Perinatal Care Region Q Database

Frequently Asked Questions (FAQ)

Where does the data submitted go?

The data submitted to PCR Q/SETRAC is used for regional quality initiatives. Only the clinical service line personnel at SETRAC see the raw data. The committee members only see the aggregate numbers for purposes of data- driven quality improvement initiatives.

Is this a state mandate?

As a RAC member in good-standing and for maternal and neonatal designation, submission of data for quality initiatives is required.

Will this data be submitted to the state?

Only in regional aggregate form. Individual hospital data will not be submitted to the state.

My numbers don't always look right for the month, as many babies have a multi-month Length of Stay.

We expect that. It will all work out when we look back over several quarters/years. Your biggest aim is to make sure not to double count babies in the denominator when they have multi-month stays.

Where do I find the definition/description of each item to be reported?

Please see the SETRAC Perinatal Data Dictionary.

How do you define NICU?

Any hospital unit delivering Level II or higher care is defined as a NICU. Level I mother-baby or well-baby nursery is not considered NICU for the purposes of this database.

Every year, we have some babies under 500 grams who are growth restricted but survive and contribute to our data outcomes. Why are we not to include these babies?

By definition, VLBW is 500-1500 grams at birth. These are the only babies to include in the VLBW-specific data reported.

The Data Reporting Form uses the term "*in defined time period*" in every question. What does this mean?

"In defined time period" basically means for you to only keep the reporting specifically to the *month* in which you are reporting the data. This avoids the issue of "double-counting" the same baby in the denominator during a multiple month stay.

Specific (by Question) Data Reporting Form FAQ's

Neonatal Data

Question #2. Length of Stay (Late Preterm Infants)

Our hospital does not automatically admit Late Preterm Infants to the NICU. Should we include those who are admitted to (and remain in) the well-baby nursery/mother-baby Unit?

No. Only babies who are admitted to the NICU should be included in this data. However, if the baby is admitted to the NICU for a few days, then transferred to a well-baby/mother-baby unit, please include their total length of stay until discharge home. If the baby starts off as a non-NICU baby, then is admitted to the NICU, please include the entire number of days in the hospital for length of stay.

Question #3. What do you mean by "Discharged"? Does this include only discharge to home, or does it include "transfer to well-baby unit"?

Good question. This is only discharge home. So, if a baby was in the NICU and then they are transferred to a well-baby unit, you would count all the days the baby is in the hospital prior to discharge home.

Question #7. Does this include babies in mother-baby/well-baby nursery that are receiving antibiotics?

No. This is only a NICU measure. Only for babies admitted to the NICU. There is merit to expedience in all patients who receive antibiotics, but this database is only regarding NICU admitted babies.

Clarification: 12/16/20

1. If the order entered before the birth of the baby, please use the birth time as the start time.
2. Do not delay ordering antibiotics due to IV access, line placement or any other reason. Orders should be written as soon as the treating physician verifies the need for antibiotics.

Questions #9 – #12. Help me define which babies we should include for mortality denominators.

For example, we have a few babies each year who are born <22 weeks, but our hospital policy is that

ANY babies born at 20 weeks GA or more are "admitted" to our NICU and pronounced by the Neonatologist. How do we count these? Do we count them in the denominator?

The intent of this database is to collect quality data and some baseline outcomes data which helps hospital stakeholders to interpret quality data. If a birth takes place at a previable gestational age (determined by the local individual clinicians at that hospital), and no resuscitation is planned nor any chance of survival is present, this would not be a patient who should be placed in the numerator or denominator of this data. The intent is to measure reasonably modifiable quality data points. A "policy decision" to physically locate the delivered neonate in the NICU, versus staying with its delivering parent, or staying on the maternity ward, is an individual hospital decision and should not modify this data set.

However, if full resuscitation is undertaken and there is still no survival out of the initial resuscitation, that patient should be included in the data even in the event that they never "made it out of the delivery room".

Questions #16 and #17. Transfer data (VLBW only).

Is this for transfer in/outborn at any point in their stay? The info obtained from immediate transfer after birth will look very different from the info obtained from those who transfer out later.

We understand that the transfer in/transfer out data can be very confusing to interpret. We are currently only collecting this raw data on "transfer in" or "transfer out" for any point in the NICU stay. Please be careful to read the questions closely.

Question #16 = VLBW transfers in…. this is the same as "outborn".

Question #17 = VLBW transfers out. These could be inborn at your institution, or they may have been transferred to you and then necessitated another transfer to a different center. So, there could be multiple transfers per baby. We understand this. This is an initial baseline measurement requested by many of our sites in order to get some decent data on transfer numbers and center-differences.

Maternal Data

Question #1. Screening for Depression

Goal: Implementation of universal depression screening in the hospital (L&D)

What if a patient is admitted to L&D, does not deliver, and goes home and comes back again then delivers?
Depression screen counts only during the birth admission. Delivery DRG only for the purposes of this data/avoid double counting patients.

Question #2. Screening for Substance Abuse Disorder (SUD)

Goal: Implementation of SUD screening in the hospital (L&D)

What if a patient is admitted to L&D, does not deliver, and goes home and comes back again and then delivers?
SUD screening counts only during the birth admission. Delivery DRG only for the purposes of this data/avoid double counting patients.

Question #3. Transfusion >= 4 units pRBC (massive transfusion)

Goal: Rate of patients admitted for a birth hospitalization who receive 4 or more units of Packed Red Blood Cells (PBRCs) for post-partum hemorrhage (PPH)

If a patient goes home after delivery and returns with bleeding and receives blood transfusions, will that patient be included?
No, it's only during the birth hospitalization.

What is the expected baseline rate?
Expected Baseline Rate: 2-4 or more cases per 1,000 mothers

The number of deliveries in my hospital is < 500/year. Do I still need to collect that data?
It's optional for such hospitals with deliveries < 500/year.

Where do I collect this data?
Suggested source: Hospital blood bank data sets or ChargeMasters

Collection steps: Identify maternity patients either by DRGs or obstetric ICD9/10 codes, then query the ChargeMaster (or blood bank data set) to identify the women who received ≥ 4 units of blood products.

Question #4: Timely Treatment for Hypertension

Goal: Timely treatment of severe range BP to reduce severe maternal morbidity from hypertension in pregnant women.

Do we include only the patients in L&D?
Target population includes pregnant and postpartum women that present to L&D, Triage/OB ED, Main ED, Antepartum, Postpartum, Critical Care, Outpatient or any other area where women receive care that have an elevated blood pressure of ≥160 systolic and/or ≥ 110 diastolic twice after repeated reading within 15 minutes. The target population includes patients with chronic or gestational HTN.

Which treatments are considered as optimal treatment for severe range hypertension in these pregnant women?
Treatment may include IV Labetalol, IV Hydralazine, or PO Nifedipine (see ACOG PB 222, Interim Update, June 2020, pp e248-9).

Where do I collect this data from?
Sources: logbook, EHR, pharmacy records