Maternal and Perinatal Care Service Jawda Guidance

Version 6

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Maternal and Perinatal KPIs

Executive Summary

The Department of Health– Abu Dhabi (DOH) is the regulatory body of the healthcare sector in the Emirate of Abu Dhabi and ensures excellence in healthcare for the community by monitoring the health status of its population.

The Emirate of Abu Dhabi is experiencing a substantial growth in the number of hospitals, centers and clinics. This is ranging from school clinics and mobile units to internationally renowned specialist and tertiary academic centers. Although, access and quality of care has improved dramatically over the last couple of decades, mirroring the economic upturn and population boom of Emirate of Abu Dhabi, however challenges remain in addressing further improvements.

The main challenges that are presented with increasingly dynamic population include an aging population with increased expectation for treatment, utilization of technology and diverse workforce leading to increased complexity of healthcare provision in Abu Dhabi. All of this results in an increased and inherent risk to quality and patient safety.

DOH has developed dynamic and comprehensive quality framework in order to bring about improvements across the health sector. This guidance relates to the quality indicators that DOH is mandating the quarterly reporting against by the operating general and specialist hospitals in Abu Dhabi.

The guidance sets out the full definition and method of calculation for patient safety and clinical effectiveness indicators. For enquiries about this guidance, please contact jawda@doh.gov.ae

This document is subject for review and therefore it is advisable to utilize online versions available on the DOH at all times.

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About this Guidance

The guidance sets out the definitions and reporting frequency of Jawda Maternal and Perinatal Care (MPC) performance indicators. The Department of Health (DoH), with consultation from local and international maternal and perinatal care expertise has developed Maternal and Perinatal Care (MPC) Performance Indicators that are aimed for assessing the degree to which a provider competently and safely delivers the appropriate clinical services to the patient within the optimal period.

The Jawda KPIs in this guidance include measures to monitor morbidity in patients receiving maternal and perinatal care.

Who is this guidance for?

All DoH licensed healthcare facilities providing Maternal and Perinatal services in the Emirate of Abu Dhabi.

How do I follow this guidance?

Each provider will nominate one member of staff to coordinate, collect, monitor and report Maternal and Perinatal services quality indicators data as per communicated dates. The nominated healthcare facility lead must in the first instance e-mail their contact details (if different from previous submission) to JAWDA@doh.gov.ae and submit the required quarterly quality performance indicators through Jawda online portal.

What are the Regulation related to this guidance?

- Legislation establishing the Health Sector
- As per DoH Policy for Quality and Patient Safety issued January 15th 2017, this guidance applies to all DOH Licensed Hospitals providing maternal and perinatal services in the Emirate of Abu Dhabi in accordance with the requirements set out in this Standard.

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC001**

KPI Description (title):	Proportion of surgically managed ectopic pregnancies that were managed by laparoscopy
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	**Proportion of ectopic pregnancies managed surgically that were treated laparoscopically**
Calculation:	***Numerator:*** Number of women with ectopic pregnancy managed by laparoscopy ***CPT Codes:*** *59150, 59151* **Numerator Exclusion:** • Cases in which the surgery started out as a laparoscopic procedure but was converted during procedure to laparotomy will not be considered as treated laparoscopically ***Denominator:*** Total number of women with ectopic pregnancy managed surgically during the reporting period. ***CPT Codes:*** *59150, 59151, 59120, 59121, 59130, 59135, 59136* **Denominator Exclusion**: (codes not limited to): • Cervical ectopic treatment. ***CPT codes:*** *59140* • Scar ectopic and abdominal live ectopic. ***CPT codes:*** *59897*
Reporting Frequency:	Quarterly
Unit of Measure:	Rate of laparoscopic management per 100 surgically managed ectopic pregnancies.
International comparison if available	"Quality Standards for Early Pregnancy Complications and loss in ontario: https://hqontario.ca/Portals/0/documents/evidence/quality-standards/qs-early-pregnancy-draft-quality-standard-en.pdf"
Desired direction:	Higher is better
Notes for all providers	
Data sources and guidance:	Patient's records Claims data

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC002**

KPI Description (title):	Proportion of elective deliveries at ≥ 37 and < 39 weeks
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Proportion of patients who had an elective vaginal delivery or elective caesarean section performed at ≥37 and <39 weeks of gestation completed
Calculation:	***Numerator:*** Patients with elective vaginal deliveries or elective cesarean sections ≥37 and <39 weeks of gestation completed. ***Numerator Inclusion***: • Medical / surgical induction of labor while not in labor prior to the procedure • Cesarean section while: Not in active labor or not experiencing spontaneous rupture of membranes. ***Denominator:*** Total number of women who delivered new-borns within ≥37 and <39 weeks of gestation completed during the reporting period. ***ICD 10CM Code:*** Delivery codes: Z37.0, Z37.1, Z37.2, Z37.3, Z37.4, Z37.50, Z37.51, Z37.52, Z37.53, Z37.54, Z37.59, Z37.60, Z37.61, Z37.62, Z37.63, Z37.64, Z37.69, Z37.7, Z37.9 And Gestational Age: Z3A.37, Z3A.38, Z3A.39 **Denominator Exclusion**: • Principal and secondary diagnosis codes for conditions possibly justifying elective delivery prior to 39 weeks gestation ***(See Appendix A)*** • Patients less than 8 years of age • Patients greater than or equal to 65 years of age • History of prior stillbirth • Length of stay > 120 days • Gestational age < 37 or >=39 weeks or UTD
Reporting Frequency:	Quarterly
Unit of Measure:	Rate of elective deliveries per 100 deliveries within ≥37 and <39 weeks of gestation completed.
International comparison if available	https://manual.jointcommission.org/releases/TJC2019A/index.html
Desired direction:	Lower is better.
Notes for all providers	
Data sources and guidance:	Patient's records (Malaffi data extraction within DOH) Claims data

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC003**

KPI Description (title):	Proportion of episiotomy procedures among vaginal deliveries
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Proportion of episiotomy procedures among vaginal deliveries
Calculation:	***Numerator:*** Number of pregnant women who delivered vaginally and had an episiotomy procedure ***Denominator:*** Total number of women who delivered vaginally during the reporting period. ***ICD 10CM Code***: Z37.0, Z37.1, Z37.2, Z37.3, Z37.4, Z37.50, Z37.51, Z37.52, Z37.53, Z37.54, Z37.59, Z37.60, Z37.61, Z37.62, Z37.63, Z37.64, Z37.69, Z37.7, Z37.9, Z3A.00, Z3A.24, Z3A.25, Z3A.26, Z3A.27, Z3A.28, Z3A.29, Z3A.30, Z3A.31, Z3A.32, Z3A.33, Z3A.34, Z3A.35, Z3A.36, Z3A.37, Z3A.38, Z3A.39, Z3A.40, Z3A.41, Z3A.42, Z3A.49 AND ***CPT Code***- 59400, 59409, 59410, 59610, 59612, 59614 (Including instrumental deliveries, forceps-and vacuum) **Denominator Exclusion:** • All Caesarean Section deliveries ***(CPT codes:*** *59510, 59514, 59515, 59618, 59620, 59622)* • Birth before arrival (BBA) to the hospital • Miscarriages (***ICD-10 CM codes not limited to****: O02.1, O03.39, O03.4, O03.89, O03.9, O20.0)* • Babies with shoulder dystocia
Reporting Frequency:	Quarterly
Unit of Measure:	**Proportion of episiotomy procedures per 100 vaginal deliveries**
International comparison if available	https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/maternity-indicators-2013-14_report2.pdf https://www.ahrq.gov/sites/default/files/wysiwyg/CHIPRA-BMI-Maternity-Care-Measures.pdf
Desired direction:	Lower is better.
Notes for all providers	
Data sources and guidance:	Patient's records Claims data

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC004**

KPI Description (title):	Proportion of third- and fourth-degree perineal tears
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	The proportion of third- or fourth-degree perineal tears after vaginal delivery
Calculation:	***Numerator:*** Number of women with third- or fourth-degree perineal tear (including anal sphincter tear). ***ICD10CM Codes:*** O70.20, O70.21, O70.22, O70.23; O70.3, O70.4 ***Denominator:*** Total number of women who delivered vaginally during the reporting period. ***ICD 10CM Code***: Z37.0, Z37.1, Z37.2, Z37.3, Z37.4, Z37.50, Z37.51, Z37.52, Z37.53, Z37.54, Z37.59, Z37.60, Z37.61, Z37.62, Z37.63, Z37.64, Z37.69, Z37.7, Z37.9, Z3A.00, Z3A.24, Z3A.25, Z3A.26, Z3A.27, Z3A.28, Z3A.29, Z3A.30, Z3A.31, Z3A.32, Z3A.33, Z3A.34, Z3A.35, Z3A.36, Z3A.37, Z3A.38, Z3A.39, Z3A.40, Z3A.41, Z3A.42, Z3A.49 AND ***CPT Code***- 59400, 59409, 59410, 59610, 59612, 59614 (Including instrumental deliveries, forceps-and vacuum) **Denominator Exclusion:** • All Caesarean Section deliveries ***(CPT codes:*** *59510, 59514, 59515, 59618, 59620, 59622)* • Birth before arrival (BBA) to the hospital • Miscarriages (***ICD-10 CM codes not limited to****: O02.1, O03.39, O03.4, O03.89, O03.9, O20.0)*
Reporting Frequency:	Quarterly
Unit of Measure:	Rate of third- or fourth-degree perineal tears per 100 vaginal deliveries.
International comparison if available	https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/maternity-indicators-2013-14_report2.pdf https://www.patientsafetyinstitute.ca/en/toolsResources/Hospital-Harm-Measure/Documents/Resource-Library/HHIR%20Obstetric%20Trauma.pdf
Desired direction:	Lower is better.
Notes for all providers	
Data sources and guidance:	Patient's records Claims data

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC005**

KPI Description (title):	Proportion of vaginal births following previous caesarean section
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Percentage of women with successful vaginal birth after prior caesarean section (VBAC) out of the total women who had prior caesarean delivery.
Calculation:	***Numerator:*** Number of women who had successful vaginal birth after prior caesarean section. **VBAC CPT codes**: 59610, 59612, 59614 ***Denominator:*** Total number of women who delivered during the reporting period and had a history of previous caesarean section. **CPT codes:** 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622. **Denominator Exclusion**: • Exclude ICD-10-CM diagnosis codes from ***Appendix B*** (abnormal presentation, preterm delivery or breach procedure, fetal death, or multiple gestation)
Reporting Frequency:	Quarterly
Unit of Measure:	Rate of VBAC per 100 deliveries by women with previous Caesarean deliveries.
International comparison if available	https://qualityindicators.ahrq.gov/Downloads/Modules/IQI/V2023/TechSpecs/ IQI_22_Vaginal_Birth_After_Cesarean_(VBAC)_Delivery_Rate_Uncomplicated.pdf
Desired direction:	Higher is better
Notes for all providers	
Data sources and guidance:	Patient's records

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC006**

KPI Description (title):	Proportion of deliveries with Postpartum Haemorrhage
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	The proportion of deliveries with postpartum hemorrhage (PPH)
Calculation:	***Numerator:*** Number of women with postpartum hemorrhage within 24 hours after delivery. ***Report Separately:*** *a. >2000 ml, severe PPH* *b. >1000–2000 ml, moderate PPH* *c. > 500-1000 ml, minor PPH* ***ICD10CM Codes*** to bleeding after delivery (not limited to): O72.0, O72.1, O72.2, O44.13, O44.33, O44.53 ***Denominator:*** Total number of women who delivered during the reporting period. ***ICD 10CM Codes:*** Z37.0, Z37.1, Z37.2, Z37.3, Z37.4, Z37.50, Z37.51, Z37.52, Z37.53, Z37.54, Z37.59, Z37.60, Z37.61, Z37.62, Z37.63, Z37.64, Z37.69, Z37.7, Z37.9, Z3A.00, Z3A.24, Z3A.25, Z3A.26, Z3A.27, Z3A.28, Z3A.29, Z3A.30, Z3A.31, Z3A.32, Z3A.33, Z3A.34, Z3A.35, Z3A.36, Z3A.37, Z3A.38, Z3A.39, Z3A.40, Z3A.41, Z3A.42, Z3A.49 **Denominator Exclusion:** • Miscarriages (***ICD-10 CM codes not limited to****: O02.1, O03.39, O03.4, O03.89, O03.9, O20.0)*
Reporting Frequency:	Quarterly
Unit of Measure:	Rate of postpartum hemorrhage ≥2000 ml per 100 deliveries.
International comparison if available	http://www.rcog.org.uk/womens-health/clinical-guidance/maternity-dashboard-clinical-performance-and-governance-score-card https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6372226/pdf/pone.0211955.pdf
Desired direction:	Lower is better.
Notes for all providers	
Data sources and guidance:	Patient's records Claims data

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC007**

KPI Description (title):	Proportion of unplanned all cause readmissions to hospital within 30 days of discharge after delivery
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	The proportion of women who are readmitted to hospital as an emergency within 30 days of inpatient discharge after delivery. *For the definition of "emergency", please refer to the DOH emergency standard.*
Calculation:	***Numerator:*** Number of women with unplanned readmission to hospital (for all causes) within 30 days of inpatient discharge after delivery **Numerator Inclusion**: • The readmission can be to any acute care hospital but is attributed to the hospital where the birth took place • If there are more than one admissions in the 30 days after delivery, the first readmission will be counted. • The counting of days will start from the discharge date after delivery. **Numerator Exclusion** • Planned readmissions, • Planned transfers, and • Where the mother was readmitted accompanying a sick infant. ***Denominator:*** Total number of women inpatient discharge with delivery during the reporting period. **Denominator Inclusion**: • ICD 10CM Code: Z37.0, Z37.1, Z37.2, Z37.3, Z37.4, Z37.50, Z37.51, Z37.52, Z37.53, Z37.54, Z37.59, Z37.60, Z37.61, Z37.62, Z37.63, Z37.64, Z37.69, Z37.7, Z37.9, Z3A.00, Z3A.24, Z3A.25, Z3A.26, Z3A.27, Z3A.28, Z3A.29, Z3A.30, Z3A.31, Z3A.32, Z3A.33, Z3A.34, Z3A.35, Z3A.36, Z3A.37, Z3A.38, Z3A.39, Z3A.40, Z3A.41, Z3A.42, Z3A.49 **Denominator Exclusion**: • Died before discharge or • Not discharged within 30 days of delivery • Miscarriage and ectopic pregnancy • Patients who are discharged against medical advice (LAMA) • Patients who were transferred to another facility.
Reporting Frequency:	Quarterly
Unit of Measure:	Rate of unplanned all cause readmission to hospital within 30 days per 100 discharges after delivery.

International comparison if available	https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/maternity-indicators-2013-14_report2.pdf
Desired direction:	Lower is better.
Notes for all providers	
Data sources and guidance:	Patient's records (Malaffi data extraction by DOH) Claims data(KEH)

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC008**

KPI Description (title):	Brachial plexus injury rate per 1000 newborns
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Proportion of neonates with Brachial plexus injury per 1,000 newborns.
Calculation:	***Numerator:*** Number of babies with brachial plexus injury **Numerator Inclusion**: ICD 10CM codes: P14.0, P14.1 P14.3 ***Denominator:*** Total number of babies born during the reporting period. **Denominator Inclusion**: • ICD 10CM – Z38.00, Z38.01, Z38.2, Z38.30, Z38.31, Z38.5, Z38.61, Z38.62, Z38.63, Z38.64, Z38.65, Z38.66, Z38.68, Z38.69, Z38.8. **Denominator Exclusion**: • Stillbirths • Born before arrival (Z38.1, Z38.4, Z38.7) • Born in another healthcare facility
Reporting Frequency:	Quarterly
Unit of Measure:	Rate of brachial plexus injury at birth per 1000 newborns
International comparison if available	http://www.birthinjuryguide.org/brachial-plexus-injury/ Am J Obstet Gynecol 2007 : 197
Desired direction:	Lower is better.
Notes for all providers	
Data sources and guidance:	Patient's records Claims data

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC009**

KPI Description (title):	Neonate patients with hypoxic-ischemic encephalopathy (Moderate or Severe) (HIE) rate per 1000 newborns
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Proportion of Neonate patients with hypoxic-ischemic encephalopathy (Moderate or Severe) (HIE) per 1,000 newborns.
Calculation:	***Numerator:*** Number of term babies born with moderate or severe hypoxic encephalopathy requiring NICU admission. ***ICD 10CM codes***: P91.62, P91.63 ***Denominator:*** Total number of babies born at term (≥ 37 weeks) during the reporting period. **Denominator inclusion**: • ICD 10CM – Z38.00, Z38.01, Z38.2, Z38.30, Z38.31, Z38.5, Z38.61, Z38.62, Z38.63, Z38.64, Z38.65, Z38.66, Z38.68, Z38.69, Z38.8. **Denominator Exclusion**: • Stillbirths • Born before arrival (Z38.1, Z38.4, Z38.7) • Born in another healthcare facility
Reporting Frequency:	Quarterly
Unit of Measure:	Rate of hypoxic-ischemic encephalopathy (Moderate or Severe) (HIE) at birth per 1000 newborns
International comparison if available	http://www.rcog.org.uk/womens-health/clinical-guidance/maternity-dashboard-clinical-performance-and-governance-score-card https://fn.bmj.com/content/103/4/F301#T3
Desired direction:	Lower is better.
Notes for all providers	
Data sources and guidance:	Patient's records Claims data

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC010**

KPI Description (title):	**Neonatal Central line-associated Bloodstream Infections (CLABSI)**
Domain	**Safety**
Indicator Type	**Outcome**
Definition:	Central line-associated bloodstream infection (CLABSI): A laboratory confirmed bloodstream infection where • An eligible BSI organism is identified and • An eligible central line is present on the Laboratory Confirmed Bloodstream Infection (LCBI) date of event (DOE) or the day before • For all inpatients up to 28 days of age **Temporary central line:** A non-tunneled, non- implanted catheter. **Permanent central line**: Includes • Tunneled catheters, including certain dialysis catheters • Implanted catheters (including ports) ***Eligible Central Line****: A Central Line (CL) that has been in place for more than two consecutive calendar days (on or after CL day 3), following the first access of the central line, in an inpatient location, during the current admission. Such lines remain eligible for CLABSI events until the day after removal from the body or patient discharge whichever comes first.*
Calculation:	**Numerator:** Each CLABSI that is identified during the period selected for surveillance in all inpatients up to 28 days age. **ICD 10 CM code:** T80.211A Must meet one of the following Laboratory-Confirmed Bloodstream Infection (LCBI) criteria: **LCBI 1:** Patient of up to 28 days of age has a recognized bacterial or fungal pathogen, not included on the NHSN common commensal list: 1. Identified from one or more blood specimens obtained by a culture OR 2. Identified to the genus or species level by non-culture based microbiologic testing (NCT) methods. AND Organism(s) identified in blood is not related to an infection at another site. **LCBI2:** Patient of up to 28 days of age has at least one of the following signs or symptoms: fever (>38.0oC), chills, or hypotension AND Organism(s) identified in blood is not related to an infection at another site AND The same NHSN common commensal is identified by a culture, from two or more blood specimens collected on separate occasions. **LCBI3:** Patient of up to 28 days of age has at least one of the following signs or symptoms: fever (>38.0oC), hypothermia (<36.0oC), apnea, or bradycardia AND

	Organism(s) identified in blood is not related to an infection at another site AND The same NHSN common commensal is identified by a culture, from two or more blood specimens collected on separate occasions **<u>Numerator Exclusions</u>:** • Extracorporeal life support (ECMO) or Ventricular Assist Device (VAD) for more than 2 days and is still in place on the BSI date of event or the day before. • Observed or suspected patient injection into the vascular access line • Epidermolysis bullosa (EB) or Munchausen Syndrome by Proxy (MSBP) diagnosis during the current admission. (Q81.0, Q81.1, Q81.2, Q81.8, Q81.9, L12.30, L12.31, L12.35, & L51.2, F68.10, F68.11, F68.12, & F68.13) • Pus at the vascular access site - T80.212A, T80.219A • Group B Streptococcus identified from blood, with a date of event during the first 6 days of life (B95.1) • Repeated infection for the same type during 14 days from Date of Event • MBI-LCBI • Secondary bloodstream infections **<u>Denominator</u>**: Number of all central line days for all patients (in all inpatient settings) of up to 28 days of age during the reporting period. ***Applicable CPT codes (not limited to):*** 36555-36590 • Report only birth weight when entering BSI denominator data. The infant's weight at the time of BSI identification is not used and should not be reported. For example, a neonate weighs 1006 grams at birth but remains in the NICU for two months and has a body weight of 1650 grams when a CLABSI develops; enter the birth weight of 1006 grams on the BSI form. • All central lines on inpatient units should be included in device day counts regardless of access. The Instructions for Completion of Denominators for Neonatal Intensive Care Unit (NICU) form contains brief instructions for collection and entry of each data element on the forms. **<u>Denominator Exclusions</u>:** • Pediatric (it will be reported under pediatric Jawda guidance) • Patients who received treatment as an inpatient for burns injury (any degree). They will be reported under Burn Jawda Guidance • All Long-term care patients. (see glossary) • Generalized and specialized hospital Jawda guidance
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 1000 central line days
International comparison if available	https://www.cdc.gov/nhsn/pdfs/pscmanual/4psc_clabscurrent.pdf
Desired direction:	Lower is better
Notes for all providers	

Data sources and guidance:	• Captured by infection control team • Patient's records • Lab reports • Hospital internal mortality and morbidity

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC011**

KPI Description (title):	**Emergency Primary Caesarian Section rate**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Percentage of unplanned cesarean deliveries woman without a prior history of cesarean deliveries.
Calculation:	***Numerator:*** Number of first time unplanned cesarean section deliveries without a hysterotomy. **Caesarian Section CPT Codes: (**59510, 59514, 59515, 59618, 59620, 59622) ***Denominator:*** Total number of deliveries during the reporting period **Denominator exclusions** • Exclude SICD-10-CM diagnosis codes from ***Appendix B*** (abnormal presentation, preterm labor with preterm delivery, fetal death, or multiple gestation) • With any-listed below SICD-10-CM diagnosis codes for previous Cesarean delivery (O34.211, O34.212, O34.218, O34.219, O66.41)
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 100 emergency C-section
International comparison if available	AHRQ
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	Patient's records

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC012**

KPI Description (title):	**Elective Primary Caesarian Section rate**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Percentage of planned cesarean deliveries for woman without a prior history of cesarean deliveries.
Calculation:	***Numerator:*** Number of planned first time cesarean section deliveries without a hysterotomy. **Caesarian Section CPT Codes:(**59510, 59514, 59515, 59618, 59620, 59622) ***Denominator:*** Total number of deliveries during the reporting period **Denominator Exclusions:** • Exclude ICD-10-CM diagnosis codes from ***Appendix B*** (abnormal presentation, preterm labor with preterm delivery, fetal death, or multiple gestation) • With any-listed below ICD-10-CM diagnosis codes for previous Cesarean delivery (O34.211, O34.212, O34.218, O34.219, O66.41)
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 100 elective C-section
International comparison if available	AHRQ
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	Patient's records

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC013**

KPI Description (title):	**Surgical site infection (SSI) for emergency caesarian section**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Percentage of patients meeting CDC NHSN SSI infection criteria within 30 days of having emergency caesarian section
Calculation and criteria to define SSI following Emergency C-Section:	***Numerator:*** *Number* of all SSI identified within 30 days for all inpatients who underwent an unplanned Caesarean Section **Numerator Inclusion**: PATOS (infection present at time of surgery) ***SSI could be presented as:*** **Superficial incisional SSI:** ***Must meet the following criteria:*** Date of event for infection occurs within 30 days after any NHSN operative procedure (**where day 1 = the procedure date**) **AND** involves only skin and subcutaneous tissue of the incision **AND** patient has at least ***one*** of the following: a) purulent drainage from the superficial incision. b) organisms identified from an aseptically obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method, which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST). c) superficial incision that is deliberately opened by a surgeon, attending physician or other designee and culture or non-culture based testing is not performed. **AND** patient has at least one of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. d) diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designee. **Deep incisional SSI:** Must meet the following criteria: The date of event for infection occurs within 30 or 90 days after the NHSN operative procedure (**where day 1 = the procedure date**) according to the list in Table 2 **AND** involves deep soft tissues of the incision (for example, fascial and muscle layers) **AND** patient has at least ***one*** of the following: a) purulent drainage from the deep incision. b) a deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician** or other designee **AND** organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of

clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed
AND
patient has at least ***one*** of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture based test that has a negative finding does not meet this criterion.

c) an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test.

Organ/Space SSI: Must meet the following criteria:
Date of event for infection occurs within 30 or 90 days after the NHSN operative procedure (**where day 1 = the procedure date**) according to the list in Table 2
AND
infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure
AND
patient has at least ***one*** of the following:

a) purulent drainage from a drain that is placed into the organ/space(for example, closed suction drainage system, open drain, T-tube drain, CT guided drainage)
b) organisms are identified from fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method, which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST).
c) an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test evidence suggestive of infection.

AND
meets at least ***one*** criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter.

REPORTING INSTRUCTIONS for Superficial SSI

The following do not qualify as criteria for meeting the definition of superficial SSI:

a) A stitch abscess alone (minimal inflammation and discharge confined to the points of suture penetration)
b) A localized stab wound or pin site infection. While it would be considered either a skin (SKIN) or soft tissue (ST) infection, depending on its depth, it is not reportable under this guidance. Note: a laparoscopic trocar site for an NHSN operative procedure is not considered a stab wound.
c) Diagnosis/treatment of "cellulitis" (redness/warmth/swelling), by itself, does not meet criterion for superficial incisional SSI. An incision that is draining or culture (+) is not considered a cellulitis.
d) Circumcision is not an NHSN operative procedure. An infected circumcision site in newborns is classified as CIRC and is not reportable under this module.
e) An infected burn wound is classified as BURN and is not reportable under this module.

Definition of an NHSN Operative Procedure

	An NHSN Operative Procedure is a procedure: a) that is included in the ICD-10-PCS or CPT NHSN operative procedure code mapping **And** b) takes place during an operation where at least one incision (including laparoscopic approach and cranial Burr holes) is made through the skin or mucous membrane, or reoperation via an incision that was left open during a prior operative procedure **And** c) takes place in an operating room (OR), defined as a patient care area that met the Facilities Guidelines Institute's (FGI) or American Institute of Architects' (AIA) criteria for an operating room when it was constructed or renovated[11]. This may include an operating room, C-section room, interventional radiology room, or a cardiac catheterization lab. ***Denominator***: Total number of all inpatients undergoing unplanned Caesarean Section in that facility during reporting period **CPT codes:** All inpatients Cesarean (59510, 59514, 59515, 59618, 59620, 59622) **Denominator Exclusions:** Procedures that are assigned an ASA score of 6 are not eligible for NHSN SSI surveillance.
Reporting Frequency:	Quarterly
Unit of Measure:	SSI Rate per 100 emergency C-Section
International comparison if available	CDC/ NHSN chapter 9, Procedure-associated Module SSI: Surgical Site Infection (SSI) Event
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	• Captured by infection control team/ nursing as part of regular surveillance activities and infection control documentation • Patient's records

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC014**

KPI Description (title):	Surgical site infection (SSI) for elective caesarian section
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Percentage of patients meeting CDC NHSN SSI infection criteria within 30 days of having elective Caesarian Section
Calculation and criteria to define SSI following Elective C-Section:	***Numerator:*** Number of all SSI identified within 30 days for all inpatients who underwent a planned caesarean section during the reporting period. **Numerator Inclusion**: PATOS (infection present at time of surgery) ***SSI could be presented as:*** **Superficial incisional SSI:** ***Must meet the following criteria:*** Date of event for infection occurs within 30 days after any NHSN operative procedure (**where day 1 = the procedure date**) **AND** involves only skin and subcutaneous tissue of the incision **AND** patient has at least ***one*** of the following: a) purulent drainage from the superficial incision. b) organisms identified from an aseptically obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method, which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST). c) superficial incision that is deliberately opened by a surgeon, attending physician or other designee and culture or non-culture based testing is not performed. **AND** patient has at least one of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. a) diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designee. **Deep incisional SSI:** Must meet the following criteria: The date of event for infection occurs within 30 or 90 days after the NHSN operative procedure (**where day 1 = the procedure date**) according to the list in Table 2 **AND** involves deep soft tissues of the incision (for example, fascial and muscle layers) **AND** patient has at least ***one*** of the following: a) purulent drainage from the deep incision. b) a deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician** or other designee a. **AND** b. organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active

Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed
AND
patient has at least ***one*** of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture based test that has a negative finding does not meet this criterion.

c) an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test.

Organ/Space SSI: Must meet the following criteria:
Date of event for infection occurs within 30 or 90 days after the NHSN operative procedure (**where day 1 = the procedure date**) according to the list in Table 2
AND
infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure
AND

a) patient has at least ***one*** of the following:
b) purulent drainage from a drain that is placed into the organ/space(for example, closed suction drainage system, open drain, T-tube drain, CT guided drainage)
c) organisms are identified from fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method, which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST).
d) an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test evidence suggestive of infection.

AND
meets at least ***one*** criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter.

REPORTING INSTRUCTIONS for Superficial SSI
The following do not qualify as criteria for meeting the definition of superficial SSI:

f) A stitch abscess alone (minimal inflammation and discharge confined to the points of suture penetration)
g) A localized stab wound or pin site infection. While it would be considered either a skin (SKIN) or soft tissue (ST) infection, depending on its depth, it is not reportable under this guidance. Note: a laparoscopic trocar site for an NHSN operative procedure is not considered a stab wound.
h) Diagnosis/treatment of "cellulitis" (redness/warmth/swelling), by itself, does not meet criterion for superficial incisional SSI. An incision that is draining or culture (+) is not considered a cellulitis.
i) Circumcision is not an NHSN operative procedure. An infected circumcision site in newborns is classified as CIRC and is not reportable under this module.
j) An infected burn wound is classified as BURN and is not reportable under this module.

Definition of an NHSN Operative Procedure

	An NHSN Operative Procedure is a procedure: d) that is included in the ICD-10-PCS or CPT NHSN operative procedure code mapping **And** e) takes place during an operation where at least one incision (including laparoscopic approach and cranial Burr holes) is made through the skin or mucous membrane, or reoperation via an incision that was left open during a prior operative procedure **And** f) takes place in an operating room (OR), defined as a patient care area that met the Facilities Guidelines Institute's (FGI) or American Institute of Architects' (AIA) criteria for an operating room when it was constructed or renovated[11]. This may include an operating room, C-section room, interventional radiology room, or a cardiac catheterization lab. ***Denominator***: Total number of all inpatients that underwent a planned Caesarean Section in that facility during the reporting period. **CPT codes:** All inpatients Cesarean section CPT codes; 59510, 59514, 59515, 59618, 59620, 59622 **Denominator Exclusions:** Procedures that are assigned an ASA score of 6 are not eligible for NHSN SSI surveillance.
Reporting Frequency:	Quarterly
Unit of Measure:	SSI Rate per 100 elective C-Section
International comparison if available	CDC/ NHSN chapter 9, Procedure-associated Module SSI: Surgical Site Infection (SSI) Event
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Captured by infection control team/ nursing as part of regular surveillance activities and infection control documentation - Patient's records - Hospital internal mortality and morbidity

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC015**

KPI Description (title):	**Early Perinatal Mortality rate per 1000 births**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	**Perinatal Mortality**: Rate of all still births and early neonatal death out of all births during the reporting period. **Early Perinatal mortality**: Fetal deaths (stillbirths) after 22 completed weeks of gestation and neonatal death before 7 completed days.
Calculation:	***Numerator:*** *Number* of: • Fetal deaths ≥500g birth weight (or stillbirths from ≥22 weeks) (at least one of the 2 criteria must be met) and • Early neonatal deaths (birth to age 7 days of life) ***Denominator:*** All births in the facility and/ or babies being cared for in the specified facility. ***Denominator Inclusion:*** • Births in the facility: Z38.00, Z38.01, Z38.2, Z38.30, Z38.31, Z38.5, Z38.61, Z38.62, Z38.63, Z38.64, Z38.65, Z38.66, Z38.68, Z38.69, Z38.8. • Born before arrival (Z38.1, Z38.4, Z38.7) • Stillbirth: P95 • Transferred from other facilities and admitted as inpatient encounter during age ≤ 7 days of life.
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 1000 births
International comparison if available	http://www.pi.nhs.uk/pnm/definitions.htm http://www.pi.nhs.uk/pnm/KHD_2008-9.pdf WHO Implementation Tools for Maternal and Perinatal Death Surveillance and Response
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Manual Data Collection - Patient's Records

Maternal and Perinatal Care Quality Indicator Indicator Number: MPC016

KPI Description (title):	**Early Perinatal Mortality - Corrected rate per 1000 births**
Domain	**Effectiveness**
Indicator Type	**Outcome** - corrected rate per 1000 births
Definition:	**Perinatal Mortality**: Rate of all stillbirths and early neonatal death out of all births during the reporting period. **Early Perinatal mortality:** Fetal deaths (stillbirths) after 22 completed weeks of gestation and neonatal death before 7 completed days. **Corrected Perinatal Mortality** = excluding major congenital anomalies, <22 weeks gestation or <500g birth weight
Calculation:	***Numerator:*** *Number* of: • Fetal deaths ≥500g birth weight (stillbirths from ≥22 weeks of gestation) (at least one of the 2 criteria must be met) and • Early neonatal deaths (birth to age 7 days of life) ***Numerator Exclusions:*** • Major congenital anomalies • <22 weeks gestation • <500g birth weight • Stillbirths / Newborns of unbooked mothers i.e. mothers present to the reporting facility for the first time in that pregnancy and the index visit results in delivery. If the mother was booked in any other of that facility network (group), she is considered booked. • Died before arrival to the reporting facility (during transfer from home, another facility or any other location to the reporting facility). • Exclude newborns that have only accessed urgent care or had 1 visit to the reporting facility • Preterms at the limit of viability (22+0 to 23+6 weeks gestation) who were not responding to initial stabilization and resuscitation at birth ***Denominator***: All births in the facility and/ or babies being cared for in the specified facility. ***Denominator Inclusion:*** • Births in the facility: Z38.00, Z38.01, Z38.2, Z38.30, Z38.31, Z38.5, Z38.61, Z38.62, Z38.63, Z38.64, Z38.65, Z38.66, Z38.68, Z38.69, Z38.8. • Born before arrival (Z38.1, Z38.4, Z38.7) • Stillbirth: P95 • Transferred from other facilities and admitted as inpatient encounter during age ≤ 7 days of life.
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 1000 births,
International comparison if available	http://www.pi.nhs.uk/pnm/definitions.htm http://www.pi.nhs.uk/pnm/KHD_2008-9.pdf WHO Implementation Tools for Maternal and Perinatal Death Surveillance and Response
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Manual Data Collection - Patient's Records

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC017**

KPI Description (title):	**Neonatal Mortality rate per 1000 live births**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	**Neonatal mortality**: Death before the age of 28 completed days following live birth.
Calculation:	***Numerator:*** Number of neonatal death during first 28 days of life during hospital stay ***Numerator Exclusion*:** • Deaths after 28 days of life • Stillbirths ***Denominator***: All live babies born in the facility and/or being cared for in the specified facility **Denominator Inclusion*:*** • Total live births in the facility: Z38.00, Z38.01, Z38.2, Z38.30, Z38.31, Z38.5, Z38.61, Z38.62, Z38.63, Z38.64, Z38.65, Z38.66, Z38.68, Z38.69, Z38.8. • Born before arrival (Z38.1, Z38.4, Z38.7) • Transferred from other facilities and admitted as inpatient encounter during first 28 days of life.
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 1000 live births
International comparison if available	http://www.pi.nhs.uk/pnm/definitions.htm http://www.pi.nhs.uk/pnm/KHD_2008-9.pdf
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Manual Data Collection - Patient's Records - Mortality and Morbidity - Patient's follow up

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC018**

KPI Description (title):	**Neonatal Mortality - Corrected rate per 1000 live births**
Domain	**Effectiveness**
Indicator Type	**Outcome** - corrected rate per 1000 live births
Definition:	**Neonatal mortality:** Death before the age of 28 completed days following live birth. **Corrected Neonatal Mortality** = excluding major congenital anomalies irrespective of gestation; also < 22weeks gestation and those <500g.
Calculation:	***Numerator:*** Number of neonatal death during first 28 days of life during hospital stay ***Numerator Exclusion*:** • Deaths after 28 days of life • Stillbirths • Major congenital anomalies irrespective of gestation • Born at < 22weeks gestation • Born at <=500g in weight • Died before arrival to the reporting facility (during transfer from home, another facility or any other location to the reporting facility). • Exclude newborns that have only accessed urgent care or had 1 visit to the reporting facility • Preterms at the limit of viability (22+0 to 23+6 weeks gestation) who were not responding to initial stabilization and resuscitation at birth ***Denominator*:** All live babies born in the facility and/or being cared for in the specified facility **Denominator Inclusion*:*** • Total live births in the facility: Z38.00, Z38.01, Z38.2, Z38.30, Z38.31, Z38.5, Z38.61, Z38.62, Z38.63, Z38.64, Z38.65, Z38.66, Z38.68, Z38.69, Z38.8. • Born before arrival (Z38.1, Z38.4, Z38.7) • Transferred from other facilities and admitted as inpatient encounter during first 28 days of life.
	Quarterly
Unit of Measure:	Rate per 1000 live births
International comparison if available	http://www.pi.nhs.uk/pnm/definitions.htm http://www.pi.nhs.uk/pnm/KHD_2008-9.pdf WHO Implementation Tools for Maternal and Perinatal Death Surveillance and Response
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Manual Data Collection - Patient's Records (Malaffi data extraction within DOH) - Mortality and Morbidity - Patient's follow up

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC019**

KPI Description (title):	**Rate of Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) in pregnancy, childbirth, and puerperium**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Rate of perioperative pulmonary embolism or deep vein thrombosis (secondary diagnosis) for all inpatients of pregnancy, childbirth, and puerperium.
Calculation:	***Numerator:*** All inpatients with principal diagnosis of pregnancy, childbirth, and puerperium who had surgical discharges in the reporting quarter and developed proximal Deep Vein Thrombosis or Pulmonary Embolism (secondary diagnosis) within 30 days from the date of the surgical procedure. ***Secondary ICD-10-CM Diagnosis Codes, as follows:*** • ***Proximal Deep Vein Thrombosis:*** ***ICD 10 CM Codes****: (I80.10, I80.11, I80.12, I80.13, I80.201, I80.202, I80.203, I80.209, I80.211, I80.212, I80.213, I80.219, I80.221, I80.222, I80.223, I80.229, I80.291, I80.292, I80.293, I80.299, I82.401, I82.402, I82.403, I82.409, I82.411, I82.412, I82.413, I82.419, I82.421, I82.422, I82.423, I82.429, I82.431, I82.432, I82.433, I82.439, I82.4Y1, I82.4Y2, I82.4Y3, I82.4Y9)* • ***Pulmonary Embolism:*** ***ICD 10 CM Codes:*** *(I26.01, I26.02, I26.09, I26.90, I26.92, I26.93, I26.94, I26.99)* ***Denominator:*** Total number inpatient surgical discharges with principal diagnosis of pregnancy, childbirth, and puerperium during the reporting period (for operating room procedures). ***Principal ICD-10 codes***: O00.00 - O9A.53 with ***Service codes***: 20, 20-01, 20-02, 20-03 **Denominator Exclusions**: • *Patients with a principal ICD-10-CM Diagnosis Code or secondary diagnosis present on admission for: proximal deep vein thrombosis Deep Vein Thrombosis and Pulmonary Embolism (please see above codes)* • *Patients where a procedure for interruption of vena cava occurs before or on the same date as the first operating room procedure (CPT Procedure Code: 37619, 37191.* • where a procedure for pulmonary arterial or dialysis access thrombectomy occurs before or on the same day as the first operating room procedure • where the only operating room procedure(s) is for pulmonary arterial or dialysis access thrombectomy • with any ICD-10-CM diagnosis code present on admission for

	acute brain or spinal injury • with any procedure code for extracorporeal membrane oxygenation (ECMO)
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 1,000 surgical discharges
International comparison if available	PSI_12_Perioperative_Pulmonary_Embolism_or_Deep_Vein_Thrombosis_Rate.pdf (ahrq.gov) Also using OECD, CQC of UK with modification following discussion with local experts and taking local culture into consideration.
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Hospital internal adverse event system and complication log - Based on list of discharged patients with specific ICD 10 Diagnosis and Procedure codes - Patient medical record.

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC020**

KPI Description (title):	**Postoperative Sepsis Rate in pregnancy, childbirth, and puerperium**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Postoperative sepsis cases (secondary diagnosis) per 1,000 surgery discharges for patients of pregnancy, childbirth, and puerperium.
Calculation:	**Numerator**: All patients with diagnosis of pregnancy, childbirth, and puerperium who had surgical discharges in the reporting quarter and developed Sepsis within 30 days from the date of the surgical procedure (In case of multiple procedures, count from the first procedure). **ICD-10 CM (not limited to)**: O86.04, A02.1, A22.7, A26.7, A32.7, A40.0, A40.1, A40.3, A40.8, A40.9, A41.01, A41.02, A41.1, A41.2, A41.3, A41.4, A41.50, A41.51, A41.52, A41.53, A41.59, A41.81, A41.89, A41.9, A42.7, A54.86, B37.7 **Denominator**: Total number of inpatient surgical discharges with principal diagnosis of pregnancy, childbirth, and puerperium during the reporting period (for operating room procedures). **Principal ICD-10 codes:** O00.00 - O9A.53 with **Service codes**: 20, 20-01, 20-02, 20-03 **Denominator Exclusions**: • Patients with a principal ICD-10-CM Diagnosis Code or secondary diagnosis present on admission for Sepsis • Patients with a principal ICD-10-CM diagnosis code (or secondary diagnosis present on admission) for infection, coded as per documentation. • Long term care patients. (see glossary)
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 1,000 surgical discharges
International comparison if available	PSI_13_Postoperative_Sepsis_Rate.pdf (ahrq.gov)
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Captured by infection control team - Patient's records - Lab reports - Hospital internal mortality and morbidity

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC021**

KPI Description (title):	**Rate of women who require ICU admission for more than 24 hours while pregnant or within 42 days postpartum**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Rational:	A pregnant woman that is young is usually in good health until she suffers from some acute injury. Her prognosis will hopefully be better if she receives timely intensive care.
Calculation:	***Numerator:*** Number of women who require at least one ICU/HDU admission for pregnancy related issues for over 24 hours, while pregnant or up to 42 days postpartum in any facility. ***Denominator:*** Total number of deliveries that full-filled the following criteria: • At least 2 antenatal visits in the reporting facility- At least one of the antenatal visit to be in the first trimester. • Delivered **in the reporting facility.** • **Who completed 42 days of postpartum** during the reporting period. • ***All*** *women with both live births and still births.* **Denominator Exclusion**: Women with an ICU admission prior to the first of the two antenatal visits are excluded.
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 100 deliveries.
International comparison if available	https://manual.jointcommission.org/releases/TJC2019A/index.htmlNo published benchmark, trend line will be used after enough data collection
Desired direction:	Lower is better.
Notes for all providers	
Data sources and guidance:	• Patient's records • Claims data • DOH Standard for Center of Excellence in High-risk Pregnancy and Neonates

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC022**

KPI Description (title):	**Rate of unexpected NICU admissions within 28 days age.**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Rate of unplanned admissions to a NICU within 28 days of birth. An unplanned NICU admission is defined as an admission to NICU that was not planned more than twenty-four hours in advance of admission to the NICU.
Calculation:	***Numerator:*** Total number of neonates from the denominator who were transferred to critical care units (NICU) from birth to 28 days of life without a prior plan documented more than twenty-four hours of NICU admission. ***Denominator***: All live babies born in the facility and/or being cared for in the reporting facility. **Denominator Inclusion:** All neonates age up to 28 days of life • Total live births in the facility: Z38.00, Z38.01, Z38.2, Z38.30, Z38.31, Z38.5, Z38.61, Z38.62, Z38.63, Z38.64, Z38.65, Z38.66, Z38.68, Z38.69, Z38.8. • Born before arrival (Z38.1, Z38.4, Z38.7) • Transferred from other facilities and admitted as inpatient encounter during first 28 days of life. • Term (37+0 to 41+6 weeks gestation), non-anomalous singleton babies **Denominator Exclusion:** • Newborns of mothers who were unbooked.
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 100 live births
International comparison if available	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8462396/pdf/nihms-1722718.pdf
Desired direction:	<10%
Notes for all providers	
Data sources and guidance:	- Hospital incident reports - Hospital ICU admission log

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC023**

KPI Description (title):	**Overall Caesarian Section rate**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Percentage of all cesarean deliveries
Calculation:	***Numerator:*** Number of cesarean section deliveries. **Numerator Inclusion**: • Unplanned and planned cesarean section deliveries **Caesarian Section CPT Codes: (**59510, 59514, 59515, 59618, 59620, 59622) ***Denominator:*** Total number of deliveries (vaginal + caesarian) during the reporting period **Denominator Inclusion:** • With any-listed below ICD-10-CM diagnosis codes for previous Cesarean delivery (O34.211, O34.212, O34.219, O66.41) • With any ICD-10-CM diagnosis codes from ***Appendix B*** (abnormal presentation, preterm labor with preterm delivery, fetal death, or multiple gestation) • Unplanned and planned deliveries • Booked and unbooked cases • term, non-anomalous singleton babies
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 100 deliveries
International comparison if available	https://monitor.srhr.org/related-sheets/Monitor%20Indicator%20sheet%20Caesarean%20section%20rate.pdf https://qualityindicators.ahrq.gov/Downloads/Modules/IQI/V2024/TechSpecs/IQI_21_Cesarean_Delivery_Rate_Uncomplicated.pdf
Desired direction:	<15% Lower is better
Notes for all providers	
Data sources and guidance:	Patient's records (Malaffi data extraction within DOH)

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC024**

KPI Description (title):	**Coverage Rate for Newborn Blood Spot Screening**
Domain	**Effectiveness**
Indicator Type	**Process**
Definition:	Percentage of all newborns (live births during the reporting quarter), who were screened for Newborn Screening Panel by the newborn blood spot screening test. This screening is crucial for early detection of various metabolic and genetic disorders.
Calculation:	**Numerator:** Total number of newborns who were screened for Newborn Screening Panel by the newborn blood spot screening test. **Denominator:** Total number of live births in the reporting healthcare facility during the reporting quarter. **Denominator Exclusion:** • Parental refusal
Reporting Frequency:	Quarterly
Unit of Measure:	Percentage
International comparison if available	UAE National Newborn Screening Guideline 2024 https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2021-to-2022/antenatal-and-newborn-screening-kpi-data-q4-summary-factsheets-1-january-to-31-march-2022#newborn-blood-spot-screening https://www.gov.uk/government/publications/standards-for-nhs-newborn-blood-spot-screening/newborn-blood-spot-screening-standards-valid-for-data-collected-from-1-april-2020#nbs-s04-test-timely-sample-collection https://phw.nhs.wales/services-and-teams/screening/screening-reports/screening-programmes-policies-and-standards/screening-programme-policies-and-standards/newborn-bloodspot-screening-wales-policies-and-standards/
Desired direction:	**Higher is better (99%)**
Notes for all providers	
Data sources and guidance:	• Hospital EMR data

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC025**

KPI Description (title):	**Percentage of newborns with first blood spot sample collected at 24 to 48 hours of age.**
Domain	**Effectiveness**
Indicator Type	**Process**
Definition:	Percentage of first blood spot (heel prick) samples collected by health facilities at 24 to 48 hours of age.
Calculation:	**Numerator:** Total number of the first blood spot (heel prick) samples "collected" by the reporting facility at 24 to 48 hours of age. **Denominator:** Total number of the first blood spot (heel prick) samples "collected" by the reporting facility during the reporting quarter. **Denominator Exclusion:** • Parental refusal
Reporting Frequency:	Quarterly
Unit of Measure:	Percentage
International comparison if available	UAE National Newborn Screening Guideline 2024 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7117765/pdf/pone.0231050.pdf https://www.gov.uk/government/publications/standards-for-nhs-newborn-blood-spot-screening/newborn-blood-spot-screening-standards-valid-for-data-collected-from-1-april-2020#nbs-s04-test-timely-sample-collection
Desired direction:	**Higher is better (100%)**
Notes for all providers	
Data sources and guidance:	• Hospital EMR data

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC026**

KPI Description (title):	**Percentage of newborns with first blood spot sample collected before 24 hours of age.**
Domain	**Effectiveness**
Indicator Type	**Process**
Definition:	Percentage of first blood spot (heel prick) samples collected by health facilities before 24 hours of age.
Calculation:	**Numerator:** Total number of the first blood spot (heel prick) samples "collected" by the reporting facility before 24 hours of age. **Denominator:** Total number of the first blood spot (heel prick) samples "collected" by the reporting facility during the reporting quarter. **Denominator Exclusion:** • Newborns who died within 24hrs prior to admission to NICU/SCBU • Parental refusal
Reporting Frequency:	Quarterly
Unit of Measure:	Percentage
International comparison if available	UAE National Newborn Screening Guideline 2024 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7117765/pdf/pone.0231050.pdf https://www.gov.uk/government/publications/standards-for-nhs-newborn-blood-spot-screening/newborn-blood-spot-screening-standards-valid-for-data-collected-from-1-april-2020#nbs-s04-test-timely-sample-collection
Desired direction:	**Lower is better (<10%)**
Notes for all providers	
Data sources and guidance:	• Hospital EMR data

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC027**

KPI Description (title):	**Coverage Rate for Newborn Hearing Screening**
Domain	**Effectiveness**
Indicator Type	**Process**
Definition:	Percentage of all newborns (live births during the reporting quarter), who completed the hearing screening before discharge. This screening is vital for the early detection of hearing impairments, allowing for timely intervention and support.
Calculation:	**Numerator:** Total number of newborns who completed hearing screening before discharge. Method: One stage screening protocol with Automated Auditory Brainstem Response (AABR). **Denominator:** Total number of live births in the reporting healthcare facility during the reporting quarter. **Denominator Exclusion:** • Newborns who died within 24 hours of birth. • Parental refusal
Reporting Frequency:	Quarterly
Unit of Measure:	Percentage
International comparison if available	UAE National Newborn Screening Guideline 2024
Desired direction:	**Higher is better (100%)**
Notes for all providers	
Data sources and guidance:	• Hospital EMR data

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC028**

KPI Description (title):	**Coverage Rate for Newborn Critical Congenital Heart Disease Screening**
Domain	**Effectiveness**
Indicator Type	**Process**
Definition:	Percentage of all newborns (live births during the reporting quarter), who completed critical congenital heart disease (CCHD) screening before discharge. This screening is essential for the early detection of CCHD, which can be life-threatening if not identified and treated promptly.
Calculation:	**Numerator:** Total number of newborns who completed newborn critical congenital heart disease (CCHD) screening before discharge. **Denominator:** Total number of live births in the reporting healthcare facility during the reporting quarter. **Denominator Exclusion:** • Newborns who died within 24 hours of birth. • Parental refusal • Newborns who already had echocardiography done • For babies requiring oxygen for more than 24 -36 hours of age and already cause of hypoxemia has been identified. • Preterm infant less than 35 weeks (required admission to NICU/SCBU). • Infants above 35 weeks gestational age at birth who were admitted to NICU/SCBU for more than 5 days
Reporting Frequency:	Quarterly
Unit of Measure:	Percentage
International comparison if available	UAE National Newborn Screening Guideline 2024
Desired direction:	**Higher is better (100%)**
Notes for all providers	
Data sources and guidance:	• Hospital EMR data

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC029**

KPI Description (title):	**Percentage of newborns screened positive for time critical diseases and were seen by treating physician within 24 hours of reporting**
Domain	**Effectiveness**
Indicator Type	**Process**
Definition:	Percentage of newborns (live births during the reporting quarter), screened positive for time critical diseases and were seen by treating physician within 24 hours of reporting
Calculation:	**Numerator:** Total number of newborns that were screened positive for time critical diseases and were seen by treating physician within 24 hours of the screening report. The treating physician may be in the birthing facility or a referral facility. **Denominator:** Total number of newborns (live births during the reporting quarter) screened positive for time critical diseases during the reporting quarter. Please see Appendix C for time critical diseases. **Denominator Exclusion:** • Newborns who died before issuing the report.
Reporting Frequency:	Quarterly
Unit of Measure:	Percentage
International comparison if available	UAE National Newborn Screening Guideline 2024 https://www.newsteps.org/media/26/download?inline
Desired direction:	**Higher is better (100%)**
Notes for all providers	
Data sources and guidance:	• Hospital EMR data

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC030**

KPI Description (title):	**Percentage of newborns screened positive for non-time critical diseases and were seen by treating physician within 72 hours of reporting**
Domain	**Effectiveness**
Indicator Type	**Process**
Definition:	Percentage of newborns (live births during the reporting quarter), screened positive for non-time critical diseases and were seen by treating physician within 72 hours of reporting
Calculation:	**Numerator:** Total number of newborns that were screened positive for non-time critical diseases and were seen by treating physician within 72 hours of the screening report. The treating physician may be in the birthing facility or a referral facility. **Denominator:** Total number of newborns (live births during the reporting quarter) screened positive for non-time critical diseases during the reporting quarter. Please see Appendix C for non-time critical diseases. **Denominator Exclusion:** • Newborns who died before issuing the report.
Reporting Frequency:	Quarterly
Unit of Measure:	Percentage
International comparison if available	UAE National Newborn Screening Guideline 2024 https://www.newsteps.org/media/26/download?inline
Desired direction:	**Higher is better (100%)**
Notes for all providers	
Data sources and guidance:	• Hospital EMR data

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC031**

KPI Description (title):	**Percentage of newborns who were screened positive for critical congenital heart diseases and had diagnostic cardiac evaluation (echocardiogram)**
Domain	**Effectiveness**
Indicator Type	**Process**
Definition:	Percentage of newborns during the reporting quarter who had diagnostic cardiac evaluation (echocardiogram) among those who were screened positive for critical congenital heart diseases (CCHD).
Calculation:	**Numerator:** Total number of newborns in the denominator population who had diagnostic cardiac evaluation (echocardiogram). **Denominator:** Total number of newborns (live births during the reporting quarter) screened positive for CCHD (as part of the newborn screening program) in the reporting healthcare facility.
Reporting Frequency:	Quarterly
Unit of Measure:	Percentage
International comparison if available	UAE National Newborn Screening Guideline 2024
Desired direction:	**Higher is better > 98%**
Notes for all providers	
Data sources and guidance:	• Hospital EMR data

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC032**

KPI Description (title):	**Percentage of routine bilirubin testing among newborns discharged within 24 hours of life**
Domain	**Effectiveness**
Indicator Type	**Process**
Definition:	Percentage of newborns (live births during the reporting quarter), who have undergone a bilirubin test prior to being discharged from the hospital within the first 24 hours of life. This testing is critical for detecting hyperbilirubinemia (high bilirubin levels), which can lead to jaundice and potential complications if not addressed promptly.
Calculation:	**Numerator:** Total number of newborns who had at least one total serum bilirubin (TSB) or transcutaneous bilirubin (TcB) measure before discharge. **Denominator:** Total number of newborns (live births during the reporting quarter), discharged at or before 24h after birth in the reporting healthcare facility. **Denominator Exclusion:** • Newborns who died within 24 hours of birth.
Reporting Frequency:	Quarterly
Unit of Measure:	Percentage
International comparison if available	https://www.aap.org/en/patient-care/hyperbilirubinemia/quality-metrics-for-the-management-of-hyperbilirubinemia/?srsltid=AfmBOoq9VZJ4OCo3iOThc1TkzI4Hylx8JNe73lrAuUVdkZ2cfodfAdW7
Desired direction:	**Higher is better (100%)**
Notes for all providers	
Data sources and guidance:	• Hospital EMR data

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC033**

KPI Description (title):	**Percentage of routine bilirubin testing among newborns discharged after 24 hours**
Domain	**Effectiveness**
Indicator Type	**Process**
Definition:	Percentage of newborns (live births during the reporting quarter), who have undergone a bilirubin test prior to being discharged from the hospital after 24 hours of life. This testing is critical for detecting hyperbilirubinemia (high bilirubin levels), which can lead to jaundice and potential complications if not addressed promptly.
Calculation:	**Numerator:** Total number of newborns who had at least one total serum bilirubin (TSB) or transcutaneous bilirubin (TcB) measure between 24h and 48h after birth. **Denominator:** Total number of newborns (live births during the reporting quarter), discharged 24h after birth from the reporting healthcare facility. **Denominator Exclusion:** • Newborns who died within 24 hours of birth.
Reporting Frequency:	Quarterly
Unit of Measure:	Percentage
International comparison if available	https://www.aap.org/en/patient-care/hyperbilirubinemia/quality-metrics-for-the-management-of-hyperbilirubinemia/?srsltid=AfmBOoq9VZJ4OCo3iOThc1TkzI4Hylx8JNe73lrAuUVdkZ2cfodfAdW7
Desired direction:	**Higher is better (100%)**
Notes for all providers	
Data sources and guidance:	• Hospital EMR data

Maternal and Perinatal Care Quality Indicator **Indicator Number: MPC034**

KPI Description (title):	**Percentage of Appropriate TSB testing after TcB measure**
Domain	**Effectiveness**
Indicator Type	**Process**
Definition:	Percentage of newborns discharged during the reporting quarter, that had the transcutaneous bilirubin (TcB) within 3 mg/dL (51 µmol/L) of the phototherapy treatment threshold or above and had total serum bilirubin (TSB) testing.
Calculation:	**Numerator:** Total number of newborns from the denominator who had total serum bilirubin (TSB) testing. **Denominator:** Total number of newborns discharged during the reporting quarter, that had the transcutaneous bilirubin (TcB) within 3 mg/dL (51 µmol/L) of the phototherapy treatment threshold or above.
Reporting Frequency:	Quarterly
Unit of Measure:	Percentage
International comparison if available	https://www.aap.org/en/patient-care/hyperbilirubinemia/quality-metrics-for-the-management-of-hyperbilirubinemia/?srsltid=AfmBOoq9VZJ4OCo3iOThc1TkzI4Hylx8JNe73lrAuUVdkZ2cfodfAdW7
Desired direction:	**Higher is better**
Notes for all providers	
Data sources and guidance:	• Hospital EMR data

Appendix A: Conditions Possibly Justifying Elective Delivery

B20	O24.013	O30.291	O31.32X5	O35.8XX2	O36.1920	O36.8135	O41.1213	O45.013
K80.00	O24.02	O30.292	O31.32X9	O35.8XX3	O36.1921	O36.8139	O41.1214	O45.021
K80.01	O24.111	O30.293	O31.33X0	O35.8XX4	O36.1922	O36.8330	O41.1215	O45.022
K80.12	O24.112	O30.801	O31.33X1	O35.8XX5	O36.1923	O36.8331	O41.1219	O45.023
K80.13	O24.113	O30.802	O31.33X2	O35.8XX9	O36.1924	O36.8332	O41.1220	O45.091
K80.42	O24.12	O30.803	O31.33X3	O36.0110	O36.1925	O36.8333	O41.1221	O45.092
K80.43	O24.311	O30.811	O31.33X4	O36.0111	O36.1929	O36.8334	O41.1222	O45.093
K80.46	O24.312	O30.812	O31.33X5	O36.0112	O36.1930	O36.8335	O41.1223	O45.8X1
K80.47	O24.313	O30.813	O31.33X9	O36.0113	O36.1931	O36.8339	O41.1224	O45.8X2
K80.62	O24.32	O30.821	O31.8X10	O36.0114	O36.1932	O40.1XX0	O41.1225	O45.8X3
K80.63	O24.410	O30.822	O31.8X11	O36.0115	O36.1933	O40.1XX1	O41.1229	O45.91
K80.66	O24.414	O30.823	O31.8X12	O36.0119	O36.1934	O40.1XX2	O41.1230	O45.92
K80.67	O24.415	O30.831	O31.8X13	O36.0120	O36.1935	O40.1XX3	O41.1231	O45.93
K81.0	O24.419	O30.832	O31.8X14	O36.0121	O36.1939	O40.1XX4	O41.1232	O46.001
K81.2	O24.420	O30.833	O31.8X15	O36.0122	O36.4XX0	O40.1XX5	O41.1233	O46.002
K83.5	O24.424	O30.891	O31.8X19	O36.0123	O36.4XX1	O40.1XX9	O41.1234	O46.003
K83.8	O24.425	O30.892	O31.8X20	O36.0124	O36.4XX2	O40.2XX0	O41.1235	O46.011
K87	O24.429	O30.893	O31.8X21	O36.0125	O36.4XX3	O40.2XX1	O41.1239	O46.012
O10.011	O24.811	O30.91	O31.8X22	O36.0129	O36.4XX4	O40.2XX2	O41.1410	O46.013
O10.012	O24.812	O30.92	O31.8X23	O36.0130	O36.4XX5	O40.2XX3	O41.1411	O46.021
O10.013	O24.813	O30.93	O31.8X24	O36.0131	O36.4XX9	O40.2XX4	O41.1412	O46.022
O10.02	O24.82	O31.11X0	O31.8X25	O36.0132	O36.5110	O40.2XX5	O41.1413	O46.023
O10.03	O24.911	O31.11X1	O31.8X29	O36.0133	O36.5111	O40.2XX9	O41.1414	O46.091
O10.111	O24.912	O31.11X2	O31.8X30	O36.0134	O36.5112	O40.3XX0	O41.1415	O46.092
O10.112	O24.913	O31.11X3	O31.8X31	O36.0135	O36.5113	O40.3XX1	O41.1419	O46.093
O10.113	O24.92	O31.11X4	O31.8X32	O36.0139	O36.5114	O40.3XX2	O41.1420	O46.8X1
O10.12	O26.611	O31.11X5	O31.8X33	O36.0910	O36.5115	O40.3XX3	O41.1421	O46.8X2
O10.13	O26.612	O31.11X9	O31.8X34	O36.0911	O36.5119	O40.3XX4	O41.1422	O46.8X3
O10.211	O26.613	O31.12X0	O31.8X35	O36.0912	O36.5120	O40.3XX5	O41.1423	O46.91
O10.212	O26.62	O31.12X1	O31.8X39	O36.0913	O36.5121	O40.3XX9	O41.1424	O46.92
O10.213	O26.831	O31.12X2	O34.212	O36.0914	O36.5122	O41.01X0	O41.1425	O46.93
O10.22	O26.832	O31.12X3	O35.0XX0	O36.0915	O36.5123	O41.01X1	O41.1429	O48.0
O10.311	O26.833	O31.12X4	O35.0XX1	O36.0919	O36.5124	O41.01X2	O41.1430	O66.6
O10.312	O30.001	O31.12X5	O35.0XX2	O36.0920	O36.5125	O41.01X3	O41.1431	O67.0
O10.313	O30.002	O31.12X9	O35.0XX3	O36.0921	O36.5129	O41.01X4	O41.1432	O67.8
O10.32	O30.003	O31.13X0	O35.0XX4	O36.0922	O36.5130	O41.01X5	O41.1433	O67.9
O10.411	O30.011	O31.13X1	O35.0XX5	O36.0923	O36.5131	O41.01X9	O41.1434	O68
O10.412	O30.012	O31.13X2	O35.0XX9	O36.0924	O36.5132	O41.02X0	O41.1435	O69.0XX0
O10.413	O30.013	O31.13X3	O35.1XX0	O36.0925	O36.5133	O41.02X1	O41.1439	O69.0XX1
O10.42	O30.031	O31.13X4	O35.1XX1	O36.0929	O36.5134	O41.02X2	O42.011	O69.0XX2
O10.43	O30.032	O31.13X5	O35.1XX2	O36.0930	O36.5135	O41.02X3	O42.012	O69.0XX3
O10.911	O30.033	O31.13X9	O35.1XX3	O36.0931	O36.5139	O41.02X4	O42.013	O69.0XX4
O10.912	O30.041	O31.21X0	O35.1XX4	O36.0932	O36.5910	O41.02X5	O42.02	O69.0XX5
O10.913	O30.042	O31.21X1	O35.1XX5	O36.0933	O36.5911	O41.02X9	O42.111	O69.0XX9
O10.92	O30.043	O31.21X2	O35.1XX9	O36.0934	O36.5912	O41.03X0	O42.112	O69.4XX0

O11.1	O30.091	O31.21X3	O35.3XX0	O36.0935	O36.5913	O41.03X1	O42.113	O69.4XX1
O11.2	O30.092	O31.21X4	O35.3XX1	O36.0939	O36.5914	O41.03X2	O42.12	O69.4XX2
O11.3	O30.093	O31.21X5	O35.3XX2	O36.1110	O36.5915	O41.03X3	O42.911	O69.4XX3
O11.4	O30.101	O31.21X9	O35.3XX3	O36.1111	O36.5919	O41.03X4	O42.912	O69.4XX4
O13.1	O30.102	O31.22X0	O35.3XX4	O36.1112	O36.5920	O41.03X5	O42.913	O69.4XX5
O13.2	O30.103	O31.22X1	O35.3XX5	O36.1113	O36.5921	O41.03X9	O42.92	O69.4XX9
O13.3	O30.111	O31.22X2	O35.3XX9	O36.1114	O36.5922	O41.1010	O43.011	O71.02
O13.4	O30.112	O31.22X3	O35.4XX0	O36.1115	O36.5923	O41.1011	O43.012	O71.03
O14.02	O30.113	O31.22X4	O35.4XX1	O36.1119	O36.5924	O41.1012	O43.013	O76
O14.03	O30.121	O31.22X5	O35.4XX2	O36.1120	O36.5925	O41.1013	O43.212	O98.72
O14.04	O30.122	O31.22X9	O35.4XX3	O36.1121	O36.5929	O41.1014	O43.213	O99.111
O14.12	O30.123	O31.23X0	O35.4XX4	O36.1122	O36.5930	O41.1015	O43.222	O99.112
O14.13	O30.131	O31.23X1	O35.4XX5	O36.1123	O36.5931	O41.1019	O43.223	O99.113
O14.14	O30.132	O31.23X2	O35.4XX9	O36.1124	O36.5932	O41.1020	O43.232	O99.12
O14.22	O30.133	O31.23X3	O35.5XX0	O36.1125	O36.5933	O41.1021	O43.233	O99.13
O14.23	O30.191	O31.23X4	O35.5XX1	O36.1129	O36.5934	O41.1022	O44.01	O99.411
O14.24	O30.192	O31.23X5	O35.5XX2	O36.1130	O36.5935	O41.1023	O44.02	O99.412
O14.92	O30.193	O31.23X9	O35.5XX3	O36.1131	O36.5939	O41.1024	O44.03	O99.413
O14.93	O30.201	O31.31X0	O35.5XX4	O36.1132	O36.8120	O41.1025	O44.11	O99.42
O14.94	O30.202	O31.31X1	O35.5XX5	O36.1133	O36.8121	O41.1029	O44.12	O99.43
O15.02	O30.203	O31.31X2	O35.5XX9	O36.1134	O36.8122	O41.1030	O44.13	O99.810
O15.03	O30.211	O31.31X3	O35.6XX0	O36.1135	O36.8123	O41.1031	O44.23	O99.814
O15.1	O30.212	O31.31X4	O35.6XX1	O36.1139	O36.8124	O41.1032	O44.33	O99.815
O15.2	O30.213	O31.31X5	O35.6XX2	O36.1910	O36.8125	O41.1033	O44.43	Z21
O16.1	O30.221	O31.31X9	O35.6XX3	O36.1911	O36.8129	O41.1034	O44.53	Z37.1
O16.2	O30.222	O31.32X0	O35.6XX4	O36.1912	O36.8130	O41.1035	O45.001	Z79.01
O16.3	O30.223	O31.32X1	O35.6XX5	O36.1913	O36.8131	O41.1039	O45.002	
O16.4	O30.231	O31.32X2	O35.6XX9	O36.1914	O36.8132	O41.1210	O45.003	
O24.011	O30.232	O31.32X3	O35.8XX0	O36.1915	O36.8133	O41.1211	O45.011	
O24.012	O30.233	O31.32X4	O35.8XX1	O36.1919	O36.8134	O41.1212	O45.012	

Appendix B: Abnormal presentation, fetal death, and multiple gestation diagnosis codes

O30.001	O30.132	O30.823	O31.13X2	O31.8X14	O32.2XX9	O36.4XX1	O60.14X9	O64.8XX0
O30.002	O30.133	O30.829	O31.13X3	O31.8X15	O32.3XX0	O36.4XX2	O63.2	O64.8XX1
O30.003	O30.139	O30.831	O31.13X4	O31.8X19	O32.3XX1	O36.4XX3	O64.0XX0	O64.8XX2
O30.009	O30.191	O30.832	O31.13X5	O31.8X20	O32.3XX2	O36.4XX4	O64.0XX1	O64.8XX3
O30.011	O30.192	O30.833	O31.13X9	O31.8X21	O32.3XX3	O36.4XX5	O64.0XX2	O64.8XX4
O30.012	O30.193	O30.839	O31.20X0	O31.8X22	O32.3XX4	O36.4XX9	O64.0XX3	O64.8XX5
O30.013	O30.199	O30.891	O31.20X1	O31.8X23	O32.3XX5	O44.03	O64.0XX4	O64.8XX9
O30.019	O30.201	O30.892	O31.20X2	O31.8X24	O32.3XX9	O44.13	O64.0XX5	O64.9XX0
O30.021	O30.202	O30.893	O31.20X3	O31.8X25	O32.4XX0	O44.23	O64.0XX9	O64.9XX1
O30.022	O30.203	O30.899	O31.20X4	O31.8X29	O32.4XX1	O44.33	O64.1XX0	O64.9XX2
O30.023	O30.209	O30.90	O31.20X5	O31.8X30	O32.4XX2	O60.10X0	O64.1XX1	O64.9XX3

O30.029	O30.211	O30.91	O31.20X9	O31.8X31	O32.4XX3	O60.10X1	O64.1XX2	O64.9XX4
O30.031	O30.212	O30.92	O31.21X0	O31.8X32	O32.4XX4	O60.10X2	O64.1XX3	O64.9XX5
O30.032	O30.213	O30.93	O31.21X1	O31.8X33	O32.4XX5	O60.10X3	O64.1XX4	O64.9XX9
O30.033	O30.219	O31.10X0	O31.21X2	O31.8X34	O32.4XX9	O60.10X4	O64.1XX5	O66.1
O30.039	O30.221	O31.10X1	O31.21X3	O31.8X35	O32.6XX0	O60.10X5	O64.1XX9	O66.6
O30.041	O30.222	O31.10X2	O31.21X4	O31.8X39	O32.6XX1	O60.10X9	O64.2XX0	Z37.1
O30.042	O30.223	O31.10X3	O31.21X5	O31.8X90	O32.6XX2	O60.12X0	O64.2XX1	Z37.2
O30.043	O30.229	O31.10X4	O31.21X9	O31.8X91	O32.6XX3	O60.12X1	O64.2XX2	Z37.3
O30.049	O30.231	O31.10X5	O31.22X0	O31.8X92	O32.6XX4	O60.12X2	O64.2XX3	Z37.4
O30.091	O30.232	O31.10X9	O31.22X1	O31.8X93	O32.6XX5	O60.12X3	O64.2XX4	Z37.50
O30.092	O30.233	O31.11X0	O31.22X2	O31.8X94	O32.6XX9	O60.12X4	O64.2XX5	Z37.51
O30.093	O30.239	O31.11X1	O31.22X3	O31.8X95	O32.8XX0	O60.12X5	O64.2XX9	Z37.52
O30.099	O30.291	O31.11X2	O31.22X4	O31.8X99	O32.8XX1	O60.12X9	O64.3XX0	Z37.53
O30.101	O30.292	O31.11X3	O31.22X5	O32.1XX0	O32.8XX2	O60.13X0	O64.3XX1	Z37.54
O30.102	O30.293	O31.11X4	O31.22X9	O32.1XX1	O32.8XX3	O60.13X1	O64.3XX2	Z37.59
O30.103	O30.299	O31.11X5	O31.23X0	O32.1XX2	O32.8XX4	O60.13X2	O64.3XX3	Z37.60
O30.109	O30.801	O31.11X9	O31.23X1	O32.1XX3	O32.8XX5	O60.13X3	O64.3XX4	Z37.61
O30.111	O30.802	O31.12X0	O31.23X2	O32.1XX4	O32.8XX9	O60.13X4	O64.3XX5	Z37.62
O30.112	O30.803	O31.12X1	O31.23X3	O32.1XX5	O32.9XX0	O60.13X5	O64.3XX9	Z37.63
O30.113	O30.809	O31.12X2	O31.23X4	O32.1XX9	O32.9XX1	O60.13X9	O64.4XX0	Z37.64
O30.119	O30.811	O31.12X3	O31.23X5	O32.2XX0	O32.9XX2	O60.14X0	O64.4XX1	Z37.69
O30.121	O30.812	O31.12X4	O31.23X9	O32.2XX1	O32.9XX3	O60.14X1	O64.4XX2	Z37.7
O30.122	O30.813	O31.12X5	O31.8X10	O32.2XX2	O32.9XX4	O60.14X2	O64.4XX3	
O30.123	O30.819	O31.12X9	O31.8X11	O32.2XX3	O32.9XX5	O60.14X3	O64.4XX4	
O30.129	O30.821	O31.13X0	O31.8X12	O32.2XX4	O32.9XX9	O60.14X4	O64.4XX5	
O30.131	O30.822	O31.13X1	O31.8X13	O32.2XX5	O36.4XX0	O60.14X5	O64.4XX9	

Appendix C: List of Time Critical and Non-Time Critical Conditions

No.		Disorders
1	Critical	Argininosuccinic aciduria (ASA)
2		Citrullinemia (CIT Type I &II)
3		Maple syrup urine disease (MSUD)
4		Methylmalonic acidemia (Methylmalonyl-CoA mutase deficiency) (MUT)
5		Methylmalonic acidemia, cblA and cblB forms (MMA, Cbl A, B)
6		Propionic acidemia (PROP)
7		Congenital adrenal hyperplasia (CAH)
8	Non-Critical	Classic Phenylketonuria (PKU)
9		Benign hyperphenylalaninemia
10		Defects of biopterin cofactor biosynthesis
11		Defects of biopterin cofactor regeneration
12		Argininemia
13		Tyrosinemia I, II, III (TYR I, II, III)
14		Homocystinuria
15		Hypermethioninaemia
16		Glutaric acidemia type I (GA I)
17		Hydroxy methyl glutaric aciduria (Hydroxymethylglutaryl lyase deficiency) (HMG)
18		Isovaleric acidemia (IVA)
19		3-Methylcrotonyl-CoA carboxylase deficiency (3MCC)
20		Beta-ketothiolase deficiency (BKT)
21		Holocarboxylase synthase deficiency
22		Isobutyryl-CoA dehydrogenase deficiency (IBDH)
23		Long-chain hydroxyacyl-CoA dehydrogenase deficiency (LCHAD)
24		Medium-chain acyl-CoA dehydrogenase deficiency (MCAD)
25		Very-long-chain acyl-CoA dehydrogenase deficiency (VLCAD)
26		Trifunctional protein deficiency (TFP)
27		Carnitine uptake defect (CUD)/Carnitine Transport Defect
28		Glutaric acidemia type II (Multiple Acyl-CoA Dehydrogenase Deficiency) (MAD; GA-II)
29		Carnitine palmityl transferase deficiency type 1
30		Carnitine palmityl transferase deficiency type 2
31		Short-chain acyl-CoA dehydrogenase deficiency (SCAD)
32		Carnitine/acylcarnitine Translocase Deficiency (Translocase)
33		Congenital hypothyroidism (CH)
34		Biotinidase deficiency (BIOT)
35		Galactosemia
36		Sickle cell anaemia (Hb SS)
37		Sickle-cell disease (Hb S/C)
38		Hb S/Beta-Thalassemia (Hb S/Th)
39		B-Thalassemia major
40		Variant hemoglobinopathies (including Hb E)

Summary of Changes 2025

KPI #	Changes
MPC001	Removed Numerator Inclusion Added CPT codes where appropriate
MPC002	Denominator exclusion: Added and Appendix A for Principal and secondary diagnosis codes for conditions possibly justifying elective delivery prior to 39 weeks gestation
MPC003	1. In Denominator exclusion: a. Birth before arrival (BBA) to the hospital b. Miscarriages (ICD-10 CM codes not limited to: O02.1, O03.39, O03.4, O03.89, O03.9, O20.0) c. Babies with shoulder dystocia 2. Added codes wherever applicable
MPC004	1. In Denominator exclusion: a. Birth before arrival (BBA) to the hospital b. Miscarriages (ICD-10 CM codes not limited to: O02.1, O03.39, O03.4, O03.89, O03.9, O20.0) 2. Added codes wherever applicable
MPC005	1. Denominator: added "at least" one previous caesarean section. 2. In Denominator exclusion: Added Appendix B for abnormal presentation, fetal death, or multiple gestation
MPC006	1. Removed "2000ml" in the title 2. Denominator exclusion: added Miscarriages (ICD-10 CM codes not limited to: O02.1, O03.39, O03.4, O03.89, O03.9, O20.0) 3. Added codes wherever applicable 4. Revise numerator and guidance Numerator: Number of women with postpartum hemorrhage within 24 hours after delivery. Report Separately: >2000ml, severe PPH >1000–2000ml, moderate PPH > 500-1000ml, minor PPH ICD10CM Codes to bleeding after delivery (not limited to): O72.0, O72.1, O72.2, O44.13, O44.33, O44.53
MPC008	Removed Numerator Exclusions: None
MPC009	Removed Numerator Exclusions: None
MPC011	Numerator: added "without a hysterotomy" Added denominator exclusion: ***O34.218***
MPC012	Numerator: added "without a hysterotomy" Added denominator exclusion: ***O34.218***
MPC015	1. Numerator: Revised weeks of gestation to "22" weeks, instead of 24 2. Added international reference
MPC016	1. Numerator: Revised weeks of gestation to "22" weeks, instead of 24 2. Numerator Exclusions: a. bulleted down the birth weight b. added: Exclude patients that have only accessed urgent care or had 1 visit to the reporting facility c. Preterms at the limit of viability (22+0 to 23+6 weeks gestation) who were not responding to initial stabilization and resuscitation at birth 3. Added international reference

MPC018	1. Numerator: Revised weeks of gestation to “22” weeks, instead of 24 2. Numerator Exclusions: a. bulleted down the birth weight b. added: Exclude patients that have only accessed urgent care or had 1 visit to the reporting facility c. Preterms at the limit of viability (22+0 to 23+6 weeks gestation) who were not responding to initial stabilization and resuscitation at birth 3. Added international reference
MPC019-MPC034	Added new KPIs