Pioneers in Quality Expert to Expert Webinar: ePC-01 and ePC-02
December 3, 2019
Questions and Answers (Q&A)

Q Estimated Gestation Age (EGA) is often incorrect as coders use EGA on admission not delivery. Manual abstractors correct this - how is this handled in an electronic measure?

A The logic captures the EGA authored (documented) closest to the time of delivery, provided it was documented the day prior to delivery up to the time of delivery.

Q What about where the documentation of gestational age was on the same date of delivery, but later in the day? A lot of times providers don't document until after the procedure is completed.

A The logic captures the EGA authored (documented) closest to the time of delivery, provided it was documented the day prior to delivery up to the time of delivery. The EGA documented after delivery will not be counted.

Q On Slide #22, "Last gestation age prior to or at the same time of delivery" seems difficult for nurses to document in their normal workflow - documentation often happens within the 1 hour following delivery depending on the clinical situation presenting itself for that delivery. Has there ever been consideration of allowing documentation after the actual delivery, but working off of the time of delivery instead of the clinical event (column header) time when going through the algorithm?

A Currently the logic captures the last EGA authored (documented) closest to the time of delivery, provided it was documented the day prior to delivery up to the time of delivery. The EGA captured after delivery will not be counted. However, with QDM 5.5., a new timing element of relevant datetime has been introduced to capture the point in time an event occurred verses when it was documented which will be considered for the next annual update.

Q Is relevant period a specific date, or a long period like a year?

A Relevant period represents a period with a start date/time and stop date/time. Some activities represented by a QDM datatype may occur at a point in time while other such activities may occur over a period of time. To more clearly define such differences, QDM 5.5 introduced a Relevant dateTime to reference activities occurring at a point in time and retained Relevant Period for activities occurring over a time interval.

Q Can you revisit the identification of Active Labor?

A The value set "Labor" contains SNOMED Codes to identify if a patient is in labor. It excludes concepts that pertain to the codes describing later stages of labor and latent labor. You can find details via the value set at https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.117.1.7.1.281

Q Why no denominator exclusion for previous Cesarean Birth for PC02?

A For PC02, the denominator only pulls in cases that are nulliparous.

Q Please re-state the definition being used to qualify for Nulliparous.

A ACOG defines nulliparous as a woman with a parity of zero. Parity is defined as the number of pregnancies reaching 20 weeks gestation regardless of the number of fetuses or outcomes. A patient will qualify for the denominator if parity = 0 or gravida = 1 or preterm/term births = 0

Q Denominator statement says, "No Previous Births" - should that say "No Previous LIVE Births"?

A The denominator statement is nulliparous patients delivered of a live term singleton newborn. ACOG defines nulliparous as a woman with a parity of zero. Parity is defined as the number of pregnancies reaching 20 weeks gestation regardless of the number of fetuses or outcomes. A patient will qualify for the denominator if parity = 0 or gravida = 1 or preterm/term births =0

Q This is a very difficult measure to try and map.

A In order for us to assist you better, please submit a ticket to the TJC eCQM Service Desk with the challenges you are experiencing.

Q If I followed the logic presented for PC-02, a patient with only a prior stillbirth (term or preterm) would NOT qualify for this measure, despite the fact that she had never had a prior LIVE birth? (TJC would include this patient in the population)?

A Correct, for ePC-02, a patient with stillbirth or fetal demise > 20 weeks should have a parity of > 0 and therefore would not be included in the denominator.

Q We had difficulty in obtaining the onset of labor when we had previously built out PC-01. As a result, our rate was falsely elevated. How are other facilities capturing this?

A The onset of labor is when labor was abstracted at face value by clinician. It should be documented as regular contractions with or without cervical change. In addition, the value set "Labor" contains SNOMED Codes to identify if a patient is in labor. It excludes concepts that pertain to the codes describing later stages of labor and latent labor. You can find details via the value set at https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.117.1.7.1.281

Q Will this be able to be printed?

A Directly following the session, the slides are available in the Event Resources pane from the Event page. Use this link and enter the required fields. Once you are within the OnDemand recording, you can select the link for the PDF. Your browser will open a new window and you will be able to download and print the slides. The slides are also posted on the Joint Commission site and accessible via this link to the Expert to Expert series page.

Q Was this recorded and how can we get it?

A Directly following the session, the same link you used to register and join this session will permit you to hear the recording for this session approximately 2 hours after the session concludes. You will be prompted to enter registration details and then you will be taken to the site with the recording. You can also access the recording on the Joint Commission site and accessible via this link to the Expert to Expert series page.

Q Do these measures need to be submitted electronically?

A For purposes of ORYX requirements a minimum of 4 eCQMs should be selected for hospitals with an ADC >10. If these two eCQMs are selected as part of the 4 eCQMs they must be submitted. Keep in mind that for hospitals with an ADC>10 they are required to submit data on chart-abstracted PC-01 and if the facility has 300 or more live births annually, they must also submit, in addition to chart-abstracted PC-01, chart-abstracted PC-02, PC-05 and PC-06

Q Where does the SROM or PROM come into the metric, by ICD code only?

A SROM is not the same as labor. SROM or PROM is accounted for as Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation as a Denominator Exclusion. Please refer to the value set Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation" (2.16.840.1.113883.3.117.1.7.1.286) on the VSAC https://vsac.nlm.nih.gov/valueset/expansions?pr=all&rel=Latest&q=2.16.840.1.113883.3.117.1.7.1.286

Q How are facilities handling when a woman presents in spontaneous labor however Labor Onset is not documented and an artificial rupture of membrane occurs close to delivery after the true onset of labor? Currently the AROM time is captured and appears as though we are initiating labor when the woman actually presented in spontaneous labor and gives a false numerator.

A AROM preceding documentation of "onset of labor" would indicate **induction** of labor.

AROM following documentation of "onset of labor" would indicate **augmentation** of labor.

The case would fail the measure if documentation of "onset of labor" is not performed.

Q What if the patient's presents with ROM but is not yet in labor… are these cases excluded.

A If you have a rupture of membrane that is coded
from the value set Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation then the case would be excluded from the denominator. Please refer to the value set Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation" (2.16.840.1.113883.3.117.1.7.1.286) on the VSAC https://vsac.nlm.nih.gov/valueset/expansions?pr=all&rel=Latest&q=2.16.840.1.113883.3.117.1.7.1.286

Q PC-01: what diagnosis code is used to indicate the patient was admitted with spontaneous onset of labor at 37 weeks 6 days.

A The value set "Labor" contains SNOMED Codes to identify if a patient is in labor. It excludes concepts that pertain to the codes describing later stages of labor and latent labor. You can find details via https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.117.1.7.1.281

Q What is the best way to determine which version of the specifications we should be looking at when we have questions about value sets, etc.?

A The ePC01 and ePC02 specifications and related documents are grouped by reporting year and can be found on The Joint Commission website here: https://www.jointcommission.org/measurement/specification-manuals/electronic-clinical-quality-measures/

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Q Are the specifications for ePC-02 available at the eCQI Resource Center?

A No the ePC-02 specifications are not available on the eCQI Resource Center as ePC-02 is not in a CMS program. Information regarding ePC-01 and ePC-02 can be found on The Joint Commission website here: https://www.jointcommission.org/measurement/specification-manuals/electronic-clinical-quality-measures/

Q For PC01, where it looks for medications, "oxytocin or Dinoprostone." will it include Misoprostol when used for induction?

A "No, Misoprostol is not included in those 2 value sets. please reference VSAC for details. Dinoprostone https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1045.56/definition and Oxytocin https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1045.55/definition"

Q I don't think the question about dinoprostone vs misoprostol was answered clearly. Can you please revisit that question?

A "Induction of labor is defined as the use of medications or other methods to bring on (induce) labor. Methods of induction of labor include, but are not limited to:
*Administration of Oxytocin (Pitocin)
*Artificial rupture of membranes (AROM) or amniotomy
*Insertion of a catheter with an inflatable balloon to dilate the cervix
*Ripening of the cervix with prostaglandins, i.e. Cervidil, Prepidil, Cytotec, etc.
*Stripping of the membranes when the clinician sweeps a gloved finger over the thin membranes that connect the amniotic sac to the wall of the uterus.
All prostaglandins should be captured."

Q "I am new to my role so may not be capturing the question with a full understanding. If you only have to submit four eCQM's if your hospital has OB/GYN is it mandatory to report ePC01 or 02? Meaning do they have to be part of the four chosen."

A If your ADC is greater than 10, you're required to select four eCQMs. And that's your choice. If you select the electronic versions of PC-01 then you will submit them. But I also want to add, because there may be confusion with the chart abstracted perinatal care measure and for hospitals that have an ADC greater than 10 that provide obstetric services, they must report chart abstracted PC-01 to The Joint Commission. And, in addition, if that facility has more than 300 Live annual births, they must also report, in addition chart-abstracted PC-02, PC-05, and PC-06.

Q Will there be a transcript of today's Q&A?

A We will have a transcript of the Q&A posted via the Expert to Expert Series page at this link.

Q Will you have all the Q&A posted with your PDF slides?

A Yes, we will post the answers to all of today's questions via the Expert to Expert Series page at this link.

Q For PC-01 if a patient present at 37 weeks with an abnormal fetal heart rate tracing would this be an exclusion?

A In order for the case to be excluded, there should be a code from the value set "Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation" (2.16.840.1.113883.3.117.1.7.1.286) Please refer to the VSAC for additional details on the code concepts for exclusions. https://vsac.nlm.nih.gov/valueset/expansions?pr=all&rel=Latest&q=2.16.840.1.113883.3.117.1.7.1.286

Q What about cases that have G4P0 patients? Would this patient be excluded from the measure?

A This case would be included in the denominator as Parity = 0. The logic includes patients with parity = 0 **OR** gravida = 1 **OR** preterm/term births =0

Q Does anyone have access to the Value Set Authority Center (VSAC) referenced on slide 84?

A "Yes anyone can access the VSAC, however, you will have to request a license first. Please see the Value Set Authority Center (VSAC) at https://vsac.nlm.nih.gov/"

Q code: 0368330 Maternal care for abnormalities of the fetal heart rate or rhythm is in the list of justifiable reasons but further definition of abnormalities would be great.

A The value set of Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation" (2.16.840.1.113883.3.117.1.7.1.286) provides more details in the coding concepts. Please go to the VSAC https://vsac.nlm.nih.gov/valueset/expansions?pr=all&rel=Latest&q=2.16.840.1.113883.3.117.1.7.1.286 and defer to your hospital coding experts for more information on coding guidance.

Q Is there a benchmark for PC-02? I know that we strive to be under 30% cesarean rate, but do we have a specific for PC-02?

A We do not have any eCQM benchmarks at present, however, the cesarean section target rate proposed by HealthyPeople.gov's 2020 is 23.9%