Perinatal Care (PC)

Set Measures

Set Measure ID	Measure Short Name
PC-01	Elective Delivery
PC-02	Cesarean Section
PC-03	Antenatal Steroids
PC-04	Health Care-Associated Bloodstream Infections in Newborns
PC-05	Exclusive Breast Milk Feeding

General Data Elements

Element Name	Collected For
Admission Date	All Records,
Birthdate	All Records,
Clinical Trial	All Records,
Discharge Date	All Records, Not collected for HBIPS-2 and HBIPS-3
Discharge Status	All Records, Not collected for HBIPS-2 and HBIPS-3; Used in algorithm for PC-04 and PC-05
ICD-9-CM Other Diagnosis Codes	All Records, Optional for HBIPS-2 and HBIPS-3; Used in algorithm for PC-01, 02, 04, and 05
ICD-9-CM Other Procedure Codes	All Records, Optional for All HBIPS Records; Used in algorithm for PC-01, 02, 04 and 05
ICD-9-CM Other Procedure Dates	All Records, Optional for All HBIPS Records
ICD-9-CM Principal Diagnosis Code	All Records, Optional for HBIPS-2 and HBIPS-3; Used in algorithm for PC-01, 02, 04, and 05
ICD-9-CM Principal Procedure Code	All Records, Optional for All HBIPS Records; Used in algorithm for PC-01, 02, 04 and 05
ICD-9-CM Principal Procedure Date	All Records, Optional for All HBIPS Records
Payment Source	All Records, Optional for HBIPS-2 and HBIPS-3
Point of Origin for Admission or Visit	All Records, Optional for HBIPS-2, HBIPS-3; Used in algorithm for PC-04
Sex	All Records,

Algorithm Output Data Elements

Element Name	Collected For
Measure Category Assignment	Calculation, Transmission, Hospital Clinical Data File
Measurement Value	Calculation, Transmission, Hospital Clinical Data File

Measure Set Specific Data Elements

Element Name	Collected For
Active Labor	PC-01,
Admission Type	PC-04, PC-05,
Antenatal Steroid Administered	PC-03,
Birth Weight	PC-04,
Discharge from NICU	PC-05,
Exclusive Breast Milk Feeding	PC-05,
Gestational Age	PC-01, PC-02, PC-03,
Parity	PC-02,
Reason for Not Administering Antenatal Steroid	PC-03,
Reason for Not Exclusively Feeding Breast Milk	PC-05,
Spontaneous Rupture of Membranes	PC-01,

Related Materials

Document Name
a. Cover page for the Joint Commission Manual
a. Table of Contents
a1. Acknowledgment and Conditions of Use
a1. Introduction to the Manual
a3. Using the The Joint Commission's National Measure Specifications Manual
b. Data Dictionary
d. Missing and Invalid Data
e. Sampling
g1. Transmission of Data
g2. Transmission Alpha Data Dictionary
g3. Transmission Data Processing Flow: Clinical
g4. Transmission Data Processing Flow: Population and Sampling
z. Appendix A - ICD-9-CM Code Tables
z. Appendix B - Medication Tables
z. Appendix C - Glossary of Terms
z. Appendix D - Overview of Measure Information Form and Flowchart Formats
z. Appendix E - Miscellaneous Tables
z. Appendix F - Resources

Perinatal Care (PC) Initial Patient Population

The PC measure set is unique in that there are two distinct Initial Patient Populations within the measure set, mothers and newborns.

Mothers
The population of the PC-Mother measures (PC-01, 02, and 03) are identified using 4 data elements:

- *Admission Date*
- *Birthdate*
- *Discharge Date*
- *ICD-9-CM Principal or Other Diagnosis Code*

Newborns
The population of the PC-Newborn measure (PC-04 and 05) are identified using 4 data elements:

- *Admission Date*
- *Birthdate*
- *Discharge Date*
- *ICD-9-CM Principal or Other Diagnosis Code*

Within the PC-Newborn population, there are two 2 sampling groups each identified by Patient Age at admission and a specific group of diagnosis codes, or lack there of. The patients in each sampling group are counted in the Initial Patient Population of multiple measures.

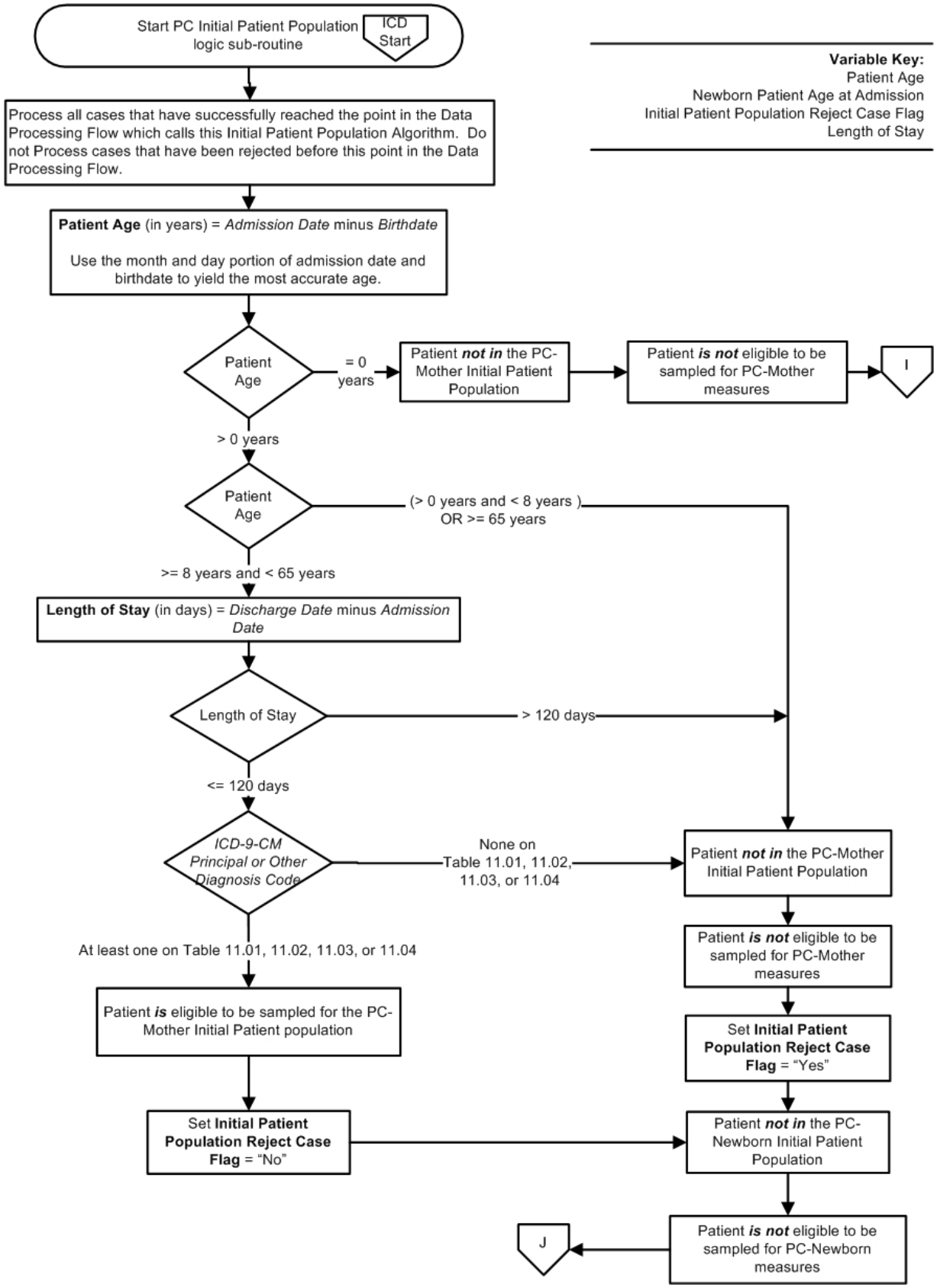
Measures	Initial Patient Population definition
PC-04	The count of all patients in sampling group 1
PC-05	The count of all patients in sampling group 2

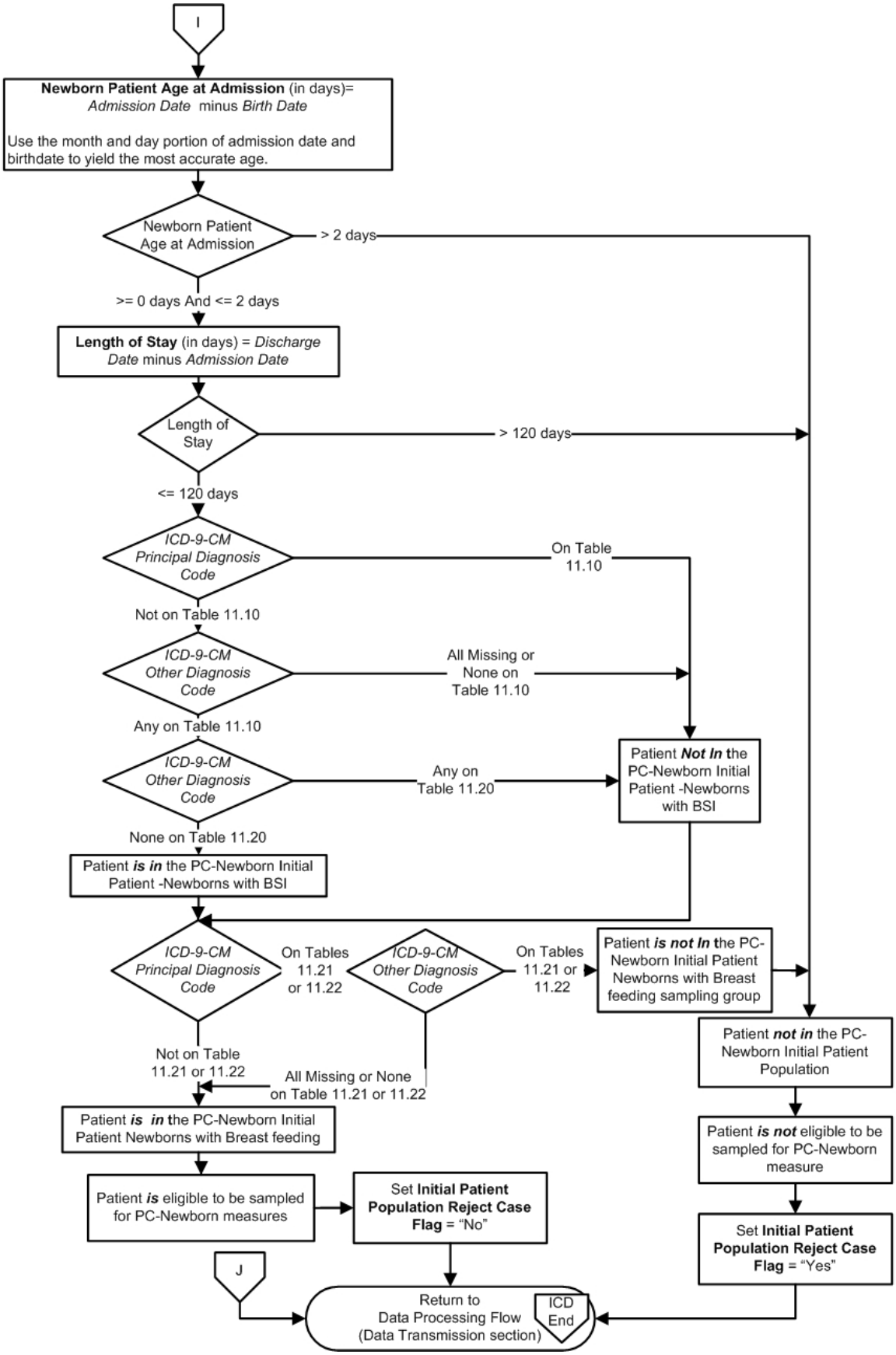
Patients admitted to the hospital for inpatient acute care are included in one of the PC Newborn Initial sampling groups if they have:

1. **Newborns with Blood Stream Infection or BSI** - Patients with a Newborn Patient Age at admission (*Admission Date – Birthdate*) < 2 days, Length of Stay (*Discharge Date - Admission Date*) <= 120 days, an *ICD-9-CM Other Diagnosis Code* of Septicemia/Bacteremia on Appendix A Table 11.10 and **NO** *ICD-9-CM Principal Diagnosis Code* as defined in Appendix A, Table 11.10 and **NO** *ICD-9-CM Other Diagnosis Code* as defined in Appendix A, Table 11.20. There is NO sampling for this measure.
2. **Newborns with Breast Feeding** - Patient Age at admission (*Admission Date – Birthdate*) < 2 days, Length of Stay (*Discharge Date - Admission Date*) <= 120 days and **NO** *ICD-9-CM Principal* or *Other Diagnosis Code* as defined in Appendix A, Table 11.22 are included in this sampling group and are eligible to be sampled.

Initial Patient Population Algorithm

PC Initial Patient Population Algorithm





Sample Size Requirements

Hospitals that choose to sample have the option of sampling quarterly or sampling monthly. A hospital may choose to use a larger sample size than is required. Hospitals whose Initial Patient Population size is less than the minimum number of cases per quarter/month for the sampling group cannot sample that sampling group. Hospitals that have five or fewer discharges for the three combined PC sampling groups (both Medicare and non-Medicare combined) in a quarter are not required to submit PC patient level data to the Joint Commission's Data Warehouse.

Regardless of the option used, hospital samples must be monitored to ensure that sampling procedures consistently produce statistically valid and useful data. Due to exclusions and contraindications, hospitals selecting sample cases MUST submit AT LEAST the minimum required sample size.

The following sample size tables for each option automatically build in the number of cases needed to obtain the required sample sizes. For information concerning how to perform sampling, refer to the Population and Sampling Specifications section in this manual.

Quarterly Sampling
A modified sampling procedure is required for hospitals performing quarterly sampling for PC. Hospitals selecting sample cases must ensure that each individual sampling group Initial Patient Population and sample size meet the following conditions:

- *Select within the two individual measure sampling groups (mothers and babies).*
- Select independently from the Newborn population.

Hospitals selecting sample cases for the **PC-Mothers** must ensure that the Initial Patient Population and sample size for this PC sampling group meets the following conditions:

Quarterly Sample Size
Based on Initial Patient Population for for Mothers

Hospital's Measure	
Average Quarterly Initial Patient Sample Group Size "N"	**Minimum Required Sampling Group Sample Size "n"**
>= 2001	401
501 – 2000	20% of the Initial Patient Population size
100 – 500	100
< 100	No sampling; 100% of the Initial Patient Population required

Within the **PC-Newborn** population, there are two 2 sampling groups each identified by Patient Age at admission and a specific group of diagnosis codes, or lack there of:

- The Liveborn and Transferred in Newborns sampling group *is not eligible* for sampling and will use the entire Newborn Initial Patient Population for reporting.
- Hospitals selecting sample cases for the Liveborn Newborns sampling group must ensure that the Initial Patient Population and sample size for this sampling group meets the following conditions:

Newborn Patient Sampling Group

Hospital's Measure	
Average Quarterly Initial Patient Population Size "N"	**Minimum Required Sample Size "n"**
>= 721	145
181 – 720	20% of the Initial Patient Population size
36 – 180	36
< 36	No sampling; 100% of Initial Patient Population required

Monthly Sampling
Hospitals selecting sample cases for the **Mothers** must ensure that the Initial Patient Population and sample size for this sampling group meets the following conditions:

Monthly Sample Size
Based on Initial Patient Population for Mothers

Hospital's Measure	
Average Monthly Initial Patient Population Size "N"	**Minimum Required Sample Size "n"**
>= 501	101
126 – 500	20% of the Initial Patient Population
25 – 125	25
< 25	No sampling; 100% Initial Patient Population required

Within the **PC-Newborn** population, there are two sampling groups each identified by Patient Age at admission and a specific group of diagnosis codes, or lack there of:

- The Newborns with BSI sampling group *is not eligible* for sampling and will use the entire Newborn Initial Patient Population for reporting.
- Hospitals selecting sample cases for the Newborns with Breast Feeding sampling group must ensure that the Initial Patient Population and sample size for this sampling group meets the following conditions:

Newborn Patient Sampling Group

Hospital's Measure	
Average Monthly Initial Patient Population Size "N"	**Minimum Required Sample Size "n"**
>= 181	37

46 – 180	20% of the Initial Patient Population
9 – 45	9
< 9	No sampling; 100% Initial Patient Population required

Sample Size Examples
Note: All sampled sampling groups in PC should be used in the calculation of all PC measures. All of the PC measures' specific exclusion criteria are used to filter out cases that do not belong in the measure denominator.

Quarterly Sampling

- A hospital's Mother Population size is 347 during the second quarter. The required sample size is 20% of the patient population or 70 cases for the quarter (twenty percent of 347 equals 69.4 rounded up to the next highest whole number is 70).

Monthly Sampling

- A hospital's Mother Population size is 56 patients during March. The required sample size would be 100% of the patient sampling group or all 56 cases for the month.
- A hospital's Newborns with Breast Feeding sampling group size is 254 newborns during September. The required sample size is 36 cases from the newborn sampling group for the month.

Measure Information Form

Measure Set: Perinatal Care(PC)

Set Measure ID: PC-01

Performance Measure Name: Elective Delivery

Description: Patients with elective vaginal deliveries or elective cesarean sections at 37 to 39 weeks of gestation completed

Rationale: For almost 3 decades, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) have had in place a standard requiring 39 completed weeks gestation prior to ELECTIVE delivery, either vaginal or operative (ACOG, 1996). A survey conducted in 2007 of almost 20,000 births in HCA hospitals throughout the U.S. carried out in conjunction with the March of Dimes at the request of ACOG revealed that almost 1/3 of all babies delivered in the United States are electively delivered with 5% of all deliveries in the U.S. delivered in a manner violating ACOG/AAP guidelines. Most of these are for convenience, and result in significant short term neonatal morbidity (neonatal intensive care unit admission rates of 13- 21%) (Clark et al., 2009).

According to Glantz (2005), compared to spontaneous labor, elective inductions result in more cesarean deliveries and longer maternal length of stay. The American Academy of Family Physicians (2000) also notes that elective induction doubles the cesarean delivery rate. Repeat elective cesarean sections before 39 weeks gestation also result in higher rates of adverse respiratory outcomes, mechanical ventilation, sepsis and hypoglycemia for the newborns (Tita et al., 2009).

Type of Measure: Process

Improvement Noted As: Decrease in the rate

Numerator Statement: Patients with elective deliveries

Included Populations: *ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes* for one or more of the following:

- Medical induction of labor as defined in Appendix A, Table 11.05
- Cesarean section as defined in Appendix A, Table 11.06

Excluded Populations: None

Data Elements:

- *ICD-9-CM Other Procedure Dates*
- *ICD-9-CM Principal Procedure Code*

Denominator Statement: Patients delivering newborns with 37 to 39 weeks of gestation completed

Included Populations: Not applicable

Excluded Populations:

- *ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes* for conditions justifying elective delivery as defined in Appendix A, Table 11.07
- Less than 8 years of age
- Greather than or equal to 65 years of age
- Length of stay > 120 days
- Enrolled in clinical trials
- *Active Labor*
- *Spontaneous Rupture of Membranes*

Data Elements:

- *Active Labor*
- *Admission Date*
- *Birthdate*
- *Clinical Trial*
- *Discharge Date*
- *Gestational Age*
- *ICD-9-CM Other Diagnosis Codes*
- *ICD-9-CM Principal Diagnosis Code*
- *Spontaneous Rupture of Membranes*

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: In order to identify areas for improvement, hospitals may want to review results based on specific ICD-9 codes or patient populations. Data could be analyzed further to determine specific patterns or trends to help reduce elective deliveries.

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

- American Academy of Family Physicians. (2000). Tips from Other Journals: Elective induction doubles cesarean delivery rate, 61, 4.Retrieved December 29, 2008 at: http://www.aafp.org/afp/20000215/tips/39.html.
- American College of Obstetricians and Gynecologists. (November 1996). ACOG Educational Bulletin.
- Clark, S., Miller, D., Belfort, M., Dildy, G., Frye, D., & Meyers, J. (2009). Neonatal and maternal outcomes associated with elective delivery. [Electronic Version]. *Am J Obstet Gynecol*. 200:156.e1-156.e4.
- Glantz, J. (Apr.2005). Elective induction vs. spontaneous labor associations and outcomes. [Electronic Version]. *J Reprod Med*. 50(4):235-40.
- Tita, A., Landon, M., Spong, C., Lai, Y., Leveno, K., Varner, M, et al. (2009). Timing of elective repeat cesarean delivery at term and neonatal outcomes. [Electronic Version]. *NEJM*. 360:2, 111-120.

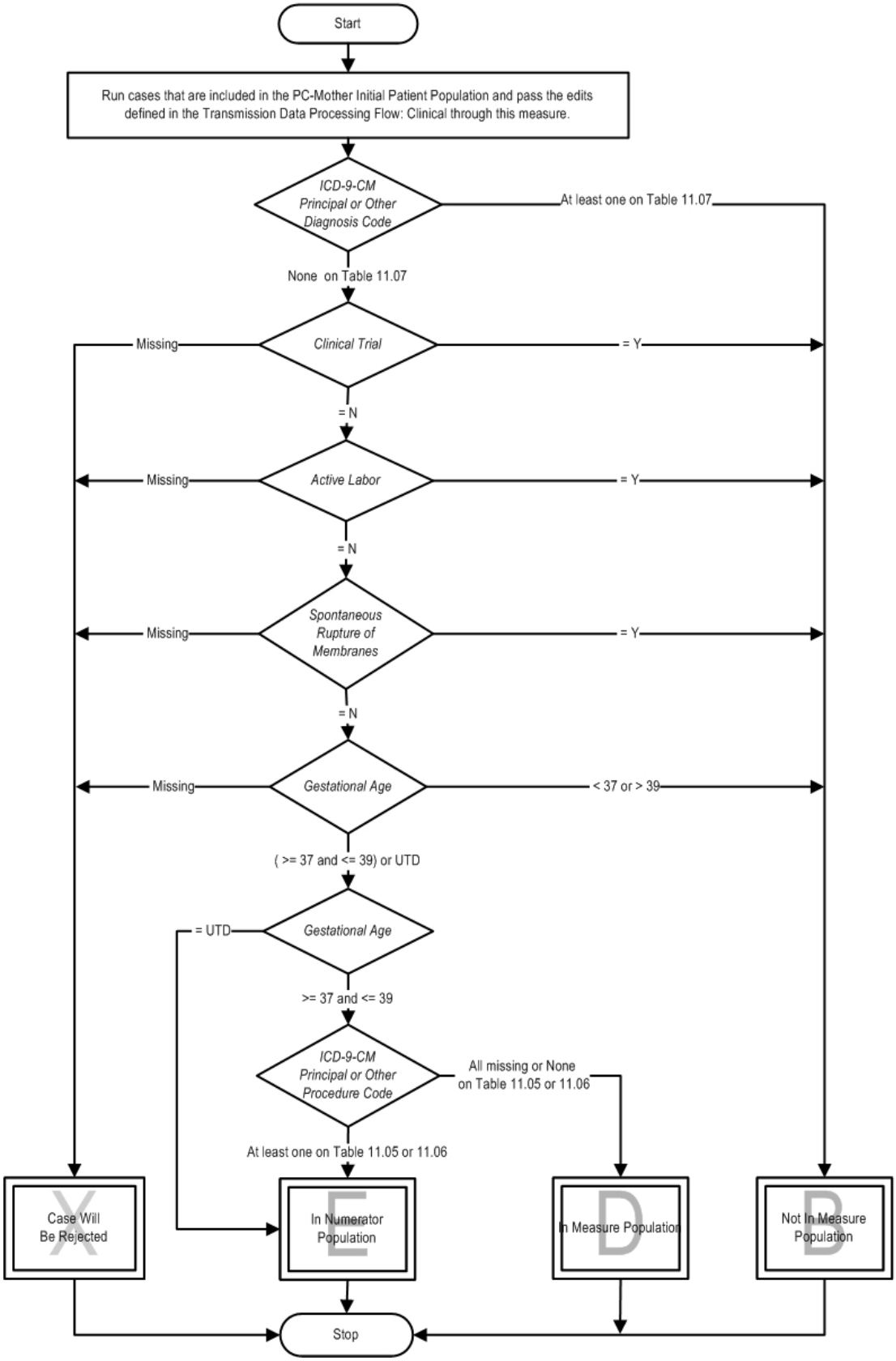
Original Performance Measure Source / Developer:
HCA St. Mark's Perinatal Center

Measure Algorithm:

PC-01: Elective Delivery

Numerator: Patients with elective deliveries completed

Denominator: Patients delivering newborns with 37 to 39 weeks of gestation completed



Related Topics
a. Table of Contents

z. Appendix A - ICD-9-CM Code Tables

Measure Information Form

Measure Set: Perinatal Care(PC)

Set Measure ID: PC-02

Performance Measure Name: Cesarean Section

Description: Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section

Rationale: : The removal of any pressure to not perform a cesarean birth has led to a skyrocketing of hospital, state and national cesarean section (CS) rates. Some hospitals now have CS rates over 50%. Hospitals with CS rates at 15-20% have infant outcomes that are just as good and better maternal outcomes (Gould et al., 2004). There are no data that higher rates improve any outcomes, yet the CS rates continue to rise. This measure seeks to focus attention on the most variable portion of the CS epidemic, the term labor CS in nulliparous women. This population segment accounts for the large majority of the variable portion of the CS rate, and is the area most affected by subjectivity.

As compared to other CS measures, what is different about NTSV CS rate (Low-risk Primary CS in first births) is that there are clear cut quality improvement activities that can be done to address the differences. Main et al. (2006) found that over 60% of the variation among hospitals can be attributed to first birth labor induction rates and first birth early labor admission rates. The results showed if labor was forced when the cervix was not ready the outcomes were poorer. Alfirevic et al. (2004) also showed that labor and delivery guidelines can make a difference in labor outcomes. Many authors have shown that physician factors, rather than patient characteristics or obstetric diagnoses are the major driver for the difference in rates within a hospital (Berkowitz, et al., 1989; Goyert et al., 1989; Luthy et al., 2003). The dramatic variation in NTSV rates seen in all populations studied is striking according to Menacker (2006). Hospitals within a state (Coonrod et al., 2008; California Office of Statewide Hospital Planning and Development [OSHPD], 2007) and physicians within a hospital (Main, 1999) have rates with a 3-5 fold variation.

Type of Measure: Outcome

Improvement Noted As: Decrease in the rate

Numerator Statement: Patients with cesarean sections

> **Included Populations:** *ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes* for cesarean section as defined in Appendix A, Table 11.06
>
> **Excluded Populations:** None
>
> **Data Elements:**
>
> - *ICD-9-CM Other Procedure Codes*
> - *ICD-9-CM Principal Procedure Code*

Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex

presentation

Included Populations: Nulliparous patients with *ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes* for outcome of delivery as defined in Appendix A, Table 11.08 and with a delivery of a newborn with 37 weeks or more of gestation completed

Excluded Populations: * *ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes*, for contraindications to vaginal delivery as defined in Appendix A, Table 11.09

- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of Stay >120 days
- Enrolled in clinical trials

Data Elements:

- *Admission Date*
- *Birthdate*
- *Clinical Trial*
- *Discharge Date*
- *Gestational Age*
- *ICD-9-CM Other Diagnosis Codes*
- *ICD-9-CM Other Procedure Codes*
- *ICD-9-CM Principal Diagnosis Code*
- *ICD-9-CM Principal Procedure Code*
- *Parity*

Risk Adjustment: Yes. This section has been moved to the ORYX Risk Adjustment Guide. This guide is available to the public on the Joint Commission's website and, in addition, it is available to performance measurement systems via the Joint Commission's extranet site for measurement systems (PET)

Data Elements

- *Birthdate*

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: In order to identify areas for improvement, hospitals may want to review results based on specific ICD-9 codes or patient populations. Data could then be analyzed further determine specific patterns or trends to help reduce cesarean sections.

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

- Agency for Healthcare Research and Quality. (2002). *AHRQ Quality Indicators—Guide to Inpatient Quality Indicators: Quality of Care in Hospitals—Volume, Mortality, and Utilization*. Revision 4

(December 22, 2004). AHRQ Pub. No. 02-RO204.
- Alfirevic, Z., Edwards, G., & Platt, M.J. (2004). The impact of delivery suite guidelines on intrapartum care in "standard primigravida." *Eur J Obstet Gynecol Reprod Biol*.115:28-31.
- American College of Obstetricians and Gynecologists. (2000). *Task Force on Cesarean Delivery Rates. Evaluation of Cesarean Delivery*. (Developed under the direction of the Task Force on Cesarean Delivery Rates, Roger K. Freeman, MD, Chair, Arnold W. Cohen, MD, Richard Depp III, MD, Fredric D. Frigoletto Jr, MD, Gary D.V. Hankins, MD, Ellice Lieberman, MD, DrPH, M. Kathryn Menard, MD, David A. Nagey, MD, Carol W. Saffold, MD, Lisa Sams, RNC, MSN and ACOG Staff: Stanley Zinberg, MD, MS, Debra A. Hawks, MPH, and Elizabeth Steele).
- Bailit, J.L., Garrett, J.M., Miller, W.C., McMahon, M.J., & Cefalo, R.C. (2002). Hospital primary cesarean delivery rates and the risk of poor neonatal outcomes. *Am J Obstet Gynecol*. 187(3):721-7.
- Bailit, J. & Garrett, J. (2003). Comparison of risk-adjustment methodologies. *Am J Obstet Gynecol*.102:45-51. * Bailit, J.L., Love, T.E., & Dawson, N.V. (2006). Quality of obstetric care and risk-adjusted primary cesarean delivery rates. *Am J Obstet Gynecol*.194:402.
- Bailit, J.L. (2007). Measuring the quality of inpatient obstetrical care. *Ob Gyn Sur*. 62:207-213.
- Berkowitz, G.S., Fiarman, G.S., Mojica, M.A., et al. (1989). Effect of physician characteristics on the cesarean birth rate. *Am J Obstet Gynecol*. 161:146-9.
- California Office of Statewide Hospital Planning and Development. (2006). *Utilization Rates for Selected Medical Procedures in California Hospitals*, Retrieved from the Internet on November 1, 2007 at: http://www.oshpd.state.ca.us/Charts/VolUtil/2006Util.pdf.
- Cleary, R., Beard, R.W., Chapple, J., Coles, J., Griffin, M., & Joffe, M. (1996). The standard primipara as a basis for inter-unit comparisons of maternity care. *Br J Obstet Gynecol*. 103:223-9.
- Coonrod, D.V., Drachman, D., Hobson, P., & Manriquez, M. (2008). Nulliparous term singleton vertex cesarean delivery rates: institutional and individual level predictors. *Am J Obstet Gynecol*. 694-696.
- DiGiuseppe, D.L., Aron, D.C., Payne, S.M., Snow, R.J., Dieker, L., & Rosenthal, G.E. (2001). Risk adjusting cesarean delivery rates: a comparison of hospital profiles based on medical record and birth certificate data. *Health Serv Res*.36:959-77.
- Gould, J., Danielson, B., Korst, L., Phibbs, R., Chance, K.,& Main, E.K., et al. (2004). Cesarean delivery rate and neonatal morbidity in a low-risk population. *Am J Obstet Gynecol*, 104:11-19.
- Goyert, G.L., Bottoms, F.S., Treadwell, M.C., et al. (1989). The physician factor in cesarean birth rates. *N Engl J Med*.320:706-9.
- Le Ray, C., Carayol, M., Zeitlin, J., Berat, G., & Goffinet, F. (2006). Level of perinatal care of the maternity unit and rate of cesarean in low-risk nulliparas. *Am J Obstet Gynecol*. 107:1269-77.
- Luthy, D.A., Malmgren, J.A., Zingheim, R.W., & Leininger, C.J. (2003). Physician contribution to a cesarean delivery risk model. *Am J Obstet Gynecol*.188:1579-85.
- Main, E.K. (1999). Reducing cesarean birth rates with data-driven quality improvement activities. *Peds*. 103: 374-383.
- Main E.K., Bloomfield, L., & Hunt, G. (2004). Development of a large-scale obstetric quality-improvement program that focused on the nulliparous patient at term. *Am J Obstet Gynecol*.190:1747-58.
- Main, E.K., Moore, D., Farrell, B., Schimmel, L.D., Altman, R.J., Abrahams, C., et al., (2006). Is there a useful cesarean birth measure? Assessment of the nulliparous term singleton vertex cesarean birth rate as a tool for obstetric quality improvement. *Am J Obstet Gynecol*. 194:1644-51.
- Menacker, F. (2005).Trends in cesarean rates for first births and repeat cesarean rates for low-risk women: United States, 1990-2003. *Nat Vital Stat Rep*. 54(4): 1-5.
- Romano, P.S., Yasmeen, S., Schembri, M.E., Keyzer, J.M., & Gilbert, W.M. (2005). Coding of perineal lacerations and other complications of obstetric care in hospital discharge data. *Am J Obstet Gynecol*.106:717-25.
- U.S. Department of Health and Human Services. (2000). *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office. Measure 16-9.
- Yasmeen, S., Romano, P.S., Schembri, M.E., Keyzer, J.M., & Gilbert, W.M. (2006). Accuracy of

obstetric diagnoses and procedures in hospital discharge data. *Am J Obstet Gynecol*. 194:992-1001.

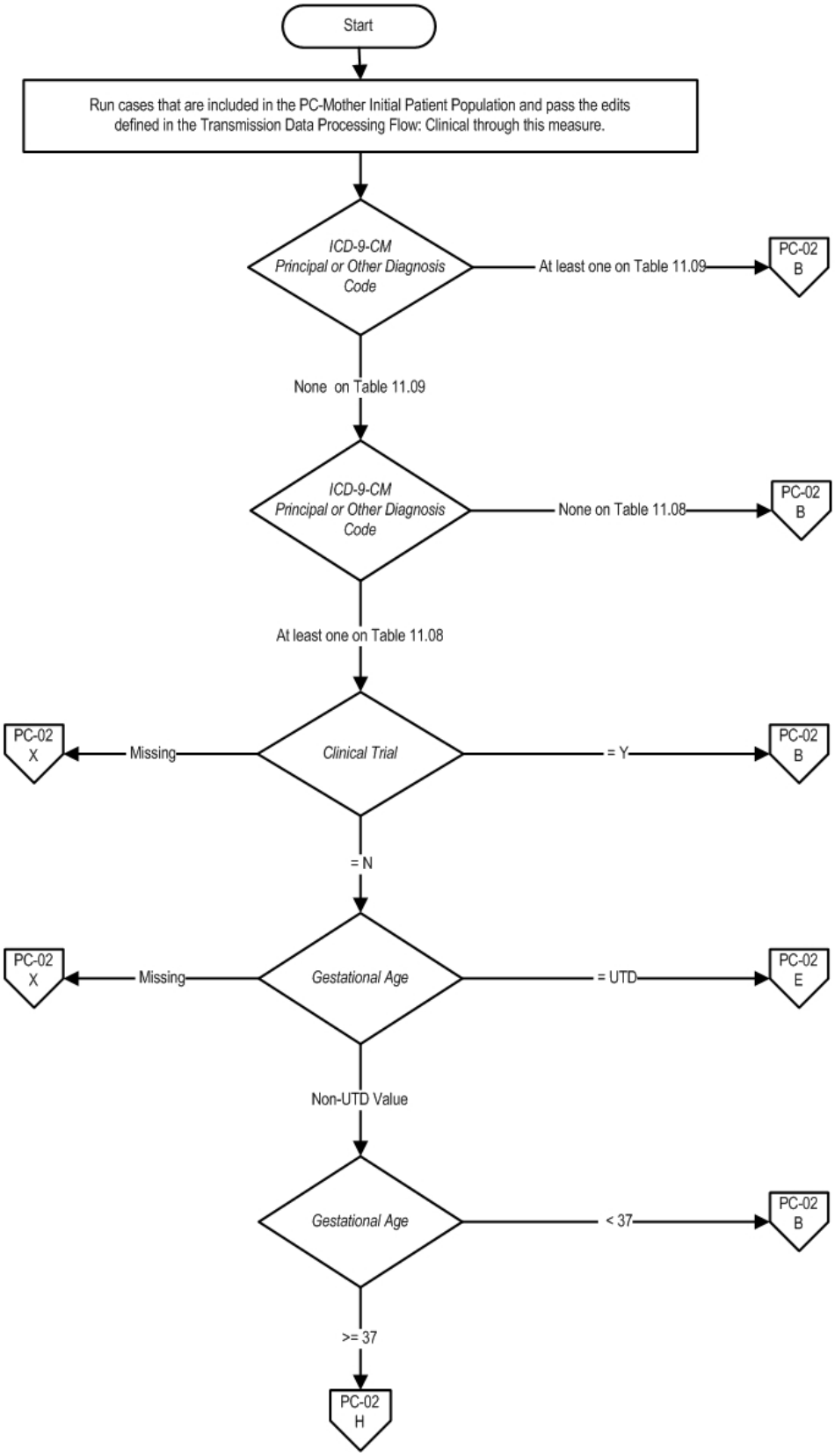
Original Performance Measure Source / Developer:
California Maternal Quality Care Collaborative

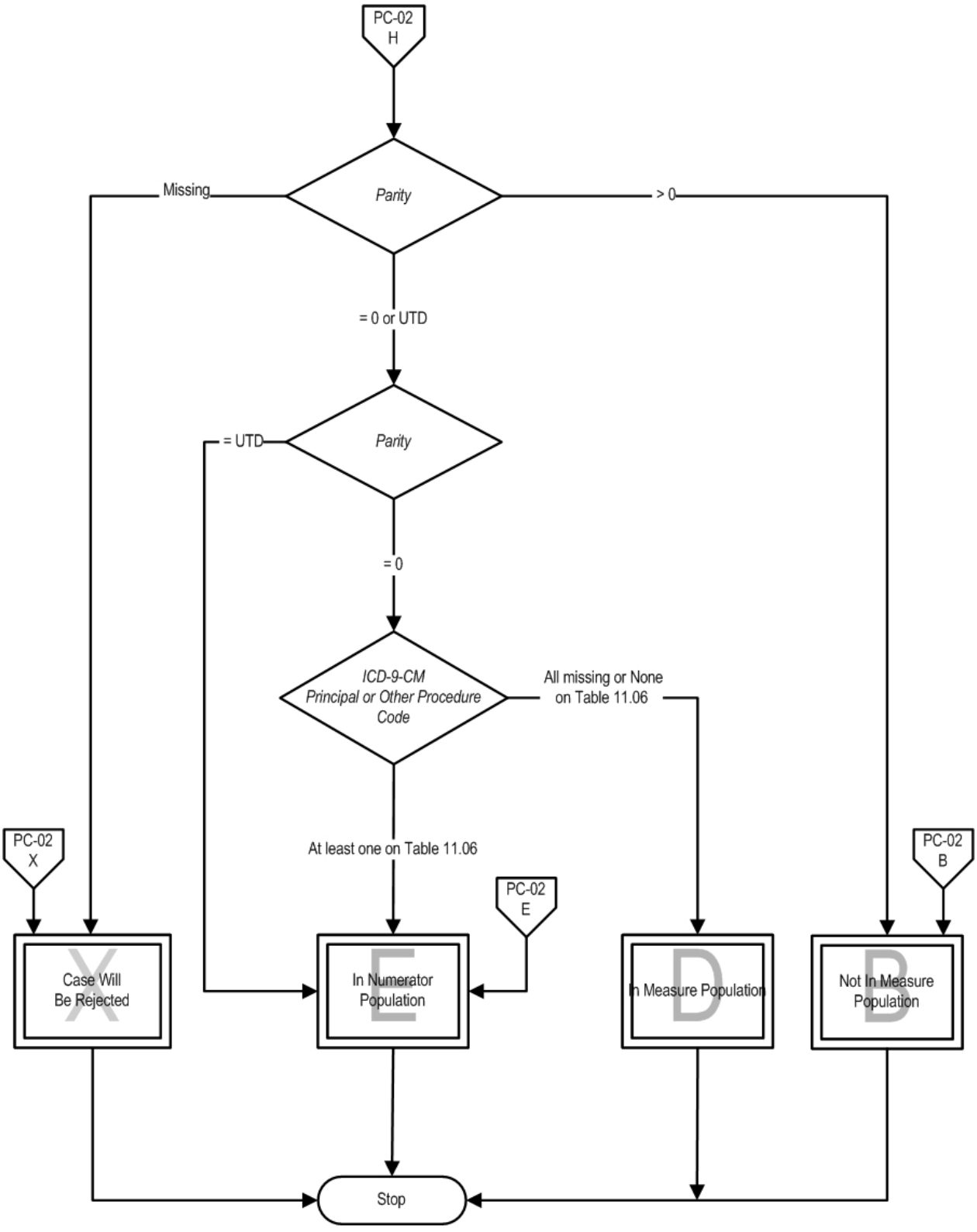
Measure Algorithm:

PC-02: Cesarean Section

Numerator: Patients with cesarean sections

Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation





Related Topics
a. Table of Contents

z. Appendix A - ICD-9-CM Code Tables

Measure Information Form

Measure Set: Perinatal Care(PC)

Set Measure ID: PC-03

Performance Measure Name: Antenatal Steroids

Description: Patients at risk of preterm delivery at 24-32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns

Rationale: The National Institutes of Health 1994 recommendation is to give a full course of corticosteroids to all pregnant women between 24 weeks and 34 weeks of gestation who are at risk of preterm delivery. Repeated corticosteroid courses should not be used routinely, because clinical trials show decreased brain size, decreased birth weight, and adrenal insufficiency in newborns exposed to repeated doses. Treatment should consist of two doses of 12 mg of betamethasone given intramuscularly 24 hours apart or four doses of 6 mg dexamethasone given intramuscularly every 12 hours. A full course of antenatal corticosteroids should be administered to women with premature rupture of membranes (PROM) before 32 weeks of gestation to reduce the risks of respiratory distress syndrome, prenatal mortality, and other morbidities. The efficacy of corticosteroid use at 32-34 completed weeks of gestation is unclear based on available evidence, but treatment may be beneficial, particularly if pulmonary immaturity is documented (Lockwood & Lemons, 2007).

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Patients with a full course of antenatal steroids completed prior to delivering preterm newborns

Included Populations: Full course of antenatal steroids (refer to Appendix B, Table 11.0, antenatal steroid medications)

Excluded Populations: None

Data Elements:

- *Antenatal Steroid Administered*

Denominator Statement: Patients delivering preterm newborns with 24-32 weeks gestation completed

Included Populations: Not applicable

Excluded Populations:

- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of Stay >120 days
- Enrolled in clinical trials

- Documented *Reason for Not Administering Antenatal Steroid*

Data Elements:

- *Admission Date*
- *Birthdate*
- *Clinical Trial*
- *Discharge Date*
- *Gestational Age*
- *Reason for Not Administering Antenatal Steroid*

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: In order to identify areas for improvement in antenatal steroid administration rates, hospitals may wish to review documentation for reasons. Education efforts can be targeted based on the specific reasons identified.

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

- Lockwood, C.J., ed. & Lemons, J.A., ed. (2007). Guidelines for Perinatal Care, Sixth Edition, *American Academy of Pediatrics and the American College of Obstetricians and Gynecologists*, ISBN 978-1-58110-270-3; ISBN 978-1-932328-36-3, pp. 178-181.
- NIH Consensus Development Conference Statement: *The Effect of Corticosteroids for Fetal Maturation on Perinatal Outcomes*. February 28-March 2, 1994.

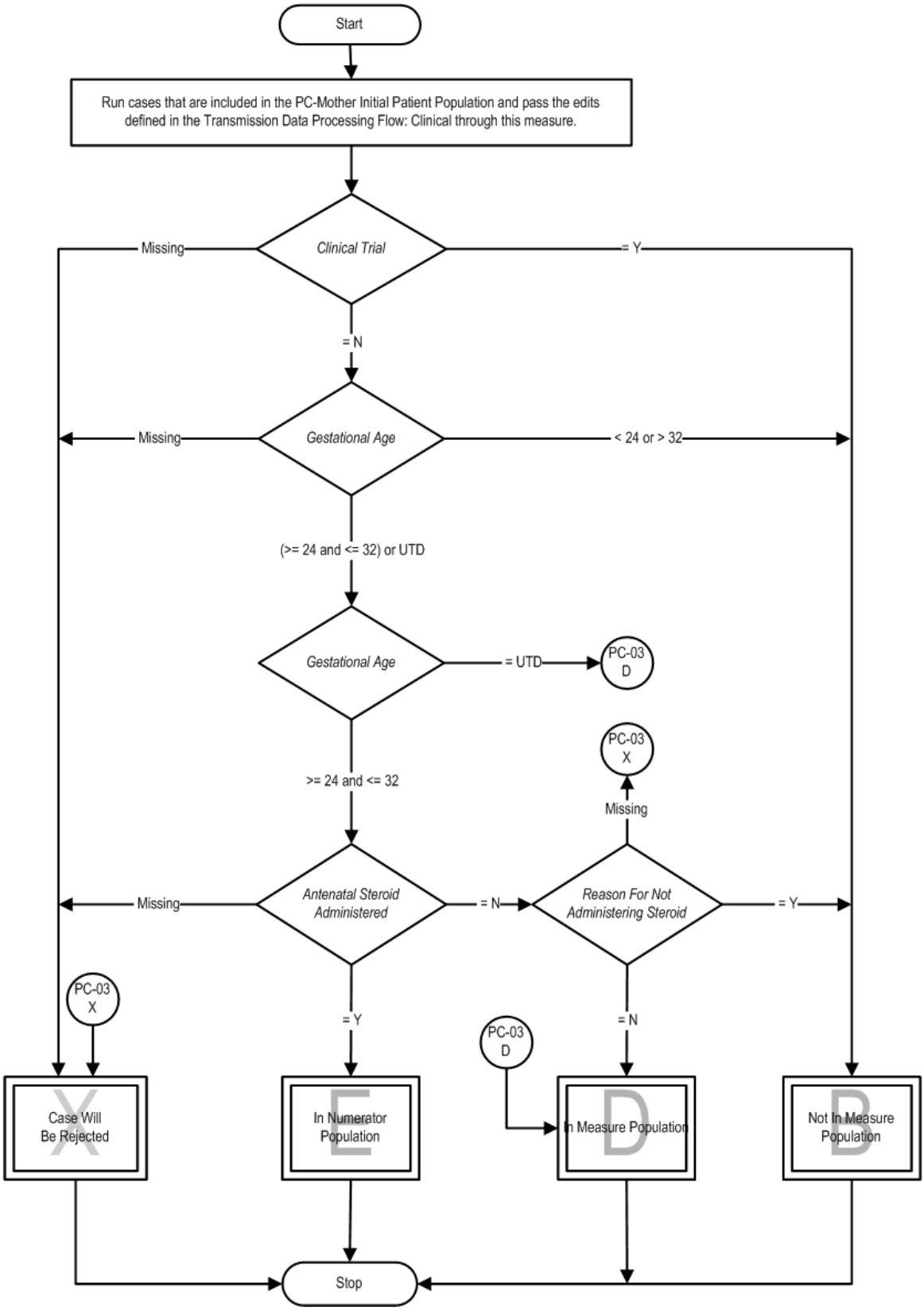
Original Performance Measure Source / Developer:
Providence St Vincent's Hospital/Council of Women and Infant's Specialty Hospitals

Measure Algorithm:

PC-03: Antenatal Steroids

Numerator: Patients receiving a full course of antenatal steroids completed prior to delivering preterm newborns

Denominator: Patients delivering preterm newborns at 24-32 weeks gestation completed



Related Topics
a. Table of Contents

z. Appendix B - Medication Tables

Measure Information Form

Measure Set: Perinatal Care(PC)

Set Measure ID: PC-04

Performance Measure Name: Health Care-Associated Bloodstream Infections in Newborns

Description: Staphylococcal and gram negative septicemias or bacteremias in high-risk newborns

Rationale: Health care-associated bacteremia is significant problem for infants admitted into neonatal intensive care units (NICUs) and other hospital units. This is especially true for very low birth weight infants who are at high risk for these infections due to their immature immune systems and need for invasive monitoring and supportive care (Adams-Chapman & Stoll, 2002; Bloom et al., 2003; Clark et al., 2004a; Clark et al., 2004b; Gaynes et al., 1996; Payne et al., 2004; Sohn et al., 2001; Stoll et al., 2002). Reported health care-associated infection rates range from 6% to 33%, but the rate varies widely among different centers (Adams-Chapman & Stoll, 2002; Bloom et al.,2003; Clark et al.,2004b ; Sohn et al.,2001; Stoll et al.,2002). Mortality rates are high and infections result in increased length of stay as well as increased hospital costs and charges (Adams-Chapman & Stoll, 2002; Bloom et al.,2003; Clark et al., 2004b; Horbar et al., 2001; Kilbride et al., 2003a; Sohn et al.,2001; Stoll et al., 2002).

The incidence of health care-associated bacteremia increases with decreasing birth weight. Other risk factors include central venous catheter use, prolonged time using parenteral nutrition, prolonged time on mechanical ventilation, use of H2-blocking agents, and overcrowding or heavy staff loads (Adams-Chapman & Stoll, 2002; Barton et al., 1999; Gaynes et al., 1996; Stoll et al., 2002). The most common causative organisms are coagulase-negative staphylococci, Staphylococcus aureus, enterococci, Enterobacter sp, and Escherichia coli (Adams-Chapman & Stoll, 2002; Clark et al., 2004b; Gaynes et al., 1996; Horbar et al., 2001; Payne et al., 2004; Sohn et al., 2001; Stoll et al., 2002).

Effective preventive measures range from simple hand-washing protocols or closed medication delivery systems to more elaborate multidisciplinary quality improvement plans involving hand-washing, nutrition, skin care, respiratory care, vascular access, and diagnostic practices. All of these interventions have been shown to substantially reduce infection rates, albeit in nonrandomized studies using historical or concurrent control units (Adams-Chapman & Stoll, 2002; Aly et al., 2005; Bloom et al., 2003; Clark et al., 2004a; Clark et al., 2004b; Horbar et al., 2001; Lam et al., 2004; Kilbride et al., 2003a; Kilbride et al., 2003b; Ng et al., 2004; Schelonka et al., 2006). For example, six Vermont Oxford Network NICUs reduced their rates of coagulase-negative staphylococcus infections from 22.0% in 1994 to 16.6% in 1996 after implementing a quality improvement model (versus a much smaller decrease from 15.4% to 14.5% at 66 comparison NICUs) (Horbar et al., 2001). A similar reduction from 24.6% to 16.4% was achieved with a multi-modality, multi-hospital intervention focusing on hand hygiene with an effective agent before and after every patient contact, eliminating hand jewelry and artificial nails, using maximal barrier precautions during central venous catheter insertion, decreasing the number of skin punctures, reducing the duration of intravenous lipid and deep line use, and improving the diagnosis of health care-associated infections. (Kilbride et al., 2003a; Kilbride et al., 2003b).

Given the fragility and susceptibility of the patient population, a baseline level of health care-associated infections will be expected, even with good protocols in place. However, those centers that have prevention protocols, and are able to encourage health care workers to adhere to these protocols, will probably have

success in reducing their rates of health care-associated bacteremia in their neonatal population. Indeed, several quasi-experimental studies have demonstrated that NICUs can lower their infection rates (based on positive blood cultures) from as high as 13.5 per 1,000 patient days to as low as 3.0 per 1,000 patient days(Adams-Chapman & Stoll, 2002; Aly et al., 2005; Bloom et al. ,2003; Clark et al., 2004a; Clark et al., 2004b; Horbar et al., 2001; Lam et al., 2004; Kilbride et al., 2003a; Kilbride et al., 2003b; Ng et al., 2004; Schelonka et al., 2006).

Type of Measure: Outcome

Improvement Noted As: Decrease in the rate

Numerator Statement: Newborns with septicemia or bacteremia

Included Populations: *ICD-9-CM Other Diagnosis Codes* for newborn septicemia or bacteremia as defined in Appendix A, Table 11.10 and one diagnosis code from Table 11.11

Excluded Populations: None

Data Elements:

- *ICD-9-CM Other Diagnosis Codes*

Denominator Statement: Live-born newborns

Included Populations:

- ICD-9-CM Other Diagnosis Codes for birth weight between 500 and 1499g as defined in Appendix A, Table 11.12, 11.13 or 11.14 OR *Birth Weight* between 500 and 1499g

OR

- ICD-9-CM Other Diagnosis Codes for birth weight ≥ 1500g as defined in Appendix A, Table 11.15,11.16 or 11.17 OR *Birth Weight* ≥ 1500g who experienced one or more of the following:
  - Experienced death
  - *ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes* for major surgery as defined in Appendix A, Table 11.18
  - *ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes* for mechanical ventilation as defined in Appendix A, Table 11.19
  - Transferred in from another acute care hospital within 2 days of birth

Excluded Populations:

- *ICD-9-CM Principal Diagnosis Code* for newborn septicemia or bacteremia as defined in Appendix A, Table 11.10
- *ICD-9-CM Other Diagnosis Codes* for birth weight < 500g as defined in Appendix A, Table 11.20 OR Birth Weight < 500g
- Length of Stay < 2 days OR > 120 days
- Enrolled in clinical trials

Data Elements:

- *Admission Date*
- *Admission Type*

- *Birth Weight*
- *Birthdate*
- *Clinical Trial*
- *Discharge Date*
- *Discharge Status*
- *ICD-9-CM Other Diagnosis Codes*
- *ICD-9-CM Other Procedure Codes*
- *ICD-9-CM Principal Diagnosis Code*
- *ICD-9-CM Principal Procedure Code*
- *Point of Origin for Admission or Visit*

Risk Adjustment: Yes. This section has been moved to the *ORYX Risk Adjustment Guide*. This guide is available to the public on the Joint Commission's website and, in addition, it is available to performance measurement systems via the Joint Commission's extranet site for measurement systems (PET).

Data Elements:

- Birth Weight
- Congenital Anomalies
- Gestational Age
- Multiple Births
- Sex

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: * Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

- Since Birth Weight is a risk factor for hospital associated blood stream infections in newborns, ICD-9-CM codes have been provided in Appendix A, Tables 11.12-11.17, 11.20 to assist in identifying newborns with prematurity and fetal growth retardation with a fifth digit subclassification to denote birth weight (less than 500 grams up to birth weight 2000-2499 grams). Therefore, newborns with birth weights greater than or equal to 2500 grams will need to be captured using the data element Birth Weight.
- It is important to ensure that all weight conversions from pounds and ounces to grams are accurate and concise. Birth Weight should not be rounded off i.e., when converting from pounds and ounces to grams, do not round to the nearest pound before converting the weight to grams.
- Discrepancies can occur between Birth Weights obtained from labor and delivery vs. nursery departments. Organizations should determine which is the most reliable source for this data element value and consistently obtain it from that source.

Measure Analysis Suggestions: In order to identify areas for improvement, hospitals may want to review results based on specific ICD-9 codes or patient populations. Data could then be analyzed further determine specific patterns or trends to help reduce bloodstream infections.

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion. per 1,000 newborns

Selected References:

- Adams-Chapman, I. & Stoll, B.J. (2002). Prevention of nosocomial infections in the neonatal intensive

care unit. *Current Opinion in Pediatrics*.14 (2):157-64.
- Aly, H., Herson, V., Duncan, A., et al. (2005). Is bloodstream infection preventable among premature infants? A tale of two cities. *Pediatrics*. 115(6):1513-8.
- Barton, L., Hodgman, J.E., & Pavlova, Z. (1999). Causes of death in the extremely low birth weight infant. *Pediatrics*. 103(2):446-51.
- Bloom, B.T., Craddock, A., Delmore, P.M., et al. (2003). Reducing acquired infections in the NICU: observing and implementing meaningful differences in process between high and low acquired infection rate centers. *Journal of Perinatology*. 23(6):489-92.
- Clark, R., Powers, R., White, R., Bloom, B., Sanchez, P., & Benjamin, D.K., Jr. (2004a). Prevention and treatment of nosocomial sepsis in the NICU. *Journal of Perinatology*. 4; 24(7):446-53.
- Clark, R., Powers, R., White, R., Bloom, B., Sanchez, P., & Benjamin, D.K., Jr. (2004b). Nosocomial infection in the NICU: a medical complication or unavoidable problem? *Journal of Perinatology*. 24(6):382-8.
- Gaynes, R.P., Edwards, J.R., Jarvis, W.R., Culver, D.H., Tolson, J.S., & Martone, W.J. (1996). Nosocomial infections among neonates in high-risk nurseries in the United States. National Nosocomial Infections Surveillance System. *Pediatrics*. 98(3 Pt 1):357-61.
- Horbar, J.D., Rogowski, J., Plsek, P.E., et al. (2001). Collaborative quality improvement for neonatal intensive care. NIC/Q Project Investigators of the Vermont Oxford Network. *Pediatrics*. 107(1):14-22.
- Kilbride, H.W., Wirtschafter, D.D., Powers, R.J., & Sheehan, M.B. (2003a). Implementation of evidence-based potentially better practices to decrease nosocomial infections. *Pediatrics*. 111(4 Pt 2):e519-33.
- Kilbride, H.W., Powers, R., Wirtschafter, D.D., et al. (2003b). Evaluation and development of potentially better practices to prevent neonatal nosocomial bacteremia. *Pediatrics*. 111(4 Pt 2):e504-18.
- Lam, B.C., Lee, J., & Lau, Y.L. (2004). Hand Hygiene Practices in a Neonatal Intensive Care Unit: A Multimodal Intervention and Impact on Nosocomial Infection. *Pediatrics*.114 (5):e565.
- Ng, P.C., Wong, H.L., Lyon, D.J., et al. (2004). Combined use of alcohol hand rub and gloves reduces the incidence of late onset infection in very low birthweight infants. Archives of Disease in Childhood Fetal & Neonatal Edition. 89(4):F336-40.
- Payne, N.R., Carpenter, J.H., Badger, G.J., Horbar, J.D., & Rogowski, J. (2004). Marginal increase in cost and excess length of stay associated with nosocomial bloodstream infections in surviving very low birth weight infants. *Pediatrics*. 114(2):348-55.
- Schelonka, R.L., Scruggs, S., Nichols, K., Dimmitt, R.A., & Carlo, W.A. (2006). Sustained reductions in neonatal nosocomial infection rates following a comprehensive infection control intervention. *Journal of Perinatology*. 26(3):176-9.
- Sohn, A.H., Garrett, D.O., Sinkowitz-Cochran, R.L., et al. (2001). Prevalence of nosocomial infections in neonatal intensive care unit patients: Results from the first national point-prevalence survey. *Journal of Pediatrics*. 139(6):821-7.
- Stoll, B.J., Hansen, N., Fanaroff, A.A., et al. (2002). Late-onset sepsis in very low birth weight neonates: the experience of the NICHD Neonatal Research Network. *Pediatrics*. 110(2 Pt 1):285-91.

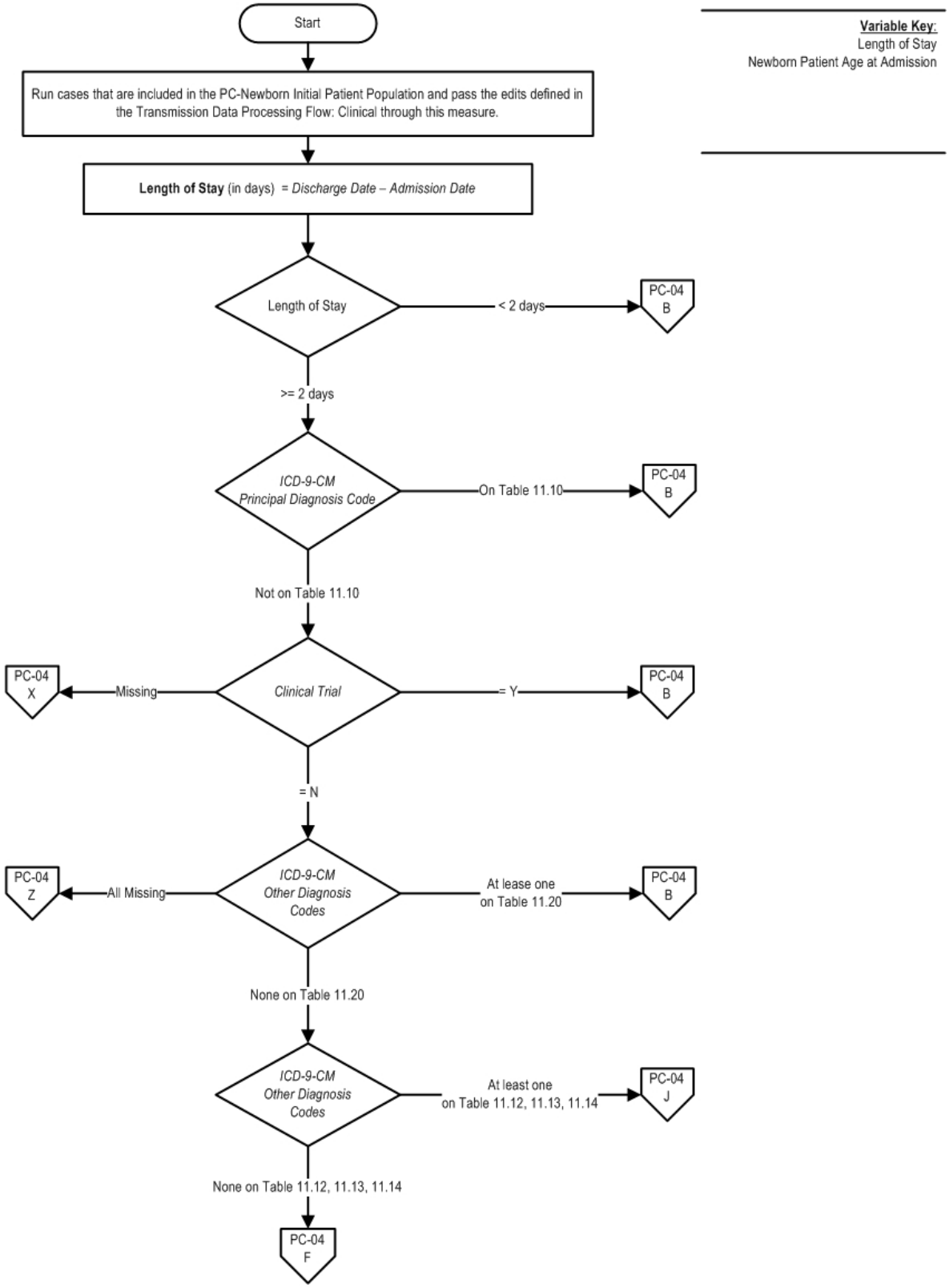
Original Performance Measure Source / Developer:
Agency for Healthcare Research and Quality

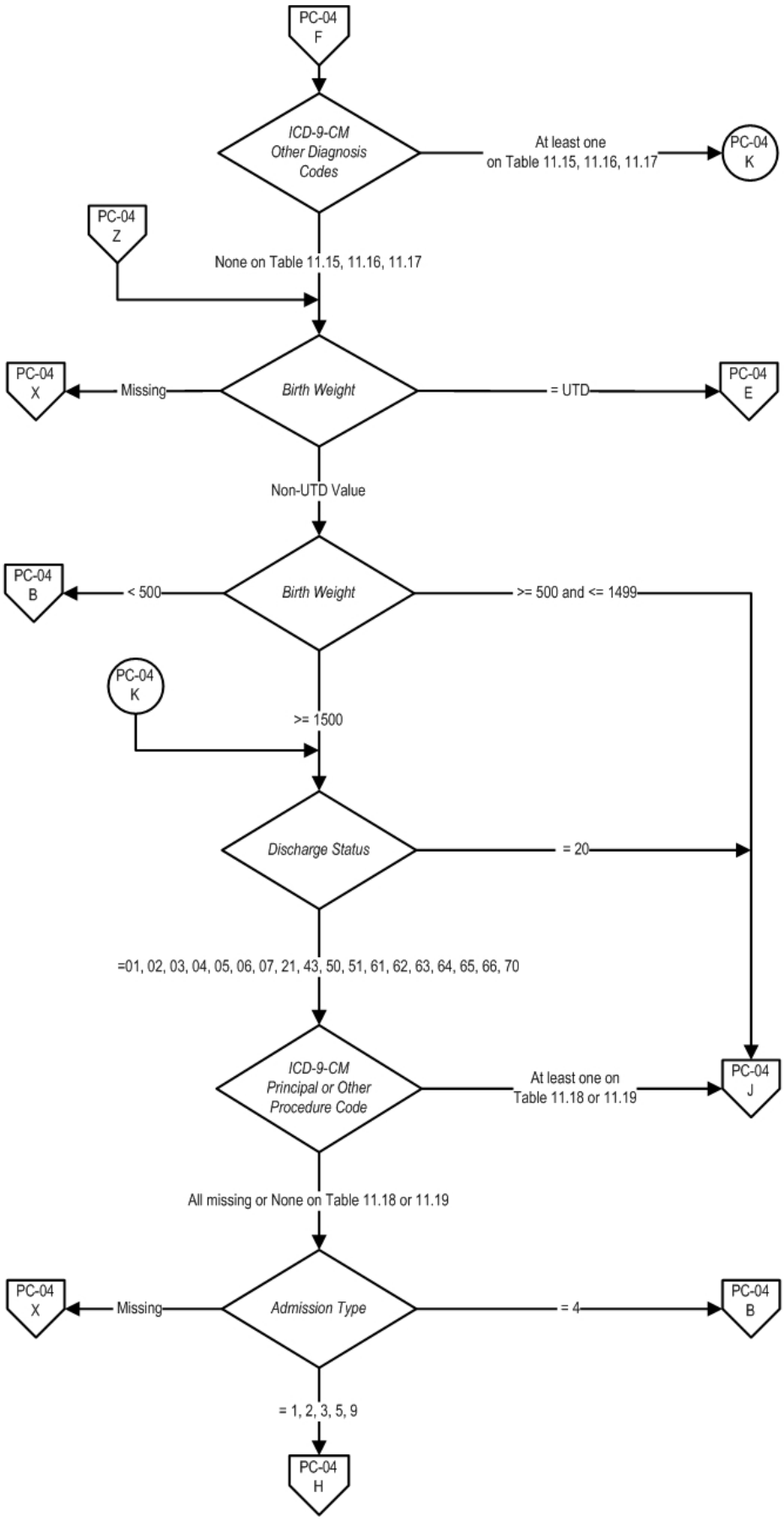
Measure Algorithm:

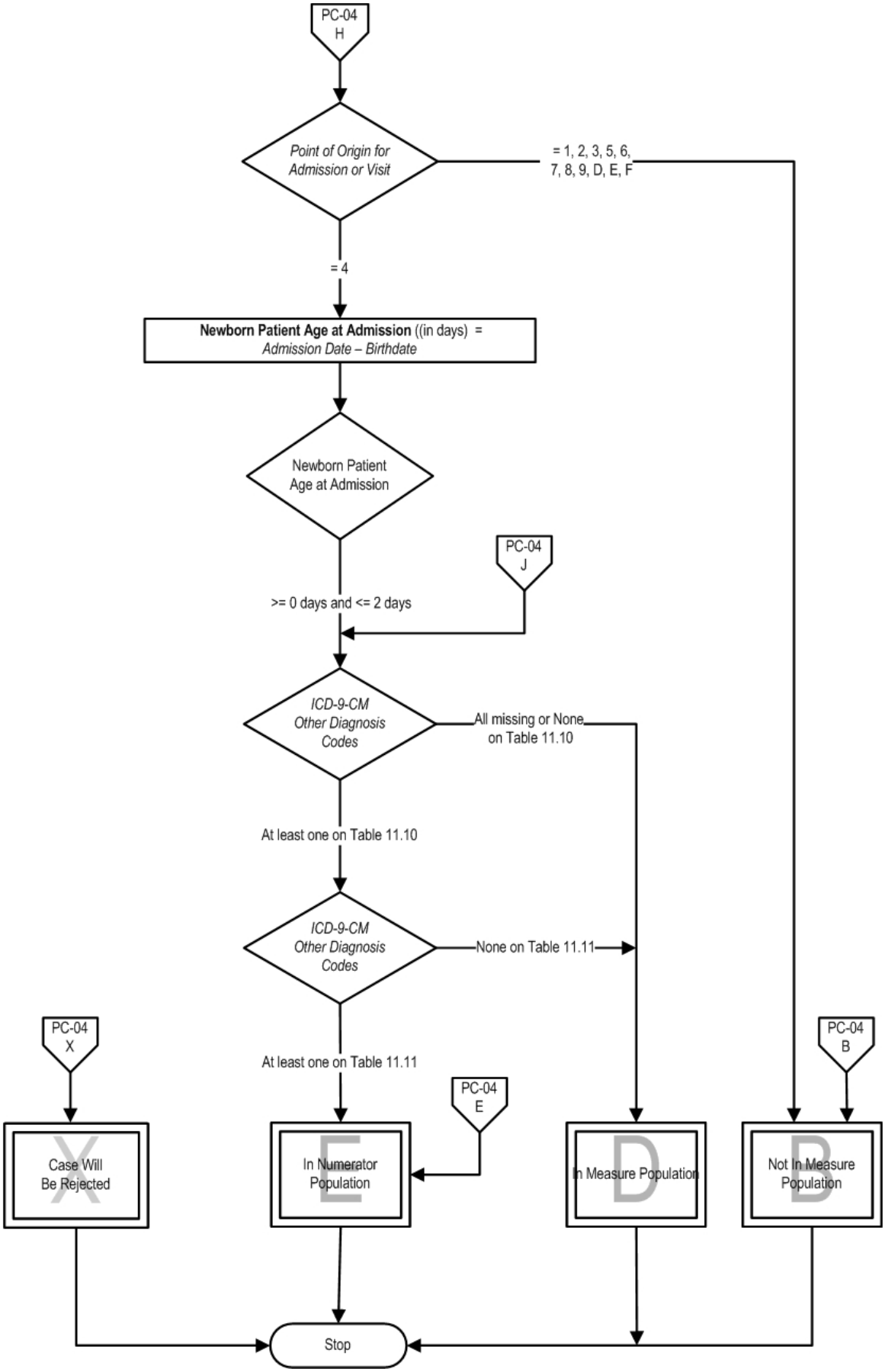
PC-04: Health Care-Associated Bloodstream Infections in Newborns

Numerator: Newborns with septicemia or bacteremia

Denominator: Live-born newborns




PC-04 F
ICD-9-CM Other Diagnosis Codes
At least one on Table 11.15, 11.16, 11.17
PC-04 K
PC-04 Z
None on Table 11.15, 11.16, 11.17
PC-04 X
Missing
Birth Weight
= UTD
PC-04 E
Non-UTD Value
PC-04 B
< 500
Birth Weight
>= 500 and <= 1499
PC-04 K
>= 1500
Discharge Status
= 20
=01, 02, 03, 04, 05, 06, 07, 21, 43, 50, 51, 61, 62, 63, 64, 65, 66, 70
ICD-9-CM Principal or Other Procedure Code
At least one on Table 11.18 or 11.19
PC-04 J
All missing or None on Table 11.18 or 11.19
PC-04 X
Missing
Admission Type
= 4
PC-04 B
= 1, 2, 3, 5, 9
PC-04 H



Related Topics
a. Table of Contents

z. Appendix A - ICD-9-CM Code Tables

Measure Information Form

Measure Set: Perinatal Care(PC)

Set Measure ID: PC-05

Performance Measure Name: Exclusive Breast Milk Feeding

Description: Exclusive breast milk feeding during the newborn's entire hospitalization

Rationale: Exclusive breast milk feeding for the first 6 months of neonatal life has long been the expressed goal of World Health Organization (WHO), Department of Health and Human Services (DHHS), American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG). ACOG has recently reiterated its position (ACOG, 2007). A recent Cochrane review substantiates the benefits (Kramer et al., 2002). Much evidence has now focused on the prenatal and intrapartum period as critical for the success of exclusive (or any) BF (Centers for Disease Control and Prevention [CDC], 2007; Petrova et al., 2007; Shealy et al., 2005; Taveras et al., 2004). Exclusive breast milk feeding rate during birth hospital stay has been calculated by the California Department of Public Health for the last several years using newborn genetic disease testing data. Healthy People 2010 and the CDC have also been active in promoting this goal.

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Newborns that were fed breast milk only since birth

Included Populations: Not applicable

Excluded Populations: None

Data Elements:

- *Exclusive Breast Milk Feeding*

Denominator Statement: Newborns discharged from the hospital

Included Populations: Live-born newborns

Excluded Populations:

- Discharged from the hospital while in the Neonatal Intensive Care Unit (NICU)
- *ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes* for galactosemia as defined in Appendix A, Table 11.21
- *ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes* for parenteral infusion as defined in Appendix A, Table 11.22
- Experienced death
- Length of Stay >120 days
- Enrolled in clinical trials

- Documented *Reason for Not Exclusively Feeding Breast Milk*

Data Elements:

- *Admission Date*
- *Admission Type*
- *Birthdate*
- *Clinical Trial*
- *Discharge Date*
- *Discharge Status*
- *Discharge from NICU*
- *ICD-9-CM Other Diagnosis Codes*
- *ICD-9-CM Other Procedure Codes*
- *ICD-9-CM Principal Diagnosis Code*
- *ICD-9-CM Principal Procedure Code*
- *Reason for Not Exclusively Feeding Breast Milk*

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: In order to identify areas for improvement in breast milk feeding rates, hospitals may wish to review documentation for reasons. Education efforts can be targeted based on the specific reasons identified.

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

- American Academy of Pediatrics. (2005). Section on Breastfeeding. Policy Statement: Breastfeeding and the Use of Human Milk. *Pediatrics*.115:496– 506.
- American College of Obstetricians and Gynecologists. (Feb. 2007). Committee on Obstetric Practice and Committee on Health Care for Underserved Women.Breastfeeding: Maternal and Infant Aspects. ACOG Committee Opinion 361.
- California Department of Public Health. (2006). Genetic Disease Branch. California In-Hospital Breastfeeding as Indicated on the Newborn Screening Test Form, Statewide, County and Hospital of Occurrence: Available at: http://www.cdph.ca.gov/data/statistics/Pages/BreastfeedingStatistics.aspx.
- Centers for Disease Control and Prevention. (Aug 3, 2007). Breastfeeding trends and updated national health objectives for exclusive breastfeeding--United States birth years 2000-2004. *MMWR - Morbidity & Mortality Weekly Report*. 56(30):760-3.
- Centers for Disease Control and Prevention. (2007). Division of Nutrition, Physical Activity and Obesity. Breastfeeding Report Card. Available at: http://www.cdc.gov/breastfeeding /data/report_card2.htm.
- Ip, S., Chung, M., Raman, G., et al. (2007). Breastfeeding and maternal and infant health outcomes in developed countries. Rockville, MD: *US Department of Health and Human Services*. Available at: http://www.ahrq.gov/downloads/pub/evidence/pdf/brfout/brfout.pdf
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Database of Systematic Reviews. (1):CD003517.
- Petrova, A., Hegyi, T., & Mehta, R. (2007). Maternal race/ethnicity and one-month exclusive breastfeeding in association with the in-hospital feeding modality. *Breastfeeding Medicine*. 2(2):92-8.
- Shealy, K.R., Li, R., Benton-Davis, S., & Grummer-Strawn, L.M. (2005).The CDC guide to breastfeeding interventions. Atlanta, GA: US Department of Health and Human Services, CDC. Available at: http://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf.
- Taveras, E.M., Li, R., Grummer-Strawn, L., Richardson, M., Marshall, R., Rego, V.H., Miroshnik, I., & Lieu, T.A. (2004). Opinions and practices of clinicians associated with continuation of exclusive breastfeeding. *Pediatrics*. 113(4):e283-90.
- U.S. Department of Health and Human Services. (2000). Office of Women's Health. Blueprint for Action on Breastfeeding. Available at: http://www.cdc.gov/breastfeeding/pdf/bluprntbk2.pdf.
- US Department of Health and Human Services. (2007). Healthy People 2010 Midcourse Review. Washington, DC: US Department of Health and Human Services. Available at: http://www.healthypeople.gov/data/midcourse.
- World Health Organization. (1991). Indicators for assessing breastfeeding practices. Geneva, Switzerland: World Health Organization. Available at: http://www.who.int/child-adolescent-health/new_publications/nutrition/who_cdd_ser_91.14.pdf.

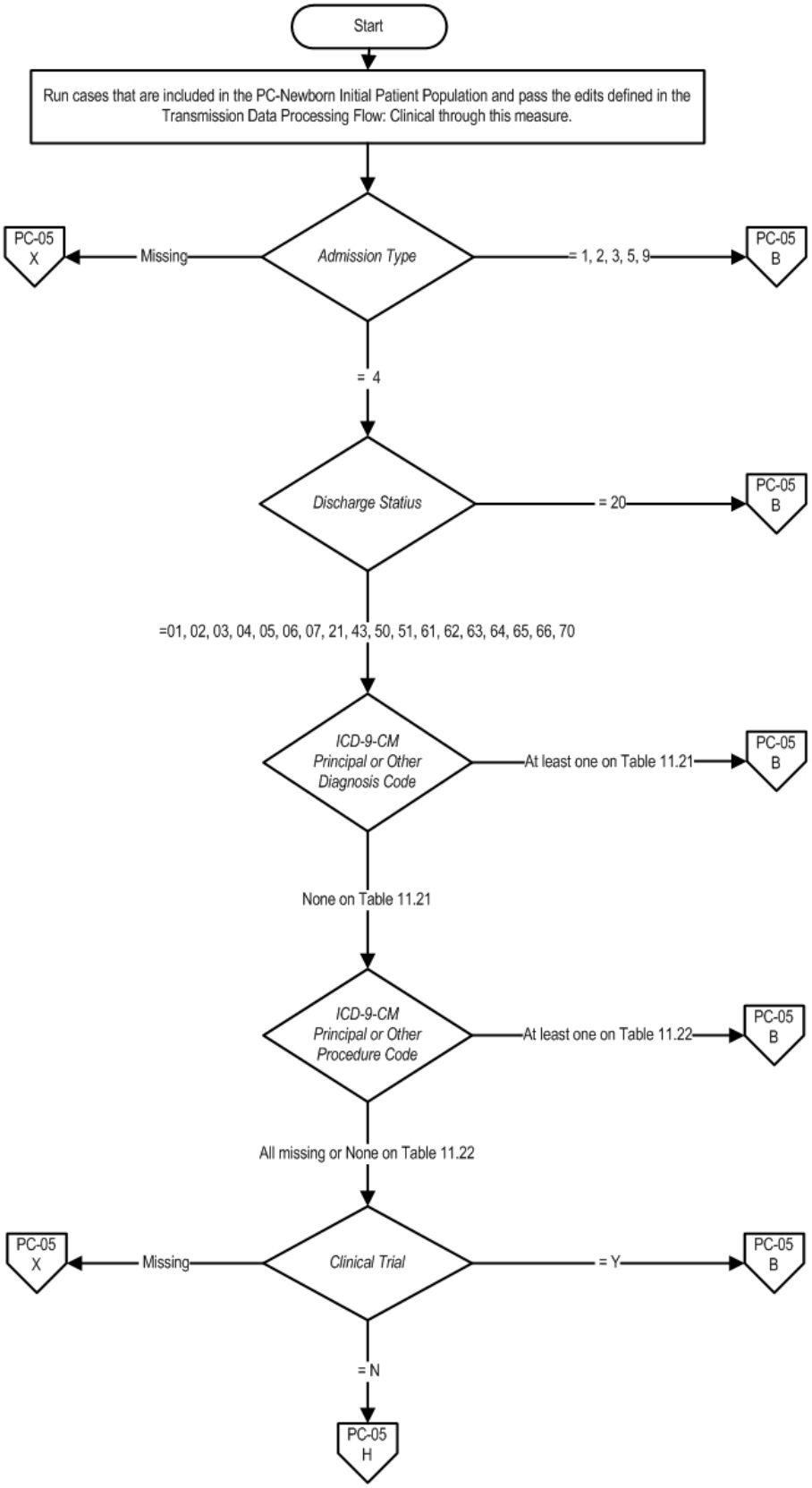
Original Performance Measure Source / Developer:
California Maternal Quality Care Collaborative

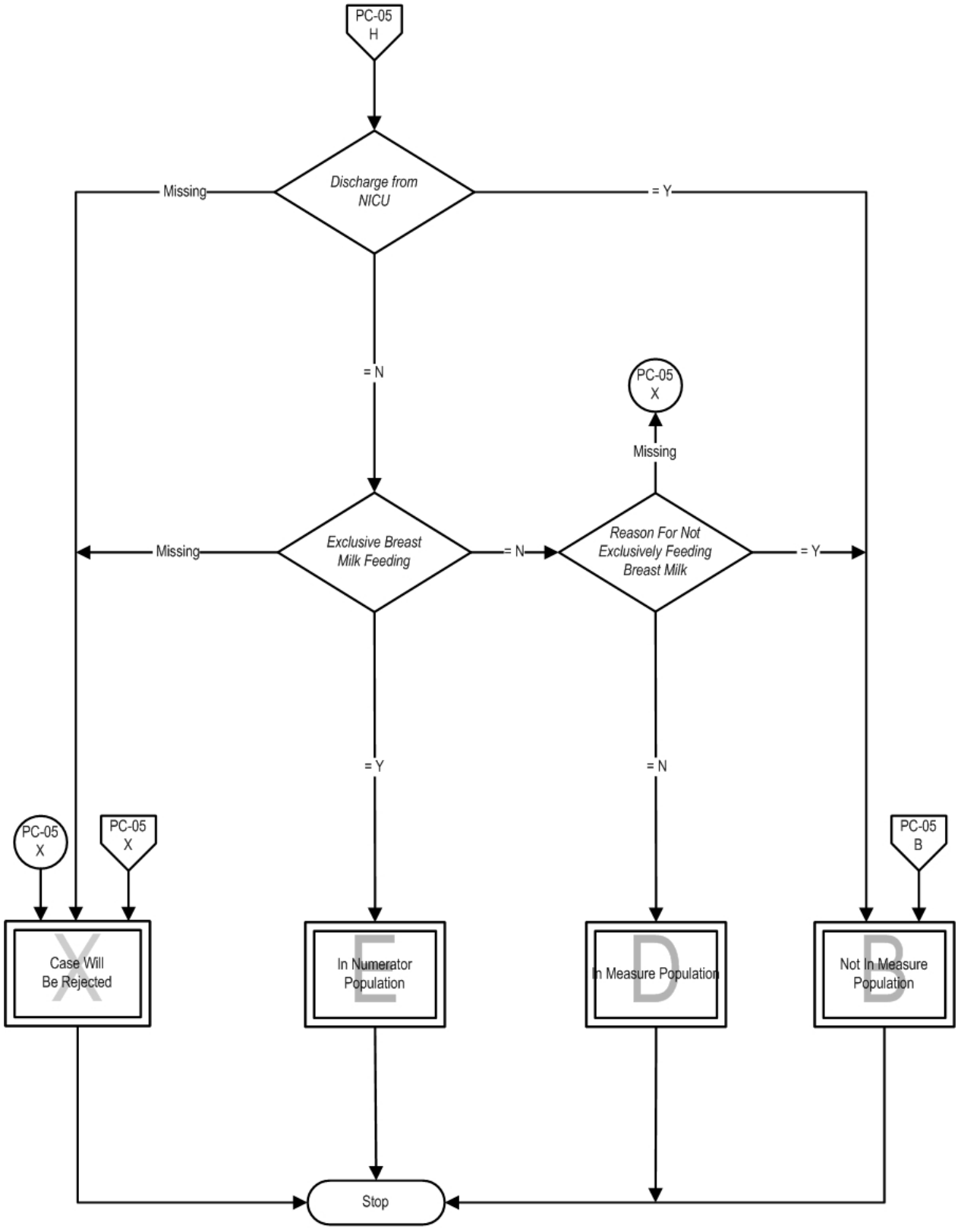
Measure Algorithm:

PC-05: Exclusive Breast Milk Feeding

Numerator: Newborns that were fed breast milk only since birth

Denominator: Newborns discharged from the hospital





Related Topics
a. Table of Contents

z. Appendix A - ICD-9-CM Code Tables

Data Element Name: *Active Labor*

Collected For: PC-01,

Definition: Documentation that the patient was in active labor with regular uterine contractions with cervical change before medical induction and/or cesarean section.

Suggested Data Collection Question: Is there documentation that the patient was in active labor with regular uterine contractions with cervical change before medical induction and/or cesarean section?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) There is documentation that the patient was in active labor with regular uterine contractions with cervical change before medical induction and/or cesarean section.

N (No) There is no documentation that the patient was in active labor with regular uterine contractions with cervical change before medical induction and/or cesarean section OR unable to determine from medical record documentation.

Notes for Abstraction: If the patient presents without a previous cesarean section scar with regular uterine contractions with demonstrated cervical change, e.g., cervical dilation increased from 1cm to 2cm before eventual augmentation and/or cesarean section, select allowable value "Yes".

If the patient presents with a previous cesarean section scar with regular uterine contractions with demonstrated cervical change, e.g., cervical dilation increases from 1cm to 2cm or a cervix dilated 2cm or more before repeat cesarean section, select allowable value "Yes".

Suggested Data Sources:

- History and physical
- Nursing notes
- Physician progress notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Admission Date*

Collected For: All Records

Definition: The month, day, and year of admission for inpatient care.

Suggested Data Collection Question: What is the date the patient was admitted to inpatient care?

Format:

Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2001-Current Year)

Notes for Abstraction:

- The intent of this data element is to determine the date that the patient was actually admitted to 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.
- A patient of a hospital is considered an inpatient upon issuance of written doctor's orders to that effect. (Refer to the Medicare Claims Processing Manual, Chapter 3, Section 40.2.2.)
- 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.
- For patients that are admitted for surgery and/or a procedure, if the admission order states the date the orders were written and they are effective for the surgery/procedure date, then the date of the surgery/procedure would be the admission date. If the medical record reflects that the admission order was written prior to the actual date the patient was admitted and there is no reference to the date of the surgery/procedure, then the date the order was written would be the admission date.
- For HBIPS only, admission dates prior to 2001 are acceptable.

Suggested Data Sources:

PRIORITY ORDER FOR THESE SOURCES

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

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• Admit to observation • Arrival date

Data Element Name: *Admission Type*

Collected For: PC-04, PC-05,

Definition: The code indicating priority/type of admission.

Suggested Data Collection Question: What was the priority/type of admission?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 **Emergency**
The patient requires immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions.

2 **Urgent**
The patient requires immediate attention for the care and treatment of a physical or mental disorder.

3 **Elective**
The patient's condition permits adequate time to schedule the services.

4 **Newborn**
Use of this code necessitates the use of special Source of Admission/Point of Origin codes -- see data element *Point of Origin for Admission or Visit*.

5 **Trauma Center**
Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.

9 **Information not available**

Notes for Abstraction: If unable to determine admission type, select "9."

Suggested Data Sources:

- Emergency department record
- History and physical
- Face sheet
- Progress notes
- UB-04, Field Location: 14

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion

• None	• None

Data Element Name: *Antenatal Steroid Administered*

Collected For: PC-03,

Definition: Documentation that a full course of antenatal steroids was administered before delivery.

A full course of antenatal steroids consists of two doses of 12mg bethamethasone IM 24 hours apart **OR** four doses of mg dexamethasone IM every 12 hours.

Suggested Data Collection Question: Is there documentation that a full course of antenatal steroids was administered before delivery?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) There is documentation that a full course of antenatal steroids was administered before delivery.

N (No) There is no documentation that a full course of antenatal steroids was administered before delivery OR unable to determine from medical record documentation.

Notes for Abstraction: If a full course of antenatal steroids was administered prior to current hospitalization in another setting of care, i.e., doctor's office, clinic, birthing center, hospital before delivery, select allowable value "Yes".

Suggested Data Sources:

- History and physical
- Progress notes
- Medication administration record (MAR)
- Prenatal forms

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix B, Table 11.0 Antenatal Steroid Medications	None

Data Element Name: *Birth Weight*

Collected For: PC-04, Risk Adjustment

Definition: The weight (in grams) of a neonate at the time of delivery.

Note:
453.5 grams = 1 pound
28.35 grams = 1 ounce
It is recommended that each ORYX Vendor provide the ability to enter birth weight in either grams or pounds. However, all birth weights must be converted to grams prior to indicator calculation.

Suggested Data Collection Question: What was the weight of the newborn at delivery?

Format:

Length: 4 or UTD
Type: Alphanumeric
Occurs: 1

Allowable Values:

150 through 8165 grams
UTD = Unable to Determine

Note:
When converting from pounds and ounces to grams, do not round to the nearest pound before converting the weight to grams. Round to the nearest whole number after the conversion to grams.

Notes for Abstraction:

- Birth weights less than 150 grams need to be verified that the baby was live born and for data quality purposes. Birth weights greater than 8165 grams need to be verified for data quality.
- If the birth weight is unable to be determined from medical record documentation, enter "UTD".
- The medical record must be abstracted as documented (taken at "face value"). When the value documented is not a valid number/value per the definition of this data element **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Example:
  Documentation indicates the *Birth Weight* was 0 grams. No other documentation in the medical record provides a valid value. Since the *Birth Weight* is not a valid value, the abstractor should select "UTD."
  Note:
  Transmission of a case with an invalid value as described above will be rejected from the Joint Commission's Data Warehouse. Use of "UTD" for *Birth Weight* allows the case to be accepted into the warehouse.

Suggested Data Sources:

- History and physical
- Nursing notes
- Nursery record
- Delivery record
- Physician progress notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Data Element Name: *Birthdate*

Collected For: All Records

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

Note:
For discharge measures, e.g., HBIPS-1, 4, 5, 6, 7, All PC measures, patient's age (in years) is calculated by *Discharge Date* minus *Birthdate*. For event measures, e.g., 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.

Suggested Data Collection Question: What is the patient's date of birth?

Format:

Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (1880-9999)

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

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Data Element Name: *CMS Certification Number*

Collected For: HBIPS, PC, Transmission , Optional for all records

Definition: Hospital's six digit acute care CMS Certification Number (CCN).

Note: This data element is not used by the HBIPS measure set. It is remaining in the data dictionary to support the common Initial Patient Population and Sample XML file layout. If data is transmitted for this data element associated to the HBIPS measure set, all edits and rules associated to this data element will be applied to the HBIPS data.

Suggested Data Collection Question: What is the hospital's six digit acute care CMS Certification Number?

Format:

Length: 6
Type: Character
Occurs: 1

Allowable Values:

Any valid six digit CMS Certification Number.

The first two digits are the numeric state code. The third digit of zero represents an acute facility. The third digit of "1" and fourth digit of "3" represents a Critical Access Hospital (CAH).

Notes for Abstraction: None

Suggested Data Sources: None

Additional Notes: None

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Clinical Trial*

Collected For: All Records

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.

Suggested Data Collection Question: During this hospital stay, was the patient enrolled in a clinical trial in which patients with the same condition as the measure set were being studied?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) There is 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,

N (No) There is no 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, or unable to determine from medical record documentation.

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.**
     It is not clear which study population the clinical trial is enrolling.
     Assumptions should not be made if it is not specified.

Suggested Data Sources:

ONLY ACCEPTABLE SOURCES:

- Signed consent form for clinical trial

FOR PC ONLY

- UB-04, Field Locations: 67A-Q

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Data Element Name: *Discharge Date*

Collected For: All Records , Not collected for HBIPS-2 and HBIPS-3

Definition: The month, day, and year the patient was discharged from acute care, left against medical advice, or expired during this stay.

Suggested Data Collection Question: What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired?

Format:

Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2001-Current Year)

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 inforation 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

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Data Element Name: *Discharge Status*

Collected For: All Records , Not collected for HBIPS-2 and HBIPS-3; Used in algorithm for PC-04 and PC-05

Definition: The place or setting to which the patient was discharged.

Suggested Data Collection Question: What was the patient's discharge disposition?

Format:

Length: 2
Type: Alphanumeric
Occurs: 1

Allowable Values:

01 **Discharged to home care or self care (routine discharge)**
Usage Note: Includes discharge to home; home on oxygen if DMS only; any other DMS only; group home, foster care, independent living and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs.

02 **Discharged/transferred to a short term general hospital for inpatient care**

03 **Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care**
Usage Note: Medicare-indicates that the patient is discharged/transferred to a Medicare certified nursing facility. For hospitals with an approved swing bed arrangement, use Code 61-Swing Bed. For reporting other discharges/transfers to nursing facilities, see 04 and 64.

04 **Discharged/transferred to a facility that provides custodial or supportive care**
Usage Note: Includes intermediate care facility (ICF) if specifically designated at a state level. Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to state designated Asisted Living Facilities.

05 **Discharged/transferred to a designated cancer center or children's hospital**
Usage Note: Transfers to non-designated cancer hospitals should use Code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at http://www3.cancer.gov/cancercenters/centerslist.html

06 **Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care**
Usage Note: Report this code when the patient is discharged/transferred to home with a **written plan of care** (tailored to the patient's medical needs) **for home care services**.

07 **Left against medical advice or discontinued care**

20 **Expired**

21 **Discharged/transferred to court/law enforcement**
Usage Note: Includes transfers to incarceration facilities such as jail, prison or other detention facilities.

30 **Still Patient**

43 **Discharged/transferred to a federal health care facility**
Usage Note: Discharges and transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.

50 **Hospice - home**

51 **Hospice - medical facility (certified) providing hospice level of care**

61 **Discharged/transferred to hospital-based Medicare approved swing bed**
Usage Note: Medicare-used for reporting patients discharged/ transferred to a SNF level of care within the hospital's approved swing bed arrangement.

62 **Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital**

63 **Discharged/transferred to a Medicare certified long term care hospital (LTCH)**
Usage Note: For hospitals that meet the Medicare criteria for LTCH certification.

64 **Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare**

65 **Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital**

66 **Discharged/transferred to a Critical Access Hospital (CAH)**

70 **Discharged/transferred to another type of health care institution not defined elsewhere in this code list (See Code 05)**

Joint Commission NOTE:
If state assigned codes are used, it is the measurement system's responsibility to crosswalk the code to one of the allowable values listed above for the purposes of ORYX®.

NOTE: The Joint Commission is aware that there are additional UB-04 allowable values for this data element; however, they are not used for the national quality core measures set at this time.

Notes for Abstraction:

- The values for *Discharge Status* are taken from the National Uniform Billing Committee (NUBC) manual which is used by the billing/HIM to complete the UB-04.
- Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the UB-04 value is what is reflected in the medical record. For abstraction purposes, it is important that the medical record reflect the appropriate discharge status. If the abstractor determines through chart review that the claim information discharge status is not what is reflected in the medical record, she/he should correct and override the downloaded value.
- It would be appropriate to work with your billing office to develop processes that can be incorporated to improve medical record documentation to support the appropriate discharge status and to ensure consistency between the claim information discharge status and the medical record.
- Allowable Value 30 (Still patient) is a valid value for HBIPS-2 and HBIPS-3 because these measures are collected concurrently. This allowable value is not valid for discharge measures, including, HBIPS-1, 4, 5, 6 and 7 and PC measures.
- 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
- Discharge instruction sheet
- Nursing discharge notes
- Social service notes
- Transfer record
- UB-04, Field Location: 17

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• Refer to Appendix E, Table 2.5 Discharge Status Disposition.	• None

Data Element Name: *Discharge from NICU*

Collected For: PC-05,

Definition: Documentation that the newborn was a patient in the Neonatal Intensive Care Unit (NICU) at the time of discharge from the hospital.

Suggested Data Collection Question: Was the newborn a patient in the NICU at the time of discharge from the hospital?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) There is documentation that the newborn was a patient in the NICU at the time of discharge from the hospital.

N (No) There is no documentation that the newborn was a patient in the NICU at the time of discharge from the hospital or unable to determine from medical record documentation.

Notes for Abstraction: None

Suggested Data Sources:

- Nursing notes
- Discharge summary
- Physician progress notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Data Element Name: *Exclusive Breast Milk Feeding*

Collected For: PC-05,

Definition: Documentation that the newborn was exclusively fed breast milk during the entire hospitalization.

Exclusive breast milk feeding is defined as a newborn receiving only breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals, or medicines.

Suggested Data Collection Question: Is there documentation that the newborn was exclusively fed breast milk during the entire hospitalization?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) There is documentation tha the newborn was exclusively fed breast milk during the entire hospitalization.

N (No) There is no documentation that the newborn was exclusively fed breast milk during the entire hospitalization OR unable to determine from medical record documentation.

Notes for Abstraction: If the newborn receives any other liquids including water during the entire hospitalization, select allowable value "No".

Exclusive breast milk feeding includes the newborn receiving breast milk via a bottle or other means beside the breast.

Suggested Data Sources:

- Discharge summary
- Feeding flow sheets
- Individual treatment plan
- Intake and output sheets
- Nursing notes
- Physician progress notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Gestational Age*

Collected For: PC-01, PC-02, PC-03,

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.

Suggested Data Collection Question: How many weeks of gestation were completed at the time of delivery?

Format:

Length: 2 or UTD
Type: Alphanumeric
Occurs: 1

Allowable Values:

1-50

UTD=Unable to Determine

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 history and physical should be reviewed first for gestational age. If gestational age is not recorded in the history and physical, then continue to review the data sources in the following order: prenatal forms, delivery or operating room record and clinician admission progrss note 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.

The clinician admission progress note may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN).

If the patient has not received prenatal care, and the gestational age is unknown, select allowable value UTD.

Suggested Data Sources: **ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE:**

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

Data Element Name: *Health Care Organization Identifier*

Collected For: HBIPS, PC, Transmission, Aggregate Data File, Patient Population Data File

Definition: A unique number, assigned by The Joint Commission, to identify the health care organization that is accredited by The Joint Commission. This number is used to identify and group a health care organization's HCO-Level performance measure data.

Suggested Data Collection Question: What is the Joint Commission's unique identification number for the provider?

Format:

Length: 6
Type: Numeric
Occurs: 1

Allowable Values:

1 – 999,999

Notes for Abstraction: None

Suggested Data Sources: Does not apply, assigned by The Joint Commission.

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *ICD-9-CM Other Diagnosis Codes*

Collected For: All Records , Optional for HBIPS-2 and HBIPS-3; Used in algorithm for PC-01, 02, 04, and 05

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the diagnosis for this hospitalization.

Suggested Data Collection Question: What were the ICD-9-CM other diagnosis codes selected for this medical record?

Format:

Length: 6 (implied decimal point)
Type: Alphanumeric
Occurs: 17

Allowable Values:

Any valid ICD-9-CM diagnosis code

Notes for Abstraction: None

Suggested Data Sources:

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

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Data Element Name: *ICD-9-CM Other Procedure Codes*

Collected For: All Records , Optional for All HBIPS Records; Used in algorithm for PC-01, 02, 04 and 05

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes identifying all significant procedures other than the principal procedure.

Note: If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, *ICD-9-CM Other Procedure Date* exists, etc.) will apply.

Suggested Data Collection Question: What were the ICD-9-CM code(s) selected as other procedure(s) for this record?

Format:

Length: 5 (with or without decimal point)
Type: Alphanumeric
Occurs: 5

Allowable Values:

Any valid ICD-9-CM procedure code

Notes for Abstraction: None

Suggested Data Sources:

- Face sheet
- Discharge summary
- UB-04, Field Location: 74A-E

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Data Element Name: *ICD-9-CM Other Procedure Dates*

Collected For: All Records , Optional for All HBIPS Records

Definition: The month, day, and year when the associated procedure(s) was (were) performed.

Note: If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, *ICD-9-CM Other Procedure Codes* exists, etc.) will apply.

Suggested Data Collection Question: What were the date(s) the other procedure(s) were performed?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 5

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2001-Current Year)
UTD = Unable to Determine

Notes for Abstraction:

- If the procedure date for the associated procedure is unable to be determined from medical record documentation, enter UTD.
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care [after *Discharge Date*]) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Examples:
  - Documentation indicates the *ICD-9-CM Other Procedure Dates* was 02- **42** -2008. No other documentation in the medical record provides a valid date. Since the *ICD-9-CM Other Procedure Dates* is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD."
  - Patient expires on 02-12-2008 and documentation indicates the *ICD-9-CM Other Procedure Dates* was 03-12-2008. Other documentation in the medical record supports the date of death as being accurate. Since the *ICD-9-CM Other Procedure Dates* is after the *Discharge Date* (death), it is outside of the parameters of care and the abstractor should select "UTD."
    Note:
    Transmission of a case with an invalid date as described above will be rejected from the Joint Commission's Data Warehouse. Use of "UTD" for *ICD-9-CM Other Procedure Dates* allows the case to be accepted into the warehouse.

Suggested Data Sources:

- Consultation notes
- Face sheet
- Progress notes
- Discharge summary
- Operative report
- Procedure notes
- Diagnostic test reports
- UB-04, Field Locations: 74A-E

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Data Element Name: *ICD-9-CM Principal Diagnosis Code*

Collected For: All Records , Optional for HBIPS-2 and HBIPS-3; Used in algorithm for PC-01, 02, 04, and 05

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.

Suggested Data Collection Question: What was the ICD-9-CM code selected as the principal diagnosis for this record?

Format:

Length: 6 (implied decimal point)
Type: Alphanumeric
Occurs: 1

Allowable Values:

Any valid ICD-9-CM diagnosis code

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

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• Refer to Appendix A, for ICD-9-CM Code Tables (AMI, HF, PN, HBIPS).	• Refer to Appendix A, for ICD-9-CM Code Tables (SCIP).

Data Element Name: *ICD-9-CM Principal Procedure Code*

Collected For: All Records , Optional for All HBIPS Records; Used in algorithm for PC-01, 02, 04 and 05

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code that identifies the principal procedure performed during this hospitalization. The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

Note: If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, *ICD-9-CM Principal Procedure Date* exists, etc.) will apply.

Suggested Data Collection Question: What was the ICD-9-CM code selected as the **principal** procedure for this record?

Format:

Length: 5 (with or without decimal point)
Type: Alphanumeric
Occurs: 1

Allowable Values:

Any valid ICD-9-CM procedure code.

Notes for Abstraction: The principal procedure as described by the Uniform Hospital Discharge Data Set (UHDDS) is one performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

Suggested Data Sources:

- Face sheet
- Discharge summary
- UB-04, Field Location: 74

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Data Element Name: *ICD-9-CM Principal Procedure Date*

Collected For: All Records , Optional for All HBIPS Records

Definition: The month, day, and year when the principal procedure was performed.

Note: If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, *ICD-9-CM Principal Procedure Code* exists, etc.) will apply.

Suggested Data Collection Question: What was the date the principal procedure was performed?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2001-Current Year)
UTD = Unable to Determine

Notes for Abstraction:

- If the principal procedure date is unable to be determined from medical record documentation, enter UTD.
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid date/format or is outside of the parameters of care [after *Discharge Date*]) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Examples:
  - Documentation indicates the *ICD-9-CM Principal Procedure Date* was 02- **42** -2008. No other documentation in the medical record provides a valid date. Since the *ICD-9-CM Principal Procedure Date* is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD."
  - Patient expires on 02-12-2008 and documentation indicates the *ICD-9-CM Principal Procedure Date* was 03-12-2008. Other documentation in the medical record supports the date of death as being accurate. Since the *ICD-9-CM Principal Procedure Date* is after the *Discharge Date* (death), it is outside of the parameter of care and the abstractor should select "UTD."
    Note:
    Transmission of a case with an invalid date as described above will be rejected from the Joint Commission's Data Warehouse. Use of "UTD" for ICD-9-CM Principal Procedure Date allows the case to be accepted into the warehouse.

Suggested Data Sources:

- Consultation notes
- Face sheet
- Progress notes
- Discharge summary
- Diagnostic test reports
- Operative notes
- Procedure notes
- UB-04, Field Location: 74

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Data Element Name: *Initial Patient Population Size – Medicare Only*

Collected For: HBIPS, PC, Transmission, Patient Population Data File , Used in transmission of the Hospital Initial Patient Population Data file.

Note:
Refer to the Hospital Initial Patient Population Data XML File Layout in the Transmission section of this manual.

Definition: Indicates the number of episode of care (EOC) records identified for a hospital with Medicare listed as a payment source prior to the application of data integrity filters, measure exclusions, and/or sampling methodology for the specified time period.

The data element is based on the hospital's initial identification of Medicare EOC records for a measure set, stratum, or sub-population. Initial Patient Population Size – Medicare Only includes all patients that are billed under Medicare or Title 18. Medicare can be listed as a primary, secondary, teritary or lower on the list of payment sources for the patient. In addition, patients who are participating as a member of a Medicare HMO/Medicare Advantage are included in the Medicare counts, e.g., Medicare Blue, Humana Gold, Secure Horizons, AARP, Coventry Advantra, etc. This initial data pull utilizes administrative data such as ICD-9-CM diagnosis and procedure codes, admission date, and birthdate.

For the discharge measures (eg. HBIPS-1, 4, PC-01), refer to the Initial Patient Population discussion in the Measure Information section of this manual for more information.

For the HBIPS event measures (HBIPS-2 and 3), the Initial Patient Population Size – Medicare Only is equal to those EOC records in the census data identified as being Medicare EOC records. The HBIPS census data are calculated by (Psychiatric Inpatient Days-Medicare Only - Total Leave Days-Medicare Only). Initial Patient Population Size – Medicare Only is not derived from those cases that pass through the Initial Patient Population algorithm.

Note:
If the hospital's data has been sampled, this field contains the population from which the sample was originally drawn, NOT the sample size.

Suggested Data Collection Question: Not Applicable

Format:

Length: 6
Type: Numeric
Occurs:

Non-stratified Measure Sets:

One Initial Patient Population Size – Medicare Only per hospital's measure set (e.g., AMI, HF, PN, and STK).

Stratified Measure Sets:

One Initial Patient Population Size – Medicare Only per measure set stratum or sub-population the hospital is participating in:
* The PC measure set has three occurrences, one for the mother sub-population and two for the newborn sub-populations.
* The HBIPS measure set has four occurrences, one for each age stratum.

Note:
Refer to the appropriate version of the Specifications Manual for National Quality Inpatient Measures for the number of occurrences for the CAC, VTE, and SCIP measure sets.

Allowable Values:

0 through 999,999

Notes for Abstraction:

Initial Patient Population Size-Medicare Only must contain the actual number of patients in the population even if the hospital has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter and has decided to not submit patient level data.

Suggested Data Sources:

Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Initial Patient Population Size – Non-Medicare Only*

Collected For: HBIPS, PC, Transmission, Patient Population Data File , Used in transmission of the Hospital Initial Patient Population Data file.

Note:
Refer to the HBIPS Hospital Initial Patient Population Data XML File Layout in the Transmission section of this manual.

Definition: Indicates the number of episode of care (EOC) records identified for a hospital with Medicare NOT listed as a payment source prior to the application of data integrity filters, measure exclusions, and/or sampling methodology for the specified time period.

The data element is based on the hospital's initial identification of non-Medicare EOC records for a measure set, stratum, or sub-population. This initial data pull utilizes administrative data such as ICD-9-CM diagnosis and procedure codes, admission date, and birthdate.

For the discharge measures (eg. HBIPS-1, 4, PC-01), refer to the Initial Patient Population discussion in the Measure Information section of this manual for more information.

For the HBIPS event measures (HBIPS-2 and 3), the Initial Patient Population Size – Non-Medicare Only is equal to those EOC records in the census data identified as not having Medicare listed as a payment source. The HBIPS census data are calculated by (Psychiatric Inpatient Day-Non-Medicare Only - Total Leave Days-Non-Medicare Only). Initial Patient Population Size – Non-Medicare Only is not derived from those cases that pass through the Initial Patient Population algorithm.

Note:
If the hospital's data has been sampled, this field contains the population from which the sample was originally drawn, NOT the sample size.

Suggested Data Collection Question: Not Applicable

Format:

Length: 6
Type: Numeric
Occurs:

Non-stratified Measure Sets:

One Initial Patient Population Size – Non-Medicare Only per hospital's measure set (e.g., AMI, HF, PN, and STK).

Stratified Measure Sets:

One Initial Patient Population Size – Non-Medicare Only per measure set stratum or sub-population the hospital is participating in:

* The PC measure set has three occurrences, one for the mother sub-population and two for the newborn sub-populations.
* The HBIPS measure set has four occurrences, one for each age stratum.

Note:
Refer to the appropriate version of the Specifications Manual for National Quality Inpatient Measures for the number of occurrences for the CAC, VTE, and SCIP measure sets.

Allowable Values:

0 through 999,999

Notes for Abstraction:

Initial Patient Population Size-Non-Medicare Only must contain the actual number of patients in the population even if the hospital has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter and has decided to not submit patient level data.

Suggested Data Sources:

Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Measure Category Assignment*

Collected For: HBIPS, PC, Calculation, Transmission, Hospital Clinical Data File , Used in calculation of the Joint Commission's aggregate data and in the transmission of the Hospital Clinical Data file.

Notes:

- Episode of care records that calculate with a *Measure Category Assignment* of "X" (missing data) for one or more measures will be rejected by the Joint Commission's Data Warehouse. Refer to the Missing and Invalid Data section in this manual for more information.
- All hospital measures use this data element. The ORYX Vendor's calculated *Measure Category Assignment* will be transmitted to The Joint Commission on a quarterly basis with the associated hospital clinical data. These measure results will be used in the Joint Commission's data quality analysis and continuous measure verification process. ORYX Vendors can refer to the Joint Commission's *ORYX Data Quality Manual* for more information.

Definition: Calculated measures results for each episode of care (EOC) that is processed through a measure algorithm.

Used to summarize the outcome for an EOC that is processed through a specific measure algorithm.

Suggested Data Collection Question: Not Applicable

Format:

Length: 1
Type: Character
Occurs: One *Measure Category Assignment* per EOC is expected for every measure that a hospital is participating in.

Allowable Values:

B **Category B - Not in Measure Population**
For rate-based and continuous variable measures:
EOC record is not a member of a measure's population.

For rate-based-ratio measures:
Does not apply.

D **Category D - In Measure Population**
For rate-based measures:
EOC record is a member of the measure's population and there has not been an occurrence of the measure.

For rate-based-ratio measures:
Does not apply.

For continuous variable measures:

EOC record is a member of the measure's population and has sufficient accurate and valid data to compute the measurement.

Note:
For continuous variable measures, EOC records that have a *Measure Category Assignment* of "D" **will** have an associated *Measurement Value*.

E **Category E - In Numerator Population**
For rate-based measures:
EOC record is a member of the measure's population and there has been an occurrence of the measure.

For rate-based-ratio measures:
Event record is a member of the measure's population and there has been an occurrence of the measure.

For continuous variable measures:
Does not apply.

U **Category U – Not In Numerator Population**

For rate-based-proportion measures:
Does not apply

For rate-based-ratio measures:
Event record is a member of the measure's population; however, it contains a data element whose allowable value excludes it from the numerator.

For continuous variable measures:
Does not apply.

X **Category X – Data Are Missing**
For rate-based and continuous variable measures:
Data are missing that is required to calculate the measure. The record will be rejected by the QIO Clinical Warehouse and the Joint Commission's Data Warehouse.

Y **Category Y – UTD Allowable Value Does Not Allow Calculation of The Measure**
For rate-based measures:
Does not apply.

For rate-based-ratio measures: Event record contains a Date, Time, or Numeric data element with a value of 'UTD'.

For continuous variable measures:
EOC record contains a Date, Time, or Numeric data element with a value of 'UTD'.

Note:
For continuous variable measures, EOC records that have a *Measure*

Category Assignment of "Y" **will not** have an associated _Measurement Value_

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Data Element Name: *Measure Set*

Collected For: HBIPS, PC, Transmission, Patient Population Data File, Hospital Clinical Data File

Definition: Indicates which measure set (topic) is being transmitted for a hospital.

Suggested Data Collection Question: Not Applicable

Format:

Length: 10
Type: Character
Occurs: Hospital Clinical Data file: 1
Hospital Initial Patient Population Data file: 1 – 10

Allowable Values:

Refer to the Hospital Clinical Data XML File Layout and the Hospital Initial Patient Population Data XML File Layout in the Transmission section of this manual.

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Measurement Value*

Collected For: HBIPS, PC, Calculation, Transmission, Hospital Clinical Data File , Used in the calculation of the Joint Commission's aggregate data, Continuous Variable Measures and in the transmission of the Hospital Clinical Data file

Note:

- The ORYX Vendor's calculated *Measurement Value* will be transmitted to The Joint Commission on a quarterly basis with the associated hospital clinical data. These measure results will be used in the Joint Commission's data quality analysis and continuous measure verification process. ORYX Vendors can refer to the Joint Commission's *ORYX Data Quality Manual* for more information.

Definition: This data element is used to store the calculated results of the measurements that are outputs from continuous variable measure algorithms.

Note:
Used in conjunction with *Measure Category Assignment* when its allowable value = "D" (In Measure Population).

Suggested Data Collection Question: Not Applicable

Format:

Length: 6
Type: Numeric
Occurs: One *Measurement Value* is expected per EOC for every continuous variable measure that a hospital is participating in.

Allowable Values:

Any valid number

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Data Element Name: *National Provider Identifier*

Collected For: HBIPS, PC, Transmission , Optional for All Records

Definition: All Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered healthcare providers must obtain a National Provider Identifier (NPI). The NPI may be provided in addition to the Medicare provider number.

Suggested Data Collection Question: What is the NPI for this provider?

Format:

Length: 10
Type: Character
Occurs: 1

Allowable Values:

Any valid 10 digit NPI number.

The 10th digit is a numeric check digit based off the first 9 digits.

Notes for Abstraction: None

Suggested Data Sources: UB-04, Field Location: 56

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Parity*

Collected For: PC-02,

Definition: The number of deliveries, whether resulting in live or stillborn infants, the patient experienced prior to current hospitalization.

Suggested Data Collection Question: How many deliveries did the patient experience prior to current hospitalization?

Format:

Length: 2 or UTD
Type: Alphanumeric
Occurs: 1

Allowable Values:

0-50

UTD=Unable to Determine

Notes for Abstraction:

The history and physical should be reviewed first for parity. If parity is not recorded in the history and physical, then continue to review the data sources in the following order: prenatal forms, delivery or operating room record and clinician admission progress note until a positive finding for parity is found. In cases where there is conflicting data, parity found in the first document according to the order listed above should be used.

The clinician admission progress note may be written by the following clincians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN).

Suggested Data Sources:

ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE:

- History and physical
- Prenatal forms
- Delivery room record
- Operating room record
- Admission clinician progress note

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
The following descriptor must precede the number when determining parity: • Parity • P	A string of three or more numbers without the alpha designation of "p" preceding the second number can not be used to determine parity. Example: 321

Examples: parity=2 or g3p2a1	

Data Element Name: *Payment Source*

Collected For: All Records , Optional for HBIPS-2 and HBIPS-3

Definition: The source of payment for this episode of care.

Suggested Data Collection Question: What is the patient's source of payment for this episode of care?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 Source of payment is Medicare.

2 Source of payment is NonMedicare.

Notes for Abstraction:

- If Medicare is listed as the primary, secondary, tertiary, or even lower down on the list or payers, select "1".
- If the patient has Medicaid only or Medicaid and another insurance type, other than Medicare, select "2". If the patient has Medicaid and Medicare, select "1".
- If the patient is an Undocumented Alien or Illegal immigrant select "1". Undocumented Alien: Section 1011 of the Medicare Modernization Act of 2003 allows for reimbursement for services rendered to patients who are: Undocumented or illegal aliens (immigrants), Aliens who have been paroled into a United States port of entry and Mexican citizens permitted to enter the United States on a laser visa.

Suggested Data Sources:

- Face sheet
- UB-04, Field Location: 50A, B or C

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
Medicare includes, but is not limited to: • Medicare Fee for Service (includes DRG or PPS) • Black Lung • End Stage Renal Disease (ESRD) • Railroad Retirement Board (RRB) • Medicare Secondary Payer • Medicare HMO/Medicare Advantage	• None

Data Element Name: *Point of Origin for Admission or Visit*

Collected For: All Records , Optional for HBIPS-2, HBIPS-3; Used in algorithm for PC-04

Definition: A code indicating the point of patient origin for this admission.

Suggested Data Collection Question: What was the point of origin for this admission?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 **Non-Health Care Facility Point of Origin**
The patient was admitted to this facility upon order of a physician. Usage Note: Includes patients coming from home, a physician's office, or workplace

2 **Clinic**
The patient was admitted to this facility as a transfer from a freestanding or non-freestanding clinic.

3 **Reserved for assignment by the NUBC**
(Discontinued effective 10/1/2007.)

4 **Transfer From a Hospital (Different Facility)**
The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient or outpatient. Usage Note: Excludes Transfers from Hospital Inpatient in the Same Facility (See Code D).

5 **Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)**
The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.

6 **Transfer from another Health Care Facility**
The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list.

7 **Emergency Room**
The patient was admitted to this facility after receiving services in this facility's emergency room. Usage Note: **Excludes** patients who came to the emergency room from another health care facility.

8 **Court/Law Enforcement**
The patient was admitted to this facility upon the direction of court of law, or upon the request of a law enforcement agency. Usage Note: Includes transfers from incarceration facilities.

9 **Information not Available**

The means by which the patient was admitted to this hospital is unknown.

A **Reserved for assignment by the NUBC** (Discontinued effective 10/1/2007.)

D **Transfer from One Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer**
The patient was admitted to this facility as a transfer from hospital inpatient within this hospital resulting in a separate claim to the payer. Usage Note: For purposes of this code, "Distinct Unit" is defined as a unique unit or level of care at the hospital requiring the issuance of a separate claim to the payer. Examples could be include observation services, psychiatric units, rehabilitation units, a unit in a critical access hospital, or a swing bed located in an acute hospital.

E **Transfer from Ambulatory Surgery Center**
The patient was admitted to this facility as a transfer from an ambulatory surgery center.

F **Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program**
The patient was admitted to this facility as a transfer from hospice.

Code of Structure for Newborn (Used For PC-04 Only)
1-4 Reserved for assignment by the NUBC. (Discontinued effective 10/1/2007)

5 **Born Inside the Hospital**
A baby born inside this Hospital
6 **Born Outside this Hospital**
A baby born outside this Hospital

Note: The Joint Commission is aware that there are additional UB-04 allowable values for this data element; however, they are not used for the national quality measure sets at this time.

Notes for Abstraction:

- The intent of this data element is to focus on patients' place or point of origin rather than the source of a physician order or referral.
- The point of origin is the direct source for the particular facility.

Example 1:
A SNF patient has chest pain is taken to the emergency department of Hospital A where it is determined that she is suffering an acute myocardial infarction. The patient is then transferred to Hospital B for admission as an inpatient. The Point of Origin for Hospital A would be 5 – Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF); the point of origin code for Hospital B would be 4 – Transfer from a Hospital.

Example 2:
An auto accident victim was taken to the emergency department of Hospital A by EMTs, stabilized, then transferred to Hospital B where he receives additional

treatment in the ED, and then is admitted as an inpatient to Hospital B. The Point of Origin code for Hospital A is 7- Emergency Room; the point of origin for Hospital B would be 4- Transfer from a Hospital.

- The emergency room code is limited to patients who receive unscheduled emergency services in the ER not originating from another health care facility. As in the auto accident example above, a victim brought to the ER would be coded as 7 since the patient was not previously at any other kind of health care facility. Code 7 also includes self-referrals in emergency situations that require immediate medical attention.

Usage Notes/Cases:

I. Transfers – From an Another Facility
Overall Scenario While at another acute care hospital/facility, the patient is seen by the emergency room physicians. The patient is then transferred to our facility through the emergency room.

- The Point of Origin code would be Code 4 – Transfer from a Hospital (Different Facility) due to the patient being seen at the other acute care facility's emergency room.
- If the decision to admit was not made by the other facility's emergency room personnel and instead was made by our facilities emergency doctor, the Point of Origin code would still be 4. Even though the decision to admit was not made by the other facility, the patient was still seen by the other facility's emergency room personnel and a decision to transfer was made by them.
- The patient is seen by the other facility's emergency room physician; the patient arrives at our emergency room, but receives no additional emergency room care at our facility. Instead, the patient is transferred immediately to the Heart Catheterization Department of our facility the Point of Origin code would still be 4. Since the patient is seen by a different hospital's emergency room personnel, the decision to transfer the patient is first made by the other facility. The arrival of the patient at the receiving hospital's emergency room and subsequent transfer to the Heart Catheterization Department is secondary to the transfer from the previous facility transfer.

II. Transfers – Skilled Nursing Facility
Overall Scenario A resident from a skilled nursing facility is taken to an acute care hospital for medical care.

- The Point of Origin code would be Code 5 – Transfer from a Skilled Nursing Facility.
- The patient's family stopped by to pick-up the patient for a routine doctor's office visit (regularly scheduled); but while at the doctor's office the doctor sends the patient to the emergency room from the acute care hospital. The Point of Origin code would be a 5 as the original Point of Origin is the skilled nursing facility. The subsequent visit to the doctor's office (or even the emergency room of the hospital) is secondary to the events that took place earlier that day.

III. Transfer by Law Enforcement or Court
Overall Scenario A patient arrives at the health care facility accompanied by police.

- The Point of Origin code would be Code 8 – Court/Law Enforcement as the patient is under the supervision of law enforcement.
- If the patient was simply transported by law enforcement to our facility, the patient is neither under arrest nor serving any jail time, then the Point of Origin code would be 7 – Emergency Room. Law enforcement is simply transporting the patient for emergency/urgent care treatment. The patient is not incarcerated (that is, neither under arrest nor serving any jail time).

Suggested Data Sources:

- Emergency department record
- History and physical
- Face sheet
- Progress notes
- Nursing admission notes
- UB-04, Field Location 15

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Predicted Value*

Collected For: PC, Transmission, Risk Adjustment, Hospital Clinical Data File , Used in the calculation of the Joint Commission's aggregate data for Risk Adjusted Measures (All PC Measures) and in the Transmission section of the Hospital Clinical Data file.

Note:

- The ORYX Vendor's calculated *Predicted Value* will be transmitted to The Joint Commission on a quarterly basis with the associated hospital clinical data. These measure results will be used in the Joint Commission's data quality analysis and continuous measure verification process. ORYX Vendors can refer to the Joint Commission's *ORYX Data Quality Manual* and *ORYX Risk Adjustment Guide* for more information.

Definition: This data element is used to store the calculated predicted value that results from applying the appropriate Joint Commission risk model to the data.

Note:
Used in conjunction with Measure Category Assignment when its allowable value = "D" (In Measure Population) or "E" (In Numerator Population).

Suggested Data Collection Question: Not Applicable

Format:

Length: 2-9 (including decimal)
Type: Numeric
Occurs: One Predicted Value is expected per EOC for every risk-adjusted measure that a hospital is participating in.

Allowable Values:

0.00000001 – 0.99999999

JOINT COMMISSION NOTE TO PROGRAMMERS:

- Round to 8 decimal places.
- Use only the seventeen ICD-9-CM Diagnosis Codes that are transmitted as part of the patient record when evaluating the patient against the risk model. Do not use additional ICD-9-CM Diagnosis Codes that may be available in the medical record or from the UB download.

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Reason for Not Administering Antenatal Steroid*

Collected For: PC-03,

Definition: Reasons for not administering a full course of antenatal steroids before delivery are clearly documented in the medical record. Reasons for not administering a full course of antenatal steroids may include fetal distress, imminent delivery or other reasons documented by physician/APN/PA/CNM.

A full course of antenatal steroids consists of two doses of 12mg bethamethasone IM 24 hours apart **OR** four doses of mg dexamethasone IM every 12 hours.

Suggested Data Collection Question: Was there documentation of reasons for not administering a full course of antenatal steroids before delivery?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) There is documentation by physician/APN/PA/CNM that the patient has one or more reasons for not administering a full course of antenatal steroids before delivery.

N (No) There is no documentation by physician/APN/PA/CNM of a reason for not administering a full course of antenatal steroids before delivery or unable to determine from medical record documentation.

Notes for Abstraction: When determining whether there is a reason documented by a physician/APN/PA or CNM for not administering the full course of antenatal steroids, reasons myst be explicitly documented (e.g., "fetal distress required emergency cesarean section - unable to complete full course of antenatal steroids") or clearly implied (e.g., "delivery is imminent-only one dose of steroid given"). If reasons are not mentioned in the context of antenatal steroid administration, do not make inferences (e.g., Do not assume that the patient did not receive the full course of antenatal steroids because the patient was in active labor upon arrival to the unit.)

Suggested Data Sources:

PHYSICIAN/APN/PA/CNM DOCUMENTATION ONLY

- History and physical
- Physician progress notes
- Prenatal forms

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Reason for Not Exclusively Feeding Breast Milk*

Collected For: PC-05,

Definition: Reasons for not exclusively feeding breast milk during the entire hospitalization are clearly documented in the medical record. These reasons are due to a maternal medical condition for which feeding breast milk should be avoided.

Exclusive breast milk feeding is defined as a newborn receiving only breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals, or medicines.

Suggested Data Collection Question: Was there documentation of a reason for not exclusively feeding breast milk during the entire hospitalization?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) There is documentation by physician/APN/PA/CNM of a reason for not exclusively feeding breast milk during the entire hospitalization due to a maternal medical condition where breast milk feeding should be avoided.

N (No) There is no documentation by physician/APN/PA/CNM of a reason for not exclusively feeding breast milk during the entire hospitalization due to a maternal medical condition for which breast milk feeding should be avoided OR unable to determine from medical record documentation.

Notes for Abstraction: The mother's refusal to feed the newborn breast milk **does not** constitute a reason for not exclusively feeding breast milk.

When determining whether there is a reason documented by a physician/APN/PA or CNM for not exclusely feeding breast milk, reasons must be explicitly documented (e.g., "mother is HIV positive - infant will not be breast fed") or clearly implied (e.g., "mother is currently abusing alcohol - infant will be fed formula"). If reasons are not mentioned in the context of infant feeding, do not make references (e.g., Do not assume that the infant is not receiving breast milk because of the medications the mother is currently taking).

Suggested Data Sources:

PHYSICIAN/APN/CNM DOCUMENATION ONLY

- History and physical
- Physician progress notes
- Physician's orders

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
These are the only acceptable maternal medical conditions for which breast milk feeding should be avoided which includes one or more of the following medical conditions: • HIV infection • Human t-lymphotrophic virus type I or II • Substance abuse and/or alcohol abuse • Active, untreated tuberculosis • Taking certain medications, i.e., prescribed cancer chemotherapy, radioactive isotopes, antimetabolites, antiretroviral medications and other medications where the risk of morbidity outweighs the benefits of breast milk feeding • Undergoing radiation therapy • Active, untreated varicella • Active herpes simplex virus with breast lesions	None

Data Element Name: *Sample*

Collected For: HBIPS, PC, Transmission, Aggregate Data File, Hospital Clinical Data File , (Used in transmission of the Joint Commission's aggregate data file and the Hospital Clinical Data file.)

Notes:

- Required for transmission of aggregate data to The Joint Commission. Refer to the *ORYX Technical Implementation Guide* for more information.

Definition: Indicates if the data being transmitted for a hospital has been sampled, or represent an entire population for the specified time period.

Suggested Data Collection Question: Does this case represent part of a sample?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) The data represents part of a sample.

N (No) The data is not part of a sample; this indicates the hospital is performing 100 percent of the discharges eligible for this topic.

Notes for Abstraction: When *Sampling Frequency* equals '3' (No, the hospital is not sampling) or '4' (N/A, submission of patient level data is not required), then abstract *Sample* as "No".

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Data Element Name: *Sample Size – Medicare Only*

Collected For: HBIPS, PC, Transmission, Patient Population Data File , Used in transmission of the Hospital Initial Patient Population Data file.

Note:
For more information refer to the Population and Sampling Specifications section and Hospital Initial Patient Population Data XML File Layout in the Transmission section of this manual.

Definition: Indicates the number of episode of care (EOC) records identified for a hospital with Medicare listed as a payment source for a hospital to perform data abstraction on. This count is after the appropriate sampling methodology, if any, has been applied for the specific time period.

Notes for discharge measures (eg. HBIPS-1, 4, PC-01):

- If the hospital is sampling the discharge measures, then the Sample Size – Medicare Only will be less than the Initial Patient Population Size – Medicare Only for the set, stratum, or sub-population.
- If the hospital is not sampling the discharge measures, then the Sample Size – Medicare Only will equal the Initial Patient Population Size – Medicare Only for the set, stratum, or sub-population.

Notes for HBIPS event measures (HBIPS-2 and 3):

- Hospitals may not sample the HBIPS event measures. For these two measures, the Sample Size – Medicare Only equals the Initial Patient Population Size – Medicare Only for the set, stratum, or sub-population.

Suggested Data Collection Question: Not Applicable

Format:

Length: 6
Type: Numeric
Occurs:

Non-stratified Measure Sets:

One Sample Size – Medicare Only per hospital's measure set (e.g., AMI, HF, PN, and STK).

Stratified Measure Sets:

One Sample Size – Medicare Only per measure set stratum or sub-population the hospital is participating in:
* The PC measure set has three occurrences, one for the mother sub-population and two for the newborn sub-populations.
* The HBIPS measure set has four occurrences, one for each age stratum.

Note:
Refer to the appropriate version of the Specifications Manual for National Quality Inpatient Measures for the number of occurrences for the CAC, VTE, and SCIP measure sets.

Allowable Values:

0 through 999,999

Notes for Abstraction:

For Discharge measures (eg. HBIPS-1,PC-01), when Sampling Frequency = 'N/A' because the hospital has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter and has decided to not submit patient level data, Sample Size – Medicare Only equals zero.

Suggested Data Sources:

Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Sample Size – Non-Medicare Only*

Collected For: HBIPS, PC, Transmission, Patient Population Data File , Used in transmission of the Hospital Initial Patient Population Data file.

Note:

- For more information, refer to the Population and Sampling Specifications section and Hospital Initial Patient Population Data XML File Layout in the Transmission section of this manual.

Definition: Indicates the number of episode of care (EOC) records identified for a hospital with Medicare NOT listed as a payment source for a hospital to perform data abstraction on. This count is after the appropriate sampling methodology, if any, has been applied for the specific time period.

Notes for discharge measures (eg HBIPS-1, 4, PC-01):

- If the hospital is sampling the HBIPS discharge measures, then the Sample Size – Non-Medicare Only will be less than the Initial Patient Population Size – Non-Medicare Only for the set, stratum, or sub-population.
- If the hospital is not sampling the discharge measures, then the Sample Size – Non-Medicare Only will equal the Initial Patient Population Size – Non-Medicare Only for the set, stratum, or sub-population.

Notes for HBIPS event measures (HBIPS-2 and 3):

- Hospitals may not sample the HBIPS event measures. For these two measures, the Sample Size – Non-Medicare Only equals the Initial Patient Population Size – Non-Medicare Only for the set, stratum, or sub-population.

Suggested Data Collection Question: Not Applicable

Format:

Length: 6
Type: Numeric
Occurs:

Non-stratified Measure Sets:

One Sample Size – Non Medicare Only per hospital's measure set (e.g., AMI, HF, PN, and STK).

Stratified Measure Sets:

One Sample Size – Non Medicare Only per measure set stratum or sub-population the hospital is participating in:
* The PC measure set has three occurrences, one for the mother sub-population and two for the newborn sub-populations.
* The HBIPS measure set has four occurrences, one for each age stratum.

Note:
Refer to the appropriate version of the Specifications Manual for National Quality Inpatient Measures for the number of occurrences for the CAC, VTE, and SCIP measure sets.

Allowable Values:

0 through 999,999

Notes for Abstraction: For Discharge measures (eg. HBIPS-1, 4, PC-01), when Sampling Frequency = 'N/A' because the hospital has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter and has decided to not submit patient level data, Sample Size – Non-Medicare Only equals zero.

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Sampling Frequency*

Collected For: HBIPS, PC, Transmission, Patient Population Data File , Used in transmission of the Hospital Initial Patient Population Data file.

Note:
Refer to the Population and Sampling Specifications section and Hospital Initial Patient Population Data XML File Layout in the Transmission section of this manual.

Definition: Indicates if the data being transmitted for a hospital has been sampled (either monthly or quarterly), or represents an entire population for the specified time period.

Suggested Data Collection Question: Not Applicable

Format:

Length: 1
Type: Character
Occurs:

Non-stratified Measure Sets:

One Sample Size – Medicare Only per hospital's measure set (e.g., AMI, HF, PN, and STK).

Stratified Measure Sets:

One Sample Size – Medicare Only per measure set stratum or sub-population the hospital is participating in:
* The PC measure set has three occurrences, one for the mother sub-population and two for the newborn sub-populations.
* The HBIPS measure set has four occurrences, one for each age stratum.

Note:
Refer to the appropriate version of the Specifications Manual for National Quality Inpatient Measures for the number of occurrences for the CAC, VTE, and SCIP measure sets.

Allowable Values:

1 Yes, the hospital is sampling data monthly.

2 Yes, the hospital is sampling data quarterly.

3 No, the hospital is not sampling.

4 N/A, submission of patient level data is not required.

Notes for Abstraction:

- Sampling Frequency must be consistent across a discharge time period. Example:

If the Sampling Frequency for April is monthly, then the Sampling Frequency for May and June must be monthly.

- For Discharge measures (e.g., HBIPS-1, 4, PC-01): Hospitals with five or fewer discharges (both Medicare and Non-Medicare combined) in a quarter are not required to submit patient level data.
- For Event measures (eg., HBIPS-2 and 3): This data element will always be equal to '3' (No, the hospital is not sampling) for the HBIPS event measures (HBIPS-2 and 3).

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Sex*

Collected For: All Records

Definition: The patient's documented sex on arrival at the hospital.

Suggested Data Collection Question: What is the patient's sex?

Format:

Length: 1
Type: Character
Occurs: 1

Allowable Values:

M = Male
F = Female
U = Unknown

Notes for Abstraction:

- Collect the documented patient's sex at admission or the first documentation after arrival.
- Consider the sex to be unable to be determined and select "Unknown" if:
  - The patient refuses to provide their sex.
  - Documentation is contradictory.
  - Documentation indicates the patient is a Transexual.
  - Documentation indicates the patient is a Hermaphrodite.

Suggested Data Sources:

- Consultation notes
- Emergency department record
- History and physical
- Face sheet
- Progress notes
- UB-04 Field Location: 11
- Nursing admission notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Data Element Name: *Spontaneous Rupture of Membranes*

Collected For: PC-01,

Definition: Documentation that the patient had spontaneous rupture of membranes (SROM) before medical induction and/or cesarean section.

Suggested Data Collection Question: Is there documentation that the patient had spontaneous rupture of membranes before medical induction and/or cesarean section?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) There is documentation that the patient had spontaneous rupture of membranes before medical induction and/or cesarean section.

N (No) There is no documentation that the patient had spontaneous rupture of membranes before medical induction and/or cesarean section OR unable to determine from medical record documentation.

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 test or equivalent
- Patient report of SROM prior to hospital arrival

Suggested Data Sources:

- History and physical
- Nursing notes
- Physician progress notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Vendor Tracking Identifier*

Collected For: HBIPS, PC, Transmission, Hospital Clinical Data File

Definition: An ORYX Vendor® -generated identifier that uniquely identifies this patient's stay or episode of care. It is a fictitious identifier generated by the ORYX Vendor to differentiate between individual patient records across hospitals.

This identifier cannot be derived from or related to information about the patient in such a way that it is possible to identify the patient via a review or manipulation of the data.

Since this identifier is transmitted to The Joint Commission, ORYX Vendors must be able to link this tracking identifier to the original record (patient and hospital) in the event that data quality issues arise. Any data that require correction and re-transmission must use the same tracking identifier as that used in the original transmission or a duplication of data within the Joint Commission's database will occur.

This identifier is linked to a patient's episode of care, not to a specific event that occurs during the episode of care. The Vendor Tracking ID must be the same each time data for a unique patient's episode of care is transmitted; regardless of whether this is the second or thirty-second record being transmitted for the patient.

Suggested Data Collection Question: Not applicable, this data element is not data entered.

Format:

Length: 100
Type: Character
Occurs: 1

Allowable Values:

The identifier cannot be a space (blank) or be the patient's social security number, Medicare number, driver license number, medical record number, account number, or other identifier assigned to the patient for purposes other than transmission of data to The Joint Commission. In addition, this identifier cannot be a combination of data in which one portion of the data directly identifies the patient or the combination of data identifies the patient.

Notes for Abstraction: None

Suggested Data Sources: Unique ORYX Vendor generated identifier

NOTE TO PROGRAMMERS:

- An ORYX Vendor may have its own case identifier. We are not requesting that ORYX Vendors change their internal processes; rather, this tracking identifier is needed for transmission of the hospital clinical data to The Joint

Commission.

- Since The Joint Commission is not receiving the Health Care Organization Identifier in the hospital clinical data, this tracking identifier identifies both the patient and the hospital. A tracking identifier cannot be reused for multiple hospitals.

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None