Release Notes for the 2015B Manual

Measure Information Forms

Section	Rationale	Description
PC	Mothers population is now identified via ICD-10-PCS Procedure Codes. For the newborns with BSI population some birth weight tables were removed due to the conversion to ICD-10-CM Diagnosis Codes. For the Newborns with Breast Feeding population, Premature Newborns table was removed and a new abstracted decision point was added to the PC-05 measure definition.	**Change** Initial Patient Population definition and flow for PC-Mother from using ICD Diagnosis Codes from table 11.01, 11.02, 11.03, or 11.04 to use the ICD-10-PCS Procedure Codes from table 11.01.1 **Remove** ICD-9-CM Tables 11.13.1, 11.16.1 and 11.17 from Other Diagnosis Codes check from Initial Patient Population definition and flow for PC-BSI, Newborns with BSI, Sub-population. **Remove** ICD-9-CM Table 11.23 from Other Diagnosis Codes check from Initial Patient Population definition and flow for PC-BF, Newborns with Breast Feeding, Sub-population

PC-01	The included numerator populations for medical induction of labor require a manual review for labor, since the ICD-10-PCS Procedure Codes are not specific to labor induction alone. The included denominator populations are now identified via ICD-10-PCS Procedure Codes.	**Change** the numerator included populations to:
		
		ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for one or more of the following:
		• Medical induction of labor as defined in Appendix A, Table 11.05 while not in *Labor* prior to the procedure
		• Cesarean birth as defined in Appendix A, Table 11.06 and all of the following:
		  ○ not in *Labor*
		  ○ no history of a *Prior Uterine Surgery*
		
		Change the first bullet under denominator included populations to:
		• *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1
		
		Algorithm Changes

		Add *Labor* check when *ICD-10-PCS Principal or Other Procedure Codes* at least one on table 11.05 • When *labor* is Yes, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. • When *labor* is No, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. • When *labor* is missing, the case will proceed to a Measure Category Assignment of X and will be rejected.
PC-02	The name was changed to conform with the ACOG standardized description which is now cesarean birth. The included denominator populations are now identified via ICD-10-PCS Procedure Codes.	**Change** the measure name to Cesarean Birth. All instances of cesarean section have been changed to cesarean birth throughout the specifications manual. **Change** the first bullet under denominator included populations to: • *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1 **Algorithm Change** **Change** Data Element name from *Parity* to *Number of Previous Live Births*
PC-03	Language changes were made to conform with the ACOG standardized description which is now antenatal steroids initiated. The included denominator populations are now identified via ICD-10-PCS Procedure Codes.	**Change** the numerator statement to: Patients with antenatal steroids initiated prior to delivering preterm newborns **Change** the numerator included populations to: Antenatal steroids initiated (refer to Appendix C, Table 11.0, antenatal steroid medications **Change** the denominator populations to: • *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1 **Change** the fifth bullet under denominator excluded populations to: Documented *Reason for Not Initiating Antenatal Steroids* **Algorithm Change** **Change** Data Element from *Antenatal Steroid Therapy Initiated* to *Antenatal Steroids Initiated* **Change** Data Element from *Reason for Not Initiating Antenatal Steroid Therapy* to *Reason for Not Initiating Antenatal Steroids*
PC-04	Some birth weight tables were removed due to the conversion to ICD-10-CM Diagnosis Codes. A new	**Change** the numerator included populations to: • *ICD-10-CM Other Diagnosis Codes* for newborn septicemia or bacteremia as defined in Appendix A, Table 11.10 with a *Bloodstream Infection Confirmed* OR

	data element was added at the numerator level to confirm whether a BSI had occurred after the first 48 hours after admission.	• *ICD-10-CM Other Diagnosis Codes* for sepsis as defined in Appendix A, Table 11.10.1 with a *Bloodstream Infection Confirmed*
		
		Add the following Numerator Data Element:
		
		Bloodstream Infection Confirmed
		
		Change the Denominator Included Populations to:
		
		• ICD-10-CM Other Diagnosis Codes for birth weight between 500 and 1499g as defined in Appendix A, Table 11.12, 11.13 or 11.14 OR *Birth Weight* between 500 and 1499g
		OR
		• ICD-10-CM Other Diagnosis Codes for birth weight ≥ 1500g as defined in Appendix A, Table 11.15 or 11.16 OR *Birth Weight* ≥ 1500g who experienced one or more of the following:
		  ○ Experienced death
		  ○ *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for major surgery as defined in Appendix A, Table 11.18
		  ○ *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for mechanical ventilation as defined in Appendix A, Table 11.19
		  ○ Transferred in from another acute care hospital or health care setting within 2 days of birth
		
		Change the second bullet under Data Accuracy to:
		
		• Since Birth Weight is a risk factor for hospital associated blood stream infections in newborns, ICD-10-CM codes have been provided in Appendix A, Tables 11.12-11.16, 11.20 to assist in identifying newborns with prematurity and fetal growth retardation to denote birth weight (less than 500 grams up to birth weight 2000-2499 grams). Therefore, newborns with birth weights greater than or equal to 2500 grams will need to be captured using the data element Birth Weight.
		
		Algorithm Change
		
		Removed Table 11.13.1, 11.16.1 and 11.17 from ICD-10-CM Other Diagnosis Codes check
		
		Add a new data element named *Bloodstream Infection Confirmed* if ICD-10-CM Other Diagnosis at least one on Table 11.10 or 11.10.1
		• When *Bloodstream Infection Confirmed* is Yes, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population.
		• When *Bloodstream Infection Confirmed* is No, the case will proceed to a Measure Category Assignment of D and will be in the Denominator Population.
		• When *Bloodstream Infection Confirmed* is Missing, the case will proceed to a Measure Category Assignment of X and and will be rejected.

PC-05	*Term Newborn* was added as a new data element in order to more accurately identify the denominator population. The name of Table 11.22 was changed to better reflect the intent of the exclusion. PC-05a was removed in its entirety in order to allow more focus on the population health measure PC-05. Maternal medical conditions were removed from the measure, since these concepts cannot be modeled in the eCQM and this will better reflect a true rate for exclusive breast milk feeding.	**Remove** all references to PC-05a throughout the measure information form and algorithm **Add** the Denominator data element *Term Newborn* **Change** the third bullet under Denominator Excluded Populations to: • *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for parenteral nutrition as defined in Appendix A, Table 11.22 **Remove** the seventh bullet under Denominator Excluded Populations: • Documented *Reason for Not Exclusively Feeding Breast Milk* **Remove** the last bullet under Denominator Excluded Populations: • *ICD-10-CM Other Diagnosis Codes* for premature newborns as defined in Appendix A, Table 11.23 **Add** the following bullet under Denominator Excluded Populations: • Patients who are not term or with < 37 weeks gestation completed **Remove** the Denominator Data Element *Reason for Not Exclusively Feeding Breast Milk* **Algorithm Changes:** **Add** a new data element *Term Newborn* • If *Term Newborn* is Missing, the case will proceed to a Measure Category Assignment of X and will be rejected. • If *Term Newborn* equals No, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing. • If *Term Newborn* equals Yes, continue processing and proceed to _Admission to NICU. **Remove** the data element *Reason for Not Exclusively Feeding Breast Milk* **Remove** PC-05a

Data Elements

Section	Rationale	Description
Antenatal Steroids Initiated	The language was changed to comform with the ACOG standardized description which is now antenatal steroids initiated.	**Change** the data element name to: Antenatal Steroids Initiated **Change** the definition to: Documentation that antenatal steroids were initiated before delivery. Initial antenatal steroids are 12mg betamethasone IM or 6mg dexamethasone IM. **Change** the suggested data collection question to: Is there documentation that antenatal steroids were initiated before delivery?

		Change the notes for abstraction to: If there is documentation that antenatal steroids were initiated prior to current hospitalization in another setting of care, i.e., doctor's office, clinic, birthing center, hospital before delivery, select allowable value "yes". If antenatal steroids were initiated in the hospital, the name of the medication must be documented in the medical record in order to select allowable value "yes". **Change** the allowable values to: Y (Yes) There is documentation that antenatal steroids were initiated before delivery. N (No) There is no documentation that antenatal steroids were initiated before delivery OR unable to determine from medical record documentation.
Appropriate Justification for Multiple Antipsychotic Medications	Clarification was added for documentation requirements for failed trials of monotherapy and a cross-taper plan and a recommended plan to taper to monotherapy.	**Change** the third and fourth paragraphs under the Notes for Abstraction to: "Failed multiple trials of monotherapy" comprises a history of three or more failed trials by history in which there was a lack of sufficient improvement in symptoms or functioning. The documentation must include at a minimum the names of the antipsychotic medications that previously failed. A cross-taper plan is defined as a plan to decrease the dosage of one or more antipsychotic medications while increasing the dosage of another antipsychotic medication to a level which results in controlling the patient's symptoms with one antipsychotic medication. Both the recommended plan to taper to monotherapy and the cross-taper plan must include the name(s) of the medication(s) to be tapered.
Bloodstream Infection Present on Admission	A typo was corrected in the definition and additional guidance was added to the Notes for Abstraction based on recommendations from the PC Technical Advisory Panel.	**Change** the Definition to: Documentation in the medical record within the first 48 hours after admission that the patient had a bloodstream infection present on admission. This includes patients with positive blood cultures or inconclusive blood cultures when the patient is suspected of having a bloodstream infection or septicemia and is being treated for the condition. A blood culture can be defined as a culture of microorganisms from specimens of blood to determine the presence and nature of bacteremia. **Add** the following paragraph under to Notes for Abstraction: If there is documentation that a course of antibiotics was started within the first 48 hours after admission which lasted less than 7 days, select allowable value “no”.
Bloodstream Infection Confirmed	This data element was added to confirm if the origin	**Add** the data element *Bloodstream Infection Confirmed*.

	of an infection occurring after the first 48 hours was health care-associated or as a result of another newborn condition.	
Clinical Trial	Changes made to remain consistent with the CMS and Joint Commission aligned Specifications Manual for National Hospital Inpatient Quality Measures.	Definition **Remove:** HF, PN Allowable Values **Remove** in 'Yes' and in 'No': HF, PN Notes for Abstraction **Remove** under first bullet in '2': HF, PN **Remove:** HF: Only capture patients enrolled in clinical trials studying patients with heart failure (HF). PN: Only capture patients enrolled in clinical trials studying patients with pneumonia.
Continuing Care Plan-Discharge Medications	Clarifications were added throughout the data element that all medications must be listed, and that the EMR must be reviewed for all of the required documentation.	**Change** the Definition to: Documentation in the medical record of a continuing care plan which includes all discharge medications, including the dosage and indication for use OR that no medications were ordered at discharge. Such documentation should be transmitted to the next level of care provider by the **fifth post-discharge day.** **Change** the Suggested Data Collection Question to: Is there documentation in the medical record of a continuing care plan which includes all discharge medications, including the dosage and indication for use OR states no medications were ordered at discharge AND was the continuing care plan including discharge medications transmitted to the next level of care provider no later than the **fifth post-discharge day?** **Change** the Allowable Values to: 1 The medical record contains a continuing care plan which includes all discharge medications, including the dosage and indication for use or that no medications were ordered at discharge and was transmitted to the next level of care provider no later than the **fifth post-discharge day.** 2 The medical record contains a continuing care plan which includes all discharge medications, including the dosage and indication for use or that no medications were ordered at discharge but was not transmitted to the next level of care provider by the **fifth post-discharge day.** 3 The medical record does not contain a continuing care plan which includes all discharge

		medications, including the dosage and indication for use or that no medications were ordered at discharge or unable to determine from medical record documentation. **Change** the third and sixth bullet points under the Notes for Abstraction to: Abstract allowable value 1 if the continuing care plan is contained in an EMR, there is documentation that the next level of care provider has access to the complete hospital EMR AND the EMR includes all discharge medications, including the dosage and indication for use or that no medications were ordered at discharge. Methods for transmitting the post-discharge continuing care plan include, but are not limited to: U.S. mail, email, fax, EMR access, doctor's mailbox, transport personnel. Giving a copy of the continuing care plan to the patient does not comprise transmission.
Continuing Care Plan-Next Level of Care	Clarifications were added about the need to review the EMR for all required documentation, methods of transmission and removal of Axis III as it is no longer used.	**Change** the second, fifth and sixth bullets under the Notes for Abstraction to: Abstract allowable value 1 if the continuing care plan is contained in an EMR, there is documentation that the next level of care provider has access to the complete hospital EMR AND the EMR includes next level of care recommendations. Methods for transmitting the post-discharge continuing care plan include, but are not limited to: U.S. mail, email, fax, EMR access, doctor's mailbox, transport personnel. Giving a copy of the continuing care plan to the patient does not comprise transmission. Next level of care recommendations may include, but are not limited to: medical follow-up, social work and benefits follow-up, pending legal issues and peer support, i.e., Alcoholics Anonymous, Narcotics Anonymous.
Continuing Care Plan-Principal Discharge Diagnosis	Clarifications were added for methods of transmission and that the EMR must be reviewed for all of the required documentation.	**Change** the second and fifth bullets under the Notes for Abstraction to: Abstract allowable value 1 if the continuing care plan is contained in an EMR, there is documentation that the next level of care provider has access to the complete hospital EMR, AND the EMR includes the principal discharge diagnosis. Methods for transmitting the post-discharge continuing care plan include, but are not limited to: U.S. mail, email, fax, EMR access, doctor's mailbox, transport personnel. Giving a copy of the continuing care plan to the patient does not comprise transmission.
Continuing Care Plan-Reason for Hospitalization	Clarifications were added for methods of transmission and that the EMR must be reviewed for all of the required documentation.	**Change** the second and fifth bullet under the Noted for Abstraction to: Abstract allowable value 1 if the continuing care plan is contained in an EMR, there is documentation that the next level of care provider has access to the complete hospital EMR, AND the EMR includes the reason for hospitalization. Methods for transmitting the post-discharge continuing care plan include, but are not limited to:

		U.S. mail, email, fax, EMR access, doctor's mailbox, ambulance transport personnel. Giving a copy of the continuing care plan to the patient does not comprise transmission.
Event Date	Clarification was added for events crossing over midnight.	**Change** the third paragraph in the Notes for Abstraction to: When an event (*Event Type*) begins and ends on different dates (crosses midnight) this is considered 2 separate events; therefore, both dates must be documented in order to determine the total amount of time associated with each *Event Date*. If one of the event dates is missing, the event will be rejected.
Gestational Age	The definition and instructions for calculating gestational age were updated to follow the American College of Obstetricians and Gynecologists reVITALize Initiative recommendations. Additional clarification was added about patients with no prenatal care.	**Change** the Description to: The weeks of gestation completed at the time of delivery. Gestational age is defined as the best obstetrical estimate (OE) of the newborn's gestation in completed weeks based on the birth attendant's final estimate of gestation, irrespective of whether the gestation results in a live birth or a fetal death. This estimate of gestation should be determined by all perinatal factors and assessments such as ultrasound, but not the newborn exam. Ultrasound taken early in pregnancy is preferred (source: American College of Obstetricians and Gynecologists reVITALize Initiative). **Change** the third and fourth paragraph under the Notes for Abstraction to: If the patient has not received prenatal care and no gestational age was documented, select allowable value UTD. Gestational age should be documented by the clinician as a numeric value between 1-50. Gestational age (written with both weeks and days, eg. 39 weeks and 0 days) is calculated using the best obstetrical Estimated Due Date (EDD) based on the following formula: Gestational Age = (280 - (EDD - Reference Date)) / 7 (source: American College of Obstetricians and Gynecologists reVITALize Initiative). The clinician, not the abstractor, should perform the calculation to determine gestational age. **Add** the following paragraph under the Notes for Abstraction: The EHR takes precedence over a hand written entry if different gestational ages are documented in equivalent data sources,e.g., delivery record and delivery summary. **Change** the first two bullets under Suggested Data Sources to: • Delivery record, note or summary • Operating room record, note or summary
ICD-10-CM Other Diagnosis Codes	The ICD-9 codes used to report medical diagnoses	**Change** data element name from: *ICD-9-CM Other Diagnosis Codes* to *ICD-10-CM Other Diagnosis Codes*

	and inpatient procedures are being replaced by ICD-10 codes per legislation.	Definition **Change**: ICD-9-CM to ICD-10-CM Suggested Data Collection Question **Change**: ICD-9-CM to ICD-10-CM Format: **Change** to: Length: 3 - 7 (without decimal point or dot; upper or lower case) Type: Character Occurs: 24 Allowable Values: **Change** to: Any valid diagnosis code as per the CMS ICD-10-CM master code table (2015 Code Descriptions in Tabular Order): http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html
ICD-10-CM Principal Diagnosis Code	The ICD-9 codes used to report medical diagnoses and inpatient procedures are being replaced by ICD-10 codes per legislation.	**Change** data element name from: *ICD-9-CM Principal Diagnosis Code* to *ICD-10-CM Principal Diagnosis Code* Definition **Change**: ICD-9-CM to ICD-10-CM Suggested Data Collection Question **Change**: ICD-9-CM to ICD-10-CM Format: **Change** to: Length: 3 - 7 (without decimal point or dot; upper or lower case) Type: Character Occurs: 1 Allowable Values: **Change** to: Any valid diagnosis code as per the CMS ICD-10-CM master code table (2015 Code Descriptions in Tabular Order): http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html

ICD-10-PCS Other Procedure Codes	The ICD-9 codes used to report medical diagnoses and inpatient procedures are being replaced by ICD-10 codes per legislation.	**Change** data element name from: *ICD-9-CM Other Procedure Codes* to *ICD-10-PCS Other Procedure Codes* Definition **Change**: ICD-9-CM to ICD-10-PCS Suggested Data Collection Question **Change**: ICD-9-CM to ICD-10-PCS Format: **Change** to: Length: 3 - 7 (without decimal point or dot; upper or lower case) Type: Character Occurs: 24 Allowable Values: **Change** to: Any valid procedure code as per the CMS ICD-10-PCS master code table (2015 PCS Long and Abbreviated Titles): http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-PCS-and-GEMs.html
ICD-10-PCS Other Procedure Dates	The ICD-9 codes used to report medical diagnoses and inpatient procedures are being replaced by ICD-10 codes per legislation.	**Change** data element name from: *ICD-9-CM Other Procedure Dates* to *ICD-10-PCS Other Procedure Dates* Definition **Change**: ICD-9-CM to ICD-10-PCS Notes for Abstraction **Change**: ICD-9-CM to ICD-10-PCS
ICD-10-PCS Principal Procedure Code	The ICD-9 codes used to report medical diagnoses and inpatient procedures are being replaced by ICD-10 codes per legislation.	**Change** data element name from: *ICD-9-CM Principal Procedure Code* to *ICD-10-PCS Principal Procedure Code* Definition **Change**: ICD-9-CM to ICD-10-PCS Suggested Data Collection Question **Change**: ICD-9-CM to ICD-10-PCS

		Format: **Change** to: Length: 3 - 7 (without decimal point or dot; upper or lower case) Type: Character Occurs: 1 Allowable Values: **Change** to: Any valid procedure code as per the CMS ICD-10-PCS master code table (2015 PCS Long and Abbreviated Titles): http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-PCS-and-GEMs.html
ICD-10-PCS Principal Procedure Date	The ICD-9 codes used to report medical diagnoses and inpatient procedures are being replaced by ICD-10 codes per legislation.	**Change** data element name from: *ICD-9-CM Principal Procedure Date* to *ICD-10-PCS Principal Procedure Date* Definition **Change**: ICD-9-CM to ICD-10-PCS Notes for Abstraction **Change**: ICD-9-CM to ICD-10-PCS
Initial Patient Population Size Medicare Only	Removing Stratification from SCIP measure set.	**Remove** SCIP from stratified measure set examples.
Initial Patient Population Size Non-Medicare Only	Removing Stratification from SCIP measure set.	**Remove** SCIP from stratified measure set examples.
Labor	Clarification was added to include physical changes as acceptable documentation of labor and guidance on how to determine induction of labor.	**Change** the definition to: Documentation by the clinician that the patient was in labor prior to induction and/or cesarean birth. **Change** the Suggested Data Collection Question to: Is there documentation by the clinician that the patient was in labor prior to induction and/or cesarean birth? **Change** the Allowable Values to: Y (Yes) There is documentation by the clinician that the patient was in labor prior to induction and/or cesarean birth. N (No) There is no documentation by the clinician that the patient was in labor prior to induction

		and/or cesarean birth OR unable to determine from medical record documentation.
		
		Change the third bullet under the Notes for Abstraction to:
		
		• Documentation of regular contractions with or without cervical change; i.e., dilation, effacement without mention of labor may be used to answer "yes" to labor.
		
		Add the following bullets under the Notes for Abstraction:
		
		• Induction of labor is defined as the use of medications or other methods to bring on (induce) labor. Methods of induction of labor include, but are not limited to:
		  ○ Administration of Oxytocin (Pitocin)
		  ○ Artificial rupture of membranes (AROM) or amniotomy
		  ○ Insertion of a catheter with an inflatable balloon to dilate the cervix
		  ○ Ripening of the cervix with prostaglandins, i.e. Cervidil, Prepidil, Cytotec, etc.
		  ○ Stripping of the membranes when the clinician sweeps a gloved finger over the thin membranes that connect the amniotic sac to the wall of the uterus.
		
		Add to the Suggested Data Sources:
		
		Medication administration record (MAR)

Minutes of Physical Restraint	Clarification was added about reporting of different event types which occur back to back.	**Add** the following paragraph under the Notes for Abstraction: If a patient is in *Event Type* 1 (physical restraint(s)) and then placed into *Event Type* 2 (seclusion), the time for *Event Type* 1 (physical restraint(s)) STOPS. The initiation of *Event Type* 2 (seclusion) stops the time for *Event Type* 1 (physical restraint(s)). **Delete** the last bullet under the Guidelines for Abstraction Exclusion.
Minutes of Seclusion	Clarification was added about reporting of different event types which occur back to back.	**Add** the following paragraph under the Notes For Abstraction: If a patient is in *Event Type* 2 (seclusion) and then placed into *Event Type* 1 (physical restraint(s)), the time for *Event Type* 2 (seclusion) STOPS. The initiation of Event Type 1 (physical restraint(s)) stops the time for *Event Type 2* (seclusion). **Delete** the last bullet under Guidelines for Abstraction Exclusion.
Number of Previous Live Births	The Parity data element was re-named and revised throughout to reflect only previous live births to enable the use of Vital Records reports for hospitals to obtain this information electronically.	**Change** the Name to: Number of Previous Live Births **Change** the Definition to: The number of deliveries resulting in a live birth the patient experienced prior to current hospitalization. **Change** the Suggested Data Collection Question to:

		How many deliveries resulting in a live birth did the patient experience prior to current hospitalization? **Change** the Notes for Abstraction to: Parity may be used for the number of previous deliveries resulting in a live birth if zero is documented. For any number greater than zero, parity may ONLY be used provided there is additional documentation indicating the same number of live births experienced prior to this hospitalization. The delivery or operating room record should be reviewed first for the number of previous live births. If the number of previous live births 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 the number of previous live births is found. In cases where there is conflicting data, the number of previous live births found in the first document according to the order listed in the Only Acceptable Sources should be used. If gravidity is documented as one, the number of previous live births should be considered zero. The previous delivery of live twins or any live multiple gestation is considered one live birth event. Documentation in the acceptable data sources may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN). It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the Only Acceptable Sources listed below. If primagravida or nulliparous is documented select zero for the number of previous live births. **Change** the first two bullets under the Suggested Data Sources to: • Delivery record, note or summary • Operating room record, note or summary **Change** the Inclusion and Exclusion under the Guidelines for Abstraction to: • None
Patient Referral to Next Level of Care Provider	Typo in the Additional Notes.	**Change** Additional Notes - corrected spelling of "regimen".

Patient Strengths	Clarification was added as to who can answer screening questions on behalf of the patient based on recommendations from the HBIPS Technical Advisory Panel.	**Add** under the Notes for Abstraction: If there is documentation that the patient is not a reliable historian, a relative or guardian if available, may answer the screening questions on behalf of the patient.
Prior Uterine Surgery	A new inclusion and clarifications were added to prior uterine surgeries based on advice from the PC Technical Advisory Panel.	**Change** the fourth bullet under the Guidelines for Abstraction Inclusion to: • History of a uterine window or thinning or defect of the uterine wall noted during prior uterine surgery or during a past or current ultrasound **Add** a new bullet under the Guidelines for Abstraction Inclusion: • History of transabdominal cerclage **Add** two new bullets under the Guidelines for Abstraction Exclusion: • History of an ectopic pregnancy without specifying cornual ectopic pregnancy • History of a cerclage without specifying transabdominal cerclage
Psychological Trauma History	Clarification was added as to who can answer screening questions on behalf of the patient based on recommendations from the HBIPS Technical Advisory Panel.	**Add** under the Notes for Abstraction: If there is documentation that the patient is not a reliable historian, a relative or guardian if available, may answer the screening questions on behalf of the patient.
Reason for Not Initiating Antenatal Steroids	Language changes were made to conform with the ACOG standardized term which is now antenatal steroids.	**Change** the data element name to: Reason for Not Initiating Antenatal Steroids **Change** the definition to: Reasons for not initiating antenatal steroids before delivery are clearly documented in the medical record. Reasons for not initiating antenatal steroids may include fetal distress, imminent delivery or other reasons documented by physician/advanced practice nurse (APN)/physician assistant (PA)/certified nurse midwife (CNM). Initial antenatal steroids are 12mg betamethasone IM or 6mg dexamethasone IM. **Change** the suggested data collection question to: Is there documentation in the medical record of reasons for not initiating antenatal steroids before delivery? **Change** the allowable values to: Y (Yes) There is documentation by physician/APN/PA/CNM that the patient has one or more reasons for not initiating antenatal steroids before delivery.

		N (No) There is no documentation by physician/APN/PA/CNM of a reason for not initiating antenatal steroids before delivery or unable to determine from medical record documentation. **Change** the notes for abstraction to: When determining whether there is a reason documented by a physician/APN/PA or CNM for not initiating antenatal steroids, reasons must be explicitly documented (e.g., "patient had an adverse reaction to the medication in the past - unable to initiate antenatal steroids") or clearly implied (i.e., there is documentation of an imminent delivery which occurs within 2 hours after admission to the hospital, there is documentation the fetus has anomalies which are not compatible with life, there is documentation that the patient has chorioamnionitis).
Sample Size Medicare Only	Removing Stratification from SCIP measure set.	**Remove** SCIP from stratified measure set examples.
Sample Size Non-Medicare Only	Removing Stratification from SCIP measure set.	**Remove** SCIP from stratified measure set examples.
Sample	Aggregation data is no longer required for Core Measures. HF and PN are retired.	**Remove** references to PN, HF, AMI and Aggregation.
Substance Use	Further documentation requirements for performing the screen and clarification has been added to the Notes for Abstraction based on recommendations from the HBIPS Technical Advisory Panel.	**Change** the Definition to: Documentation in the medical record that an admission screening for substance use and alcohol use which occurred over the past twelve (12) months was performed within the first three days of admission. The screening must include: the type, amount, frequency of use and any problems due to past use. **Change** the Suggested Data Collection Question to: Is there documentation in the medical record that the patient was screened for substance use and alcohol use which occurred over the past twelve (12) months within the first three days of admission? **Change** the Allowable Values to: Y (Yes) Documentation in the medical record includes a screening for substance use and alcohol use which occurred over the past twelve (12) months performed within the first three days of admission. N (No) Documentation in the medical record does not include a screening for substance use and alcohol use which occurred over the past twelve (12) months OR the screening was not performed within the first three days of admission OR unable to determine from medical record

		documentation. X (Unable to complete admission screening) Documentation in the medical record that a screening for substance use and alcohol use cannot be completed due to the patients inability or unwillingness to answer assessment questions within the first three days of admission OR patient has a previous admission to the psychiatric unit during a single hospitalization. **Add** under the Notes for Abstraction: • For the purpose of this data element, substance refers to alcohol, drugs and any other substances used for purposes other than intended. • If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, select the first admission to the psychiatric unit. • If there is documentation that the patient is not a reliable historian, a relative or guardian if available, may answer the screening questions on behalf of the patient. **Change** the second bullet under the Notes for Abstraction to: • A screening for substance use and alcohol use must be completed by a qualified psychiatric practitioner e.g., psychiatrist, registered nurse (RN), physicians assistant (PA) or Master of Social Work (MSW) within the first three days of admission. Titles of qualified psychiatric practitioners vary from state to state. **Change** Guidelines for Abstraction Inclusion to: Some examples of problems due to past substance and/or alcohol use include, but are not limited to: • Job loss • Feeling that life is out of control and fear of what might happen • Loss of family support • Arrested for drug possession • Sustained bodily harm for failure to pay for drugs • Girlfriend/boyfriend/spouse ended relationship • Loss of driver's license • Uncontrolled anger • Attempted suicide • Estranged from family members
Term Newborn	This new data element was added in order to more accurately identify term newborns for inclusion in the	**Add** the data element *Term Newborn*.

	denominator population for PC-05.	
Violence Risk to Others	Further documentation requirements for performing the screen and clarification has been added to the Notes for Abstraction based on recommendations from the HBIPS Technical Advisory Panel.	**Change** the Definition to: Documentation in the medical record that an admission screening for violence risk to others over the past six months was performed within the first three days of admission. Violence Risk to Others includes: threats of violence and/or actual commission of violence toward others. Documentation should include violence risk within the 6 months prior to admission AND any lifetime risk of violence to others beyond the 6 months prior to admission. **Add** to the Notes for Abstraction: • If there is documentation that the patient is not a reliable historian, a relative or guardian if available, may answer the screening questions on behalf of the patient.
Violence Risk to Self	Further documentation requirements for performing the screen and clarification has been added to the Notes for Abstraction based on recommendations from the HBIPS Technical Advisory Panel.	**Change** the Definition to: Documentation in the medical record that an admission screening for violence risk to self over the past six months was performed within the first three days of admission. Violence Risk to Self includes: ideation, plans/preparation and/or intent to act if ideation present, past suicidal behavior and risk/protective factors within the 6 months prior to admission. **Add** to the Notes for Abstraction: • If there is documentation that the patient is not a reliable historian, a relative or guardian if available, may answer the screening questions on behalf of the patient. **Change** under the Guidelines for Abstraction Inclusion to: Examples of risk factors may include but are not limited to: • Family history of suicide • Previous suicide attempt(s) • History of alcohol and substance abuse • History of mental disorders, particularly clinical depression • Feelings of hopelessness • Impulsive and/or aggressive tendencies • Cultural and religious beliefs, such as the belief that suicide is a noble resolution of a personal dilemma • Local clusters of suicide • Lack of social support and sense of isolation • Loss (relational, social, work, or financial) • Physical illness • Easy access to lethal means, e.g., weapons, etc.

		• History of trauma or abuse • Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts • Barriers to accessing mental health treatment • Exposure to others who have died by suicide (in real life or via the media and Internet) Examples of protective factors may include but are not limited to: • Receiving clinical care for mental, physical and substance use disorders • Access to a variety of clinical interventions and support for help seeking • Restricted access to highly lethal means of suicide, e.g., weapons, etc. • Interpersonal relationships and supports, i.e., family, friends, peers, community • Support through ongoing medical and mental health care relationships • Skills in problem solving, conflict resolution and nonviolent handling of disputes • Cultural and religious beliefs that discourage suicide and support self-preservation

Supplemental Materials

Section	Rationale	Description
Appendix A - ICD-10 Code Tables	The ICD-9 codes used to report medical diagnoses and inpatient procedures are being replaced by ICD-10 codes per legislation. The names of tables have been updated to better reflect the intent of the tables. Table 11.23 has been replaced with a data element.	**Change** all of the ICD-9 codes with ICD-10 codes. **Remove** Tables 11.01, 11.02, 11.03, 11.04, 11.13.1, 11.16.1, 11.17 and 11.23 **Add** Table 11.01.01 Delivery **Change** the name for Table 11.06 to: Cesarean Birth **Change** the name for Table 11.06.1 to: Planned Cesarean Birth in Labor **Change** the name for Table 11.22 to: Parenteral Nutrition
Appendix C - Medication Tables	A new medication was added to Table 10.0.	**Add** Abilify Maintena to the medication list and Aripiprazole to the Generic list on Table 10.0.
Appendix D - Glossary of Terms	PC data terms added using ACOG national standardized definitions. Updated Stratified and	**Add** the following terms: **cesarean birth** Birth of the fetus(es) from the uterus through an abdominal incision. Does not apply if any of the following occur: abdominal pregnancy, ectopic pregnancy. **clinical chorioamnionitis** Usually includes otherwise unexplained fever (at or above 38 degree

	Subset Measure to align with the CMS Performance Measures Manual.	C (100.4F)) with one or more of the following: uterine tenderness and/or irritability, leukocytosis, fetal tachycardia, maternal tachycardia or malodorous vaginal discharge. **estimated due date** The best estimated due date is determined by: last menstrual period if confirmed by early ultrasound or no ultrasound performed, or early ultrasound if no known last menstrual period or the ultrasound is not consistent with last menstrual period, or known date of fertilization (eg, assisted reproductive technology). **gravida** A woman who currently is pregnant or has been in the past, irrespective of the pregnancy outcome. **gravidty** The number of pregnancies, current and past, regardless of the pregnancy outcome **induction of labor** The use of pharmacological and/or mechanical methods to initiate labor. Examples of methods include but are not limited to: artificial rupture of membranes, balloons, oxytocin, prostaglandin, laminaria, or other cervical ripening agents. Still applies even if any of the following are performed: unsuccessful attempts at initiating labor or initiation of labor following spontaneous ruptured membranes without contractions. **nulliparous** A woman with a parity of zero. **spontaneous onset of labor** Labor without the use of pharmacological and/or mechanical interventions to initiate labor. Does not apply if the following is performed: artificial rupture of membranes before the onset of labor. **stratified measure** A performance measure that is classified into a number of strata to assist in analysis and interpretation. The overall or un-stratified measure evaluates all of the strata together. The stratified measure or each stratum consists of a subset of the overall measure. **subset measure(s)** A subset measure contains overlapping sets of patients. For example, the patients in the TOB-2a measure are a subset of those in the TOB-2 measure, i.e., the two measures have overlapping populations. **term** Greater than or equal to 37 weeks and 0 days using best EDD. It is divided into the following categories: Early Term - 37 weeks and 0 days through 38 weeks and 6 days, Full Term - 39 weeks and 0 days through 40 weeks and 6 days, Late Term - 41 weeks and 0 days through 41 weeks and 6 days and Post Term - Greater than or equal to 42 weeks and 0 days. **vertex presentation** A fetal presentation where the head is presenting first in the pelvic inlet. Does not apply if compound or breech presentation or if brow, face, hand, shoulder, etc., present first in the pelvic inlet. **Remove** the following term: **cesarean section** Surgical delivery of a fetus through incision in the abdominal wall and the uterine wall. Does not include removal of the fetus from the abdominal cavity in case of rupture

		of the uterus or abdominal pregnancy. **Add** the following reference: American College of Obstetricians and Gynecologists (2014) Obstetric Data Definitions. Available at: http://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize-Obstetric-Data-Definitions
Appendix E - Overview of Measure Information Form and Flowchart Formats	Changes made to remain consistent with the CMS and Joint Commission aligned Specifications Manual for National Hospital Inpatient Quality Measures.	Measure Set **Change** in sentence: pneumonia To stroke Description **Change** sentence to: A brief explanation of the measure's focus, such as the activity or the area on which the measure centers attention (e.g., ischemic stroke patients prescribed antithrombotic therapy at hospital discharge). Improvement Noted As **Change** second bullet to: • A decrease in the rate/score/number of occurrences (e.g., potentially preventable venous thromboembolism).
Introduction to the Manual	Remove references to processes no longer used.	**Remove** the following sections: **Priority Focus Process** The Priority Focus Process (PFP) is a data-driven tool that helps focus survey activity on issues most relevant to patient safety and quality of care at the specific health care organization being surveyed. The survey is directed by a PFP that aggregates organization-specific information through an automated, rules-based tool. Input information includes ORYX® measure data, previous recommendations, demographic data related to clinical service groups and diagnostic-related groups, complaints, sentinel event information, and Applications/LocalApps.MedPar data. The process identifies systems and processes that are relevant to patient safety and healthcare quality. **Strategic Surveillance System(S3)** The Strategic Surveillance System is a benefit provided to hospitals accredited by the Joint Commission. S3 is a tool that provides a series of risk assessment and comparative performance measure reports to help hospitals improve their care processes. Specifically S3 uses data the Joint Commission currently has, which includes past survey findings, ORYX® core measure data, data from the Office of Quality Monitoring (complaints and non-self reported sentinel events), data from an organizations electronic application and MedPAR data.
Sampling	Aligning with the CMS/TJC	**Change** 'QIO Clinical warehouse' to 'CMS warehouse'.

	manual in using CMS terms instead of QIO Clinical. Removing Stratification from SCIP measure set	**Remove** SCIP from stratified measure set examples
Table of Contents	Preview section no longer necessary	**Remove** all of Appendix P

General Release Notes

Rationale	Description
The ICD-9 codes used to report medical diagnoses and inpatient procedures are being replaced by ICD-10 codes per legislation.	**Change** all locations: ICD-9-CM to ICD-10-CM for all diagnosis code instances ICD-9-CM to ICD-10-PCS for all procedure code instances
Conform with the ACOG standardized description which is now cesarean birth.	**Change** All instances of 'cesarean section' have been changed to 'cesarean birth' throughout the specifications manual.
The data element Reason for Not Exclusively Feeding Breast Milk will no longer be used, since PC-05a was removed in its entirety in order to allow more focus on the population health measure PC-05. Maternal medical conditions were removed from PC-05 in order to align with the eCQM, since these concepts cannot be modeled in the eCQM.	**Remove** the data element Reason for Not Exclusively Feeding Breast Milk in its entirety.