



دائرة الصحة
DEPARTMENT OF HEALTH

Maternal and Perinatal Care Service Jawda Guidance

Version 6.2

Table of Contents

Maternal and Perinatal KPIs

About this Guidance	5
Proportion of surgically managed ectopic pregnancies that were managed by laparoscopy	6
Proportion of elective deliveries at ≥ 37 and < 39 weeks	7
Proportion of episiotomy procedures among vaginal deliveries	8
Proportion of third- and fourth-degree perineal tears.....	9
Proportion of vaginal births following previous caesarean section.....	10
Proportion of deliveries with Postpartum Haemorrhage	11
Proportion of unplanned all cause readmissions to hospital within 30 days of discharge after delivery	12
Brachial plexus injury rate per 1000 newborns	13
Neonate patients with hypoxic-ischemic encephalopathy (Moderate or Severe) (HIE) rate per 1000 newborns	14
Neonatal Central line-associated Bloodstream Infections (CLABSI)	15
Emergency Primary Caesarian Section rate	17
Elective Primary Caesarian Section rate	18
Surgical site infection (SSI) for emergency caesarian section	19
Surgical site infection (SSI) for elective caesarian section	22
Early Perinatal Mortality rate per 1000 births	25
Early Perinatal Mortality - Corrected rate per 1000 births	26
Neonatal Mortality rate per 1000 live births	27
Neonatal Mortality - Corrected rate per 1000 live births	28
Rate of Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) in pregnancy, childbirth, and puerperium	29
Postoperative Sepsis Rate in pregnancy, childbirth, and puerperium	30
Rate of women who require ICU admission for more than 24 hours while pregnant or within 42 days postpartum	31
Rate of unexpected NICU admissions during the birthing encounter.	32
Overall Caesarian Section rate	33
Coverage Rate for Newborn Blood Spot Screening	34
Percentage of newborns with first blood spot sample collected at 24 to 48 hours of age. 35	
Percentage of newborns with first blood spot sample collected before 24 hours of age. ...	36
Coverage Rate for Newborn Hearing Screening	37
Coverage Rate for Newborn Critical Congenital Heart Disease Screening	38

Percentage of newborns screened positive for time critical diseases and were seen by treating physician within 24 hours of reporting	39
Percentage of newborns screened positive for non-time critical diseases and were seen by treating physician within 72 hours of reporting.....	40
Percentage of newborns who were screened positive for critical congenital heart diseases and had diagnostic cardiac evaluation (echocardiogram).....	41
Percentage of routine bilirubin testing among newborns discharged within 24 hours of life.....	42
Percentage of routine bilirubin testing among newborns discharged after 24 hours.....	43
Appendix A: Conditions Possibly Justifying Elective Delivery	44
Appendix B: Abnormal presentation, fetal death, and multiple gestation diagnosis codes	45
Appendix C: List of Time Critical and Non-Time Critical Conditions	47
Summary of Changes 2025 V6	48
Summary of Changes 2025 V6.1	49
Summary of Changes 2025 V6.2	49

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.

Issued:	January 2020
Published updates:	Version 2, January 2021
	Version 3, October 2021
	Version 4, April 2022
	Version 5, June 2022
	Version 6, December 2024
	Version 6.1, February 2025
	Version 6.2, September 2025
Effective:	Q3 Version 6.2, 2025

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:	<u>Numerator:</u> Number of women with ectopic pregnancy managed by laparoscopy <i>CPT Codes: 59150, 59151</i> <u>Numerator Exclusion:</u> - 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 <u>Denominator:</u> Total number of women with ectopic pregnancy managed surgically during the reporting period. <i>CPT Codes: 59150, 59151, 59120, 59121, 59130, 59135, 59136</i> <u>Denominator Exclusion:</u> (codes not limited to): - Cervical ectopic treatment. <i>CPT codes: 59140</i> - Scar ectopic and abdominal live ectopic. <i>CPT codes: 59897</i>
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:	<u>Numerator:</u> Patients with elective vaginal deliveries or elective cesarean sections ≥ 37 and < 39 weeks of gestation completed. <u>Numerator Inclusion:</u> • 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. <u>Denominator:</u> Total number of women who delivered new-borns within ≥ 37 and < 39 weeks of gestation completed during the reporting period. <u>ICD 10CM Code:</u> <u>Delivery codes:</u> 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 <u>Gestational Age:</u> Z3A.37, Z3A.38 <u>Denominator Exclusion:</u> • Principal and secondary diagnosis codes for conditions possibly justifying elective delivery prior to 39 weeks gestation (<i>See Appendix A</i>) • 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:	<u>Numerator:</u> Number of pregnant women who delivered vaginally and had an episiotomy procedure <u>Denominator:</u> Total number of women who delivered vaginally during the reporting period. <i>ICD 10CM Code:</i> 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 <i>CPT Code-</i> 59400, 59409, 59410, 59610, 59612, 59614 (Including instrumental deliveries, forceps-and vacuum) <u>Denominator Exclusion:</u> • All Caesarean Section deliveries (<i>CPT codes:</i> 59510, 59514, 59515, 59618, 59620, 59622) • Birth before arrival (BBA) to the hospital • Miscarriages (<i>ICD-10 CM codes not limited to:</i> 002.1, 003.39, 003.4, 003.89, 003.9, 020.0) • 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:	<u>Numerator:</u> Number of women with third- or fourth-degree perineal tear (including anal sphincter tear). ICD10CM Codes: 070.20, 070.21, 070.22, 070.23; 070.3, 070.4 <u>Denominator:</u> 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) <u>Denominator Exclusion:</u> • 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: 002.1, 003.39, 003.4, 003.89, 003.9, 020.0)
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:	<u>Numerator:</u> Number of women who had successful vaginal birth after prior caesarean section. VBAC CPT codes: 59610, 59612, 59614 <u>Denominator:</u> Total number of women who delivered during the reporting period and had a history of one previous caesarean section. CPT codes: 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622. <u>Denominator Exclusion:</u> 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:	<u>Numerator:</u> Number of women with postpartum hemorrhage within 24 hours after delivery. <u>Report Separately:</u> a. >2000 ml, severe PPH b. >1000–2000 ml, moderate PPH c. > 500-1000 ml, minor PPH <u>ICD10CM Codes</u> to bleeding after delivery (not limited to): 072.0, 072.1, 072.2, 044.13, 044.33, 044.53 <u>Denominator:</u> Total number of women who delivered during the reporting period. <u>ICD 10CM Codes:</u> 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 <u>Denominator Exclusion:</u> • Miscarriages (<i>ICD-10 CM codes not limited to: 002.1, 003.39, 003.4, 003.89, 003.9, 020.0</i>)
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. <i>For the definition of “emergency”, please refer to the DOH emergency standard.</i>
Calculation:	<u>Numerator:</u> Number of women with unplanned readmission to hospital (for all causes) within 30 days of inpatient discharge after delivery <u>Numerator Inclusion:</u> • 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. <u>Numerator Exclusion</u> • Planned readmissions • Planned transfers • Where the mother was readmitted accompanying a sick infant. <u>Denominator:</u> Total number of women inpatient discharge with delivery during the reporting period. <u>Denominator Inclusion:</u> • 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 <u>Denominator Exclusion:</u> • 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.

Restricted

Jawda Maternal and Perinatal Care Quality Performance Indicators

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:	<u>Numerator:</u> Number of babies with brachial plexus injury <u>Numerator Inclusion:</u> ICD 10CM codes: P14.0, P14.1 P14.3 <u>Denominator:</u> Total number of babies born during the reporting period. <u>Denominator Inclusion:</u> • 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. <u>Denominator Exclusion:</u> • 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:	<u>Numerator:</u> Number of term babies born with moderate or severe hypoxic encephalopathy requiring NICU admission. ICD 10CM codes: P91.62, P91.63 <u>Denominator:</u> Total number of babies born at term (≥ 37 weeks) during the reporting period. <u>Denominator inclusion:</u> • 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. <u>Denominator Exclusion:</u> • 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) <i>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.</i>
Calculation:	<u>Numerator:</u> 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: <u>LCBI 1:</u> 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. <u>LCBI2:</u> 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. <u>LCBI3:</u> Patient of up to 28 days of age has at least one of the following signs or symptoms:

Restricted

Jawda Maternal and Perinatal Care Quality Performance Indicators

	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. <u>Applicable CPT codes (not limited to):</u> 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 Restricted

Jawda Maternal and Perinatal Care Quality Performance Indicators

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:	<u>Numerator:</u> Number of first time unplanned cesarean section deliveries without a hysterotomy. Caesarian Section CPT Codes: (59510, 59514, 59515, 59618, 59620, 59622) <u>Denominator:</u> Total number of deliveries during the reporting period <u>Denominator exclusions</u> - 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 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:	<u>Numerator:</u> Number of planned first time cesarean section deliveries without a hysterotomy. Caesarian Section CPT Codes:(59510, 59514, 59515, 59618, 59620, 59622) <u>Denominator:</u> Total number of deliveries during the reporting period <u>Denominator Exclusions:</u> - 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: - purulent drainage from the superficial incision. - 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). - 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. - 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: - purulent drainage from the deep incision. - 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

Restricted

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

Jawda Maternal and Perinatal Care Quality Performance Indicators

	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 renovated¹¹. This may include an operating room, C-section room, interventional radiology room, or a cardiac catheterization lab. <u>Denominator:</u> 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) <u>Denominator Exclusions:</u> 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:	<u>Numerator:</u> Number of all SSI identified within 30 days for all inpatients who underwent a planned caesarean section during the reporting period. <u>Numerator Inclusion:</u> PATOS (infection present at time of surgery) <i>SSI could be presented as:</i> 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

Jawda Maternal and Perinatal Care Quality Performance Indicators

	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 renovated¹¹. This may include an operating room, C-section room, interventional radiology room, or a cardiac catheterization lab. <u>Denominator:</u> 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 <u>Denominator Exclusions:</u> 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:	<u>Numerator:</u> 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) <u>Denominator:</u> All births in the facility and/ or babies being cared for in the specified facility. <u>Denominator Inclusion:</u> - 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:	<u>Numerator:</u> 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) <u>Numerator Exclusions:</u> - 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 <u>Denominator:</u> All births in the facility and/ or babies being cared for in the specified facility. <u>Denominator Inclusion:</u> - 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:	<u>Numerator:</u> Number of neonatal death during first 28 days of life during hospital stay <u>Numerator Exclusion:</u> - Deaths after 28 days of life - Stillbirths <u>Denominator:</u> All live babies born in the facility and/or being cared for in the specified facility <u>Denominator Inclusion:</u> - 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:	<u>Numerator:</u> Number of neonatal death during first 28 days of life during hospital stay <u>Numerator Exclusion:</u> - 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 <u>Denominator:</u> All live babies born in the facility and/or being cared for in the specified facility <u>Denominator Inclusion:</u> - 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:	<u>Numerator:</u> 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. <u>Secondary ICD-10-CM Diagnosis Codes, as follows:</u> • 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) <u>Denominator:</u> Total number inpatient surgical discharges with principal diagnosis of pregnancy, childbirth, and puerperium during the reporting period (for operating room procedures). <u>Principal ICD-10 codes:</u> 000.00 - 09A.53 with <u>Service codes:</u> 20, 20-01, 20-02, 20-03 <u>Denominator Exclusions:</u> • 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

Restricted

Jawda Maternal and Perinatal Care Quality Performance Indicators

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 elective surgery discharges for patients of pregnancy, childbirth, and puerperium.
Calculation:	<u>Numerator:</u> All patients with diagnosis of pregnancy, childbirth, and puerperium who had elective surgical discharges in the reporting quarter and developed Sepsis within 30 days from the date of the elective 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 <u>Denominator:</u> Total number of elective inpatient surgical discharges with principal diagnosis of pregnancy, childbirth, and puerperium during the reporting period (for elective operating room procedures). Principal ICD-10 codes: 000.00 - 09A.53 with Service codes: 20, 20-01, 20-02, 20-03 <u>Denominator Exclusions:</u> • 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) Restricted

Jawda Maternal and Perinatal Care Quality Performance Indicators

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:	<u>Numerator:</u> 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. <u>Denominator:</u> 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. • <i>All women with both live births and still births.</i> <u>Denominator Exclusion:</u> 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.html No 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 During the Birthing Encounter
Domain	Effectiveness
Indicator Type	Outcome
Definition:	Rate of unexpected admissions to a NICU within the birthing encounter.
Calculation:	<u>Numerator:</u> Total number of neonates from the denominator who were transferred to critical care units (NICU) from birth before discharge. <u>Numerator Inclusion</u> - Newborn admission to NICU of mothers who were <i>unbooked</i>. <i>Unbooked</i> mothers are those who 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. - Newborn admission to NICU of booked mothers. <u>Denominator:</u> All term (37+0 to 41+6 weeks gestation), non-anomalous singleton live babies born in the reporting facility (birthing encounter). <u>Denominator Inclusion:</u> All newborns as follows: - 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)
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:	<u>Numerator:</u> Number of cesarean section deliveries. <i>Report separately</i> - Unplanned cesarean section deliveries - Planned cesarean section deliveries Caesarian Section CPT Codes: (59510, 59514, 59515, 59618, 59620, 59622) <u>Denominator:</u> Total number of deliveries (vaginal + caesarian) during the reporting period <u>Denominator Inclusion:</u> - With any listed below ICD-10-CM diagnosis codes for previous Cesarean delivery (034.211, 034.212, 034.219, 066.41) - 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: • Newborns who died within 24hrs • 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 • 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 were discharged with deceased disposition. • Parental refusal • Newborns transferred to another facility within 24 hours of admission due to the need for a higher level of care.
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. • Newborns transferred to another facility within 24 hours of admission due to the need for a higher level of care.
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 or newborns being cared for 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. • Critically ill babies that are transferred to another hospital within 24 hours.
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=AfmBOoq9VZJ40Co3i0Thc1TkzI4Hylx8jNe73lrAuUVdkZ2cfodfAdW7
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: - Within the first 24 hours of birth. - Between 24h and 48h after birth. - After 48 hours of 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=AfmB0oq9VZJ40Co3i0Thc1TkzI4Hylx8JNe73lrAuUVdkZ2cfodfAdW7
Desired direction:	Higher is better (100%)
Notes for all providers	
Data sources and guidance:	Hospital EMR data

Appendix A: Conditions Possibly Justifying Elective Delivery

B20	024.013	030.291	031.32X5	035.8XX2	036.1920	036.8135	041.1213	045.013
K80.00	024.02	030.292	031.32X9	035.8XX3	036.1921	036.8139	041.1214	045.021
K80.01	024.111	030.293	031.33X0	035.8XX4	036.1922	036.8330	041.1215	045.022
K80.12	024.112	030.801	031.33X1	035.8XX5	036.1923	036.8331	041.1219	045.023
K80.13	024.113	030.802	031.33X2	035.8XX9	036.1924	036.8332	041.1220	045.091
K80.42	024.12	030.803	031.33X3	036.0110	036.1925	036.8333	041.1221	045.092
K80.43	024.311	030.811	031.33X4	036.0111	036.1929	036.8334	041.1222	045.093
K80.46	024.312	030.812	031.33X5	036.0112	036.1930	036.8335	041.1223	045.8X1
K80.47	024.313	030.813	031.33X9	036.0113	036.1931	036.8339	041.1224	045.8X2
K80.62	024.32	030.821	031.8X10	036.0114	036.1932	040.1XX0	041.1225	045.8X3
K80.63	024.410	030.822	031.8X11	036.0115	036.1933	040.1XX1	041.1229	045.91
K80.66	024.414	030.823	031.8X12	036.0119	036.1934	040.1XX2	041.1230	045.92
K80.67	024.415	030.831	031.8X13	036.0120	036.1935	040.1XX3	041.1231	045.93
K81.0	024.419	030.832	031.8X14	036.0121	036.1939	040.1XX4	041.1232	046.001
K81.2	024.420	030.833	031.8X15	036.0122	036.4XX0	040.1XX5	041.1233	046.002
K83.5	024.424	030.891	031.8X19	036.0123	036.4XX1	040.1XX9	041.1234	046.003
K83.8	024.425	030.892	031.8X20	036.0124	036.4XX2	040.2XX0	041.1235	046.011
K87	024.429	030.893	031.8X21	036.0125	036.4XX3	040.2XX1	041.1239	046.012
O10.011	024.811	030.91	031.8X22	036.0129	036.4XX4	040.2XX2	041.1410	046.013
O10.012	024.812	030.92	031.8X23	036.0130	036.4XX5	040.2XX3	041.1411	046.021
O10.013	024.813	030.93	031.8X24	036.0131	036.4XX9	040.2XX4	041.1412	046.022
O10.02	024.82	031.11X0	031.8X25	036.0132	036.5110	040.2XX5	041.1413	046.023
O10.03	024.911	031.11X1	031.8X29	036.0133	036.5111	040.2XX9	041.1414	046.091
O10.111	024.912	031.11X2	031.8X30	036.0134	036.5112	040.3XX0	041.1415	046.092
O10.112	024.913	031.11X3	031.8X31	036.0135	036.5113	040.3XX1	041.1419	046.093
O10.113	024.92	031.11X4	031.8X32	036.0139	036.5114	040.3XX2	041.1420	046.8X1
O10.12	026.611	031.11X5	031.8X33	036.0910	036.5115	040.3XX3	041.1421	046.8X2
O10.13	026.612	031.11X9	031.8X34	036.0911	036.5119	040.3XX4	041.1422	046.8X3
O10.211	026.613	031.12X0	031.8X35	036.0912	036.5120	040.3XX5	041.1423	046.91
O10.212	026.62	031.12X1	031.8X39	036.0913	036.5121	040.3XX9	041.1424	046.92
O10.213	026.831	031.12X2	034.212	036.0914	036.5122	041.01X0	041.1425	046.93
O10.22	026.832	031.12X3	035.0XX0	036.0915	036.5123	041.01X1	041.1429	048.0
O10.311	026.833	031.12X4	035.0XX1	036.0919	036.5124	041.01X2	041.1430	066.6
O10.312	030.001	031.12X5	035.0XX2	036.0920	036.5125	041.01X3	041.1431	067.0
O10.313	030.002	031.12X9	035.0XX3	036.0921	036.5129	041.01X4	041.1432	067.8
O10.32	030.003	031.13X0	035.0XX4	036.0922	036.5130	041.01X5	041.1433	067.9
O10.411	030.011	031.13X1	035.0XX5	036.0923	036.5131	041.01X9	041.1434	068
O10.412	030.012	031.13X2	035.0XX9	036.0924	036.5132	041.02X0	041.1435	069.0XX0
O10.413	030.013	031.13X3	035.1XX0	036.0925	036.5133	041.02X1	041.1439	069.0XX1
O10.42	030.031	031.13X4	035.1XX1	036.0929	036.5134	041.02X2	042.011	069.0XX2
O10.43	030.032	031.13X5	035.1XX2	036.0930	036.5135	041.02X3	042.012	069.0XX3
O10.911	030.033	031.13X9	035.1XX3	036.0931	036.5139	041.02X4	042.013	069.0XX4
O10.912	030.041	031.21X0	035.1XX4	036.0932	036.5910	041.02X5	042.02	069.0XX5
O10.913	030.042	031.21X1	035.1XX5	036.0933	036.5911	041.02X9	042.111	069.0XX9
O10.92	030.043	031.21X2	035.1XX9	036.0934	036.5912	041.03X0	042.112	069.4XX0

Restricted

Jawda Maternal and Perinatal Care Quality Performance Indicators

011.1	030.091	031.21X3	035.3XX0	036.0935	036.5913	041.03X1	042.113	069.4XX1
011.2	030.092	031.21X4	035.3XX1	036.0939	036.5914	041.03X2	042.12	069.4XX2
011.3	030.093	031.21X5	035.3XX2	036.1110	036.5915	041.03X3	042.911	069.4XX3
011.4	030.101	031.21X9	035.3XX3	036.1111	036.5919	041.03X4	042.912	069.4XX4
013.1	030.102	031.22X0	035.3XX4	036.1112	036.5920	041.03X5	042.913	069.4XX5
013.2	030.103	031.22X1	035.3XX5	036.1113	036.5921	041.03X9	042.92	069.4XX9
013.3	030.111	031.22X2	035.3XX9	036.1114	036.5922	041.1010	043.011	071.02
013.4	030.112	031.22X3	035.4XX0	036.1115	036.5923	041.1011	043.012	071.03
014.02	030.113	031.22X4	035.4XX1	036.1119	036.5924	041.1012	043.013	076
014.03	030.121	031.22X5	035.4XX2	036.1120	036.5925	041.1013	043.212	098.72
014.04	030.122	031.22X9	035.4XX3	036.1121	036.5929	041.1014	043.213	099.111
014.12	030.123	031.23X0	035.4XX4	036.1122	036.5930	041.1015	043.222	099.112
014.13	030.131	031.23X1	035.4XX5	036.1123	036.5931	041.1019	043.223	099.113
014.14	030.132	031.23X2	035.4XX9	036.1124	036.5932	041.1020	043.232	099.12
014.22	030.133	031.23X3	035.5XX0	036.1125	036.5933	041.1021	043.233	099.13
014.23	030.191	031.23X4	035.5XX1	036.1129	036.5934	041.1022	044.01	099.411
014.24	030.192	031.23X5	035.5XX2	036.1130	036.5935	041.1023	044.02	099.412
014.92	030.193	031.23X9	035.5XX3	036.1131	036.5939	041.1024	044.03	099.413
014.93	030.201	031.31X0	035.5XX4	036.1132	036.8120	041.1025	044.11	099.42
014.94	030.202	031.31X1	035.5XX5	036.1133	036.8121	041.1029	044.12	099.43
015.02	030.203	031.31X2	035.5XX9	036.1134	036.8122	041.1030	044.13	099.810
015.03	030.211	031.31X3	035.6XX0	036.1135	036.8123	041.1031	044.23	099.814
015.1	030.212	031.31X4	035.6XX1	036.1139	036.8124	041.1032	044.33	099.815
015.2	030.213	031.31X5	035.6XX2	036.1910	036.8125	041.1033	044.43	Z21
016.1	030.221	031.31X9	035.6XX3	036.1911	036.8129	041.1034	044.53	Z37.1
016.2	030.222	031.32X0	035.6XX4	036.1912	036.8130	041.1035	045.001	Z79.01
016.3	030.223	031.32X1	035.6XX5	036.1913	036.8131	041.1039	045.002	
016.4	030.231	031.32X2	035.6XX9	036.1914	036.8132	041.1210	045.003	
024.011	030.232	031.32X3	035.8XX0	036.1915	036.8133	041.1211	045.011	
024.012	030.233	031.32X4	035.8XX1	036.1919	036.8134	041.1212	045.012	

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

030.001	030.132	030.823	031.13X2	031.8X14	032.2XX9	036.4XX1	060.14X9	064.8XX0
030.002	030.133	030.829	031.13X3	031.8X15	032.3XX0	036.4XX2	063.2	064.8XX1
030.003	030.139	030.831	031.13X4	031.8X19	032.3XX1	036.4XX3	064.0XX0	064.8XX2
030.009	030.191	030.832	031.13X5	031.8X20	032.3XX2	036.4XX4	064.0XX1	064.8XX3
030.011	030.192	030.833	031.13X9	031.8X21	032.3XX3	036.4XX5	064.0XX2	064.8XX4
030.012	030.193	030.839	031.20X0	031.8X22	032.3XX4	036.4XX9	064.0XX3	064.8XX5
030.013	030.199	030.891	031.20X1	031.8X23	032.3XX5	044.03	064.0XX4	064.8XX9
030.019	030.201	030.892	031.20X2	031.8X24	032.3XX9	044.13	064.0XX5	064.9XX0
030.021	030.202	030.893	031.20X3	031.8X25	032.4XX0	044.23	064.0XX9	064.9XX1
030.022	030.203	030.899	031.20X4	031.8X29	032.4XX1	044.33	064.1XX0	064.9XX2
030.023	030.209	030.90	031.20X5	031.8X30	032.4XX2	060.10X0	064.1XX1	064.9XX3

Jawda Maternal and Perinatal Care Quality Performance Indicators

030.029	030.211	030.91	031.20X9	031.8X31	032.4XX3	060.10X1	064.1XX2	064.9XX4
030.031	030.212	030.92	031.21X0	031.8X32	032.4XX4	060.10X2	064.1XX3	064.9XX5
030.032	030.213	030.93	031.21X1	031.8X33	032.4XX5	060.10X3	064.1XX4	064.9XX9
030.033	030.219	031.10X0	031.21X2	031.8X34	032.4XX9	060.10X4	064.1XX5	066.1
030.039	030.221	031.10X1	031.21X3	031.8X35	032.6XX0	060.10X5	064.1XX9	066.6
030.041	030.222	031.10X2	031.21X4	031.8X39	032.6XX1	060.10X9	064.2XX0	Z37.1
030.042	030.223	031.10X3	031.21X5	031.8X90	032.6XX2	060.12X0	064.2XX1	Z37.2
030.043	030.229	031.10X4	031.21X9	031.8X91	032.6XX3	060.12X1	064.2XX2	Z37.3
030.049	030.231	031.10X5	031.22X0	031.8X92	032.6XX4	060.12X2	064.2XX3	Z37.4
030.091	030.232	031.10X9	031.22X1	031.8X93	032.6XX5	060.12X3	064.2XX4	Z37.50
030.092	030.233	031.11X0	031.22X2	031.8X94	032.6XX9	060.12X4	064.2XX5	Z37.51
030.093	030.239	031.11X1	031.22X3	031.8X95	032.8XX0	060.12X5	064.2XX9	Z37.52
030.099	030.291	031.11X2	031.22X4	031.8X99	032.8XX1	060.12X9	064.3XX0	Z37.53
030.101	030.292	031.11X3	031.22X5	032.1XX0	032.8XX2	060.13X0	064.3XX1	Z37.54
030.102	030.293	031.11X4	031.22X9	032.1XX1	032.8XX3	060.13X1	064.3XX2	Z37.59
030.103	030.299	031.11X5	031.23X0	032.1XX2	032.8XX4	060.13X2	064.3XX3	Z37.60
030.109	030.801	031.11X9	031.23X1	032.1XX3	032.8XX5	060.13X3	064.3XX4	Z37.61
030.111	030.802	031.12X0	031.23X2	032.1XX4	032.8XX9	060.13X4	064.3XX5	Z37.62
030.112	030.803	031.12X1	031.23X3	032.1XX5	032.9XX0	060.13X5	064.3XX9	Z37.63
030.113	030.809	031.12X2	031.23X4	032.1XX9	032.9XX1	060.13X9	064.4XX0	Z37.64
030.119	030.811	031.12X3	031.23X5	032.2XX0	032.9XX2	060.14X0	064.4XX1	Z37.69
030.121	030.812	031.12X4	031.23X9	032.2XX1	032.9XX3	060.14X1	064.4XX2	Z37.7
030.122	030.813	031.12X5	031.8X10	032.2XX2	032.9XX4	060.14X2	064.4XX3	
030.123	030.819	031.12X9	031.8X11	032.2XX3	032.9XX5	060.14X3	064.4XX4	
030.129	030.821	031.13X0	031.8X12	032.2XX4	032.9XX9	060.14X4	064.4XX5	
030.131	030.822	031.13X1	031.8X13	032.2XX5	036.4XX0	060.14X5	064.4XX9	

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 bipterin cofactor biosynthesis
11		Defects of bipterin 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 V6

KPI #	Changes
MPC001	Removed Numerator Inclusion Added CPT codes where appropriate
MPC002	Denominator exclusion: Added and Appendix A for Principal <u>and secondary diagnosis</u> codes for conditions possibly justifying elective delivery prior to 39 weeks gestation
MPC003	- In Denominator exclusion: - Birth before arrival (BBA) to the hospital - Miscarriages (ICD-10 CM codes not limited to: 002.1, 003.39, 003.4, 003.89, 003.9, 020.0) - Babies with shoulder dystocia - Added codes wherever applicable
MPC004	- In Denominator exclusion: - Birth before arrival (BBA) to the hospital - Miscarriages (ICD-10 CM codes not limited to: 002.1, 003.39, 003.4, 003.89, 003.9, 020.0) - Added codes wherever applicable
MPC005	- Denominator: added "at least" one previous caesarean section. - In Denominator exclusion: Added Appendix B for abnormal presentation, fetal death, or multiple gestation
MPC006	- Removed "2000ml" in the title - Denominator exclusion: added Miscarriages (ICD-10 CM codes not limited to: 002.1, 003.39, 003.4, 003.89, 003.9, 020.0) - Added codes wherever applicable - Revise numerator and guidance Numerator: Number of women with postpartum hemorrhage within 24 hours after delivery. Report Separately: >2000 ml, severe PPH >1000–2000 ml, moderate PPH > 500-1000 ml, minor PPH ICD10CM Codes to bleeding after delivery (not limited to): 072.0, 072.1, 072.2, 044.13, 044.33, 044.53
MPC008	Removed Numerator Exclusions: None
MPC009	Removed Numerator Exclusions: None
MPC011	Numerator: added "without a hysterotomy" Added denominator exclusion: 034.218
MPC012	Numerator: added "without a hysterotomy" Added denominator exclusion: 034.218
MPC015	- Numerator: Revised weeks of gestation to "22" weeks, instead of 24 - Added international reference
MPC016	- Numerator: Revised weeks of gestation to "22" weeks, instead of 24 - Numerator Exclusions: - bulleted down the birth weight - added: Exclude patients 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 - Added international reference
MPC018	- Numerator: Revised weeks of gestation to "22" weeks, instead of 24 - Numerator Exclusions: Restricted

Jawda Maternal and Perinatal Care Quality Performance Indicators

	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

Summary of Changes 2025 V6.1

KPI #	Changes
MPC002	Removed Gestational Age ICD-10 Z3A.39

Summary of Changes 2025 V6.2

KPI #	Changes
MPC005	Denominator: added the word “one”, history of one previous caesarean section.
MPC011	Corrected Denominator Exclusion: Removed the letter “S” - 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)
MPC018	Numerator Exclusion: Typo correction from $\leq 500\text{gm}$ to $<500\text{gm}$
MPC020	Specified the surgical procedures / surgical discharges to be “Elective”
MPC022	Definition: The word unplanned is replaced by unexpected. Numerator: - Removed “without a prior plan documented more than twenty-four hours of NICU admission.” Denominator Inclusion: Removed -Term (37+0 to 41+6 weeks gestation), non-anomalous singleton babies and included the same in the Denominator definition as- All term (37+0 to 41+6 weeks gestation), non-anomalous singleton. Denominator Exclusion: Definition of unbooked mothers is added.
MPC023	Split the numerator: Report separately - Unplanned cesarean section deliveries - Planned cesarean section deliveries
MPC025	Added denominator exclusion: - Newborns who died within 24hrs
MPC026	Denominator Exclusion: - Modified “Newborns who died within 24hrs prior to admission to NICU/SCBU” to “Newborns who died within 24hrs”
MPC027	Denominator Exclusion: Restricted

Jawda Maternal and Perinatal Care Quality Performance Indicators

	- Replaced “Newborns who died within 24 hours of birth” to “Newborns who were discharged with deceased disposition.” - Added: Newborns transferred to another facility within 24 hours of admission due to the need for a higher level of care.
MPC028	Denominator Exclusion: - Added: Newborns transferred to another facility within 24 hours of admission due to the need for a higher level of care.
MPC032	Denominator: Added “or newborns being cared for” Denominator Exclusion: Added -Critically ill babies that are transferred out to another hospital within 24 hours.
MPC033	Numerator: Categorized the numerator into three by adding: - Within the first 24 hours of birth - After 48 hours of birth
MPC034	Removed the KPI