RY2013
Technical Specifications Manual for
MassHealth Acute Hospital Quality Measures
(Version 6.0)

# Appendix A-8:
# Data Dictionary for
# MassHealth Specific Measures

# Enhancements to Data Dictionary (v 6.0)

This Appendix contains the full set of clinical and administrative data element definitions to supplement the maternity and care coordination measures technical specifications outlined under Section 3 of this manual. It also includes definitions for all patient identifier administrative data elements required in the MassHealth Crosswalk Files to supplement the MassHealth Payer Files for the nationally reported hospital quality measures data.

This version of the data dictionary contains changes to definitions for existing data elements and introduces new data elements effective with Q3-2012 data. These changes are summarized in table below.

**Updates to Data Dictionary (version 6.0)**

| Change to Data Element | Maternity Measures (MAT-1, 2a, 2b, 3) | Care Coordination Measures (CCM-1, 2, 3) | All MassHealth Records |
|---|---|---|---|
| **Existing** | • Active Labor<br>• Gestational Age<br>• Infection prior to cesarean<br>• IV antibiotic (MAT-1)<br>• IV antibiotic (MAT-2, b)<br>• Live newborn | • Advance Care plan<br>• Contact information 24h/7d<br>• Current medication list<br>• Major procedures & tests<br>• Patient instructions<br>• Plan for follow up care<br>• Primary Physician/ HCP for follow up care<br>• Principle diagnosis at discharge<br>• Reason for inpatient admission<br>• Studies pending at discharge<br>• Transition record<br>• Transmission date | • Episode of care<br>• MassHealth Member ID<br>• Patient identifier<br>• Payer source |
| **Add New** (As of Q3-2012) | • Prior Uterine Surgery | • Reconciled Medication List | |

All updates to existing and/or new data elements are shown in *underlined italic font* on the table of contents and throughout this data dictionary. The table of contents also shows which data element corresponds to the specific measure it is being collected for and the page number locator.

## Data Dictionary Format and Terms

This data dictionary contains detailed information necessary for defining and formatting the collection of all data elements, as well as the allowable values for each data element that uses the following format:

- *Data Element Name*: A short phrase identifying the data element.
- *Collected For*: Identifies the measure(s) requiring that data element to be collected.
- *Definition*: A detailed explanation of the data element.
- *Suggested Data Collection Question*: The wording for a data element question in a data abstraction tool.
- *Format: Length*: The number of characters or digits allowed for the data element.
- *Type*: The type of information the data element contains (e.g., numeric, alphanumeric, date, character, or time).
- *Occurs*: The number of times the data element occurs in a single episode of care record.
- *Allowable Values*: A list of acceptable responses for this data element.
- *Notes for Abstraction*: Notes to assist abstractor in the selection of appropriate value for a data element.
- *Suggested Data Sources*: Source document from which data may be identified such as administrative or medical record. Please note the data sources listed are not intended to reflect a comprehensive list.
- *Guidelines for Abstraction*: Notes to assist abstractors in determining how data element inclusions/exclusions should be answered.

Adherence to data dictionary definitions provided in this EOHHS manual are necessary to ensure that data element abstraction is accurate and reliable. This data dictionary should be used in conjunction with Section 6 (Table 6.1) of this EOHHS manual for a list of the data elements that are subject to data validation scoring.

Contact the MassQEX Customer Support Help Desk for questions if you have any questions about the information contained in this dictionary at 781-419-2818 or massqexhelp@masspro.org .

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| Hospital Bill Number | HOSPBILL# | 35 | All MassHealth Records |
| ICD-9-CM Other Diagnosis Codes | OTHERDX# | 36 | All MassHealth Records |
| ICD-9-CM Other Procedure Codes | OTHERPX# | 37 | All MassHealth Records |
| ICD-9-CM Other Procedure Dates | OTHERPX#DT | 38 | All MassHealth Records |
| ICD-9-CM Principal Diagnosis Code | PRINDX | 39 | All MassHealth Records |
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NOTE: The asterisk (*) on the table of contents indicates new data element definitions are effective with Q3-2012 discharge data.

**Data Element Name:** *Active Labor*

**Collected For:** MAT-3

**Definition:** Documentation that the patient was in active labor *or presented* with regular uterine contractions with cervical change before medical induction and/or Cesarean section.

**Suggested Data Collection Question:** Is there documentation that the patient was in active labor *or presented* with regular uterine contractions with cervical change before medical induction and/or Cesarean section?

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

**Allowable Values:** Y (Yes) There is documentation that the patient was in active labor *or presented* with regular uterine contractions with cervical change before medical induction and/or Cesarean section.

N (No) There is no documentation that the patient was in active labor *or presented* with regular uterine contractions with cervical change before medical induction and/or Cesarean section OR unable to determine from medical record documentation.

**Notes for Abstraction:** If the patient presents without a previous cesarean section scar with regular uterine contractions with demonstrated cervical change, e.g., cervical dilation increased from 1cm to 2cm before eventual augmentation and/or cesarean section, select allowable "Yes".

If the patient presents with previous cesarean section scar with regular uterine contractions with demonstrated cervical change, e.g., cervical dilation increases from 1 cm to 2cm or a cervix dilated 2cm or more before repeat cesarean section, select allowable "Yes".

*Prodromal labor is not active labor.*

**Suggested Data Sources:** History and physical
Nursing Notes
Physician progress notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Admission Date*

**Collected For:** All MassHealth 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 (01-12)
DD = Day (01-31)
YYYY = Year (2000 – 9999)

**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 many measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.

A patient of a hospital is considered an inpatient upon issuance of written doctors orders to that effect.

For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.

For patients that are admitted for surgery and/or a procedure, if the admission order states the date the orders were written and they are effective for the surgery/procedure date, then the date of the surgery/procedure would be the admission date. If the medical record reflects that the admission order was written prior to the actual date the patient was admitted and there is no reference to the date of the surgery/procedure, then the date the order was written would be the admission date.

**Suggested Data Sources:** ***PRIORITY ORDER FOR THESE SOURCES***
Physician orders
Face sheet

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | Admit to observation<br>Arrival date |

**Data Element Name:** *Admission Time*

**Collected For:** MAT-1

**Definition:** The time (military time) of admission to the Labor and Delivery unit.

**Suggested Data Collection Question:** At what time was the mother admitted to the Labor and Delivery unit?

**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

Military Time – A 24-hour period from midnight to midnight using a four digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

Converting clock time to military time:
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:

| | *Correct Entry* | | *Correct Entry* |
|---|---|---|---|
| Midnight = | 00:00 | Noon = | 12:00 |
| 5:31 am = | 05:31 | 5:31 pm = | 17:31 |
| 11:59 am = | 11:59 | 11:59 pm = | 23:59 |

**Notes for Abstraction:** Time must be abstracted in military time format.

For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the time that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the time that the patient was admitted to Observation.

00:00 = midnight.

If the time of admission is unable to be determined from medical record documentation, enter "UTD".

**Suggested Data Sources:** Face sheet

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Advance Care Plan*

**Collected For:** CCM-2

**Definition:** A transition record that included indication of an Advance Care Plan or a documented reason for not providing an advance care plan.

An advance care plan includes an Advance Directive, a written statement of patient wishes regarding future use of life-sustaining medical treatment, or documentation of a health care proxy.

**Suggested Data Collection Question:** Does the Transition Record include *indication of* an Advance Care Plan?

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

**Allowable Values:**

Y (Yes) The transition record includes *indication of* an Advance Care Plan or a documented reason for not providing an advance care plan.

N (No) The transition record does not include *indication of* an Advance Care Plan or a documented reason for not providing an advance care plan.

**Notes for Abstraction:** The advance care plan must be addressed on the transition record for all patients 18 years and over.

A checkbox or indication of the presence of an advance directive, health care proxy, power of attorney, etc must be documented.

If there is no advance care plan, a reason must be documented

A documented reason for not providing an advance care plan includes:

- The care plan was discussed but the patient did not wish or was not able to name a health care proxy
- The patient was not able to provide an advance care plan
- Documentation as appropriate that the patient's cultural and/ or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician patient relationship
- The patient was < 18 years of age
- *Patient refusal of advance care plan information or decision for an advance care plan, select Y(Yes)*

A copy of the Advance Directive is not required to be attached to the transition record.

**Suggested Data Sources**: Transition Record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| Advance Care Directives<br>Power of Attorney<br>Health care proxy<br>Do Not Resuscitate – DNR etc<br>*Living Will* | Patients < 18 years of age |

**Data Element Name:** *Amniotic Membrane Rupture 18 or More Hours*

**Collected For:** MAT-1

**Definition:** Documentation of amniotic membrane rupture for 18 or more hours.

**Suggested Data Collection Question:** Is there documentation that the amniotic membranes were ruptured for 18 or more hours?

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation that the amniotic membranes were ruptured for 18 hours or longer. |
| N (No) | There is no documentation that the amniotic membranes were ruptured for 18 hours or longer or duration of amniotic membrane rupture cannot be determined from medical record documentation. |

**Notes for Abstraction:** None

**Suggested Data Sources:** History and physical
Nursing notes
Progress notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Antibiotic Administration Date*

**Collected For:** MAT-1, MAT-2a

**Definition:** The date (month, date, and year) for which an antibiotic dose was administered.

**Suggested Data Collection Question:** What was the date of administration for the antibiotic dose?

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

**Allowable Values:**
MM = Month (0-12)
DD = Day (01-31)
YYYY = Year (2000 – 9999)
*UTD* = *Unable to Determine*

**Notes for Abstraction:** Only one administration of an antibiotic is abstracted.

For MAT-1, if the antibiotic was administered on multiple occasions, abstract the date of the last dose administered before birth.

For MAT-2a, abstract the administration date that falls within, or closest, to the targeted time frame (one hour prior to Cesarean Section incision time).

If the date an antibiotic was administered is unable to be determined from medical record documentation, enter "UTD".

When converting midnight or 24:00 to 00:00, do not forget to change the Antibiotic Administration Date. Example: midnight or 24:00 on 11-24-20XX = 00:00 on 11-25-20XX

**Suggested Data Sources:**
IV flowsheets
Medication administration record (MAR)
Nursing notes
Perfusion record

For MAT-2a, these additional sources may also be utilized
Anesthesia record
Delivery note
Operating room record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Antibiotic Administration Time*

**Collected For:** MAT-1, MAT-2a

**Definition:** The time (military time) for which an antibiotic dose was administered.

**Suggested Data Collection Question:** What was the time of administration for the antibiotic dose?

**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

Military Time – A 24-hour period from midnight to midnight using a four digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

Converting clock time to military time:
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:

| | Correct Entry | | Correct Entry |
|---|---|---|---|
| Midnight = | 00:00 | Noon = | 12:00 |
| 5:31 am = | 05:31 | 5:31 pm = | 17:31 |
| 11:59 am = | 11:59 | 11:59 pm = | 23:59 |

**Notes for Abstraction:** 00:00 = midnight

When converting midnight or 24:00 to 00:00, do not forget to change the Antibiotic Administration Date. Example: midnight or 24:00 on 11-24-20XX = 00:00 on 11-25-20XX

When collecting the time of administration of an antibiotic administered via infusion (IV), Antibiotic Administration Time refers to the time the antibiotic infusion was started.

For MAT-1, if the antibiotic was administered on multiple occasions, abstract the time of the last dose administered before birth.

For MAT-2a, abstract the administration time that falls within, or closest, to the targeted time frame (one hour prior to Cesarean Section incision time*).*

If multiple administration times are documented for an antibiotic dose, abstract the time recorded by the clinician administering the drug. If more than one time is documented by the same clinician for the same medication dose, abstract the earliest time documented by that clinician. If it is unclear who administered the drug, abstract the earliest time documented for that dose.

If the time an antibiotic was administered is unable to be determined from medical record documentation, enter "UTD".

If the antibiotic time is documented in a grid, measure from the midpoint of the symbol, arrow, number or letter. If the value falls between two lines on the grid, abstract the earliest value.

**Suggested Data Sources:**

IV flowsheets
Medication administration record (MAR)
Nursing notes
Perfusion record

For MAT-2a, these additional sources may also be utilized
Anesthesia record
Delivery note
Operating room record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Antibiotic Name for Cesarean Section Prophylaxis*

**Collected For:** MAT-2b

**Definition:** A code indicating the name of the IV antibiotic administered for Cesarean section surgical prophylaxis.

**Suggested Data Collection Question:** What is the antibiotic name of the IV antibiotic administered for Cesarean section surgical prophylaxis?

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

**Allowable Values:**
1 = Ampicillin
2 = Cefazolin
3 = Gentamycin
4 = Other

**Notes for Abstraction:** Data is collected on one *intravenous* antibiotic administered within the targeted time frame, i.e., within one (1) hour prior to surgical incision.

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Only the allowable values should be abstracted. For a crosswalk of Trade and Generic Names, consult Table 2.1 of Appendix C in the appropriate version of the NHIQM Specifications Manual. If the medical record contains two antibiotic names within the appropriate timeframe, abstract the antibiotic name that matches one of the names on the list of allowable values first before choosing an "Other" antibiotic.

A physician order is not sufficient to abstract this data, there must be documentation that the medication was administered.

**Suggested Data Sources:**
Anesthesia record
IV flowsheet
Labor and delivery flow sheet
Labor and delivery summary
Medication administration record (MAR)
Nursing notes
Operative report
Operating room record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Antibiotic Name for GBS Prophylaxis*

**Collected For:** MAT-1

**Definition:** A code indicating the name of the IV antibiotic administered for GBS prophylaxis.

**Suggested Data Collection Question:** What is the name of the IV antibiotic administered for GBS prophylaxis?

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

**Allowable Values:**
1 = Ampicillin
2 = Cefazolin
3 = Clindamycin
5 = Penicillin
6 = Vancomycin
7 = Other

*Note: (4= Erythromycin has been removed as a recommended choice for prophylaxis)*

**Notes for Abstraction:** Data is collected on the last administration of the intrapartum intravenous antibiotic for GBS prophylaxis.

Only the allowable values should be abstracted. For a crosswalk of Trade and Generic Names, consult Table 2.1 of Appendix C in the appropriate version of the NHIQM Specifications Manual. If the medical record contains two antibiotic names within the appropriate timeframe, abstract the antibiotic name that matches one of the names on the list of allowable values first before choosing an "Other" antibiotic.

A physician order is not sufficient to abstract this data; there must be documentation that the medication was administered.

**Suggested Data Sources:**
Delivery room record
IV flowsheet
Labor and delivery flow sheet
Labor and delivery summary
Medication administration record (MAR)
Nursing notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Birthdate*

**Collected For:** All MassHealth 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 birthdate to yield the most accurate age.

**Suggested Data Collection Question:** What is the patient's date of birth?

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

**Allowable Values:**
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (1880 – 9999)

**Notes for Abstraction:** Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the date of birth on the claim information.

**Suggested Data Sources:**
Emergency department record
Face sheet
Registration form

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Cesarean Delivery*

**Collected For:** MAT-1

**Definition:** Documentation that a Cesarean delivery prior to Onset of Labor with Intact Membranes was performed.

**Suggested Data Collection Question:** Is there documentation that a Cesarean delivery was performed prior to the onset of labor with intact membranes?

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation that a Cesarean delivery prior to the onset of labor with intact membranes was performed. |
| N (No) | There is no documentation that a Cesarean delivery prior to the onset of labor with intact membranes was performed. |

**Notes for Abstraction:** Both conditions must be met (prior to onset of labor with intact membranes) in order to select Y (Yes).

If there is documentation of "labor" by the physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant, or registered nurse, select N (No).

If it is unclear if membranes have ruptured (ie question of leak) or no clear documentation of ruptured membranes AND prior to onset of labor, select Y (Yes).

**Suggested Data Sources:** Delivery note
Discharge summary
History and physical
Progress notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Cesarean Section Incision Time*

**Collected For:** MAT-2a

**Definition:** The time (military time) the initial incision was made for the Cesarean section procedure.

**Suggested Data Collection Question:** At what time was the initial incision made for the Cesarean section procedure?

**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*

Military Time – A 24-hour period from midnight to midnight using a four digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

Converting clock time to military time:
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:

| | Correct Entry | | Correct Entry |
|---|---|---|---|
| Midnight = | 00:00 | Noon = | 12:00 |
| 5:31 am = | 05:31 | 5:31 pm = | 17:31 |
| 11:59 am = | 11:59 | 11:59 pm = | 23:59 |

**Notes for Abstraction:** Follow the priority order below. If multiple times are found, abstract the earliest time found within the highest priority grouping.

**First Priority:** Incision Time = Cut time

**Second Priority:**

- Begin time
- Operation start time
- Procedure start time
- Start of surgery (SOS)
- Surgery start time
- Symbol used on grid and indicated in legend to be incision time

**Third Priority:**

- Skin time

**Fourth priority:**

- Anesthesia begin time
- Anesthesia start time
- Operating room start time

Example #1: If surgery start time is documented at 10:10 and skin time is documented at 10:05, abstract 10:10 for the data element Cesarean Section Incision Time since surgery start time is in the second priority.

**Notes for Abstraction: continued**

Example #2: If documentation of 15:10 for anesthesia start time and 15:20 for operating room start time are found in the medical record, abstract 15:10 for the data element Cesarean Section Incision Time since this is the earliest time found within the fourth priority, anesthesia time.

00:00 = midnight.

If the time of initial incision is unable to be determined from medical record documentation, enter "UTD".

**Suggested Data Sources:**

Anesthesia record
Circulation record
Nursing notes
Operative report
Progress notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Cesarean Section Start Date*

**Collected For:** MAT-2a

**Definition:** The date (month, day, and year) the Cesarean section procedure started.

**Suggested Data Collection Question:** On what date did the Cesarean section procedure start?

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

**Allowable Values:**
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2000 – 9999)
*UTD* = *Unable to Determine*

**Notes for Abstraction:** If the date the Cesarean section procedure was started is unable to be determined from medical record documentation, enter "UTD".

**Suggested Data Sources:**
Anesthesia record
Circulation record
Nursing notes
Operative report
Progress notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Clinical Trial*

**Collected For:** All MassHealth 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:** Clinical trials are organized studies to provide large bodies of clinical data for strategically valid evaluation or treatment. These studies are usually rigorously controlled tests of new drugs, invasive medical devices, or therapies on human subjects.

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.
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.

Select "No" for this data element if the signed consent form is for an observational study only, it is not clear whether the study described in the signed consent form is experimental or observational, or it is not clear which study population the clinical trial is enrolling.

**Suggested Data Sources:** **ONLY ACCEPTABLE SOURCES:**
- Signed consent form for clinical trial

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Contact Information 24hrs/ 7 days*

**Collected For:** CCM-2

**Definition:** A transition record that included 24 hr/ 7 day Contact Information for emergencies related to the inpatient stay.

**Suggested Data Collection Question:** Does the Transition Record include 24 hr/ 7 day Contact Information for emergencies related to the inpatient stay?

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

**Allowable Values:**
Y (Yes) The transition record includes 24 hr/ 7 day Contact Information for emergencies related to the inpatient stay.

N (No) The transition record does not include 24 hr/ 7 day Contact Information for emergencies related to the inpatient stay.

**Notes for Abstraction:** *Any number listed that is answered 24 hours a day, 7 days a week.*

*Must be clear to the patient that this is the number to call for emergencies.*

*Examples:*
- *For any questions, please call your PCP at …*
- *24/7 Contact Information: Emergency Department phone number is ____*

**Suggested Data Sources:** Transition Record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| • Call 911<br>• Emergency Room Phone Number<br>• Primary Care Physician Phone Number<br>• Specialist Phone Number<br>• Discharging Unit Phone Number | |

**Data Element Name:** *Contact Information for Studies Pending at Discharge*

**Collected For:** CCM-2

**Definition:** A transition record that included Contact Information for obtaining results of studies pending at discharge.

**Suggested Data Collection Question:** Does the Transition Record include Contact Information for obtaining results of studies pending at discharge?

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | The transition record includes Contact Information for Studies Pending at Discharge or documentation of no Studies Pending at Discharge. |
| N (No) | The transition record does not include Contact Information for Studies Pending at Discharge or documentation of no Studies Pending at Discharge. |

**Notes for Abstraction:** If it is documented on the transition record that there are no studies pending at discharge, contact information for studies pending is not required and the abstractor should select Y (Yes).

Statements such as "Contact the Follow-up Physician listed above for any pending test results" will be accepted as long as the physician's name and phone number are documented on the transition record.
"Dr Jackson will discuss pending test results at your follow up appointment" will be accepted.
"MD to discuss at next visit" will NOT be accepted.

**Suggested Data Sources:** Transition Record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| • Primary Care Physician<br>• Name of Next Provider or Site of Care<br>• Specialist Office<br>• HIM/ Medical Records Department if phone number is provided | |

**Data Element Name:** *Current Medication List*

**Collected For:** CCM-2

**Definition:** A transition record that included a Current Medication List at discharge.

A Current Medication List includes all medications to be taken by the patient after discharge including all continued and new medications.

**Suggested Data Collection Question:** Does the Transition Record include a Current Medication List?

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | The Transition Record includes a current medication list at the time of discharge. |
| N (No) | The Transition Record does not include a current medication list at the time of discharge. |

**Notes for Abstraction:** *If the medication list is on a separate page from the transition record, there must be reference to see the attached medication list documented on the transition record.*

**Suggested Data Sources:** Transition Record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| | |

**Data Element Name:** *Delivery Date*

**Collected For:** MAT-1

**Definition:** The month, day, and year the baby was delivered.

The Delivery Date cannot be before the Admission Date or after the Discharge Date.

**Suggested Data Collection Question:** On what date was the infant delivered?

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

**Allowable Values:**
MM = Month (0-12)
DD = Day (01-31)
YYYY = Year (2000 – 9999)
*UTD* = *Unable to Determine*

**Notes for Abstraction:** If there are multiple births, abstract data on the infant born first.

If the delivery date is unable to be determined from medical record documentation, enter "UTD".

**Suggested Data Sources:**
Birth Certificate
Delivery note
Discharge summary
Labor and delivery flow sheet
Labor and delivery summary
Nursing notes
Physician progress notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Delivery Time*

**Collected For:** MAT-1

**Definition:** The time (military time) the baby was delivered.

**Suggested Data Collection Question:** At what time was the infant delivered?

**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*

Military Time – A 24-hour period from midnight to midnight using a four digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

Converting clock time to military time:
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:

| | Correct Entry | | Correct Entry |
|---|---|---|---|
| Midnight = | 00:00 | Noon = | 12:00 |
| 5:31 am = | 05:31 | 5:31 pm = | 17:31 |
| 11:59 am = | 11:59 | 11:59 pm = | 23:59 |

**Notes for Abstraction:** If there are multiple births;
abstract data on the infant born first for MAT-1.

00:00 = midnight.

If the time of delivery is unable to be determined from medical record documentation, enter "UTD".

If multiple delivery times are documented in the medical record:

- abstract the earliest time for MAT-1

**Suggested Data Sources:**
Birth Certificate
Delivery note
Discharge summary
Labor and delivery flow sheet
Labor and delivery summary
Nursing notes
Physician progress notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Discharge Date*

**Collected For:** All MassHealth Records

**Definition:** The month, day, and year the patient was discharged from acute care, left against medical advice (AMA), 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 during this stay?

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

**Allowable Values:**
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2000 – 9999)

**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, for purposes of abstraction, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.

**Suggested Data Sources:**
Discharge summary
Face sheet
Nursing discharge notes
Physician orders
Progress notes
Transfer note

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Discharge Disposition*

**Collected For:** All MassHealth Records

**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 from the day of or the day before 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".

- Consider discharge disposition documentation in the discharge summary or a post-discharge addendum as day of discharge documentation, regardless of when it was dictated/written.
- 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.
- 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"
- To select value "7" there must be explicit documentation that he patient left against medical advice.

**Suggested Data Sources:**
Discharge instruction sheet
Discharge planning notes
Discharge summary
Nursing discharge notes

***Suggested Data Sources continued:***

Physician orders
Progress notes
Social service notes
Transfer record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| For Value 1:<br>• Assisted Living Facilities<br>• Court/Law Enforcement- includes detention facilities, jails, prison<br>• Home- includes board and care, foster or residential care, group or personal care homes, and homeless shelters<br>• Home with Home Health Services<br>• Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs and Partial Hospitalization<br><br>For Value 3:<br>• Hospice Care- General Inpatient and Respite<br>• Hospice Care- Residential and Skilled Facilities<br>• Hospice Care- Other Health Care Facilities (excludes home)<br><br>For Value 4:<br>• Acute Short Term General and Critical Access Hospitals<br>• Cancer and Children's Hospitals<br>• Department of Defense and Veteran's Administration Hospitals<br><br>For Value 5:<br>• Extended or Immediate Care Facility (ECF/ICF)<br>• Long Term Acute Care Hospital (LTACH)<br>• Nursing Home or Facility including Veteran's Administration Nursing Facility<br>• Psychiatric Hospital or Psychiatric Unit of a Hospital<br>• Rehabilitation Facility including Inpatient Rehabilitation Facility/ Hospital or Rehabilitation Unit of a Hospital<br>• Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed<br>• Transitional Care Unit (TCU) | Any documentation prior to the day of or day before discharge |

**Data Element Name:** *Episode of Care*

**Collected For:** All MassHealth Records

**Definition:** The measure code for the data that is being submitted.

**Suggested Data Collection Question:** What is the measure code for the data being submitted?

**Format:**

| | |
|---|---|
| **Length:** | 22 |
| **Type:** | Alphanumeric |
| **Occurs:** | 1 |

**Allowable Values:**

| | |
|---|---|
| CAC | Children's Asthma Care (includes CAC 1a, 2a and 3) |
| CCM | Care Coordination (includes *CCM-1*, CCM-2, & CCM-3) *CCM-1 Effective with Q3-2012 discharges* |
| *ED* | *Emergency Department Times for admitted patients Effective with Q1-2013 discharges* |
| MAT-1 | Intrapartum Antibiotic Prophylaxis for GBS |
| MAT-2 | Perioperative Antibiotics for Cesarean Section (includes MAT-2a and MAT-2b) |
| MAT-3 | Elective Delivery |
| PN | Community Acquired Pneumonia |
| SCIP | Surgical Care Infection Prevention |

**Notes for Abstraction:** None

**Suggested Data Sources:** Not Applicable

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Ethnicity (DHCFP)*

**Collected For:** All MassHealth Records

**Definition:** A code indicating the patient's self-reported ethnicity as defined by Massachusetts DHCFP regulations.

**Suggested Data Collection Question:** What is the patient's self-reported ethnicity?

**Format:**
**Length:** 6
**Type:** Alphanumeric
**Occurs:** 1

**Allowable Values:** Select one:

| Code | Allowable Value | Code | Allowable Value |
|---|---|---|---|
| **2060-2** | African | **2071-9** | Haitian |
| **2058-6** | African American | **2158-4** | Honduran |
| **AMERCN** | American | **2039-6** | Japanese |
| **2028-9** | Asian | **2040-4** | Korean |
| **2029-7** | Asian Indian | **2041-2** | Laotian |
| **BRAZIL** | Brazilian | **2148-5** | Mexican, Mexican American, Chicano |
| **2033-9** | Cambodian | **2118-8** | Middle Eastern |
| **CVERDN** | Cape Verdean | **PORTUG** | Portuguese |
| **CARIBI** | Caribbean Island | **2180-8** | Puerto Rican |
| **2034-7** | Chinese | **RUSSIA** | Russian |
| **2169-1** | Columbian | **2161-8** | Salvadoran |
| **2182-4** | Cuban | **2047-9** | Vietnamese |
| **2184-0** | Dominican | **2155-0** | Central American (not specified) |
| **EASTEU** | Eastern European | **2165-9** | South American (not specified) |
| **2108-9** | European | **OTHER** | Other Ethnicity |
| **2036-2** | Filipino | **UNKNOW** | Unknown/not specified |
| **2157-6** | Guatemalan | | |

**Notes for Abstraction:**

The Massachusetts DHCFP codes and allowable values for ethnicity differ significantly from ones required for National Hospital Inpatient Quality Measures reporting. Hospitals must use the DHCFP ethnicity codes and allowable values when preparing all MassHealth data files for submission. Section 2 Table 2.4 *contains a comparison chart on allowable values and the DHCFP hierarchy for ethnicity reporting.*

Only collect ethnicity data that is self-reported by the patient. Do not abstract a clinician's assessment documented in the medical record.

The terms "nationality" and "culture" are synonymous to ethnicity.

If numeric code is used, include the hyphen after the fourth number.

If the medical record contains conflicting documentation on patient self-reported ethnicity, abstract the most recent dated documentation. If the medical record contains multiple patient self-reported ethnicities on one document, abstract the first self-reported ethnicity listed (e.g. – American/Irish/French, select American).

If the medical record contains 1) self reported as Unknown or 2) no ethnicity can be found in the medical record, select "UNKNOW".

If the ethnicity documented in the medical record is not listed in any of the allowable values in Section 2, Table 2.3, select "OTHER".

If codes and allowable values, other than those listed above, are documented in the medical record, a crosswalk that links the hospitals' codes/values to the DHCFP requirements must be provided for chart validation.

**Suggested Data Sources:**

Administrative record
Face sheet (Emergency Department / Inpatient)
Nursing admission assessment
Prenatal initial assessment form

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *First Name*

**Collected For:** All MassHealth Records

**Definition:** The patient's first name.

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

**Format:**
**Length:** 30
**Type:** Alphanumeric
**Occurs:** 1

**Allowable Values:** Enter the patient's first name.

**Notes for Abstraction:** None

**Suggested Data Sources:** Emergency department record
Face sheet
History and physical

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *GBS Bacteriuria*

**Collected For:** MAT-1

**Definition:** Documentation that the mother had GBS bacteriuria at any time during this pregnancy.

GBS Bacteriuria is defined as the presence of any GBS reported on a urine culture (not a vaginal/rectal culture).

**Suggested Data Collection Question:** Is there documentation that the mother had GBS bacteriuria at any time during this pregnancy?

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation that the mother had GBS bacteriuria at any time during this pregnancy. |
| N (No) | There is no documentation that the mother had GBS bacteriuria at any time during this pregnancy or unable to determine from medical record documentation. |

**Notes for Abstraction:** GBS Bacteriuria must be documented for the current pregnancy.

A urinary tract infection during pregnancy is not necessarily GBS. There must be documentation of GBS bacteriuria to select Y(Yes).

**Suggested Data Sources:**
History and physical
Lab reports
Pre-natal record
Physician progress notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *GBS Screening*

**Collected For:** MAT-1

**Definition:** Documentation of results of the mother's vaginal and rectal screening culture for GBS performed at 35 weeks 0 days – 37 weeks 6 days gestation or within 5 weeks prior to birth.

**Suggested Data Collection Question:** What is the result of the mother's vaginal and rectal screening culture for GBS performed at 35 weeks 0 days – 37 weeks 6 days or within 5 weeks prior to birth?

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

**Allowable Values:**

P Positive: there is documentation that the mother's vaginal and rectal screening culture for GBS performed at 35 weeks 0 days – 37 weeks 6 days gestation or within 5 weeks prior to birth was positive.

N Negative: there is documentation that the mother's vaginal and rectal screening culture for GBS performed at 35 weeks 0 days – 37 weeks 6 days gestation or within 5 weeks prior to birth was negative.

U Unknown / Unable to Determine or not performed within specified time frame

**Notes for Abstraction:** Documentation must indicate that the screening culture was performed between the 35th and 37th week (35 weeks 0 days – 37 weeks 6 days) of pregnancy or within 5 weeks prior to birth, if not, select U "Unknown/ Unable to Determine".

If the GBS vaginal and rectal screening culture results are documented, but there is no documentation as to when the culture was performed, select U "Unknown/ Unable to Determine".

**Suggested Data Sources:**
Delivery note
History and physical
Lab reports
Labor and delivery flow sheets
Labor and delivery summary
Prenatal record
Physician progress notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Gestational Age*

**Collected For:** MAT-1, MAT-3

**Definition:** The gestational age of the infant in completed weeks 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 gestation results in a live birth or fetal death.*

**Suggested Data Collection Question:** What was the infant's gestational age at the time of delivery?

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

**Allowable Values:**
In completed weeks
No leading zero
UTD

**Notes for Abstraction:** Use completed weeks of gestation, do not "round up". For example, an infant born at 35 weeks 6 days is at a gestational age of 35 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.*

If the gestational age is unable to be determined from medical record documentation, enter "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.*

*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 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 multiple gestational ages are documented, abstract the last gestational age documented prior to birth. The phrase "estimated gestational age" is an acceptable descriptor for gestational age.

*The clinician admission progress note may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN).*

**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*

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Gestational Age < 37 Weeks*

**Collected For:** MAT-1

**Definition:** A gestational age at the time of delivery less than 37 weeks.

**Suggested Data Collection Question:** Is there documentation that the gestational age of the infant at the time of delivery was less than 37 weeks?

**Format:**

| | |
|---|---|
| **Length:** | 1 |
| **Type:** | Alphanumeric |
| **Occurs:** | 1 |

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation that the gestational age of the infant at the time of delivery was less than 37 weeks. |
| N (No) | There is no documentation that the gestational age of the infant at the time of delivery was less than 37 weeks or unable to determine from medical record documentation. |

**Notes for Abstraction:** None

**Suggested Data Sources:**
Delivery note
History and physical
Labor and delivery flow sheets
Labor and delivery summary
Progress notes
Nursing notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Hispanic Indicator (DHCFP)*

**Collected For:** All MassHealth Records

**Definition:** Documentation that the patient self-reported as Hispanic, Latino, or Spanish.

**Suggested Data Collection Question:** Is there documentation that the patient self-reported as Hispanic, Latino, or Spanish?

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

**Allowable Values:**
Y (Yes) Patient self-reported as Hispanic / Latino / Spanish.

N (No) Patient did not self-report as Hispanic / Latino / Spanish or unable to determine from medical record documentation.

**Notes for Abstraction:** The Massachusetts DHCFP definition for Hispanic Indicator differs from the definition used for National Hospital Inpatient Quality Measures reporting. Hospitals must use the DHCFP definition and allowable values when preparing all MassHealth data files for submission. Section 2, Table 2.3 contains a comparison chart on allowable values and definitions for Hispanic Indicator reporting.

Only collect data that is self-reported by the patient. Do not abstract a clinician's assessment documented in the medical record.

If the medical record contains conflicting documentation on patient self-reported Hispanic Indicator, abstract the most recent dated documentation. If the patient's self-reported Race is Hispanic, abstract "Yes" for Hispanic Indicator.

**Suggested Data Sources:**
Administrative records
Face sheet (Emergency Department / Inpatient)
Nursing admission assessment
Prenatal initial assessment form

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| The term "Hispanic" or "Latino" can be used in addition to "Spanish origin" to include a person of Spanish culture or origin regardless of race. | None |

**Data Element Name:** *Hospital Bill Number*

**Collected For:** All MassHealth Records

**Definition:** The unique number assigned to each patient's bill that distinguishes the patient and their bill from all others in that institution as defined by Massachusetts DHCFP.

**Suggested Data Collection Question:** What is the patient's hospital bill number?

**Format:**
**Length:** 20
**Type:** Alphanumeric
**Occurs:** 1

**Allowable Values:** Up to 20 letters and/ or numbers

**Notes for Abstraction:** None

**Suggested Data Sources:** Face sheet

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *ICD-9-CM Other Diagnosis Codes*

**Collected For:** All MassHealth Records

**Definition:** The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the diagnosis for this hospitalization.

**Suggested Data Collection Question:** What were the ICD-9-CM other diagnosis codes selected for this medical record?

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

**Allowable Values:** Any valid ICD-9-CM diagnosis code

**Notes for Abstraction:** None

**Suggested Data Sources:** Discharge summary
Face sheet

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *ICD-9-CM Other Procedure Codes*

**Collected For:** All MassHealth Records

**Definition:** The International Classification of Diseases, Ninth Revision, Clinical Modification (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 other procedure(s) for this record?

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

**Allowable Values:** Any valid ICD-9-CM diagnosis code

**Notes for Abstraction:** None

**Suggested Data Sources:** Discharge summary
Face sheet

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *ICD-9-CM Other Procedure Dates*

**Collected For:** All MassHealth 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 (included dashed) or UTD
**Type:** Date
**Occurs:** 24

**Allowable Values:**
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2001 – Current Year)
UTD = Unable to Determine

**Notes for Abstraction:**

- If the procedure date for the associated procedure is unable to be determined from the medical record, select "UTD".
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not 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 records 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 abstractor should select "UTD"

Notes: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *ICD-9-CM Other Procedure Dates* allows the case to be accepted in the warehouse

**Suggested Data Sources:**
Consultation notes
Diagnostic test reports
Discharge summary
Face sheet
Operative notes
Procedure notes
Progress notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *ICD-9-CM Principal Diagnosis Code*

**Collected For:** All MassHealth Records

**Definition:** The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code associated with the diagnosis established after study to be chiefly responsible for occasioning the admission of the patient for this hospitalization.

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

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

**Allowable Values:** Any valid ICD-9-CM diagnosis code

**Notes for Abstraction:** The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

**Suggested Data Sources:**
Discharge summary
Face sheet

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *ICD-9-CM Principal Procedure Code*

**Collected For:** All MassHealth Records

**Definition:** The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code that identifies the principal procedure performed during this hospitalization. The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

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

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

**Allowable Values:** Any valid ICD-9-CM diagnosis code

**Notes for Abstraction:** The principal procedure as described by the Uniform Hospital Discharge Data Set (UHDDS) is one performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

**Suggested Data Sources:**
Discharge summary
Face sheet

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *ICD-9-CM Principal Procedure Date*

**Collected For:** All MassHealth 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 dashes) or UTD
**Type:** Date
**Occurs:** 1

**Allowable Values:**
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2001-Current Year)
UTD = Unable to Determine

**Notes for Abstraction:** If the principal procedure date is unable to be determined from medical record documentation, select "UTD"

The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not valid date/format or is outside of the parameters of care [after *Discharge Date*]) **and** no other documentation is found that provides this information, the abstractor should select "UTD"
Examples:

- Documentation indicates the *ICD-9-CM Principal Procedure Date* was 02-42-20xx. No other documentation n the medical record provides a valid date. Since the *ICD-9- CM Principal Procedure Date* is outside of the range listed in the Allowable Values for "Day", it is not a valid date and the abstractor should select "UTD"
- Patient expires on 02-12-20xx 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".

Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *ICD-9-CM Principal Procedure Dat*e allows the case to be accepted into the warehouse.

**Suggested Data Sources:**
Consultation notes
Diagnostic test reports
Discharge summary
Face sheet
Operative notes
Procedure notes
Progress notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Infection Prior to Cesarean Section*

**Collected For:** MAT-2a and MAT-2b

**Definition:** Documentation the patient had, or was suspected to have, an infection during this hospitalization prior to the Cesarean section procedure or that the patient's amniotic membranes were ruptured for 18 or more hours.

**Suggested Data Collection Question:** Is there documentation that the patient had a confirmed or suspected infection during this hospitalization prior to the Cesarean section or that the patient's amniotic membranes were ruptured for 18 or more hours?

**Format:**

**Length:** 1
**Type:** Alphanumeric
**Occurs:** 1

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is physician / advanced practice nurse (APN)/ physician assistant (PA) documentation that the patient had a confirmed or suspected infection during this hospitalization prior to the Cesarean section procedure or that the patient's amniotic membranes were ruptured for 18 or more hours. |
| N (No) | There is no physician / APN / PA documentation that the patient had a confirmed or suspected infection during this hospitalization prior to the Cesarean section procedure or that the patient's amniotic membranes were ruptured for 18 or more hours, or unable to determine from medical record documentation. |

**Notes for Abstraction:**

If there is documentation of an infection or possible / suspected infection, select "Yes."

If there is documentation the amniotic membranes were ruptured for 18 or more hours, select "Yes."

Documentation of symptoms (example: fever, elevated white blood cells, etc.) should not be considered infections unless documented as an infection or possible/suspected infection.

If a patient has a principal ICD-9-CM diagnosis code suggestive of pre-operative infectious diseases (as defined in Appendix A Table 5.09 of the Specifications Manual for National Hospital Inpatient Quality Measures) *the abstractor should select Y(Yes).*

A positive result on GBS Screening is not evidence of infection.

*Documentation of suspected or confirmed chorioamnionitis, select Y(Yes).*

**Suggested Data Sources:**

Anesthesia record
History and physical
Progress notes

**Guidelines for Abstraction:**

| Inclusions | Exclusions |
|---|---|
| Refer to Appendix A, Table 5.09 in the appropriate version of the Specifications Manual for National Hospital Inpatient Quality Measures. | Colonized MRSA<br>History (Hx) of MRSA<br>Viral infections |

**Data Element Name:** *Intrapartum Antibiotics*

**Collected For:** MAT-1

**Definition:** Documentation the patient received IV antibiotics for GBS prophylaxis in the intrapartum period.

**Suggested Data Collection Question:** Is there documentation that the patient received IV antibiotics for GBS prophylaxis in the intrapartum period?

**Format:**

| | |
|---|---|
| **Length:** | 1 |
| **Type:** | Alphanumeric |
| **Occurs:** | 1 |

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation that the patient received IV antibiotics for GBS prophylaxis in the intrapartum period. |
| N (No) | There is no documentation that the patient received IV antibiotics for GBS prophylaxis in the intrapartum period or unable to determine from medical record documentation. |

**Notes for Abstraction:** Intrapartum is defined as during labor and delivery or childbirth.

**Suggested Data Sources:**
Delivery note
Discharge summary
Labor and delivery flow sheet
Labor and delivery summary
Medication administration record (MAR)
Physician notes
Physician orders

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Intrapartum Temperature*

**Collected For:** MAT-1

**Definition:** Documentation that a temperature taken on the mother during the intrapartum period was greater than or equal to 100.4 F (38.0 C).

**Suggested Data Collection Question:** Is there documentation that a temperature taken on the mother during the intrapartum period was greater than or equal to 100.4 F (38.0 C)?

**Format:**

| | |
|---|---|
| **Length:** | 1 |
| **Type:** | Alphanumeric |
| **Occurs:** | 1 |

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation that a temperature taken on the mother during the intrapartum period was greater than or equal to 100.4 F (38.0 C). |
| N (No) | There is no documentation that a temperature taken on the mother during the intrapartum period was greater than or equal to 100.4 F (38.0 C) or unable to determine from medical record documentation. |

**Notes for Abstraction:** Intrapartum is defined as during labor and delivery or childbirth.

**Suggested Data Sources:**
History and physical
Labor and delivery flow sheet
Physician notes
Nursing notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *IV Antibiotic for Cesarean Section Prophylaxis*

**Collected For:** MAT-2a and MAT-2b

**Definition:** Documentation the patient received an IV antibiotic for Cesarean section prophylaxis.

**Suggested Data Collection Question:** Is there documentation that the patient received an IV antibiotic for Cesarean section surgical prophylaxis?

**Format:**

| | |
|---|---|
| **Length:** | 1 |
| **Type:** | Alphanumeric |
| **Occurs:** | 1 |

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation that the patient received an IV antibiotic for Cesarean section surgical prophylaxis. |
| N (No) | There is no documentation that the patient received an IV antibiotic for Cesarean section surgical prophylaxis or unable to determine from medical record documentation. |

**Notes for Abstraction:** None

**Suggested Data Sources:**
Anesthesia record
IV flowsheet
Medication administration record (MAR)
Nursing notes
Operating room record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *IV Antibiotic (Non-GBS) – MAT-1*

**Collected For:** MAT-1

**Definition:** Documentation the patient received an intravenous (IV) antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to delivery.

**Suggested Data Collection Question:** Is there documentation that the patient received an IV antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to delivery?

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation that the patient received an IV antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to delivery. |
| N (No) | There is no documentation that the patient received an IV antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to delivery or unable to determine from medical record documentation. |

**Notes for Abstraction:** This question refers to IV antibiotics administered for reasons other than GBS or Cesarean section prophylaxis. The reason can be documented or undocumented.

*A physician order alone is not sufficient to abstract this data, there must also be documentation that the medication was administered.*

Do not select "Yes" for intravenous antibiotics administered prior to the birth admission.

**Suggested Data Sources:**
Discharge summary
History and physical
*Medication administration record (MAR)*
*Physician notes*
Progress notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *IV Antibiotic (Non-GBS) – MAT-2a,2b*

**Collected For:** MAT-2a and MAT-2b

**Definition:** Documentation the patient received an intravenous (IV) antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to surgical incision time.

**Suggested Data Collection Question:** Is there documentation that the patient received an IV antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to surgical incision time?

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

**Allowable Values:**

Y (Yes) There is documentation that the patient received an IV antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to surgical incision time.

N (No) There is no documentation that the patient received an IV antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to surgical incision time or unable to determine from medical record documentation.

**Notes for Abstraction:** *This question refers to IV antibiotics administered for reasons other than GBS or Cesarean section prophylaxis. The reason can be documented or undocumented.*

A physician order alone is not sufficient to abstract this data, there must also be documentation that the medication was administered.

*Do not select "Yes" for intravenous antibiotics administered prior to the birth admission.*

**Suggested Data Sources:** *Discharge summary*
*History and physical*
Medication administration record (MAR)
Physician notes
*Progress notes*

Guidelines for Abstraction:

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Last Name*

**Collected For:** All MassHealth Records

**Definition:** The patient's last name.

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

**Format:**
**Length:** 60
**Type:** Alphanumeric
**Occurs:** 1

**Allowable Values:** Enter the patient's last name.

**Notes for Abstraction:** None

**Suggested Data Sources:** Emergency department record
Face sheet
History and physical

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Live Newborn*

**Collected For:** MAT-1

**Definition:** Documentation the baby delivered was born alive

**Suggested Data Collection Question:** Is there documentation that the mother delivered a live newborn?

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation that the mother delivered a live newborn. |
| N (No) | There is documentation that the mother *did not* deliver a live newborn or unable to determine from medical record documentation. |

**Notes for Abstraction:** In cases of multiple births and one infant is born alive, select "Yes".

*For deliveries resulting in stillbirths identified by ICD-9-CM principal and secondary diagnosis codes of V27.1, V27.3, V27.4, V27.6, V27.7, the abstractor may select N(No).*

**Suggested Data Sources:**
Birth certificate
Delivery note
Discharge summary
Nurses notes
Physician progress notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Major Procedures and Tests*

**Collected For:** CCM-2

**Definition:** A transition record includes the Major Procedures and Tests that were significant and relevant to the care of the patient performed during inpatient stay and a Summary of Results.

**Suggested Data Collection Question:** Does the Transition Record include the Major Procedure(s) and Test(s) and a Summary of Results?

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | The transition record includes the Major Procedure(s) and Test(s) and a Summary of Results or documentation of No Major Procedures and Tests. |
| N (No) | The transition record does not include the Major Procedure(s) and Test(s) and a Summary of Results or documentation of No Major Procedures and Tests. |

**Notes for Abstraction:** Some examples of Major Procedures/ Tests and Summary of results that will be accepted:

| | | |
|---|---|---|
| -C-section | *-CXR w/ infiltrate* | *- Knee replacement* |
| -Vaginal delivery | *-Heart cath w/ stent* | *- Blood culture- abnormal* |
| *-CT Scan- normal* | *-Appendectomy* | |

There must be a summary of results for each major procedure or test documented.

Any reference to actual study results or summary results will answer Y (Yes). Example: "Echo results pending," "Abnormal results to be discussed with physician," "Within normal limits," "Complicated," "Abnormal," or the actual test results

*Surgical Procedures documented do not require a summary of the results. Example: Appendectomy would not require a summary of the results.*

The definition requires documentation of Major Procedures and Tests and a Summary of Results or documentation of none. If there is documentation of No major procedures or tests/ None/ N/A, the abstractor should select Y (Yes).

In the event of a transfer to another facility or nursing home, if there is documentation on the transition record that copies of all procedures and tests performed during inpatient stay were transported with the patient to the receiving facility, this element may be documented as Y (Yes).

**Suggested Data Sources:** Transition Record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| *Normal/ Abnormal*<br>*Within normal limits*<br>*Results to be discussed with physician* | |

**Data Element Name:** *MassHealth Member ID*

**Collected For:** All MassHealth Records

**Definition:** The patient's MassHealth Member ID.

**Suggested Data Collection Question:** What is the patient's MassHealth Member ID?

**Format:**
**Length:** *20*
**Type:** Alphanumeric
**Occurs:** 1

**Allowable Values:**
Any valid MassHealth Member ID number
Alpha characters must be upper case
No embedded dashes or spaces or special characters

**Notes for Abstraction:**

*The Provider Regulations define a valid MassHealth Member ID as a twelve (12) digit number that contains numeric characters only. This 12 digit member ID number applies to members enrolled within various Medicaid managed care or fee-for-service insurance programs.*

*However, some MassHealth managed care insurance plans may issue different MassHealth member ID numbers that use alphanumeric type and exceed the 12 digit numeric requirement. For the purposes of measures reporting the "format length" was expanded to 20 fields within the portal environment only. This portal edit allows data files that may exceed the 12 characters to not be rejected by the portal. The change in the portal environment* ***does not*** *constitute a change to existing MassHealth Provider Regulation definitions of member ID number.*

*Once a member is assigned a MassHealth ID number it will not change through the duration of their enrollment or if they change managed care plans (e.g.: coverage changed from fee-for-service to an MCO plan).Member ID numbers can be verified using the on-line Eligibility Verification System (EVS) at:*

http://www.mass.gov/eohhs/provider/insurance/masshealth/claims/eligibility-verification/. *EVS provides historical data on a member for any given point in time that can be reviewed by entering a particular date of service.*

The abstractor should NOT assume that *their hospital's* claim information for the patient's MassHealth Member ID number is correct. If the abstractor determines through chart review that the MassHealth Member ID number is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.

**Suggested Data Sources:**
Emergency department record
Face sheet

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Maternal Allergies*

**Collected For:** MAT-1, MAT-2b

**Definition:** Documentation the patient has an allergy, sensitivity, or intolerance to any of the recommended antibiotic classes for this measure. An allergy can be defined as an acquired, abnormal immune response to a substance (allergen) that does not normally cause a reaction.

**Suggested Data Collection Question:** Is there documentation that the patient has allergies, sensitivities, or intolerances to any of the recommended antibiotic classes for this measure?

**Format:**

| | |
|---|---|
| **Length:** | 1 |
| **Type:** | Alphanumeric |
| **Occurs:** | 1 |

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation that the patient has an allergy, sensitivity, or intolerance to any of the recommended antibiotic classes for this measure**.** |
| N (No) | There is no documentation that the patient has an allergy, sensitivity, or intolerance to any of the recommended antibiotic classes for this measure or unable to determine from medical record documentation. |

**Notes for Abstraction:** This question should only be answered if "Other" was selected as the prophylactic antibiotic.

If a physician/advanced practice nurse/physician assistant (physician/APN/PA) documents a specific reason(s) not to give any of the recommended antibiotic classes for this measure, select "Yes."

The antibiotic classes include:
MAT-1: Penicillins/Beta lactams, cephalosporins, lincosamides, or glycopeptides.

MAT-2b: Penicillins/Beta lactams, cephalosporins, or aminoglycosides.

**Suggested Data Sources:**
Consultation notes
History and physical
Medication administration record (MAR)
Nursing admission assessment
Nursing notes
Physician orders
Progress notes

**Guidelines for Abstraction:**

| Inclusions | Exclusion |
|---|---|
| Symptoms include:<br>Adverse effect<br>Adverse reaction<br>Anaphylaxis<br>Anaphylactic reaction<br>Hives<br>Rash | None |

**Data Element Name:** *National Provider ID*

**Collected For:** All MassHealth Records

**Definition:** The provider's ten digit national provider identifier.

**Suggested Data Collection Question:** What is the provider's ten digit national provider identifier?

**Format:**
**Length:** 10
**Type:** Alphanumeric
**Occurs:** 1

**Allowable Values:** Any valid ten digit national provider ID.

**Notes for Abstraction:** Hospitals must submit either their valid Medicare or Medicaid Provider ID or their National Provider ID for all MassHealth maternity measure files.

**Suggested Data Sources:** Administrative record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Other Surgeries*

**Collected For:** MAT-2a and MAT-2b

**Definition:** Other procedures requiring general or spinal/epidural anesthesia that occurred within three days prior to or after the principal procedure during this hospital stay.

**Suggested Data Collection Question:** Were there any other procedures requiring general or spinal anesthesia that occurred within three days prior to or after the principal procedure during this hospital stay?

**Format:**

| | |
|---|---|
| **Length:** | 1 |
| **Type:** | Alphanumeric |
| **Occurs:** | 1 |

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation of another procedure requiring general or spinal/epidural anesthesia that occurred within three days prior to or after the principal procedure during this hospital stay. |
| N (No) | There is no documentation of any other procedure requiring general or spinal/epidural anesthesia that occurred within three days prior to or after the principal procedure during this hospital stay or unable to determine from medical record documentation. |

**Notes for Abstraction:** The following are two scenarios that must be clarified:

- If multiple procedures are performed during the same surgical episode, select "No."
- If other procedures are performed during separate surgical episodes requiring general or spinal/epidural anesthesia and occur within three days of the principal procedure during this hospital stay, select "Yes."

**Suggested Data Sources:**
Admitting physician orders
Admitting progress notes
Consultation notes
Discharge summary
Emergency department record
History and physical
Nursing notes
Operative notes/reports
Physician admission notes
Physician progress notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Patient Identifier* *(formerly Hospital Patient Identifier)*

**Collected For:** All MassHealth Records

**Definition:** The identification number used by the Hospital to identify this patient.

**Suggested Data Collection Question:** What is the patient's hospital patient identification number?

**Format:**
**Length:** 40
**Type:** Alphanumeric
**Occurs:** 1

**Allowable Values:** Up to 40 letters and / or numbers

**Notes for Abstraction:** When abstracting this data element for a clinical measure file, the data in this field must match the hospital patient ID number submitted in the corresponding crosswalk file.

**Suggested Data Sources:** Administrative record
Face sheet

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Patient Instructions*

**Collected For:** CCM-2

**Definition:** A transition record that included patient instructions (discharge instructions) related to the inpatient stay.

**Suggested Data Collection Question:** Does the Transition Record include Patient Instructions?

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | The transition record includes Patient Instructions |
| N (No) | The transition record does not include Patient Instructions |

**Notes for Abstraction:** Patient instructions include post-discharge patient self-management instructions.

*If the discharge instructions are on a separate page from the transition record, there must be reference to see the attached discharge instructions documented on the transition record.*

*Patient instructions should be transmitted to the next provider of care with the Transition Record.*

**Suggested Data Sources:** Transition Record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| | |

**Data Element Name:** *Payer Source (DHCFP)*

**Collected For:** All MassHealth Records

**Definition:** Source of payment for services provided.

**Suggested Data Collection Question:** *What is the patient's primary source of payment for care provided?*

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

**Allowable Values:** *Payment source code values assigned by DHCFP include*:

- 103 Medicaid - includes MassHealth Fee-for-Service, and includes "MassHealth Limited"
- 104 Medicaid Managed Care – Primary Care Clinician (PCC) Plan
- 108 Medicaid Managed Care - Fallon Community Health Plan
- 110 Medicaid Managed Care – Health New England
- 113 Medicaid Managed Care – Neighborhood Health Plan
- 118 Medicaid Mental Health/Substance Abuse Plan- Mass Behavioral Health Partnership
- 207 Network Health - Cambridge Health Alliance MCD Program
- 208 HealthNet – Boston Medical Center MCD Program
- 119 Medicaid Managed Care Other (not listed elsewhere). *This code is a catchall for other insurance products that existed or new products that may arise during a given time period. These products may be assigned different revenue codes by the hospital depending on how they use it.*
- 98 Healthy Start
- 178 Children's Medical Security Plan (CMSP)

**Notes for Abstraction:**

***Primary source of payment is a MassHealth insurance program:***

- *If Medicaid is the only payer listed (see payer codes above);*
- *If Medicaid is primary and another secondary insurance is listed.*

***Primary source of payment is NOT a MassHealth insurance program:***

- *If Medicare is the only payer listed;*
- *If Medicare is primary and lists Medicaid as secondary(ex: dual eligible)*
- *If HMO/Commercial Plan and lists Medicaid as secondary*

**Suggested Data Sources:** Face sheet (Emergency Department / Inpatient)
*UB-04, filed location, 50A, B, C*

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Plan for Follow-up Care*

**Collected For:** CCM-2

**Definition:** A transition record that included a Plan for Follow-up Care related to the inpatient stay *OR documentation by a physician of no follow-up care required OR patient is a transfer to another inpatient facility*.

**Suggested Data Collection Question:** Does the Transition Record include a Plan for Follow-up Care related to the inpatient stay *OR documentation by a physician of no follow-up care required OR patient is a transfer to another inpatient facility?*

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

**Allowable Values:**

Y (Yes) The transition record includes a Plan for Follow-up Care *OR documentation by a physician of no follow-up care required OR patient is a transfer to another inpatient facility.*

N (No) The transition record does not include a Plan for Follow-up Care.

**Notes for Abstraction:** The Plan for Follow-up Care may include:

- *Follow-up appointments*
- Any post-discharge therapy needed (eg oxygen therapy, physical therapy, or occupational therapy)
- Any durable medical equipment needed
- Family/ psychosocial resources available for patient support, etc.

A scheduled appointment or specific instructions for the patient to call within a certain timeframe to make an appointment with a specific physician/ health care professional will be accepted.
Example: Call Dr Jackson for appointment in 1 week.
*Dr Jackson's office to call patient with appointment date/time*.

*If the patient does not have a primary care physician, then the patient can be referred to a healthcare clinic for follow up*.

*If it is documented that the patient has declined any plan for follow-up care OR a primary care provider or clinic cannot be identified, then the patient can be referred to the Emergency Department for emergent care.*

In the event the patient is transferred to another inpatient facility where the plan for follow-up care will be determined at the time of discharge from that facility, this element may be documented as Y (Yes).

If it is determined and documented by the physician that the patient requires no follow-up care, documentation of this on the transition record will be acceptable and Y(Yes) should be selected.

**Suggested Data Sources:** Transition Record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| • Instruction for patient to call specific physician / health care professional to schedule appointment within a specific time frame<br>• A scheduled appointment<br>• Oxygen therapy<br>• Physical therapy<br>• Occupational therapy<br>• DME | |

**Data Element Name:** *Postal Code*

**Collected For:** All MassHealth Records

**Definition:** The postal code of the patient's residence. For the United States zip codes, the hyphen is implied. If the patient is determined to not have a permanent residence, then the patient is considered homeless.

**Suggested Data Collection Question:** What is the postal code of the patient's residence?

**Format:**
**Length:** 9
**Type:** Alphanumeric
**Occurs:** 1

**Allowable Values:** Any valid five or nine digit postal code or "HOMELESS" if the patient is determined not to have a permanent residence. If the patient is not a resident of the United States, use "Non-US."

**Notes for Abstraction:** If the postal code of the patient is unable to be determined from medical record documentation, enter the provider's postal code.

**Suggested Data Sources:** Face sheet
Social service notes

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Previous Infant with Invasive GBS*

**Collected For:** MAT-1

**Definition:** Documentation that the patient delivered a previous infant with invasive GBS disease.

**Suggested Data Collection Question:** Is there documentation that the patient delivered a previous infant with invasive GBS disease?

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

**Allowable Values:**
Y (Yes) There is documentation that the patient delivered a previous infant with invasive GBS disease.

N (No) There is no documentation that the patient delivered a previous infant with invasive GBS disease or unable to determine from medical record documentation.

**Notes for Abstraction:** None

**Suggested Data Sources:**
History and physical
Prenatal record
Physician progress note

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Primary Physician/Health Care Professional for Follow-up Care*

**Collected For:** CCM-2

**Definition:** A transition record that included the name of the Primary Physician or other Health Care Professional or site designated for follow-up care.

**Suggested Data Collection Question:** Does the Transition Record include the Primary Physician or other Health Care Professional or site designated for follow-up care?

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | The transition record includes the Primary Physician or other Health Care Professional or site designated for follow-up care. |
| N (No) | The transition record does not include the Primary Physician or other Health Care Professional or site designated for follow-up care. |

.

**Notes for Abstraction:** May be the designated primary care physician (PCP), a medical specialist, other physician or health care professional, or site. The health care provider's name must be specified *except for a site such as a nursing home when the physician name may not be known.*

In the event the patient is transferred to another inpatient facility where the plan for follow-up care will be determined at the time of discharge from that facility, this element may be documented as Y (Yes).

If the patient is transferred to a nursing home and the physician designated for follow-up is unknown, "nursing home physician" will be accepted and this element may be documented as Y (Yes).

If a follow-up appointment is made with a clinic where the physician / other health care professional is not known at the time of the appointment, this element may be documented as Y (Yes).
Ex. Follow up appointment made at GI Clinic in one week

*If it is determined and documented by the physician that the patient requires no follow-up care, the patient's primary physician or other health care professional or site designated for care should be documented. The transition record should be transmitted to the next provider even if there is no follow-up care required.*

**Suggested Data Sources:** Transition Record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| Specific physician name<br>*Clinic or site name*<br>*Transferred* | |

**Data Element Name:** *Principal Diagnosis at Discharge*

**Collected For:** CCM-2

**Definition:** A transition record that included the Principal Diagnosis at discharge.

**Suggested Data Collection Question:** Does the Transition Record include the Principal Diagnosis at discharge?

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

**Allowable Values:**
Y (Yes) The transition record includes the Principal Diagnosis at discharge.

N (No) The transition record does not include the Principal Diagnosis at discharge.

**Notes for Abstraction:** *The principal diagnosis at discharge must be specifically documented as the discharge diagnosis.*

*If the admission and discharge diagnosis are the same, documentation of "Same" for the discharge diagnosis will be accepted. The abstractor should select Y (Yes).*

**Suggested Data Sources:** Transition Record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| • Discharge diagnosis<br>• Final diagnosis<br>• Primary diagnosis at discharge<br>• *Principal diagnosis* | *Post-op diagnosis*<br>*Secondary diagnosis* |

**Data Element Name:** *Prior Uterine Surgery*

**Collected For:** *MAT-3*

**Definition:** Documentation that the patient experienced prior uterine surgery, i.e., classical cesarean section, myomectomy.

**Suggested Data Collection Question:** Is there documentation that the patient experienced prior uterine surgery, i.e., classical cesarean section, myomectomy?

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

**Allowable Values:**
1. The medical record contains documentation that the patient experienced a prior classical cesarean section.
2. The medical record contains documentation that the patient experienced a prior myomectomy.
3. The medical record does not contain documentation that the patient experienced a prior classical cesarean section or prior myomectomy OR unable to determine from medical record documentation.

**Notes for Abstraction:** The **only** prior uterine surgeries considered for the purposes of the measure are classical cesarean section and myomectomy.

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

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| | |

**Data Element Name:** *Provider ID*

**Collected For:** All MassHealth Records

**Definition:** The provider's seven digit acute care Medicaid or six digit Medicare provider identifier.

**Suggested Data Collection Question:** What is the provider's seven digit acute care Medicaid or six digit Medicare provider identifier?

**Format:**
**Length:** 7
**Type:** Alphanumeric
**Occurs:** 1

**Allowable Values:** Any valid seven digit Medicaid or six digit Medicare provider ID.

**Notes for Abstraction:** Hospitals must submit either their valid Medicare or Medicaid Provider ID or their National Provider ID for all MassHealth measure files.

**Suggested Data Sources:** Administrative record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Provider Name*

**Collected For:** All MassHealth Records

**Definition:** The name of the provider of acute care inpatient services.

**Suggested Data Collection Question:** What is the name of the provider of acute care inpatient services?

**Format:**
**Length:** 60
**Type:** Alphanumeric
**Occurs:** 1

**Allowable Values:** Provider name

**Notes for Abstraction:** The provider name is the name of the hospital.

**Suggested Data Sources:** Face sheet

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Race (DHCFP)*

**Collected For:** All MassHealth Records

**Definition:** A code indicating the patient's self-reported race as defined by the Massachusetts DHCFP regulations.

**Suggested Data Collection Question:** What is the patient's self-reported race?

**Format:**
**Length:** 6
**Type:** Alphanumeric
**Occurs:** 1

**Allowable Values:** Select one:

| Code | Race |
|---|---|
| R1 | American Indian or Alaska Native: |
| R2 | Asian: |
| R3 | Black / African American: |
| R4 | Native Hawaiian or other Pacific Islander: |
| R5 | White. |
| R9 | Other Race: |
| UNKNOW | Unknown / not specified: |

**Notes for Abstraction:** The Massachusetts DHCFP codes and allowable values for race listed above differ significantly from ones required for National Hospital Quality Measures reporting. Hospitals must use the DHCFP race codes and allowable values when preparing all MassHealth data files for submission. Section 2, Table 2.3, contains a comparison chart on allowable values.

Only collect race data that is self-reported by the patient. Do not abstract a clinician's assessment documented in the medical record.

If the medical record contains conflicting documentation on patient self-reported race, abstract the most recent dated documentation. If the medical record contains multiple patient self-reported races on one document, abstract the first self-reported race listed (e.g. – Black/Asian, select Black).

If the patient self reports as Hispanic, the Race selected is "Other Race".

If codes and allowable values, other than those listed above, are documented in the medical record, a crosswalk that links the hospitals' codes/values to the DHCFP requirements must be provided for chart validation.

**Suggested Data Sources:**
Administrative records
Face sheet (Emergency Department / Inpatient)
Nursing admission assessment
Prenatal initial assessment form

**Guidelines for Abstraction:**

| Inclusions | Exclusion |
|---|---|
| • **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliations or community attachment, e.g. any recognized tribal entity in North and South America (including Central America), Native American.<br><br>• **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.<br><br>• **Black / African American:** A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro", can be used in addition to "Black or African American".<br><br>• **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.<br><br>• **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa, e.g., Caucasian, Iranian, White.<br><br>• **Other Race:** A person having an origin other than what has been listed above.<br><br>• **Unknown:** Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide). | None |

**Data Element Name:** *Reason for Inpatient Admission*

**Collected For:** CCM-2

**Definition:** A transition record that included the Reason for Inpatient Admission.

**Suggested Data Collection Question:** Does the Transition Record include the Reason for Inpatient Admission?

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

**Allowable Values:**
Y (Yes) The transition record includes the Reason for Inpatient Admission.

N (No) The transition record does not include the Reason for Inpatient Admission.

**Notes for Abstraction:** Documentation of a diagnosis, symptoms, or procedure is acceptable *for Reason for Admission.*

**Suggested Data Sources:** Transition Record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| • *This list is not all-inclusive*<br>• Reason for Admission<br>• Admission diagnosis<br>• *Primary diagnosis*<br>• *Chief complaint* | |

**Data Element Name:** *Reconciled Medication List*

**Collected For:** *CCM-1*

**Definition:** A reconciled medication list was received by the patient/caregiver(s) at the time of discharge including, at the minimum, medications in the categories "Discontinued," "Continued," and "New" with documentation of the dosage, route, and frequency on continued and new medications.

**Suggested Data Collection Question:** Did the patient/ caregiver(s) receive a copy of the reconciled medication list at the time of discharge?

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

**Allowable Values:**

Y (Yes) The patient/caregiver(s) received a reconciled medication list at the time of discharge.

N (No) The patient/caregiver(s) did not receive a reconciled medication list that the time of discharge.

**Notes for Abstraction:**

**Discontinued** – Medications that should be discontinued or held after discharge, AND
**Continued –** Medications (including any prescribed before inpatient stay and any started during inpatient stay) that patient should continue to take after discharge, AND
**New –** Newly prescribed medications that patient should begin taking after discharge.

In the case of electronic health records, when determining that the New, Continued, and Discontinued sections of the medication reconciliation form are present, if one or more of the sections is missing, and it is determined that there are no medications ordered that would be included in those sections, you may answer "YES" to this element.

Example: If there are no medications to be discontinued at discharge, and there is no discontinued section in the electronic health record due to this fact, then this would be acceptable.

In the event the medication reconciliation form is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.

Prescribed dosage, instructions, and intended duration if applicable (ex Amoxicillin PO x 10 days), must be included for each *continued* and *new* medication list.

If discharge medications are noted using only references such as "continue home meds", "resume other meds, " or "same medications," rather than list the names of the discharge medications, the abstractor should select N (No).

Oxygen should not be considered a medication.

Medication which the patient will not be taking at home (and/or the caregiver will not be giving at home) are NOT required in the medication list included in the written discharge instructions (e.g., monthly B12 injections, intermittent IV dobutamin, Natrecor infusions, dialysis meds, chemotherapy)

If the patient refused written discharge instructions/ material which addressed discharge medications, select Y(Yes).

Do not give credit in cases where the patient was given written discharge medication instructions only in the form of written prescriptions.

**Suggested Data Sources:** Medication Reconciliation Form provided to the patient at discharge

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| Reconciled medication list that includes new, continued, and discontinued medications with documentation of the dosage, route, and frequency of the new and continued medications | |

**Data Element Name:** *Sample*

**Collected For:** All MassHealth Records

**Definition:** Indicates if the data being transmitted for a hospital has been sampled, or represent an entire population for the specified time period.

**Suggested Data Collection Question:** Does this case represent part of a sample?

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

**Allowable Values:**
Y (Yes) The data represents part of a sample.

N (No) The data is not part of a sample; this indicates the hospital is abstracting 100 percent of the discharges eligible for this topic.

**Notes for Abstraction:** None

**Suggested Data Sources:** Not Applicable

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Sex*

**Collected For:** All MassHealth Records

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

**Suggested Data Collection Question:** What was the patient's sex on arrival at the hospital?

**Format:**
**Length:** 1
**Type:** Alphanumeric
**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 determine and select "Unknown" if:
- The patient refuses to provide their sex
- Documentation is contradictory
- Documentation indicates the patient is a transsexual
- 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

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Spontaneous Rupture of Membranes*

**Collected For:** MAT-3

**Definition:** Documentation that the patient had spontaneous rupture of membranes (SROM) before medical induction and/or cesarean section.

**Suggested Data Collection Question:** Is there documentation that the patient had spontaneous rupture of membranes before medical induction and/or cesarean section?

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

**Allowable Values:**

Y (Yes) There is documentation that the patient had spontaneous rupture of membranes before medical induction and/or cesarean section

N (No) There is no documentation that the patient had spontaneous rupture of membranes before medical induction and/or cesarean section OR unable to determine from medical record documentation.

**Notes for Abstraction:** If the patient's spontaneous rupture of membranes is confirmed before medical induction and/or cesarean section by one of the following methods, select the allowable value "Yes"

- Positive ferning test
- Positive nitrazine test
- Positive pooling (gross fluid in vagina)
- Positive Amnisure test or equivalent
- Patient report or SROM prior to hospital arrival

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

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| None | None |

**Data Element Name:** *Studies Pending at Discharge*

**Collected For:** CCM-2

**Definition:** A transition record that included the Studies Pending at Discharge or documentation that no studies are pending.

**Suggested Data Collection Question:** Does the Transition Record include documentation of Studies Pending at Discharge or that no studies were pending?

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | The transition record includes documentation of studies pending at discharge or documentation that no studies were pending. |
| N (No) | The transition record does not include documentation of studies pending at discharge or documentation that no studies were pending. |

**Notes for Abstraction:** The definition requires documentation of Studies Pending at Discharge or documentation of none. If there is documentation of No studies pending/ None/ N/A, the abstractor should select Y (Yes).

*Any studies pending must be listed, not just documented as "Yes" on the transition record.*

**Suggested Data Sources:** Transition Record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| • No studies pending, None, NA<br>• Tissue Pathology Studies<br>• Radiology Studies<br>• Biopsy Reports<br>• CT Scan results<br>• X-ray results<br>• Lab results | |

**Data Element Name:** *Transition Record*

**Collected For:** CCM-2

**Definition:** *Transition Record, including any or all of the required elements, received by the patient/ caregiver(s) at the time of discharge.*

*Transition Record, document(s) defined by the hospital, should include* information that contains a standardized minimum core set of (11) data elements relevant to the patient's diagnosis and treatment that is discussed with and provided to the patient, and transmitted in a timely manner to the healthcare professional entity (physician, facility, other health professional) providing follow-up care.

Core set of Required Elements (11):

- Advance Care Plan
- Contact Information 24 hrs/7 days
- Contact Information for Studies Pending
- Current Medication List
- Major Procedures and Tests
- Patient Instructions
- Plan for Follow-up Care
- Primary Physician/ Health Care Professional for Follow-up Care
- Principal Diagnosis at Discharge
- Reason for Inpatient Admission
- Studies Pending at Discharge

**Suggested Data Collection Question:** Did the patient/ caregiver(s) receive a transition record at the time of discharge?

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | The patient/caregiver(s) received a transition record at the time of discharge. |
| N (No) | The patient/caregiver(s) did not receive a transition record at the time of discharge. |

**Notes for Abstraction:** The data elements may be found on a single source or multiple sources but the source must be provided to the patient and transmitted to the facility, physician, or other health care professional providing follow-up care.

When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/ caregiver has signed the material.

*The caregiver is defined as the patient's family or any other person (e.g., home health, VNA provider, prison official, or other law enforcement personnel) who will be responsible for care of the patient after discharge.*

Documents used for the Transition Record may include, but are not limited to:

- Transition Record
- Discharge Instructions
- Care Coordination Documentation Form
- Transfer Forms
- Any document that includes ANY or ALL of the Care Coordination elements and is signed by the patient, the patient's caregiver, or staff will be used for abstraction during the validation process.

**Suggested Data Sources:** Transition Record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| | |

**Data Element Name:** *Transmission Date*

**Collected For:** CCM-3

**Definition:** The month, day, and year the transition record given to the patient was transmitted to the facility or physician or other health care professional designated for follow-up care.

The transmission date may be the day of discharge or within the following 2 days.

**Suggested Data Collection Question:** What was the date the Transition Record was transmitted?

**Format:**

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

**Allowable Values:**

| | | |
|---|---|---|
| MM | = | Month (01-12) |
| DD | = | Day (01-31) |
| YYYY | = | Year (2000 – 9999) |
| *UTD* | **=** | *Unable to determine/ No transmission date* |

**Notes for Abstraction:** A transition record was transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure email, or mutual access to an electronic health record within 2 days of discharge. Any documentation used to complete the Transition Record must be transmitted with the Transition Record (ex. Medication Reconciliation Form, Discharge Instructions)

In the case of Electronic Medical Records (EMR), there must be an electronic record by discharging staff confirming that the information has been transmitted to the next provider of care.

In the case of mutual access, there must be documented notification to the provider that the patient has been discharged and the transition record elements are ready for review. The next provider of care having access to the EMR without notification is not enough to pass this measure.

*If the Emergency Room is the referral for follow-up, mutual access is the assumed answer and the date of discharge may be documented for the Transmission Date.*

A transition record given to the patient to hand carry to physician is not acceptable.

In the case of a transfer to acute or sub-acute facility by EMS transport, the transmission date of the transition record elements may be documented as the discharge date.

*Select UTD if no date of transmission can be found in the medical record selected.*

*In the case of a fax transmission, there must be documentation of the date the fax was sent to the next provider.*

**Suggested Data Sources:** Transition Record

**Guidelines for Abstraction:**

| Inclusion | Exclusion |
|---|---|
| • Faxed<br>• Secure Email<br>• Mail<br>• EMR with proper documentation of notification to next provider of care | • Hand carried by patient |