

# Release Notes for the 2022A Manual

## Measure Information Forms

| Section | Rationale  | Description  |
|---------|--|--|
| CSTK-01 | The Measure Information Form was updated because The Joint Commission withdrew the measure from the NQF endorsement process. | Adoption Status (header note)<br><b>Remove:</b><br><b>*NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE*</b>   |
| CSTK-03 | The Measure Information Form was updated because The Joint Commission withdrew the measure from the NQF endorsement process. | Adoption Status (header note)<br><b>Remove:</b><br><b>*NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE*</b>   |
| CSTK-06 | The Measure Information Form was updated because The Joint Commission withdrew the measure from the NQF endorsement process. | Adoption Status (header note)<br><b>Remove:</b><br><b>*NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE*</b>   |
| CSTK-11 | The measure algorithm was updated to harmonize with GWTG data collection tool.   | Algorithm<br><b>Move</b><br>"ICD-10-PCS Principal or Other Procedure Codes" decision box above "Elective Carotid Intervention" and after "ICD-10-CM Diagnosis Code". |
| PC      | Specification Manual for PC measures updated includes code table names where Appendix A code tables are                      | Perinatal Care (PC) Initial Patient Population<br><br>Mothers:   |

|              |  |   |
|--------------|--|---|
|              | <p>referenced in the MIF. This provides the user with the category of codes included in the table being referenced. The additional information creates an improved experience for users and allows for more information within the MIF without listing all codes.</p>  | <p><b>Changed from:</b> Patients admitted to the hospital for inpatient acute care are included in the PC Mother Initial sampling group if they have: ICD-10-PCS Principal or Other Procedure Codes as defined in Appendix A, Table 11.01.1, a Patient Age (Admission Date – Birthdate) <math>\geq 8</math> years and <math>&lt; 65</math> and a Length of Stay (Discharge Date - Admission Date) <math>\leq 120</math> days.</p> <p><b>To:</b> Patients admitted to the hospital for inpatient acute care are included in the PC Mother Initial sampling group if they have: ICD-10-PCS Principal or Other Procedure Codes as defined in Appendix A, Table 11.01.1 Delivery, a Patient Age (Admission Date – Birthdate) <math>\geq 8</math> years and <math>&lt; 65</math> and a Length of Stay (Discharge Date - Admission Date) <math>\leq 120</math> days.</p> <p>Newborns:</p> <p><b>Changed from:</b> Patients admitted to the hospital for inpatient acute care are included in the PC Newborn Initial population if they have: A Patient Age (Admission Date – Birthdate) <math>\leq 1</math> day and ICD-10-CM Principal or Other Diagnosis Codes as defined in Appendix A, Table 11.20.1</p> <p><b>To:</b> Patients admitted to the hospital for inpatient acute care are included in the PC Newborn Initial population if they have: A Patient Age (Admission Date – Birthdate) <math>\leq 1</math> day and ICD-10-CM Principal or Other Diagnosis Codes as defined in Appendix A, Table 11.20.1 Single Liveborn Newborn</p> |
| <p>PC-01</p> | <p>Specification Manual for PC measures updated includes code table names where Appendix A code tables are referenced in the MIF. This provides the user with the category of codes included in the table being referenced. The additional information creates an improved experience for users and allows for more information within the MIF without listing all codes. Updated rationale based on</p> | <p>Numerator Statement</p> <p>Included Populations:</p> <p><b>Change from:</b></p> <ul style="list-style-type: none"> <li>• Medical induction of labor as defined in Appendix A, Table 11.05 while not in <i>Labor</i> prior to the procedure</li> <li>• Cesarean birth as defined in Appendix A, Table 11.06 and all of the following:             <ul style="list-style-type: none"> <li>◦ not in <i>Labor</i></li> <li>◦ no history of a <i>Prior Uterine Surgery</i></li> </ul> </li> </ul> <p><b>To:</b></p> <ul style="list-style-type: none"> <li>• Medical induction of labor as defined in Appendix A, Table 11.05 Medical Induction of Labor while not in <i>Labor</i> prior to the procedure</li> </ul>  |

new reference. Updated reference list.

- Cesarean birth as defined in Appendix A, Table 11.06 Cesarean Birth and all of the following:
  - not in *Labor*
  - no history of a *Prior Uterine Surgery*

#### Denominator Statement

#### Included Populations:

##### Change from:

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

##### 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 Delivery
- *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for planned cesarean birth in labor as defined in Appendix A, Table 11.06.1 Planned Cesarean Birth in Labor

#### Excluded Populations:

##### Change from:

- *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07

##### To:

- *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07 Conditions Possibly Justifying Elective Delivery

## Rationale

**Change from:**

For almost 3 decades, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) have had in place a standard requiring 39 completed weeks gestation prior to ELECTIVE delivery, either vaginal or operative (ACOG, 1996). A survey conducted in 2007 of almost 20,000 births in HCA hospitals throughout the U.S. carried out in conjunction with the March of Dimes at the request of ACOG revealed that almost 1/3 of all babies delivered in the United States are electively delivered with 5% of all deliveries in the U.S. delivered in a manner violating ACOG/AAP guidelines. Most of these are for convenience, and result in significant short term neonatal morbidity (neonatal intensive care unit admission rates of 13- 21%) (Clark et al., 2009).

According to Glantz (2005), compared to spontaneous labor, elective inductions result in more cesarean births and longer maternal length of stay. The American Academy of Family Physicians (2000) also notes that elective induction doubles the cesarean delivery rate. Repeat elective cesarean births before 39 weeks gestation also result in higher rates of adverse respiratory outcomes, mechanical ventilation, sepsis and hypoglycemia for the newborns (Tita et al., 2009).

**To:**

For almost 3 decades, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) have had in place a standard requiring 39 completed weeks gestation prior to ELECTIVE delivery, either vaginal or operative (ACOG, 1996). A survey conducted in 2007 of almost 20,000 births in HCA hospitals throughout the U.S. carried out in conjunction with the March of Dimes at the request of ACOG revealed that almost 1/3 of all babies delivered in the United States are electively delivered with 5% of all deliveries in the U.S. delivered in a manner violating ACOG/AAP guidelines. Most of these are for convenience, and result in significant short term neonatal morbidity (neonatal intensive care unit admission rates of 13- 21%) (Clark et al., 2009).

According to Glantz (2005), compared to spontaneous labor, elective inductions result in more cesarean births and longer maternal length of stay. Interventions that decrease the chance of a cesarean delivery include avoiding non-medically indicated induction of labor prior to 39 weeks gestation (Quinlan and Murphy, 2015). Repeat elective cesarean births

|              |   |  |
|--------------|---|--|
|              |   | <p>before 39 weeks gestation also result in higher rates of adverse respiratory outcomes, mechanical ventilation, sepsis and hypoglycemia for the newborns (Tita et al., 2009).</p> <p><b>Selected References</b></p> <p><b>Remove:</b></p> <ul style="list-style-type: none"> <li>American Academy of Family Physicians. (2000). Tips from Other Journals: Elective induction doubles cesarean delivery rate, 61, 4. Retrieved December 29, 2008 at: <a href="http://www.aafp.org/afp/20000215/tips/39.html">http://www.aafp.org/afp/20000215/tips/39.html</a>.</li> </ul> <p><b>Add:</b></p> <ul style="list-style-type: none"> <li>Quinlan, J. D., &amp; Murphy, N. J. (2015). Cesarean delivery: counseling issues and complication management. American family physician, 91(3), 178–184.</li> </ul>  |
| <p>PC-02</p> | <p>Specification Manual for PC measures updated includes code table names where Appendix A code tables are referenced in the MIF. This provides the user with the category of codes included in the table being referenced. The additional information creates an improved experience for users and allows for more information within the MIF without listing all codes.</p> | <p>Numerator Statement</p> <p>Included Populations:</p> <p><b>Change from:</b> <i>ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes</i> for cesarean birth as defined in Appendix A, Table 11.06</p> <p><b>To:</b> <i>ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes</i> for cesarean birth as defined in Appendix A, Table 11.06 Cesarean Birth</p> <p>Denominator Statement</p> <p>Included Populations:</p> <p><b>Change from:</b></p> <ul style="list-style-type: none"> <li><i>ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes</i> for delivery as defined in Appendix A, Table 11.01.1</li> <li>Nulliparous patients with <i>ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes</i> for outcome of delivery as defined in Appendix A, Table 11.08 and with a delivery of a newborn with 37 weeks or more of gestation completed</li> </ul> |

|              |   |  |
|--------------|---|--|
|              |   | <p><b>To:</b></p> <ul style="list-style-type: none"> <li>• <i>ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes</i> for delivery as defined in Appendix A, Table 11.01.1 Delivery</li> <li>• Nulliparous patients with <i>ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes</i> for outcome of delivery as defined in Appendix A, Table 11.08 Outcome of Delivery and with a delivery of a newborn with 37 weeks or more of gestation completed</li> </ul> <p>Excluded Populations:</p> <p><b>Change from:</b></p> <ul style="list-style-type: none"> <li>• <i>ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes</i> for multiple gestations and other presentations as defined in Appendix A, Table 11.09</li> </ul> <p><b>To:</b></p> <ul style="list-style-type: none"> <li>• <i>ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes</i> for multiple gestations and other presentations as defined in Appendix A, Table 11.09 Multiple Gestations and Other Presentations</li> </ul> |
| <p>PC-05</p> | <p>Specification Manual for PC measures updated includes code table names where Appendix A code tables are referenced in the MIF. This provides the user with the category of codes included in the table being referenced. The additional information creates an improved experience for users and allows for more information within the MIF without listing all codes. Updated the Rationale and Selected References sections to reflect updated references.</p> | <p>Denominator Statement</p> <p>Included Populations:</p> <p><b>Change from:</b> Liveborn newborns with <i>ICD-10-CM Principal Diagnosis Code</i> for single liveborn newborn as defined in Appendix A, Table 11.20.1</p> <p><b>To:</b> Liveborn newborns with <i>ICD-10-CM Principal Diagnosis Code</i> for single liveborn newborn as defined in Appendix A, Table 11.20.1 Single Liveborn Newborn</p> <p>Excluded Populations:</p> <p><b>Change from:</b></p> <ul style="list-style-type: none"> <li>• <i>ICD-10-CM Other Diagnosis Codes</i> for galactosemia as defined in Appendix A, Table 11.21</li> </ul> <p><b>To:</b></p>   |

- *ICD-10-CM Other Diagnosis Codes* for galactosemia as defined in Appendix A, Table 11.21 Galactosemia

**Change from:**

- *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for parenteral nutrition as defined in Appendix A, Table 11.22

**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 Parenteral Nutrition

## Rationale

**Change from:**

Exclusive breast milk feeding for the first 6 months of neonatal life has long been the expressed goal of World Health Organization (WHO), Department of Health and Human Services (DHHS), American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG). ACOG has recently reiterated its position (ACOG, 2007). A recent Cochrane review substantiates the benefits (Kramer et al., 2002). Much evidence has now focused on the prenatal and intrapartum period as critical for the success of exclusive (or any) BF (Centers for Disease Control and Prevention [CDC], 2007; Petrova et al., 2007; Shealy et al., 2005; Taveras et al., 2004). Exclusive breast milk feeding rate during birth hospital stay has been calculated by the California Department of Public Health for the last several years using newborn genetic disease testing data. Healthy People 2010 and the CDC have also been active in promoting this goal.

**To:**

Exclusive breast milk feeding for the first 6 months of neonatal life has long been the expressed goal of World Health Organization (WHO), Department of Health and Human Services (DHHS), American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG). ACOG has recently reiterated its position (ACOG, 2018). A Cochrane review substantiates the benefits (Kramer et al., 2012). Much evidence has now focused on the prenatal and intrapartum period as critical for the success of exclusive (or any) BF (Centers for Disease Control and Prevention [CDC], 2020; CDC, 2013; Petrova et al., 2007; Taveras et al., 2004). Exclusive breast milk feeding rate during birth hospital

stay has been calculated by the California Department of Public Health for the last several years using newborn genetic disease testing data. Healthy People 2020 and the CDC have also been active in promoting this goal.

#### Selected References

##### Remove:

- American College of Obstetricians and Gynecologists. (Feb. 2007). Committee on Obstetric Practice and Committee on Health Care for Underserved Women. Breastfeeding: Maternal and Infant Aspects. ACOG Committee Opinion 361.
- Centers for Disease Control and Prevention. (Aug 3, 2007). Breastfeeding trends and updated national health objectives for exclusive breastfeeding--United States birth years 2000-2004. *MMWR - Morbidity & Mortality Weekly Report*. 56(30):760-3.
- Centers for Disease Control and Prevention. (2017). Division of Nutrition, Physical Activity and Obesity. Breastfeeding Report Card. Available at: <https://www.cdc.gov/breastfeeding/data/reportcard.htm>
- Ip, S., Chung, M., Raman, G., et al. (2007). Breastfeeding and maternal and infant health outcomes in developed countries. Rockville, MD: *US Department of Health and Human Services*. Available at: <https://archive.ahrq.gov/downloads/pub/evidence/pdf/brfout/brfout.pdf>
- Kramer, M.S. & Kakuma, R. (2002). Optimal duration of exclusive breastfeeding. [107 refs] Cochrane Database of Systematic Reviews. (1):CD003517.
- Shealy, K.R., Li, R., Benton-Davis, S., & Grummer-Strawn, L.M. (2005). The CDC guide to breastfeeding interventions. Atlanta, GA: US Department of Health and Human Services, CDC. Available at: [http://www.cdc.gov/breastfeeding/pdf/breastfeeding\\_interventions.pdf](http://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf).
- US Department of Health and Human Services. (2007). Healthy People 2010 Mid-course Review. Washington, DC: US Department of Health and Human Services. Available at: <https://www.healthypeople.gov/2010/data/midcourse/html/default.htm?visit=1>

##### Add:

- ACOG Committee Opinion No. 756: Optimizing Support for Breastfeeding as Part of Obstetric Practice. (2018). *Obstetrics and gynecology*, 132(4), e187–e196. <https://doi.org/10.1097/AOG.0000000000002890>



|           |  |  |
|-----------|--|--|
|           |  | <ul style="list-style-type: none"> <li>• Perrine CG, Chiang KV, Anstey EH, et al. Implementation of Hospital Practices Supportive of Breastfeeding in the Context of COVID-19 – United States, July 15–August 20, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1767–1770. DOI: <a href="http://dx.doi.org/10.15585/mmwr.mm6947a3">http://dx.doi.org/10.15585/mmwr.mm6947a3</a></li> <li>• Centers for Disease Control and Prevention. (2020). Division of Nutrition, Physical Activity and Obesity. Breastfeeding Report Card. Available at: <a href="https://www.cdc.gov/breastfeeding/data/reportcard.htm">https://www.cdc.gov/breastfeeding/data/reportcard.htm</a></li> <li>• Feltner, C., Weber, R. P., Stuebe, A., Grodensky, C. A., Orr, C., &amp; Viswanathan, M. (2018). Breastfeeding Programs and Policies, Breastfeeding Uptake, and Maternal Health Outcomes in Developed Countries. Agency for Healthcare Research and Quality (US).</li> <li>• Kramer, M. S., &amp; Kakuma, R. (2012). Optimal duration of exclusive breastfeeding. The Cochrane database of systematic reviews, 2012(8), CD003517. <a href="https://doi.org/10.1002/14651858.CD003517.pub2">https://doi.org/10.1002/14651858.CD003517.pub2</a></li> <li>• Centers for Disease Control and Prevention. Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies. Atlanta: U.S. Department of Health and Human Services; 2013. Available at: <a href="https://www.cdc.gov/breastfeeding/pdf/bf-guide-508.pdf">https://www.cdc.gov/breastfeeding/pdf/bf-guide-508.pdf</a></li> <li>• US Department of Health and Human Services. (2020). Healthy People 2020 Final Review. Washington, DC: US Department of Health and Human Services. Available at: <a href="https://www.cdc.gov/nchs/healthy_people/hp2020-final-review.htm">https://www.cdc.gov/nchs/healthy_people/hp2020-final-review.htm</a></li> </ul> |
| PC-06     | The Measure Information Form was updated to acknowledge this measure has NQF endorsement.  | <p>Adoption Status (header note)</p> <p><b>Add:</b></p> <p><b>NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE</b></p>   |
| THKR-IP-5 | Correcting typos in the algorithm and updating the Post Assessment Day calculation. It currently reads as "ICD-10-PCS Principal Procedure Date" minus "Postoperative Assessments Completion Date", it is re- | <p>Algorithm</p> <p><b>Change from:</b></p> <p>ICD-10-PCS Principal Procedure Date minus Postoperative Assessments Completion Date</p> <p><b>To:</b></p> <p>Postoperative Assessments Completion Date minus ICD-10-PCS Principal Procedure Date</p>  |

|           |   |   |
|-----------|---|---|
|           | <p>versed and read "Postoperative Assessments Completion Date" minus "ICD-10-PCS Principal Procedure Date", because the assessment is taking place after the surgical procedure and needs to be performed within 90 days of the surgery.</p>  |   |
| THKR-OP-5 | <p>Correcting typos in the algorithm and updating the Post Assessment Day calculation. It currently reads as "CPT® Code Procedure Date" minus "Postoperative Assessments Completion Date", it is reversed and read "Postoperative Assessments Completion Date" minus "CPT® Code Procedure Date", because the assessment is taking place after the surgical procedure and needs to be performed within 90 days of the surgery.</p> | <p>Algorithm</p> <p><b>Change from:</b><br/>CPT® Code Procedure Date minus Postoperative Assessments Completion Date</p> <p><b>To:</b><br/>Postoperative Assessments Completion Date minus CPT® Code Procedure Date</p> |
| TOB-2     | <p>"Light Smokers" were removed from the Numerator exclusions because they should be assessed for FDA-Approved Medications for Tobacco Cessation.</p>   | <p><b>Change From:</b></p> <p>Excluded Populations:</p> <p>TOB-2 and TOB-2a</p> <p>For FDA Approved Medications Only</p>  |

|              |   |  |
|--------------|---|--|
|              |   | <ul style="list-style-type: none"> <li>• Smokeless tobacco users</li> <li>• Pregnant smokers</li> <li>• Light smokers</li> <li>• Patients with reasons for not administering FDA-approved cessation medication.</li> </ul> <p><b>Change To:</b></p> <p>Excluded Populations:</p> <p>TOB-2 and TOB-2a</p> <p>For FDA Approved Medications Only</p> <ul style="list-style-type: none"> <li>• Smokeless tobacco users</li> <li>• Pregnant smokers</li> <li>• Patients with reasons for not administering FDA-approved cessation medication.</li> </ul>  |
| <p>TOB-3</p> | <p>"Light Smokers" were removed from the Numerator exclusions because they should be assessed for FDA-Approved Medications for Tobacco Cessation.</p> | <p>For FDA Approved Medications Only</p> <ul style="list-style-type: none"> <li>• Smokeless tobacco users</li> <li>• Pregnant smokers</li> <li>• Light smokers</li> <li>• Patients with reasons for not administering FDA-approved cessation medication.</li> </ul> <p><b>Change To:</b></p> <p>Excluded Populations:</p> <p>TOB-2 and TOB-2a</p> <p>For FDA Approved Medications Only</p> <ul style="list-style-type: none"> <li>• Smokeless tobacco users</li> <li>• Pregnant smokers</li> <li>• Patients with reasons for not administering FDA-approved cessation medication.</li> </ul> |

## Data Elements

| Section  | Rationale  | Description  |
|--|--|--|
| Education Addresses Activation of Emergency Medical System                   | The data element definition was updated to align with the CMS HOP specifications manual.   | Inclusion Guidelines for Abstraction<br><b>Add:</b> <ul style="list-style-type: none"> <li>• Syncope</li> <li>• Seizure</li> </ul>   |
| Prior Uterine Surgery  | Including descriptive terms for acceptable documentation will help manual abstractors determine which value should be chosen for the prior uterine surgery data element. | Guidelines for Abstraction-<br><b>Add</b> 9th bullet under Inclusion: <ul style="list-style-type: none"> <li>• Documentation of prior uterine incision with descriptors including "high" or "vertical" or "mid" or "active segment" or "classical".</li> </ul>   |
| Reason for Not Administering Antithrombotic Therapy by End of Hospital Day 2 | The data element was updated to align with GWTG.   | Notes for Abstraction<br><b>Remove:</b> <ul style="list-style-type: none"> <li>• For patients receiving ticagrelor as antithrombotic therapy for acute coronary syndrome (ACS), NSTEMI-ACS treated with early invasive strategy and/or coronary stenting, or other indications, select "Yes" if it is administered on the day of or day after hospital arrival.</li> </ul> |
| Reason for Not Prescribing Antithrombotic Therapy at Discharge               | The data element was updated to align with GWTG.   | Notes for Abstraction<br><b>Remove:</b> <ul style="list-style-type: none"> <li>• For patients prescribed ticagrelor as antithrombotic therapy at discharge due to a history of acute coronary syndrome (ACS), NSTEMI-ACS treated with early invasive strategy and/or coronary stenting, or other indications, select "Yes."</li> </ul>                                     |
| Reason for Not Prescribing Anticoagulation Therapy at Discharge              | The data element was updated to correct a typo.  | Notes for Abstraction:<br><b>Change</b> last bullet from: antithrombotic<br><br>To: anticoagulant  |
| Tobacco Use Status   | To further clarify when there is conflicting docu-   | Notes for Abstraction: Seventh bullet  |

|  |   |   |
|--|---|---|
|  | <p>mentation how to abstract the allowable value.</p> | <p><b>Change from</b></p> <ul style="list-style-type: none"> <li>If there is any conflicting documentation about the patient’s tobacco use status, e.g., RN assessment states patient does not use any tobacco products but there is also physician documentation in the H &amp; P that the patient is a “smoker,” select Value “6” since tobacco use status is unable to be determined.</li> </ul> <p><b>To</b></p> <ul style="list-style-type: none"> <li>If there is any conflicting documentation about the patient’s tobacco use status, where there is documentation of both tobacco use and no tobacco use, e.g., RN assessment states patient does not use any tobacco products but there is also physician documentation in the H &amp; P that the patient is a “smoker,” select Value “6” since tobacco use status is unable to be determined.</li> </ul> <p>Notes for Abstraction: Eighth bullet</p> <p><b>Add</b></p> <ul style="list-style-type: none"> <li>When both daily and sporadic (“some day”) tobacco use are documented, select Value “1”.</li> </ul> |
|--|---|---|

## Supplemental Materials

| Section                        | Rationale   | Description   |
|--------------------------------|---|---|
| Appendix C - Medication Tables | Update table 8.2 Antithrombotic Medications-Stroke and 8.1 Statin Medications to add and remove medications based on literature scan of approved medications. | <p><b>Added medications to table 8.2 Antithrombotic Medications-Stroke:</b> Brilinta Ticagrelor</p> <p><b>Remove medications from table 8.2 Antithrombotic Medications-Stroke:</b> Aggrenox</p> <p><b>Remove medications from table 8.1 Statin Medications:</b> Pravachol</p> |
| Appendix D - Glossary of Terms | Added 3 data elements- CMS Certification Number, Health Care Organization   | <b>Add</b> CMS Certification Number, Health Care Organization Identifier, and Measurement Value in Appendix D, General Glossary of Terms.   |

|  |   |   |
|--|---|---|
|  | <p>Identifier, and Measurement Value in Appendix D, General Glossary of Terms for information purpose only. They are used in the chart-based measures but not needed for any specific measure sets.</p> <p>Updated newborn, parity, and prenatal care (PC) definitions for clarity.</p> | <p><b>Change from: newborn</b> A very young child from birth to one year who has not yet begun to walk or talk.</p> <p><b>To: newborn</b> A newborn infant or neonate is a child from birth to &lt;28 days.</p> <p><b>Change from: parity</b> The number of live deliveries the patient experienced prior to current hospitalization.</p> <p><b>To: parity</b> The number of pregnancies reaching 20 weeks and 0 days of gestation or beyond, regardless of the number of fetuses or outcomes.</p> <p><b>Change from: perinatal care (PC)</b> The care and management of the fetus and newborn infant in the perinatal period before, during, and after delivery.</p> <p><b>To: perinatal care (PC)</b> Care for maternal, fetal, and newborn health.</p> |
| <p>Global Initial Patient Population</p> | <p>Updated Global Quarterly sampling table and Sample Size example since the concept of "Five or Fewer" no longer exists as the hospitals are not providing patient-level data.</p>   | <p><b>Remove</b> one of the rows "0-5 Submission of patient level data is encouraged but not required: if submission occurs, 100% Initial Patient Population required" from Global Quarterly sampling table and Sample Size Example.</p>  |
| <p>Introduction to the Manual</p>        | <p>Updating to reflect current program information and report name.</p>   | <p><b>Change From</b></p> <p><b>ORYX® Performance Measure Report</b></p> <p>The ORYX® Performance Measure Report, available quarterly, is designed to support and help guide Joint Commission-accredited hospitals in their performance assessment and improvement activities through the use of summary dashboards and comprehensive measure details depicting the organization's performance on each measure for which The Joint Commission receives data from the organization. Joint Commission surveyors receive an identical copy of the report prior to an onsite survey. Surveyors use the report as a guide to understanding how the organization uses and responds to performance measure data.</p>   |

|                 |  |   |
|-----------------|--|---|
|                 |  | <p><b>To</b></p> <p><b>Accelerate PI™ Performance Report</b></p> <p>The dashboard report displays chart-based and electronic clinical quality measure (eCQM) quality measurement data reported by hospitals to The Joint Commission under the ORYX® program. In addition, the report uses a select subset of the most recent and available external data from the US Centers for Medicare &amp; Medicaid Services (CMS) Compare websites that meet Joint Commission unique criteria for impact and actionability. For each measure, the dashboard shows that organization’s performance compared to national, state, and Joint Commission–accredited organization averages. The dashboard is not a scorable element on survey, but rather, a tool to facilitate discussion about ongoing quality improvement work. The report also includes access to vetted national improvement resources that help organizations explore solutions to challenge areas.</p> |
| <p>Sampling</p> | <p>Added a statement regarding Five and Fewer rule when processing patient level data.</p> | <p><b>Add</b> a statement regarding Five and Fewer rule when processing patient level data.</p>   |