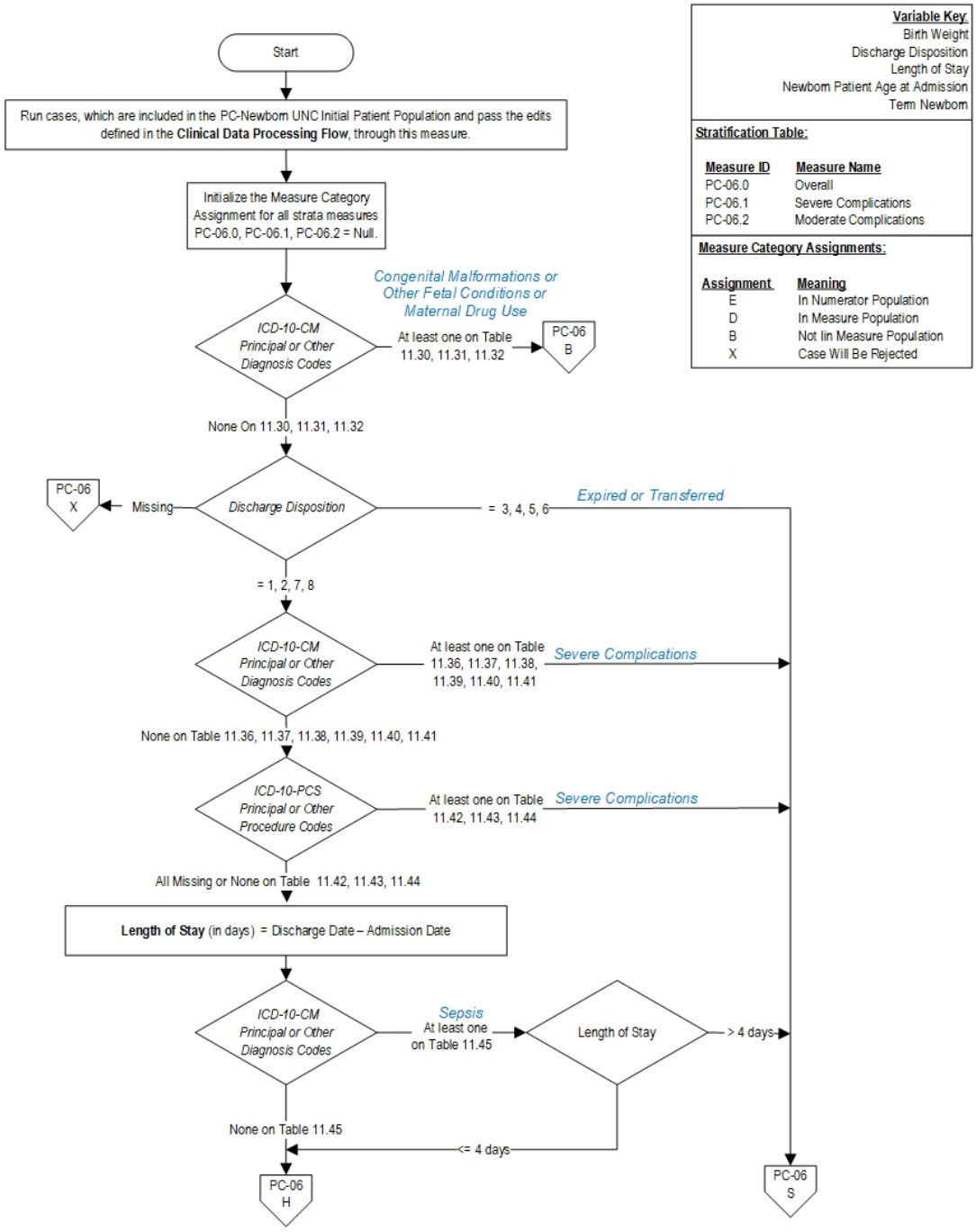
Measure Algorithm:

PC-06: Unexpected Complications in Term Newborns

Numerator: Newborns with severe complications and moderate complications.
Denominator: Liveborn single term newborns 2500 gm or over in birth weight.



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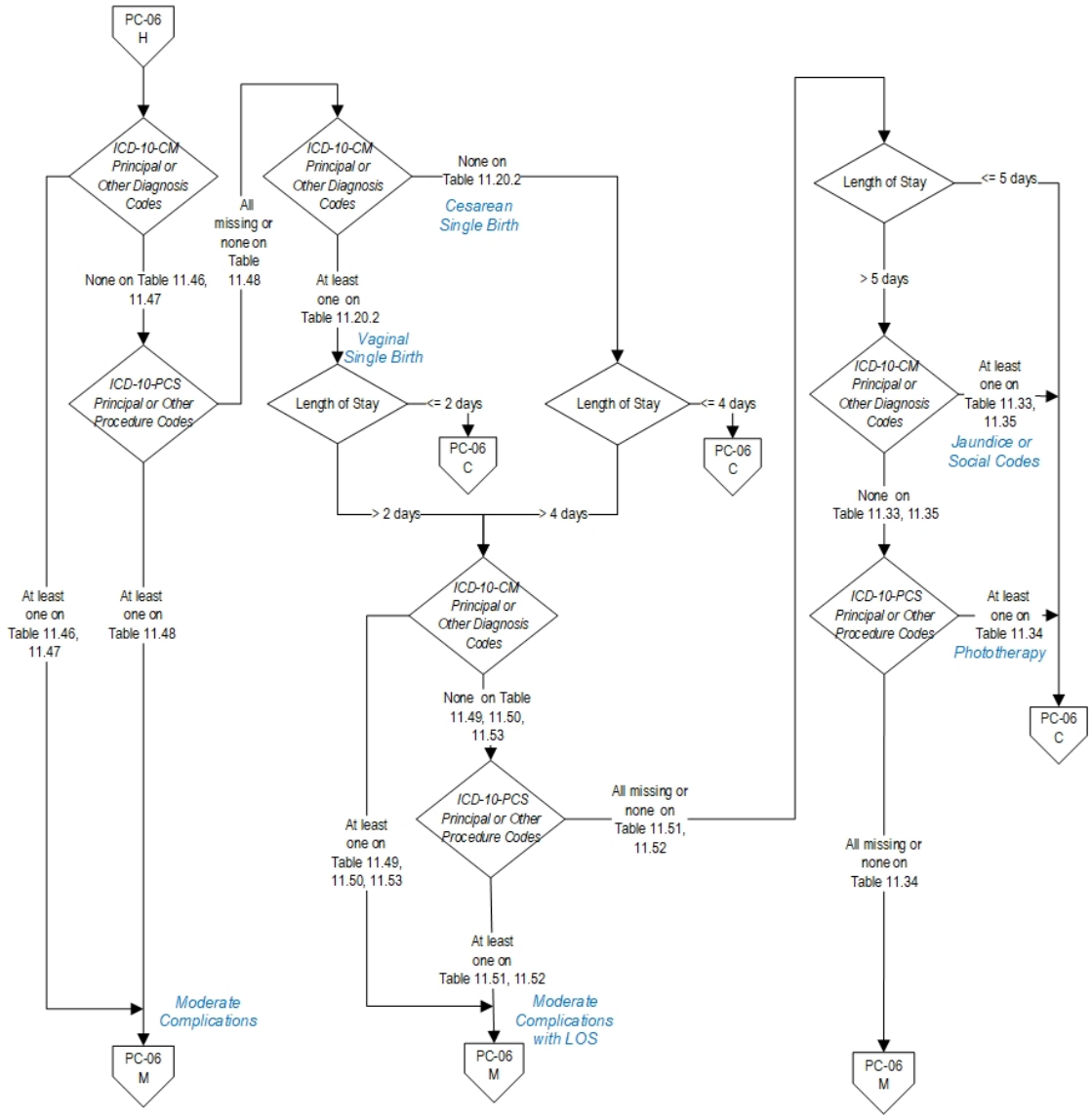

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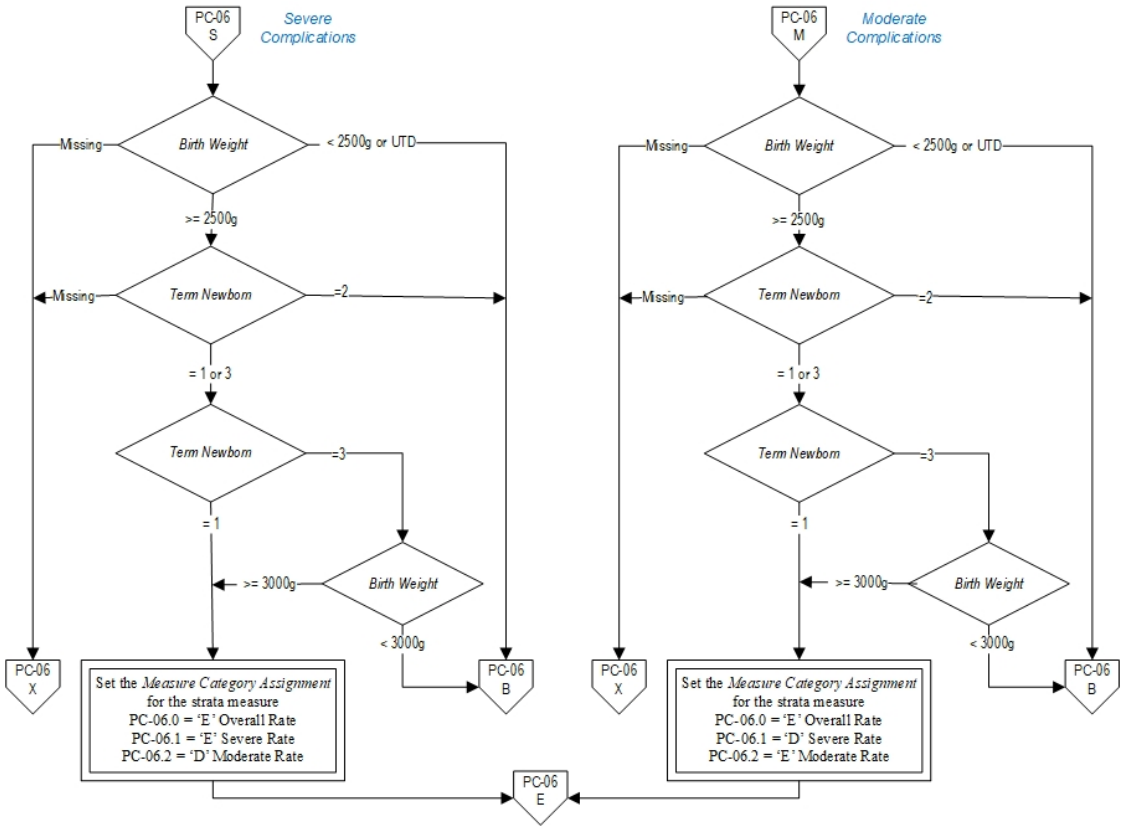

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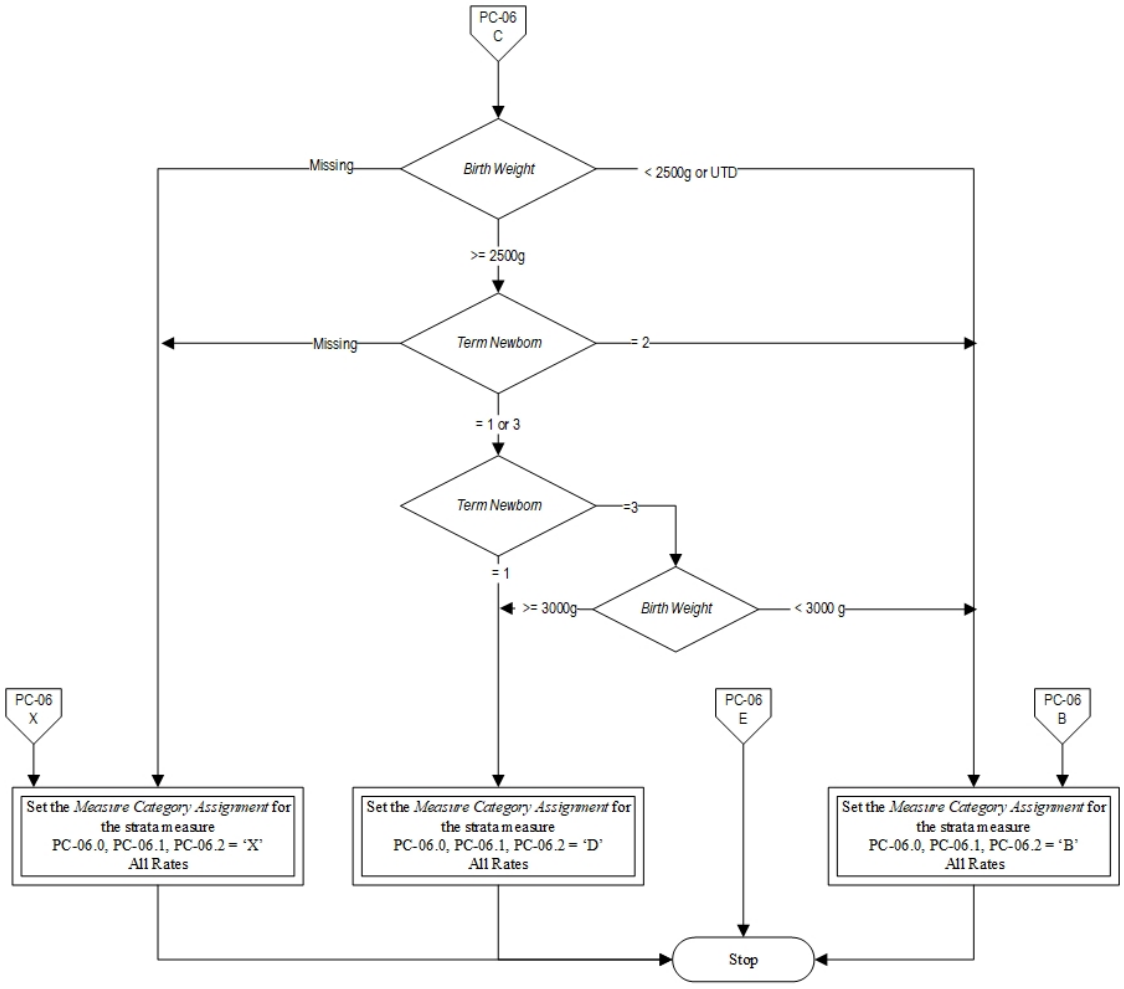

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MEASURE LBW-CH: LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS

Centers for Disease Control and Prevention

(National Center for Health Statistics)

A. DESCRIPTION

Percentage of live births that weighed less than 2,500 grams at birth during the measurement year.

Note: A lower rate indicates better performance.

Data Collection Method: State Vital Records submitted to the National Center for Health Statistics (NCHS) National Vital Statistics System, Natality.

Guidance for Reporting:

- To reduce state burden and streamline reporting, CMS will calculate this measure for states using state natality data obtained through the Centers for Disease Control and Prevention Wide-ranging Online Data for Epidemiologic Research (CDC WONDER). **States are not asked to report data for this measure for FFY 2021 Core Set reporting.**
- The most recent NCHS natality data for each state are available at: http://wonder.cdc.gov/natality-expanded-current.html.
- The measurement period for this measure is the calendar year before the Child Core Set reporting year. For example, calendar year 2020 data should be used for the FFY 2021 reporting year.
- Eligibility for this measure is based on deliveries that have Medicaid as principal source of payment for delivery as indicated on the birth certificate. For more information on the principal source of payment field see "21. Principal source of payment" in NCHS's Guide to Completing the Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death.

B. ADMINISTRATIVE SPECIFICATION

Denominator

The number of resident live births in the state in the reporting period with Medicaid as the principal source of payment for the delivery.

The following four principal sources of payment for the delivery are available in all states' birth certificates: (1) Private insurance, (2) Medicaid (or a comparable state program), (3) Self-pay, or (4) Other. More detailed information for the "other" category is available for 34 states and the District of Columbia. In some states, deliveries covered by CHIP may be included in the "Medicaid" category. For more information on the principal source of payment field see "21. Principal source of payment" in NCHS's Guide to Completing the Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death.

Numerator

The number of resident live births in the state weighing less than 2,500 grams at birth with Medicaid as the principal source of payment for the delivery.

Units

Report as a percentage.

C. EXCLUSIONS

Exclude resident live births from both the denominator and numerator with a birth weight that is “Unknown or Not Stated.”