**ILPQC Early Elective Delivery Initiative**
**Data Collection Sheet**
**Hospital ID: 02-__ __ __**

PC-01 Measure Data

POPULATION

1. What was your hospital's total Initial Patient Population? _____
2. What was your hospital's sample size? _____
3. What was your hospital's sampling frequency?
   a. Monthly
   b. Quarterly
   c. Not Sampled

NUMERATOR

4. What was the number of patients with elective deliveries between >=37 and <39 weeks of gestation? _____

DENOMINATOR

5. What was the total number of patients delivering newborns with >=37 and <39 weeks of gestation? _____

EXCLUSIONS

*ICD-9CM Principal or Other Diagnosis Code for Elective Delivery*

6. What was the exclusion count for the ICD-9-CM Principal or Other Diagnosis Code for Elective Delivery? _____

*Enrolled in a clinical trial*

7. What was the exclusion count for those enrolled in a clinical trial? _____

*Prior uterine surgery*

8. What was the exclusion count for prior uterine surgery? _____

*Gestational age <37 or >=39 weeks*

9. What was the exclusion count for gestational age <37 or >=39 weeks? _____

RESULTS

10. Total Exclusion Count: sum of Q 6-9 _____
11. Percentage of Patients with Elective Deliveries: Q4/Q5 _____

**ILPQC Early Elective Delivery Initiative**
**Data Dictionary**

POPULATION
Refer to: https://manual.jointcommission.org/releases/TJC2014A1/DataElem0250.html
https://manual.jointcommission.org/releases/TJC2014A1/DataElem0251.html

NUMERATOR, DENOMINATOR, EXCLUSIONS
Refer to: https://manual.jointcommission.org/releases/TJC2014A1/MIF0166.html

DATA DICTIONARY
Admission Date (https://manual.jointcommission.org/releases/TJC2014A1/DataElem0006.html)
*Definition*: The month, day, and year of admission to acute inpatient care.
*Notes for Abstraction*:

- The intent of this data element is to determine the date that the patient was actually admitted to acute inpatient care. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value. If using claim information, the 'Statement Covers Period' is not synonymous with the 'Admission Date' and should not be used to abstract this data element. These are two distinctly different identifiers:
    - The Admission Date (Form Locator 12) is purely the date the patient was admitted as an inpatient to the facility.
    - The Statement Covers Period ("From" and "Through" dates in Form Locator 6) identifies the span of service dates included in a particular claim. The "From" Date is the earliest date of service on the claim.
- For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.

Example: Medical record documentation reflects that the patient was admitted to observation on 04-05-20xx. On 04-06-20xx the physician writes an order to admit to acute inpatient effective 04-05-20xx. The *Admission Date* would be abstracted as 04-06-20xx; the date the determination was made to admit to acute inpatient care and the order was written.

- If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.
- For newborns that are born within this hospital, the admission date is the date the baby was born.
- The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.

Example: Preoperative Orders are dated as 04-06-20xx with an order to admit to Inpatient. Postoperative Orders, dated 05-01-20xx, state to admit to acute inpatient. All other documentation

supports that the patient presented to the hospital for surgery on 05-01-20xx. The admission date would be abstracted 05-01-20xx.

*Suggested Data Sources:*

ONLY ALLOWABLE SOURCES

- Physician orders
- Face sheet
- UB-04, Field Location: 12

Note: The physician order is the priority data source for this data element. If there is not a physician order in the medical record, use the other only allowable sources to determine the Admission Date.

Excluded Data Sources

- UB-04, Field Location: 06

Birthdate (https://manual.jointcommission.org/releases/TJC2014A1/DataElem0246.html)

*Definition:* The month, day, and year the patient was born.

Note:

- Patient's age (in years) is calculated by Admission Date minus Birthdate. The algorithm to calculate age must use the month and day portion of admission date and birthdate to yield the most accurate age.
- For HBIPS discharge measures, i.e., HBIPS-1, 4, 5, 6, 7, patient's age (in years) is calculated by Discharge Date minus Birthdate. For event measures, i.e., HBIPS-2, 3, patient's age at time of event (in years) is calculated by Event Date minus Birthdate. The algorithm to calculate age must use the month and day portion of birthdate, and discharge date or event, as appropriate to yield the most accurate age.

*Notes for Abstraction:* Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the date of birth on the claim information.

*Suggested Data Sources:*

- Emergency department record
- Face sheet
- Registration form
- UB-04, Field Location: 10

Clinical Trial (https://manual.jointcommission.org/releases/TJC2014A1/DataElem0030.html)

*Definition:* Documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied.

*Notes for Abstraction:*

- To select “Yes” to this data element, BOTH of the following must be true
    1. There must be a signed consent form for clinical trial. For the purposes of abstraction, a clinical trial is defined as an experimental study in which research subjects are recruited and assigned a

treatment/intervention and their outcomes are measured based on the intervention received. Treatments/interventions most often include use of drugs, surgical procedures, and devices. Often a control group is used to compare with the treatment/intervention. Allocation of different interventions to participants is usually randomized.

2. There must be documentation on the signed consent form that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied. Patients may either be newly enrolled in a clinical trial during the hospital stay or enrolled in a clinical trial prior to arrival and continued active participation in that clinical trial during this hospital stay.
   PC:
   Only capture patients enrolled in clinical trials studying pregnant patients or newborns. For Perinatal Care measures ONLY, it is appropriate for the ORYX® Vendor to default the data element to "No" unless the ICD-9-CM diagnosis code of V70.7, "Examination of participant in a clinical trial" is present. If this code is present, or the organization knows via some other electronic method that the patient is participating in a clinical trial, default the data element to "Yes". Hospital abstractors may change defaulted value of "No" based on hospital participation in clinical trial.

- In the following situations, select "No":
  1. There is a signed patient consent form for an observational study only. Observational studies are non-experimental and involve no intervention (e.g., registries). Individuals are observed (perhaps with lab draws, interviews, etc.), data is collected, and outcomes are tracked by investigators. Although observational studies may include the assessment of the effects of an intervention, the study participants are not allocated into intervention or control groups.
  2. It is not clear whether the study described in the signed patient consent form is experimental or observational.
  3. It is not clear which study population the clinical trial is enrolling. Assumptions should not be made if it is not specified.

Discharge Date (https://manual.jointcommission.org/releases/TJC2014A1/DataElem0248.html)
*Definition:* The month, day, and year the patient was discharged from acute care, left against medical advice, or expired during this stay.
*Notes for Abstraction:* Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.
For HBIPS only, if the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital.
*Suggested Data Sources:*

- Face sheet

- Progress notes
- Physician orders
- Discharge summary
- Nursing discharge notes
- Transfer note
- UB-04, Field Location: 6

Gestational Age (https://manual.jointcommission.org/releases/TJC2014A1/DataElem0265.html)
*Definition*: The weeks of gestation completed at the time of delivery.
Gestational age is defined as the number of weeks that have elapsed between the first day of the last normal menstrual period (not presumed time of conception) and the date of delivery, irrespective of whether the gestation results in a live birth or a fetal death.
*Notes for Abstraction*: Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks.
The delivery or operating room record should be reviewed first for gestational age. If gestational age is not recorded in the delivery or operating room record, then continue to review the data sources in the following order: history and physical, prenatal forms, clinician admission progress note and discharge summary until a positive finding for gestational age is found. In cases where there is conflicting data, the gestational age found in the first document according to the order listed above should be used. The phrase "estimated gestational age" is an acceptable descriptor for gestational age.
If the patient has not received prenatal care, estimated gestational age (EGA) may be used to answer gestational age.
When the admission date is different from the delivery date, use documentation of the gestational age completed closest to the delivery date.
Gestational age should be documented by the clinician as a numeric value between 1-50. The clinician, not the abstractor, should perform the calculation to determine gestational age based on the first day of the last normal menstrual period (not presumed time of conception) and the date of delivery.
Ultrasound-based dating is also an acceptable method of determining gestational age.
If the gestational age entered by the clinician in the first document listed above is obviously incorrect (in error) but it is a valid number and the correct number can be supported with other documentation in the other acceptable data sources in the medical record, the correct number may be entered.
Documentation in the acceptable data sources may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN).
It is acceptable to use data derived from vital records reports received from state or local departments of public health if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed below.
*Suggested Data Sources*:
ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE:

- Delivery room record
- Operating room record
- History and physical
- Prenatal forms
- Admission clinician progress notes
- Discharge summary

ICD-9-CM Other Diagnosis Codes
(https://manual.jointcommission.org/releases/TJC2014A1/DataElem0072.html)
*Definition*: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the diagnosis for this hospitalization.
*Suggested Data Sources*:

- Face sheet
- Discharge summary
- UB-04, Field Locations: 67A-Q
  NOTE: Medicare will only accept codes listed in fields A-H

ICD-9-CM Principal Diagnosis Code
(https://manual.jointcommission.org/releases/TJC2014A1/DataElem0075.html)
*Definition*: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code associated with the diagnosis established after study to be chiefly responsible for occasioning the admission of the patient for this hospitalization.
*Notes for Abstraction*: The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
*Suggested Data Sources*:

- Face sheet
- Discharge summary
- UB-04, Field Location: 67
- Outpatient medical record

Labor (https://manual.jointcommission.org/releases/TJC2014A1/DataElem0263.html)
*Definition*: Documentation by the clinician that the patient was in labor.
*Notes for Abstraction*: A clinician is defined as a physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN). Documentation of labor by the clinician should be abstracted at face value. No additional documentation of regular contractions or cervical change is required in order to answer yes to labor.
Guidelines for abstraction:
Inclusion: The following are acceptable descriptors for labor: Active, Early, Spontaneous
Exclusion: The following are not acceptable descriptors for labor: Latent, Prodromal
*Suggested Data Sources*:

- History and physical

- Nursing notes
- Physician progress notes

Prior Uterine Surgery (https://manual.jointcommission.org/releases/TJC2014A1/DataElem0520.html)
*Definition*: Documentation that the patient had undergone prior uterine surgery.
*Guidelines for abstraction:*
Inclusion: The only prior uterine surgeries considered for the purposes of the measure are:
- Prior classical cesarean section which is defined as a vertical incision into the upper uterine segment
- Prior myomectomy
- Prior uterine surgery resulting in a perforation of the uterus due to an accidental injury
- History of a uterine window or thinning of the uterine wall noted during prior uterine surgery or during ultrasound
- History of uterine rupture requiring surgical repair

Exclusion:
- Prior low transverse cesarean section
- Prior cesarean section without specifying prior classical cesarean section

*Suggested Data Sources*:
- History and physical
- Nursing admission assessment
- Progress notes
- Physician's notes
- Prenatal forms

Spontaneous Rupture of Membranes
(https://manual.jointcommission.org/releases/TJC2014A1/DataElem0264.html)
*Definition*: Documentation that the patient had spontaneous rupture of membranes (SROM) before medical induction and/or cesarean section.
*Notes for Abstraction*: If the patient's spontaneous rupture of membranes is confirmed before medical induction and/or cesarean section by one of the following methods, select allowable value "Yes":
- Positive ferning test
- Positive nitrazine test
- Positive pooling (gross fluid in vagina)
- Positive Amnisure® ROM test or equivalent
- Patient report of SROM prior to hospital arrival

*Suggested Data Sources*:
- History and physical
- Nursing notes
- Physician progress notes