



## On Demand Expert to Expert 2025 Reporting Year Annual Updates for ePC-01, ePC-05, and ePC-06 eQMs

Recorded: August 2024

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Welcome to our On Demand. Expert to Expert Webinar 2025 Reporting Year Annual updates for ePC-01 Elective Delivery ePC-05, Exclusive Human Milk Feeding and ePC-06, Unexpected Complications in Term newborns. I'm Susan Funk, an Associate Project Director with the Engagement on Quality Improvement team, and today I'll be serving as this webinar's facilitator. Thank you for joining us. CE Credit is available for this On-Demand webinar for six weeks following its release. We encourage healthcare organizations to share the link to this recording and the slides with their staff and colleagues. There is no limit on how many staff can take advantage of this educational webinar.

Before we start, we'd like to offer just a few tips about the webinar platform functionality. Use your computer speakers or headphones to listen, feedback or dropped audio are common for streaming video. Refresh your screen if this occurs. You can pause the playback at any time. You can return and replay the video by using the same access link from your registration email. We have captioned this recording and the slides are designed to follow Americans with Disabilities Act rules. Before we get started covering today's electronic Clinical Quality Measure content, we do want to explain that this webinar is highly technical and requires a baseline understanding of eQm logic and concepts. Participant feedback from previous webinars indicated that the content is often too technical for individuals that are new to eQMs. We recommend that anyone new to eQMs visit the eCQI Resource Center at the hyperlink provided on this slide. You will find a collection of resources to help you get started with eQMs.

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The slides are available now within the viewing platform. On the left side of your navigation pan, select the document icon. A new pop-up window will open and you can select the name of the file. A new browser window will open and from it you can download or print the PDF of the slides. The slides are also currently available on the Joint Commission's website and will remain posted after the CE period expires. We've provided the link at the bottom of this screen. One last note about the slides. The links within the webinar video are not clickable on screen. However, if you download the slides, all the links provided during the webinar are functional.

This webinar is approved for 1.5 continuing education credits or qualifying education hours for the following organizations; Accreditation Council for Continuing Medical Education, American Nurses Credentialing Center, American College of Healthcare Executives and the California Board of Registered Nursing. Participants receive a certificate after completing the webinar and survey. Although we've listed the organizations that accredit Joint Commission to provide CEs, many other professional societies and state boards that are not listed accept credits or will match credit from Joint Commission's educational courses. To earn CE credit, participants must individually register for this recorded webinar, participate for the entire recorded webinar and complete a post-program



evaluation and attestation survey. For more information on The Joint Commission's continuing education policies, visit the link at the bottom of this slide.

Just a few words about how to navigate to the CE survey and obtain your CE certificate. You will receive the CE certificate in two ways. On the last slide, we've included a QR code accessible via most mobile devices. If you miss the QR code, after you finish the recording, you will also receive an automated email that includes the survey link. After you access and submit the online evaluation survey, you will be redirected to a link from which you can print or download and save a CE certificate. In case you miss the pop-up screen with the certificate, an automated email will also deliver the certificate link.

The participant learning objectives for this webinar are: Locate measure specifications, Value Sets, measure flow diagrams and Technical Release Notes on the Joint Commission's website. Facilitate their organization's implementation of PC-01, -05 and -06 eCQM annual updates for the 2025 calendar year and utilize answers regarding common issues and questions regarding PC-01, -05 and -06 eCQMs to inform 2025 eCQM use and implementation. This webinar does not cover these topics; basic eCQM concepts, topics related to chart abstracted measures, process improvement efforts related to these measures and eCQM validation. I'd like to introduce today's presenters.

These staff and speakers have disclosed that they do not have any conflicts of interest. For example, financial arrangements, affiliations with or ownership of organizations that provide grants, consultancies, honoraria, travel, or other benefits that would impact the presentation of today's webinar content. Myself, Susan Funk, Associate Project Director, Engagement in Quality Improvement Programs, Melissa Breth, Associate Project Director, Clinical Quality Informatics, Raquel Belarmino, Associate Project Director, Clinical Quality Informatics, and Kelley Franklin, Associate Project Director, Clinical Quality Measures.

The agenda for today's discussion follows: Highlight how to access eCQM resources on the Joint Commission's website, review the measure flow and algorithm, review the PC-01, -05 and -06 eCQMs annual updates for the Reporting Year 2025, and finally, review frequently asked questions. Next, Melissa will explain how to locate helpful documents on the Joint Commission's Electronic Clinical Quality Measures. Melissa, please take it away.

(00:06:27):

Thank you, Susan. This is Melissa Breath Associate project director for Clinical Quality Informatics and measure lead for PC maternal EC eCQMs. To find helpful documents for eCQMs, navigate to The Joint Commission or TJC website@[www.jointcommission.org](http://www.jointcommission.org) and in the blue banner towards the top of the screen, click on the word measurement. Then the window will change below that banner and you will see words listed down the left hand side of the screen. From that list, select specification manuals and a gray panel will slide in from the right from that panel, select the words electronic clinical quality measures on the TJC electronic clinical quality measures webpage, a slightly shaded box for each of the current and recent past reporting periods are found towards the bottom of the page. Click within the desired reporting periods box to expand it and find a list of hyperlinks to download the EQM specifications, measure flows, value sets, technical release notes, and if applicable, known issues log for all the related reporting year when the QM value sets hyperlink is selected.

The first document listed in the downloaded folder is the download VS expansion XML education, PDF file. That document is a handy reference guide that walks through how to download Value Set codes for the current Reporting Year. Please note that the spreadsheets contained in the downloaded folder provide all the Value Sets for each measure along with the expansion version and Steward information needed to look up and find the codes contained within each Value Set in the Value Set Authority Center or VSAC. The VSAC requires a free login with a UMLS license or account. For more information on these available documents, go to the navigation recording or find the link on the additional resources page towards the end of the presentation slides. Next up, Kelley will kick off our discussion on ePC-01, Elective Delivery.

(00:08:47):

Thank you, Melissa. I'm Kelley Franklin, I'm an Associate Project Director for Clinical Quality Measures and I'm the clinical lead for the perinatal measures. ePC-01 is elective delivery. PC-01 elective delivery is a measure that looks at elective vaginal or cesarean deliveries that occur at greater than or equal to 37 weeks and less than 39 weeks gestation. The intent of the measure is to avoid elective vaginal deliveries or cesarean births prior to 39 weeks unless there is a medical indication for early delivery. Compared to spontaneous labor, elective inductions result in more cesarean births and longer maternal lengths of stay. Repeat elective cesarean births before 39 weeks gestation also result in higher rates of adverse respiratory outcomes, mechanical ventilation, sepsis and hypoglycemia for the newborn.

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Early elective deliveries can result in significant short-term neonatal morbidity. The focus on efforts to reduce the early elective deliveries headless led to quality improvement activities and changes in practice resulting in significant reductions in births at 37 and 38 weeks. MS retired. The measure effective 2024 citing that the measure has topped out the national rate for calendar year 2022 was about 2.2%. It remains optional for The Joint Commission for accreditation. PCO one allows for hospitals to establish baseline performance rates and monitor their quality improvement efforts for effectiveness. For this measure, the lower the Numerator rate the better. However, this rate is not expected to consistently reach 0% as every conceivable justification for an elective delivery is not able to be accounted for.

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The codes used to exclude cases from the Denominator are selected with guidance from ACOG's committee opinion for medically indicated late, preterm or early term delivery. As stated previously, the PC-01 rate is not expected to consistently reach 0% as every conceivable justification for elective delivery is not able to be accounted for. Part of this reason is that not all conditions have codes which are specific enough to include the conditions as an exclusion. For example, the range of severity of the condition, which indicates the medical justification for early delivery is not able to be determined in the codes. Conditions that would be included in the code may range from mild to severe in which only the severe conditions would indicate a medical justification. Also, some conditions are rare and should not greatly impact the hospital rate. The Technical Advisory Panel or TAP, concluded that approximately 98% of the total number of medical indications were included.

The measure description for PC-01 is patients with elective vaginal deliveries or elective cesarean births at greater than or equal to 37 and less than 39 weeks of gestation completed. Please note that there are no changes to the population descriptions this year. The Initial Population is Inpatient Hospitalized Patients Aged Greater Than or Equal to Eight Years and Less Than 65, admitted to the hospital for inpatient acute care that undergo a delivery procedure with a discharge date that ends during the measurement period. The Denominator is inpatient hospitalizations for patients delivering newborns with greater than or equal to 37 and less than 39 weeks of gestation completed. The Denominator Exclusion is inpatient hospitalizations for patients with conditions possibly justifying elective delivery prior to 39 weeks gestation, and the Numerator reads inpatient hospitalizations for patients with elective deliveries by either medical induction of labor while not in labor prior to the induction or cesarean birth while not in labor and with no history of a prior uterine surgery.

Now, we will summarize the major measure changes for 2025. Please note throughout this presentation that the star in a circle icon on the left side of the slide will denote changes for this Reporting Year where new content will be underlined while stricken text denotes removed content. For Reporting Year 2025, all references from NQF have been changed to CBE to identify the Consensus Based Entity role and the endorsement information has been updated to not applicable since TJC will no longer maintain consensus based entity endorsement for optional measures. CBE endorsement efforts will be focused on eQMs. The measure will continue to be maintained and monitored for measure performance. This year, the second of three approaches to determine gestational age, that Estimated Gestational Age or EGA is obtained from a discreet field in the electronic health record that may be captured 24 hours or less prior to delivery and ending before midnight on the same day as the delivery. We recognize that some precipitous deliveries do not allow time to document the EGA before delivery. Melissa will now review the technical aspects of ePC-01.

Thank you, Kelley. I will present technical changes to the measure listed on this and the following tables. The first labor function was added to the logic to select the first labor assessment that occurs during the delivery encounter to better align with measure intent when multiple labor assessments are available. This function was also used to update the definitions for cesarean birth procedure while not in labor, delivery encounter with cesarean birth without labor or history of uterine surgery and delivery encounter with medical induction started while not in labor to align with measure intent comparing event timing to the first labor assessed. Value Set Payer was renamed to Payer Type to more accurately reflect the contents and intent of the Value Set. There were multiple changes based on terminology updates for this year. Please see the eCQM Value Set 2025 Reporting Year period and Technical Release Notes on the TJC eCQM webpage for more details. And to distinguish libraries specifically used for measures designed to use with the quality data model or QDM versus the fast healthcare interoperability resources FHIR information model. The letters QDM have been added to the MAT Global common functions QDM library and the PCMaternal QDM library.

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The Global.Inpatient Encounter definition was added since the Length of Stay requirement was removed from the global common library to better align with measure intent and logic. Here we see how it is utilized in the PCMaternal.encounter with age range definition for 2025. In addition, day of timing was removed from the Initial Population to align date time precision of Numerator and Denominator, which fixed a known issue with the measure. Let's review the measure flow diagram

for ePC-01. Measure flow diagrams provide high level overview of the algorithm flows. While the measure specifications are the source of truth, the measure flow diagrams can be helpful to understand the main concepts. We start with determining the Initial Population, which is delivery encounter with age range. Three conditions must be met to meet this definition. One, an inpatient encounter must be present. Two, the patient must be greater than or equal to eight and less than 65 years of age and three, there must be a procedure code from the delivery procedure Value Set with a start date during the hospitalization encounter. If all the criteria is met, the patient is in the Initial Population and the processing proceeds to the Denominator. If any of the criteria is not present, the patient is not in the Initial Population and processing ends.

Next in the flow is the Denominator for ePC-01 that has three different approaches to evaluate gestational age. First is the calculated gestational age, greater than or equal to 37 weeks and less than 39 weeks. The second is the Estimated Gestational Age. If the calculated gestational age is null, the estimated gestational is the next preferred method in the hierarchy to determine gestational age. The third and last way to determine gestational age is based on ICD-10 or SNOMED codes. This is the lowest in the hierarchy. Calculated and Estimated Gestational Age must be null to invoke this logic. If for each of the three decision points, criteria is not met, processing ends and the case is not in the measure. If criteria is met, the case is included in the Denominator.

Next, in the process flow, Denominator Exclusions are determined. The logic will evaluate for inpatient hospitalizations for patients with conditions that could possibly justify elective delivery prior to 39 weeks gestation such as stillbirth or history of stillbirth. If a patient has any of the conditions to possibly justify elective delivery prior to 39 weeks gestation, follow the algorithm to yes, the patient is then excluded from the Denominator and the processing ends for that patient. If the patient does not have any of these conditions, you will follow the algorithm to no and that logic proceeds to the Numerator evaluation. To determine the Numerator, the logic will evaluate if the patient had an elective cesarean birth. If yes, was the patient in labor for 24 hours or less prior to the C-section or the patient has a history of uterine surgery. The patient is not included in the Numerator and the process ends there. Whereas if the patient had a C-section but was not in labor for 24 hours or has a history of uterine surgery, then the patient is included in the Numerator. If the patient did not have a C-section, was not medically induced or induced 24 hours or less prior to labor starting, then the patient is not included in the Numerator. However, a patient that did not have a C-section and was medically induced 24 hours or less prior to labor starting meets criteria and is included in the Numerator.

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At the bottom of the flow diagram document, you will find the formula for the overall performance rate. The Numerator A is divided by the Denominator B minus the Denominator exclusions C. Next we will review the logic. The main Initial Population definition is delivery encounter with age range, which is stored in the PC maternal QDM library. This definition identifies patients with a qualifying delivery procedure During the HospitalizationWithObservation Recall that HospitalizationWithObservation function returns the total interval from the start of the immediately prior emergency department visit or OB triage visit through the observation visit to the discharge of the given encounter. Note that day of was removed to align datetime precision of Numerator and Denominator, which fixes a known issue. This definition calls a definition called encounter with age range, which is also stored in the PC maternal QDM library. Since the length of stay requirement was removed from the global common library, the global inpatient encounter definition has been added and utilized here. Please recall that

the star in a circle icon denotes new content along with underlined text, while stricken text denotes removed content for this reporting year.

Let's move on to the Denominator. The Denominator definition is delivery encounter near term. Three definitions are unioned here to reflect the three approaches to determining gestational age greater than or equal to 37 weeks and less than 39 weeks. The calculated gestational age, the Estimated Gestational Age and gestational age based on coding. Let's start with the first definition in the union statement delivery encounter with calculated gestational age greater than or equal to 37 weeks and less than 39 weeks. This definition calls the Calculated Gestational Age Function. This function was introduced four years ago and is stored in the PCMaternal QDM library. It calculates the gestational age based on ACOG's revitalized definition. The function calculates the difference in days between the time of delivery and the estimated delivery date, subtracts that from 280 and divides by seven. We will talk about the included functions in the next couple of slides.

Let's talk about the last time a delivery function. This function's purpose is to gather all assessments that document delivery, date, time, sort these items by relevant date time that the assessment was performed and identify the last assessment. It then stores the result of the assessment as the last time a delivery. There are no changes to this function this year. Next, we'll discuss the last estimated delivery date function, which identifies the last time the estimated delivery date or due date was assessed 42 weeks or less prior to or on delivery and stores the result of that assessment. This yields a result as date time so that the result is stored as a date. Clinically, a woman's due date is reported as date only. However, the QDM or quality data model does not support date only, so we must store the result as date time. The time will be populated as midnight or 0 0 0 if not submitted by the hospital. Now that we have defined the last time of delivery and the last estimated delivery date, we can plug those values to the equation to arrive at the calculated gestational age. Then the logic determines if the calculated gestational age is greater than or equal to 37 and less than 39.

Melissa, I have a question.

Oh, okay. Yes,

Thank you. Hi, everyone. I am Raquel, bill Armino from the eClinical team. Can you repeat that calculation?

(00:25:03):

Sure Raquel, subtract the reference date for this measure, the actual delivery date or estimated delivery date, which is more commonly referred to as the due date, then subtract that result from 280 days, which is seven days per week, four weeks per month, and 10 months of pregnancy and divide by seven, does that help?

Yes, it does. Thanks, Melissa.



Now this definition, PCMaternal.Variable Calculated Gestational Age establishes a variable of CGA, Calculated Gestational Age. CGA is a supplemental data element that stores the calculated result from the calculated gestational age function. The data element enables capturing and saving the CGA for data analysis post data receipt, so hospitals do not need to submit any additional data to comply. This other definition calls the PCMaternal.Variable Calculated Gestational Age. This logic was necessary since the measure authoring tools measure packager does not allow library definitions to be supplemental data elements. Let's turn our attention to the second definition of the union statement, Delivery Encounter with Estimated Gestational Age Greater Than or Equal to 37 Weeks and Less Than 39 Weeks. This definition calls the calculated gestational age function that we just covered to determine if the CGA is null. Then it calls the last Estimated Gestational Age function from the PCMaternal library.

The last Estimated Gestational Age function is constructed similarly to the last EDD and the last time of delivery functions that we discussed a moment ago. This function's purpose is to gather all assessments that document the patient's Estimated Gestational Age 24 hours or less before the last time of delivery or, and this is new for this Reporting Year, on the same day as last time of delivery. Sort these assessments by the relevant date, time, and identify the last assessment. It then stores the result of that assessment as a quantity representing estimated weeks gestation. Note that the EGA assessments relevant date time must be 24 hours or less before or on the last time of delivery and now includes the same day as the last time of delivery up until before midnight. This is to capture when staff need to catch up on their documentation after a precipitous delivery.

The third definition of the union statement is Delivery Encounter with Gestational Age Greater Than or Equal to 37 Weeks and Less Than 39 Weeks Based on Coding. This provides more flexibility for hospitals to identify patients with the desired gestational age based on coding. If the calculated gestational age is null and the Estimated Gestational Age is null, then the diagnoses codes are evaluated. So circling back to the highest level Denominator definition, we union the calculated gestational age, the Estimated Gestational Age and the gestational age based on coding definitions to identify delivery encounters greater than or equal to 37 weeks.

So Melissa, in simpler terms, how do you know when the logic will move on to the next option to capture the gestational age? Well, first, the logic looks to calculate the gestational age.

Well, first, the logic looks to calculate the gestational age. If the due date or estimated due date is not documented in the EHR, the logic moves to the Estimated Gestational Age, EGA. The EGA must be documented in a discreet and codified field of the EHR. If neither the due date nor the EGA are present, then the logic looks for the gestational age based on coding, does that help?

Yes. Thank you.

Next, we move on to our Denominator Exclusions, which are inpatient hospitalizations for patients with conditions possibly justifying elective delivery prior to 39 weeks gestation. Examples of such conditions include HIV, preeclampsia, gestational hypertension, and gestational diabetes. There are no changes to this population this year. To review, the diagnosis data type is used to determine if a patient has a diagnosis code in the conditions possibly justifying elective delivery prior to 39 weeks

gestation Value Set, which overlaps the hospitalization with ED, OB triage observation encounter. This means that the condition can be present prior to the encounter. The union operator is stated and in the second condition, the logic is looking for an inpatient encounter that has a diagnosis in the same Value Set. This portion evaluates encounter performed data types attribute of diagnosis. Timing does not need to be specified when using the encounter performed data type with the diagnosis attribute. The diagnosis is already tied to the current encounter. Therefore, the Denominator Exclusion is looking for delivery encounters with either one of two data types containing codes in the conditions possibly justifying elective delivery prior to 39 weeks gestation Value Set.

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Lastly, our Numerator includes patients with elective deliveries by either medical induction of labor while not in labor prior to the procedure or cesarean birth while not in labor and with no history of a prior uterine surgery. Note that PC-01 is an inverted measure. In other words, a lower calculated performance rate indicates better clinical care, so the last patients in the Numerator improves the performance rate. Let's start with the first definition in the union statement. Delivery Encounter with Medical Induction Started While Not in Labor. This definition is looking for either an induction by a procedure such as artificial rupture of membranes or by medication such as oxytocin that was started 24 hours or less before labor. The medication and procedure Value Sets are in one definition which simplifies the logic. Now, there are two timing relationships to consider in this definition. First, the logic is looking for labor assessed during the hospitalization encounter.

We recognize the possible presence of multiple labor times in some EHR systems, so the first labor function has been added to this Reporting Year to select the first labor assessment that occurs during the delivery encounter to better align with measure intent. For the second timing relationship, the logic also looks for the induction starting 24 hours or less before labor. Onto the second definition of the union statement for the Numerator, which is Delivery Encounter with Cesarean Birth without Labor or History of Uterine Surgery. This definition previously had three conditions expressed by with and without clauses. For this Reporting Year, the first condition that addresses cesarean birth procedure occurring during the delivery encounter was added to the cesarean birth procedure while not in labor definition, so it is no longer needed here. Notice that the measure intent and logic outcome have not changed for Reporting Year 2025. What we have done is reconstruct definitions to include the new first labor function in the cesarean birth procedure while not in labor definition. The rest of the logic looks for uterine procedure and diagnosis codes to be present prior to the start of the hospitalization, which ensures the patient has a history of these procedures or diagnoses.

Let's look at the first condition's definition in greater detail, cesarean birth procedure while not in labor. This definition previously called in another definition In Labor, which was very simple definition that looked for any assessment of labor. However, it is possible to have multiple assessments of labor documented in the delivery encounter, so we use the FirstLabor function to only consider the first assessment of labor. The backup to the cesarean birth procedure while not in labor definition, we use the procedure performed data type to determine if a patient had a cesarean birth in this encounter. Where not, a first labor assessment occurred nor labor started 24 hours or less before the start of the cesarean birth or first time labor is null. This is where the first with condition was removed on the previous slide.



Let's return to the second definition of the union statement, delivery encounter with cesarean birth without labor or history of uterine surgery. The logic looks for uterine procedure or diagnosis code to be present prior to the start of the hospitalization, which ensures the patient has a history of these procedures or diagnoses. The second condition is without uterine surgery procedure where it combines all the surgical procedures listed into one list. We take the list of cesarean births while not in labor that we just described, and now, we want to ensure that they are without history of prior uterine surgery. If any of these procedures are present in the EHR and we have a start date prior to the start of this encounter, the patient will not be in the Numerator. Remember that this is an inverted measure. In other words, a lower calculated performance rate indicates better clinical care, so removing these procedures from the Numerator improves the performance rate. The third condition is without uterine surgery diagnosis where it combines all these diagnoses into one list. We take the list of cesarean births while not in labor and without history of uterine surgery that we just described, and now we want to ensure that they are without history of prior uterine diagnosis so that if any of these diagnosis codes are present in the EHR, the patient will not be included in the Numerator and the diagnosis prevalence period must start before the hospitalization, which refers to the history of diagnosis.

To sum up the Numerator, the two definitions just described are unioned with the main definition for the Numerator. I now turn the presentation over to Kelly and Raquel to cover EPC five.

Thank you Melissa, ePC-05 is Exclusive Human Milk Feeding. Let's review the rationale for ePC-05. Exclusive human milk feeding for the first six months of life is recommended by many health organizations such as the American Academy of Pediatrics and the Department of Health and Human Services. There are documented health benefits for both infants and mothers including a decreased risk of diabetes. Increasing the rates of exclusive human milk feeding has long been a goal by the World Health Organization, CDC and the Healthy People Initiative. We continue to see room for improvement in exclusive human milk feeding rates. The average national rate was approximately 56% for calendar year 2022. Due to the limited exclusion criteria and support for maternal feeding choice, the measure is not expected to reach a hundred percent. A 70% threshold is a more reasonable target, which has been reached by organizations. CMS has retired ePC-05 for calendar year 2024. The Joint Commission continues to support exclusive human milk feeding for this first six months of life.

Take a quick overview of the populations for the ePC-05 measure on this table. The Initial Population, it's inpatient hospitalizations for single newborns born in the hospital with a discharge date during the measurement period with either the following conditions, an Estimated Gestational Age at birth of greater than or equals to 37 weeks or a birth weight greater than or equal to 3000 grams when Estimated Gestational Age is not available. Data shows that most newborns with gestational age 37 weeks or more have a birth weight 3000 grams or more. Birth weight 3000 grams or more is a proxy to capture term newborns without gestational age recorded in the EHR system. The Denominator equals the inpatient population. The Denominator Exclusion criteria is inpatient hospitalizations for newborns who have any of the following conditions; were admitted to the NICU or transferred to a regular Intensive Care Unit, transferred to an acute care facility or other healthcare facility, expired during the hospitalization, has a diagnosis of Galactosemia, received parenteral nutrition, which is captured by procedure or medication codes. The Numerator is inpatient hospitalization for newborns who are fed human milk only since birth. Please note that this includes human donor milk as well.



Now, we will summarize the major measure changes for 2025. Please note throughout this presentation that the star in a circle icon located on the left side of the slide will denote new content with the underlying text. While stricken text denotes removed content. For Reporting Year 2025, all references from NQF have been changed to CBE to identify the consensus based entity role and the endorsement information was updated since TJC is no longer maintaining consensus based entity endorsement for optional measures. CBE endorsement efforts will be focused again on the eCQMs, the measure will continue to be maintained and monitored for measure performance. To remove redundancy, "that ends" was removed from the Initial Population description. Please note that these changes have no impact to the measure outcome. I now turn the presentation over to Raquel to cover the technical aspects of ePC-05.

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Thank you, Kelley. I am Raquel Belarmino, the Measure Lead for ePC-05 and ePC-06. I will now present some of the technical changes to the measure listed on this table. To distinguish libraries specifically used for measures designed for use with the quality data model, QDM versus the fast healthcare interoperability resources, FHIR information model. The letters QDM have been added to the MAT Global common functions QDM library and the PCNewborn QDM library. Value Set Payer was renamed to Payer Type to more accurately reflect the contents and intent of the Value Set. Value Set Breast Milk was renamed to Human Milk and Value Set Dietary Intake Other than Breast Milk was renamed to Dietary Intake Other than Human Milk to more accurately reflect the contents and intent of the Value Set. There were Value Set changes made to the human milk and Galactosemia Value Set for Reporting Year 2025 with addition or deletion of codes. These changes were made based on terminology updates. Please see the eCQM Value Set 2025 reporting period and Technical Release Notes on the TJC eCQM webpage for more details. Please note with this change, there is no impact to the measure outcome.

Let us review the measure flow diagram for ePC-05. As previously mentioned, the TJC measure flow can be found on the TJC electronic Clinical Quality Measures website. The document header will show that this is the measure flow diagram for 2025 and the version number's 13. The description of the measure is provided on the top right corner of the document. Let's start with the Initial Population. The first decision point evaluates single live newborn born in hospital with a discharge date during the measurement period. If patient is not a single live newborn born in the hospital with a discharge date during the measurement period, you will follow the algorithm to know and the patient will not meet the Initial Population and therefore, processing would stop here. If answered yes, then we ask if there is a gestational age at birth greater or equal to 37 weeks. If the answer is yes and the encounter ends during the measurement period, then the patient is in the Initial Population and processing proceeds to the Denominator. If gestational age is not greater or equal to 37 weeks and gestational age is null, the logic evaluates for birth weight greater or equal to 3000 grams. If birth weight is greater or equal to 3000 grams and the encounter ends during the measurement period, then the patient is in the Initial Population and processing proceeds to the Denominator. If the birth weight is not greater or equal to 3000 grams, the patient is not in the Initial Population.

Moving along the algorithm, the patient will meet the Denominator criteria as well, since the Denominator is equal to the Initial Population. Then we move onto the Denominator Exclusion processing. The logic will evaluate for inpatient hospitalizations for newborns who were with any of the following conditions; admitted to the NICU or transferred to a regular Intensive Care Unit, ICU, transferred to an acute care facility or other healthcare facility or expired during the hospitalization. A diagnosis of Galactosemia or receives parental nutrition. If patient does meet any of the conditions, you will follow the algorithm to yes, and the patient will meet the Denominator Exclusion and the processing ends there. If patient does not have any of these conditions, you will follow the algorithm to know and the Numerator logic is evaluated.

Next, let us review the Numerator process. The logic will evaluate for inpatient hospitalizations for newborns who were fed human milk only since birth. If the answer is yes, patient will meet the Numerator and process ends there. If the answer is no, the patient will not be in the Numerator and the process ends there. At the bottom of page two on the flow diagram, you will find the calculations for the overall performance rate. The Numerator is divided by the Denominator minus the Denominator Exclusions. Now that we have completed an overview of the flow diagram, let's look at the measure logic together. We will start by reviewing the Initial Population. The Initial Population definition is Single Live Term Newborn encounter, which is stored in the PCNewborn QDM library. The PCNewborn QDM library stores definitions and functions which are used by both ePC-05 and ePC-06. This Initial Population has two definitions listed and constructed with a union; single live birth encounter with gestational age at 37 weeks or more, union single live birth encounter with birth weight 3000 grams or more without gestational age, Union means or, this means the logic will look to see if the newborn either has a gestational age greater than 37 weeks or more, or birth weight greater or equal to 3000 grams if no Estimated Gestational Age is available.

Let us review the two union definitions within the Initial Population in greater detail. The first union definition is Single Live Birth Encounter with Gestational Age 37 weeks or More. This will evaluate for Single Live Newborns with an Estimated Gestational Age at Birth of Greater or Equal to 37 Weeks. Note that a direct reference code is used to capture gestational age at birth instead of a Value Set. This is because when a concept can be adequately captured with only one code, Value Sets are not to be used and the direct reference code is called directly. The logic uses the earliest of function from the global common library. If both the relevant DateTime, and relevant period are present, we choose the relevant DateTime. If only the relevant period is specified, the starting point of the period is used. Otherwise, the endpoint of the period is used. Within the logic, the definition is calling out the single live birth encounter definition where the encounter diagnosis attribute identifies the Single Live Born Newborn Born in Hospital Value Sets. This will evaluate the newborn status of an inpatient encounter with a diagnosis indicating a single live newborn. This last point indicates that the encounter must end during the day of the measurement period. This way, the logic will evaluate the relevant period earlier in the algorithm.

Next, let's discuss a Frequently Asked Question related to the logic that was just presented. Question, when is the gestational age date/time assessed for the newborn to populate into the Initial Population? Answer, the gestational age is evaluated after the newborn is delivered and can be assessed any time during the inpatient encounter. This is not the time the gestational age value was entered in the EHR system. To capture this, the logic uses the earliest function from the global common library.

Hi, Raquel, this is Melissa again. To clarify, if the gestational age was documented prior to the newborn delivery, the newborn will not meet the Initial Population?

Yes, you are correct, Melissa. We teamed up with some healthcare organizations to investigate struggles with the timing of gestational age documentation. We found that the gestational age was documented prior to the newborn delivery or the gestational age was documented on the mother's record instead of the newborn's record, the gestational age must be documented on the newborn's inpatient encounter at any point of time on the newborn's record to meet the Initial Population.

Does that help?

I understand now. Yes, it does. Thanks.

Next, let us discuss the second union definition for the Initial Population. This is Single Live Birth Encounter with Birth Weight 3000 Grams or More without Gestational Age. The single live birth encounter is called again in this definition. This was discussed on the previous slide. Now we are trying to identify patients who do not have a gestational age on the EHR, so we use similar logic that we discussed on the previous slide as if we are looking for a gestational age and then we add the operator without to capture those newborns without a gestational age. If there is no gestational age, we then evaluate if there is a birth weight greater or equal to 3000 grams during the encounter. Please note this logic uses the first birth weight function. The FirstBirthWeight function is used to capture the first birth weight for newborns with multiple birth weights present. This function will sort the birth weight assessments by relevantDateTime to identify the first assessment of birth weight and the result will be considered the first birth weight.

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As mentioned earlier, the Denominator equals the Initial Population. The definition is simply called Equals Initial Population, so then the Initial Population definition, which is PCNewborn Single Live Term Newborns, becomes the qualifying encounter to continue moving through the measure algorithm. The Denominator Exclusion has two definitions and they are Single Live Term Newborn Encounter with NICU or ICU Admission or Selected Discharge Disposition or Single Live Term Newborn Encounter with Galactosemia or Parenteral Nutrition. The two definitions are joined by a union, which means if the newborn meets either of these conditions, they will be excluded from the Denominator.

We will now review the Denominator Exclusion definitions one at a time. The first definition, Single Live Term Newborn Encounter with NICU or ICU Admission or Selected Discharge Disposition covers the first three Denominator Exclusions admitted to the NICU or transferred to a regular Intensive Care Unit, ICU. As a reminder, the Intensive Care Unit was added as an exclusion in order to capture newborn who was transferred to a general ICU, in addition to the NICUs for special care or temporary stay. This change was based on feedback from hospitals. If you recall earlier, we used Single Live Term Newborn as a qualifying encounter to continue moving through the measure. We used the encounter perform attributes of facility, locations and code to identify a Neonatal Intensive Care Unit or Intensive Care Unit. The other two exclusions this definition covers are; Expired During the Hospitalization, Transferred to an Acute Care Facility or Other Healthcare Facility. We use the

attribute dischargeDisposition to identify patient expired or discharged to an acute care facility or other healthcare facility. Any newborns transferred or discharged to any of these locations will be excluded from the Denominator. For Reporting Year 2025, there were no concept changes made to the Denominator Exclusions from 2024.

The second definition, Single Live Term Newborn Encounter with Galactosemia or Parenteral Nutrition covers the last two Denominator Exclusions of newborn with a diagnosis of Galactosemia or subject to parenteral nutrition. The first portion of the definition will exclude encounters with the newborn receives parental nutrition. The logic will capture this by looking at either a procedure or medication administered indicative of parental nutrition during the encounter. The procedure performed and medication performed data types both have relevantDateTime and relevantPeriod timing attributes. This logic applies the normalized interval function to the parental nutrition collection to assess the timing elements. The second portion we exclude Newborns with Encounter Diagnosis of Galactosemia. Patients with a diagnosis of Galactosemia during the encounter will be excluded from the Denominator. For Reporting Year 2025, there were no concept changes to this definition.

Next, we will discuss the Numerator. The Numerator is Single Live Term Newborns who were fed human milk only since birth. Please recall that the star in the circle icon denotes new content along with the underlying text, while stricken text denotes removed content for this Reporting Year. We start with our qualifying encounter. The logic looks for documentation of human milk feeding that starts during the encounter and uses the human milk Value Set to capture this, the intent of the human milk Value Set is to capture a newborn who receives breast milk. And then we look to see that there was no other dietary intake except human milk. The dietary intake other than human milk Value Sets include substances such as water, formula and glucose. The logic also applies the normalized interval function to the substance administered data type timing attributes to assess either relevantDateTime or relevantPeriod. For Reporting Year 2025, there were no concept changes to this definition besides the Value Set name changes from breast to human, as mentioned earlier on this presentation.

I will now turn the presentation to Kelley to cover the clinical aspects of ePC-06.

Thank you Raquel.

ePC-06 is Unexpected Complications in Term Newborns. Let's review the rationale for ePC-06. ePC-06; Unexpected complications in term newborns assesses the health outcomes of term infants who represent over 90% of all births. This measure addresses the gap related to term newborn measures, engages adverse outcomes resulting in severe or moderate morbidity in otherwise healthy term infants without preexisting conditions. Importantly, this metric also serves as a balancing measure for other maternal measures such as Nulliparous Term Singleton Vertex, or NTSV cesarean rates and early elective delivery rates. The purpose of a balancing measure is to guard against any unanticipated or unintended consequences of quality improvement activities For these measures. This measure is useful for identifying potential quality improvement opportunities. The measure can be categorized into diagnosis buckets such as those on the slide to help facilitate QI projects by understanding the specific drivers behind the rate. The complications are divided into overall, severe and moderate rates. Severe unexpected newborn complications are where most attention should be

focused. However, review of all Numerator cases can help identify QI opportunities for both clinical and coding practices.

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Let's review the measure considerations for ePC-06. ePC-06 is reported as a rate per 1,000 live births. The 2022 national rate was approximately 31 for 1,000 live births. As more data is collected, we will be able to determine trends for ePC-06. Currently, there's no target rate, however, 0% is not the goal and is unlikely to be achieved over a quarter or annual period. Hospitals should use this measure to monitor their own rates and be alert to any substantive increases. They should also use PC-06 as a balancing measure, looking for trends along with PC-01, early elective delivery rates and PC-02, cesarean birth rates

Let us take a quick overview of the populations for the ePC-06 measure. This metric focuses on full term single newborns who otherwise would be expected to be healthy. As such, the following exclusions are made from this newborn population, preterm, small for dates, multiple gestations, congenital malformations, fetal diagnoses, and exposure to maternal drug use. Let's discuss how the populations are determined. The Initial Population is inpatient hospitalizations for single live newborns who are born in the hospital with a discharge date that ends during the measurement period and either of the following conditions; an Estimated Gestational Age at birth of greater or equal to 37 weeks, or a birth weight greater or equal to 3000 grams, when Estimated Gestational Age is not available. The Denominator equals the Initial Population. The Denominator Exclusion criteria is inpatient hospitalizations for newborns who are born with congenital malformations or genetic diseases, preexisting fetal conditions or maternal drug use exposure in utero. Each code is vetted through our perinatal technical advisory panel or TAP, but not every conceivable code could be added to the table as these conditions are rare. Examples of preexisting fetal conditions include congenital viral diseases, hemolytic disease of the newborn and newborns affected by intrauterine fetal blood loss. Exclusions from maternal drug use exposure are determined by codes in the Value Set which represent the newborn was affected by the drug exposure. For example, exhibited withdrawal symptoms. Maternal drug use or history of drug use alone is not an Exclusion Criteria.

The Numerator is Inpatient Hospitalizations for Newborns with Severe or Moderate Complications. If a case falls into more than one complication bucket, the case will be considered severe complication only to prevent double counting. Let's take a closer look at what constitutes a severe or moderate complication. A newborn with the discharge status of expired or discharged to an acute care facility should be included in the severe complication category. Other Severe Complications are made up of diagnoses and procedure codes related to severe birth injuries such as Intracranial Hemorrhage, Severe Respiratory, Neurological, and Infectious Complications. Cases which have codes in the neonatal severe septicemia Value Set will be included as a severe complication Numerator case if the Length of Stay is greater than four days regardless of the delivery type. The moderate complication Numerator cases include diagnosis or procedures that raise concern but at a lower level than the list for Severe Complications. The categories of moderate complications include birth trauma and respiratory complications.



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Other moderate complication cases require a Length of Stay modifier. The modern complication categories for birth trauma, respiratory complications and procedures, infection and neurological complication procedures include a Length of Stay modifier based on the type of delivery. A Length of Stay greater than two days for vaginal deliveries and greater than four days for cesarean deliveries. Only cases which have the moderate complication codes and meet the Length of Stay criteria will be included as moderate complication Numerator case. The last condition to constitute a moderate complication is the Length of Stay greater than five days in which no codes for Jaundice or social indications are found. Cases which have further complication codes and a Length of Stay greater than five days will count as a moderate complication Numerator case unless they have a code in the Value Sets, neonatal Jaundice, phototherapy or social indications. Length of Stay is used to guard against overcoding and undercoding of conditions.

Now we'll summarize the major measure changes for 2025. Same as ePC-05 changes, all references from MQF have been changed to CBE to identify the consensus based entity role and the Initial Population was updated to remove that end from the description. Next, we will discuss codes that were updated based on technical expert subject matter expert or public feedback. From the Value Sets severe birth trauma, SNOMED code 206209004, fracture of clavicle due to birth trauma was removed from the severe birth trauma Value Set. This was removed due to an overlapping of the same code in the Moderate Birth Trauma with Length of Stay Value Set. From the congenital malformations values set ICD-10 code D18.1, Lymphangioma, was added due to a request that it be added to the exclusion list as this could be diagnosed prenatally and should be referred to selected tertiary centers. This is a rare occurrence, in the neonate, it is used for cystic hygroma, which is a major issue.

From the fetal conditions Value Set ICD-10 code P76.9, intestinal obstruction of newborn, unspecified was added after a request was made. The code was discussed with our medical advisor who felt it was a valid exclusion. From the social indications Value Set ICD-10 code Z74.2, need for assistance at home and no other household member able to render care was added to help address the Length of Stay for healthy infants. This code was added for those cases in which the infant stays only because there's a maternal condition keeping the mother in the hospital.

I'll now turn the presentation over to Raquel to cover the technical aspects of ePC-06.

Thank you, Kelly.

I'll now present some of the technical changes to the measure listed on this table.

As mentioned earlier, to distinguish libraries specifically used for measures designed for use with the quality data model QDM, the letters QDM have been added to the MAT Global common functions QDM library and the PCNewborn QDM library. Same as ePC-05, Value Set payer was renamed to payer type to more accurately reflect the contents and intent of the Value Sets. There are multiple Value Set changes made for Reporting Year 2025 with addition or deletion of codes. These changes were made based on terminology updates. Please see the eCQM Value Set 2025 reporting period and Technical Release Notes on the TJC eCQM webpage for more details. Let's review the measure flow diagram for ePC-06. ePC-05 and ePC-06 share the same Initial Population. We will move on to the Denominator.

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Again, just like ePC-05, the patient will meet the Denominator criteria as well, since the Denominator is equal to the Initial Population. Then, we move on to the Denominator Exclusion processing. If there is a diagnosis of congenital malformation, fetal conditions or maternal drug use exposure in utero, the patient will be excluded from the Denominator and the processing stops there. If there is no such diagnosis, the Numerator logic is evaluated. Next, let us discuss the Numerator evaluation process.

Next, let us discuss the Numerator evaluation process. If the newborn meets any of the selected discharge dispositions, severe morbidities diagnosis or procedures, or with diagnosis of severe septicemia and Length of Stay greater than four days, follow the yes on the algorithm and the patient is in Severe Complications and will be in the Numerator. That is the Stratification one of the Numerator. If the newborn does not meet any of the severe complication conditions, we continue to move along the algorithm. If the newborn meets any one of the following conditions of having moderate complication diagnosis or procedures or with cesarean birth with Length of Stay greater than four days or vaginal birth with Length of Stay greater than two days, that has a moderate complication diagnosis or procedure code or Length of Stay greater than five days without Jaundice or social indications for prolonged stay, follow the yes on the algorithm and the patient is in moderate complications and will be in the Numerator. This is Stratification two of the Numerator. If patient does not meet any of the conditions listed for severe or moderate conditions, follow the no on the algorithm and the patient will not be in the Numerator and the processing will stop there.

At the bottom of the measure flow diagram, you will find the calculations for the overall performance rate and the two Stratifications. The Numerator is divided by the Denominator minus the Denominator Exclusions, and the quotient is multiplied by 1000 to arrive at a rate per 1000 live births. Now that we have completed an overview of the flow diagram, let us review the measure logic together. The Initial Population definition is Single Live Term Newborn encounter, which is stored in the PCNewborn QDM library. Please note ePC-05 and ePC-06 shares the same Initial Population, so we will not go into further detail. Like ePC-05, the Denominator is equal to the Initial Population. The definition is simply called equals Initial Population, so then the Initial Population definition, which is PCNewborn.Single Live Term Newborn becomes the qualifying encounter to continue moving through the measurable algorithm.

The Denominator Exclusion definition is Single Live Term Newborn Encounter with Congenital Malformation or Fetal Conditions or Maternal Drug Use. As mentioned on the prior slide, we used the encounter Single Live Term Newborn encounter as qualifying encounter to continue moving through the measure. The Denominator Exclusions will be evaluated. The Denominator Exclusion will look for a Single Live Term Newborn encounter that contains diagnosis codes that are listed in the Congenital Malformations, Fetal Conditions or Maternal Drug Use Value Set. The newborn will be excluded from the Denominator if the newborn meets any of those diagnosis. For a Reporting Year 2025, there were no changes made to the Denominator Exclusion from 2024.

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Next, let us discuss the Numerator. The Numerator is looking for newborns with severe or moderate complications. There are two definitions in the Numerator that is constructed by a union, which means that newborns with any complications from the severe or moderate list will be included in the Numerator. Let's look at the two definitions within the Numerator. The first definition, Single Live Term Newborn Encounter with Severe Complication has three conditions listed, Single Live Term Newborn Encounter with Selected Discharge Disposition or with Severe Morbidities or with Sepsis and Length of Stay More Than Four days. By using union in the logic, a newborn that meets any one of these three condition will be in the Numerator for Severe Complications. We will discuss shortly the details of each condition. The first condition for severe complication is Single Live Term Newborn Encounter with Selected Discharge Disposition. The logic is looking for the discharge disposition in patient expired or discharged to acute care facility or other healthcare facility or discharged to healthcare facility for hospice care. Please note no concept changes were made to this condition for 2025.

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The second condition for severe complication is Single Live Term Newborn encounter with severe morbidities. The logic uses encounter diagnosis to identify if newborns have any diagnosis codes that are found within the six Value Sets. The six Value Sets are Severe Birth Trauma, Severe Hypoxia or Asphyxia, Severe Shock and Resuscitation, Neonatal Severe Respiratory Complications, Neonatal Severe Infection and Neonatal Severe Neurological Complications. The logic also looks for severe complication procedures.

Please note no concept changes were made to this condition for 2025. The third condition for severe complication is Single Live Term Newborn encounter with sepsis and Length of Stay more than four days. The logic identifies if newborns have an encounter diagnosis from the neonatal severe septicemia Value Set. We call our global function length in days to calculate Length of Stay. Therefore, newborns with a diagnosis in severe septicemia and Length of Stay greater than four days will be in the Numerator.

Please note no concept changes were made to this condition for 2025. The second definition of the Numerator is Single Live Term Newborn Encounter with Moderate Complications or Length of Stay Criteria Met. By using union in the logic, a newborn that meet any one of the three conditions in this definition will be in the Numerator for moderate complications. Please note that except Severe Complications. The except to operator returns the difference of two arguments. It's used to ensure that a moderate complication encounter does not also satisfy severe complication condition. Therefore, if a newborn has both severe and moderate complications, the case will not be in the moderate complication category. We will discuss shortly the details of each condition, but please note there are also no concept changes made for 2025 from 2024.

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The first condition for moderate complication is Single Live Term Newborn Encounter with Moderate Complication. The logic is looking for an encounter diagnosis code in Moderate Birth Trauma or Moderate Respiratory Complications or Moderate Complication Procedures Value Sets. For Moderate Complication Procedures, the logic is looking at procedures performed that starts during day of the encounter. Please note there are no concept changes were made to this condition for 2025. The second condition for moderate complication is Single Live Term Newborn Encounter with Moderate

Complications by Cesarean Birth with Length of Stay More Than Four Days or by Vaginal Birth with Length of Stay More Than Two Days. A logic identifies if a newborn has an encounter diagnosis code from either of the three Value Sets, Moderate Birth Trauma with Length of Stay, Moderate Respiratory Complications with Length of Stay or Moderate Infection with Length of Stay. Or any diagnostic procedure from the moderate neurological complications with Length of Stay procedure Value Sets. For the procedures, the logic looks at the procedure performed that starts during the day of the encounter relevant period. Newborns with any encounter diagnosis, code, or procedure in those Value Set will satisfy the Numerator for moderate complications.

The third condition for moderate complication is Single Live Term Newborn Encounter, Length of Stay More Than Five Days without Jaundice and Social Indications. The logic is looking for Single Live Term Newborns without any moderate complications and without Jaundice, social indications or given any phototherapy if their Length of Stay is greater than five days. If newborn meets any of the condition, the newborn will be considered in the moderate complications category. The logic checks if any newborns have encountered diagnosis code in the neonatal Jaundice or social indications Value Sets. The logic will also identify phototherapy procedure that starts during day of the encounter as this procedure is indicative of Jaundice. Now that we have reviewed both the severe and moderate complications in the Numerator, to recap, newborns with any conditions in either severe or moderate complication categories will be in the Numerator population.

Next, we will discuss a Frequently Asked Question about the Value Sets mentioned on the previous slide. Question: Moderate infection with Length of Stay Value Set has the same codes as Neonatal Severe Septicemia. How does the measure logic evaluate this? Answer, yes, there are overlapping codes on the Neonatal, Severe Septicemia and moderate infection with Length of Stay Value Sets. Those codes are listed on both Value Sets because of the clinical intent. However, when you follow the algorithm, you would get to a severe complication before you would have to account for moderate complication codes. Cases with Length of Stay greater than four days would therefore be in a severe complication category.

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Next, let us discuss Stratification. As you can recall, we mentioned this during the flow diagram review. ePC-06 measure contains two Stratifications. The Stratification one is for Severe Complications and Stratification two is for moderate complications. In the eCQM, Stratification can occur at any population level. In ePC-06, defining the Stratification encounter assures that any Denominator Exclusion case that is also satisfying Numerator conditions will not be stratified. Therefore, when Stratification encounter intersects Severe Complications, encounters only satisfying Severe Complications will be counted in Stratification one. Same applies to Stratification two. This is a Frequently Asked Question related to Stratification. What if a case has both Severe and Moderate Complications? How does this case get stratified? Answer, the case falls into Severe Complications, so severe and moderate strata are mutually exclusive. If a newborn has both severe and moderate complications, the case will not satisfy the moderate complication category because the newborn has been already included in the Severe Complications category. I will now turn the presentation back to Susan to close out our webinar.



Thanks team for presenting the updates for the eQMs and the Frequently Asked Questions. We've included an additional resource slide and provided links to direct you to the eCQI Resource Center, CMS Eligible Hospital Measures page, Teach me Clinical Quality Language video series, including a video short on hospitalization with observation, and what is a Value Set. Pioneers in Quality landing page on the Joint Commission's website. Expert to Expert series landing page the Find the Specifications link for the Electronic Clinical Quality Measures on the Joint Commission's website and finally, the Joint Commission eQCM Question Tracking System where clinical and technical questions about these eQMs should be submitted.

All Expert to Expert Webinar recording links, slides, transcripts, and where applicable, Q&A documents can currently be accessed on the joint commission's webpage, and after this webinar, is no longer available for CE credit. The recording and materials will remain available via the link we've provided on this slide. Before this webinar concludes, a reminder about the CE survey. We use your feedback to determine education gaps and your organization's needs, inform future content and assess the quality of our educational programs. As explained earlier, a QR code is provided on the next slide. If you prefer to take the CE survey later, an automated email also delivers the survey link. At the end of the survey, when you click submit, you'll be redirected to a page from which you can print or download a certificate that you will complete by adding your name and credentials. In case you log off without downloading or printing your certificate, an automated email will also be sent to you that includes this link. This email is sent to the email address that you provide within the CE survey.

Thank you, Melissa, Raquel, and Kelley for developing and presenting the content and thanks to all of you that attended this on demand webinar. We will pause on this slide for several moments to permit those that wish to use the QR code to scan it with their mobile device. Have a great day.