



Pioneers in Quality:

eCQM Expert to Expert Webinar Series: PC-01 & PC-05 eCQMs

March 26, 2019

Q & A Document

QUESTION 1: Will the questions and answers be on the slide deck also?

A: Following the presentation today, the questions and answers will be transcribed into a separate document that will be loaded on the Pioneers in Quality portal along with the slide deck and recording. The follow-up documents for each of the Expert to Expert sessions can be found at this location: https://www.jointcommission.org/piq_expert_to_expert_series/

Question 2: I have a few very basic questions regarding CQL. I'm new to my organization and essentially uninitiated into what's going on here.

A: To assist you, please review the previous Expert to Expert webinars for background information on CQL and how it is applied within each measure. The previous sessions are available at: https://www.jointcommission.org/piq_expert_to_expert_series/

Question 3: If you just need an extract from us, why do we need to implement CQL? If we do need to implement CQL, what kind of hardware does it run on? What kind of software? None of my machines will accept CQL commands.

A: CQL changes went into effect with 1/1/2019 discharge (CY 2019 reporting year). Here is a link to a presentation from MITRE regarding technical implementation from Health Information and Management Systems Society (HIMSS) 2018: <https://health.mitre.org/blog/getting-started-with-cql-technical-implementation-for-vendors/>.

For additional questions, please submit a JIRA ticket here:
<https://oncprojectracking.healthit.gov/support/projects/CQLIT>

Question 4: Does unstable lie or breech presentation count as an exclusion prior to 39 weeks?

A: No, malpresentations are not necessarily a reason to deliver early and in most cases these conditions can be managed through labor and delivery at 39 weeks or greater.

Question 5: What will the definition of NICU be? Is this the state designation? We have a Special Care Nursery, not state certified as a NICU, however providers tend to document NICU anyway.

A: On slide 66, NICU is expressed as a facility location in the logic expression. So, if your organization has that unit identified as a NICU within its facility structure then that would count as an exclusion.

According to the American Academy of Pediatrics' definition: A NICU is defined as a hospital unit providing critical care services which is organized with personnel and equipment to provide continuous life support and comprehensive care for extremely high-risk newborn infants and those with complex and critical illness.

Question 6: Is there a definition for labor? Must there be cervical changes?

A: There must be documentation by the clinician

- the patient was in labor
OR
- there was regular contractions with or without cervical change, for example: contractions every 4 to 5 minutes; regular contractions and dilation; effacement 50% with contractions every 3 minutes; steady contractions.

You can search the eligible SNOMED codes for the Labor value set (2.16.840.1.113883.3.117.1.7.1.281) from VSAC
<https://www.nlm.nih.gov/vsac/support/usingvsac/searchvsac.html>

Question 7: In PC-01, if labor precedes C-section then the case does not meet the numerator?

A: This is correct, the case will not meet the numerator. To clarify, if there is documentation by the clinician that patient is in labor prior to the intervention, cesarean birth or induction procedure, the case will not fail the measure.

Question 8: On slide 35, where can we find the most updated version of the "Diagnoses in Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation"?

A: You can find the most updated version of the Value Set in the NLM at the VSAC website
<https://www.nlm.nih.gov/vsac/support/usingvsac/searchvsac.html>.

Question 9: For PC-01, we often have patients with a thin uterine segment, but doctors only document within their progress notes in the office. If they don't add the diagnosis code prior to admission encounter, even though it is a true diagnosis, it would exclude patient, but our reports are not able to count this. Why can't we add this after the delivery encounter even if it's true to exclude this patient?

A: Clinically a thin uterine segment would be considered a prior uterine procedure or diagnosis. On slide #44, it states that the Prior Uterine Procedure must start before the start of the delivery encounter to satisfy the condition. And on slide #46, the History of Uterine Surgery diagnosis onset datetime must be before the delivery encounter to satisfy the condition. Therefore, the

doctor's documentation datetime will not impact the measure outcome. But when the procedure starts and diagnosis starts (onset time) will determine the case pass or fail the numerator.

Question 10: Does the hospital have to be designated as a Baby-Friendly Hospital in order to meet the PC-05 measure?

Answer: No, you can use any processes or procedures that your hospital chooses to improve your breastfeeding rate. Baby-Friendly designation is just one example of many programs, tools, or bundles that you can use.

Question 11: Referring to the definition of labor, if documentation shows only regular uterine contractions, but no cervical change, how does this meet the definition of labor? If a patient is then given Pitocin, would this be considered an induction of labor and fall out under PC-01 if there is no medical indication to deliver?

A: No, regular uterine contractions is considered a positive finding for labor and if there are regular contractions prior to the administration of Pitocin this would be considered augmentation rather than induction.

Question 12: I see for PC-05 the national average is hanging around 52%. What is the benchmark for this measure, as you did state there is opportunity for improvement.

Answer: The Joint Commission nor CMS has established a benchmark.

Question 13: Regarding the question about "thin uterine segment." If the office notes are scanned in, are we able to count that?

A: No, unfortunately, if documentation is scanned in, that is not typically a discrete field that can be extracted for use in the eCQM. If someone took that scanned document and reentered the information and transcribed it into a discrete field in the EHR that could count. But that adds additional workload and is not typically found in the normal workflow.

Question 14: Off topic, but has CMS provided benchmarks for PC-06 yet?

A: PC-06 is not a measure that has been adopted by CMS. PC-06 is part of the Joint Commission perinatal care measures. Joint Commission accredited hospitals with at least 300 live births are required to report on all the chart-abstracted perinatal care measures, including PC-06 which was effective starting with 1/1/2019 discharges. This measure has been in use for several years by the California Maternity Quality Care Collaborative. You can go to their web site for more information on their implementation and target rates.

Question 15: Is there a plan to align the measure definition of labor for PC-01 with the ACOG and AWHON definition of labor?

A: We definitely attempt to align with definition of labor in terms of other national organizations such as ACOG and AWHON. If there is something specific that you're looking for that you don't see, please forward that to us.

Question 16: More general question - Any indications on CMS keeping PC-01 beyond 2020 and not retiring the measure? Will TJC keep this measure as an eCQM beyond 2020?

Answer: CMS is removing ePC-01 from the Hospital Inpatient Quality Reporting Program for the CY 2020 reporting period/FY 2022 payment determination and subsequent years. CMS is retaining the chart-abstracted version of PC-01.

The Joint Commission continues its commitment to actively developing and testing additional eQMs. Current plans for Joint Commission eQMs for CY 2020 include:

PC-01 eQm The Joint Commission will maintain the perinatal care PC-01 (elective delivery eQm) and it will be available for selection for ORYX® CY 2020 eQm reporting.

PC-02 eQm The Joint Commission will release specifications for PC-02 cesarean section eQm by early July 2019. This measure will be available for selection in the Joint Commission list of available eQMs for CY 2020 data collection.

The Joint Commission will determine and publish the final CY 2020 ORYX performance measurement reporting requirements for chart-based and eQMs in fall 2019, following the release of the CMS' FY 2020 IPPS final.

Question 17: Do you also have the national rate and benchmark for PC-02, PC-03, and PC-04?

A: Joint Commission doesn't set a benchmark for the measures. However, the national rates were reported within our 2017 annual hospital report (a 2018 report was not published) and available on our website.

Question 18: I am concerned that more patients will be delivered prior to 39 weeks with the definition of labor as regular contractions without cervical change. Is this a new criteria?

A: The definition of labor has not changed.

Question 19: For PC01, Induction of Labor seems to be limited to inductions that take 24 hours or less prior to the start of labor. What happens to cases of induction that take longer than 24 hours to get labor started?

A: Yes, you are correct that Labor is limited to be within 24 hours prior to the medical induction starts. Therefore, if the medical induction that takes longer than 24 hours to Labor start, the case will fail the numerator condition.