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<tr>
<td></td>
<td>Copy of Scheduled Delivery Form</td>
<td>16</td>
</tr>
</tbody>
</table>
**General Instructions**

General Instructions for Collecting Data

1. **Case Definition:** Scheduled deliveries are defined as inductions or Cesarean sections prior to the onset of labor between 36 0/7 and 38 6/7 weeks gestational age.

2. **Special Instructions for Pre-Work:** Follow the instructions in this data collection field manual for pre-work data collection. Complete the New York State Perinatal Quality Collaborative (NYSPQC) Scheduled Delivery Form for each scheduled delivery that occurs during the pre-work timeframe and prepare to data enter the pre-work data in the database that is provided by the New York State Department of Health (NYSDOH).

   a. Pre-Work Data Submission: Complete the 20 NYSPQC Scheduled Delivery Forms and data enter these forms into the Scheduled Delivery Management System (SDMS). Contact Todd Gerber at (518) 473-3511 if there are any questions about completing the form or using the SDMS. These data will be submitted to the NYSDOH and merged into a master file which will be used for monthly generation of improvement measures and charts. The monthly improvement measures will then be reviewed with participating hospitals.

   b. If the Medical Record Number or Obstetrician Initials are entered onto the form, please note that these will not be included in the data transmission to the NYSDOH.

   c. Pre-Work data collection questions: Please direct questions about the Pre-Work data collection to:

      Todd Gerber, M.S.
      New York State Department of Health
      Room 2162, Corning Tower
      Albany, NY 12237
      **Phone:** (518) 473-3511
      **FAX:** (518) 474-1420
      **Email:** tmg02@health.state.ny.us

3. **Instructions for Monthly Quality Collaborative Data Collection:** Beginning June 1, 2012, hospitals should complete a NYSPQC Scheduled Delivery Form for every scheduled delivery as it occurs during the month.

4. **Monthly Reporting to NYSDOH:** After completing the monthly data collection:

   a. Enter the collected information into the NYSDOH data management electronic tool “NYSPQC Scheduled Delivery Management System”. NYSPQC SDMS will provide data entry and management functions. You will report by submitting the “export” database file for this system which will be used by the NYSDOH to process aggregated measures for all sites.

   b. The database extract which excludes confidential data will be created by using the IMPORT/EXPORT feature of the software. This feature creates a file in your local “My Documents” folder that is named: “C:\Documents and Settings\[username]\My Documents\ExportScheduledDeliveryData\NEONATAL2010_beExportData.accdb” Submitting your monthly report to the NYSPQC is as simple as creating this file in the SDMS and then uploading the file to the NYSDOH via the Health Commerce...
System (HCS) ‘secure file transfer utility’.

c. The database file does not include patient identifiers and should be forwarded to NYS after completing all scheduled deliveries but no later than the last Wednesday of each subsequent month. Earlier data submission is encouraged. Details for installing and using the NYSPQC SDMS will be provided in a separate document which is called the “Installation and User Guide New York State Perinatal Quality Collaborative Scheduled Delivery Management System”.

d. Stillbirth Tracking: Please submit the monthly total stillbirths and total deliveries (using the NYSDOH Stillbirth Log) and the individual stillbirth information for stillbirths between 36 0/7 and 38 6/7 weeks of gestational age at the same time as submission of data under section 4a. These data will submitted electronically at the same time that you perform the data export.

5. **Who to Call for Help:**

   If you need help completing this form, require additional forms or you need technical assistance with the SDMS, please contact:

   Todd Gerber, M.S.
   New York State Department of Health
   Room 2162, Corning Tower
   Albany, NY 12237
   **Phone:** (518) 473-3511
   **FAX:** (518) 474-1420
   **Email:** tmg02@health.state.ny.us
**Patient Demographics**

1. **Permanent Facility Identifier (PFI):** This is a unique identifier that is assigned to each hospital by the NYSDOH. You can locate this number on the upper right-hand side of your facility’s NYSDOH issued operating certificate. The PFI can also be located by browsing the NYSDOH web site at: http://www.nyhealth.gov/nysdoh/hospital/statewdm.htm

   **Note:** This field should not be left blank.

2. **Facility Name:** Enter the official name of the facility as it appears on the NYSDOH issued Article 28 operating certificate. **Note:** This field should not be left blank.

3. **Sequence Number:** Enter a site assigned sequence number that will be used in lieu of the medical record number for each delivery. The sequence number should be consecutive and not duplicate another patient’s number. The site-assigned sequence number should be recorded on the paper form and the electronic form. Duplicate numbers from the same facility will be rejected. **Note:** This field should not be left blank.

4. **Medical Record Number:** Enter the patient’s medical record number on the paper form for site use only. **Note:** This field will be recorded in the database as an encrypted field and will not be copied or transmitted to the NYSDOH during the export process.

5. **Admit Date:** Enter the month and year of the maternal date of admission. **Note:** This field should not be left blank.

6. **Maternal Age:** Record the mother’s age on the date of admission using years of age as the measure. **Note:** This field should not be left blank.

7. **Notes:** Use this space to write any notes or other miscellaneous documentation about the delivery that qualifies the data input.

8. **Delivery Type Vaginal:** Classify vaginal births as “spontaneous” or “operative”. Use “operative” to classify vaginal assisted deliveries that required the use of obstetrical forceps or vacuum extraction and which did not result in Cesarean section to achieve the delivery. Use “spontaneous” to indicate that the birth occurred without the need for forceps, vacuum, or any other instrumentation. **Note:** Vaginal birth must also have field 9. Induced Labor completed as “Yes”. 
8. **Delivery Type Cesarean**: Classify Cesarean births as “primary” or “repeat”. Categorize all Cesarean births that were not preceded by a Cesarean birth as “primary”. Categorize all Cesarean births that were preceded by another Cesarean birth as “repeat”. **Note**: All Cesarean births recorded on this form must leave field #7 “Delivery Type Vaginal” blank.

9. **Delivery Type Induced Labor**: Check “Yes” if the labor was induced and “No if the labor was not induced. **Note**: This field should not be left blank.

10. **Patient Ethnicity**: Enter the ethnicity of the patient as “Hispanic” if the patient indicated Hispanic as her primary, self-identified ethnicity. This would be a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race. Enter “Non-Hispanic” if the patient indicated that she is not of Hispanic ethnicity. Enter “Unknown” if the patient did not provide information about her ethnicity. **Note**: This field should not be left blank.

11. **Patient Race**: Enter the patient self-identified race as follows: **Note**: This field should not be left blank.
   a. **White**: Enter the selection as White for any patient having origins in any of the original people of Europe, the Middle East or North Africa. It includes women who indicate their race as “White” or report entries such as Irish, German, Italian, Near Easterner, Arab or Polish.
   b. **Black or African American**: Enter the selection as Black or African American for any patient having origins in any of the Black racial groups of Africa. It includes people who indicate their race as Black, African American, Afro American, Kenyan, Nigerian or Haitian.
   c. **American Indian and Alaska Native**: Enter the selection as American Indian and Alaska Native for any patient having origins in any of the original women of North and South America (including Central America) and who maintain tribal affiliation or community attachment.
   d. **Asian**: Enter the selection as Asian for any patient having origins in any of the original people of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. Includes Asian Indian, Chinese, Filipino, Korean, Japanese, Vietnamese and other Asian.
   e. **Native Hawaiian and Other Pacific Islander**: Enter the selection as Native Hawaiian and Other Pacific Islander for any patient having origins in any of the original peoples of Hawaii,
Guam, Samoa or other Pacific Islands. Includes women who indicate their race as Native Hawaiian, Guamanian or Chamarro, Samoan and other Pacific Islander.

<table>
<thead>
<tr>
<th>A. Patient Demographics</th>
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</thead>
<tbody>
<tr>
<td>1. Permanent Facility Identifier (PFI):</td>
</tr>
<tr>
<td>2. Facility Name:</td>
</tr>
<tr>
<td>3. Sequence Number:</td>
</tr>
<tr>
<td>4. Delivery Date (Month and Year): mm/yyyy</td>
</tr>
<tr>
<td>5. Maternal Age: years</td>
</tr>
<tr>
<td>6. NOTES:</td>
</tr>
<tr>
<td>7. Vaginal: Spontaneous</td>
</tr>
<tr>
<td>8. Cesarean: Primary</td>
</tr>
<tr>
<td>9. Induced Labor: Yes</td>
</tr>
<tr>
<td>10. Race: White</td>
</tr>
<tr>
<td>11. Primary Insurer: Medicaid</td>
</tr>
</tbody>
</table>

f. **Other Race:** Enter the selection as “Other Race” for any patient who has indicated a race not included in the previous categories. Patients who identify as multiracial, mixed, interracial or Hispanic/Latino group (for example, Mexican, Puerto Rican, or Cuban) in the “Some other race” category should be included in this category which includes all other responses not included in the “White”, “Black or African American”, “American Indian and Alaska Native”, “Asian” and “Native Hawaiian and other Pacific Islander” race categories described above.

g. **Race Unknown:** Enter the selection as “Race Unknown” for a patient who has not provided information on her race.

12. **Primary Insurer:** Enter the primary insurer category using the selections provided. For “Medicaid” include all Medicaid programs such as Medicaid Managed Care and Family Health Plus. For “Other”, include other government insurance programs such as Child Health Plus, Indian Health Service, CHAMPUS and Tricare for Life.
Clinical Data

Reporting Clinical Data: Clinical data should reflect the documented care provided to the patient during this hospitalization. All reports for multiple births should be reported as a single delivery.

13. Enter the gestational age fields using both week and day measures.
   a. Final Gestational Age at Delivery Weeks: Enter the final gestational age of the child at birth by entering the number of weeks of gestation in whole numbers without any decimal places. This field must not be less than 36 0/7 weeks or greater than 38 6/7 weeks. Note: This field should not be left blank.

   b. Final Gestational Age at Delivery Days: Enter the final gestational age of the child at birth by entering the days of gestation in whole numbers using a range of 0 to 6. For example: enter 0 days when the gestational age is exactly 36 weeks. When the gestational age is 36 weeks and 2 days, this field would receive the value “2”. Note: This field should not be left blank.

14. Was Gestational Age Documented in the Chart: Record “Yes” if the gestational age was documented in the chart regardless of the method used to determine the gestational age. Answer “No” if the chart did not document the final gestational age. Note: This field should not be left blank.

15. Was Gestational Age of less than 39 weeks confirmed by one of the following:
   Enter “Yes” if the gestational age was confirmed using one of the following methods:
   - First or second trimester ultrasound < 20 weeks
   - Fetal heart tones documented for 30 weeks by Doppler ultrasonography
   - 36 weeks since positive serum/urine human chorionic gonadotropin pregnancy test result

   Enter “No” if the gestational age was not confirmed by any of these methods. Note: This field should not be left blank.

16. Was fetal lung maturity documented by amniocentesis?: Enter “Yes” if the fetal lung maturity was documented by amniocentesis. Enter “No” if the fetal lung maturity was not documented. Note: This field should not be left blank.
17. For inductions, was the Bishop Score of cervical status 8 or greater for a primigravida birth mother or 6 or greater for a multigravida birth mother?

1. Enter “Score ≥8 primigravida, ≥6 multigravida” if the Bishop Score was 8 or greater for a primigravida birth mother or 6 or greater for a multigravida birth mother.

2. Enter “Determined, did not meet criteria” if the Bishop Score was determined, but did not meet these criteria.

3. Enter “Not measured or cannot be calculated” if the Bishop Score was not measured or cannot be calculated because elements are missing.

**NOTE:** If the actual number of the Bishop Score was not calculated but all of the elements are present in the chart, the reviewer may calculate the Bishop Score as below and enter “Score ≥8 primigravida, ≥6 multigravida” if ≥8 for primigravida and ≥6 for multigravida.

<table>
<thead>
<tr>
<th>Cervix</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Position</td>
<td>Posterior</td>
</tr>
<tr>
<td>Consistency</td>
<td>Firm</td>
</tr>
<tr>
<td>Effacement</td>
<td>0-30%</td>
</tr>
<tr>
<td>Dilation</td>
<td>Closed</td>
</tr>
<tr>
<td>Baby’s Station</td>
<td>-3</td>
</tr>
</tbody>
</table>

18. Patient Counseling: Enter “Yes” if the medical record shows documentation of patient counseling to discuss the maternal and fetal/newborn risks and benefits of scheduled delivery. Enter “No” if documentation is not present in the medical record.
19. **Reason for Scheduled Delivery**: Was there documentation in the medical or prenatal record of a primary reason for scheduled delivery? Enter “Yes” if there was documentation in either the medical or prenatal record of a primary reason for scheduled delivery and “No” if no reason was noted in these records. Record the single maternal, fetal or psychosocial reason in one of fields 20, 21 or 22.

**Note**: Field 19 should not be left blank. Determine the primary maternal, fetal or psychosocial reason for the scheduled delivery and indicate the category in the appropriate field (#20-22) below.

20. **Maternal Reasons for Scheduled Delivery**: Check the box next to the single primary maternal reason that was documented in the medical records for a scheduled delivery between 36 0/7 and 38 6/7 weeks of gestation. When the maternal reason for scheduled delivery includes instructions to specify below, then proceed to field 23 and describe the reason. If the scheduled delivery was due to fetal or psychosocial reasons, leave this section blank and proceed to field 21 or 22.

**Note**: For Fields 20, 21 and 22, select only one category (maternal, fetal or psychosocial). Additionally, select only one reason within the category. Describe the primary reason in field 23 when indicated.
21. **Fetal Reasons for Scheduled Delivery**: Check the box next to the single primary fetal reason for delivery. When the fetal reason for scheduled delivery includes instructions to specify below, or the fetal reason is “Other” then proceed to field 23 and describe the reason. If “Maternal Reasons for Scheduled Delivery” field has been checked, do not check the “Fetal Reasons for Scheduled Delivery” field. If the scheduled delivery was due to psychosocial reasons, leave this section blank and proceed to field 22 (below).

<table>
<thead>
<tr>
<th>Fetal Reasons</th>
<th>Check Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oligohydramnios</td>
<td></td>
</tr>
<tr>
<td>Intrauterine growth restriction</td>
<td></td>
</tr>
<tr>
<td>Macrosomia—Sono EFW&gt;5,000 grrs.</td>
<td></td>
</tr>
<tr>
<td>Major fetal anomaly</td>
<td></td>
</tr>
<tr>
<td>Fetal demise</td>
<td></td>
</tr>
<tr>
<td>Abnormal fetal testing (by NST, Doppler)</td>
<td></td>
</tr>
<tr>
<td>Other (specify in #23 below)</td>
<td></td>
</tr>
<tr>
<td>Alloimmunization/fetal hydrops</td>
<td></td>
</tr>
</tbody>
</table>

22. **Psychosocial Reasons for Scheduled Delivery**: Check the box next to the single primary Psychosocial reason for delivery. If either the “Fetal Reason for Delivery” or “Maternal Reasons for Scheduled Delivery” field have been checked, do not check a “Psychosocial Reasons for Scheduled Delivery” field.

<table>
<thead>
<tr>
<th>Psychosocial Reasons</th>
<th>Check Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial stress (e.g., domestic violence, no social support, working long hrs. upright)</td>
<td></td>
</tr>
<tr>
<td>Patient request— “Elective”</td>
<td></td>
</tr>
<tr>
<td>Convenience of patient/doctor (includes scheduling difficulties)</td>
<td></td>
</tr>
<tr>
<td>Other (specify in #23 below)</td>
<td></td>
</tr>
</tbody>
</table>

23. **Specify (narrative)** Please explain the choice made as requested above in fields 20, 21 and 22.
24a. When Maternal or Fetal Reason is ‘Other’, was the reason for scheduled delivery reviewed by a designated reviewer or panel?

When Maternal or Fetal Reason is ‘Other’, Check “Yes” if a designated reviewer or panel reviewed the reason for scheduled delivery to determine if there was a valid medical indication for scheduled delivery that was not included on Question 20. “Maternal Reasons for Scheduled Delivery”; or Question 21. “Fetal Reasons for Scheduled Delivery”; or Question 22. “Psychosocial Reasons for Scheduled Delivery”. Check “No” if the scheduled delivery was not reviewed by a designated reviewer or panel. Check “Review Pending” when the review is not yet completed.

24b. Medically indicated based on review?

If Questions 24a. is checked “Yes” then check “Yes” when the scheduled delivery was medically indicated based upon the review. Check “No” if the scheduled delivery was not medically indicated based upon the review. If Question 24a. is checked “Review Pending” then leave Q24b blank to be updated later.

25. Plurality: Enter the number of infants delivered.

26. Was the infant admitted to the Neonatal Intensive Care Unit (NICU) for more than 4 hours:

Check “Yes” if any infant born during this delivery was admitted to the NICU. Check “No” if the infant was not admitted or stayed in the NICU for less than 4 hours. If “Yes”, respond to questions 25, 26 and 27 if applicable.

Then proceed to Fields 25 through 27 for single or multiple births.

27. If ‘Yes’: Number of days in NICU for the first birth if single or multiple birth: Enter the number of days in the NICU if the first infant born during this delivery was admitted to the NICU.

28. If ‘Yes’: Number of days in NICU for the second birth if multiple birth: Enter the number of days in the NICU if the second infant born during this delivery was admitted to the NICU.

29. If ‘Yes’: Number of days in NICU for the third birth if multiple birth: Enter the number of days in the NICU if the third infant born during this delivery was admitted to the NICU. You may enter “0” in the field if an infant of multiple births is not admitted the NICU. (i.e., one infant is admitted and one infant is not).
Data Collection, Entry and Verification

General Instructions:

30. **Initials of individual completing this form**: Enter the initials of the person who completed the form.

‡ **Initials of obstetrician**: Enter the initials of the obstetrician who performed the delivery. This information will be used by the site only. **Note**: This field will not be recorded in the database and will not be transmitted to the NYSDOH.

31. **Optional Field for Data Collection(#1)**: Use this field to collect optional site data. These data are not required by the NYSPQC project and can be constructed to suit individual site needs. Each optional field has a set of drop-down values that can be changed on the database by selecting the “Change Values” control button.

32. **Optional Field for Data Collection(#2)**: Use this field to collect optional site data. These data are not required by the NYSPQC project and can be constructed to suit individual site needs. Each optional field has a set of drop-down values that can be changed on the database by selecting the “Change Values” control button.

33. **Optional Field for Data Collection(#3)**: Use this field to collect optional site data. These data are not required by the NYSPQC project and can be constructed to suit individual site needs. Each optional field has a set of drop-down values that can be changed on the database by selecting the “Change Values” control button.

34. **Optional Field for Data Collection(#4)**: Use this field to collect optional site data. These data are not required by the NYSPQC project and can be constructed to suit individual site needs. Each optional field has a set of drop-down values that can be changed on the database by selecting the “Change Values” control button.

35. **Optional Field for Data Collection(#5)**: Use this field to collect optional site data. These data are not required by the NYSPQC project and can be constructed to suit individual site needs. Each optional field has a set of drop-down values that can be changed on the database by selecting the “Change Values” control button.
**Stillbirth Balancing Measure Data Collection**

The stillbirth balancing measure is calculated using the following:

1. Monthly totals for: a) live births, b) all stillbirths, c) live births between 36 0/7 and 38 6/7 weeks gestational age, and d) stillbirths between 36 0/7 and 38 6/7 weeks gestational age.
2. Monthly data collection for each individual stillbirth

**Instructions for Collecting Stillbirth Data Using the Stillbirth Summary Log to Collect Counts:**

1. **Case Definition:** For the purposes of this project, stillbirth will be defined as a spontaneous fetal death occurring at >20 weeks gestational age or weighing >350 g.

2. **Data Collection:** Hospitals should begin to track their stillbirths and enter the total count that occurs for each month in the attached “Stillbirth Summary Log”. The total live births occurring at the hospital during each month of the study should also be entered in the Stillbirth Summary Log. This will be used to calculate the percentage of all births that resulted in stillbirths.

3. **Stillbirth balancing measure:** Beginning July 1, 2011, please collect additional data for the stillbirths and live births occurring between 36 0/7 and 38 6/7 weeks gestational age.

4. **Reporting to NYSDOH:** After completing the monthly data collection, each participating site will data enter the monthly total of stillbirths and total live births into the data system.

<table>
<thead>
<tr>
<th>Stillbirth Log</th>
<th>Count of Total Stillbirths, Live Births and Deliveries Each Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>PFI</td>
<td>FacilityName</td>
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<td></td>
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</tbody>
</table>
Instructions for Collecting Stillbirth Data Using the Stillbirth Individual Log:

1. **Case Definition**: For the purposes of this project, stillbirth will be defined as a spontaneous fetal death occurring at >20 weeks gestational age or weighing >350 g.

2. **Data Collection**: Hospitals should record additional information for each stillbirth and enter each stillbirth that occurs during the month in the attached “Stillbirth Individual Log”. Assign a unique sequence number to each stillbirth that will be used to anonymously identify the case. Record the year and month of delivery, gestational age, weight at delivery in grams and the known or possible diagnosis. These data will be used to calculate the balancing measure for the quality improvement project.

3. **Reporting to NYSDOH**: After completing the monthly data collection, each participating site should enter the data into the Scheduled Delivery Data System for submission to the Quality Improvement project.

4. **Pending Update of Data System**: Sites that have not updated their data system to version 6.2 or greater should schedule an update with Todd Gerber (tmg02@health.state.ny.us).

### Stillbirth Individual Log

**Listing for each Stillbirth**

<table>
<thead>
<tr>
<th>Sequence Number</th>
<th>Year (yyyy)</th>
<th>Month (1-12</th>
<th>Gestational Age (wks/days)</th>
<th>weight at delivery (&gt;350g)</th>
<th>Known or Possible Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Weeks (20-42)</td>
<td>Days (1-7)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
## Copy of Scheduled Delivery Form

### A. Patient Demographics

1. Permanent Facility Identifier (PFI): 
2. Facility Name: 
3. Sequence Number: 
4. Admit Date (Month and Year): \( mm/yyyy \) / \( mm/yyyy \) 
5. Maternal Age: \( \_\_\_\_ \) years 
6. NOTES: 

#### Delivery Type

7. Vaginal: Spontaneous ☐ Operative ☐ 
8. Cesarean: Primary ☐ Repeat ☐ 
9. Induced Labor: Yes ☐ No ☐ 
10. Patient ethnicity: Hispanic ☐ Non-Hispanic ☐ Ethnicity Unknown ☐ 
11. Patient race: White ☐ Black or African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Some Other Race ☐ Race Unknown ☐ 
12. Primary Insurer: Medicaid ☐ Uninsured ☐ Private ☐ Other ☐ 

### B. Clinical Data

13. Final Gestational Age at Delivery: \( \_\_\_\_ \) weeks \( \_\_\_\_ \) days 
14. Was gestational age documented in the chart? ☐ Yes ☐ No 
15. Was gestational age of less than 39 weeks confirmed by one of the following? 
- First or second trimester ultrasound < 20 weeks 
- Fetal heart tones documented for 30 weeks by Doppler ultrasonography 
- 36 weeks since positive serum/urine human chorionic gonadotropin pregnancy test result 
- ☐ Yes ☐ No 
16. Was fetal lung maturity documented by amniocentesis? ☐ Yes ☐ No 
17. For inductions, was the Bishop Score of cervical status 8 or greater for a primigravida birth mother or 6 or greater for a multigravida birth mother? ☐ Score ≥8 primigravida, ≥6 multigravida ☐ Determined, did not meet criteria ☐ Not measured or cannot be calculated 

### Patient Counseling

18. Was there documentation in the medical record that the maternal and fetal/newborn risks and benefits of scheduled delivery at 36 0/7 – 38 6/7 weeks were discussed with the mother? ☐ Yes ☐ No 

### Reason for Scheduled Delivery

19. Was there documentation in the medical or prenatal record of the primary reason for scheduled delivery? ☐ Yes ☐ No 

### Which of the following was the PRIMARY reason documented in the medical records for a scheduled delivery between 36 0/7 and 38 6/7 weeks gestation? (Reasons can be maternal, fetal, psychosocial) ☐ SELECT ONLY ONE (AND SPECIFY BELOW AS NEEDED) ☐ 

#### 20. Maternal Reasons for Scheduled Delivery ☐ SELECT ONLY ONE ☐ 

- Premature rupture of membranes ☐ 
- Prepregnancy hypertension ☐ 
- Hematological condition (specify in #23 below) ☐ 
- Prolonged rupture of membranes ☐ 
- Gestational diabetes ☐ 
- Active genital herpes infection ☐ 
- Chorioamnionitis ☐ 
- Diabetes (Type I/II) ☐ 
- Prior myomectomy ☐ 
- Placental abruption ☐ 
- Heart disease (specify in #23 below) ☐ 
- Prior vertical or “T” incision c-section ☐ 
- Placenta previa/Vasa ☐ 
- Liver disease (specify in #23) ☐ 
- History of poor pregnancy ☐ 

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16
<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>previa</td>
<td>below)</td>
<td>outcomes(specify in #23 below)</td>
</tr>
<tr>
<td>Gestational hypertension</td>
<td>Renal disease(specify in #23 below)</td>
<td>History of fast labor (&lt;3 hrs) and distant from hospital</td>
</tr>
<tr>
<td>Preeclampsia/Eclampsia</td>
<td>Pulmonary disease(specify in #23 below)</td>
<td>HIV</td>
</tr>
<tr>
<td>Other (specify in #23 below)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Sequence Number (from front of form):

21. Fetal Reasons for Scheduled Delivery  ***SELECT ONLY ONE IF NO MATERNAL REASON SPECIFIED***

<table>
<thead>
<tr>
<th>Maternal Reason</th>
<th>Fetal Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oligohydramnios</td>
<td>Intrauterine growth restriction (&lt; 5th percentile for gestational age)</td>
</tr>
<tr>
<td>Macrosomia–Sono EFW&gt;5,000 gms</td>
<td>Abnormal fetal testing (by NST, BPP, or continuous wave Doppler)</td>
</tr>
<tr>
<td>Major fetal anomaly</td>
<td>Alloimmunization/fetal hydrops</td>
</tr>
</tbody>
</table>

22. Psychosocial Reasons for Scheduled Delivery  ***SELECT ONLY ONE IF NO MATERNAL OR FETAL REASON SPECIFIED***

<table>
<thead>
<tr>
<th>Psychosocial Reason</th>
<th>Convenience of patient/doctor (includes scheduling difficulties)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial stress (e.g., domestic violence, no social support, working long hrs. upright)</td>
<td></td>
</tr>
<tr>
<td>Patient request – “Elective”</td>
<td></td>
</tr>
<tr>
<td>Other (specify in #23 below)</td>
<td></td>
</tr>
</tbody>
</table>

23. Specify (narrative as directed above)

______________________________________________________________________________________________
______________________________________________________________________________________________
__________________________________________________________________________________________

24a. When ‘Other’ is selected as the Maternal or Fetal reason, was the reason for scheduled delivery reviewed by a designated reviewer or panel?  

<table>
<thead>
<tr>
<th>Review Pending</th>
<th>Results of scheduled delivery review from Q24a:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Medically indicated based on review?</td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Infant Outcome

25. Plurality – please enter the number of infants delivered: 

26. Was any infant(s) admitted to the Neonatal Intensive Care Unit (NICU) for more than 4 hours?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

27. If 'Yes': Number of days in NICU (Baby #1)  

28. If 'Yes': Number of days in NICU (Baby #2)  

29. If 'Yes': Number of days in NICU (Baby #3)  

C. Data collection, entry and verification

30. Initials of individual completing this form: ____________

D. Optional Data Collection (for site use only)

31. Optional Field for Data Collection(#1)  

32. Optional Field for Data Collection(#2)  

33. Optional Field for Data Collection(#3)  

34. Optional Field for Data Collection(#4)  

35. Optional Field for Data Collection(#5)  

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