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Arkansas Medicaid Inpatient Quality Incentive Guidelines SFY2016, v2016a
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Introduction

This manual is the AFMC Data Abstraction Specifications and Guidelines for the Inpatient Quality Incentive project for SFY2016. The measures were carefully selected to improve care for a large number of Arkansans, including Arkansas Medicaid beneficiaries.

AMART will be available for hospitals to begin collecting the data for 3rd Quarter 2015 and 4th Quarter 2015 discharges.

The criteria were developed jointly by Arkansas Medicaid, the Arkansas Hospital Association, the Arkansas Foundation for Medical Care and the advisory committee, made up of hospital quality professionals.

This manual describes the data elements required to collect and submit the data for the Obstetric, Tobacco Treatment, Newborn Screening, and Medical Imaging measures for the Medicaid Inpatient Quality Incentive program for SFY 2016. It includes information necessary for defining and formatting the data elements, as well as the allowable values for each data element required for the Obstetric (OBS), Tobacco Treatment (TOB), Newborn Screening (NBS), and Abdomen CT Use of Contrast Material (OP-10) measures.

We have included information from the CMS Specifications Manual for National Hospital Inpatient Quality Measures and the Joint Commission Specifications Manual for discharges 01/01/2015 thru 12/31/2015. If/when any information in this manual changes, the information will be provided to hospitals participating in the IQI Project via Release Notes.

General Abstraction Guidelines
The General Abstraction Guidelines are a resource designed to assist abstractors in determining how a question should be answered. The abstrator should first refer to the specific notes and guidelines under each data element. These instructions should take precedence over the following General Abstraction Guidelines. All of the allowable values for a given data element are outlined, and notes and guidelines are often included that provide the necessary direction for abstracting a data element. It is important to use the information found in the notes and guidelines when entering or selecting the most appropriate answer.

Suggested Data Sources
• Suggested Data Sources are NOT listed in priority order, unless otherwise specified in the data element.
• Suggested Data Sources are designed to provide guidance to the abstrator as to the locations/sources where the information needed to abstract a data element will likely be found. However, the abstrator is not limited to these sources for abstracting the information and must review the entire medical record unless otherwise specified in the data element.
• In some instances, a data element may restrict the sources that may be used to gain the information. If so, these sources will be identified and labeled as “Excluded Data Sources.”
• If, after due diligence, the abstractor determines that a value is not documented or is not able to determine the answer value, the abstractor must select “Unable to Determine (UTD)” as the answer if that option is available.
• Hospitals often label forms and reports with unique names or titles. Suggested Data Sources are listed by commonly used titles; however, information may be abstracted from any source that is equivalent to those listed.

Example:
If the “nursing admission assessment” is listed as a suggested source, an acceptable alternative might be titled “nurses initial assessment” or “nursing data base.”

Note:
Element-specific notes and guidelines should take precedence over the General Abstraction Guidelines.

Inclusions/Exclusions
• Inclusions are “acceptable terms” that should be abstracted as positive findings (e.g., “Yes”).
• Inclusion lists are limited to those terms that are believed to be most commonly used in medical record documentation. The list of inclusions should not be considered all-inclusive, unless otherwise specified in the data element.
• Exclusions are “unacceptable terms” that should be abstracted as negative findings (e.g., “No”).
• Exclusion lists are limited to those terms an abstractor may most frequently question whether or not to abstract as a positive finding for a particular element (e.g., “cardiomyopathy” is an unacceptable term for heart failure and should be abstracted as "No"). The list of exclusions should not be considered all-inclusive, unless otherwise specified in the data element.
• When both an inclusion and exclusion are documented in a medical record, the inclusion takes precedence over the exclusion and would be abstracted as a positive finding (e.g., answer “Yes”), unless otherwise specified in the data element.
Medicaid Inpatient Quality Incentive Criteria
State Fiscal Year 2016

Overview
The 2016 program is aimed at identifying and rewarding hospitals that provide a higher level of care to Arkansas Medicaid beneficiaries. The program will focus on eight performance measures and one outcome measure.

Criteria
- Hospitals must submit data on all eligible measures and have a minimum of five Arkansas Medicaid cases per eligible topic for Quarters 3 and 4, 2015.
- Hospitals must pass 80 percent of the eligible measures (see thresholds).
- If measure denominator is 0 after data analysis, the hospital will not be eligible for that measure.
- Hospitals must pass validation.

Bonus Payments
- Qualifying PPS hospitals will receive 5.8 percent of their per diem, or up to $50 per day, on their Medicaid primary discharge (excluding dual eligible beneficiaries and those under one year of age).
- Hospitals that are not eligible for a bonus payment but would like to participate in the evaluation for recognition will have the same requirements.

Thresholds for OBS 4, 5 and 6; NBS 1 and 2; TOB 1, 2 and 3; OP 10
Threshold 1: Performance in Quarter 3-Quarter 4, 2015, at or above the 75th percentile from Quarters 3 and 4, 2014. Exceptions: OBS 4 performance must be 5 percent or below; OBS 6 must be 24 percent or lower. OP-10 must be 15.3 percent* or below for combined Quarter 3 and Quarter 4, 2015.
- Threshold 2: Hospitals must achieve a 35 percent reduction in failure rate based on submitted data from Quarters 3 and 4, 2014. Exceptions: OBS 4 performance must be 5 percent or below; OBS 5 performance must achieve a 25 percent reduction in failure rate based on submitted data from Quarters 3 and 4, 2014. OP-10 must be 15.3 percent* or below for combined Quarter 3 and Quarter 4, 2015.
- TOB and NBS-1: Performance of 50 percent minimum must be achieved to qualify for passing.
- AMART will be available for abstraction of OBS, TOB, and NBS records.
- Hospitals using a vendor for measure submission will have XML data files required.

<table>
<thead>
<tr>
<th># of Eligible Measures</th>
<th># of Measures Required to Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>
Sampling Requirements

- AFMC will provide a monthly Arkansas Medicaid case count per topic in AMART.
- Hospitals will have the option to abstract 100 percent of the cases or select a random sample. Exception: There will be no sampling option for OBS Mother or the NBS measures. Hospitals will abstract 100 percent of their NBS and OBS Mother Medicaid population.
- AMART will generate a monthly case listing.
- Hospitals that utilize a vendor will be able to download the case listing from AMART and provide it to their vendor.
- The monthly patient list will be based on Arkansas Medicaid paid cases.
- Hospitals may choose to submit all payers for individual hospital use only. The data from non-Medicaid records will not be used to determine performance rates for the Medicaid IQI Project.

Validation

- Two randomly selected charts from each topic per quarter for Quarters 3 and 4, 2015 will be requested for validation.
- OP-10 will not have charts validated.
- To pass validation, a combined score of 80 percent across both quarters will be required.
## 9 Inpatient Quality Incentive Measures for SFY 2016
(Must pass 80% of the eligible measures)

<table>
<thead>
<tr>
<th>PERFORMANCE MEASURES</th>
<th>CRITERIA TO PASS MEASURE</th>
<th>VALIDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>OBS 4: EARLY ELECTIVE DELIVERY</td>
<td>Must be 5 percent or below for combined Quarter 3 and Quarter 4, 2015.</td>
<td>Two randomly selected charts from OBS Mother from each Quarter 3 and 4, 2015. Must achieve 80 percent for combined Quarters 3 and 4, 2015.</td>
</tr>
<tr>
<td>OBS 5: EXCLUSIVE BREAST MILK FEEDING</td>
<td>Must meet threshold 1 or a 25 percent reduction in failure rate for combined Quarter 3 and Quarter 4, 2015.</td>
<td>Two randomly selected charts from OBS Newborn from each Quarter 3 and 4, 2015. Must achieve 80 percent for combined Quarters 3 and 4, 2015.</td>
</tr>
<tr>
<td>OBS 6: CESAREAN SECTION: NULLIPAROUS WOMEN</td>
<td>Must be 24 percent or lower or a 35 percent reduction in failure rate for combined Quarter 3 and Quarter 4, 2015.</td>
<td>Two randomly selected charts from the OBS Mother from each Quarter 3 and 4, 2015. Must achieve 80 percent for combined Quarters 3 and 4, 2015.</td>
</tr>
<tr>
<td>TOB 1: TOBACCO USE SCREENING</td>
<td>Must meet thresholds 1 or 2 listed above for combined Quarter 3 and Quarter 4, 2015.</td>
<td>Two randomly selected charts from the TOB measure set from each Quarter 3 and 4, 2015. Must achieve 80 percent for combined Quarters 3 and 4, 2015.</td>
</tr>
<tr>
<td>TOB 2: TOBACCO USE TREATMENT PROVIDED OR OFFERED</td>
<td>Must meet thresholds 1 or 2 listed above for combined Quarter 3 and Quarter 4, 2015.</td>
<td>Two randomly selected charts from the TOB measure set from each Quarter 3 and 4, 2015. Must achieve 80 percent for combined Quarters 3 and 4, 2015.</td>
</tr>
<tr>
<td>TOB 3: TOBACCO USE TREATMENT PROVIDED OR OFFERED AT DISCHARGE</td>
<td>Must meet thresholds 1 or 2 listed above for combined Quarter 3 and Quarter 4, 2015.</td>
<td>Two randomly selected charts from the TOB measure set from each Quarter 3 and 4, 2015. Must achieve 80 percent for combined Quarters 3 and 4, 2015.</td>
</tr>
<tr>
<td>NBS 1: TIMELY COLLECTION OF NEWBORN SCREENING SPECIMEN</td>
<td>Must meet thresholds 1 or 2 listed above for combined Quarter 3 and Quarter 4, 2015.</td>
<td>Two randomly selected charts from the NBS measure set from each Quarter 3 and 4, 2015. Must achieve 80 percent for combined Quarters 3 and 4, 2015.</td>
</tr>
<tr>
<td>NBS 2: TIMELY SUBMISSION OF NEWBORN SCREENING (NBS) SPECIMEN TO THE ARKANSAS DEPARTMENT OF HEALTH PUBLIC HEALTH LABORATORY</td>
<td>Must meet thresholds 1 or 2 listed above for combined Quarter 3 and Quarter 4, 2015.</td>
<td>Two randomly selected charts from the NBS measure set from each Quarter 3 and 4, 2015. Must achieve 80 percent for combined Quarters 3 and 4, 2015.</td>
</tr>
</tbody>
</table>

### OUTCOME MEASURES

<table>
<thead>
<tr>
<th>OUTCOME MEASURES</th>
<th>CRITERIA TO PASS MEASURE</th>
<th>VALIDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP-10: ABDOMEN CT – USE OF CONTRAST MATERIAL</td>
<td>Must be 15.3 percent* or below for combined Quarter 3 and Quarter 4, 2015.</td>
<td>There will be no validation for this measure.</td>
</tr>
</tbody>
</table>

*Based on State rate between 07/01/2012-06/30/2013 from Hospital Compare ([http://www.medicare.gov/hospitalcompare/search.html](http://www.medicare.gov/hospitalcompare/search.html))

Arkansas Medicaid Inpatient Quality Incentive Guidelines SFY2016, v2016a
Discharges 07/01/2015 (3Q2015) through 09/30/2015 (3Q2015)
Measure Information Form and Flow Chart

Measure Set: Obstetric Services

Measure ID#: OBS-4

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 and all of the following: not in Labor, no history of a Prior Uterine Surgery

Excluded Populations:
None
Data Elements:
- ICD-9-CM Other Procedure Codes
- ICD-9-CM Principal Procedure Code
- Labor
- Prior Uterine Surgery

Denominator Statement: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed

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

Excluded Populations:
- ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation 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
- Gestational Age < 37 or >= 39 weeks or UTD

Data Elements:
- Admission Date
- Birthdate
- Clinical Trial
- Discharge Date
- Gestational Age
- ICD-9-CM Other Diagnosis Codes
- ICD-9-CM Principal Diagnosis Code

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:** No. Hospitals will abstract 100% of the OBS-Mother population.

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

**Selected References:**

**Original Performance Measure Source / Developer:**
Hospital Corporation of America-Women's and Children's Clinical Services
PC-01: Elective Delivery

Numerator: Patients with elective deliveries
Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed

Start

Run cases that are included in the PC-Mother Inpatient Population and pass the edits defined in the Transmission Data Processing flow. Complete through this measure.

ICD-9-CM
Principal or Other Diagnosis Codes
At least one on Table 11.07 → PC-01 B
None on Table 11.07

PC-01 X Missing
Clinical Trial = Y
PC-01 B
PC-01 B

PC-01 X Missing
Clinical Trial = N
Gestational Age
< 37 or >= 39 or UTD
PC-01 B
PC-01 B

Gestational Age
>= 37 and < 39
ICD-9-CM
Principal or Other Diagnosis Codes
At least one on Table 11.08.1 → PC-01 D
None on Table 11.08.1
PC-01 X
Measure Set: Obstetric Services

Measure ID#: OBS-5

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: Single term newborns discharged alive from the hospital

Included Populations: Liveborn newborns with ICD-9-CM Principal Diagnosis Code for single liveborn newborn as defined in Appendix A, Table 11.20.1

Excluded Populations:
- Admitted to the Neonatal Intensive Care Unit (NICU) at this hospital during the hospitalization
- 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
- Patients transferred to another hospital
- ICD-9-CM Other Diagnosis Codes for premature newborns as defined in Appendix A, Table 11.23

Data Elements:
- Admission Date
- Admission to NICU
- Birthdate
- Clinical Trial
- Discharge Date
- Discharge Disposition
- ICD-9-CM Other Diagnosis Codes
- ICD-9-CM Other Procedure Codes
- ICD-9-CM Principal Diagnosis Code
- ICD-9-CM Principal Procedure Code
- Reason for Not Exclusively Feeding Breast Milk

Risk Adjustment: No

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

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

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

Sampling: Yes. For additional information, see the Sampling Requirements in the SFY2016 Criteria on page 7 of this manual.

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
PC-05: Exclusive Breast Milk Feeding

Numerator: Newborns that were fed breast milk only since birth
Denominator: Single term newborns discharged alive from the hospital

Start

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

Discharge Disposition

= 4, 6

= 1, 2, 3, 5, 7, 8

Clinical Status

= Y

= N

Admission to NICU?

= Y

= N

Exclusive Breast Milk Feeding

= Y

= N

Reason For Not Exclusively Feeding Breast Milk

= 1

= 2, 3

For Original Rate (PC-05)

For In-Numerator Population (PC-05)

For In-Numerator Population (PC-05)

For In-Measure Population (PC-05)

For In-Measure Population (PC-05)

Case Will Be Rejected

For Original Rate (PC-05)

Stop

Arkansas Medicaid Inpatient Quality Incentive Guidelines SFY2016, v2016a
Discharges 07/01/2015 (3Q2015) through 09/30/2015 (3Q2015)
Measure Set: Obstetric Services

Measure ID#: OBS-6

Measure Name: Cesarean Section

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

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

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

Type of Measure: Outcome

Improvement Noted As: Decrease in the rate

Numerator Statement: Patients with cesarean sections

Included Populations:
ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes for cesarean section as defined in Appendix A, Table 11.06

Excluded Populations:
None
Data Elements:
- ICD-9-CM Other Procedure Codes
- ICD-9-CM Principal Procedure Code

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

Included Populations:
- ICD-9-CM Principal or ICD-9-CM Other Diagnosis Codes for pregnancy as defined in Appendix A, Tables 11.01, 11.02, 11.03 or 11.04
- 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 multiple gestations and other presentations 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
- Gestational Age < 37 weeks or UTD

Data Elements:
- Admission Date
- Birthdate
- Clinical Trial
- Discharge Date
- Gestational Age
- ICD-9-CM Other Diagnosis Codes
- ICD-9-CM Principal Diagnosis Code
- Parity

Risk Adjustment: Yes. Applied through direct standardization. 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: No. Hospitals will abstract 100% of the OBS-Mother population.

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
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 11.03

PC-02 B

None on Table 11.03

None on Table 11.03

At least one on Table 11.02

ICD-9-CM Principal or Other Diagnosis Code

Clinical Trial

PC-02 B

X

PC-02

Missing

Y

= N

Gestational Age

PC-02

Missing

< 37 or UTD

>= 37

PC-02

H

Arkansas Medicaid Inpatient Quality Incentive Guidelines SFY2016, v2016a
Discharges 07/01/2015 (3Q2015) through 09/30/2015 (3Q2015)
Discharges 07/01/2015 (3Q2015) through 09/30/2015 (3Q2015)
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.

Note: Hospitals are NOT required to sample their data. If sampling offers minimal benefit (i.e., a hospital has 80 cases for the quarter and must select a sample of 76 cases), or if the hospital has access to a data source which makes medical record review unnecessary (e.g., using vital records, delivery logs or clinical information systems as a data source for some of the maternal measures in the perinatal measure set), the hospital may choose to use all cases.

Newborns

The population of the PC-Newborn measure (PC-04 and 05) are identified using 5 data elements:

- Admission Date
- Birthdate
- Discharge Date (PC-05 only)
- ICD-9-CM Principal or Other Diagnosis Code
- ICD-9-CM Principal or Other Procedure Code

Within the PC-Newborn population, there are two 2 subpopulations, i.e Newborns with Blood Stream Infection or BSI, Newborns with Breast Feeding, each identified by Patient Age at admission and a specific group of diagnosis and procedure codes or lack thereof. The patients in each subpopulation are processed independently through each initial patient population flow. Patients may fall in both subpopulations depending on the presence or absence of the diagnosis codes or procedure codes and other data elements defined by the respective initial patient subpopulations.
<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 PC-Newborns with BSI</td>
</tr>
<tr>
<td>PC-05</td>
<td>The count of all patients in PC-Newborns with Breast Feeding</td>
</tr>
</tbody>
</table>

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

**Newborns with BSI** - Patients with a Newborn Patient Age at admission (Admission Date – Birthdate) ≤ 2 days AND satisfy conditions #1 through #3.

1. **NO** ICD-9-CM Principal Diagnosis Code as defined in Appendix A, Table 11.10.2,
2. **ONE** of the following:
   - an ICD-9-CM Other Diagnosis Code as defined in Appendix A, Tables 11.12, 11.13, 11.13.1, 11.14 Or Birth Weight >= 500g and <= 1499g
   - an ICD-9-CM Other Diagnosis Code as defined in Appendix A, Tables 11.15, 11.16, 11.16.1, 11.17 Or Birth Weight =1500g with **ANY** OF THE FOLLOWING:  
     - an ICD-9-CM-Principal or Other Procedure Code as defined in Appendix A, Tables 11.18 or 11.19  
     - Discharge Disposition of 6 (expired) or a Missing Discharge Disposition  
     - **NO** ICD-9-CM Principal Diagnosis Code as defined in Appendix A, Table 11.10.3
   - Birth Weight Missing or Unable To Determine (UTD).
3. **NO** ICD-9-CM Other Diagnosis Code as defined in Appendix A, Table 11.20 Or Birth Weight < 500g

There is NO sampling for this measure.

**Newborns with Breast Feeding** - Patient Age at admission (Admission Date – Birthdate) ≤ 2 days, Length of Stay (Discharge Date - Admission Date) ≤ 120 days, an ICD-9-CM Principal as defined in Appendix A, Table 11.20.1, **NO** ICD-9-CM Other Diagnosis Codes as defined in Appendix A, Table 11.21, **NO** ICD-9-CM-Principal or Other Procedure Code as defined in Appendix A, Table 11.22 and **NO** ICD-9-CM Other Diagnosis Codes as defined in Appendix A, Table 11.23 are included in this subpopulation and are eligible to be sampled.
PC Initial Patient Population Algorithm

Start PC Initial Patient Population logic sub-routine

Process all cases that have successfully reached the point in the Data Processing Flow which calls this Initial Patient Population Algorithm. Do not Process cases that have been rejected before this point in the Data Processing Flow.

Patient Age (in years) = Admission Date minus Birthdate
Use the month and day portion of admission date and birthdate to yield the most accurate age.

Patient Age

= 0 years

Patient Age

> 0 years

Patient Age

>= 8 years and < 65 years

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

Length of Stay

<= 120 days

ICD-9-CM Principal or Other Diagnosis Code

None on Table 11.01, 11.02, 11.03, or 11.04

Patient is eligible to be sampled for the PC-Mother Initial Patient population

Set Initial Patient Population Reject Case Flag = "No"

Patient is not eligible to be sampled for PC-Mother measures

Patient is not in the PC-Mother Initial Patient Population

Patient is not eligible to be sampled for PC-Newborn measures

Patient is not in the PC-Newborn Initial Patient Population

Variable Key:
- Patient Age
- Newborn Patient Age at Admission
- Initial Patient Population Reject Case Flag
- Length of Stay
- BSI Flag
- Breastfeeding Flag

Specifications Manual for Joint Commission National Quality Core Measures v2015A1
Discharges 01-01-15 (1Q15) through 09-30-15 (3Q15)
Measure Set: Newborn Screening (NBS)

Measure ID#: NBS-1

Measure Name: Timely Collection of Newborn Screening Specimen

Description: Percentage of newborns from an inpatient hospital for whom the NBS specimen was collected 24 to 72 hours after birth

Rationale: The Centers for Disease Control recommends all newborns be checked or screened for certain medical conditions. Finding these conditions soon after birth can help prevent some serious problems. Early diagnosis means treatment can be started quickly and can make a difference with health outcomes for these newborns

Type of measure: Performance

Numerator Statement: All newborn screening specimens collected within 24 to 72 hours after birth.

Included Populations:
Newborns who had collection of newborn screening specimens

Excluded Populations: None

Denominator Statement: All births occurring in the hospital

Included Populations:
Liveborn newborns with ICD-9-CM principal Diagnosis Code for Liveborn newborns as defined in Appendix A, Table 11.10.3.

Excluded Populations:
- Newborns who expired before discharge from the hospital
- Newborns discharged to home or transferred to another facility within 24 hours of birth

Sampling: No. Hospitals will abstract 100% of the NBS population.
NBS-1 Timely Collection of Newborn Screening Specimen

Numerator: All newborn screening specimens collected within 24 to 72 hours after birth.

Denominator: All births occurring in the hospital.

START

Cases that are included in the NBS population

Discharge Disposition

Not = 6

Stay 24 hrs in Hospital

= Y

Collect Sample

= Y

Birth Date

= Non-UTD Value

NBS-1

H

NBS-1

B

NBS-1

B

NBS-1

D

NBS-1

D

NBS-1

D
Measure Set:  *Newborn Screening (NBS)*

Measure ID#:  *NBS-2*

Measure Name:  *Timely Submission of Newborn Screening (NBS) Specimen to the Arkansas Department of Health Public Health Laboratory*

Description:  Percentage of newborns from an inpatient hospital for whom the NBS specimen was submitted to the Arkansas Department of Health Public Health Laboratory (PHL) within 24 hours of collection

Rationale:  The Centers for Disease Control recommends all newborns be checked or screened for certain medical conditions. Finding these conditions soon after birth can help prevent some serious problems. Early diagnosis means treatment can be started quickly and can make a difference with health outcomes for these newborns.

Type of measure:  *Performance*

Numerator Statement:  All newborn screening specimens submitted to the Arkansas Department of Health Public Health Laboratory within 24 hours of collection

Included Populations:  
*Newborns screening specimens submitted after collection*

Excluded Populations:  
*None*

Denominator Statement:  All births in hospital with collected newborn screening specimens.

Included Populations:  
*Liveborn newborns with ICD-9-CM principal Diagnosis Code for Liveborn newborns as defined in Appendix A, Table 11.10.3.*

Excluded Populations:  
- Newborns who expired before discharge from the hospital
- Newborns discharged to home or transferred to another facility within 24 hours of birth

Sampling:  *No. Hospitals will abstract 100% of the NBS population.*
**NBS-2: Timely Submission of Newborn Screening Specimen**

**Numerator:** All newborn screening specimens submitted to the Arkansas Department of Health Public Health Laboratory within 24 hours of collection

**Denominator:** All births in hospital with collected newborn screening specimens
NBS-2

Submit Collection

= N

NBS-2 D

= Y

Submission Date

= UTD

NBS-2 D

= Non-UTD Value

Submission Time

= UTD

NBS-2 D

= Non-UTD Value

Time to Submission = Sample Submission Date and Time - Sample Collection Date and Time (in minutes)

Time to Submission

> 1440 min

NBS-2 H

<= 1440 min

NBS-2 H

= Non-UTD Value

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Measure Set: Tobacco Treatment

Measure ID#: TOB-1

Measure Name: Tobacco Use Screening

Description: Hospitalized patients who are screened within the first three days of admission for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days.

Rationale: Tobacco use is the single greatest cause of disease in the United States today and accounts for more than 435,000 deaths each year (CDC MMWR 2008; McGinnis 1993). Smoking is a known cause of multiple cancers, heart disease, stroke, complications of pregnancy, chronic obstructive pulmonary disease, other respiratory problems, poorer wound healing, and many other diseases (DHHS 2004). Tobacco use creates a heavy cost to society as well as to individuals. Smoking-attributable health care expenditures are estimated at $96 billion per year in direct medical expenses and $97 billion in lost productivity (CDC 2007).

There is strong and consistent evidence that tobacco dependence interventions, if delivered in a timely and effective manner, significantly reduce the user’s risk of suffering from tobacco-related disease and improved outcomes for those already suffering from a tobacco-related disease (DHHS 2000; Baumeister 2007; Lightwood 2003 and 1997; Rigotti 2008). Effective, evidence-based tobacco dependence interventions have been clearly identified and include brief clinician advice, individual, group, or telephone counseling, and use of FDA-approved medications. These treatments are clinically effective and extremely cost-effective relative to other commonly used disease prevention interventions and medical treatments. Hospitalization (both because hospitals are a tobacco-free environment and because patients may be more motivated to quit as a result of their illness) offers an ideal opportunity to provide cessation assistance that may promote the patient’s medical recovery. Patients who receive even brief advice and intervention from their care providers are more likely to quit than those who receive no intervention.

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: The number of patients who were screened for tobacco use status within the first three days of admission.

Included Populations:
Patients who refused screening
Excluded Populations: None

Data Elements: Tobacco Use Status

Denominator Statement: The number of hospitalized inpatients 18 years of age and older

Included Populations: Not applicable

Excluded Populations:
- Patients less than 18 years of age
- Patient who are cognitively impaired
- Patients who have a duration of stay less than or equal to three days or greater than 120 days
- Patients with Comfort Measures Only documented

Data Elements:
- Admission Date
- Birthdate
- Comfort Measures Only
- Discharge Date
- Tobacco Use Status

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-9-CM diagnosis and procedure codes, which require retrospective data entry.

Data Accuracy: Data accuracy is enhanced when all definitions are used without modification. The data dictionary should be referenced for definitions and abstraction notes when questions arise during data collection.

Measure Analysis Suggestions: Hospitals may wish to analyze data to show the rate of those who were actually screened for tobacco use status, subtracting those that refused the screen.

Sampling: Yes. For additional information, see the Sampling Requirements in the SFY2016 Criteria on page 7 of this manual.
Data Reported As: Aggregate rate generated from count data reported as proportion.

Selected References:
TOB-1: Tobacco Use Screening

Numerator: The number of patients who were screened for tobacco use status within the first three days of admission

Denominator: The number of hospitalized inpatients 18 years of age and older

START

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

Patient Age (in years) = Admission Date - Birthdate
Use the month and day portion of Admission date and Birthdate to yield the most accurate age.
Only cases with valid Admission Date and Birthdate will pass the front end edits into the measure specific algorithm.

Patient Age

≥18

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

Length of Stay

≥3

Combust Measures Only

= 1, 2, 3

Missing

Missing

Tobacco Use Status

= 1, 2, 3, 4, 5

Cases Will Be Rejected

Tobacco Use Status

= 5

In Measure Population

E

D

Not In Measure Population

STOP
Measure Set: Tobacco Treatment

Measure ID#: TOB-2

Measure Name: Tobacco Use Treatment Provided or Offered

Description: Patients identified as tobacco product users within the past 30 days who receive or refuse practical counseling to quit AND receive or refuse FDA-approved cessation medications during the first three days after admission.

The measure is reported as an overall rate which includes all patients to whom tobacco use treatment was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received tobacco use treatment. The Provided or Offered rate (TOB-2), describes patients identified as tobacco product users within the past 30 days who receive or refuse practical counseling to quit AND receive or refuse FDA-approved cessation medications during the hospital stay. The Tobacco Use Treatment (TOB-2a) rate describes only those who received counseling AND medication as well as those who received counseling and had reason for not receiving the medication. Those who refused are not included.

Rationale: Tobacco use is the single greatest cause of disease in the United States today and accounts for more than 435,000 deaths each year (CDC MMWR 2008; McGinnis 1993). Smoking is a known cause of multiple cancers, heart disease, stroke, complications of pregnancy, chronic obstructive pulmonary disease, other respiratory problems, poorer wound healing, and many other diseases (DHHS 2004). Tobacco use creates a heavy cost to society as well as to individuals. Smoking-attributable health care expenditures are estimated at 96 billion dollars per year in direct medical expenses and 97 billion dollars in lost productivity (CDC 2007).

There is strong and consistent evidence that tobacco dependence interventions, if delivered in a timely and effective manner, significantly reduce the user's risk of suffering from tobacco-related disease and improve outcomes for those already suffering from a tobacco-related disease (DHHS 2000; Baumeister 2007; Lightwood 2003 and 1997; Rasmussen 2005; Hurley 2005; Critchley 2004; Ford 2007; Rigotti 2008). Effective, evidence-based tobacco dependence interventions have been clearly identified and include brief clinician advice, individual, group, or telephone counseling, and use of FDA-approved cessation medications. These treatments are clinically effective and extremely cost-effective relative to other commonly used disease prevention interventions and medical treatments. Studies indicate that the combination of counseling and medications is more effective for tobacco cessation than either medication or counseling alone (Fiore 2008), except in specific populations for which there is insufficient evidence of the effectiveness and/or safety of the FDA-approved cessation medications. These populations include pregnant women, smokeless tobacco users, light smokers, and adolescents. Hospitalization (both because hospitals are a tobacco-free environment and because patients may be more motivated to quit as a result of their illness) offers an ideal opportunity to provide cessation assistance that
may promote the patient’s medical recovery. Patients who receive even brief advice and intervention from their care providers are more likely to quit than those who receive no intervention.

**Type of Measure:** Process

**Improvement Noted As:** Increase in the rate

**Numerator Statement:** The number of patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications during the first three days after admission.

**Included Populations:**
- Patients who refuse counseling
- Patients who refuse FDA-Approved cessation medication

**Excluded Populations (for FDA approved medications only):**
- Smokeless tobacco users
- Pregnant smokers with an ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes for pregnancy as defined in Appendix A, Table 12.3.
- Light smokers
- Patients with reasons for not administering FDA-Approved cessation medication

**Data Elements:**
- ICD-9-CM Other Diagnosis Codes
- ICD-9-CM Principal Diagnosis Code
- Reason for No Tobacco Cessation Medication During the Hospital Stay
- Tobacco Use Status
- Tobacco Use Treatment FDA-Approved Cessation Medication
- Tobacco Use Treatment Practical Counseling

**Denominator Statement:** The number of hospitalized inpatients 18 years of age and older identified as current tobacco users

**Included Populations:**
*Not applicable*

**Excluded Populations:**
- Patients less than 18 years of age
- Patient who are cognitively impaired
- Patients who are not current tobacco users
- Patients who refused or were not screened for tobacco use during the hospital stay
- Patients who have a duration of stay less than or equal to three days and greater than 120 days
- Patients with Comfort Measures Only documented

Arkansas Medicaid Inpatient Quality Incentive Guidelines SFY2016, v2016a
Discharges 07/01/2015 (3Q2015) through 09/30/2015 (3Q2015)
Data Elements:
- Admission Date
- Birth date
- Comfort Measures Only
- Discharge Date
- Tobacco Use Status

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal and other ICD-9-CM diagnoses that require retrospective data entry.

Data Accuracy: Data accuracy is enhanced when all definitions are used without modification. The data dictionary should be referenced for definitions and abstraction notes when questions arise during data collection. Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: Hospitals may wish to identify those patients that refused either counseling or medications or both to have a better understanding of which treatment type is refused so that efforts can be directed toward improving care.

Sampling: Yes. For additional information, see the Sampling Requirements in the SFY2016 Criteria on page 7 of this manual.

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

Selected References:
Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2007.


TOB-2: Tobacco Use Treatment Provided or Offered

Numerator: The number of patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications during the first three days after admission.

Denominator: The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.
**TOB-2a: Tobacco Use Treatment Provided or Offered**

**Numerator:** The number of patients who received practical counseling to quit AND received FDA-approved cessation medications during the first three days after admission.

**Denominator:** The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.
Measure Set: Tobacco Treatment

Measure ID#: TOB-3

Measure Name: Tobacco Use Treatment Provided or Offered at Discharge

Description: Patients identified as tobacco product users within the past 30 days who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication upon discharge.

The measure is reported as an overall rate which includes all patients to whom tobacco use treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received tobacco use treatment at discharge. The Provided or Offered rate (TOB-3) describes patients identified as tobacco product users within the past 30 days who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication upon discharge. The Tobacco Use Treatment at Discharge (TOB-3a) rate describes only those who were referred to evidence-based outpatient counseling AND received a prescription for FDA-approved cessation medication upon discharge as well as those who were referred to outpatient counseling and had reason for not receiving a prescription for medication. Those who refused are not included.

Rationale: Tobacco use is the single greatest cause of disease in the United States today and accounts for more than 435,000 deaths each year (CDC MMWR 2008; McGinnis 1993). Smoking is a known cause of multiple cancers, heart disease, and stroke, complications of pregnancy, chronic obstructive pulmonary disease, other respiratory problems, poorer wound healing, and many other diseases (DHHS 2004). Tobacco use creates a heavy cost to society as well as to individuals. Smoking-attributable health care expenditures are estimated at 96 billion dollars per year in direct medical expenses and 97 billion dollars in lost productivity (CDC 2007). There is strong and consistent evidence that tobacco dependence interventions, if delivered in a timely and effective manner, significantly reduce the smoker’s risk of suffering from tobacco-related disease and improved outcomes for those already suffering from a tobacco-related disease (DHHS 2000; Baumeister 2007; Lightwood 2003 and 1997; Rasmussen 2005; Hurley 2005; Critchley 2004; Ford 2007; Rigotti 2008). Effective, evidence-based tobacco dependence interventions have been clearly identified and include clinician advice; individual, group, or telephone counseling; and use of FDA-approved medications. These treatments are clinically effective and extremely cost-effective relative to other commonly used disease prevention interventions and medical treatments. Hospitalization (both because hospitals are a tobacco-free environment and because patients may be more motivated to quit because of their illness) offers an ideal opportunity to provide cessation assistance that may promote the patient’s medical recovery. Patients who receive even brief advice and intervention from their care providers are more likely to quit than those who receive no intervention. Studies indicate that the combination of counseling and medications is
more effective for tobacco cessation than either medication or counseling alone, except in specific populations for which there is insufficient evidence of the effectiveness of the FDA-approved cessation medications. These populations include pregnant women, smokeless tobacco users, light smokers, and adolescents. Tobacco dependence should be viewed as a chronic disease. The treatment of this chronic disease is most effective when the initial interventions provided in the hospital setting are continued upon discharge to other care settings.

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement:
TOB-3: The number of patients who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at discharge.

Included Populations:
- Patients who refused a prescription for FDA-approved tobacco cessation medication at discharge
- Patients who refused a referral to evidence-based outpatient counseling

Excluded Populations (for FDA approved medications only):
- Smokeless tobacco users
- Pregnant smokers with an ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes for pregnancy as defined in Appendix A, Table 12.3
- Light smokers
- Patients with reasons for not administering FDA-approved cessation medication

Data Elements:
- ICD-9-CM Other Diagnosis Codes
- ICD-9-CM Principal Diagnosis Codes
- Prescription for Tobacco Cessation Medication
- Reason for No Tobacco Cessation Medication at Discharge
- Referral for Outpatient Tobacco Cessation Counseling
- Tobacco Use Status

Denominator Statement: The number of hospitalized inpatients 18 years of age and older identified as current tobacco users

Included Populations: Not applicable

Excluded Populations:
- Patients less than 18 years of age
- Patient who are cognitively impaired
- Patients who are not current tobacco users
- Patients who refused or were not screened for tobacco use status during the hospital stay
- Patients who have a duration of stay less than or equal to three days and greater than 120 days
- Patients who expired
- Patients who left against medical advice
- Patients discharged to another hospital
- Patients discharged to another health care facility
- Patients discharged to home for hospice care
- Patients who do not reside in the United States
- Patients with Comfort Measures Only documented

Data Elements:
- Admission date
- Birthdate
- Comfort Measures Only
- Discharge date
- Discharge disposition
- Tobacco use status

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal and other ICD-9-CM diagnoses, which require retrospective data entry.

Data Accuracy: Data accuracy is enhanced when all definitions are used without modification. The data dictionary should be referenced for definitions and abstraction notes when questions arise during data collection. Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: Hospitals may wish to identify those patients that refused either counseling or medications or both at discharge so as to have a better understanding of which treatment or type of treatment was accepted or refused so that efforts can be directed toward improving care.

Sampling: Yes. For additional information, see the Sampling Requirements in the SFY2016 Criteria on page 7 of this manual.

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

**TOB-3: Tobacco Use Treatment Provided or Offered at Discharge**

**Numerator:** The number of patients who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at discharge.

**Denominator:** The number of hospitalized inpatients 18 years of age and older identified as current tobacco users.

---

**START**

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

- **Patient Age (in years) = Admission Date - Birthdate**
  - Use the month and day portion of Admission date and Birthdate to yield the most accurate age.
  - Only cases with valid Admission Date and Birthdate will pass the front-end edits into the measure specific algorithm.

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

  - **Length of Stay**
    - **< 3**
      - **TCB-3 X**
    - **> 3**
      - **TCB-3 A**

  - **Tobacco Use Status**
    - **= 1, 2**
      - **= 3, 4, 5, 6**
    - **= 3, 4, 5, 6**
      - **= 7**

  - **Discharge Disposition**
    - **= 1, 8**
      - **= 2, 3, 4, 5, 6, 7**
OP-10: ABDOMEN CT USE OF CONTRAST MATERIAL

Description of Measure
This measure calculates the percentage of abdomen studies that are performed with and without contrast out of all abdomen studies performed (those with contrast, those without contrast, and those with both). The measure is calculated based on a one-year window of claims data.

Technical Note: To reflect changes made to the CPT coding system, codes for combined abdomen/pelvis studies have been added to those contained within the numerator and denominator, beginning in July 2013, for claims data from 2011 and beyond.

Numerator Statement
The number of Abdomen CT studies with and without contrast (“combined studies”).

Denominator Statement
The number of Abdomen CT studies performed (with contrast, without contrast, or both with and without contrast).

Numerator Codes
CPT code
74170 Abdomen CT with and without Contrast Material
74178 Abdomen and Pelvis CT with and without Contrast Material

Denominator Codes
CPT codes
74150 Abdomen CT without Contrast Material
74160 Abdomen CT with Contrast Material
74170 Abdomen CT with and without Contrast Material
74176 Abdomen and Pelvis CT without Contrast Material
74177 Abdomen and Pelvis CT with Contrast Material
74178 Abdomen and Pelvis CT with and without Contrast Material

Denominator Exclusion Codes:
Indications for measure exclusion include any patients with the following procedures or diagnosis codes:
• Adrenal Mass:
  ICD-9 codes: 255.9 Unspecified disorder of adrenal glands; 194.xx Benign neoplasm of other endocrine glands and related structures; 227.xx Malignant neoplasm of other endocrine glands and related structures; 237.xx Neoplasm of uncertain behavior of endocrine glands and nervous system

• Blunt Abdominal Trauma:
  ICD-9 codes: 863 Injury to gastrointestinal tract; 864 Injury to liver; 865 Injury to spleen; 866 Injury to kidney; 867 Injury to pelvic organs; 868 Injury to other intra-abdominal
• Hematuria:
  ICD-9 codes: 120.0 Schistosoma haematobium; 599.70 Hematuria, Unspecified; 599.71 Gross hematuria; 599.72 Microscopic hematuria

• Infections of Kidney:
  ICD-9 codes: 590.1x Acute pyelonephritis; 590.8x Other pyelonephritis or pyonephrosis not specified as acute or chronic; 590.9 Infection of kidney, unspecified

• Jaundice
  ICD-9 codes: 782.4 Jaundice, unspecified, not of newborn

• Liver Lesion (Mass or Neoplasm)
  ICD-9 codes: 155; Malignant neoplasm of liver and intrahepatic bile ducts; 197.7 Malignant neoplasm of liver, secondary; 209.72 Secondary neuroendocrine tumor of liver; 211.5 Benign neoplasm of liver and biliary passages; 230.8 Carcinoma in situ of liver and biliary system; 235.3 Neoplasm of uncertain behavior of liver and biliary passages

• Malignant Neoplasm of Bladder
  ICD-9 codes: 188 Malignant neoplasm of bladder; 233.7 Carcinoma in situ of bladder

• Malignant Neoplasm of Pancreas:
  ICD-9 codes: 157.0 Head of Pancreas; 157.1 Body of Pancreas; 157.2 Tail of Pancreas; 157.3 Pancreatic Duct; 157.4 Islets of Langerhans; 157.8 Other specific sites of pancreas; 157.9 Pancreas, part unspecified; 189.0 Malignant Neoplasm of Kidney; 211.5 Benign neoplasm of liver and biliary passages; 211.6 Pancreas, except islets of Langerhans; 211.7 Islets of Langerhans; 223.0 Benign neoplasm of kidney except pelvis

• Diseases of Urinary System
  ICD-9 codes: 599.0 Urinary tract infection, site not specified; 599.9 Unspecified disorder of urethra and urinary tract; 595 Cystitis; 597 Urethritis not sexually transmitted and urethral syndrome

• Pancreatic:
  ICD-9 codes: 250.8x Diabetes with other specified manifestations; 251.0 Hypoglycemia with coma; 251.1 Other specified hypoglycemia; 251.2 Hypoglycemia, unspecified; 270.3 Disturbances of branched-chain amino-acid metabolism; 577.0 Acute pancreatitis; 577.1 Chronic pancreatitis

• Unspecified Disorder of Kidney and Ureter:
  ICD-9 code: 593.9
Technical Note: An exclusion diagnosis must be in one of the diagnoses fields on the CT abdomen claim. If the diagnosis code is a three-digit ICD-9 code, then all codes starting with the three digits are used in the measure calculation, that is, “all inclusive.” If the diagnosis code is specified as a four-digit ICD-9 code, then only the specific four-digit diagnosis code is used. If the diagnosis code is a five-digit code, the code used is either the specific five-digit diagnosis code if all five numeric digits are shown, or if the fifth digit is designated with an “x” then this is Designating an “all inclusive” range to the fifth digit.
OP-10: ABDOMEN CT USE OF CONTRAST MATERIAL ICD-10 SPECIFICATIONS

Description of Measure
This measure calculates the percentage of abdomen studies that are performed with and without contrast out of all abdomen studies performed (those with contrast, those without contrast, and those with both). The measure is calculated based on a one-year window of claims data.

**Technical Note:** To reflect changes made to the CPT coding system, codes for combined abdomen/pelvis studies have been added to those contained within the numerator and denominator, beginning in July 2013, for claims data from 2011 and beyond.

Numerator Statement
The number of Abdomen CT studies with and without contrast (“combined studies”).

Denominator Statement
The number of Abdomen CT studies performed (with contrast, without contrast, or both with and without contrast).

Numerator Codes
CPT codes
74170 Abdomen CT with and without Contrast Material
74178 Abdomen and Pelvis CT with and without Contrast Material

Denominator Codes
CPT codes
74150 Abdomen CT without Contrast Material
74160 Abdomen CT with Contrast Material
74170 Abdomen CT with and without Contrast Material
74176 Abdomen and Pelvis CT without Contrast Material
74177 Abdomen and Pelvis CT with Contrast Material
74178 Abdomen and Pelvis CT with and without Contrast Material

Denominator Exclusion Codes:
Indications for measure exclusion include any patients with the following procedures or diagnosis codes:

*Schistosomiasis due to Schistosoma haematobium [urinary schistosomiasis]*
B65.0

*Malignant neoplasm of liver and intrahepatic bile ducts*
C22.0-C22.9

*Malignant neoplasm of pancreas*
C25.0-C25.9
Malignant neoplasm of kidney, except renal pelvis  
C64.1-C64.9

Malignant neoplasm of bladder  
C67.0-C67.9

Malignant neoplasm of adrenal gland  
C74.00-C74.92

Malignant neoplasm of other endocrine glands and related structures  
C75.0-C75.9

Secondary carcinoid tumors of liver  
C7B.02

Secondary malignant neoplasm of liver and intrahepatic bile duct  
C78.7

Carcinoma in situ of liver, gallbladder and bile ducts  
D01.5

Carcinoma in situ of bladder  
D09.0

Benign neoplasm of other and ill-defined parts of digestive system  
D13.4-D13.7

Benign neoplasm of kidney  
D30.00-D30.02

Benign neoplasm of other and unspecified endocrine glands  
D35.00-D35.9

Neoplasm of uncertain behavior of liver, gallbladder and bile ducts  
D37.6

Neoplasm of uncertain behavior of meninges  
D42.0-D42.9

Neoplasm of uncertain behavior of brain and central nervous system  
D43.0-D43.9

Neoplasm of uncertain behavior of endocrine glands  
D44.0-D44.9
Other disorders of glucose regulation and pancreatic internal secretion

Disorder of adrenal gland, unspecified
E27.9

Disorders of branched-chain amino-acid metabolism and fatty-acid metabolism
E71.0-E71.2

Acute pancreatitis
K85.0-K85.9

Other diseases of pancreas
K86.0-K86.1

Renal tubulo-interstitial diseases
N10, N12, N15.9, N16

Other disorders of kidney and ureter
N28.9-N29

Cystitis
N30.00-N30.91

Urethritis and urethral syndrome
N34.0-N34.3

Urethral disorder, unspecified
N36.9

Other disorders of urinary system
N39.0, N39.9

Neurofibromatosis (nonmalignant)
Q85.00-Q85.09

Unspecified Jaundice
R17

Hematuria
R31.0-R31.9

Injuries to the abdomen, lower back, lumbar spine, pelvis and external genitals
Crushing injury of unspecified hip with thigh, initial encounter
S77.20X*

Technical Note: An exclusion diagnosis must be in one of the diagnoses fields on the CT abdomen claim. Please note that an asterisk (*) represents a wildcard for that digit.

Technical Note: The specifications included in this document represent a crosswalk of the ICD-9 specifications to ICD-10 specifications based on both a forward and backward crosswalk of the General Equivalence Mapping (GEM) file. The contractor made additional modifications to the ICD-10 specifications as a result of public comment and review by contractor clinicians and ICD-10 subject matter experts. Additional refinement of the ICD-10 specifications may occur as data comes available for testing.

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Alphabetical Data Dictionary

Data Element Name: Admission Date

Collected For: All Records

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

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

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

Allowable Values:
- MM = Month (0-12)
- DD = Day (1-31)
- 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 acute 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 from billing is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.
- If using claim information, the ‘Statement Covers Period’ is not synonymous with the ‘Admission Date’ and should not be used to abstract this data element. These are two distinctly different identifiers:
  - The Admission Date is purely the date the patient was admitted as an inpatient to the facility.
  - The Statement Covers Period (“From” and “Through” dates) identifies the span of service dates included in a particular claim. The “From” Date is the earliest date of service on the claim.
- 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.
  Example: Medical record documentation reflects that the patient was admitted to observation on 04-05-20xx. On 04-06-20xx the physician writes an order to admit to acute inpatient effective 04-05-20xx. The Admission Date would be abstracted as 04-06-20xx; the date the determination was made to admit to acute inpatient care and the order was written.
• The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.
Example: Preoperative Orders are dated as 04-06-20xx with an order to admit to Inpatient. Postoperative Orders, dated 05-01-20xx, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 05-01-20xx. The Admission Date would be abstracted as 05-01-20xx.
• If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.
• For newborns that are born within this hospital, the Admission Date would be the date the baby was born.

Suggested Data Sources:
Note: The physician order is the priority data source for this data element. If there is not a physician order in the medical record, use the other only allowable sources to determine the Admission Date.

ONLY allowable sources
• Physician Orders
• Face Sheet
• UB-04

Excluded Data Sources:
UB-04 “From” and “Through” dates

Inclusion Guidelines for Abstraction
None

Exclusion Guidelines for Abstraction
• Admit to observation
• Arrival date
Data Element Name: Admission to NICU

Collected For: OBS-5

Definition: Documentation that the newborn was admitted to the Neonatal Intensive Care Unit (NICU) at this hospital any time during the hospitalization.

Suggested Data Collection Question: Was the newborn admitted to the NICU at this hospital at any time during the hospitalization?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
- Y (Yes) There is documentation that the newborn was admitted to the NICU at this hospital at any time during the hospitalization.
- N (No) There is no documentation that the newborn was admitted to the NICU at this hospital at any time during the hospitalization or unable to determine from medical record documentation.

Notes for Abstraction:
- A NICU is defined as a hospital unit providing critical care services, which is organized with personnel and equipment to provide continuous life support and comprehensive care for extremely high-risk newborn infants and those with complex and critical illness.
- If the newborn is admitted to the NICU for observation or transitional care, select allowable value “no.” Transitional care is defined as a stay of 4 hours or less in the NICU.
- If an order to admit to the NICU is not found in the medical record, there must be supporting documentation present in the medical record indicating that the newborn received critical care services in the NICU in order to answer “yes”. Examples of supporting documentation include, but are not limited to the NICU admission assessment and NICU flow sheet.

Suggested Data Sources:
- Nursing notes
- Discharge summary
- Physician progress notes

Inclusion Guidelines for Abstraction
See Appendix B, Table 1.0 for a list of Arkansas hospitals that have qualifying Level 3 NICUs.
Exclusion Guidelines for Abstraction

None
Data Element Name: Birthdate

Collected For: All records

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

Note: Patient's age (in years) is calculated by Admission Date minus Birthdate. The algorithm to calculate age must use the month and day portion of admission date and birth date 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 (1980-Current Year)

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 birth 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 birth date 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

Inclusion Guidelines for Abstraction

None

Exclusion Guidelines for Abstraction

None
Data Element Name: Birth Time

Collected For: NBS-1

Definition: The earliest documented time (military time) the newborn was born at the hospital.

Suggested Data Collection Question: At what time was the newborn born? Use military time.

Format:
- Length: 5 - HH:MM (with or without colon) or UTD
- Type: Time
- Occurs: 1

Allowable Values:
- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format.

With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:
- Midnight - 00:00
- Noon - 12:00
- 5:31 am - 05:31
- 5:31 pm - 17:31
- 1:59 am - 11:59
- 1:59 pm - 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the Arrival Time should remain 11-24-20xx or if it should be converted to 11-25-20xx.
When converting Midnight or 24:00 to 00:00, do not forget to change the Arrival Date.
Example:
- Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:
- For times that include “seconds,” remove the seconds and record the time as is. Example:
  - 15:00:35 would be recorded as 15:00
- If the time of birth is unable to be determined from medical record documentation, select “UTD.”
The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range) and no other documentation is found that provides this information, the abstractor should select “UTD.”

Suggested Data Sources:
ONLY allowable sources
- Emergency Department record
- Nursing admission assessment/admitting note
- Labor and Delivery Notes
- Procedure notes
- Vital signs graphic record

Inclusion Guidelines for Abstraction
None

Exclusion Guidelines for Abstraction
None
Data Element Name: Clinical Trial

Collected For: All OBS Records

Definition: Documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied.

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

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
Y (Yes) There is documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied.
N (No) There is no documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied, or unable to determine from medical record documentation.

Notes for Abstraction:
To select “Yes” to this data element, BOTH of the following must be true:
1. There must be a signed consent form for clinical trial. For the purposes of abstraction, a clinical trial is defined as an experimental study in which research subjects are recruited and assigned a treatment/intervention and their outcomes are measured based on the intervention received. Treatments/interventions most often include use of drugs, surgical procedures, and devices. Often a control group is used to compare with the treatment/intervention. Allocation of different interventions to participants is usually randomized.
2. There must be documentation on the signed consent form that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AMI, CAC, HF, PN, SCIP, STK, VTE). 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.

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.

3. 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

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: Comfort Measures Only

Collected For: TOB

Definition: Comfort Measures Only refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. Comfort Measures Only is commonly referred to as "comfort care" by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

Suggested Data Collection Question: When is the earliest physician/APN/PA documentation of comfort measures only?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1  **Day 0 or 1:** The earliest day the physician/APN/PA documented comfort measures only was the day of arrival (Day 0) or day after arrival (Day 1).
2  **Day 2 or after:** The earliest day the physician/APN/PA documented comfort measures only was two or more days after arrival day (Day 2+).
3  **Timing unclear:** There is physician/APN/PA documentation of comfort measures only during this hospital stay, but whether the earliest documentation of comfort measures only was on day 0 or 1 OR after day 1 is unclear.
4  **Not Documented/UTD:** There is no physician/APN/PA documentation of comfort measures only, or unable to determine from medical record documentation.

Notes for Abstraction:
Only accept terms identified in the list of inclusions. No other terminology will be accepted.
- Physician/APN/PA documentation of comfort measures only (hospice, comfort care, etc.) mentioned in the following contexts suffices:
  o Comfort measures only recommendation
  o Order for consultation or evaluation by a hospice care service
  o Patient or family request for comfort measures only
  o Plan for comfort measures only
  o Referral to hospice care service
  o Discussion of comfort measures
• Determine the earliest day comfort measures only (CMO) was DOCUMENTED by the physician/APN/PA. If any of the inclusion terms are documented by the physician/APN/PA, select value “1,” “2,” or “3” accordingly. Example: “Discussed comfort care with family on arrival” noted in day 2 progress note – Select “2.”

• State-authorized portable orders (SAPOs):
  o SAPOs are specialized forms or identifiers authorized by state law that translate a patient’s preferences about specific end-of-life treatment decisions into portable medical orders. Examples:
    ▪ DNR-Comfort Care form
    ▪ MOLST (Medical Orders for Life-Sustaining Treatment)
    ▪ POLST (Physician Orders for Life-Sustaining Treatment)
    ▪ Out-of-Hospital DNR (OOH DNR)
  o If there is a SAPO in the record that is dated and signed prior to arrival with an option in which an inclusion term is found that is checked, select value “1.”
  o If a SAPO lists different options for CMO and any CMO option is checked, select value “1,” “2,” or “3” as applicable.
  o If one or more dated SAPOs are included in the record (and signed by the physician/APN/PA), use only the most recent one. Disregard undated SAPOs.
  o For cases where there is a SAPO in the record with a CMO option selected: If the SAPO is dated prior to arrival and there is documentation on the day of arrival or the day after arrival that the patient does not want CMO, and there is no other documentation regarding CMO found in the record, disregard the SAPO.
    Example: Patient has a POLST dated prior to arrival in his chart and ED physician states in current record “Patient is refusing comfort measures, wants to receive full treatment and be a full code.”

• Documentation of an inclusion term in the following situations should be disregarded. Continue to review the remaining physician/APN/PA documentation for acceptable inclusion terms. If the ONLY documentation found is an inclusion term in the following situations, select value “4.”
  o Documentation (other than SAPOs) that is dated prior to arrival or documentation which refers to the pre-arrival time period. Examples:
    ▪ Comfort measures only order in previous hospitalization record.
    ▪ “Pt. on hospice at home” in MD ED note.
  o Inclusion term clearly described as negative or conditional. Examples:
    ▪ “No comfort care”
    ▪ "Not appropriate for hospice care"
    ▪ “Comfort care would also be reasonable - defer decision for now”
    ▪ “DNRCCA” (Do Not Resuscitate – Comfort Care Arrest)
    ▪ "Family requests comfort measures only should the patient arrest."
  o Documentation of “CMO” should be disregarded if documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., “hx dilated CMO” – Cardiomyopathy context).
• If there is physician/APN/PA documentation of an inclusion term in one source that indicates the patient is Comfort Measures Only, AND there is physician/APN/PA documentation of an inclusion term in another source that indicates the patient is NOT CMO, the source that indicates the patient is CMO would be used to select value “1,” “2,” or “3” for this data element. Examples:
  o Physician documents in progress note on day 1 “The patient has refused Comfort Measures” AND then on day 2 the physician writes an order for a Hospice referral. Select value “2.”
  o ED physician documents in a note on day of arrival “Patient states they want to be enrolled in Hospice” AND then on day 2 there is a physician progress note with documentation of “Patient is not a Hospice candidate.” Select value “1.”

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY
• Consultation notes
• Discharge summary
• DNR/MOLST/POLST forms
• Emergency Department record
• History and physical
• Physician orders
• Progress notes

Excluded Data Sources:
Restraint order sheet

Inclusion Guidelines for Abstraction:
• Brain dead
• Brain death
• Comfort care
• Comfort measures
• Comfort measures only (CMO)
• Comfort only
• DNR-CC
• End of life care
• Hospice
• Hospice care
• Organ harvest
• Terminal care
• Terminal extubation

Exclusion Guidelines for Abstraction:
None
Data Element Name: Discharge Date

Collected For: All Records

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 slashes)
- Type: Date
- Occurs: 1

Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)

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, s/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, s/he should default to the discharge date on the claim information.

Suggested Data Sources:
- Discharge Summary
- Face Sheet
- Nursing Discharge Notes
- Physician Orders
- Progress Notes
- Transfer Note
- UB-04

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: Discharge Disposition

Collected For: OBS Newborn, TOB, NBS

Definition: The final place or setting to which the patient was discharged on the day of discharge.

Suggested Data Collection Question: What was the patient’s discharge disposition on the day of discharge?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
1. Home
2. Hospice - Home
3. Hospice – Health Care Facility
4. Acute Care Facility
5. Other Health Care Facility
6. Expired
7. Left Against Medical Advice/AMA
8. Not Documented or Unable to Determine (UTD)

Notes for Abstraction:
- Only use documentation written on the day prior to discharge through 30 days after discharge when abstracting this data element.
  Example:
  Documentation in the Discharge Planning notes on 04-01-20xx state that the patient will be discharged back home. On 04-06-20xx the physician orders and nursing discharge notes on the day of discharge reflect that the patient was being transferred to skilled care. The documentation from 04-06-20xx would be used to select value “5” (Other Health Care Facility).
- The medical record must be abstracted as documented (taken at “face value”). Inferences should not be made based on internal knowledge.
- If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract. If documentation is contradictory, use the latest documentation.
  Examples:
  o Discharge summary dictated 2 days after discharge states patient went “home.” Physician note on day of discharge further clarifies that the patient will be going “home with hospice.” Select value “2” (“Hospice - Home”).


Discharge planner note from day before discharge states “XYZ Nursing Home.” Discharge order from day of discharge states “Discharge home.” Contradictory documentation, use latest. Select value “1” (“Home”).

Physician order on discharge states “Discharge to ALF.” Discharge instruction sheet completed after the physician order states patient discharged to “SNF.” Contradictory documentation, use latest. Select value “5” (“Other Health Care Facility”).

If documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. See Inclusion lists for examples.

- Acute Care Facility
- Hospice – Health Care Facility
- Hospice – Home
- Other Health Care Facility
- Home

Hospice (values “2” and “3”) includes discharges with hospice referrals and evaluations.

If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select value “4” (“Acute Care Facility”).

If the medical record identifies the facility the patient is being discharged to by name only (e.g., “Park Meadows”), and does not reflect the type of facility or level of care, select value “5” (“Other Health Care Facility”).

If the medical record states only that the patient is being “discharged” and does not address the place or setting to which the patient was discharged, select value “1” (“Home”).

When determining whether to select value “7” (“Left Against Medical Advice/AMA”):

- Explicit “left against medical advice” documentation is not required. E.g., “Patient is refusing to stay for continued care” – Select value “7.”
- Documentation suggesting that the patient left before discharge instructions could be given does not count.
- A signed AMA form is not required, for the purposes of this data element.
- Do not consider AMA documentation and other disposition documentation as “contradictory.” If any source states the patient left against medical advice, select value “7,” regardless of whether the AMA documentation was written last. E.g., AMA form signed and discharge instruction sheet states “Discharged home with belongings” – Select “7.”

**Suggested Data Sources:**

- Discharge instruction sheet
- Discharge planning notes
- Discharge summary
- Nursing discharge notes
- Physician orders
- Progress notes
- Social service notes
- Transfer record

Excluded Data Sources:
- Any documentation prior to the last two days of hospitalization
- Coding documents
- UB-04

Inclusion Guidelines for Abstraction:

Home (Value 1):
- Assisted Living Facilities (ALFs) – Includes ALFs and assisted living care at nursing home, intermediate care, and skilled nursing facilities
- Court/Law Enforcement – includes detention facilities, jails, and prison
- Home – includes board and care, foster or residential care, group or personal care homes, retirement communities, and homeless shelters
- Home with Home Health Services
- Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs and Partial Hospitalization

Hospice – Home (Value 2):
Hospice in the home (or other “Home” setting as above in Value 1)

Hospice – Health Care Facility (Value 3):
- Hospice - General Inpatient and Respite
- Hospice - Residential and Skilled Facilities
- Hospice - Other Health Care Facilities

Acute Care Facility (Value 4):
- Acute Short Term General and Critical Access Hospitals
- Cancer and Children’s Hospitals
- Department of Defense and Veteran’s Administration Hospitals

Other Health Care Facility (Value 5):
- Extended or Intermediate Care Facility (ECF/ICF)
- Long Term Acute Care Hospital (LTACH)
- Nursing Home or Facility including Veteran’s Administration Nursing Facility
- Psychiatric Hospital or Psychiatric Unit of a Hospital
- Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
- Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed
- Transitional Care Unit (TCU)
- Veterans Home

Exclusion Guidelines for Abstraction:
None
Data Element Name: Exclusive Breast Milk Feeding

Collected For: OBS-5

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.
- Sweet-Ease® or a similar 24% sucrose and water solution given to the newborn for the purpose of reducing discomfort during a painful procedure is classified as a medication and is not considered a supplemental feeding.
- If the newborn receives donor breast milk, select allowable value “Yes.”
- If breast milk fortifier is added to the breast milk, select allowable value “Yes.”
- In cases where there is conflicting documentation and both exclusive breast milk feeding and formula supplementation is documented, select allowable value “No.”
- If the newborn received drops of water or formula dribbled onto the mother’s breast to stimulate latching and not an actual feeding, select “Yes.”
Suggested Data Sources:
- Discharge summary
- Feeding flow sheets
- Individual treatment plan
- Intake and output sheets
- Nursing notes
- Physician progress notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: First Name

Collected For: All records

Definition: The patient’s first name

Suggested Data Collection Question: What is the patient’s first name?

Format:
- Length: 30
- Type: Character
- Occurs: 1

Allowable Values:
Enter the patient’s first name. Up to 30 letters, numbers, and/or special characters can be entered.

NOTE: Only the following special characters will be allowed:
~ ! @ # $ % ^ * ( ) _ + { } | : ? ` - = [ ] ; ' . , / and space

Notes for Abstraction:
None

Suggested Data Sources:
- Emergency Department record
- Face sheet
- History and physical

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: Gestational Age

Collected For: OBS-4, OBS-6

Definition: The weeks of gestation completed at the time of delivery.

Gestational age is defined as the number of weeks that have elapsed between the first day of the last normal menstrual period (not presumed time of conception) and the date of delivery, irrespective of whether the gestation results in a live birth or a fetal death.

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

Format:

- Length: 3 or UTD
- Type: Alphanumeric
- Occurs: 1

Allowable Values:

- 1-50
- UTD = Unable to Determine

Notes for Abstraction:

- Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks.
- The delivery or operating room record should be reviewed first for gestational age. If gestational age is not recorded in the delivery or operating room record, then continue to review the data sources in the following order: history and physical, prenatal forms, clinician admission progress note and discharge summary until a positive finding for gestational age is found. In cases where there is conflicting data, the gestational age found in the first document according to the order listed above should be used. The phrase “estimated gestational age” is an acceptable descriptor for gestational age.
- If the patient has not received prenatal care select allowable value “UTD.”
- When the admission date is different from the delivery date, use documentation of the gestational age completed closest to the delivery date.
- Gestational age should be documented by the clinician as a numeric value between 1-50. The clinician, not the abstractor, should perform the calculation to determine gestational age based on the first day of the last normal menstrual period (not presumed time of conception) and the date of delivery. Ultrasound-based dating is also an acceptable method of determining gestational age.
- If the gestational age entered by the clinician in the first document listed above is obviously incorrect (in error) but it is a valid number, or two different numbers are
listed in the first document, and the correct number can be supported with other documentation in the other acceptable data sources in the medical record, the correct number may be entered.

- Documentation in the acceptable data sources may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN).

- It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs, or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed below.

Suggested Data Sources:
ONLY acceptable sources in order of preference:
- Delivery room record
- Operating room record
- History and physical
- Prenatal forms
- Admission clinician progress notes
- Discharge summary

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: Hospital Stay > 24 Hours

Collected For: NBS-1, NBS-2

Definition: The length of stay at this hospital after birth until the newborn was discharged.

Suggested Data Collection Question: Did the newborn stay at least 24 hours in your hospital?

Format:
   Length: 1
   Type: Alphanumeric
   Occurs: 1

Allowable Values:
   Y (Yes) The newborn did stay at least 24 hours in this hospital.
   N (No) The newborn did not stay at least 24 hours in this hospital.

Notes for Abstraction:
None

Suggested Data Sources:
ONLY acceptable sources
   • Delivery room record
   • Discharge summary
   • History and physical
   • Operating room record
   • Nurses’ discharge notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: ICD-9-CM Other Diagnosis Codes

Collected For: All Records

Definition: The other or secondary 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 record?

Format:
- Length: 6 (with or without decimal point)
- Type: Alphanumeric
- Occurs: 24

Allowable Values:
Any valid diagnosis code as per the CMS ICD-9-CM master code table (ICD-9-CM Full and Abbreviated Code Titles):

Notes for Abstraction:
None

Suggested Data Sources:
- Discharge summary
- Face sheet
- UB-04

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: ICD-9-CM Other Procedure Codes

Collected For: All Records

Definition: The other or secondary ICD-9-CM codes identifying all significant procedures other than the principal procedure.

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

Format:
- Length: 5 (with or without decimal point)
- Type: Alphanumeric
- Occurs: 24

Allowable Values:
Any valid procedure code as per the CMS ICD-9-CM master code table (ICD-9-CM Full and Abbreviated Code Titles):

Notes for Abstraction:
None

Suggested Data Sources:
- Discharge summary
- Face sheet
- UB-04

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: ICD-9-CM Other Procedure Dates

Collected For: All Records

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

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: 24

Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)
- UTD = Unable to Determine

Notes for Abstraction:
- If the procedure date for the associated procedure is unable to be determined from medical record documentation, select “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 02-42-20xx. 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 02-12-20xx and documentation indicates the ICD-9-CM Other Procedure Dates was 03-12-20xx. 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.”

Suggested Data Sources:
- Consultation notes
- Diagnostic test reports
- Discharge summary
• Face sheet
• Operative notes
• Procedure notes
• Progress notes
• UB-04

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: ICD-9-CM Principal Diagnosis Code

Collected For: All Records

Definition: The ICD-9-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.

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

Format:
- Length: 6 (with or without decimal point)
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
Any valid diagnosis code as per the CMS ICD-9-CM master code table (ICD-9-CM Full and Abbreviated Code Titles):

Notes for Abstraction:
None

Suggested Data Sources:
- Discharge summary
- Face sheet
- UB-04

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: ICD-9-CM Principal Procedure Code

Collected For: All Records

Definition: 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.

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

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

Allowable Values:
Any valid procedure code as per the CMS ICD-9-CM master code table (ICD-9-CM Full and Abbreviated Code Titles):

Notes for Abstraction:
None

Suggested Data Sources:
• Discharge summary
• Face sheet
• UB-04

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: ICD-9-CM Principal Procedure Date

Collected For: All Records

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

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

Format:
   Length: 10 – MM/DD/YYYY (includes slashes) or UTD
   Type: Date
   Occurs: 1

Allowable Values:
   MM = Month (01-12)
   DD = Day (01-31)
   YYY = Year (20xx)
   UTD = Unable to Determine

Notes for Abstraction:
   • If the principal procedure date is unable to be determined from medical record documentation, select “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:
   o Documentation indicates the ICD-9-CM Principal Procedure Date was 02-42-20xx. 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.”
   o Patient expires on 02-12-20xx and documentation indicates the ICD-9-CM Principal Procedure Date was 03-12-20xx. 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.”

Suggested Data Sources:
   • Consultation notes
   • Diagnostic test reports
   • Discharge summary
   • Face sheet
- Operative notes
- Procedure notes
- Progress notes
- UB-04

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: Labor

Collected For: OBS-4

Definition: Documentation by the clinician that the patient was in labor

Suggested Data Collection Question: Is there documentation by the clinician that the patient was in labor?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
- Y (Yes) There is documentation by the clinician that the patient was in labor.
- N (No) There is no documentation by the clinician that the patient was in labor OR unable to determine from medical record documentation.

Notes for Abstraction:
- A clinician is defined as a physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN).
- Documentation of labor by the clinician should be abstracted at face value. There is no requirement for acceptable descriptors to be present in order to answer “yes” to labor.
- Documentation of regular contractions or cervical change without mention of labor cannot be used to answer “yes” to labor.

Suggested Data Sources:
- History and physical
- Nursing notes
- Physician progress notes

Inclusion Guidelines for Abstraction
The following are acceptable descriptors for labor:
- Active
- Early
- Spontaneous

Exclusion Guidelines for Abstraction
The following are not acceptable descriptors for labor:
- Latent
- Prodromal
Data Element Name: Last Name

Collected For: All Records

Definition: The patient’s last name

Suggested Data Collection Question: What is the patient’s last name?

Format:
   Length: 60
   Type: Character
   Occurs: 1

Allowable Values:
   Enter the patient’s last name. Up to 60 letters, numbers, and/or special characters can be entered.

   NOTE: Only the following special characters will be allowed: ~ ! @ # $ % ^ * ( ) _ + { } | : ? ` - = [ ] ` ; ' , / and space

Notes for Abstraction:
   None

Suggested Data Sources:
   - Emergency Department record
   - Face sheet
   - History and physical

Inclusion Guidelines for Abstraction:
   None

Exclusion Guidelines for Abstraction:
   None
Data Element Name: Parity

Collected For: OBS-6

Definition: The number of live deliveries the patient experienced prior to current hospitalization.

Suggested Data Collection Question: How many live 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 delivery or operating room record should be reviewed first for parity. If parity is not recorded in the delivery or operating room record, then continue to review the data sources in the following order: history and physical, prenatal forms, clinician admission progress note and discharge summary 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.
- If parity entered by the clinician in the first document listed above is obviously incorrect (in error) but it is a valid number, or two different numbers are listed in the first document, and the correct number can be supported with other documentation in the other acceptable data sources in the medical record, the correct number may be entered.
- If parity is not documented and GTPAL terminology is documented where G= Gravida, T= Term, P= Preterm, A= Abortions and L= Living, all previous term and preterm deliveries prior to this hospitalization should be added together to determine parity.
- If parity is not documented and gravidity is documented as one, parity should be considered zero.
- The previous delivery of twins or any multiple gestation is considered one parous event.
- Documentation in the acceptable data sources may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN).
- It is acceptable to use data derived from vital records reports received from state or local departments of public health delivery logs or clinical information systems if they are available and are directly derived from the medical record with a
process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed below.

- If the number for parity documented in the EHR includes the delivery for the current hospitalization, parity should be answered as one number less than the number documented.
- If primigravida is documented select zero for parity

Suggested Data Sources:
ONLY Acceptable Sources in Order of Preference
- Delivery room record
- Operating room record
- History and physical
- Prenatal forms
- Admission clinician progress note
- Discharge summary

Inclusion Guidelines for Abstraction:
The following descriptor must precede the number when determining parity:
- Para
- Parity
- P
Examples: parity=2 or g3p2a1

Exclusion Guidelines for Abstraction:
- A string of three or more numbers without the alpha designation of “p” preceding the second number cannot be used to determine parity. Example: 321
- When GTPAL terminology is documented, G=Gravida, T=Term, P=Preterm, A=Abortions, L=Living, P does not equal parity.
Data Element Name: Patient Identifier

Collected For: All Records

Definition: The number used by the hospital to identify this patient’s stay. The number provided will be used to identify the patient in communications with the hospital, e.g. Medical Record Number, Account Number or Unique Identifiable Number as determined by the facility.

Suggested Data Collection Question: What was the number used by the hospital to identify this patient’s stay?

Format:
- Length: 40
- Type: Character
- Occurs: 1

Allowable Values:
- Up to 40 letters, numbers, and/or characters.
- Note: The only characters that will be allowed are spaces, hyphens, dashes and under-scores.

Notes for Abstraction:
None

Suggested Data Sources:
None

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: Prescription for Tobacco Cessation Medication

Collected For: TOB-3

Definition: Documentation that an FDA-approved tobacco cessation medication was prescribed at hospital discharge.

Suggested Data Collection Question: Was an FDA-approved tobacco cessation medication prescribed at discharge?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
1. A prescription for an FDA-approved tobacco cessation medication was given to the patient at discharge.
2. A prescription for an FDA-approved tobacco cessation medication was offered at discharge and the patient refused.
3. The patient's residence is not in the USA.
4. A prescription for an FDA-approved tobacco cessation medication was not offered at discharge or unable to determine from medical record documentation.

Notes for Abstraction
- In determining whether a tobacco cessation medication was prescribed at discharge, it is not uncommon to see conflicting documentation among different medical record sources. For example, the discharge summary may list Varenicline, and this is not included in any of the other discharge medication sources (e.g., discharge orders). All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
- In cases where there is tobacco cessation medication in one source that is not mentioned on other sources, it should be interpreted as a discharge medication. Select value “1” unless documentation elsewhere in the medical record suggests that it (tobacco cessation medication) was not prescribed at discharge.
- If documentation is contradictory (physician noted “d/c Varenicline” or “hold Varenicline” in the discharge orders, but Varenicline is listed in the discharge summary’s discharge medication list), or after careful examination of circumstance, context, timing, etc., documentation raises enough questions, the case should be deemed unable to determine, select value “4”.
- If the physician wishes the patient to continue on medication that does not require a prescription, for example, over the counter nicotine replacement therapy (NRT) or medication that will be provided by the outpatient counseling
such as the quit line, if the medication is listed on the discharge medication list this would be sufficient to select value “1.”

- If the patient does not have a residence in the USA, value “3” must be selected.

**Suggested Data Sources:**
- Discharge instruction sheet
- Discharge summary
- Medication reconciliation form
- Nursing discharge notes
- Physician order sheet
- Transfer sheet

**Inclusion Guidelines for Abstraction:**
Refer to Appendix C, Table 9.1 for a comprehensive list of FDA-approved tobacco cessation medications

**Exclusion Guidelines for Abstraction:**
None
Data Element Name: Prior Uterine Surgery

Collected For: OBS 4

Definition: Documentation that the patient had undergone prior uterine surgery

Suggested Data Collection Question: Is there documentation that the patient had undergone prior uterine surgery?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
- Y (Yes) The medical record contains documentation that the patient had undergone prior uterine surgery.
- N (No) The medical record does not contain documentation that the patient had undergone a prior uterine surgery OR unable to determine from medical record documentation.

Notes for Abstraction:
None

Suggested Data Sources:
- History and physical
- Nursing admission assessment
- Progress notes
- Physician’s notes
- Prenatal forms

Inclusion Guidelines for Abstraction:
The only prior uterine surgeries considered for the purposes of the measure are:
- Prior classical cesarean section which is defined as a vertical incision into the upper uterine segment
- Prior myomectomy
- Prior uterine surgery resulting in a perforation of the uterus due to an accidental injury
- History of a uterine window or thinning of the uterine wall noted during prior uterine surgery or during ultrasound
- History of uterine rupture requiring surgical repair
- History of cornual ectopic pregnancy
Exclusion Guidelines for Abstraction:

- Prior low transverse cesarean section
- Prior cesarean section without specifying prior classical cesarean section
Data Element Name: Reason for No Tobacco Cessation Medication at Discharge

Collected For: TOB-3

Definition: Reasons for not prescribing an FDA-approved tobacco cessation medication at discharge include:
- Allergy to all of the FDA-approved tobacco cessation medications
- Drug interaction (for all of the FDA-approved medications) with other drugs the patient is currently taking
- Other reasons documented by physician, advanced practice nurse (APN), physician assistant (PA), or pharmacist

Suggested Data Collection Question: Is there documentation of a reason for not prescribing one of the FDA-approved tobacco cessation medications at discharge?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
Y (Yes) There is documentation of a reason for not prescribing an FDA-approved cessation medication at discharge.
N (No) There is no documentation of a reason for not prescribing an FDA-approved cessation medication at discharge or unable to determine from medical record documentation.

Notes for Abstraction
- Reasons for prescribing FDA-approved tobacco cessation medications must be documented by a physician/APN/PA or pharmacist.
- An allergy or adverse reaction to one of the FDA-approved cessation medications would not be a reason for not prescribing another of the cessation medications.
- In determining whether there is a reason documented by physician/APN/PA or pharmacist for not prescribing tobacco cessation medications, the reason must be explicitly documented.
- When conflicting information is documented in the medical record, select the appropriate value for the indicated reasons present for not prescribing the tobacco cessation medications.

Suggested Data Sources:
- Anesthesia record
- Consultation record
- Discharge summary
- Emergency Department record
• History and physical
• Medication administration record (MAR)
• Physician orders
• Progress notes
• Transfer form

Inclusion Guidelines for Abstraction:
• Allergy or sensitivity
• Refer to Appendix C, Table 9.1 for a list of FDA-approved tobacco cessation medications

Exclusion Guidelines for Abstraction:
Medication allergy using a negative modifier or qualifier (questionable, risk of, suspect, etc.)
Data Element Name: Reason for No Tobacco Cessation Medication during the Hospital Stay

Collected For: TOB-2

Definition: Reasons for not administering an FDA-approved tobacco cessation medication during the first three days of admission include:

- Allergy to all of the FDA-approved tobacco cessation medications
- Drug interaction (for all of the FDA-approved medications) with other drugs the patient is currently taking
- Other reasons documented by physician, advanced practice nurse (APN), physician assistant (PA), or pharmacist

Suggested Data Collection Question: Is there documentation of a reason for not administering one of the FDA-approved tobacco cessation medications during the first three days of admission?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
- Y (Yes) There is documentation of a reason for not administering an FDA-approved cessation medication during the first three days of admission.
- N (No) There is no documentation of a reason for not administering an FDA approved cessation medication during the first three days of admission or unable to determine from medical record documentation.

Notes for Abstraction

- Reasons for administering FDA-approved tobacco cessation medications must be documented by a physician/APN/PA or pharmacist.
- An allergy or adverse reaction to one of the FDA-approved cessation medications would not be a reason for not administering another of the cessation medications.
- In determining whether there is a reason documented by physician/APN/PA or pharmacist for not administering tobacco cessation medications, the reason must be explicitly documented.
- When conflicting information is documented in the medical record, select the appropriate value for the indicated reasons present for not administering the tobacco cessation medications.
• The timeframe for documenting a reason for not administering FDA-approved tobacco cessation medications must have occurred within the first three days of admission. The day after admission is defined as the first day.

Suggested Data Sources:
• Anesthesia record
• Consultation record
• Discharge summary
• Emergency Department record
• History and physical
• Medication administration record (MAR)
• Physician orders
• Progress notes
• Transfer form

Inclusion Guidelines for Abstraction:
• Allergy or sensitivity
• Refer to Appendix C, Table 9.1 for a list of FDA-approved tobacco cessation medications

Exclusion Guidelines for Abstraction:
Medication allergy using a negative modifier or qualifier (questionable, risk of, suspect, etc.)
Data Element Name: Reason for Not Exclusively Feeding Breast Milk

Collected For: OBS-5

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 or due to mother’s initial feeding plan which included formula feeding upon admission of the newborn.

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:
1. There is documentation by physician/advanced practice nurse (APN)/physician assistant (PA)/certified nurse midwife (CNM)/international board certified lactation consultant (IBCLC)/certified lactation counselor (CLC) of a reason for not exclusively feeding breast milk during the entire hospitalization due to a maternal medical condition with which breast milk feeding should be avoided.
2. There is documentation by physician/APN/PA/CNM/IBCLC/CLC/RN that the newborn’s mother’s initial feeding plan for the hospitalization included formula upon admission of the newborn.
3. None of the above or unable to determine from medical record documentation.

Notes for Abstraction:
- Admission is defined as the birth of the newborn. The mother’s initial feeding plan or diet plan must be documented in the newborn’s medical record and may only be used if it is documented prior to the first feeding. If the discussion of the mother’s initial feeding plan occurred prior to birth of the newborn, this may be used provided the date and time of the discussion appears in the newborn’s medical record. The date and time the discussion took place must also be prior to the date and time of the first feeding.
Example: The discussion of the initial feeding plan with the mother was documented in the mother’s medical record on 6-1-20xx at 10:00. The baby was born (admitted) on 6-1-20xx at 13:00. The first feeding was documented on 6-1-20xx at 13:30 in the newborn’s medical record. The newborn’s medical record should have documentation of the discussion of the initial feeding plan that took place with the mother, the content of the discussion and the mother’s decision for the initial feeding plan along with the date and time of the discussion (6-1-20xx at 10:00). If the date and time documented in the newborn’s medical record does not match that of the original discussion documented in the mother’s record and it turns out to be a another discussion and feeding plan taking place after the first feeding, this documentation cannot be used, e.g., discussion occurring at 6-1-20xx at 14:00.

- When determining whether there is a reason due to a medical maternal condition documented by a physician/APN/PA/CNM/IBCLC or CLC for not exclusively feeding breast milk, reasons must be explicitly documented (e.g., “mother is HIV positive - newborn will not be breast fed”) or clearly implied (e.g., “mother is currently abusing alcohol - newborn will be fed formula”). If reasons are not mentioned in the context of newborn feeding, do not make inferences (e.g., do not assume that the newborn is not receiving breast milk because of the medications the mother is currently taking). RN or certified lactation educator (CLE) documentation is not acceptable for maternal medical conditions.

- If newborn medical conditions, i.e., hypoglycemia, weight loss, hyperbilirubinemia, etc. are documented as a reason for not exclusively feeding breast milk, select allowable value “3”.

- A mother’s initial feeding plan existing at the time of admission of the newborn that includes formula feeding during the hospitalization must be clearly documented in the newborn’s medical record in the context of the newborn substance fed in order to select allowable value "2". Do not assume that the newborn was not exclusively fed breast milk due to the mother’s initial feeding plan in the absence of such documentation.

- There is no evidence to support feeding both breast milk and formula, so the discussion of the mother’s initial feeding plan should focus on the benefits of exclusive breast milk feeding and the risks of adding formula when breast feeding. If there is documentation in the newborn’s medical record of the discussion and the mother’s initial feeding plan for the hospitalization, and the mother still elected to feed both formula and breast milk upon admission select allowable value "2".
If the mother’s initial feeding plan was to exclusively feed breast milk upon admission, and the mother’s feeding plan changed later in the hospitalization to include formula feeding select allowable value "3". Standing orders and check boxes listing the method of feeding to include formula based on the mother’s initial feeding plan cannot be used alone to select allowable value "2". There must be additional supporting documentation from the physician/APN/PA/CNM/IBCLC/CLC that the initial feeding plan was discussed with the mother. RN documentation of the discussion and the mother’s initial feeding plan to include formula discussed upon admission is acceptable ONLY if there is supporting documentation by the physician/APN/PA/CNM/IBCLC/CLC at some point during the hospitalization to corroborate the RN’s initial discussion with the mother. If the mother decides to feed formula prior to the supporting documentation, only the initial feeding plan findings can be used.

The mother's medical record cannot be used to determine the mother's initial feeding plan. This documentation must appear in the newborn's medical record without using the mother’s medical record to perform the abstraction even if there is a link between the mother and newborn medical records in the EHR.

Bottle is a method of feeding and is not the same as formula. Bottle cannot be used interchangeably for formula, since breast milk can also be fed via a bottle.

Suggested Data Sources:
PHYSICIAN/APN/CNM/LACTATION CONSULTANT DOCUMENTATION ONLY
- Clinician progress notes
- History and physical
- Nursing assessment
- Physician progress notes
- Physician’s orders

Inclusion Guidelines for Abstraction:
These are the only acceptable maternal medical conditions for which breast milk feeding should be avoided which includes one or more of the following medical conditions:
- HIV infection
- Human t-lymphotrophic virus type I or II
- Substance abuse and/or alcohol abuse
- Active, untreated tuberculosis
- Taking certain medications, i.e., prescribed cancer chemotherapy, radioactive isotopes, antimetabolites, antiretroviral medications and other medications where the risk of morbidity outweighs the benefits of breast milk feeding
- Undergoing radiation therapy
- Active, untreated varicella
- Active herpes simplex virus with breast lesions
- Admission to Intensive Care Unit (ICU) post-partum
- Newborn and mother will be separated after discharge from the hospital, and the mother will not be providing care for the newborn after the hospitalization. Some examples include, but are not limited to: adoption, foster home placement, surrogate delivery, incarceration of the mother
- Previous breast surgery, i.e., bilateral mastectomy, bilateral breast reduction or augmentation where the mother is unable to produce breast milk
- Breast abnormality, i.e., hypoplasia, tumor, etc. where the mother is unable to produce breast milk

Exclusion Guidelines for Abstraction:
None
Data Element Name: Referral for Outpatient Tobacco Cessation Counseling

Collected For: TOB-3

Definition: Documentation that a referral was made at discharge for ongoing evidence-based counseling with clinicians (physician or non-physician such as nurse, psychologist, counselor). Outpatient counseling may include proactive telephone counseling, group counseling, individual counseling and/or e-health and internet intervention. A counseling referral may be defined as an appointment made by the healthcare provider or hospital either through telephone contact, fax or e-mail. For quitline referrals, the healthcare provider or hospital can either fax or e-mail a quitline referral or assist the patient in directly calling the quitline prior to discharge.

Suggested Data Collection Question: Did the patient receive a referral for Outpatient Tobacco Cessation Counseling?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
1. The referral to outpatient tobacco cessation counseling treatment was made by the healthcare provider or health care organization at any time prior to discharge.
2. Referral information was given to the patient at discharge but the appointment was not made by the provider or health care organization prior to discharge.
3. The patient refused the referral for outpatient tobacco cessation counseling treatment and the referral was not made.
4. The patient’s residence is not in the USA.
5. The referral for outpatient tobacco cessation counseling treatment was not offered at discharge or unable to determine from the medical record documentation.

Notes for Abstraction
- If a referral is made to a Quitline, defined as a telephone counseling in which at least some of the contact is initiated by the Quitline counselor to deliver tobacco use interventions, select value “1.”
- If the patient is provided with contact information for e-health or internet smoking cessation programs which tailor program content to the tobacco user’s needs (collect information from the tobacco user and use algorithms to tailor feedback or recommendations, permitting the user to select from various features including extensive information on quitting, tobacco dependence, and related topics) select value “2.”
• If the patient is provided with self-help materials that are not tailored to the patient’s needs and do not provide a structured program, select value “5.”
• Select value “5” if it cannot be determined if a referral for outpatient cessation counseling was made or if it is unclear if the absence of the referral was due to a patient refusal or it simply was not offered.
• If the patient does not have a residence in the USA, value “4” must be selected.

Suggested Data Sources:
• Discharge instruction sheet
• Discharge summary
• Nursing discharge notes
• Physician order sheet
• Transfer sheet

Inclusion Guidelines for Abstraction:
• Group counseling
• E-health
• Individual counseling
• Internet structured programs
• Quitline

Exclusion Guidelines for Abstraction:
Self-help interventions (brochures, videotapes, audiotapes)
Data Element Name: Sex

Collected For: All Records

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

Suggested Data Collection Question: What was the patient’s sex on arrival?

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
- Face sheet
- History and physical
- Nursing admission notes
- Progress notes
- UB-04

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None
Data Element Name: Specimen Collection

Collected For: NBS-1

Definition: Documentation that the newborn screening specimen was collected during this hospital stay prior to discharge.

Suggested Data Collection Question: Was the newborn screening specimen collected in your hospital prior to discharge?

Format:
   Length: 1
   Type: Alphanumeric
   Occurs: 1

Allowable Values:
   Y (Yes)  There is documentation that the newborn screening specimen was collected during this hospital stay prior to discharge.
   N (No)   There is no documentation that the newborn screening specimen was collected during this hospital stay prior to discharge.

Notes for Abstraction:
None

Suggested Data Sources:
- Arkansas Department of Health Public Health Laboratory Newborn Screening tool
- Hospital’s laboratory report: As long as there is a copy of the NBS tool in the medical record
- Arkansas Department of Health Newborn Screening Results Report
  Note: This can only be used to document the date and time the specimen was collected and that it was submitted. Do not use the “Received” date or time when abstracting the date and time of submission.

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: Specimen Collection Date

Collected For: NBS-1

Definition: The date the newborn screening specimen was collected.

Suggested Data Collection Question: On what date was the newborn screening specimen collected?

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

Allowable Values:
- MM = Month (0-12)
- DD = Day (1-31)
- YYYY = Year (2001-Current Year)
- UTD = Unable to Determine

Notes for Abstraction:
If the date of specimen collection is unable to be determined from medical record documentation, select “UTD.”

Suggested Data Sources:
- Only allowable sources
  - Arkansas Department of Health Public Health Laboratory Newborn Screening tool
  - Hospital’s laboratory report: As long as there is a copy of the NBS tool in the medical record
  - Arkansas Department of Health Newborn Screening Results Report
    Note: This can only be used to document the date and time the specimen was collected and that it was submitted. Do not use the “Received” date or time when abstracting the date and time of submission.

Excluded Data Sources:
None

Inclusion Guidelines for Abstraction
None

Exclusion Guidelines for Abstraction
None
Data Element Name: Specimen Collection Time

Collected For: NBS-1

Definition: The earliest documented time (military time) the newborn screening specimen was collected at the hospital.

Suggested Data Collection Question: At what time was the newborn screening specimen collected? Use military time.

Format:
- **Length:** 5 - HH:MM (with or without colon) or UTD
- **Type:** Time
- **Occurs:** 1

Allowable Values:
- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

**Examples:**
- Midnight - 00:00
- Noon - 12:00
- 5:31 am - 05:31
- 5:31 pm - 17:31
- 1:59 am - 11:59
- 1:59 pm - 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the Arrival Time should remain 11-24-20xx or if it should be converted to 11-25-20xx.
When converting Midnight or 24:00 to 00:00, do not forget to change the Arrival Date.

**Example:**
- Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:
- For times that include “seconds,” remove the seconds and record the time as is.
  **Example:**
  - 15:00:35 would be recorded as 15:00
- If the time of specimen collection is unable to be determined from medical record documentation, select “UTD.”
• The Newborn Screening tool must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range) and no other documentation is found that provides this information, the abstractor should select “UTD.”

Suggested Data Sources:
• Arkansas Department of Health Public Health Laboratory Newborn Screening tool
  • Hospital’s laboratory report: As long as there is a copy of the NBS tool in the medical record
  • Arkansas Department of Health Newborn Screening Results Report
    Note: This can only be used to document the date and time the specimen was collected and that it was submitted. Do not use the “Received” date or time when abstracting the date and time of submission.

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: Specimen Submission

Collected For: NBS-2

Definition: Documentation that the newborn screening specimen was submitted to the Arkansas Department of Health Public Health Laboratory.

Suggested Data Collection Question: Was the newborn screening specimen submitted to the Arkansas Department of Health Public Health Laboratory?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
- Y (Yes) The newborn screening specimen was submitted to the Arkansas Department of Health Public Health Laboratory.
- N (No) The newborn screening specimen was not submitted to the Arkansas Department of Health Public Health Laboratory.

Notes for Abstraction:
None

Suggested Data Sources:
- Arkansas Department of Health Public Health Laboratory Newborn Screening tool
- Hospital’s laboratory report: As long as there is a copy of the NBS tool in the medical record
- Arkansas Department of Health Newborn Screening Results Report
  Note: This can only be used to document the date and time the specimen was collected and that it was submitted. Do not use the “Received” date or time when abstracting the date and time of submission.

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: Specimen Submission Date

Collected For: NBS-2

Definition: The date the newborn screening specimen was submitted to the Arkansas Department of Health Public Health Laboratory.

Suggested Data Collection Question: On what date was the newborn screening specimen submitted to the Arkansas Department of Health Public Health Laboratory?

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

Allowable Values:
- MM = Month (0-12)
- DD = Day (1-31)
- YYYY = Year (2001-Current Year)
- UTD = Unable to Determine

Notes for Abstraction:
If the date of specimen submission is unable to be determined from medical record documentation, select “UTD.”

Suggested Data Sources:
ONLY allowable sources
- Arkansas Department of Health Public Health Laboratory Newborn Screening tool
- Hospital’s laboratory report: As long as there is a copy of the NBS tool in the medical record
- Arkansas Department of Health Newborn Screening Results Report
  Note: This can only be used to document the date and time the specimen was collected and that it was submitted. Do not use the “Received” date or time when abstracting the date and time of submission.

Excluded Data Sources:
None

Inclusion Guidelines for Abstraction
None

Exclusion Guidelines for Abstraction
None
Data Element Name: Specimen Submission Time

Collected For: NBS-2

Definition: The earliest documented time (military time) the newborn screening specimen was submitted to the Arkansas Department of Health Lab.

Suggested Data Collection Question: At what time was the newborn screening specimen submitted to the Arkansas Department of Health Lab?

Format:
- Length: 5 - HH:MM (with or without colon) or UTD
- Type: Time
- Occurs: 1

Allowable Values:
- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:
- Midnight - 00:00
- Noon - 12:00
- 5:31 am - 05:31
- 5:31 pm - 17:31
- 1:59 am - 11:59
- 1:59 pm - 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the Arrival Time should remain 11-24-20xx or if it should be converted to 11-25-20xx.
When converting Midnight or 24:00 to 00:00, do not forget to change the Arrival Date.

Example:
- Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:
- For times that include “seconds,” remove the seconds and record the time as is.
  - Example: 15:00:35 would be recorded as 15:00
- If the time of specimen submission is unable to be determined from medical record documentation, select “UTD.”
• The Newborn Screening tool must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range) and no other documentation is found that provides this information, the abstractor should select “UTD.”

Suggested Data Sources:  
ONLY allowable sources

• Arkansas Department of Health Public Health Laboratory Newborn Screening tool
• Hospital’s laboratory report: As long as there is a copy of the NBS tool in the medical record
• Arkansas Department of Health Newborn Screening Results Report
  Note: This can only be used to document the date and time the specimen was collected and that it was submitted. Do not use the “Received” date or time when abstracting the date and time of submission.

Excluded Data Sources:  
None

Inclusion Guidelines for Abstraction
None

Exclusion Guidelines for Abstraction
None
Data Element Name: Tobacco Use Status

Collected For: All TOB Measures

Definition: Documentation of the adult patient’s tobacco use status within the past 30 days prior to the day of hospital admission. Tobacco use includes all forms of tobacco including cigarettes, smokeless tobacco products, pipe, and cigars. A tobacco use screen should identify the type of tobacco product used, the volume used, and the timeframe of use.

Suggested Data Collection Question: What is the patient’s tobacco use status?

Format:
- Length: 2
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
1. The patient has smoked cigarettes daily on average in a volume of five or more cigarettes (=>1/4 pack) per day and/or cigars daily and/or pipes daily during the past 30 days.
2. The patient has smoked cigarettes daily on average in a volume of four or less cigarettes (< ¼ pack) per day and/or used smokeless tobacco and/or smoked cigarettes but not daily and/or cigars but not daily and/or pipes but not daily during the past 30 days.
3. The patient has not used any forms of tobacco in the past 30 days.
4. The patient refused the tobacco use screen.
5. The patient was not screened for tobacco use during this hospitalization or unable to determine the patient’s tobacco use status from medical record documentation.
6. The patient was not screened for tobacco use during the first three days of admission because of cognitive impairment.

Notes for Abstraction
- If there is definitive documentation that the patient either currently uses tobacco products or is an ex-user that quit less than 30 days prior to admission, select the appropriate allowable value for the type of product used, regardless of whether or not there is conflicting documentation.
- For the History and Physical (H&P) source, use only the H&P report for the current admission. The H&P may be a dictated report, a handwritten report on an H&P form, or a separate entry labeled as the H&P in the progress notes.
- Classify a form as a nursing admission assessment if the content is typical of nursing admission assessment (e.g., med/surg/social history, current meds, allergies, physical assessment) AND the form is completed/reviewed by a nurse or labeled as a “nursing form.”
- Disregard documentation of tobacco use history if the current tobacco use status or timeframe that patient quit is not defined (e.g., “20 pk/yr smoking history,” “History of tobacco abuse”).
- Do not include documentation of smoking history referenced as a “risk factor” (e.g., “risk factor: tobacco,” “risk factor: smoking,” “risk factor: smoker”), where current tobacco use status is indeterminable.
- When there is conflicting information in the record with regard to volume, for instance, one document indicates patient is a light smoker and another indicates patient is a volume greater than light smoking; select the allowable value “1” indicating the heaviest usage.
- If the medical record indicates the patient smokes cigarettes and the volume is not documented or is unknown, assume smoking at the heaviest level and select allowable value “1.”
- The tobacco use status screening timeframe must have occurred within the first three days of admission. The day after admission is defined as the first day.
- Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set is related to documentation that the patient cannot be screened for tobacco use due to the impairment (e.g., comatose, obtunded, confused, memory loss) during the entire first three days of hospitalization.
- Cognitive impairment must be documented at all times during the first three days of the hospitalization in order to select value “6.” If there is documentation in the medical record that a patient is cognitively impaired, and there is no additional documentation that the patient’s mental status was normal at any other time during the first three days of the hospitalization, i.e., alert and oriented, the abstractor can select value “6.”
- If there is documentation that the patient has temporary cognitive impairment due to acute substance use (e.g., overdose or acute intoxication) value “6” cannot be selected.

Examples of cognitive impairment include:
  - Altered Level of Consciousness (LOC)
  - Altered Mental Status
  - Cognitive impairment
  - Cognitively impaired
  - Confused
  - Memory loss
  - Mentally retarded
  - Obtunded

**Suggested Data Sources:**
- Emergency department record
- History and physical
- Nursing admission assessment
- Nursing admission notes
- Physician progress notes
- Respiratory therapy notes
Inclusion Guidelines for Abstraction:
- *Chewing (spit) tobacco*
- *Dry snuff*
- *Moist snuff*
- *Plug tobacco*
- *Redman*
- *Smokeless tobacco*
- *Snus*
- *Twist*

Exclusion Guidelines for Abstraction:
- *E-cigarettes*
- *Hookah pipe*
- *Illegal drug use only (e.g., marijuana)*
Data Element Name: Tobacco Use Treatment FDA-Approved Cessation Medication

Collected For: TOB-2

Definition: The FDA-approved tobacco cessation medications may be referenced in Appendix C on Table 9.1

Suggested Data Collection Question: Did the patient receive one of the FDA-approved tobacco cessation medications during the first three days after admission?

Format:
   Length: 1
   Type: Alphanumeric
   Occurs: 1

Allowable Values:
1. The patient received one of the FDA-approved tobacco cessation medications during the first three days after admission.
2. The patient refused the FDA-approved tobacco cessation medications during the first three days after admission.
3. FDA-approved tobacco cessation medications were not offered to the patient during the first three days after admission or unable to determine from medical record documentation.

Notes for Abstraction
- If nicotine replacement therapy (NRT) is ordered PRN and the patient does not receive any doses during the hospital stay, select value “2” (the patient refused the FDA-approved tobacco cessation medications during the hospital stay).
- The timeframe for receiving FDA-approved tobacco cessation medications must have occurred within the first three days of admission. The day after admission is defined as the first day.

Suggested Data Sources:
- Medication administration record (MAR)
- Physician orders

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 9.1 for the list of FDA-approved tobacco cessation medications

Exclusion Guidelines for Abstraction:
For Medication
- Light smokers (4 or less cigarettes per day)
- Pregnant smokers
• *Smokeless tobacco user (chewing [spit] tobacco)*
Data Element Name: Tobacco Use Treatment Practical Counseling

Collected For: TOB-2

Definition: The components of practical counseling require interaction with the patient to address the following: recognizing danger situations, developing coping skills, and providing basic information about quitting.

Suggested Data Collection Question: Did the patient receive all of the components of practical counseling during the first three days after admission?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
1 The patient received all components of practical counseling during the first three days after admission.
2 The patient refused/declined practical counseling during the first three days after admission.
3 Practical counseling was not offered to the patient during the first three days after admission or unable to determine if tobacco use treatment was provided from medical record documentation.

Notes for Abstraction:
- A referral to the Quitline may be considered a component of practical counseling (providing basic information about quitting), however, handing the patient a phone number to call for the quit line will not meet the intent of practical counseling. There must be interaction between the patient and the caregiver.
- Danger situations covered in practical counseling might include alcohol use during the first month after quitting, being around smoke and/or other smokers, or times/situations when the patient routinely smoked (in the car, on break at work, with coffee, after a meal, upon waking up, social events, etc.).
- If there is not documentation that practical counseling was given to the patient, select value “3.”
- Select value “3” if the documentation provided is not explicit enough to determine if the counseling provided contained all components or if the counseling meets the intent of the measure.
- The timeframe for receiving practical counseling must have occurred within the first three days of admission. The day after admission is defined as the first day.
Suggested Data Sources:
- Medication administration record (MAR)
- Nursing notes
- Physician progress notes
- Respiratory therapy notes

Inclusion Guidelines for Abstraction:
Referral to Quitline

Exclusion Guidelines for Abstraction:
Severe cognitive impairment
### Appendix A

#### Table 11.01 Complication Mainly Related to Pregnancy

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<th>Description</th>
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Table 11.05 Medical Induction of Labor

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### Table 11.06.1 Planned Cesarean Section in Labor

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### Table 11.07 Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation

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**Table 11.08 Outcome of Delivery**

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**Table 11.09 Multiple Gestations and Other Presentations**

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676.93  LACTAT DIS NOS-ANTEPART
V22.0  SUPERVIS NORMAL 1ST PREG
V22.1  SUPERVIS OTH NORMAL PREG
V22.2  PREG STATE, INCIDENTAL
V23.0  PREG W HX OF INFERTILITY
V23.1  PREG W HX-TROPHOBLAS DIS
V23.2  PREG W HX OF ABORTION
V23.3  GRAND MULTIPARITY
V23.41  PREG W HX PRE-TERM LABOR
V23.42  PREG W HX ECTOPIC PREG
V23.49  PREG W POOR OBS HX NEC
V23.5  PREG W POOR REPRODUCT HX
V23.7  INSUFFICNT PRENATAL CARE
V23.81  SUPRV ELDERLY PRIMIGRAV
V23.82  SUPRV ELDERLY MULTIGRAV
V23.83  SUPRV YOUNG PRIMIGRAVIDA
V23.84  SUPRV YOUNG MULTIGRAVIDA
V23.87  PREG W INCON FETL VIABIL
V23.89  SUPRV HIGH-RISK PREG NEC
V23.9  SUPRV HIGH-RISK PREG NOS
### Appendix B

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Appendix C

Table 9.1: FDA-Approved Tobacco Cessation Medications

- Bupropion
- Chantix
- Commit Lozenge
- Habitrol Patch
- Nicoderm CQ
- Nicorette
- Nicorette gum
- Nicorette lozenge
- Nicorette DS (double strength) gum
- Nicorette gum
- Nicotine gum
- Nicotine inhaler
- Nicotine NA SOLN
- Nicotine nasal spray
- Nicotine Polacrilex
- Nicotine Polacrilex gum
- Nicotine Polacrilex lozenge
- Nicotine Step 1
- Nicotine Step 2
- Nicotine Step 3
- Nicotine TD
References


