# Perinatal Care (PC)

## Set Measures

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</tr>
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<td>PC-02</td>
<td>Cesarean Section</td>
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<td>PC-03</td>
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<td>PC-04</td>
<td>Health Care-Associated Bloodstream Infections in Newborns</td>
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<td>PC-05</td>
<td>Exclusive Breast Milk Feeding</td>
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## General Data Elements

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Collected For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date</td>
<td>All Records,</td>
</tr>
<tr>
<td>Birthdate</td>
<td>All Records,</td>
</tr>
<tr>
<td>Clinical Trial</td>
<td>All Records,</td>
</tr>
<tr>
<td>Discharge Date</td>
<td>All Records, Not collected for HBIPS-2 and HBIPS-3</td>
</tr>
<tr>
<td>Discharge Status</td>
<td>All Records, Not collected for HBIPS-2 and HBIPS-3; Used in algorithm for PC-04 and PC-05</td>
</tr>
<tr>
<td>ICD-9-CM Other Diagnosis Codes</td>
<td>All Records, Optional for HBIPS-2 and HBIPS-3; Used in algorithm for PC-01, 02, 04, and 05</td>
</tr>
<tr>
<td>ICD-9-CM Other Procedure Codes</td>
<td>All Records, Optional for All HBIPS Records; Used in algorithm for PC-01, 02, 04 and 05</td>
</tr>
<tr>
<td>ICD-9-CM Other Procedure Dates</td>
<td>All Records, Optional for All HBIPS Records</td>
</tr>
<tr>
<td>ICD-9-CM Principal Diagnosis Code</td>
<td>All Records, Optional for HBIPS-2 and HBIPS-3; Used in algorithm for PC-01, 02, 04, and 05</td>
</tr>
<tr>
<td>ICD-9-CM Principal Procedure Code</td>
<td>All Records, Optional for All HBIPS Records; Used in algorithm for PC-01, 02, 04 and 05</td>
</tr>
<tr>
<td>ICD-9-CM Principal Procedure Date</td>
<td>All Records, Optional for All HBIPS Records</td>
</tr>
<tr>
<td>Payment Source</td>
<td>All Records, Optional for HBIPS-2 and HBIPS-3</td>
</tr>
<tr>
<td>Point of Origin for Admission or Visit</td>
<td>All Records, Optional for HBIPS-2, HBIPS-3; Used in algorithm for PC-04, PC-05</td>
</tr>
<tr>
<td>Sex</td>
<td>All Records,</td>
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</table>
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<table>
<thead>
<tr>
<th>Element Name</th>
<th>Collected For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Category Assignment</td>
<td>Calculation, Transmission, Hospital</td>
</tr>
<tr>
<td></td>
<td>Clinical Data File</td>
</tr>
<tr>
<td>Measurement Value</td>
<td>Calculation, Transmission, Hospital</td>
</tr>
<tr>
<td></td>
<td>Clinical Data File</td>
</tr>
</tbody>
</table>

Measure Set Specific Data Elements

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Collected For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Labor</td>
<td>PC-01,</td>
</tr>
<tr>
<td>Admission Type</td>
<td>PC-04, PC-05,</td>
</tr>
<tr>
<td>Antenatal Steroid Administered</td>
<td>PC-03,</td>
</tr>
<tr>
<td>Birth Weight</td>
<td>PC-04,</td>
</tr>
<tr>
<td>Discharge from NICU</td>
<td>PC-05,</td>
</tr>
<tr>
<td>Exclusive Breast Milk Feeding</td>
<td>PC-05,</td>
</tr>
<tr>
<td>Gestational Age</td>
<td>PC-01, PC-02, PC-03,</td>
</tr>
<tr>
<td>Parity</td>
<td>PC-02,</td>
</tr>
<tr>
<td>Reason for Not Administering Antenatal Steroid</td>
<td>PC-03,</td>
</tr>
<tr>
<td>Reason for Not Exclusively Feeding Breast Milk</td>
<td>PC-05,</td>
</tr>
<tr>
<td>Spontaneous Rupture of Membranes</td>
<td>PC-01,</td>
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</tbody>
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<td>a1. Introduction to the Manual</td>
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<td>b. Data Dictionary</td>
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ERROR: DBCALL reached max recursion at
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

Patients admitted to the hospital for inpatient acute care are included in the PC Mother Initial sampling group if they have: ICD-9-CM Principal or Other Diagnosis Code as defined in Appendix A, Tables 11.01, 11.02, 11.03, or 11.04, a Patient Age (Admission Date – Birthdate) >= 8 years and < 65 and a Length of Stay (Discharge Date - Admission Date) ≤ 120 days.

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.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Initial Patient Population definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC-04</td>
<td>The count of all patients in sampling group 1</td>
</tr>
<tr>
<td>PC-05</td>
<td>The count of all patients in sampling group 2</td>
</tr>
</tbody>
</table>

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, 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, NO ICD-9-CM Principal or Other Diagnosis Code as defined in Appendix A, Table 11.21 and NO ICD-9-CM-Principal or Other Procedure 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

Discharges 04-01-10 (2Q10) through 09-30-10 (3Q10)
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:

<table>
<thead>
<tr>
<th>Hospital’s Measure</th>
<th>Average Quarterly Initial Patient Sample Group Size “N”</th>
<th>Minimum Required Sampling Group Sample Size “n”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quarterly Sample Size</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Based on Initial Patient Population for Mothers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;= 2001</td>
<td>401</td>
<td>401</td>
</tr>
<tr>
<td>501 – 2000</td>
<td>20% of the Initial Patient Population size</td>
<td>100</td>
</tr>
<tr>
<td>100 – 500</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>&lt; 100</td>
<td>No sampling; 100% of the Initial Patient Population required</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Hospital's Measure</th>
<th>Minimum Required Sample Size “n”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average Quarterly Initial Patient Population Size “N”</strong></td>
<td></td>
</tr>
<tr>
<td>&gt;= 721</td>
<td>145</td>
</tr>
<tr>
<td>181 – 720</td>
<td>20% of the Initial Patient Population size</td>
</tr>
<tr>
<td>36 – 180</td>
<td>36</td>
</tr>
<tr>
<td>&lt; 36</td>
<td>No sampling; 100% of Initial Patient Population required</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Hospital's Measure</th>
<th>Minimum Required Sample Size “n”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average Monthly Initial Patient Population Size “N”</strong></td>
<td></td>
</tr>
<tr>
<td>&gt;= 501</td>
<td>101</td>
</tr>
<tr>
<td>126 – 500</td>
<td>20% of the Initial Patient Population</td>
</tr>
<tr>
<td>25 – 125</td>
<td>25</td>
</tr>
<tr>
<td>&lt; 25</td>
<td>No sampling; 100% Initial Patient Population required</td>
</tr>
</tbody>
</table>

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:
### 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 100 cases for the quarter.

#### Monthly Sampling

- A hospital’s Mother Population size is 56 patients during March. The required sample size would be 25 cases for the month.
- A hospital’s Newborns with Breast Feeding sampling group size is 254 newborns during September. The required sample size is 37 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 and < 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 and < 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
- Greater 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:


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

**Measure Algorithm:**
Related Topics

PC-01: Elective Delivery
Numerator: Patients with elective deliveries completed
Denominator: Patients delivering newborns with \( \geq 37 \) and \( < 39 \) weeks of gestation completed

Discharges 04-01-10 (2Q10) through 09-30-10 (3Q10)
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
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:

- Main E.K., Bloomfield, L., & Hunt, G. (2004). Development of a large-scale obstetric quality-


**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

Start

Run cases that are included in the PC-Mother Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow Clinical through this measure.

ICD-9-CM Principal or Other Diagnosis Code

At least one on Table 11.09

PC-02

None on Table 11.09

PC-02

ICD-9-CM Principal or Other Diagnosis Code

None on Table 11.08

PC-02

At least one on Table 11.08

PC-02

Clinical Title

= Y

PC-02

= N

PC-02

Missing

Gestational Age

= UTD

PC-02

Missing

Non-UTD Value

Gestational Age

< 37

PC-02

>= 37

PC-02
Related Topics

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Discharges 04-01-10 (2Q10) through 09-30-10 (3Q10)
| Appendix A - ICD-9-CM Code Tables |

Discharges 04-01-10 (2Q10) through 09-30-10 (3Q10)
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:**


**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

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**Related Topics**

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Discharges 04-01-10 (2Q10) through 09-30-10 (3Q10)
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 multimodality, 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...
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 to 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:**


**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 sepsis or bacteremia
Denominator: Live-born newborns

Start

Run cases that are included in the PC-Newborn Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.

Length of Stay (in days) = Discharge Date - Admission Date

Length of Stay

< 2 days

>= 2 days

ICD-9-CM Principal Diagnosis Code

On Table 11.10

PC-04 B

Not on Table 11.10

PC-04 X

Missing

Clinical Trial

Y

N

PC-04 B

PC-04 Z

All Missing

ICD-9-CM Other Diagnosis Codes

At least one on Table 11.20

None on Table 11.20

PC-04 Z

PC-04 B

PC-04 Z

ICD-9-CM Other Diagnosis Codes

At least one on Table 11.12, 11.13, 11.14

None on Table 11.12, 11.13, 11.14

PC-04 F
PC-04 H

Point of Origin for Admission or Visit

= 4

Newborn Patient Age at Admission (in days) = Admission Date - Birthdate

Newborn Patient Age at Admission

>= 0 days and <= 2 days

ICD-9-CM Other Diagnosis Codes

All missing or None on Table 11.10

At least one on Table 11.10

ICD-9-CM Other Diagnosis Codes

None on Table 11.11

At least one on Table 11.11

Case Will Be Rejected

In Nominator Population

In Measure Population

Not in Measure Population

Stop

Related Topics
a. Table of Contents
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
- Point of Origin for Admission or Visit
- 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:**


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

Start

Run cases that are included in the PC-Newborn Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow Clinical through this measure.

PC-05 X

Admission Type

1, 2, 3, 5, 9

= 4

Point of Origin for Admission or Visit

PC-04 B

= 6

Discharge Status

PC-05 B

= 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 Diagnosis Code

At least one on Table 11.21

PC-05 B

None on Table 11.21

ICD-9-CM Principal or Other Procedure Code

At least one on Table 11.22

PC-05 B

All missing or None on Table 11.22

Missing

= Y

= N

= PC-05 H

= PC-05 B

= PC-05 X
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:

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<thead>
<tr>
<th>Inclusion</th>
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</table>
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
Additional Notes:

**Guidelines for Abstraction:**

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<tr>
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<tbody>
<tr>
<td>None</td>
<td>Admit to observation</td>
</tr>
<tr>
<td></td>
<td>Arrival date</td>
</tr>
</tbody>
</table>
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
**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 6 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:**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Refer to Appendix B, Table 11.0 Antenatal Steroid Medications</td>
<td>None</td>
</tr>
</tbody>
</table>
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:

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</table>
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:

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<td>• None</td>
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</table>
Data Element Name: CMS Certification Number

Collected For: HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC 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:

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<tr>
<td>None</td>
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<tr>
<td>Data Element Name:</td>
<td>Clinical Trial</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Collected For:</td>
<td>All Records</td>
</tr>
<tr>
<td>Definition:</td>
<td>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.</td>
</tr>
<tr>
<td>Suggested Data Collection Question:</td>
<td>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?</td>
</tr>
<tr>
<td>Format:</td>
<td>Length: 1 Type: Alphanumeric Occurs: 1</td>
</tr>
<tr>
<td>Allowable Values:</td>
<td>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.</td>
</tr>
<tr>
<td>Notes for Abstraction:</td>
<td>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</td>
</tr>
</tbody>
</table>
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:**

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<tr>
<td>• None</td>
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</tr>
</tbody>
</table>
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 information should be abstracted only once at the time of discharge from the hospital.

Suggested Data Sources:
- Face sheet
- Progress notes
- Physician orders
- Discharge summary
- Nursing discharge notes
- Transfer note
- UB-04, Field Location: 6

Additional Notes:

Guidelines for Abstraction:

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</table>
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 centerXstlist.html](http://www3.cancer.gov/cancercenters centerXstlist.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
Additional Notes:

Guidelines for Abstraction:

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<tbody>
<tr>
<td>🔹 Refer to Appendix E, Table 2.5 Discharge Status Disposition.</td>
<td>🔹 None</td>
</tr>
</tbody>
</table>
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:

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</table>
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 that 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:

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<tr>
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<tr>
<td>Data Element Name:</td>
<td>Gestational Age</td>
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<tr>
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<tr>
<td>Collected For:</td>
<td>PC-01, PC-02, PC-03</td>
</tr>
<tr>
<td>Definition:</td>
<td>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.</td>
</tr>
<tr>
<td>Suggested Data Collection Question:</td>
<td>How many weeks of gestation were completed at the time of delivery?</td>
</tr>
<tr>
<td>Format:</td>
<td>Length: 2 or UTD Type: Alphanumeric Occurs: 1</td>
</tr>
<tr>
<td>Allowable Values:</td>
<td>1-50 UTD=Unable to Determine</td>
</tr>
<tr>
<td>Notes for Abstraction:</td>
<td>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 progress 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 &quot;estimated gestational age&quot; 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.</td>
</tr>
<tr>
<td>Suggested Data Sources:</td>
<td>ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE:</td>
</tr>
</tbody>
</table>
• History and physical
• Prenatal forms
• Delivery room record
• Operating room record
• Admission clinician progress notes

Additional Notes:

Guidelines for Abstraction:

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</table>
Data Element Name: Health Care Organization Identifier

Collected For: HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC 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:

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</table>
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:

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</table>
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:

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</table>
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:**

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</table>
Data Element Name: \textit{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:
- \textbf{Length:} 6 (implied decimal point)
- \textbf{Type:} Alphanumeric
- \textbf{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:

\textbf{Guidelines for Abstraction:}

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<tr>
<td>• Refer to Appendix A, for ICD-9-CM Code Tables (AMI, HF, PN, HBIPS).</td>
<td>• Refer to Appendix A, for ICD-9-CM Code Tables (SCIP).</td>
</tr>
</tbody>
</table>
**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:

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</table>
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:**

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</table>
Data Element Name: Initial Patient Population Size – Medicare Only

Collected For: HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS PC PC PC PC PC PC PC PC PC PC PC PC PC PC PC PC,

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, tertiary 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
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:

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</table>
**Data Element Name:**  
*Initial Patient Population Size – Non-Medicare Only*

**Collected For:**  

**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:**

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</table>
**Data Element Name:** Measure Category Assignment

**Collected For:** HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC 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:**

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<tr>
<td>• None</td>
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</table>
**Data Element Name:** Measure Set

**Collected For:** HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC 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:**

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</table>
Data Element Name: Measurement Value

Collected For: HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC 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:

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<tr>
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</table>
Data Element Name: National Provider Identifier

Collected For: All

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:

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</table>
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 clinicians: 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:**

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<tbody>
<tr>
<td>The following descriptor must precede the number when determining parity:</td>
<td>A string of three or more numbers without the alpha designation of &quot;p&quot; preceding the second number can not be used to determine parity.</td>
</tr>
<tr>
<td>Parity</td>
<td>Example: 321</td>
</tr>
<tr>
<td>--------</td>
<td>--------------</td>
</tr>
<tr>
<td>P</td>
<td></td>
</tr>
</tbody>
</table>

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:

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<tr>
<td>Medicare includes, but is not limited to:</td>
<td>None</td>
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<tr>
<td>• Medicare Fee for Service (includes DRG or PPS)</td>
<td></td>
</tr>
<tr>
<td>• Black Lung</td>
<td></td>
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<tr>
<td>• End Stage Renal Disease (ESRD)</td>
<td></td>
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<tr>
<td>• Railroad Retirement Board (RRB)</td>
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<tr>
<td>Medicare Secondary Payer</td>
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<td>---------------------------</td>
<td></td>
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<tr>
<td>Medicare HMO/Medicare Advantage</td>
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</tbody>
</table>
**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, PC-05

**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:**

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Data Element Name: Predicted Value

Collected For: PC PC PC PC PC 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:

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</table>
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 6 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 must 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:

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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 exclusively 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
Additional Notes:

Guidelines for Abstraction:

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<tbody>
<tr>
<td><strong>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:</strong></td>
<td>None</td>
</tr>
<tr>
<td>• HIV infection</td>
<td></td>
</tr>
<tr>
<td>• Human t-lymphotrophic virus type I or II</td>
<td></td>
</tr>
<tr>
<td>• Substance abuse and/or alcohol abuse</td>
<td></td>
</tr>
<tr>
<td>• Active, untreated tuberculosis</td>
<td></td>
</tr>
<tr>
<td>• 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</td>
<td></td>
</tr>
<tr>
<td>• Undergoing radiation therapy</td>
<td></td>
</tr>
<tr>
<td>• Active, untreated varicella</td>
<td></td>
</tr>
<tr>
<td>• Active herpes simplex virus with breast lesions</td>
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</table>
Data Element Name: Sample

Collected For: HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS
HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC PC PC PC PC 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:

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<td>• None</td>
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**Data Element Name:** Sample Size – Medicare Only

**Collected For:** HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC 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:**

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

**Collected For:** HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC PC PC PC PC 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:**

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**Sampling Frequency**

**Data Element Name:**

**Collected For:** HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC 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:

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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:

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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:

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Data Element Name: Vendor Tracking Identifier

Collected For: HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC 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:

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