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Arkansas Medicaid Inpatient Quality Incentive Guidelines SFY2020
Discharges 07/01/2019 (3Q2019) through 12/31/2019 (4Q2019)
Introduction

This is the AFMC Data Abstraction Specifications and Guidelines for the Inpatient Quality Incentive project for SFY2020. The measures were carefully selected to improve care for a large number of Arkansans, including Arkansas Medicaid beneficiaries.

An AFMC data collection tool will be available for hospitals to begin collecting the data for 3rd Quarter 2019 and 4th Quarter 2019 discharges.

The criteria were developed jointly by Arkansas Medicaid, the Arkansas Hospital Association, AFMC and the advisory committee, which is made up of hospital quality professionals.

This manual describes the data elements required to collect and submit the data for the Obstetric, Tobacco Treatment, Behavioral Health Screening, and Obstetric Hemorrhage measures for the Medicaid Inpatient Quality Incentive program for SFY 2020. 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), Behavioral Health Screening (BHS) and Obstetric Hemorrhage (OBH)

measures.

We have included information and links from the CMS Specifications Manual for National Hospital Inpatient Quality Measures, the CMS Specifications Manual for National Hospital Outpatient Quality Measures and the Joint Commission Specifications Manual. When any information in these manual changes, the information will be provided to hospitals participating in the IQI project via release notes.

Please note: all highlighted text is new for SFY2020.

General Abstraction Guidelines

The General Abstraction Guidelines are a resource designed to assist abstractors in determining how a question should be answered. The abstractor 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 which provide the necessary direction for abstracting a data element. It is important to utilize the information found in the notes and guidelines when entering or selecting the most appropriate answer.

Suggested data sources

Unless otherwise specified in the data element, the suggested data sources are listed in alphabetical order, not priority order.

- Suggested data sources are designed to provide guidance to the abstractor as to the locations/sources where the information needed to abstract a data element will likely be found. However, the abstractor 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, list a priority in which the sources should be used or may restrict documentation by only physician/advanced practice nurse/physician assistant. If so, these sources will be identified and labeled as “Excluded Data Sources,” “ONLY ACCEPTABLE SOURCES,” “Priority Source,” or “PHYSICIAN/APN/PA DOCUMENTATION ONLY.” 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 database.”

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 2020

Overview
The 2020 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, two submission measures, one outcome measure and four structural measures.

Criteria
- Hospitals must submit data on all eligible measures and have a minimum of five Arkansas Medicaid cases per eligible topic for Q3 and Q4 of 2019.
- Hospitals must pass 80% of the eligible measures (see thresholds).
- If measure denominator is zero 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% 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 not eligible for a bonus payment but would like to participate in the evaluation for recognition will have the same requirement.

Performance Measures: OBS 4, 5a, 6, and 9; TOB 1, 2, 3, and BHS 1
- Threshold 1: Performance in Q3 and Q4 of 2019 at or above the 75th percentile from Q3 and Q4 of 2018.
  - Exceptions: OBS 4 performance must be 3% or below and OBS 6 must be 22% or lower for combined Q3 and Q4 of 2018.
- Threshold 2: Hospitals must achieve a 35% reduction in failure rate based on submitted data from Q3 and Q4 of 2018.
  - Exceptions: OBS 4 performance must be 3% or below, OBS 6 must be 22% or lower, and OBS 5a and OBS 9 performance must have a 25% reduction in failure rate based on submitted data from Q3 and Q4 of 2018.
- TOB, OBS 5a/OBS 9, and BHS 1: Performance of 50% minimum must be achieved to qualify for passing.

Submission measures OBS 5, BHS 2
- OBS 5: Hospitals will abstract and submit 100% of their OBS Newborn population.
- BHS 2: Hospitals will abstract and submit an adequate sample of their BHS population.
Structural measures OBS 8, HIV 1, OBH 2, OBH 3

- **OBS 8**: Document the number of patients who were screened for depression and the total number of deliveries.
- **HIV 1**: Document the number of patients who had documentation of HIV status prior to delivery and the total number of deliveries.
- **OBH 2**: Does your facility have a hemorrhage cart immediately available on all maternity units? (Yes/No)
- **OBH 3**: Does your hospital have an OB hemorrhage policy and procedure (reviewed and updated in the last 2-3 years) that:
  - Provides a unit-standard approach using a stage-based management plan with checklists
  - Ensures availability to OB hemorrhage supplies at all times

**Outcome measure: OBH 1**

- **OBH 1**: Severe Maternal Morbidity

**Sampling requirements**

- AFMC will provide a monthly Arkansas Medicaid case count per topic in.
- Hospitals will have the option to abstract 100% of the cases or select a random sample.
  - *Exception*: There will be no sampling option for OBS measures. Hospitals will abstract 100% of their OBS Medicaid population.
- The monthly patient list will be based on Arkansas Medicaid **paid** claims (either primary or secondary if paid by Medicaid). This number may differ from the actual number of cases a hospital has during a quarter.

**Validation**

- Two randomly selected charts from each topic per quarter for Q3 and Q4 of 2019 will be requested for validation.
- OBS 8, HIV 1, and the new OBH measures will not have charts validated.
- To pass validation, a combined score of 80% across both quarters will be required.

<table>
<thead>
<tr>
<th># of Eligible Measures</th>
<th># of Measures Required to Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>
# 15 Quality Incentive Measures for SFY 2020
(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 3% or below for combined Quarter 3 and Quarter 4, 2019</td>
<td>Two randomly selected charts from OBS Mother from each Quarter 3 and 4, 2019</td>
</tr>
<tr>
<td>OBS 5a: BREASTMILK FEEDING – OBSERVATION/ASSESSMENT</td>
<td>Must meet thresholds 1 or 2 listed above for combined Quarter 3 and Quarter 4, 2019</td>
<td>Two randomly selected charts from OBS Newborn from each Quarter 3 and 4, 2019</td>
</tr>
<tr>
<td>OBS 6: CESAREAN SECTION: NULLIPAROUS WOMEN</td>
<td>Must be 22% or lower for combined Quarter 3 and Quarter 4, 2019</td>
<td>Two randomly selected charts from OBS Mother from each Quarter 3 and 4, 2019</td>
</tr>
<tr>
<td>OBS 9: BREASTMILK FEEDING - PROVIDE ADVICE AND INSTRUCTIONS TO PATIENT</td>
<td>Must meet thresholds 1 or 2 listed above for combined Quarter 3 and Quarter 4, 2019</td>
<td>Two randomly selected charts from OBS Mother from each of Quarters 3 and 4, 2019</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, 2019</td>
<td>Two randomly selected charts from TOB measure set from each Quarter 3 and 4, 2019</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, 2019</td>
<td>Two randomly selected charts from TOB measure set from each Quarter 3 and 4, 2019</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, 2019</td>
<td>Two randomly selected charts from TOB measure set from each Quarter 3 and 4, 2019</td>
</tr>
<tr>
<td>BHS 1: SUICIDE RISK SCREENING</td>
<td>Must meet thresholds 1 or 2 listed above for combined Quarter 3 and Quarter 4, 2019</td>
<td>Two randomly selected charts from BHS from each Quarter 3 and 4, 2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTCOME MEASURES</th>
<th>CRITERIA TO PASS MEASURE</th>
<th>VALIDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>OBH 1: SEVERE MATERNAL MORBIDITY</td>
<td>Baseline score will be established from combined quarter 3 and quarter 4 2019 claims data</td>
<td>There will be no validation for this measure</td>
</tr>
<tr>
<td>SUBMISSION MEASURES</td>
<td>CRITERIA TO PASS MEASURE</td>
<td>VALIDATION</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>OBS 5: EXCLUSIVE BREAST MILK FEEDING</td>
<td>Abstract and submit 100% of OBS Newborn cases for Quarters 3 and 4, 2019</td>
<td>Two randomly selected charts from OBS Newborn from each Quarter 3 and 4, 2019.</td>
</tr>
<tr>
<td>BHS 2: SUICIDE RISK SCREENING FOLLOW-UP</td>
<td>Abstract and submit an adequate sample for Quarters 3 and 4, 2019</td>
<td>Two randomly selected charts from BHS from each Quarter 3 and 4, 2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STRUCTURAL MEASURES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OBS 8: DEPRESSION SCREENING IN PREGNANCY</td>
<td>Document the number of patients who were screened for depression and the total number of deliveries during Quarters 3 and 4, 2019</td>
<td>There will be no validation for this measure in SFY2020</td>
</tr>
<tr>
<td>HIV 1: HIV STATUS DOCUMENTATION</td>
<td>Document the number of patients who had documentation of HIV status prior to delivery and the total number of deliveries during Quarters 3 and 4, 2019</td>
<td>There will be no validation for this measure in SFY2020</td>
</tr>
<tr>
<td>OBH 2: Hemorrhage Cart</td>
<td>Do you have a hemorrhage cart immediately available on all maternity units? (Yes/No)</td>
<td>There will be no validation for this measure in SFY2020</td>
</tr>
</tbody>
</table>
| OBH 3: Hemorrhage Unit Policy             | Does your hospital have an OB hemorrhage policy and procedure (reviewed and updated in the last 2-3 years) that:  
  ● Provides a unit-standard approach using a stage-based management plan with checklists  
  ● Ensures availability to OB hemorrhage supplies at all times | There will be no validation for this measure in SFY2020                     |
Measure Information Forms and Flowcharts

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 four data elements:

- Admission date
- Birth date
- Discharge date
- ICD-10-PCS principal or other procedure code

Patients admitted to the hospital for inpatient acute care are included in the PC Mother Initial sampling group if they have: ICD-10-PCS Principal or Other Procedure Codes as defined in Appendix A, Table 11.01.1; a Patient Age (admission date–birth date) ≥8 years and <65; and a Length of Stay (discharge date–admission date) ≤120 days.

Newborns
The population of the PC-Newborn measures (PC-04, 05 and PC-06) are identified using 6 data elements:

- Admission date
- Birth date
- Discharge date
- ICD-10-CM principal or other diagnosis code
- ICD-10-PCS principal or other procedure code
- Birth weight

Within the PC-Newborn population, there are three subpopulations, i.e Newborns with Blood Stream Infection or BSI, Newborns with Breast Feeding, and Newborns with Unexpected Complications, 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 any one or two or three 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>Measures</td>
<td>Initial Patient Population Definition</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>PC-05</td>
<td>The count of all patients in PC-Newborns with Breastfeeding</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:

1. **NO ICD-10-CM Principal Diagnosis Code** as defined in Appendix A, Table 11.10.2,
2. **ONE** of the following:
   - an **ICD-10-CM Other Diagnosis Code** as defined in Appendix A, Tables 11.12, 11.13, 11.14 Or **Birth Weight >= 500g and <= 1499g**
   - an **ICD-10-CM Other Diagnosis Code** as defined in Appendix A, Tables 11.15, 11.16, Or **Birth Weight >=1500g** with **ANY OF THE FOLLOWING:**
     - an **ICD-10-PCS-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-10-CM Principal Diagnosis Code** as defined in Appendix A, Table 11.10.3
   - **Birth Weight Missing or Unable To Determine (UTD).**
3. **NO ICD-10-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-10-CM Principal Diagnosis Code as defined in Appendix A, Table 11.20.1, NO ICD-10-CM Other Diagnosis Codes as defined in Appendix A, Table 11.21, NO ICD-10-PCS-Principal or Other Procedure Code as defined in Appendix A, Table 11.22 are included in this subpopulation and are eligible to be sampled.
Length of Stay (in days) = Discharge Date minus Admission Date

Length of Stay
<= 120 days

ICD-10-CM
Principal Diagnosis Code
On Table 11.20.1

Not on Table 11.20.1

ICD-10-PCS
Principal or Other Procedure Code
On Table 11.22

All missing or None on Table 11.22

ICD-10-CM
Other Diagnosis Code
On Table 11.21

All Missing or None on Table 11.21

Set BreastFeeding Flag = "Yes"

Patient is in the PC-Newborns with Breast feeding subpopulation

Patient is eligible to be sampled for PC-Newborns with Breast feeding measures

Set BreastFeeding Flag = "No"

Patient not in the PC-Newborns with Breast feeding subpopulation
Measure Set: Obstetric Services

Set measure ID: OBS-4

Performance measure name: Elective delivery

Description: Patients with elective vaginal deliveries or elective cesarean births at ≥37 and <39 weeks of gestation completed

Rationale: For almost three 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 United States carried out in conjunction with the March of Dimes at the request of ACOG revealed that almost one-third of all babies delivered in the United States are electively delivered, with 5% of all deliveries in the country 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 with spontaneous labor, elective inductions result in more cesarean births 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 births 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-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for one or more of the following:
- Medical induction of labor as defined in Appendix A, Table 11.05 while not in Labor prior to the procedure
- Cesarean birth as defined in Appendix A, Table 11.06 and all the following:
  - Not in Labor
  - No history of a Prior Uterine Surgery

Excluded populations: None

Data elements:
- ICD-10-PCS Other Procedure Codes
- ICD-10-PCS Principal Procedure Code
- Labor
- Prior uterine surgery
**Denominator statement:** Patients delivering newborns with ≥37 and <39 weeks of gestation completed

**Included populations:**
- ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for delivery as defined in Appendix A, Table 11.01.1
- ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for planned cesarean birth in labor as defined in Appendix A, Table 11.06.1

**Excluded populations:**
- ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07
- History of prior stillbirth
- Less than eight years of age
- Greater than or equal to 65 years of age
- Length of stay greater than 120 days
- Gestational age <37 or ≥39 weeks or UTD

**Data elements:**
- Admission date
- Birth date
- Discharge date
- Gestational age
- History of stillbirth
- ICD-10-CM Other Diagnosis Codes
- ICD-10-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-10 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-10 codes or patient populations. Data could be analyzed further to determine specific patterns or trends to help reduce elective deliveries.

**Sampling:** Hospitals will abstract 100% of OBS-Newborn cases available

**Data reported as:** Aggregate rate generated from count data reported as a proportion
Abstraction resources:

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 \( \geq 37 \) and \( < 39 \) weeks of gestation completed

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-10-CM Principal or Other Diagnosis Codes

At least one on Table 11.07
PC-01 B

None on Table 11.07

Gestational Age

\( < 37 \text{ or } \geq 39 \text{ or UTD} \)
PC-01 B

\( \geq 37 \text{ and } < 39 \)

ICD-10-CM Principal or Other Diagnosis Codes

At least one on Table 11.06.1
PC-01 D

None on Table 11.06.1

PC-01 H

PC-01 X

Missing

Arkansas Medicaid Inpatient Quality Incentive Guidelines SFY2020
Discharges 07/01/2019 (3Q2019) through 12/31/2019 (4Q2019)
Arkansas Medicaid Inpatient Quality Incentive Guidelines SFY2020
Discharges 07/01/2019 (3Q2019) through 12/31/2019 (4Q2019)
Measure Set: Obstetric Services

Set measure ID: OBS-5

Measure name:
- OBS-5 Exclusive Breast Milk Feeding
- OBS-5a Breast Milk Feeding – Observe and Assess Breastfeeding

Description:
- OBS-5: Exclusive breast milk feeding during the newborn's entire hospitalization
- OBS-5a: Newborns delivered at this hospital who received breast milk feeding observation and assessment from qualified hospital staff

Rationale: Exclusive breast milk feeding for the first six 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:
- OBS-5: Newborns that were fed breast milk only since birth
- OBS-5a: Newborns that received breast milk observation and assessment from qualified hospital staff

Included populations: Not applicable

Excluded populations: None

Data elements:
- Exclusive breast milk feeding
- Breast milk feeding – observe and assess breastfeeding

Denominator statement:
Single-term newborns discharged alive from the hospital
Included populations:
Live-born newborns with ICD-10-CM Principal Diagnosis Code for single live-born 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-10-CM Other Diagnosis Codes for galactosemia as defined in Appendix A, Table 11.21
- ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for parenteral nutrition as defined in Appendix A, Table 11.22
- Experienced death
- Length of stay >120 days
- Patients transferred to another hospital
- Patients who are not term or with <37 weeks gestation completed

Data elements:
- Admission date
- Admission to NICU
- Birth date
- Discharge date
- Discharge disposition
- ICD-10-CM Other Diagnosis Codes
- ICD-10-PCS Other Procedure Codes
- ICD-10-CM Principal Diagnosis Code
- ICD-10-PCS Principal Procedure Code
- Term newborn

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-10-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: Hospitals will abstract 100% of OBS-Newborn cases available.

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

Selected references:

- California Department of Public Health. (2017). Division of Maternal, Child and Adolescent Health, Breastfeeding Initiative, In-Hospital Breastfeeding Initiation Data, Hospital of Occurrence: Available at: [https://www.cdph.ca.gov/Programs/CFH/DMCAH/Breastfeeding/Pages/In-Hospital-Breastfeeding-Initiation-Data.aspx](https://www.cdph.ca.gov/Programs/CFH/DMCAH/Breastfeeding/Pages/In-Hospital-Breastfeeding-Initiation-Data.aspx)
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
**OBS-5a: Breastmilk Feeding – Observe and Assess Breastfeeding**

Numerator: Newborns who received breastmilk feeding observation and assessment from qualified hospital staff

Denominator: Single term newborns discharged alive from the hospital

Top section is same as OBS-5
Measure set: Obstetric Services

Set measure ID: OBS-6

Measure name: Cesarean Birth

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

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

As compared with other CB measures, what is different about NTSV CB rate (low-risk primary CB in first births) is that there are clear-cut quality improvement activities that can be carried out to address the differences. Main et al. (2006) found that more than 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 three- to five-fold variation.

Type of measure: Outcome

Improvement noted as: Decrease in the rate

Numerator statement: Patients with cesarean births

Included populations: ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for cesarean birth as defined in Appendix A, Table 11.06

Excluded populations: None
Data elements:
- ICD-10-PCS Other Procedure Codes
- ICD-10-PCS Principal Procedure Code

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

Included populations:
- ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for delivery as defined in Appendix A, Table 11.01.1
- Nulliparous patients with ICD-10-CM Principal Diagnosis Code or ICD-10-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-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for multiple gestations and other presentations as defined in Appendix A, Table 11.09
- Less than eight years of age
- Older than or equal to 65 years of age
- Length of stay >120 days
- Gestational age <37 weeks or UTD

Data elements:
- Admission date
- Birth date
- Discharge date
- Gestational age
- ICD-10-CM Other Diagnosis Codes
- ICD-10-CM Principal Diagnosis Code
- Previous live births

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-10-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-10 codes or patient populations. Data could then be analyzed further determine specific patterns or trends to help reduce Cesarean births.
**Sampling:** Hospitals will abstract 100% of the OBS-Mother population available.

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

**Abstraction resources:**

**Selected references:**

- California Office of Statewide Hospital Planning and Development. (2017). Hospital Volume and Utilization Indicators for California, Retrieved from the Internet on February 22, 2018 at:
https://www.oshpd.ca.gov/HID/AHRQ-Volume-Utilization.html


**Original performance measure source/developer:**
California Maternal Quality Care Collaborative
PC-02: Cesarean Birth

Numerator: Patients with cesarean births

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

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-10-CM Principal or Other Diagnosis Codes

At least one on Table 11.09

PC-02 B

None on Table 11.09

ICD-10-CM Principal or Other Diagnosis Codes

None on Table 11.08

PC-02 B

At least one on Table 11.08

Gestational Age

< 37 or UTD

PC-02 B

>= 37

PC-02 H

Ark
Discharges 07/01/2019 (3Q2019) through 12/31/2019 (4Q2019)
Measure set: Obstetric Services

Set measure ID: OBS-9

Measure name: Breast Milk Feeding – Provide advice and instructions to patient

Description: Mothers who deliver at this hospital received breast milk feeding advice and instructions from qualified hospital staff

Rationale: Exclusive breast milk feeding for the first six 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: Patients who received breast milk feeding advice and instructions from qualified hospital staff

Included populations: Patients who refused screening

Excluded populations: None

Data elements: Breast milk feeding – provide advice and instructions to patient

Denominator statement: All mothers who deliver live-born newborns at this hospital

Included populations: ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for delivery as defined in Appendix A, Table 11.01.1

Excluded populations:
- Younger than eight years of age
- Older than or equal to 65 years of age
- Length of stay >120 days
- ICD-10-PCS principal and other diagnosis codes Z371, Z374, and Z377
- In the event a mother will be leaving the hospital without the newborn
- Mother has a positive drug screen
Data elements:
- Admission date
- Birth date
- Discharge date
- ICD-10-CM Other Diagnosis Codes
- ICD-10-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-10-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-10 codes or patient populations. Data could then be analyzed further to determine specific patterns or trends to help reduce cesarean births.

Sampling: Hospitals will abstract 100% of the OBS-Mother population that is available.

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

Selected reference:
Centers for Disease Control Breastfeeding
http://www.cdc.gov/breastfeeding/

OBS-9: Breast Milk Feeding – Provide advice and instructions to patient
Numerator: Patients who received breast milk feeding advice and instructions from qualified hospital staff.
Denominator: All mothers who deliver live-born newborns in hospital

START

Cases that are included in the OBS-Mother population

Include Stillbirth

ICD-10-CM Principle or Other Diagnosis Codes

Not Include Stillbirth

Breastmilk Feeding Advice/Instruction

= 4

= 2

= 1 or 3

In Numerator Population

Not In Measure Population

In Measure Population

STOP
Measure set: Tobacco Treatment

Set measure ID: TOB-1

Performance measure name: Tobacco Use Screening

Description: Hospitalized patients who are screened within the first day 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 day of admission (by end of Day 1)

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 younger than 18 years of age
- Patient who are cognitively impaired
- Patients who have a duration of stay less than or equal to one day or greater than 120 days
- Patients with *Comfort Measures Only* documented

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 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-10 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

Data reported as: Aggregate rate generated from count data reported as proportion

Abstraction resources:
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPag e%2FQnetTier3&cid=1228776364473
Selected references:

TOB-1: Tobacco Use Screening

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

Denominator: The number of hospitalized inpatients 18 years of age and older
Measure set: Tobacco Treatment

Set measure ID: TOB-2

Performance 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 hospital stay.

The measure is reported as an overall rate that 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 480,000 deaths each year (CDC MMWR 2014). 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 2014). Tobacco use creates a heavy cost to society as well as to individuals. Smoking-attributable health care expenditures are estimated to be at least $130 billion per year in direct medical expenses for adults, and over $150 billion in lost productivity (DHHS 2014).

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; Rigotti 2012). 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 (DHHS, 2008).

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 \textbf{AND} received or refused FDA-approved cessation medications during the hospital stay

**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
- Light smokers
- Patients with reasons for not administering FDA-approved cessation medication

**Data elements:**
- 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
- Patients 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 one day or greater than 120 days
- Patients with \textit{Comfort Measures Only} documented

**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-10-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-10-CM codes; therefore, coding practices may require evaluation to ensure consistency.

**Measure analysis suggestions:** Hospitals may wish to identify those patients who 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

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

**Abstraction resources:**
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPaging%2FQnetTier3&cid=1228776364473

**Selected References:**

**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 hospital stay.

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

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The diagram outlines the process of determining whether a patient received treatment for tobacco use. It involves calculating the patient's age and length of stay, then checking if the length of stay is less than or equal to 1 day. The flowchart also considers whether the measure measures only, measures only and missing, or is missing, with specific conditions for each scenario. The final outcome determines whether the measure is met or not, with codes for the result.
Measure set: Tobacco Treatment

Set 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 that includes all patients to whom tobacco use treatment was provided, or offered and refused, at the time of hospital 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 480,000 deaths each year (CDC MMWR 2014). 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 2014). Tobacco use creates a heavy cost to society as well as to individuals. Smoking-attributable health care expenditures are estimated to be at least $130 billion per year in direct medical expenses for adults, and over $150 billion in lost productivity (DHHS 2014).

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; Rigotti 2012). 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 (DHHS, 2008).

Type of measure: Process

Improvement noted as: Increase in the rate
**Numerator statement:** 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
- Light smokers
- Patients with reasons for not administering FDA-approved cessation medication

**Data elements:**
- 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
- Patients 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 one day or 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
- Birth date
- 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-10-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-10-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

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

Abstraction resources: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPag e%2FQnetTier3&cid=1228776364473

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

Variable Key:
- Patient Age
- Length of Stay

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 ≤ 1

Condition Measures

Missing

Missing

TOB-3 ≥ 0

TOB-3 ≥ 0

Discharge Disposition

Missing

Missing

TOB-3 ≥ 0

Arkansas Medicaid Inpatient Quality Incentive Guidelines SFY2020
Discharges 07/01/2019 (3Q2019) through 12/31/2019 (4Q2019)
Measure Set: Behavioral Health Services

Set measure ID: BHS-1

Performance measure name: Suicide Risk Screening in the Hospital Emergency Department

Description: Patients screened for suicide risk during the hospital emergency department stay or visit

Rationale: The rate of suicide is increasing in America. Suicide is the 10th leading cause of death overall in Arkansas. (CDC, 2016) On average, one person dies by suicide every 15 hours in the state. (CDC, 2016) It is estimated, in Arkansas, the combined lifetime medical and work loss cost for suicide in 2010 was an average of $1,208,615 per suicide death. (CDC, 2016) At the point of care, providers often do not detect suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death (Ahmedani BK, et al, 2013), usually for reasons unrelated to suicide or mental health. Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.

Type of measure: Process

Improvement noted as: Increase in the rate

Numerator Statement: Patients who received suicide risk screening in the ED

Included populations: Patients who refused screening

Data Elements:
- Suicide Risk Screening in the Emergency Department

Denominator Statement: Patients who were admitted to the ED

Included populations:
- Any ED admission aged eight years or older
- Patients seen in a hospital emergency department (E/M Code in Appendix A OP Table 1.0)

Excluded populations:
- Patients who expired in the ED
- Less than eight years of age
- Patients who left against medical advice/AMA
- Patients who are cognitively impaired

Data elements:
- Birthdate
- E/M code or ED Revenue Codes
- Discharge code
- ED patient

**Risk adjustment:** No.

**Data collection approach:** Retrospective data sources for required data elements include administrative data and medical records.

**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 suicide risk, subtracting those that refused the screen.

**Sampling:** Yes

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

**References:**
Behavioral Health Services Population Algorithm

START

Medicaid Paid Claims

Patient Age

< 8 years

>= 8 years

E/M Code*

= Y

= N

Patient Is Eligible for BHS Initial Patient Population

Patient Is Not Eligible for BHS Initial Patient Population

*E/M code indicates CPT procedure codes
**BHS-1: Behavioral Health Services**

**Numerator:** Patients who received suicide risk screening in ER

**Denominator:** Patients who were admitted to ER

---

**Cases that are included in the BHS population**

**ED Patient**

- **= N**
  - **= Y**
  - **Discharge Code**
    - **= 6, 7 or 8**
    - **= 1, 2, 3, 4a, 4b, 4c, 4d or 5**
  - **Suicide Risk Screening**
    - **= 1 or 3**
    - **= 2**

---

**In Numerator Population**

**In Denominator Population**

**Not In Measure Population**
Set measure ID: BHS-2

Performance measure name: Plan for Follow-up Care

Description: Patients who are screened positive in the emergency department that have a plan for follow-up care at discharge.

Rationale: The rate of suicide is increasing in America. Suicide is the 10th leading cause of death overall in Arkansas (CDC, 2016). On average, one person dies by suicide every 15 hours in the state (CDC, 2016). It is estimated, in Arkansas, the combined lifetime medical and work loss cost for suicide in 2010 was an average of $1,208,615 per suicide death (CDC, 2016). At the point of care, providers often do not detect suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death (Ahmedani BK, et al, 2013), usually for reasons unrelated to suicide or mental health. Timely, supportive continuity of care for those identified as at risk for suicide is crucial.

Type of measure: Process

Improvement noted as: Increase in the rate

Numerator Statement: The number of patients received plan for follow-up care

Included populations:
- Patients who received plan for follow-up care
- Patients who refused to receive follow-up care

Data Elements:
- Plan for follow-up care

Denominator Statement: Patients who were admitted to the ED

Included populations:
- Any ED admission aged eight years or older
- Patients seen in a hospital emergency department (E/M Code in Appendix A OP Table 1.0) or ED Revenue Codes
- Patients who had positive suicide risk screening result

Excluded populations:
- Patients who expired in the ED
- Less than eight years of age
- Patients who left against medical advice/AMA

Data elements:
- Birthdate
- E/M code
• Discharge code
• ED patient

Risk adjustment: No.

Data collection approach: Retrospective data sources for required data elements include administrative data and medical records.

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 identify those patients who did not receive the plan for the follow-up care.

Sampling: Yes
Data reported as: Aggregate rate generated from count data reported as a proportion

References:
• Centers for Disease Control and Prevention (CDC) Data & Statistics Fatal Injury Report for 2016
• https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4026491/pdf/11606_2014_Article_2767.pdf
BHS-2: Plan for Follow-up Care

Numerator: Patients who received the follow-up care plan
Denominator: Patients who were admitted to ER

START

Cases that are included in the BHS population

ED Patient

= N
= Y

Discharge Code

= 6, 7 or 8
= 1, 2, 3, 4a, 4b, 4c, 4d or 5

Suicide Risk Screening

= N or N/A
= Y

J

B
Positive Screening Result = N or UTD

Follow-Up Care = 3

In Numerator Population = 1 or 2

In Denominator Population

Not In Measure Population = B

Arkansas Medicaid Inpatient Quality Incentive Guidelines SFY2020
Discharges 07/01/2019 (3Q2019) through 12/31/2019 (4Q2019)
Measure Set: Structural Measures

Set Measure ID: OBS-8

Performance Measure Name: Depression Screening in Pregnancy

Description: Patients who deliver and are screened for depression during the hospital stay.

Measure ascertains response to the following question(s):
- What was the total number of patients who delivered and were screened for depression during the hospital stay (numerator)?
- What was the total number of patients who delivered (denominator)?

The structural measures will be reported in AMART quarterly.

Set Measure ID: HIV-1

Performance Measure Name: HIV Status Documentation

Description: Patients with documentation of HIV status prior to delivery.

Measure ascertains response to the following question(s):
- What was the total number of patients with documentation of HIV status prior to delivery (numerator)?
- What was the total number of patients who delivered (denominator)?

Patients who have had no prenatal care are excluded from this measure.

The structural measures will be reported in AMART quarterly.

Set Measure ID: OBH-2

Performance Measure Name: Hemorrhage Cart

Description: Hemorrhage cart immediately available on all maternity units

Measure ascertains response to the following question(s):
- Does your hospital have OB hemorrhage supplies readily available, typically in a cart or mobile box?
  o Yes
  o No
The structural measures will be reported in AMART quarterly.

Set Measure ID: OBH-3

Performance Measure Name: Hemorrhage Unit Policy

Description: Hemorrhage Unit policy and procedure

Measure ascertains response to the following question(s):
  • Does your hospital have an OB hemorrhage policy and procedure (reviewed and updated in the last 2-3 years) that:
    o Provides a unit-standard approach using a stage-based management plan with checklists
      ▪ Yes or No
    o Ensures availability to OB hemorrhage supplies at all times
      ▪ Yes or No

The structural measures will be reported in AMART quarterly.
Measure Set: Outcome Measures

Set Measure ID: OBH-1

Performance Measure Name: Severe Maternal Morbidity

Description: Identification and documentation of Severe Maternal Morbidity indicators during delivery hospitalizations

Rational: Severe maternal morbidity (SMM) includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman’s health. (Kilpatrick SK, et al, 2016) SMM has been steadily increasing in recent years and affected more than 50,000 women in the United States in 2014. (CDC 2019). It is essential to track the patterns of SMM in order to develop and carry out interventions that will improve the quality of maternal care and reduce SMM.

Type of measure: Outcome

Improvement noted as: Decrease in the rate

Numerator Statement: The number of patients with any one of the 18 SMM codes during birth admission.

https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/severe-morbidity-ICD.htm

1. Acute myocardial infarction
2. Acute renal failure
3. Adult respiratory distress syndrome
4. Amniotic fluid embolism
5. Cardiac arrest/ventricular fibrillation
6. Disseminated intravascular coagulation
7. Eclampsia
8. Heart failure/arrest during surgery or procedure
9. Puerperal cerebrovascular disorders
10. Pulmonary edema/acute heart failure
11. Severe anesthesia complications
12. Sepsis
13. Shock
14. Sickle cell disease with crisis
15. Air and thrombotic embolism
16. Blood transfusion
17. Hysterectomy
18. Temporary tracheostomy

Data Elements:
- ICD-10-CM Principal Diagnosis Code
- ICD-10-CM Other Diagnosis Codes

Denominator Statement: All mothers during their birth admission, excluding ectopics and miscarriages
Data Elements:
- ICD-10-CM Principal/Other Diagnosis Codes
- ICD-10-PCS Principal/Other Procedure Codes
- Admission Date
- Discharge Date

References:
Data Element Abstraction Resources

The data element specifications for the TOB measure set are found at the following link:

https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228776364473

- Data element name: Admission date
- Data element name: Birth date
- Data element name: Comfort measures only
- Data element name: Discharge date
- Data element name: Discharge disposition
- Data element name: First name
- Data element name: Last name
- Data element name: Patient identifier
- Data element name: Prescription for tobacco cessation medication
- Data element name: Reason for no tobacco cessation medication at discharge
- Data element name: Reason for no tobacco cessation medication during the hospital stay
- Data element name: Referral for outpatient tobacco cessation counseling
- Data element name: Sex
- Data element name: Tobacco use status
- Data element name: Tobacco use treatment FDA-approved cessation medication
- Data element name: Tobacco use treatment practical counseling

The data element specifications for the OBS-Mother and OBS-Newborn measure sets are found at the following link:


- Data element name: Admission to NICU
- Data element name: Discharge disposition
- Data element name: Exclusive breast milk feeding
- Data element name: Gestational age
- Data element name: History of stillbirth
- Data element name: ICD-10-PCS Other Procedure Codes
- Data element name: ICD-10-PCS other procedure dates
- Data element name: ICD-10-PCS Principal Procedure Code
- Data element name: ICD-10-PCS principal procedure date
- Data element name: Labor
- Data element name: Previous live births
- Data element name: Prior uterine surgery
- Data element name: Term newborn
Alphabetical Data Dictionary

Data element name: Breast Milk Feeding – Observe and Assess Breastfeeding

Collected for: OBS-5a

Definition: Documentation that qualified hospital staff observed and assessed breast milk feeding

Suggested data collection question: Is there documentation that qualified hospital staff observed and assessed breast milk feeding during hospital stay?

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

Allowable values:
- Y (Yes): There is documentation that qualified hospital staff observed and assessed breast milk feeding during hospital stay
- N (No): There is no documentation that qualified hospital staff observed and assessed breast milk feeding during hospital stay
- N/A (not applicable): The mother chose to not breastfeed during the stay

Notes for abstraction:
- Qualified hospital staff includes:
  - Physician/APN/PA
  - Nursing staff
  - Lactation specialist
  - Direct patient care provider
- Documentation of a latch assessment (score) is sufficient to meet the intent of this measure
- If the mother chose to not breastfeed during the stay, select N/A

Suggested data sources:
- Nursing notes
- Lactation education
- Patient education notes
- Physician history and physical
- Progress notes
- Discharge summary
Data element name: Breast Milk Feeding – Provide Advice and Instructions to Patient

Collected for: OBS-9

Definition: Documentation that the mother received breast milk feeding assistance/instruction from qualified hospital staff

Suggested data collection question: Is there documentation that qualified hospital staff provided breastfeeding advice and instructions to patient during hospital stay?

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

Allowable values:
- 1 There is documentation that qualified hospital staff provided breast-feeding advice and instructions to patient during hospital stay
- 2 There is no documentation that qualified hospital staff provided breast-feeding advice and instructions to patient during hospital stay
- 3 There is documentation that the mother refuses the breastfeeding advice and instruction
- 4 In the event a mother will be leaving the hospital without the newborn (i.e. stillbirth, adoption, or foster care placement) or if there is documentation that the mother has a positive drug screen

Notes for abstraction:
- In the event a mother will be leaving the hospital without the newborn (i.e. stillbirth, adoption, or foster care placement) select option N/A
- If there is documentation that the mother has a positive drug screen, answer option N/A
- If there is documentation that the mother refuses the breastfeeding advice and instruction, answer option N/A
- Qualified hospital staff includes:
  - Physician/APN/PA
  - Nursing staff
  - Lactation specialist
  - Direct patient care provider

Suggested data sources:
- Nursing notes
- Lactation education
- Patient education notes
- Physician history and physical
- Progress notes
- Discharge summary
Data element name: Discharge Code

Collected for: BHS-1

Definition: The final place or setting to which the patient was discharged from the outpatient setting.

Suggested data collection question: What was the patient's discharge code from the outpatient setting?

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

Allowable values:
1. Home
2. Hospice – Home
3. Hospice – Health Care Facility
4a. Acute Care Facility – General Inpatient Care
4b. Acute Care Facility – Critical Access Hospital
4c. Acute Care Facility – Cancer Hospital or Children’s Hospital
4d. Acute Care Facility – Department of Defense or Veteran’s Administration
5. Other Health Care Facility
6. Expired
7. Left Against Medical Advice/AMA
8. Not Documented or Unable to Determine (UTD)

Notes for abstraction:
- If documentation is contradictory, use the latest documentation. If there is documentation that further clarifies the level of care, that documentation should be used to determine the correct value to abstract.
  
  *Example:* Nursing discharge note documentation reflects that the patient is being discharged to “XYZ” Hospital. The Social Service notes from the day before discharge further clarify that the patient will be transferred to the rehab unit at “XYZ” Hospital; select value 5.

- 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 4a.

- When determining whether to select value 7 (“Left Against Medical Advice”):
  
  - A signed AMA form is not required for this data element, but in the absence of a signed form, the medical record must contain physician or nurse documentation that the patient left against medical advice or AMA.
  
  - 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 value 7).

- Physician order written to discharge to home. Nursing notes reflect that the patient left before discharge instructions could be given; select value 1.

**Suggested data sources:**
- Discharge instruction sheet
- Emergency department record
- Nursing discharge notes
- Physician orders
- Progress notes
- Transfer record
Data Element Name: ED Patient

Collected For: BHS-1

Definition: Patient received care in a dedicated emergency department of the facility.

Suggested Data Collection Question: Was the patient an ED patient at the facility?

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

Allowable Values:
- Y (Yes) There is documentation the patient was an ED patient.
- N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation.

Notes for Abstraction:
- For the purposes of this data element an ED patient is defined as any patient receiving care or services in the emergency department.
- Patients seen in an urgent care, ER fast track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient).
- Patients presenting to the ED who do not receive care or services in the ED abstract as a “No” (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).
- Patients presenting to the ED for outpatient services such as lab work will abstract as a “Yes.”

Emergency Department:
- If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select “No.” This applies even if the emergency department or observation unit is part of your hospital’s system (e.g., your hospital’s free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select “No,” even if the transferred patient is seen in this facility’s ED.
- If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select “No.” This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select “No” even if the transferred patient is seen in this facility’s ED.

Suggested Data Sources:
- Emergency department record
• Fact sheet
• Registration form

Inclusion Guidelines for Abstraction:
• None

Exclusion Guidelines for Abstraction:
• Fast Track ED
• Terms synonymous with urgent care
• Urgent care
Data element name: Suicide Risk Screening in the Emergency Department

Collected for: BHS-1

Definition: Documentation that the patient was screened for suicide risk during the hospital emergency department stay.

Suggested data collection question: Is there documentation that the patient was screened for suicide risk during the hospital emergency department stay?

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

Allowable values:
1. There is documentation that the patient was screened for suicide risk during the hospital emergency department stay
2. There is no documentation that the patient was screened for suicide risk during the hospital emergency department stay
3. There is documentation that the patient refused the screening for suicide risk
4. There is documentation of cognitive impairment during the hospital emergency department stay

Notes for abstraction:
- A suicide risk screening must be completed by a physician, APN, PA or registered nurse (RN) during the emergency department stay.
- If there is documentation of any of the examples of cognitive impairment below during the hospital emergency department stay, select Value “4” regardless of conflicting documentation. Examples of cognitive impairment include:
  - Altered mental status
  - Cognitive impairment
  - Cognitively impaired
  - Confused
  - Dementia
  - Memory loss
  - Mentally handicapped
  - Obtunded
  - Psychotic/psychosis with documented symptoms

Suggested data sources:
- Emergency department record
Data element name: Suicide Risk Screening Plan for Follow-up Care

Collected for: BHS-2

Definition: Plan for follow-up care such as:
- Additional risk assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Suicide risk assessment
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Suggested data collection question: Documentation that the patient received a plan for follow-up care?

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

Allowable values:
1. The patient received a plan for follow-up care
2. The patient refused the plan for follow-up care
3. The follow-up care plan was not offered to the patient at the discharge or unable to determine from medical record documentation

Notes for abstraction:
- The follow-up plan must be completed by a physician, APN, PA or registered nurse (RN) during the emergency department stay

Suggested data sources:
- Emergency department record
Data element name: Suicide Risk Screening Result

Collected for: BHS-2

Definition: The result of suicide risk screening.

Suggested data collection question: Was the result of suicide risk screening positive?

Format:
- Length: 3
- Type: Alphanumeric
- Occurs: 1

Allowable values:
- Y (Yes): The result of suicide risk screening was positive
- N (No): The result of suicide risk screening was negative
- UTD (Unable to Determine): There is no documentation of the suicide risk screening result

Notes for abstraction:
- The result of suicide risk screening must be documented by a physician, APN, PA or registered nurse (RN) during the emergency department stay.

Suggested data sources:
- Emergency department record
Appendix A – Diagnosis & Procedure Code Tables

BHS diagnosis code tables


- OP Table 1.0 E/M Codes for Emergency Department Encounters

OBS diagnosis code tables

https://manual.jointcommission.org/releases/TJC2019A/AppendixATJC.html

- Table 11.01.1 Delivery
- Table 11.05 Medical Induction of Labor
- Table 11.06 Cesarean Birth
- Table 11.06.1 Planned Cesarean Birth in Labor
- Table 11.07 Conditions Possibly Justifying Elective Delivery
- Table 11.08 Outcome of Delivery
- Table 11.09 Multiple Gestations and Other Presentations
- Table 11.20.1 Single Live-born Newborn
- Table 11.21 Galactosemia
- Table 11.22 Parenteral Infusion

Appendix B–Hospitals with Acceptable NICU Classification

- Arkansas Children’s Hospital Little Rock Level III C
- Baptist Health Medical Center Little Rock Level III B
- CHI St. Vincent Infirmary Little Rock Level III B
- UAMS Medical Center Little Rock Level III B
- St. Bernards Medical Center Jonesboro Level III A
- Mercy Hospital Fort Smith Fort Smith Level III B
- Mercy Hospital Northwest AR Rogers Level III A
- Washington Regional Med Ctr Fayetteville Level III A
- NW Health Sys Willow Creek Johnson Level III A
- Regional One Memphis Level III
Appendix C – Tobacco Approved Medications

References

- Specifications Manual for National Hospital Inpatient Quality Measures, Discharges 07-01-2018 through 12-31-2018, v5.4a
- Hospital Outpatient Quality Reporting Specifications Manual, Discharges 01-01-2019 through 12-31-2019, v12.0a
- Centers for Diseases Control Breastfeeding http://www.cdc.gov/breastfeeding/