ILPQC
Early Elective Deliveries Initiative
Data Collection Overview

Presented to: ILPQC Hospital Teams
Presented on: June 23, 2014
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Clinical Quality Leader, Northwestern Memorial Hospital
CMS - QualityNet Data Collection Screen

nQ20yy Measure Data Details

**POPULATION**
What was your hospital’s total Initial Patient Population? 
What was your hospital’s sample size? 
What was your hospital’s sampling frequency? Monthly Quarterly Not Sampled N/A - Submission not required

**NUMERATOR**
What was the number of patients with elective deliveries?

**DENOMINATOR**
What was the total number of patients delivering newborns with >=37 and <39 weeks of gestation?

**EXCLUSIONS**
ICD-9-CM Principal or Other Diagnosis Code for Elective Delivery
What was the exclusion count for the ICD-9-CM Principal or Other Diagnosis Code for Elective Delivery?
Enrolled in a clinical trial
What was the exclusion count for those Enrolled in a clinical trial?
Prior uterine surgery
What was the exclusion count for Prior uterine surgery?
Gestational age <37 or >=39 weeks
What was the exclusion count for Gestational age patients <37 or >= 39 weeks?

**RESULTS**
Total Exclusion Count: 
Percentage of Patients with Elective Deliveries: 

[Buttons: Calculate Save]
ILPQC Early Elective Delivery Initiative
Data Collection Sheet

POPULATION
1. What was your hospital’s total initial inpatient population?
2. What was your hospital’s sample size?
3. What was your hospital’s sampling frequency?
   a. Monthly
   b. Quarterly
   c. Not Sampled
Total Initial Patient Population

Population is identified using: admission date, birth date, discharge date, and ICD-9-CM Principal or Other Diagnosis Code

Population includes:

- ICD-9-CM Principal or Other Diagnosis Code (Appendix A, Tables 11.01, 11.02, 11.03, 11.04)
- Age $\geq 8$ and $< 65$ years
- Length of stay $\leq 120$ days
## Sample Size and Frequency

### Quarterly Sample Size

<table>
<thead>
<tr>
<th>Initial Population</th>
<th>Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 1501</td>
<td>301</td>
</tr>
<tr>
<td>376-1500</td>
<td>20% initial population size</td>
</tr>
<tr>
<td>75-375</td>
<td>75</td>
</tr>
<tr>
<td>&lt; 75</td>
<td>100% initial population size</td>
</tr>
</tbody>
</table>

### Monthly Sample Size

<table>
<thead>
<tr>
<th>Initial Population</th>
<th>Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 501</td>
<td>101</td>
</tr>
<tr>
<td>126-500</td>
<td>20% initial population size</td>
</tr>
<tr>
<td>25-125</td>
<td>25</td>
</tr>
<tr>
<td>&lt; 25</td>
<td>100% initial population size</td>
</tr>
</tbody>
</table>

### Sampling Frequency:
- Monthly
- Quarterly
- Not Sampled
NUMERATOR
4. What was the number of patients with elective deliveries between ≥37 and < 39 weeks of gestation?

DENOMINATOR
5. What was the total number of patients delivering newborns with ≥37 and < 39 weeks of gestation?
Numerator: Number of Patients with Elective Deliveries Between ≥ 37 and < 39 Weeks of Gestation

Included Populations:

• Medical induction of labor as defined in Appendix A. Table 11.05
• Cesarean section as defined in Appendix A, Table 11.06
AND ALL OF THE FOLLOWING:
• Not in labor
• Not experiencing spontaneous rupture of membranes
• No history of a prior uterine surgery
Labor

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Yes – There is documentation by the clinician that the patient was in labor

No – There is no documentation by the clinician that the patient was in labor
   OR unable to determine from medical record documentation

Notes:

Clinician = Physician, CNM, APN/PA or RN

Documentation of labor should be abstracted at face value. No additional documentation of regular contractions or cervical change is required in order to answer yes to labor

Suggested Data Sources: H&P; Nursing notes; Physician progress notes

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptable descriptors for labor:</td>
<td>Not Acceptable descriptors for labor:</td>
</tr>
<tr>
<td>• Active</td>
<td>• Latent</td>
</tr>
<tr>
<td>• Early</td>
<td>• Prodromal</td>
</tr>
<tr>
<td>• Spontaneous</td>
<td></td>
</tr>
</tbody>
</table>
Spontaneous Rupture of Membranes (SROM)

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

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: If the patient’s SROM is confirmed before medical induction and/or cesarean section by one of the following methods, select YES:

– Positive ferning test
– Positive nitrazine test
– Positive pooling (gross fluid in vagina)
– Positive Amnisure ROM test or equivalent
– Patient report of SROM prior to hospital arrival

Suggested Data Sources: H&P, Nursing notes, Physician progress notes
Prior Uterine Surgery

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Yes – The medical record contains documentation that the patient had undergone prior uterine surgery

No – The medical record does not contain documentation that the patient had undergone prior uterine surgery OR unable to determine from medical record documentation

Suggested Data Sources: H&P, Nursing admission assessment, Progress notes, Physician’s notes, Prenatal forms
## Prior Uterine Surgery

**TJCv2014A1**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion: (only prior uterine surgeries considered for this measure)</th>
<th>Exclusion:</th>
</tr>
</thead>
</table>
| • Prior classical cesarean section (vertical incision into the upper uterine segment)  
• Prior myomectomy  
• Prior uterine surgery resulting in a perforation of the uterus due to an accidental injury  
• History of a uterine window or thinning of the uterine wall noted during prior uterine surgery or during ultrasound  
• History of uterine rupture requiring surgical repair | • Prior low transverse cesarean section  
• Prior cesarean section without specifying prior classical cesarean section |
Denominator: Number of Patients Delivering with ≥ 37 and < 39 Weeks of Gestation

Included Populations:
• ICD-9-CM Principal or Other Diagnosis Codes for pregnancy as defined in Appendix A, Tables 11.01, 11.02, 11.03 or 11.04
• ICD-9-CM Principal Diagnosis Code or Other Diagnosis Codes for planned cesarean section in labor as defined in Appendix A, Table 11.06.1

Excluded Populations:
• ICD-9-CM Principal or Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07
• < 8 years or ≥ 65 years of age
• Length of stay > 120 days
• Enrolled in clinical trials
• Gestational Age < 37 or ≥ 39 weeks
Clinical Trial

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

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:

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.
Clinical Trial

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To select Yes, BOTH of the following must be true:

– Signed consent form for clinical trial
– 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.

In the following situations, select No:

– There is a signed patient consent form for an observational study
– 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
Gestational Age
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Definition: Weeks of gestation completed at the time of delivery
• Gestational age should be rounded off to the nearest completed week
• Only acceptable data sources in order of preference:
  – Delivery room record
  – Operating room record
  – History and physical
  – Prenatal forms
  – Admission clinician progress notes
  – Discharge summary
• Documentation in the acceptable data source may be written by MD, CNM, APN/PA or RN
EXCLUSIONS

6. What was the exclusion count for ICD-9-CM Principal or Other Diagnosis Codes for Elective Delivery?
7. What was the exclusion count for those enrolled in a clinical trial?
8. What was the exclusion count for prior uterine surgery?
9. What was the exclusion count for gestational age < 37 or ≥ 39 weeks of gestation?

RESULTS

10. Total Exclusion Count (sum of questions 6-9)
11. Percentage of Patients with Elective Deliveries (Q4/Q5)
Questions?