The Joint Commission

Specifications Manual for Joint Commission National Quality Core Measures

Version 2015B

Specifications Manual for Joint Commission National Quality Core Measures

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Release Notes

- Release Notes for Manual v2015B - May 6, 2015

Show previous release notes...

Printable Version

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Notes

- Please note that earlier versions of Microsoft Internet Explorer do not clearly display some graphics images. If you have difficulty viewing measure algorithms, please upgrade your browser. This problem has not been reported with other web browsers.
    - Download MS Internet Explorer
- If you have difficulty viewing PDF documents on the site, please download the latest Adobe Reader application:
    - Download Adobe Reader

Acknowledgement

Introduction and Background

The Joint Commission Quality Initiative

In 1987, The Joint Commission announced its *Agenda for Change*, which outlined a series of major steps designed to modernize the accreditation process. A key component of the *Agenda for Change* was the eventual introduction of standardized core performance measures into the accreditation process. As the vision to integrate performance measurement into accreditation became more focused, the name ORYX® was chosen for the entire initiative. ORYX® is The Joint Commissions performance measurement and improvement initiative, which integrates outcomes and other performance measure data into the accreditation process.

The ORYX® initiative became operational in March of 1999, when performance measurement systems began transmitting data to The Joint Commission on behalf of accredited hospitals. ORYX® measurement requirements are intended to support Joint Commission accredited organizations in their quality improvement efforts.

The initial phase of the ORYX® initiative provided healthcare organizations a great degree of flexibility in terms of the measures that could be reported. Over time, the ORYX® measures have evolved into standardized sets of valid, reliable, and evidence-based quality measures

Related Joint Commission Activities

Accreditation Process

In January 2000, Joint Commission surveyors began using organization-specific ORYX® *Pre-Survey Reports*, effectively commencing the use of performance measure data in the survey process.

In 2004, the survey process was substantially modified to be more data-driven and patient-centered thus enhancing its value, relevance, and credibility. Many of the key components of the survey process utilize data derived from the national hospital inpatient quality measures. The survey process now has a greater focus on evaluating actual care processes because patients are traced through the care, treatment and/or services they receive. In addition, surveyors conduct systems tracers to analyze key operational systems that directly impact the quality and safety of patient care.

In June 2010 The Joint Commission categorized its process core performance measures into accountability and non-accountability measures. This approach places more emphasis on an organizations performance on accountability measures quality measures that meet four criteria designed to identify measures that produce the greatest positive impact on patient outcomes when hospitals demonstrate improvement:

- **Research**: Strong scientific evidence demonstrates that performing the evidence-based care process improves health outcomes (either directly or by reducing risk of adverse outcomes).
- **Proximity**: Performing the care process is closely connected to the patient outcome; there are relatively few clinical processes that occur after the one that is measured and before the improved outcome occurs.
- **Accuracy**: The measure accurately assesses whether or not the care process has actually been provided. That is, the measure should be capable of indicating whether the process has been delivered with sufficient effectiveness to make improved outcomes likely.
- **Adverse Effects**: Implementing the measure has little or no chance of inducing unintended adverse consequences.

Beginning in January 2012, The Joint Commission also incorporated a standards-based expectation for minimum performance on ORYX® accountability measures against which hospitals are surveyed and requirements for improvement (RFIs) can be made

Data Analysis

The Joint Commission has developed a target measure range approach (target analysis) as a basis to evaluate Joint Commission accredited organizations rating for the performance measures.

The use of target analysis in addition to a control chart is a key feature of the Joint Commissions analytic methods in the ORYX® initiative. The two analyses are alike in that an organizations actual (or observed) performance level is evaluated against a comparative norm, but are fundamentally different as to how such a norm is established. In control chart analysis, the norm is determined from an organizations own historic data so that one may assess the organizations internal process stability. In target analysis, the norm is obtained based on multiple organizations performance data to evaluate an organizations relative performance level. Therefore, the two analyses evaluate an organizations performance in two distinct perspectives and, as a result, can provide a more comprehensive framework to assess an organizations overall performance level.

ORYX® Performance Measure Report

The ORYX® Performance Measure Report assists health care organizations in using their ORYX® data for ongoing performance improvement activities. 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. The report, available quarterly, summarizes performance measure information at both the measure set and individual measure level. This includes highlighting measures with standards compliance issues and performance issues.

Quality Check

In July 2004, The Joint Commission launched a new generation of reporting healthcare information about the quality and safety of care provided in its accredited healthcare organizations across the country.

The Joint Commission's Quality Check provides clear, objective data to individuals for the purpose of comparing the performance of local hospitals, home care agencies, nursing homes, laboratories, and ambulatory care organizations with others on state and national levels. Additionally, The Joint Commission provides hospital-specific information about clinical performance in the care of patients for the ORYX® core measures. In addition, Quality Check includes HCAHPs data and the CMS 30-day mortality measures.

Individuals are also able to determine how healthcare organizations compare with others in meeting national requirements that help them prevent devastating medical accidents. The requirements specifically seek to avoid misidentification of patients, surgery on the wrong body part, miscommunication among caregivers, unsafe use of infusion pumps, medication mix-ups, problems with equipment alarm systems, and infections acquired in the healthcare setting.

Consumers can access Quality Check at http://www.qualitycheck.org and search for healthcare organizations by name, type, and/or location. Interactive links to information are designed to help individuals better understand how to use and interpret the information presented.

Annual Report

Improving Americas Hospitals: The Joint Commissions Annual Report on Quality and Safety has been released annually since 2008. This comprehensive report summarizes the performance of all Joint Commission-accredited hospitals on ORYX® accountability measures.

Top Performers

In 2012, The Joint Commission introduced the *Top Performers on Key Quality Measures* program. This initiative recognizes accredited hospitals that attain excellence on accountability measure performance.

Related National Activities

National Quality Forum

The NQF has approved a set of national voluntary consensus standards for measuring the quality of hospital care.

These measures will permit consumers, providers, purchasers, and quality improvement professionals to evaluate and compare the quality of care in general acute care hospitals across the nation using a standard set of measures. The majority of the Joint Commissions measures are endorsed by NQF and are denoted on the measure information forms.

National Quality Measures Clearinghouse

The National Quality Measures Clearinghouse (NQMC), sponsored by AHRQ, U.S. Department of HHS, has included Joint Commission measures in its public database for evidence-based quality measures and measure sets. NQMC is sponsored by AHRQ to promote widespread access to quality measures by the healthcare community and other interested individuals.

Using The Specifications Manual for Joint Commission National Quality Core Measures

This portion of *The Specifications Manual* provides a brief overview of the information contained within each section of the manual. It is intended for use as a quick reference to assist in the implementation of the Joint Commission national quality core measures. The sections of this manual are interrelated and are most useful when considered together.

This manual contains references to CMS and QIO programs that, while not applicable to the Joint Commission, have been retained to remain consistent with the CMS and Joint Commission aligned *Specifications Manual for National Hospital Inpatient Quality Measures*.

Section 1: Data Dictionary

The Data Dictionary describes the patient-level and facility-level data elements required to capture and calculate individual measurements. It specifies those data elements that must be collected for each patient that falls into the selected measure population and the data elements needed for a specific measure.

Section 2 - Measurement Information

The measure set sections contain specific measure information forms for each measure. This is followed by a data element list for the measures, including the general data elements, algorithm output data elements, and the specific measure data elements. Next is a document that describes the initial patient population and sample size requirements for each measure set. Also included are subsections for each specific measure. These contain a Measure Information Form (MIF) and the Performance Measure Algorithm.

The algorithms and data elements needed to calculate each of the Joint Commission national quality core measures are identified in the MIF. Each algorithm provides the logical steps, data element evaluation, arithmetic calculations, and data manipulation steps that are required to calculate a given measure.

Section 3: Missing and Invalid Data

This section addresses the Joint Commissions approach to missing and invalid data. Missing data refers to data elements that have no values present for one or more episodes of care and invalid data refers to data element values that fall outside the range of the allowable values. Information and examples are provided on how the Unable to Determine (UTD) value is utilized within the measure algorithm and on submission into the Joint Commissions Data Warehouse. This section also describes the general and measure specific data elements that are required for submission and how missing and/or invalid data will be handled.

Section 4: Population and Sampling Methods

Sampling is an available option for all Joint Commission national quality core measures if certain requirements are met. This section provides guidance on defining the hospitals Initial Patient Population and information and examples on the order of data flow, sample size requirements, sampling approaches and the transmission of Initial Patient Population and sample data elements to the Joint Commissions Data Warehouse. Specific measure set sample size requirements tables are located in the Measure Information section.

Section 5 Joint Commission National Quality Core Measure Verification Process

This section has been moved to the *ORYX Technical Implementation Guide* and is available to ORYX Vendors via the Joint Commissions extranet site for measurement systems (PET).

Section 6 Joint Commission National Quality Core Measures Data Transmission

This section of the manual is provided to highlight the unique data transmission specifications for Joint Commission national quality core measure data. This section is divided into four parts: Joint Commission National Quality Core Measure Data Transmission, Guidelines for Submission of Data, Transmission Data Element List, and Transmission Data Processing Flow.

The Joint Commission Data Transmission section provides information related to the transmission of Joint Commission national quality core measure data to the Joint Commissions Data Warehouse. The Guidelines for Submission of Data includes an overview of the data required to be submitted to the Joint Commissions Data Warehouse, as well as the Hospital Clinical Data XML file layout and the Hospital Initial Patient Population Data XML file Layout.

The Transmission Data Element List describes the data elements that are either used to identify the hospital and measure set associated to the transmitted data or are calculated by the vendor using the hospitals patient-level data and measure results. These data elements are not used in the Initial Patient Population Algorithms or Measure Algorithms. The Transmission Data Processing Flows contains information regarding the order in which the Joint Commissions Data Warehouse evaluates the Joint Commission national quality core measures and the population and sampling data.

Appendix A - ICD-10 Code Tables

For many of the measures, eligibility for inclusion or exclusion in the Initial Patient Population of interest is defined by the presence of certain ICD-10-CM diagnosis and ICD-10-PCS procedure codes within the patient-level record. Appendix A contains the ICD-10 code tables that define these indicator populations for all measures within each measure set. There is a description of the code as defined in a coding manual and a shortened description that may be used in a data abstraction tool. The Measure Information Section also refers to the codes or tables provided in this section. ICD-10 codes are modified by the National Center for Health Statistics (NCHS) and the Centers for Medicare & Medicaid Services (CMS). The code tables in this Appendix are evaluated semiannually and modified based on these changes. Potential changes become effective beginning with either April 1st or October 1st discharges. Updates will be provided as indicated.

Appendix C - Medication Tables

Some of the Joint Commission national quality core measures address the use of certain medications. This Appendix contains tables with the specific names of medications that may be associated with medication categories (e.g., trade names). For example, Haloperidol may also be documented as Haldol. These tables are provided to facilitate appropriate data collection of applicable medications. These tables are not meant to be an inclusive list of all available therapeutic agents; rather they represent current information available at the time of publication. Approved medication tables will be updated regularly. Discrepancies must be reported. See the Resource Section of this manual for contact information.

Appendix D - Glossary of General Terms

Appendix E - Overview of Measure Information Form and Flowchart Formats

Each measure has an associated Measure Information Form and Flowchart (calculation algorithm). This Appendix explains each of the terms used on the Measure Information Form and provides a brief introduction to flowcharting, including an explanation of flowchart symbols.

Appendix G - Resources

This section lists resources that are available to assist with the Joint Commission measures.

Appendix H - Miscellaneous Tables

The tables in this Appendix contain clinical information to supplement the data element dictionary and provide

additional details for data abstraction. They are referenced under the data dictionary under the Notes for Abstraction or the Guidelines for Abstraction.

Appendix P - Preview Section

The preview section is intended to provide an overview of future updates. The information provided in this section **is not** to be programmed or submitted. Placement in this appendix does not assume that the information listed will be implemented in a future manual.

Hospital Based Inpatient Psychiatric Services (HBIPS)

Set Measures

Set Measure ID	Measure Short Name
HBIPS-1	Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed
HBIPS-2	Hours of physical restraint use
HBIPS-3	Hours of seclusion use
HBIPS-4	Patients discharged on multiple antipsychotic medications
HBIPS-5	Patients discharged on multiple antipsychotic medications with appropriate justification
HBIPS-6	Post discharge continuing care plan created
HBIPS-7	Post discharge continuing care plan transmitted to next level of care provider upon discharge

General Data Elements

Element Name	Collected For
Admission Date	All Records,
Birthdate	All Records,
CMS Certification Number	Hospital Clinical Data File, Optional for All Records,
Discharge Date	All Records, Not collected for HBIPS-2 and HBIPS-3
Health Care Organization Identifier	All Records, Patient Population Data File, Hospital Clinical Data File,
Hispanic Ethnicity	All Records,
ICD-10-CM Other Diagnosis Codes	All Records, Optional for HBIPS-2, HBIPS-3
ICD-10-CM Principal Diagnosis Code	All Records, Optional for HBIPS-2, HBIPS-3
ICD-10-PCS Other Procedure Codes	All Records, Optional for All HBIPS Records
ICD-10-PCS Other Procedure Dates	All Records, Optional for All HBIPS Records
ICD-10-PCS Principal Procedure Code	All Records, Optional for All HBIPS Records
ICD-10-PCS Principal Procedure Date	All Records, Optional for All HBIPS Records
Payment Source	All Records, Optional for HBIPS-2 and HBIPS-3

Element Name	Collected For
Psychiatric Care Setting	All Records,
Race	All Records,
Sex	All Records,

Algorithm Output Data Elements

Element Name	Collected For
Measure Category Assignment	Calculation, Transmission, Hospital Clinical Data File

Measure Set Specific Data Elements

Element Name	Collected For
Appropriate Justification for Multiple Antipsychotic Medications	HBIPS-5,
Continuing Care Plan-Discharge Medications	HBIPS-6, HBIPS-7,
Continuing Care Plan-Next Level of Care	HBIPS-6, HBIPS-7,
Continuing Care Plan-Principal Discharge Diagnosis	HBIPS-6, HBIPS-7,
Continuing Care Plan-Reason for Hospitalization	HBIPS-6, HBIPS-7,
Discharge Disposition	HBIPS-4, HBIPS-5, HBIPS-6, HBIPS-7,
Event Date	HBIPS-2, HBIPS-3,
Event Type	HBIPS-2, HBIPS-3,
Minutes of Physical Restraint	HBIPS-2,
Minutes of Seclusion	HBIPS-3,
Number of Antipsychotic Medications Prescribed at Discharge	HBIPS-4, HBIPS-5,
Patient Referral to Next Level of Care Provider	HBIPS-4, HBIPS-5, HBIPS-6, HBIPS-7,
Patient Strengths	HBIPS-1,
Psychiatric Inpatient Days - Medicare Only	HBIPS-2, HBIPS-3,
Psychiatric Inpatient Days-Non-Medicare Only	HBIPS-2, HBIPS-3,
Psychological Trauma History	HBIPS-1,
Substance Use	HBIPS-1,
Total Leave Days - Medicare Only	HBIPS-2, HBIPS-3,
Total Leave Days-Non-Medicare Only	HBIPS-2, HBIPS-3,
Violence Risk to Others	HBIPS-1,

Element Name	Collected For
Violence Risk to Self	HBIPS-1,

Related Materials

	Document Name	
	Acknowledgment and Conditions of Use	
	Appendix A - ICD-10 Code Tables	
	Appendix C - Medication Tables	
	Appendix D - Glossary of Terms	
	Appendix E - Overview of Measure Information Form and Flowchart Formats	
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	Appendix H - Miscellaneous Tables	
	b. Data Dictionary	
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	Missing and Invalid Data	
	Sampling	
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	Transmission Alpha Data Dictionary	
	Transmission Data Processing Flow: Clinical	
	Transmission Data Processing Flow: Population and Sampling	
	Transmission of Data	
	Using the The Joint Commission's National Measure Specifications Manual	

Hospital-Based Inpatient Psychiatric Services (HBIPS) Measure Set Initial Patient Population

The HBIPS measure set is unique in that there are two distinct Initial Patient Populations within the measure set, one for the discharge measures (HBIPS-1, HBIPS-4, HBIPS-5, HBIPS-6, and HBIPS-7) and the other for event measures (HBIPS-2 and HBIPS-3).

Initial Patient Population for Discharge Measures (HBIPS-1, HBIPS-4, HBIPS-5, HBIPS-6, and HBIPS-7)
The general population of the HBIPS discharge measures can be identified by using four data elements that are common to the discharge performance measures in the HBIPS set:

- ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes
- *Discharge Date*
- *Birthdate*
- *Psychiatric Care Setting*

The HBIPS Discharge Topic Population is defined as patients discharged from the Psychiatric Care Setting with an ICD-10-CM Principal or Other Diagnosis Code for Mental Disorders as defined in Appendix A, Table 10.01 and a Patient Age at Discharge (*Discharge Date - Birthdate*) >= 1 year.

There are four distinct strata within the HBIPS Discharge Topic Population; each is identified by a specific age range. The patients in each stratum are counted in the HBIPS Initial Patient Population for discharge measures of multiple measures.

Discharge Measures	Age Strata	Initial Patient Population definition
HBIPS-1a, 4a, 5a, 6a, and 7a (overall measures)	Age greater than and equal to 1 year	The count of all patients in strata 1, 2, 3, and 4
HBIPS-1b, 4b, 5b, 6b, and 7b	Age 1 year through 12 years	The count of all patients in stratum 1
HBIPS-1c, 4c, 5c, 6c, and 7c	Age 13 years through 17 years	The count of all patients in stratum 2
HBIPS-1d, 4d, 5d, 6d, and 7d	Age 18 years through 64 years	The count of all patients in stratum 3
HBIPS-1e, 4e, 5e, 6e, and 7e	Age greater than and equal to 65 years	The count of all patients in stratum 4

Patients discharged from the hospital with an ICD-10-CM Principal or Other Diagnosis Code for Mental Disorders as defined in Appendix A, Table 10.01 are included in one of the HBIPS Strata Initial Populations for discharge measures and are eligible to be sampled if they have:

Discharge Stratum 1 Age 1 year through 12 years stratum A Patient Age at Discharge (*Discharge Date - Birthdate*) >= 1 year and < 13 years

Discharge Stratum 2 - Age 13 years through 17 years stratum A Patient Age at Discharge (*Discharge Date - Birthdate*) >= 13 years and < 18 years

Discharge Stratum 3 - Age 18 years through 64 years stratum A Patient Age at Discharge (*Discharge Date - Birthdate*) >= 18 years and < 65 years

Discharge Stratum 4 - Age greater than and equal to 65 years stratum A Patient Age at Discharge (*Discharge Date - Birthdate*) >= 65 years

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Initial Patient Population for Event Measures (HBIPS-2 and HBIPS-3)
The population of the HBIPS event measures can be identified by using two data elements that are common to the event performance measures in the HBIPS set:

- Event Date
- Psychiatric Care Setting

The HBIPS Event Topic Population (common to all HBIPS event measures) is defined as patients with an event (Event Date exists) while they are in the hospital with a Patient Age at Time of Event (Event Date - *Birthdate*) >= 1 year and the patient was in a Psychiatric Care Setting (=Y) when the event occurred. There are four distinct strata or sub-populations within the HBIPS Event Topic Population, each identified by a specific age range. The patients in each stratum are counted in the HBIPS Initial Patient Population for event measures of multiple measures.

Event Measures	Age Strata	Initial Patient Population definition

Event Measures	Age Strata	Initial Patient Population definition
HBIPS-2a and 3a (overall measures)	Age greater than and equal to 1 year	The count of all patients in strata 1, 2, 3, and 4
HBIPS-2b and 3b	Age 1 year through 12 years	The count of all patients in stratum 1
HBIPS-2c and 3c	Age 13 years through 17 years	The count of all patients in stratum 2
HBIPS-2d and 3d	Age 18 years through 64 years	The count of all patients in stratum 3
HBIPS-2e and 3e	Age greater than and equal to 65 years	The count of all patients in stratum 4

Patients for which an event occurs (Event Date exists) while in a Psychiatric Care Setting (=Y) in the hospital are included in one of the Strata Initial Populations for the event measures. There is no sampling for the HBIPS event measures. All patients in the Initial Population for HBIPS event measures are automatically sampled.

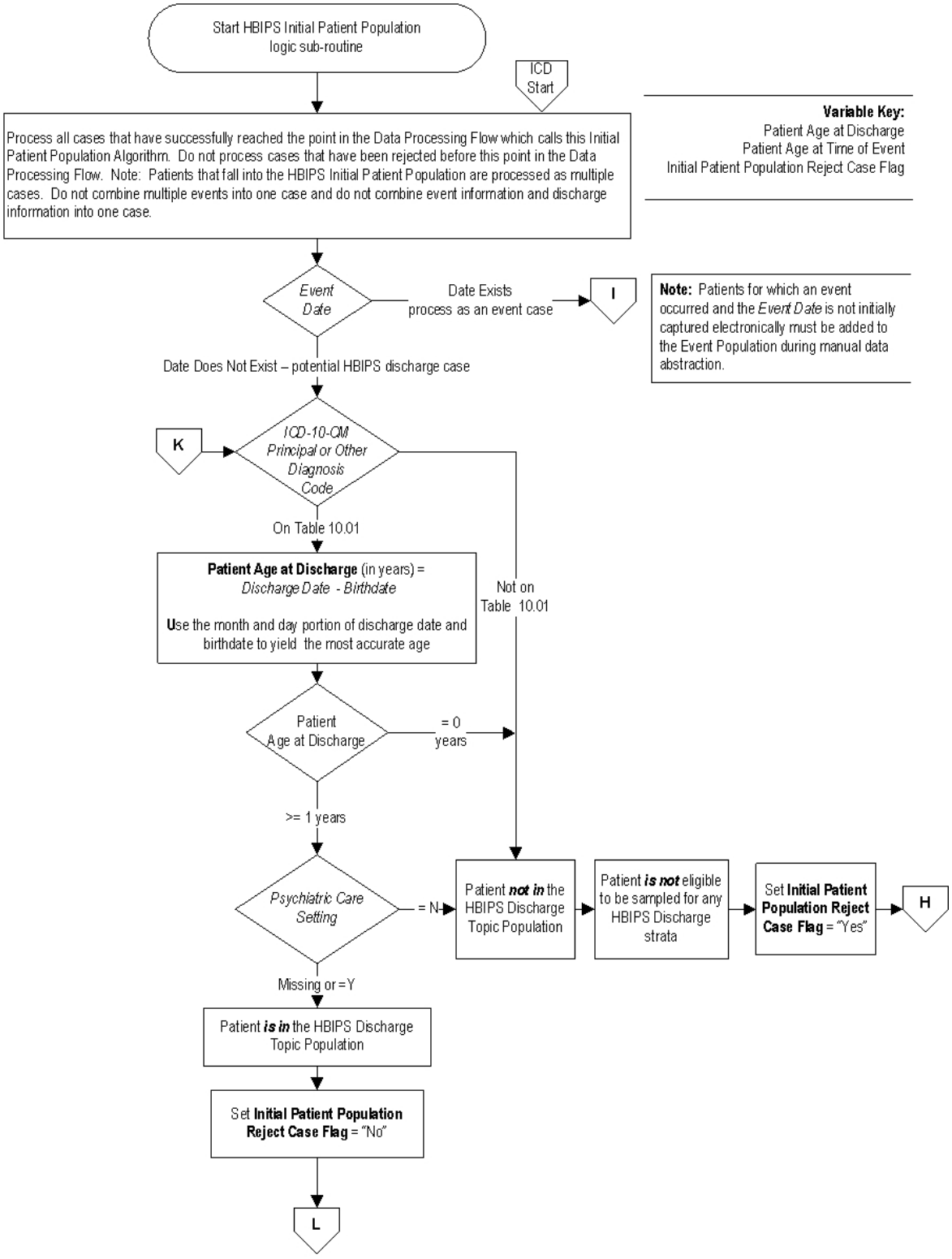
Event Stratum 1 Age 1 year through 12 years stratum A Patient Age at Time of Event (Event Date - *Birthdate*) >= 1 year and < 13 years

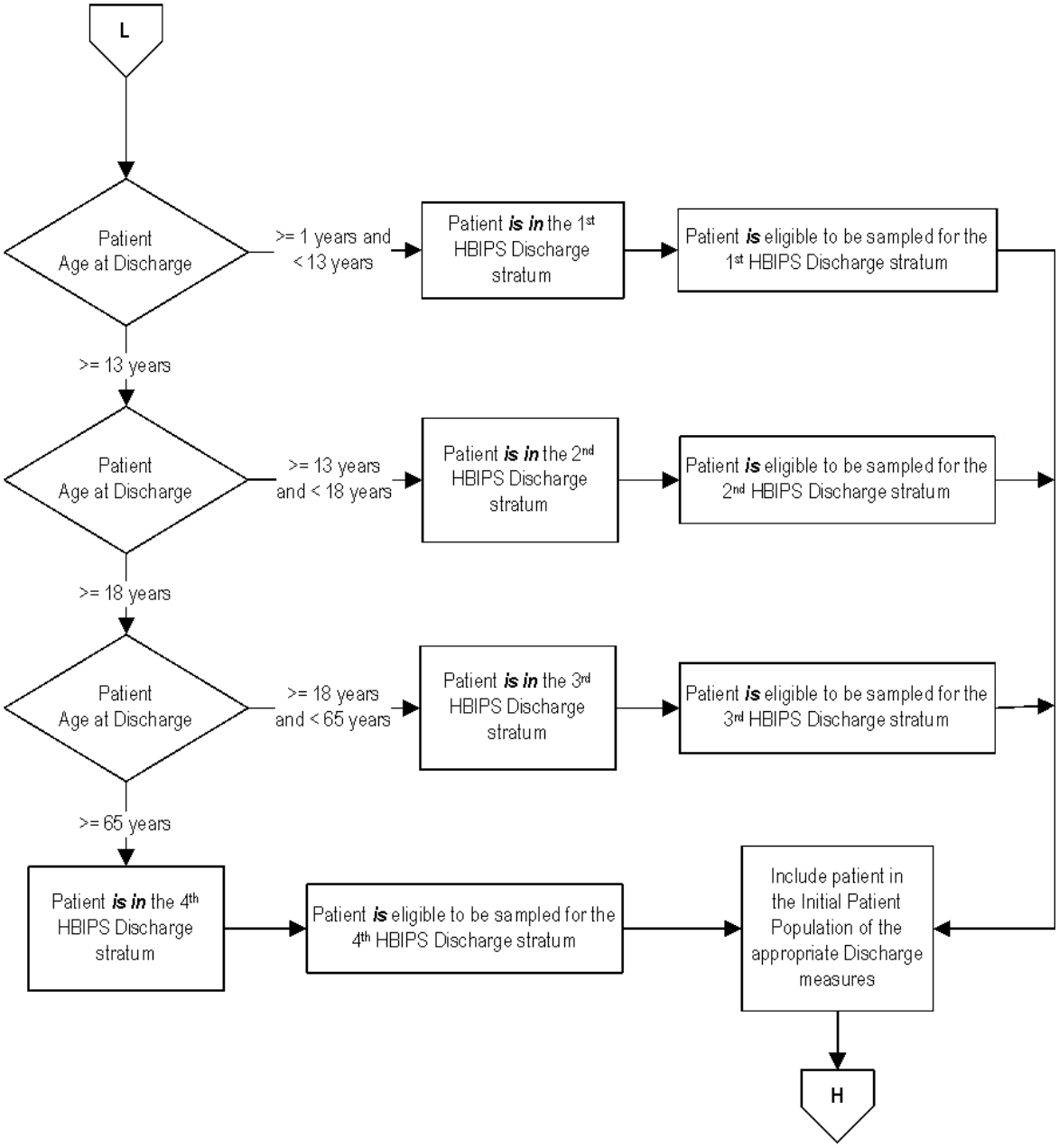
Event Stratum 2 - Age 13 years through 17 years stratum A Patient Age at Time of Event (Event Date - *Birthdate*) >= 13 years and < 18 years

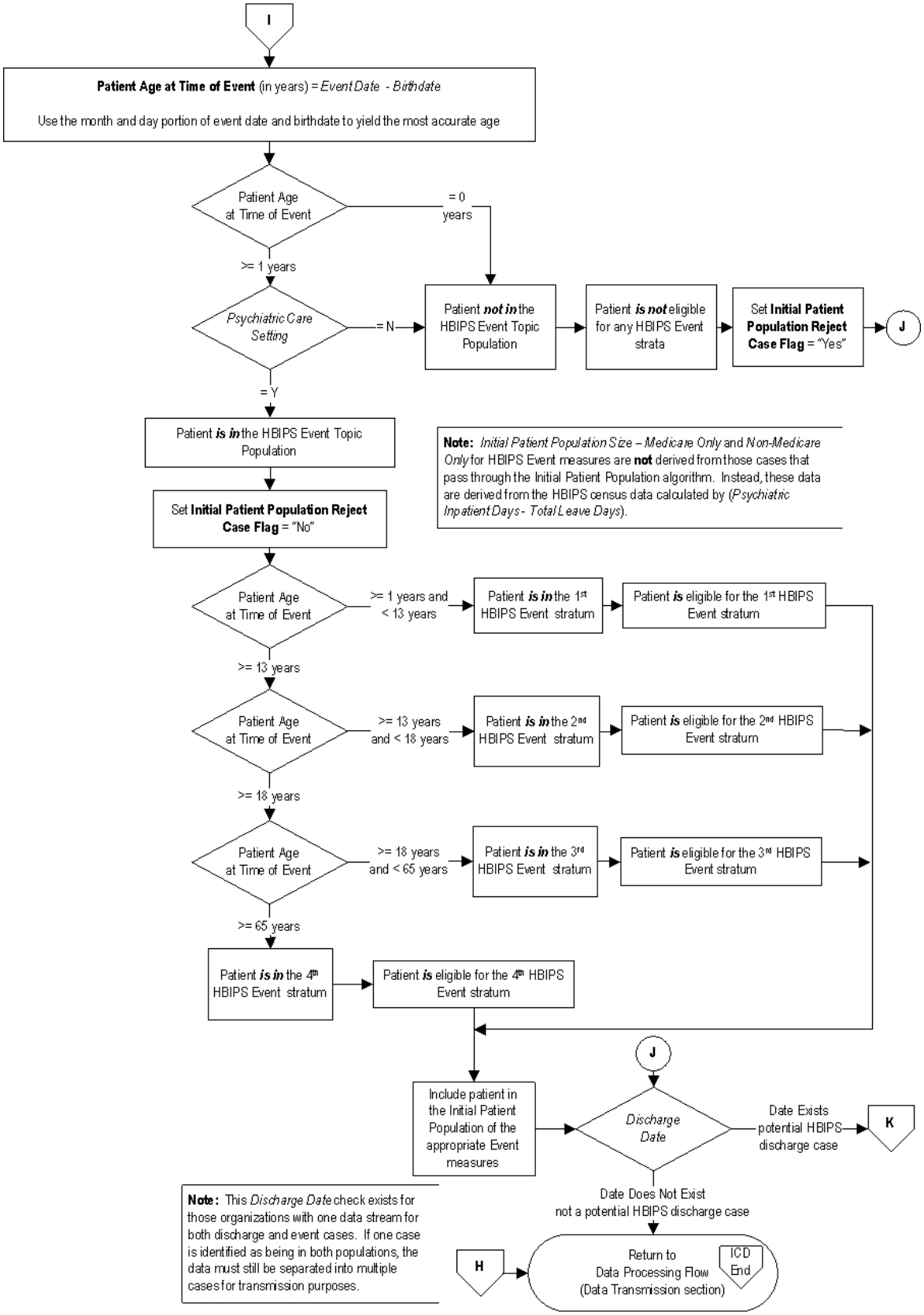
Event Stratum 3 - Age 18 years through 64 years stratum A Patient Age at Time of Event (Event Date - *Birthdate*) >= 18 years and < 65 years

Event Stratum 4 - Age greater than and equal to 65 years stratum A Patient Age at Time of Event (Event Date - *Birthdate*) >= 65 years

HBIPS Initial Patient Population Algorithm




L
Patient Age at Discharge
>= 1 years and < 13 years
Patient is in the 1st HBIPS Discharge stratum
Patient is eligible to be sampled for the 1st HBIPS Discharge stratum
>= 13 years
Patient Age at Discharge
>= 13 years and < 18 years
Patient is in the 2nd HBIPS Discharge stratum
Patient is eligible to be sampled for the 2nd HBIPS Discharge stratum
>= 18 years
Patient Age at Discharge
>= 18 years and < 65 years
Patient is in the 3rd HBIPS Discharge stratum
Patient is eligible to be sampled for the 3rd HBIPS Discharge stratum
>= 65 years
Patient is in the 4th HBIPS Discharge stratum
Patient is eligible to be sampled for the 4th HBIPS Discharge stratum
Include patient in the Initial Patient Population of the appropriate Discharge measures
H



Sample Size Requirements

Note For Joint Commission purposes, the HBIPS measure set is not included in the aligned Global Sampling methodology. All patients meeting the definition of the HBIPS Initial Patient Populations are eligible to be sampled, abstracted, and transmitted to the Joint Commission's Data Warehouse.

Sample Size Requirements for HBIPS Discharge Measures (HBIPS-1, HBIPS-4, HBIPS-5, HBIPS-6, and HBIPS-7)
Hospitals that choose to sample have the option of sampling quarterly or sampling monthly. A hospital may choose to use a larger sample size than is required. Hospitals whose Initial Patient Population size is less than the minimum number of cases per quarter/month for the stratum cannot sample that stratum.

Regardless of the option used, hospital samples must be monitored to ensure that sampling procedures consistently produce statistically valid and useful data. Because the sample for a measure set will rarely be equal to the effective sample due to exclusions and contraindications, hospitals selecting sample cases MUST submit AT LEAST the minimum required sample size.

The following sample size tables for each option automatically build in the number of cases needed to obtain the required sample sizes. For information concerning how to perform sampling, refer to the Population and Sampling Specifications section in this manual.

Quarterly Sampling

For hospitals selecting sample cases for the HBIPS discharge measures, a modified sampling procedure is required. Hospitals selecting sample cases for this set must ensure that each individual stratum's population and effective quarterly sample size meets the following conditions:

- Select within each of the four individual measure strata. The effective quarterly sample size within a stratum is at least 44 cases per quarter. Cases are placed into the appropriate stratum based upon the patient's age.
- The required quarterly sample size is at least 20% of the stratum population for the quarter.

Quarterly Sample Size
Based on Initial Patient Population for the HBIPS Discharge (HBIPS-DSC) Measures

Hospital's Measures	
Average Quarterly Stratum Initial Patient Population Size N	**Minimum Required Stratum Sample Size n**
> 877	176
221 - 877	20% of the Initial Patient Population
44 - 220	44
< 44	No sampling; 100% of the Initial Patient Population is required

Monthly Sampling

For hospitals selecting sample cases for HBIPS discharge measures, a modified sampling procedure is required. Hospitals selecting sample cases for this set must ensure that each individual strata population and effective monthly sample size meets the following conditions:

- Select within each of the four individual measure strata. The effective monthly sample size within a stratum is at least 15 cases per month. Cases are placed into the appropriate stratum based upon the patient's age.
- The required monthly sample size is at least 20% of the stratum population for the month.

Monthly Sample Size
Based on Initial Patient Population for the HBIPS Discharge (HBIPS-DSC) Measures

Hospital's Measures	
Average Monthly Stratum Initial Patient Population Size N	**Minimum Required Stratum Sample Size n**
> 295	60
76 - 295	20% of the Initial Patient Population
15 - 75	15
< 15	No sampling; 100% of the Initial Patient Population is required

Sample Size Examples

All sampled strata in HBIPS should be used in the calculation of all HBIPS discharge measures. All of the HBIPS discharge measures' specific exclusion criteria are used to filter out cases that do not belong in the measure denominator. Using HBIPS-1b as an example, include cases covering all sampled strata, although the measure-specific exclusion criteria would only allow cases with an age of 1 year through 12 years to be included in the denominator.

- Quarterly sampling:
  When applicable, larger hospitals must also abide by the required quarterly sample sizes for the four individual measure strata a minimum of 44 or 20% of population required sample cases per stratum when Initial Patient Population size is 44 or greater.
  - The HBIPS Initial Patient Population sizes for a hospital are 5, 100, 221, and 876 patients for each stratum respectively per quarter. The required quarterly sample sizes would be 5, 44, 45, and 176.
    - The 1st stratum is less than the minimum required quarterly sample size, so 100% of this stratum is sampled.
    - The 2nd stratum has 100 patients per quarter, which falls in the average quarterly population size of 44 to 220 patients, so 44 cases are sampled.
    - The 3rd stratum has 221 patients per quarter, which requires a 20% sample size, of 45 cases (twenty percent of 221 equals 44.2 rounded to the next highest whole number = 45).
    - The 4th stratum has 876 patients per quarter, which is more than the maximum condition, so a minimum of 176 cases are required to be sampled.

- Monthly sampling:
  When applicable, larger hospitals must also abide by the required monthly sample sizes for the four individual measure strata a minimum of 15 required sample cases per stratum when Initial Patient Population size is 15 or greater.
  - The HBIPS Initial Patient Population sizes for a hospital are 5, 45, 294 and 400 patients respectively in July. The required monthly sample sizes would be 5, 15, 59, and 60.
    - The 1st stratum is less than the minimum required monthly sample size, so 100% of this stratum is sampled.
    - The 2nd stratum has 45 patients per month, which falls in the average monthly population size of 15 to 75 patients, so 15 cases are sampled.
    - The 3rd stratum has 294 patients per month, which requires a 20% sample size, of 59 cases (twenty percent of 294 equals 58.8 rounded to the next highest whole number = 59).
    - The 4th stratum has 400 patients per month, which is more than the maximum condition, so a minimum of 60 cases are required to be sampled.

Sampling Requirements for HBIPS Event Measures (HBIPS-2 and HBIPS-3)

The measures in HBIPS-EVT (HBIPS-2 and HBIPS-3) are not eligible for sampling and will use the entire Initial Patient Population for reporting.

**** NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE ****

Measure Information Form

Measure Set: Hospital Based Inpatient Psychiatric Services (HBIPS)

Measure ID: HBIPS-1

Set Measure ID	Performance Measure Name
HBIPS-1a	Admission Screening- Overall Rate
HBIPS-1b	Admission Screening- Children (1 through 12 years)
HBIPS-1c	Admission Screening- Adolescent (13 through 17 years)
HBIPS-1d	Admission Screening- Adult (18 through 64 years)
HBIPS-1e	Admission Screening- Older Adult (≥65 years)

Name: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed

Description: Patients admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of admission for all of the following: risk of violence to self or others, substance use, psychological trauma history and patient strengths.

Rationale: Substantial evidence exists that there is a high prevalence of co-occurring substance use disorders as well as history of trauma among persons admitted to acute psychiatric settings. Professional literature suggests that these factors are under-identified yet integral to current psychiatric status and should be assessed in order to develop appropriate treatment (Ziedonis, 2004; NASMHPD, 2005). Similarly, persons admitted to inpatient settings require a careful assessment of risk for violence and the use of seclusion and restraint. Careful assessment of risk is critical to safety and treatment. Effective, individualized treatment relies on assessments that explicitly recognize patients strengths. These strengths may be characteristics of the individuals themselves, supports provided by families and others, or contributions made by the individuals community or cultural environment (Rapp, 1998). In the same way, inpatient environments require assessment for factors that lead to conflict or less than optimal outcomes.

Type Of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Psychiatric inpatients with admission screening within the first three days of admission for **all** of the following: risk of violence to self or others; substance use; psychological trauma history; and patient strengths

> **Included Populations:** Not applicable
>
> **Excluded Populations:** None
>
> **Data Elements:**
>
> - *Patient Strengths*
> - *Psychological Trauma History*
> - *Substance Use*
> - *Violence Risk to Others*
> - *Violence Risk to Self*

Denominator Statement: Psychiatric inpatient discharges

Included Populations:

- Patients with *ICD-10-CM Principal* or *Other Diagnosis Codes* for Mental Disorders as defined in Appendix A, Table 10.01

Excluded Populations:

- Patients for whom there is an inability to complete admission screening for *Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths* within the first three days of admission
- Patients with a Length of Stay ≤ 3 days or ≥ 365 days

Data Elements:

- *Admission Date*
- *Birthdate*
- *Discharge Date*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *Psychiatric Care Setting*

Risk Adjustment: No.

Data Accuracy: Hospitals may wish to implement periodic audits to monitor and ensure data accuracy.

Measure Analysis Suggestions: The data elements for each of the five initial assessment elements provide an opportunity to assess each component individually. However, completion of all **five** initial assessment categories is required for this measure.

Sampling: Yes. For additional information see the Sampling Section.

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

Selected References:

- American Psychiatric Association. (2003). Practice guidelines for psychiatric evaluation of adults. Arlington (VA): American Psychiatric Association. http://www.guideline.gov/summary/summary.aspx?doc_id=9317
- Lyons JS, Uziel-Miller ND, Reyes F, Sokol PT (2000). Strengths of children and adolescents in residential settings: Prevalence and associations with psychopathology and discharge placement. Journal of the American Academy of Child & Adolescent Psychiatry, Vol 39(2): 176-181.
- NASMHPD. (2005) *Position Statement on Services and Supports to Trauma Survivors*. Alexandria, VA: NASMHPD.
- Rapp CA (1998). The strengths model: Case management with people suffering from severe and persistent mental illness. London: Oxford University Press.
- Ruiz P (2004). Addressing Culture, Race, & Ethnicity in Psychiatric Practice. Psychiatric Annals, Vol 34(7): 527-532.
- Ziedonis DM (2004). Integrated treatment of co-occurring mental illness and addiction: Clinical intervention, program, and system perspectives. CNS Spectrums 9(12): 892,894-904,925.

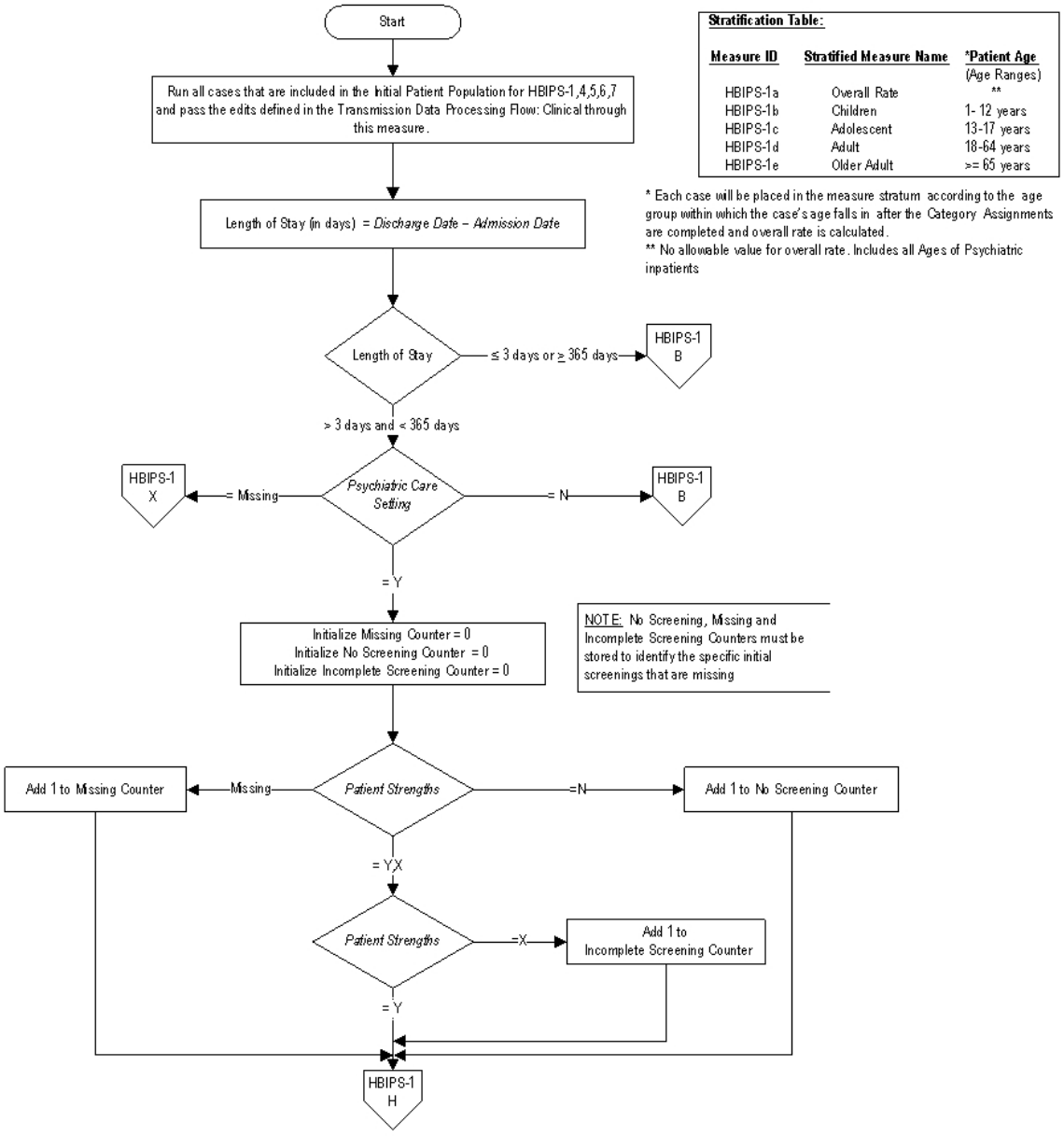
Measure Algorithm:

HBIPS-1: Admission Screening For Violence Risk, Substance Use, Psychological Trauma History And Patient Strengths Completed

Numerator Statement: Psychiatric inpatients with admission screening within the first three days of admission for all of the following: risk of violence to self or others; substance use; history of psychological trauma history, and patient strengths.

Denominator Statement: Psychiatric inpatient discharges.

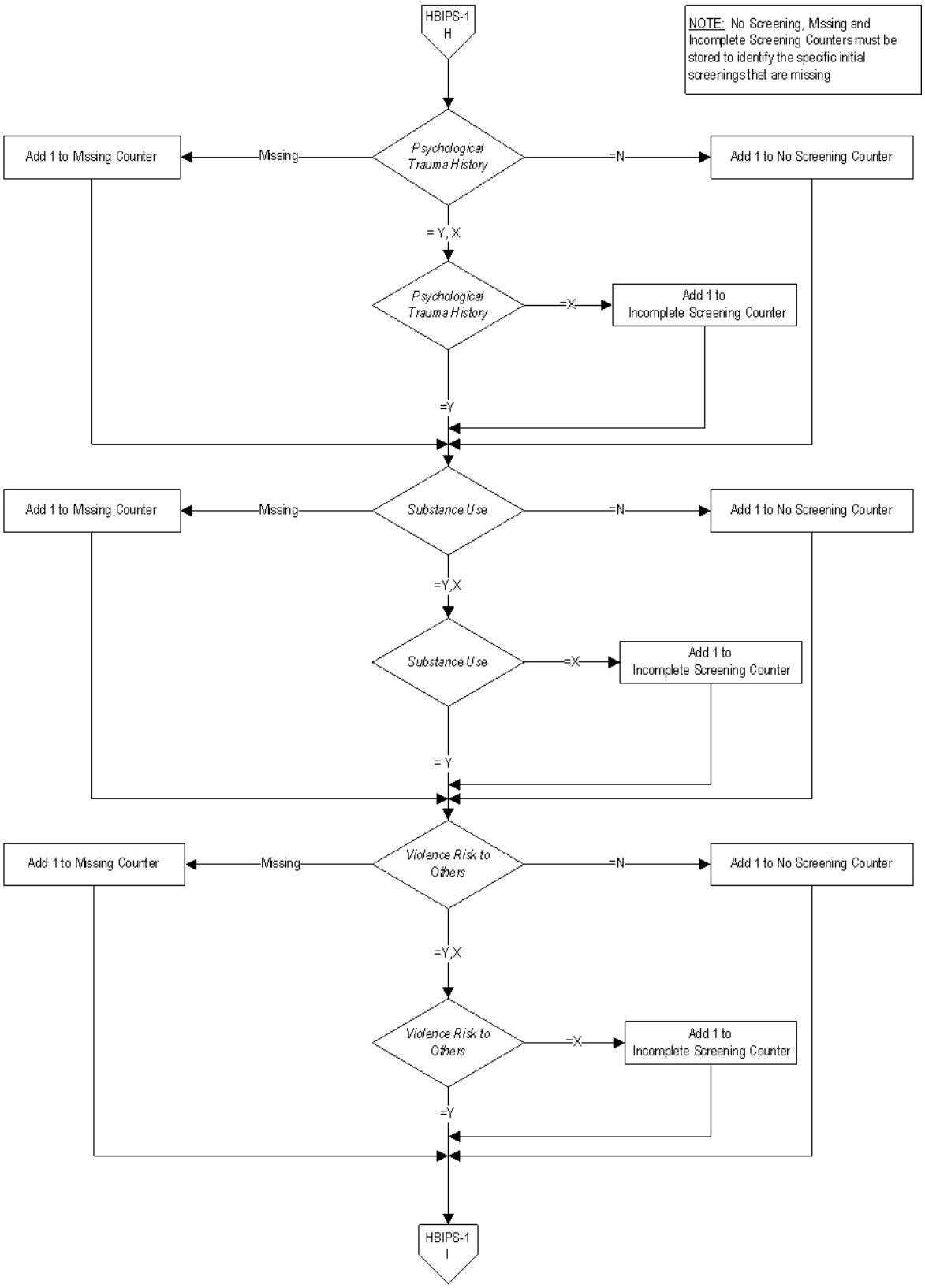
Variable Key:
Patient Age at Discharge
Length of Stay
Missing Counter
No Screening Counter
Incomplete Screening Counter

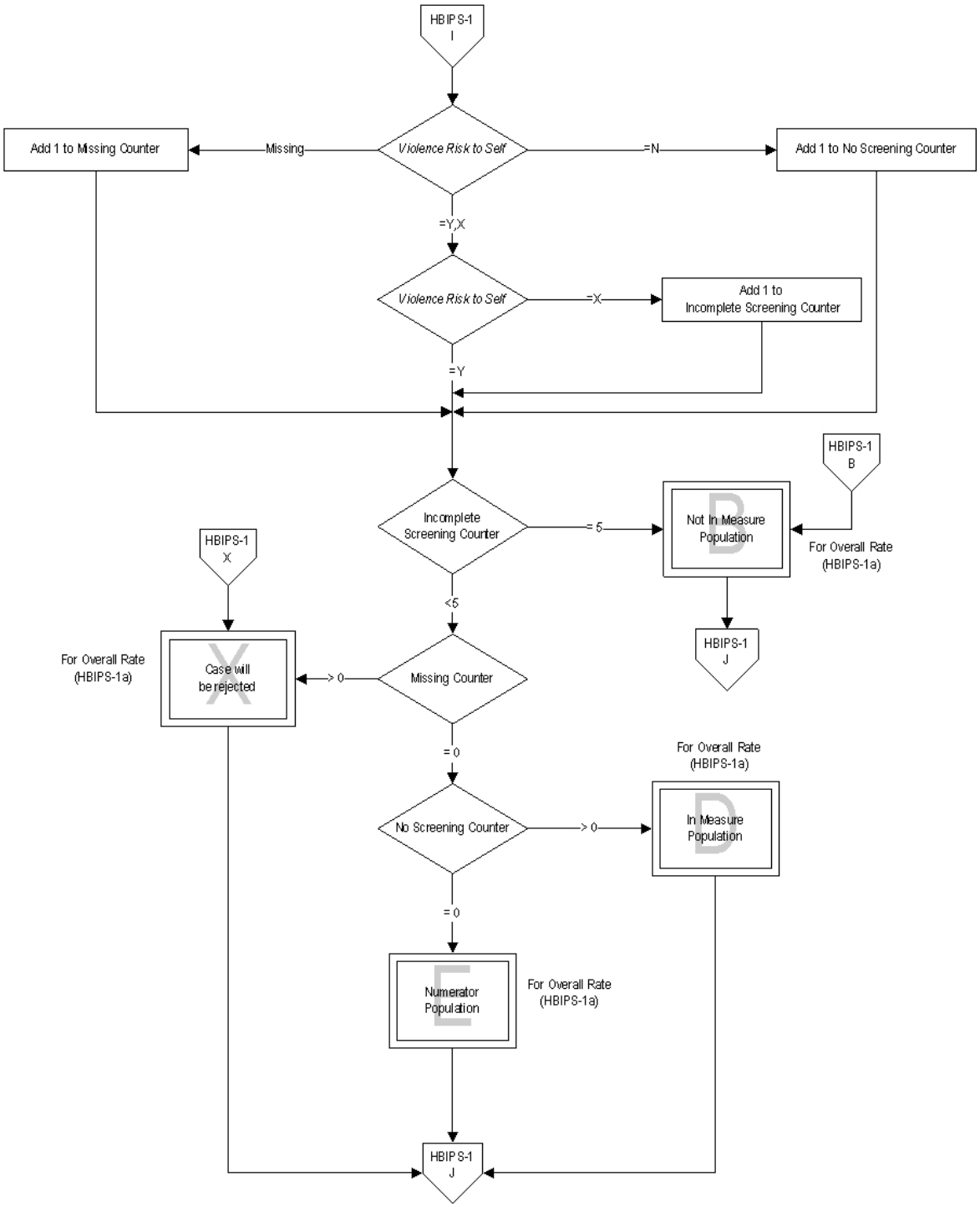


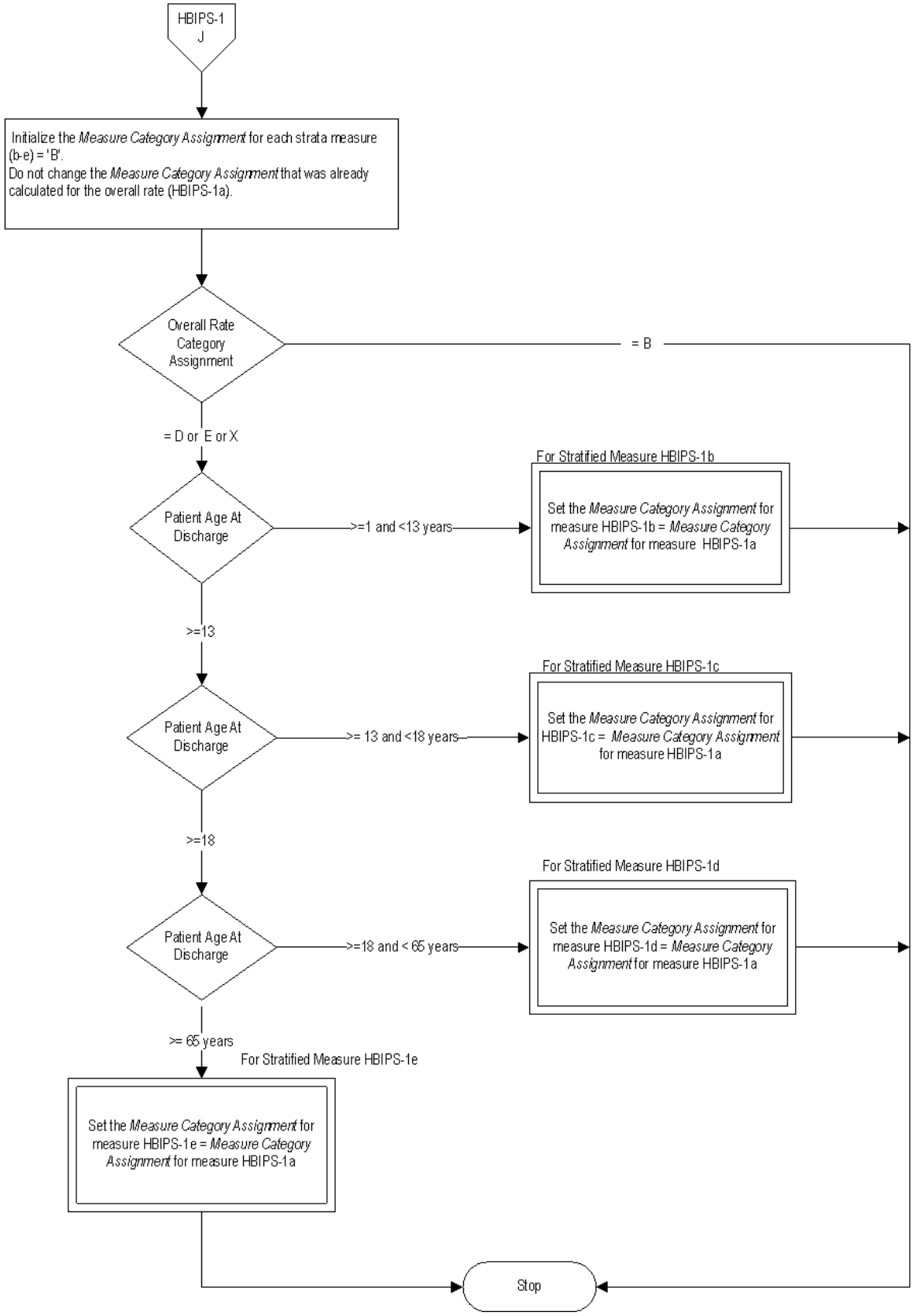
Stratification Table:

Measure ID	Stratified Measure Name	*Patient Age (Age Ranges)
HBIPS-1a	Overall Rate	**
HBIPS-1b	Children	1- 12 years
HBIPS-1c	Adolescent	13-17 years
HBIPS-1d	Adult	18-64 years
HBIPS-1e	Older Adult	>= 65 years

* Each case will be placed in the measure stratum according to the age group within which the case's age falls in after the Category Assignments are completed and overall rate is calculated.
** No allowable value for overall rate. Includes all Ages of Psychiatric inpatients


HBIPS-1
H
NOTE: No Screening, Mssing and Incomplete Screening Counters must be stored to identify the specific initial screenings that are missing
Psychological Trauma History
Missing
Add 1 to Mssing Counter
=N
Add 1 to No Screening Counter
= Y, X
Psychological Trauma History
=X
Add 1 to Incomplete Screening Counter
=Y
Substance Use
Missing
Add 1 to Mssing Counter
=N
Add 1 to No Screening Counter
=Y,X
Substance Use
=X
Add 1 to Incomplete Screening Counter
= Y
Violence Risk to Others
Missing
Add 1 to Missing Counter
=N
Add 1 to No Screening Counter
=Y,X
Violence Risk to Others
=X
Add 1 to Incomplete Screening Counter
=Y
HBIPS-1
I


HBIPS-1
I
Violence Risk to Self
Missing
Add 1 to Missing Counter
=N
Add 1 to No Screening Counter
=Y,X
Violence Risk to Self
=X
Add 1 to
Incomplete Screening Counter
=Y
HBIPS-1
B
Incomplete
Screening Counter
= 5
Not In Measure
Population
For Overall Rate
(HBIPS-1a)
HBIPS-1
X
<5
For Overall Rate
(HBIPS-1a)
Case will
be rejected
> 0
Missing Counter
HBIPS-1
J
= 0
For Overall Rate
(HBIPS-1a)
No Screening Counter
> 0
In Measure
Population
= 0
Numerator
Population
For Overall Rate
(HBIPS-1a)
HBIPS-1
J


HBIPS-1
J
Initialize the *Measure Category Assignment* for each strata measure (b-e) = 'B'.
Do not change the *Measure Category Assignment* that was already calculated for the overall rate (HBIPS-1a).
Overall Rate Category Assignment
= B
= D or E or X
Patient Age At Discharge
>=1 and <13 years
For Stratified Measure HBIPS-1b
Set the *Measure Category Assignment* for measure HBIPS-1b = *Measure Category Assignment* for measure HBIPS-1a
>=13
Patient Age At Discharge
>= 13 and <18 years
For Stratified Measure HBIPS-1c
Set the *Measure Category Assignment* for HBIPS-1c = *Measure Category Assignment* for measure HBIPS-1a
>=18
Patient Age At Discharge
>=18 and < 65 years
For Stratified Measure HBIPS-1d
Set the *Measure Category Assignment* for measure HBIPS-1d = *Measure Category Assignment* for measure HBIPS-1a
>= 65 years
For Stratified Measure HBIPS-1e
Set the *Measure Category Assignment* for measure HBIPS-1e = *Measure Category Assignment* for measure HBIPS-1a
Stop

Measure Information Form

Measure Set: Hospital Based Inpatient Psychiatric Services (HBIPS)

Measure ID: HBIPS-2

Set Measure ID	Performance Measure Name
HBIPS-2a	Physical Restraint- Overall Rate
HBIPS-2b	Physical Restraint- Children (1 through 12 years)
HBIPS-2c	Physical Restraint- Adolescent (13 through 17 years)
HBIPS-2d	Physical Restraint- Adult (18 through 64 years)
HBIPS-2e	Physical Restraint- Older Adult (≥ 65 years)

Name: Hours of physical restraint use

Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.

Rationale: Mental health providers that value and respect an individuals autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint and seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).

Type Of Measure: Process

Improvement Noted As: Decrease in the rate

Numerator Statement: The total number of hours that all psychiatric inpatients were maintained in physical restraint

Numerator Basis: The numerator evaluates the number of hours of physical restraint; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. Convert the minutes to hours when analyzing and reporting this measure.

> **Included Populations:**
>
> - Patients for whom at least one physical restraint event is reported during the month
>
> **Excluded Populations:** None
>
> **Data Elements:**
>
> - *Event Date*
> - *Event Type*
> - *Minutes of Physical Restraint*

Denominator Statement: Number of psychiatric inpatient days

Denominator Basis: per 1,000 hours

Included Populations:

- All psychiatric inpatient days

Excluded Populations:

- Total leave days

Data Elements:

- *Admission Date*
- *Birthdate*
- *Psychiatric Care Setting*
- *Psychiatric Inpatient Days - Medicare Only*
- *Psychiatric Inpatient Days-Non-Medicare Only*
- *Total Leave Days - Medicare Only*
- *Total Leave Days-Non-Medicare Only*

Risk Adjustment: No.

Data Accuracy: Hospitals may wish to implement periodic audits to monitor and ensure data accuracy.

Measure Analysis Suggestions: In order to further examine the issue of restraint use within a facility it may be useful to study the incidence of physical restraint use by collecting additional information about the clinical justification for use.

Sampling: No.

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

Selected References:

- Donat, D. (August, 2003). An analysis of successful efforts to reduce the use of seclusion and restraint at a public psychiatric hospital. *Psychiatric Services*. 54(8): 1119-1123.
- Fisher, W. A. (2003). Elements of successful restraint and seclusion reduction programs and their application in a large, urban, state psychiatric hospital. *Journal of Psychiatric Practice*, 9(1), 7-15.
- Huckshorn, K.A. (2004/September). Reducing seclusion and restraint use in mental health settings: Core strategies for prevention. *Journal of Psychosocial Nursing and Mental Health Services*. 42(9). Pp. 22-31.
- Mohr, W. K., & Anderson, J. A. (2001). Faulty assumptions associated with the use of restraints with children. *Journal of Child and Adolescent Psychiatric Nursing*, 14(3), 141- 151.
- Special Section on Seclusion and Restraint, (2005, Sept). *Psychiatric Services*, 56 (9), 1104-1142.
- *Success Stories and Ideas for Reducing Restraint/Seclusion*. (2003). A compendium of strategies created by the American Psychiatric Association (APA), the American Psychiatric Nurses Association (APNA), the National Association of Psychiatric Health Systems (NAPHS), and the American Hospital Association Section for Psychiatric and Substance Abuse Services (AHA). Retrieved from the Internet on February 10, 2010 at http://www.naphs.org

Adopted for CMS Inpatient Psychiatric Facility Quality Reporting Program FY 2014

Measure Algorithm:

HBIPS-2: Hours of Physical Restraint Use

Numerator Statement: The total number of hours that all psychiatric inpatients spent in physical restraint

Denominator Statement: Number of psychiatric inpatient days

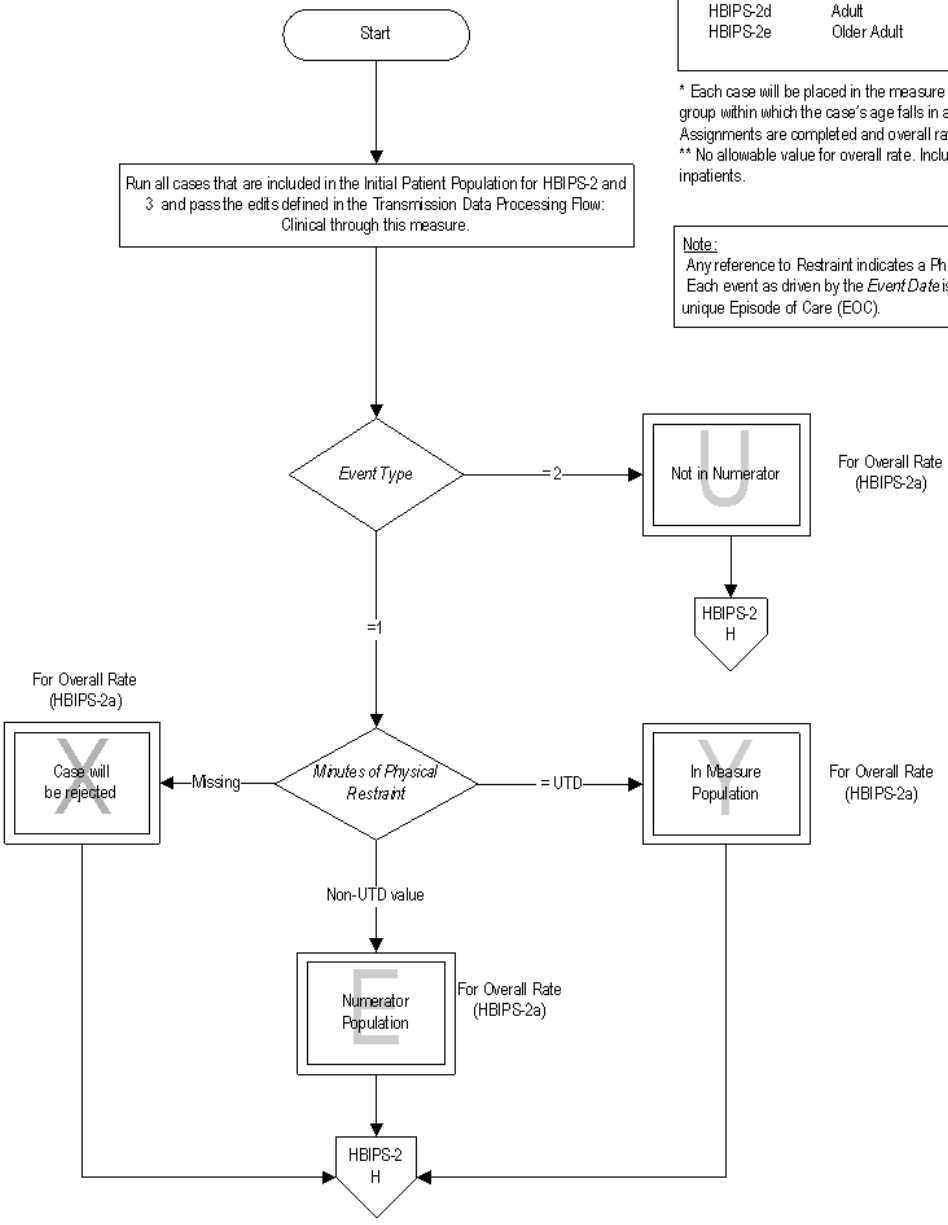
Variable Key:
Patient Age at Time of Event

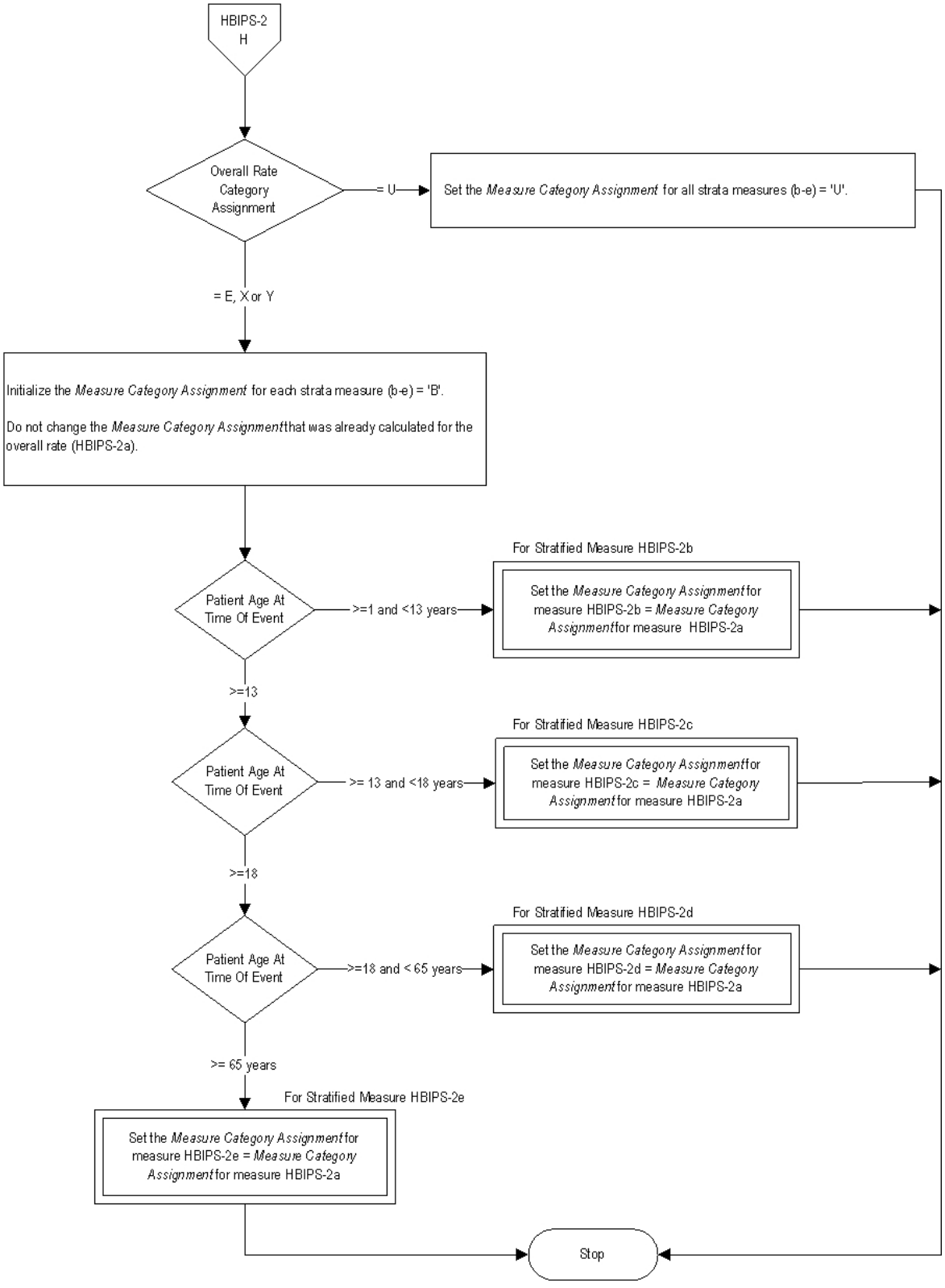
Stratification Table For Numerator:

Measure ID	Stratified Measure Name	*Patient Age (Age Ranges)
HBIPS-2a	Overall Rate	**
HBIPS-2b	Children	1- 12 years
HBIPS-2c	Adolescent	13-17 years
HBIPS-2d	Adult	18-64 years
HBIPS-2e	Older Adult	>= 65 years

* Each case will be placed in the measure stratum according to the age group within which the case's age falls in after the Category Assignments are completed and overall rate is calculated.
** No allowable value for overall rate. Includes all Ages of Psychiatric inpatients.

Note:
Any reference to Restraint indicates a Physical Restraint Event. Each event as driven by the *Event Date* is processed as a unique Episode of Care (EOC).




HBIPS-2 H
Overall Rate Category Assignment
= U
Set the *Measure Category Assignment* for all strata measures (b-e) = 'U'.
= E, X or Y
Initialize the *Measure Category Assignment* for each strata measure (b-e) = 'B'.
Do not change the *Measure Category Assignment* that was already calculated for the overall rate (HBIPS-2a).
For Stratified Measure HBIPS-2b
Patient Age At Time Of Event
>=1 and <13 years
Set the *Measure Category Assignment* for measure HBIPS-2b = *Measure Category Assignment* for measure HBIPS-2a
>=13
For Stratified Measure HBIPS-2c
Patient Age At Time Of Event
>= 13 and <18 years
Set the *Measure Category Assignment* for measure HBIPS-2c = *Measure Category Assignment* for measure HBIPS-2a
>=18
For Stratified Measure HBIPS-2d
Patient Age At Time Of Event
>=18 and < 65 years
Set the *Measure Category Assignment* for measure HBIPS-2d = *Measure Category Assignment* for measure HBIPS-2a
>= 65 years
For Stratified Measure HBIPS-2e
Set the *Measure Category Assignment* for measure HBIPS-2e = *Measure Category Assignment* for measure HBIPS-2a
Stop

Measure Calculation for Aggregated Denominator

Denominator
For the overall measure and each strata measure calculate the denominator by aggregating the Psychiatric Inpatient Days and Leave Days:

Number of Denominator Cases for the overall measure = (*Psychiatric Inpatient Days – Leave Days*)
for all patients for the reporting month

Number of Denominator Cases for each strata measure = (*Psychiatric Inpatient Days – Leave Days*)
for all patients with a **Patient Age (Reporting Date - *Birthdate*)** appropriate for the strata for the reporting month
where Reporting Date is the last date of the reporting month that the census data is being reported.

Performance Measurement Systems can refer to the Joint Commission's ORYX Technical Implementation Guide for information concerning the aggregation of HCO level data, including the *Observed Rate* and Population Size for this measure.

Measure Information Form

Measure Set: Hospital Based Inpatient Psychiatric Services (HBIPS)

Measure ID: HBIPS-3

Set Measure ID	Performance Measure Name
HBIPS-3a	Seclusion- Overall Rate
HBIPS-3b	Seclusion- Children (1 through 12 years)
HBIPS-3c	Seclusion- Adolescent (13 through 17 years)
HBIPS-3d	Seclusion- Adult (18 through 64 years)
HBIPS-3e	Seclusion- Older Adult (≥ 65 years)

Name: Hours of seclusion use

Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion.

Rationale: Mental health providers that value and respect an individuals autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).

Type Of Measure: Process

Improvement Noted As: Decrease in the rate

Numerator Statement: The total number of hours that all psychiatric inpatients were held in seclusion

Numerator Basis: The numerator evaluates the number of hours of seclusion; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. Convert the minutes to hours when analyzing and reporting this measure.

> **Included Populations:**
>
> - Patients for whom at least one seclusion event is reported during the month
>
> **Excluded Populations:** None
>
> **Data Elements:**
>
> - *Event Date*
> - *Event Type*
> - *Minutes of Seclusion*

Denominator Statement: Number of psychiatric inpatient days

Denominator Basis: per 1,000 hours

Included Populations:

- All psychiatric inpatient days

Excluded Populations:

- Total leave days

Data Elements:

- *Admission Date*
- *Birthdate*
- *Psychiatric Care Setting*
- *Psychiatric Inpatient Days - Medicare Only*
- *Psychiatric Inpatient Days-Non-Medicare Only*
- *Total Leave Days - Medicare Only*
- *Total Leave Days-Non-Medicare Only*

Risk Adjustment: No.

Data Accuracy: Hospitals may wish to implement periodic audits to monitor and ensure data accuracy.

Measure Analysis Suggestions: In order to further examine the issue of seclusion use within your facility it may be useful to study the incidence of seclusion use by collecting additional information about the clinical justification for use.

Sampling: No.

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

Selected References:

- Donat, D. (August, 2003). An analysis of successful efforts to reduce the use of seclusion and restraint at a public psychiatric hospital. *Psychiatric Services*. 54(8): 1119-1123.
- Fisher, W. A. (2003). Elements of successful restraint and seclusion reduction programs and their application in a large, urban, state psychiatric hospital. *Journal of Psychiatric Practice*, 9(1), 7-15.
- Huckshorn, K.A. (2004/September). Reducing seclusion and restraint use in mental health settings: Core strategies for prevention. *Journal of Psychosocial Nursing and Mental Health Services*. 42(9). Pp. 22-31.
- Mohr, W. K., & Anderson, J. A. (2001). Faulty assumptions associated with the use of restraints with children. *Journal of Child and Adolescent Psychiatric Nursing*, 14(3), 141- 151.
- Special Section on Seclusion and Restraint, (2005, Sept). *Psychiatric Services*, 56 (9), 1104-1142.
- *Success Stories and Ideas for Reducing Restraint/Seclusion*. (2003). A compendium of strategies created by the American Psychiatric Association (APA), the American Psychiatric Nurses Association (APNA), the National Association of Psychiatric Health Systems (NAPHS), and the American Hospital Association Section for Psychiatric and Substance Abuse Services (AHA). Retrieved from the Internet on February 10, 2010 at http://www.naphs.org

Adopted for CMS Inpatient Psychiatric Facility Quality Reporting Program FY 2014

Measure Algorithm:

HBIPS-3: Hours of Seclusion Use

Numerator Statement: The total number of hours that all psychiatric inpatients spent in seclusion

Denominator Statement: Number of psychiatric inpatient days

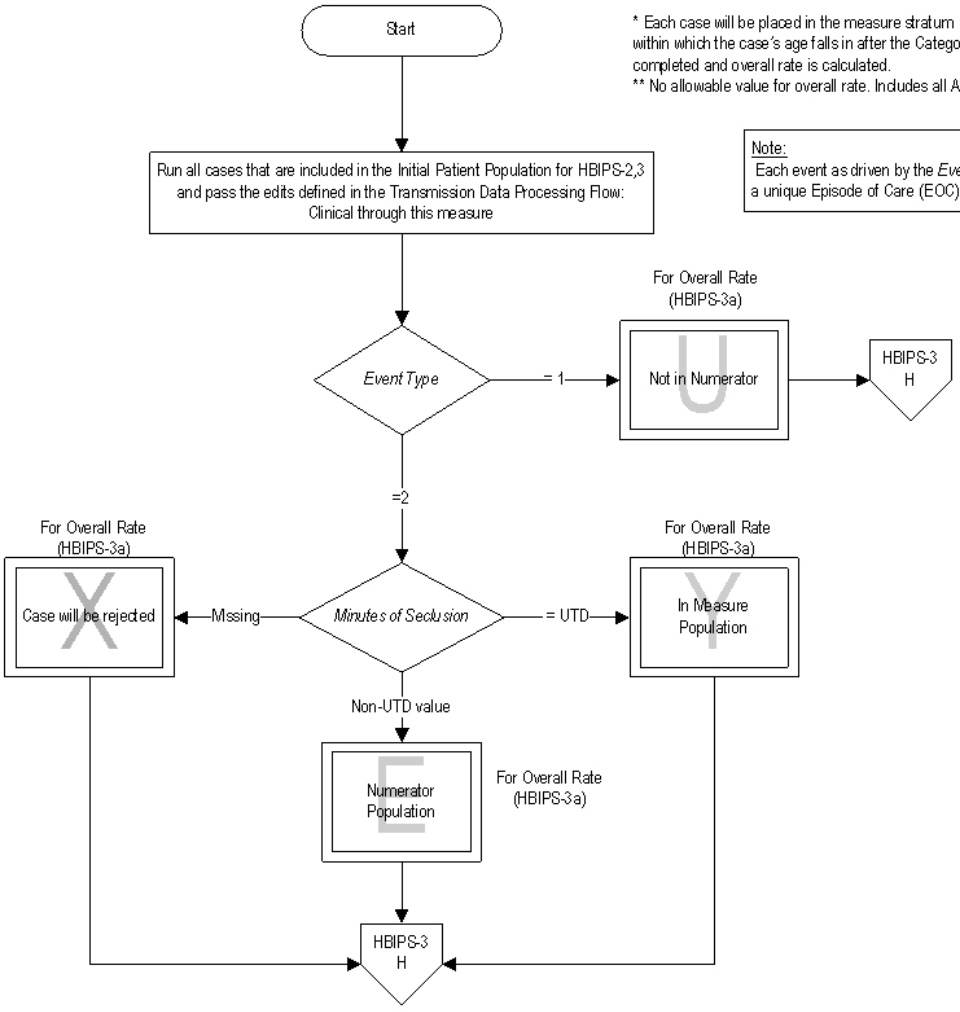
Variable Key:
Patient Age at Time of Event

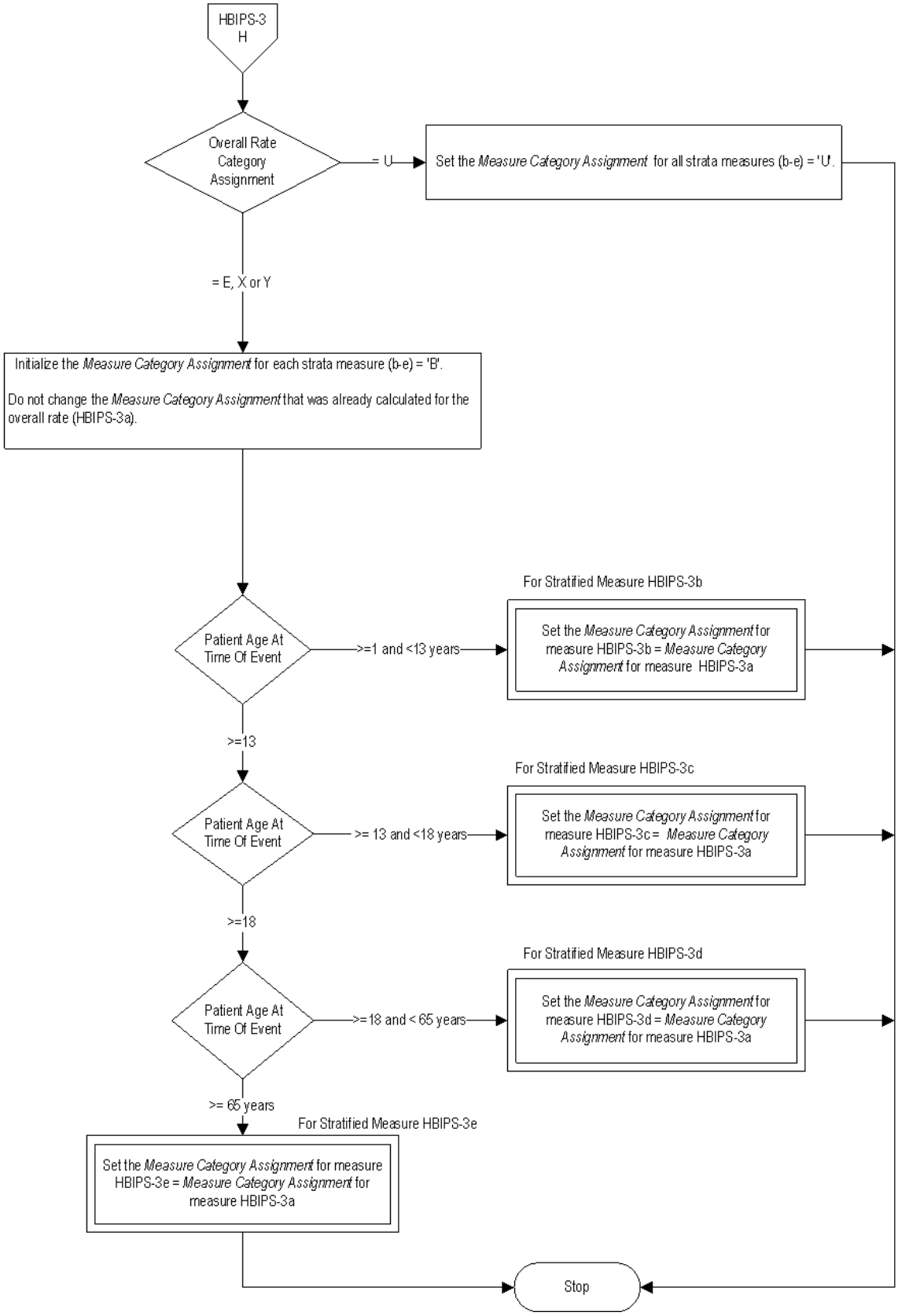
Stratification Table For Numerator:

Measure ID	Stratified Measure Name	*Patient Age (Age Ranges)
HBIPS-3a	Overall Rate	**
HBIPS-3b	Children	1- 12 years
HBIPS-3c	Adolescent	13-17 years
HBIPS-3d	Adult	18-64 years
HBIPS-3e	Older Adult	>= 65 years

* Each case will be placed in the measure stratum according to the age group within which the case's age falls in after the Category Assignments are completed and overall rate is calculated.
** No allowable value for overall rate. Includes all Ages of Psychiatric inpatients.

Note:
Each event as driven by the *Event Date* is processed as a unique Episode of Care (EOC).




HBIPS-3
H
Overall Rate
Category
Assignment
= U
Set the *Measure Category Assignment* for all strata measures (b-e) = 'U'.
= E, X or Y
Initialize the *Measure Category Assignment* for each strata measure (b-e) = 'B'.
Do not change the *Measure Category Assignment* that was already calculated for the overall rate (HBIPS-3a).
For Stratified Measure HBIPS-3b
Patient Age At
Time Of Event
>=1 and <13 years
Set the *Measure Category Assignment* for measure HBIPS-3b = *Measure Category Assignment* for measure HBIPS-3a
>=13
For Stratified Measure HBIPS-3c
Patient Age At
Time Of Event
>= 13 and <18 years
Set the *Measure Category Assignment* for measure HBIPS-3c = *Measure Category Assignment* for measure HBIPS-3a
>=18
For Stratified Measure HBIPS-3d
Patient Age At
Time Of Event
>=18 and < 65 years
Set the *Measure Category Assignment* for measure HBIPS-3d = *Measure Category Assignment* for measure HBIPS-3a
>= 65 years
For Stratified Measure HBIPS-3e
Set the *Measure Category Assignment* for measure HBIPS-3e = *Measure Category Assignment* for measure HBIPS-3a
Stop

Measure Calculation for Aggregated Denominator

Denominator
For the overall measure and each strata measure calculate the denominator rate by aggregating the *Psychiatric Inpatient Days* and *Leave Days*:

Number of Denominator Cases for the overall measure = (*Psychiatric Inpatient Days – Leave Days*)
for all patients for the reporting month

Number of Denominator Cases for each strata measure = (*Psychiatric Inpatient Days – Leave Days*)
for all patients with a **Patient Age (Reporting Date - *Birthdate*)** appropriate for the strata for the reporting month
where Reporting Date is the last date of the reporting month that the census data is being reported.

Performance Measurement Systems can refer to the Joint Commission's ORYX Technical Implementation Guide for information concerning the aggregation of HCO level data, including the *Observed Rate* and Population Size for this measure.

Measure Information Form

Measure Set: Hospital Based Inpatient Psychiatric Services (HBIPS)

Measure ID: HBIPS-4

Set Measure ID	Performance Measure Name
HBIPS-4a	Multiple Antipsychotic Medications at Discharge- Overall Rate
HBIPS-4b	Multiple Antipsychotic Medications at Discharge- Children (1 through 12 years)
HBIPS-4c	Multiple Antipsychotic Medications at Discharge- Adolescent (13 through 17 years)
HBIPS-4d	Multiple Antipsychotic Medications at Discharge- Adult (18 through 64 years)
HBIPS-4e	Multiple Antipsychotic Medications at Discharge- Older Adult (≥ 65 years)

Name: Patients discharged on multiple antipsychotic medications

Description: Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications

Rationale: Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganocyz, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006). Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation with a second antipsychotic in treatment resistant patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic (Tranulis, Skalli, Lalonde, & Nicole, 2008). Among patients without a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other controlled trials failed to show a benefit of antipsychotic polypharmacy over monotherapy (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Potkin, Thyrum, Alva, Bera, Yeh, & Arvanitis, 2002; Shim et al., 2007; Stahl,& Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient on multiple antipsychotics with an aftercare plan to transition to monotherapy. In such cases, effective communication between the inpatient and aftercare clinician is an essential element of care.

Type Of Measure: Process

Improvement Noted As: Decrease in the rate

Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications

> **Included Populations:** Not applicable
>
> **Excluded Populations:** None
>
> **Data Elements:**

- *Number of Antipsychotic Medications Prescribed at Discharge*

Denominator Statement: Psychiatric inpatient discharges

Included Populations:

- Patients with *ICD-10-CM Principal or Other Diagnosis Codes* for Mental Disorders as defined in Appendix A, Table 10.01 discharged on one or more routinely scheduled antipsychotic medications (refer to Appendix C, Table 10.0- Antipsychotic Medications).

Excluded Populations:

- Patients who expired
- Patients with an unplanned departure resulting in discharge due to elopement
- Patients with an unplanned departure resulting in discharge due to failing to return from leave
- Patient's residence is not in the USA, and they are returning to another country after discharge

Data Elements:

- *Birthdate*
- *Discharge Date*
- *Discharge Disposition*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *Number of Antipsychotic Medications Prescribed at Discharge*
- *Patient Referral to Next Level of Care Provider*
- *Psychiatric Care Setting*

Risk Adjustment: No.

Data Accuracy: Hospitals may wish to implement periodic audits to monitor and ensure data accuracy.

Measure Analysis Suggestions: For quality improvement purposes, the measurement system may want to create reports to identify patients discharged on two or more antipsychotic medications without appropriate supporting documentation. This would allow healthcare organizations to target education efforts.

Sampling: Yes. For additional information see the Sampling Section.

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

Selected References:

- American Psychiatric Association (APA). (2004). Steering Committee on Practice Guidelines. Practice guideline for the treatment of patients with schizophrenia, second edition. *Am J Psychiatry*. 161(2 Suppl):1-56
- Ananth, J., Parameswaran, S., & Gunatilake, S. (2004). Antipsychotic polypharmacy comparing monotherapy with polypharmacy and augmentation. *Curr Med Chem*. 11(3):313-327 *Curr Pharm Des*. 10(18):2231-2238.
- Centorrino, F., Gören, J.L., Hennen, J., Salvatore, P., Kelleher, J.P., & Baldessarini, R.J. (2004) Multiple versus single antipsychotic agents for hospitalized psychiatric patients: a case control study of risk versus benefit. *Am J Psychiatry*. 161 (4):700-706.
- Covell, N.H., Jackson, C.T., Evans, A.C., & Essock, S.M. (2002). Antipsychotic prescribing practices in Connecticuts public mental health system: rates of changing medication prescribing styles. *Schiz Bull*. 28(1):17-29,

- Ganguly, R., Kotzan, J.A., Miller, L.S., Kennedy, K., & Martin, B.C. (2004). Prevalence, trends, and factors associated with antipsychotic polypharmacy among Medicaid-eligible schizophrenia patients, 1998-2000. *J Clin Psychiatry*. 65(10):1377-88.
- Gilmer, T.P., Dolder, C.R., Folsom, D.P., Mastin, W., & Jeste, D.V. (2007), Antipsychotic polypharmacy trends among Medicaid beneficiaries with schizophrenia in San Diego County, 1999 - 2004. *Psychiatric Serv*. 59(7):1007-1010.
- Jaffe, A.B. & Levine, J. (2003). Antipsychotic medication co-prescribing in a large state hospital system. *Pharmacoepidemiol Drug Saf*.12:41-48.
- Kreyenbuhl, J., Valenstein, M., McCarthy, J.F., Ganocyz, D., & Blow, F.C. (2006). Long-term combination antipsychotic treatment in VA patients with schizophrenia. *Schiz Res*.84:90-99.
- National Association of State Mental Health Program Directors (NASMHPD). (2001).Technical report on psychiatric polypharmacy. Alexandria, VA.
- Potkin, S.G., Thyrum, P.T., Alva, G., Bera, R., Yeh, C., & Arvanitis, L.A. (2002). The safety and pharmacokinetics of quetiapine when coadministered with haloperidol, risperidone or thioridazine. *J Clin Psychopharmacol*. 22:121-130.
- Shim, J.C., Shin, J.G., Kelly, D.L., Jung, D.U., Seo, Y.S., Liu, K.H., et al. (2007). Adjunctive treatment with a dopamine partial agonist aripiprazole, for treatment of antipsychotic-induced hyperprolactinemia: A placebo controlled trial. *Am J Psych.164*:1404-1410.
- Stahl, S.M. & Grady, M.M. (2004). A critical review of atypical antipsychotic utilization: comparing monotherapy with polypharmacy augmentation. *Curr Med Chem.11*:313-327.
- Tranulis, C., Skalli, L., Lalonde, P., & Nicole, L. (2008). Benefits and risks of antipsychotic polypharmacy. An evidence based review of the literature. _Drug Saf. 31_(1):7-20
- University HealthSystem Consortium. (2006). Mental health performance measures field brief. Oakbrook, IL.

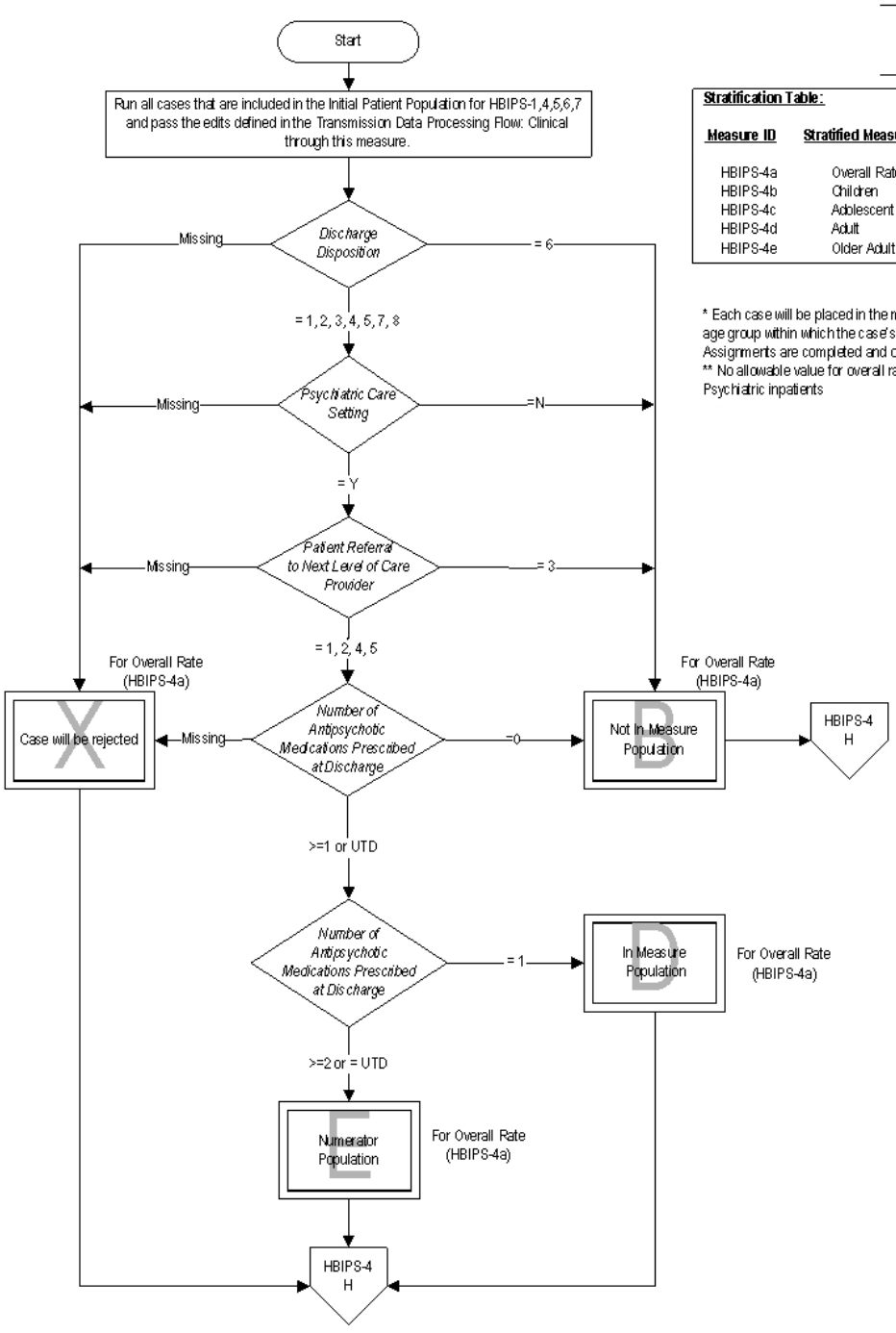
Adopted for CMS Inpatient Psychiatric Facility Quality Reporting Program FY 2014

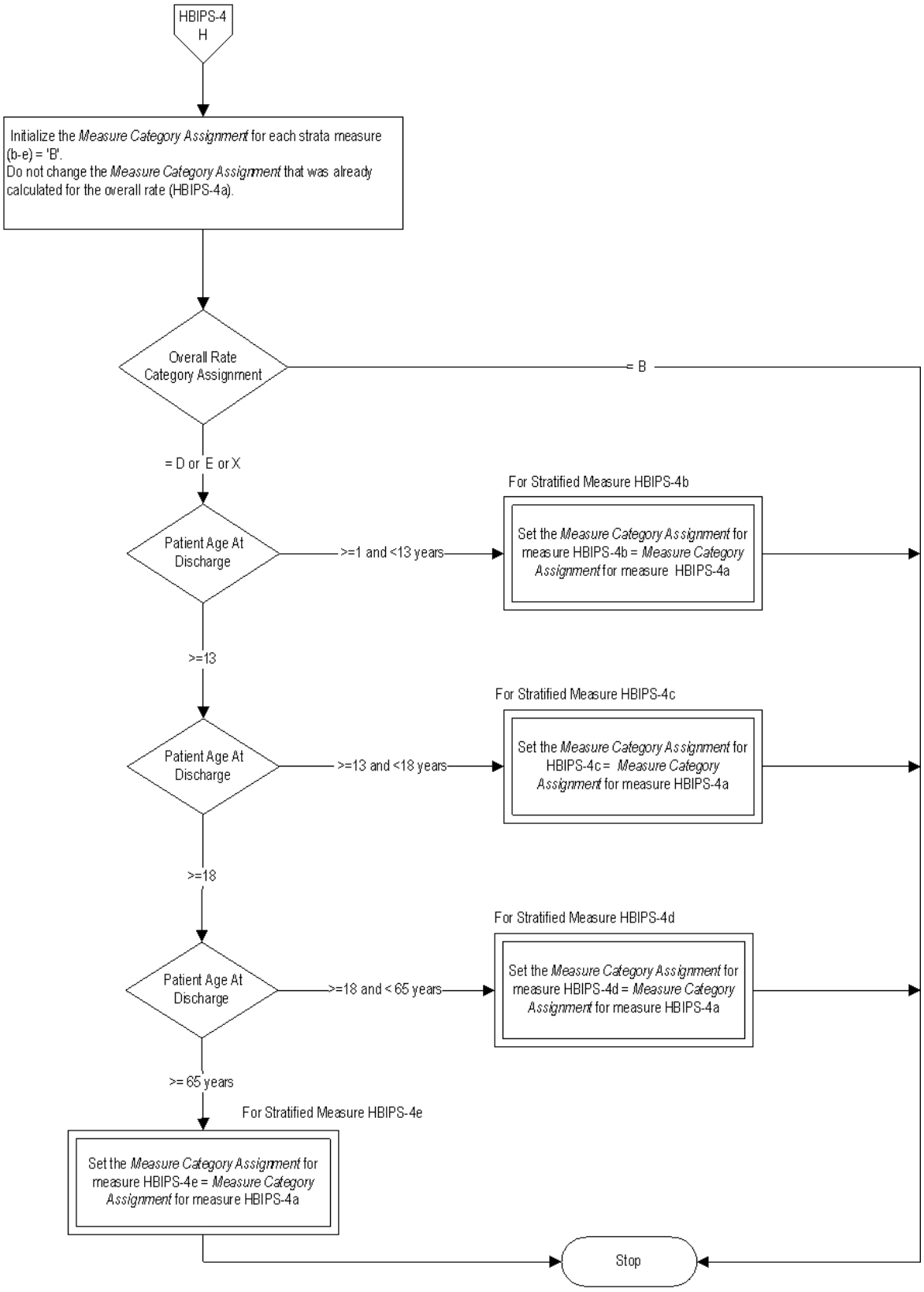
Measure Algorithm:

HBIPS-4: Patients Discharged On Multiple Antipsychotic Medications

Numerator Statement: Psychiatric inpatients who are discharged on two or more routinely scheduled antipsychotic medications.

Denominator Statement: Psychiatric inpatient discharges.




HBIPS-4 H
Initialize the *Measure Category Assignment* for each strata measure (b-e) = 'B'.
Do not change the *Measure Category Assignment* that was already calculated for the overall rate (HBIPS-4a).
Overall Rate Category Assignment
= B
= D or E or X
For Stratified Measure HBIPS-4b
Patient Age At Discharge
>=1 and <13 years
Set the *Measure Category Assignment* for measure HBIPS-4b = *Measure Category Assignment* for measure HBIPS-4a
>=13
For Stratified Measure HBIPS-4c
Patient Age At Discharge
>=13 and <18 years
Set the *Measure Category Assignment* for HBIPS-4c = *Measure Category Assignment* for measure HBIPS-4a
>=18
For Stratified Measure HBIPS-4d
Patient Age At Discharge
>=18 and < 65 years
Set the *Measure Category Assignment* for measure HBIPS-4d = *Measure Category Assignment* for measure HBIPS-4a
>= 65 years
For Stratified Measure HBIPS-4e
Set the *Measure Category Assignment* for measure HBIPS-4e = *Measure Category Assignment* for measure HBIPS-4a
Stop

Measure Information Form

Measure Set: Hospital Based Inpatient Psychiatric Services (HBIPS)

Measure ID: HBIPS-5

Set Measure ID	Performance Measure Name
HBIPS-5a	Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Overall Rate
HBIPS-5b	Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Children (1 through 12 years)
HBIPS-5c	Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Adolescent (13 through 17 years)
HBIPS-5d	Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Adult (18 through 64 years)
HBIPS-5e	Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Older Adult (≥ 65 years)

Name: Patients discharged on multiple antipsychotic medications with appropriate justification

Description: Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification

Rationale: Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganocyz, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006). Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation with a second antipsychotic in treatment resistant patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic (Tranulis, Skalli, Lalonde, & Nicole, 2008). Among patients without a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other controlled trials failed to show a benefit of antipsychotic polypharmacy over monotherapy (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Potkin, Thyrum, Alva, Bera, Yeh, & Arvanitis, 2002; Shim et al., 2007; Stahl,& Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient on multiple antipsychotics with an aftercare plan to transition to monotherapy. In such cases, effective communication between the inpatient and aftercare clinician is an essential element of care.

Type Of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification

Included Populations: Not applicable

Excluded Populations: None

Data Elements:

- *Appropriate Justification for Multiple Antipsychotic Medications*

Denominator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications

Included Populations: Not applicable

Excluded Populations:

- Patients who expired
- Patients with an unplanned departure resulting in discharge due to elopement
- Patients with an unplanned departure resulting in discharge due to failing to return from leave
- Patients with a length of stay ≤ 3 days
- Patient's residence is not in the USA, and they are returning to another country after discharge

Data Elements:

- *Admission Date*
- *Birthdate*
- *Discharge Date*
- *Discharge Disposition*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *Number of Antipsychotic Medications Prescribed at Discharge*
- *Patient Referral to Next Level of Care Provider*
- *Psychiatric Care Setting*

Risk Adjustment: No.

Data Accuracy: Hospitals may wish to implement periodic audits to monitor and ensure data accuracy.

Measure Analysis Suggestions: For quality improvement purposes, the measurement system may want to create reports to identify patients discharged on two or more antipsychotic medications without appropriate supporting documentation. This would allow healthcare organizations to target education efforts.

Sampling: Yes. For additional information see the Sampling Section.

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

Selected References:

- American Psychiatric Association (APA). (2004). Steering Committee on Practice Guidelines. Practice guideline for the treatment of patients with schizophrenia, second edition. *Am J Psychiatry*. 161(2 Suppl):1-56
- Ananth, J., Parameswaran, S., & Gunatilake, S. (2004). Antipsychotic polypharmacy comparing monotherapy with polypharmacy and augmentation. *Curr Med Chem*. 11(3):313-327 *Curr Pharm Des*. 10(18):2231-2238.
- Centorrino, F., Gören, J.L., Hennen, J., Salvatore, P., Kelleher, J.P., & Baldessarini, R.J. (2004) Multiple versus single antipsychotic agents for hospitalized psychiatric patients: a case control study of risk versus benefit. *Am*

J Psychiatry. 161 (4):700-706.
- Covell, N.H., Jackson, C.T., Evans, A.C., & Essock, S.M. (2002). Antipsychotic prescribing practices in Connecticuts public mental health system: rates of changing medication prescribing styles. *Schiz Bull*. 28(1):17-29,
- Ganguly, R., Kotzan, J.A., Miller, L.S., Kennedy, K., & Martin, B.C. (2004). Prevalence, trends, and factors associated with antipsychotic polypharmacy among Medicaid-eligible schizophrenia patients, 1998-2000. *J Clin Psychiatry*. 65(10):1377-88.
- Gilmer, T.P., Dolder, C.R., Folsom, D.P., Mastin, W., & Jeste, D.V. (2007), Antipsychotic polypharmacy trends among Medicaid beneficiaries with schizophrenia in San Diego County, 1999 - 2004. *Psychiatric Serv*. 59(7):1007-1010.
- Jaffe, A.B. & Levine, J. (2003). Antipsychotic medication co-prescribing in a large state hospital system. *Pharmacoepidemiol Drug Saf*.12:41-48.
- Kreyenbuhl, J., Valenstein, M., McCarthy, J.F., Ganocyz, D., & Blow, F.C. (2006). Long-term combination antipsychotic treatment in VA patients with schizophrenia. *Schiz Res*.84:90-99.
- National Association of State Mental Health Program Directors (NASMHPD). (2001).Technical report on psychiatric polypharmacy. Alexandria, VA.
- Potkin, S.G., Thyrum, P.T., Alva, G., Bera, R., Yeh, C., & Arvanitis, L.A. (2002). The safety and pharmacokinetics of quetiapine when coadministered with haloperidol, risperidone or thioridazine. *J Clin Psychopharmacol*. 22:121-130.
- Shim, J.C., Shin, J.G., Kelly, D.L., Jung, D.U., Seo, Y.S., Liu, K.H., et al. (2007). Adjunctive treatment with a dopamine partial agonist aripiprazole, for treatment of antipsychotic-induced hyperprolactinemia: A placebo controlled trial. *Am J Psych.164*:1404-1410.
- Stahl, S.M. & Grady, M.M. (2004). A critical review of atypical antipsychotic utilization: comparing monotherapy with polypharmacy augmentation. *Curr Med Chem.11*:313-327.
- Tranulis, C., Skalli, L., Lalonde, P., & Nicole, L. (2008). Benefits and risks of antipsychotic polypharmacy. An evidence based review of the literature. *Drug Saf*.31(1):7-20
- University HealthSystem Consortium. (2006). Mental health performance measures field brief. Oakbrook, IL.

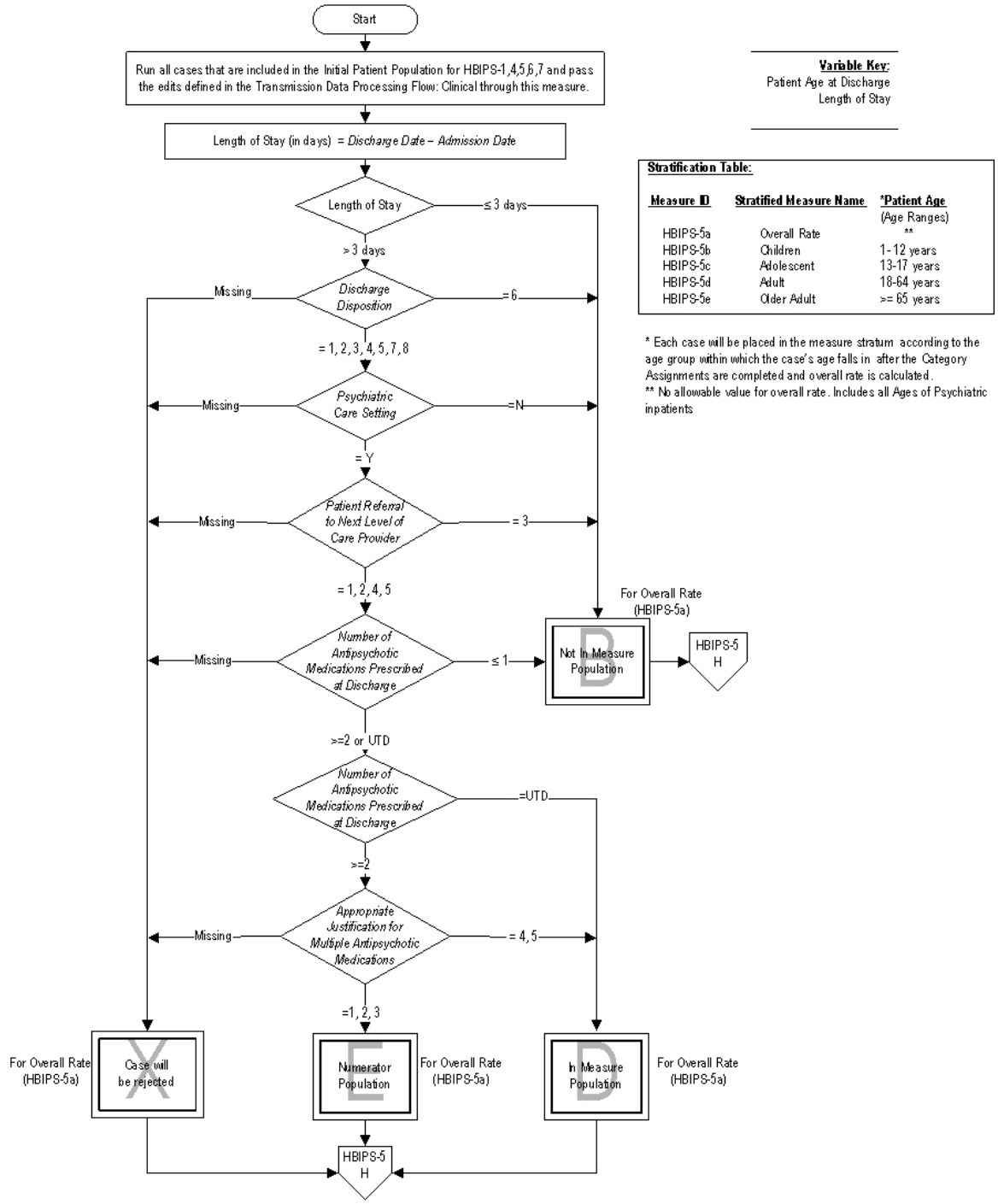
Adopted for CMS Inpatient Psychiatric Facility Quality Reporting Program FY 2014

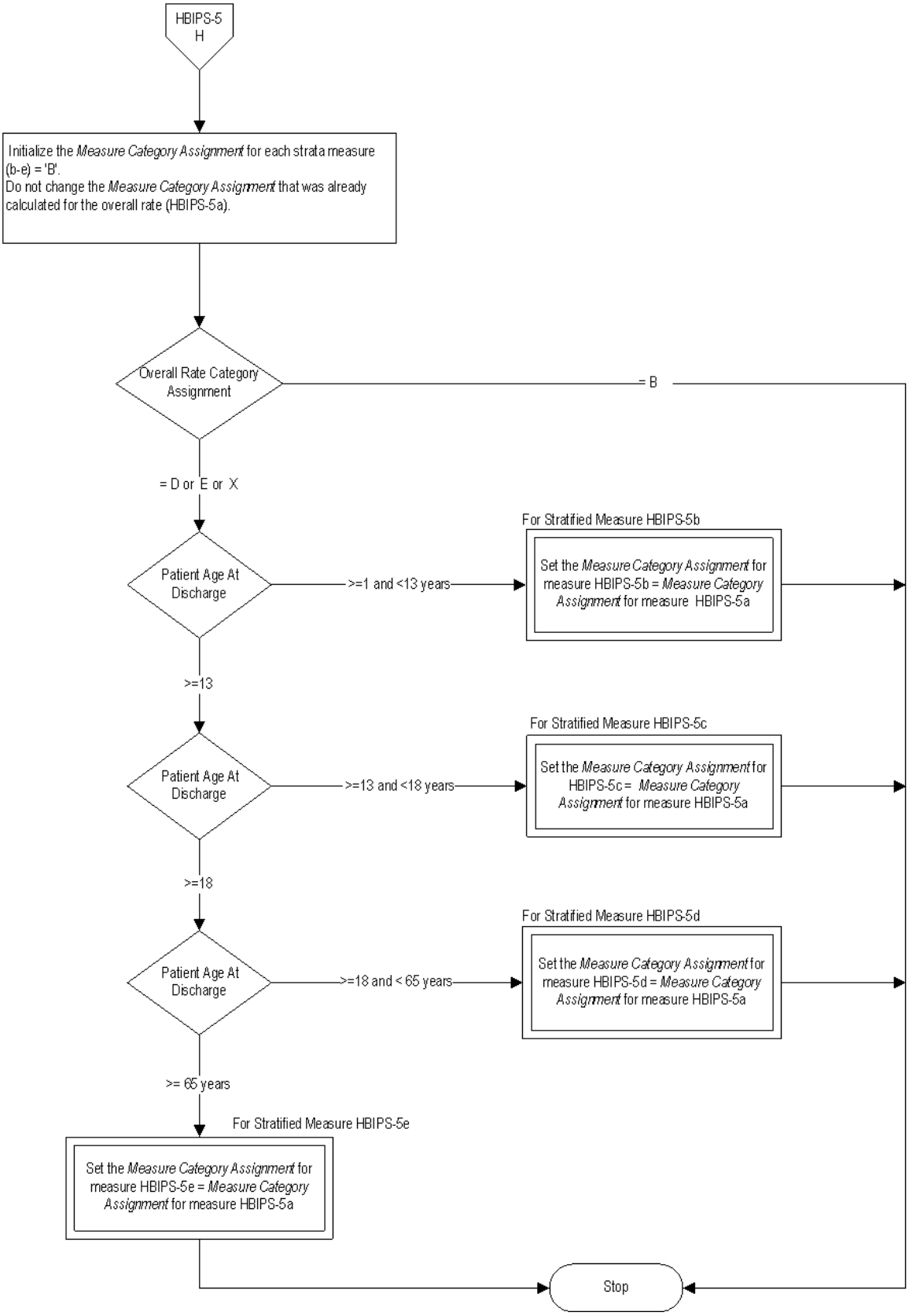
Measure Algorithm:

HBIPS-5: Patients Discharged On Multiple Antipsychotic Medications With Appropriate Justification

Numerator Statement: Psychiatric inpatients who are discharged on two or more routinely scheduled antipsychotic medications with appropriate justification.

Denominator Statement: Psychiatric inpatients who are discharged on two or more routinely scheduled antipsychotic medications.




HBIPS-5 H
Initialize the *Measure Category Assignment* for each strata measure (b-e) = 'B'.
Do not change the *Measure Category Assignment* that was already calculated for the overall rate (HBIPS-5a).
Overall Rate Category Assignment
= B
= D or E or X
Patient Age At Discharge
>=1 and <13 years
For Stratified Measure HBIPS-5b
Set the *Measure Category Assignment* for measure HBIPS-5b = *Measure Category Assignment* for measure HBIPS-5a
>=13
Patient Age At Discharge
>=13 and <18 years
For Stratified Measure HBIPS-5c
Set the *Measure Category Assignment* for HBIPS-5c = *Measure Category Assignment* for measure HBIPS-5a
>=18
Patient Age At Discharge
>=18 and < 65 years
For Stratified Measure HBIPS-5d
Set the *Measure Category Assignment* for measure HBIPS-5d = *Measure Category Assignment* for measure HBIPS-5a
>= 65 years
For Stratified Measure HBIPS-5e
Set the *Measure Category Assignment* for measure HBIPS-5e = *Measure Category Assignment* for measure HBIPS-5a
Stop

Measure Information Form

Measure Set: Hospital Based Inpatient Psychiatric Services (HBIPS)

Measure ID: HBIPS-6

Set Measure ID	Performance Measure Name
HBIPS-6a	Post Discharge Continuing Care Plan- Overall Rate
HBIPS-6b	Post Discharge Continuing Care Plan- Children (1 through 12 years)
HBIPS-6c	Post Discharge Continuing Care Plan- Adolescent (13 through 17 years)
HBIPS-6d	Post Discharge Continuing Care Plan- Adult (18 through 64 years)
HBIPS-6e	Post Discharge Continuing Care Plan- Older Adult (≥ 65 years)

Name: Post discharge continuing care plan created

Description: Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created

Rationale: Patients may not be able to fully report to their next level of care health-care provider their course of hospitalization or discharge treatment recommendations. The aftercare instructions given the patient may not be available to the next level of care provider at the patients initial intake or follow-up appointment. In order to provide optimum care, next level of care providers need to know details of precipitating events immediately preceding hospital admission, the patients treatment course during hospitalization, discharge medications and next level of care recommendations (American Association of Community Psychiatrists [AACP], 2001).

Type Of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Psychiatric inpatients for whom the post discharge continuing care plan is created and contains **all** of the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations.

> **Included Populations:** Not applicable
>
> **Excluded Populations:** None
>
> **Data Elements:**
>
> - *Continuing Care Plan-Discharge Medications*
> - *Continuing Care Plan-Next Level of Care*
> - *Continuing Care Plan-Principal Discharge Diagnosis*
> - *Continuing Care Plan-Reason for Hospitalization*

Denominator Statement: Psychiatric inpatient discharges

> **Included Populations:**
>
> - Patients referred for next level of care with *ICD-10-CM Principal or Other Diagnosis Codes* for Mental

Disorders as defined in Appendix A, Table 10.01

Excluded Populations:

- Patients who expired
- Patients with an unplanned departure resulting in discharge due to elopement
- Patients or their guardians who refused aftercare
- Patients or guardians who refused to sign authorization to release information
- Patients with an unplanned departure resulting in discharge due to failing to return from leave
- Patients readmitted to the same facility within 5 days after discharge
- Patient's residence is not in the USA, and they are returning to another country after discharge

Data Elements:

- *Birthdate*
- *Discharge Date*
- *Discharge Disposition*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *Patient Referral to Next Level of Care Provider*
- *Psychiatric Care Setting*

Risk Adjustment: No.

Data Accuracy: Hospitals may wish to implement periodic audits to monitor and ensure data accuracy.

Measure Analysis Suggestions: The data elements for each of the four discharge elements provide an opportunity to assess each component individually. However, completion of **all four** discharge categories is required for this measure.

Sampling: Yes. For additional information see the Sampling Section.

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

Selected References:

- Adair, C.E., McDougall, G.M., Mitton, C.R. et al (2005). Continuity of care and health outcomes among persons with severe mental illness. *Psychiatric Services*, 56(9), 1061-1069.
- American Psychiatric Association (APA). (1995). Practice guideline for psychiatric evaluation of adults. Washington (DC): American Psychiatric Press, Inc; 1995. 28 p. [58 references]
- American Association of Community Psychiatrists Continuity of Care Guidelines (2001) http://psychservices.psychiatryonline.org/cgi/content/full/55/11/1271

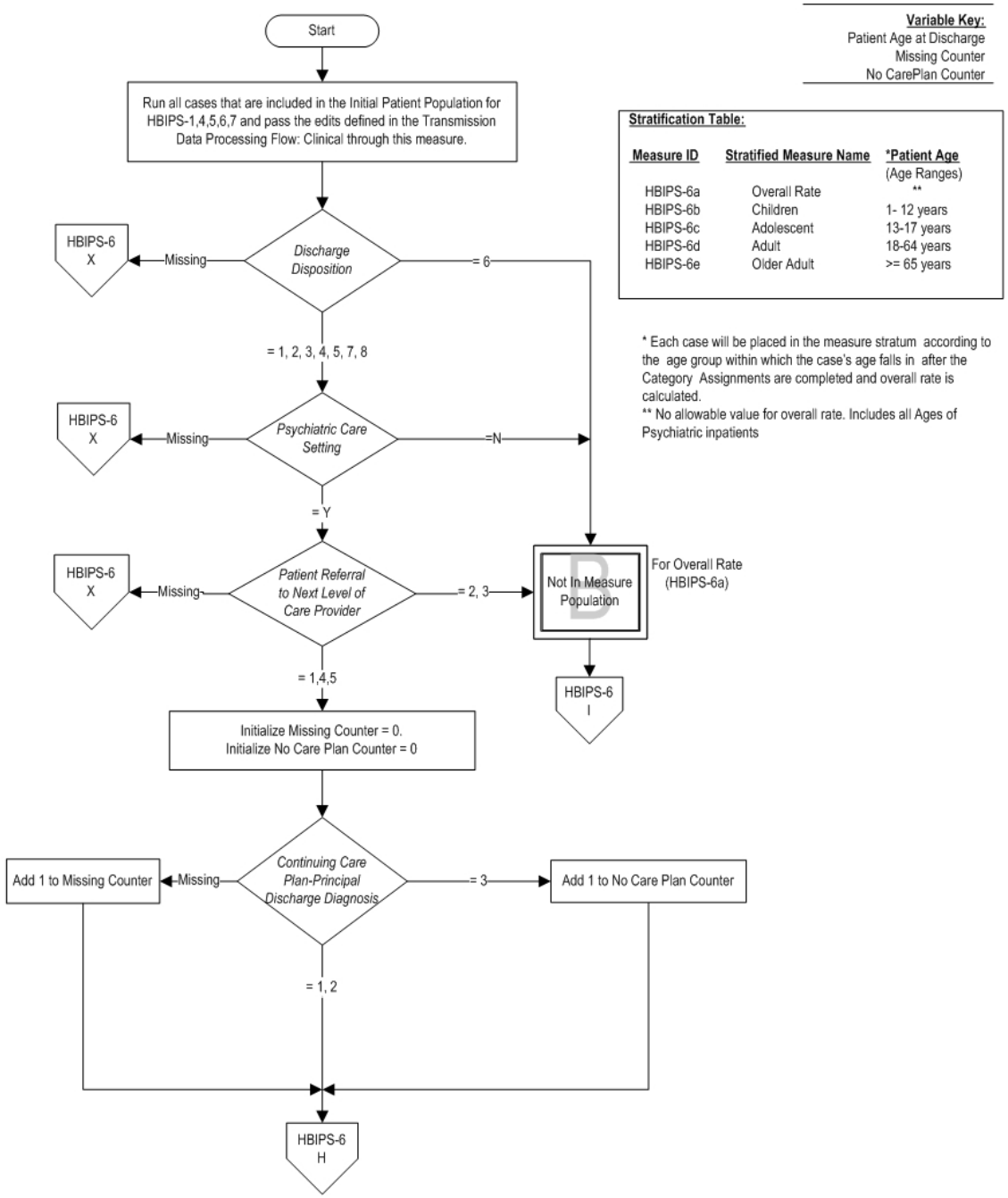
Adopted for CMS Inpatient Psychiatric Facility Quality Reporting Program FY 2014

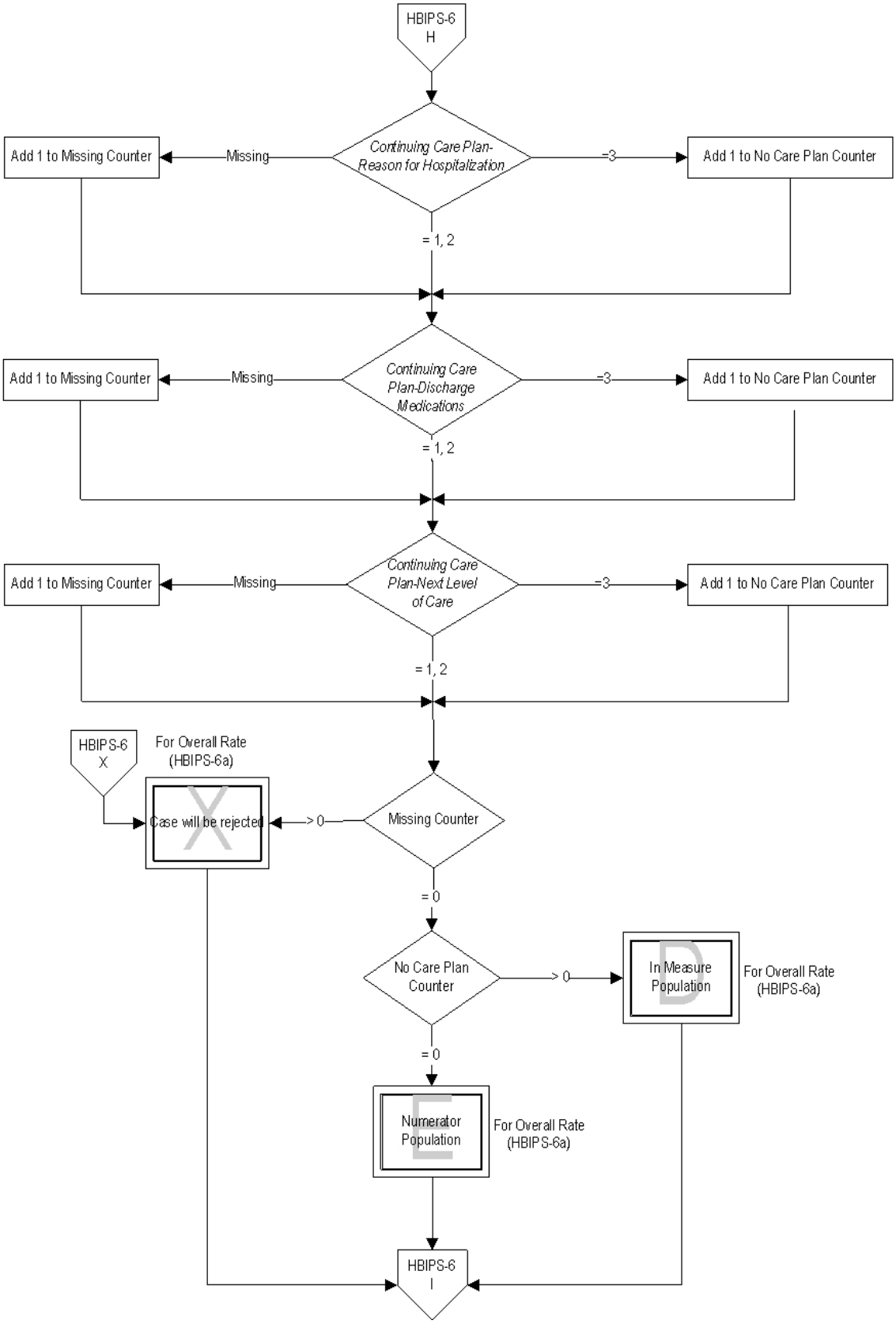
Measure Algorithm:

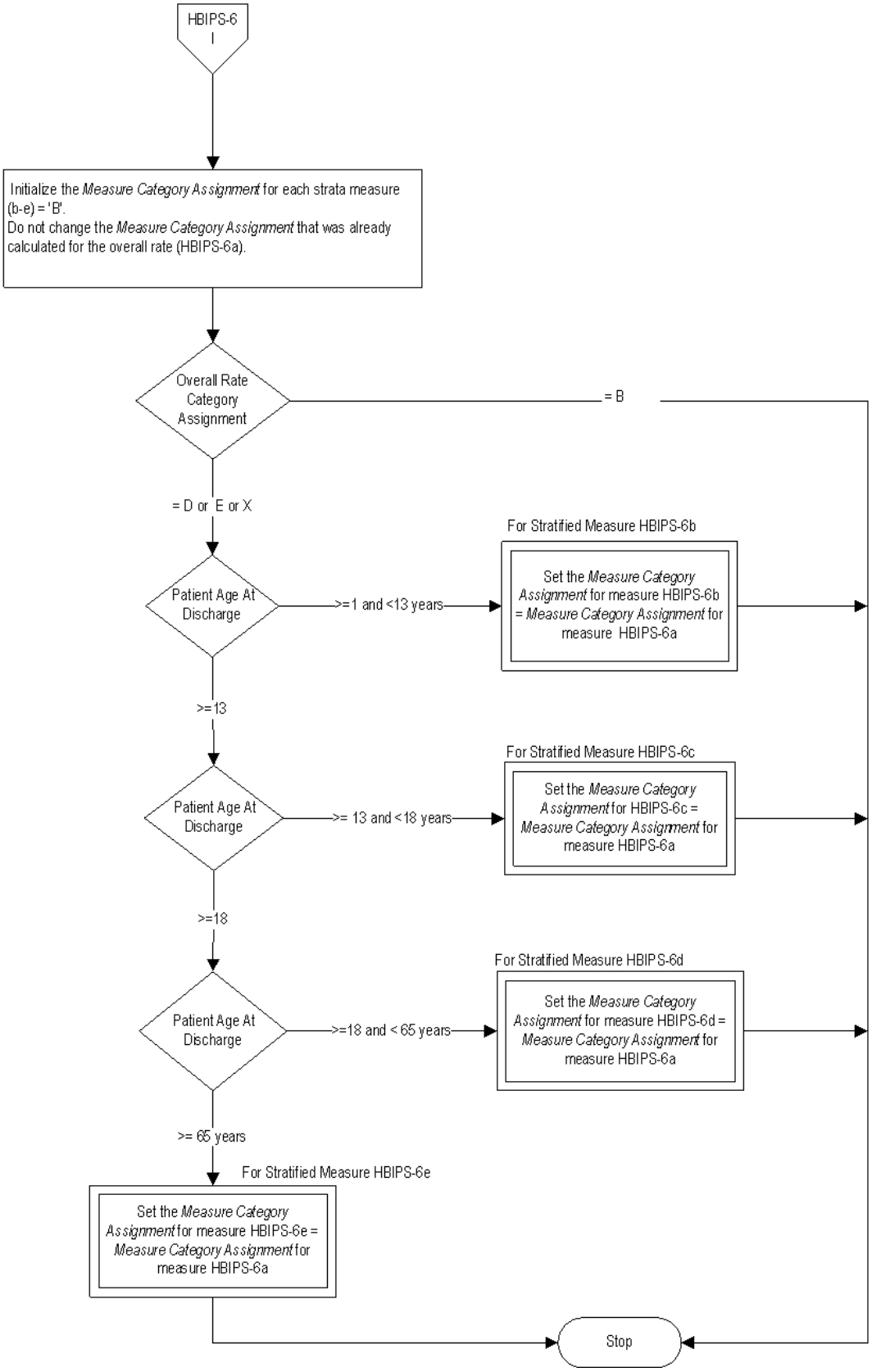
HBIPS-6: Post Discharge Continuing Care Plan Created

Numerator Statement: Psychiatric inpatients for whom the post discharge continuing care plan is created and contains of all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications, next level of care recommendations.

Denominator Statement: Psychiatric inpatient discharges.




HBIPS-6
H
Continuing Care Plan-Reason for Hospitalization
Missing
Add 1 to Missing Counter
=3
Add 1 to No Care Plan Counter
= 1, 2
Continuing Care Plan-Discharge Medications
Missing
Add 1 to Missing Counter
=3
Add 1 to No Care Plan Counter
= 1, 2
Continuing Care Plan-Next Level of Care
Missing
Add 1 to Missing Counter
=3
Add 1 to No Care Plan Counter
= 1, 2
HBIPS-6
X
For Overall Rate
(HBIPS-6a)
X
Case will be rejected
> 0
Missing Counter
= 0
No Care Plan Counter
> 0
D
In Measure Population
For Overall Rate
(HBIPS-6a)
= 0
E
Numerator Population
For Overall Rate
(HBIPS-6a)
HBIPS-6
I


HBIPS-6
I
Initialize the *Measure Category Assignment* for each strata measure (b-e) = 'B'.
Do not change the *Measure Category Assignment* that was already calculated for the overall rate (HBIPS-6a).
Overall Rate Category Assignment
= B
= D or E or X
For Stratified Measure HBIPS-6b
Patient Age At Discharge
>=1 and <13 years
Set the *Measure Category Assignment* for measure HBIPS-6b = *Measure Category Assignment* for measure HBIPS-6a
>=13
For Stratified Measure HBIPS-6c
Patient Age At Discharge
>= 13 and < 18 years
Set the *Measure Category Assignment* for HBIPS-6c = *Measure Category Assignment* for measure HBIPS-6a
>=18
For Stratified Measure HBIPS-6d
Patient Age At Discharge
>=18 and < 65 years
Set the *Measure Category Assignment* for measure HBIPS-6d = *Measure Category Assignment* for measure HBIPS-6a
>= 65 years
For Stratified Measure HBIPS-6e
Set the *Measure Category Assignment* for measure HBIPS-6e = *Measure Category Assignment* for measure HBIPS-6a
Stop

Measure Information Form

Measure Set: Hospital Based Inpatient Psychiatric Services (HBIPS)

Measure ID: HBIPS-7

Set Measure ID	Performance Measure Name
HBIPS-7a	Post Discharge Continuing Care Plan Transmitted- Overall Rate
HBIPS-7b	Post Discharge Continuing Care Plan Transmitted - Children (1 through 12 years)
HBIPS-7c	Post Discharge Continuing Care Plan Transmitted - Adolescent (13 through 17 years)
HBIPS-7d	Post Discharge Continuing Care Plan Transmitted - Adult (18 through 64 years)
HBIPS-7e	Post Discharge Continuing Care Plan Transmitted - Older Adult (≥65 years)

Name: Post discharge continuing care plan transmitted to next level of care provider upon discharge

Description: Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity

Rationale: Patients may not be able to fully report to their next level of care health-care provider their course of hospitalization or discharge treatment recommendations. The aftercare instructions given the patient may not be available to the next level of care provider at the patients initial intake or follow-up appointment. In order to provide optimum care, next level of care providers need to know details of precipitating events immediately preceding hospital admission, the patients treatment course during hospitalization including rationale and target symptoms for medications changed, discharge medications and next level of care recommendations (American Association of Community Psychiatrists [AACP], 2001).

Type Of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Psychiatric inpatients for whom the post discharge continuing care plan was transmitted to the next level of care

> **Included Populations:** Not applicable
>
> **Excluded Populations:** None
>
> **Data Elements:**
>
> - *Continuing Care Plan-Discharge Medications*
> - *Continuing Care Plan-Next Level of Care*
> - *Continuing Care Plan-Principal Discharge Diagnosis*
> - *Continuing Care Plan-Reason for Hospitalization*

Denominator Statement: Psychiatric inpatient discharges

> **Included Populations:**
>
> - Patients referred for next level of care with *ICD-10-CM Principal or Other Diagnosis Codes* for Mental

Disorders as defined in Appendix A, Table 10.01

Excluded Populations:

- Patients who expired
- Patients with an unplanned departure resulting in discharge due to elopement
- Patients or their guardians who refused aftercare
- Patients or guardians who refused to sign authorization to release information
- Patients with an unplanned departure resulting in discharge due to failing to return from leave
- Patients readmitted to the same facility within 5 days after discharge
- Patient's residence is not in the USA, and they are returning to another country after discharge

Data Elements:

- *Birthdate*
- *Discharge Date*
- *Discharge Disposition*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *Patient Referral to Next Level of Care Provider*
- *Psychiatric Care Setting*

Risk Adjustment: No.

Data Accuracy: Hospitals may wish to implement periodic audits to monitor and ensure data accuracy.

Measure Analysis Suggestions: The data elements for each of the four discharge elements provide an opportunity to assess each component individually. However, completion of **all four** discharge categories is required for this measure.

Sampling: Yes. For additional information see the Sampling Section.

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

Selected References:

- Adair, C.E., McDougall, G.M., Mitton, C.R. et al (2005). Continuity of care and health outcomes among persons with severe mental illness. *Psychiatric Services*, 56(9), 1061-1069.
- American Psychiatric Association (APA). Practice guideline for psychiatric evaluation of adults. Washington (DC): American Psychiatric Press, Inc; 1995. 28 p. [58 references]
- American Association of Community Psychiatrists Continuity of Care Guidelines (2001) http://psychservices.psychiatryonline.org/cgi/content/full/55/11/1271

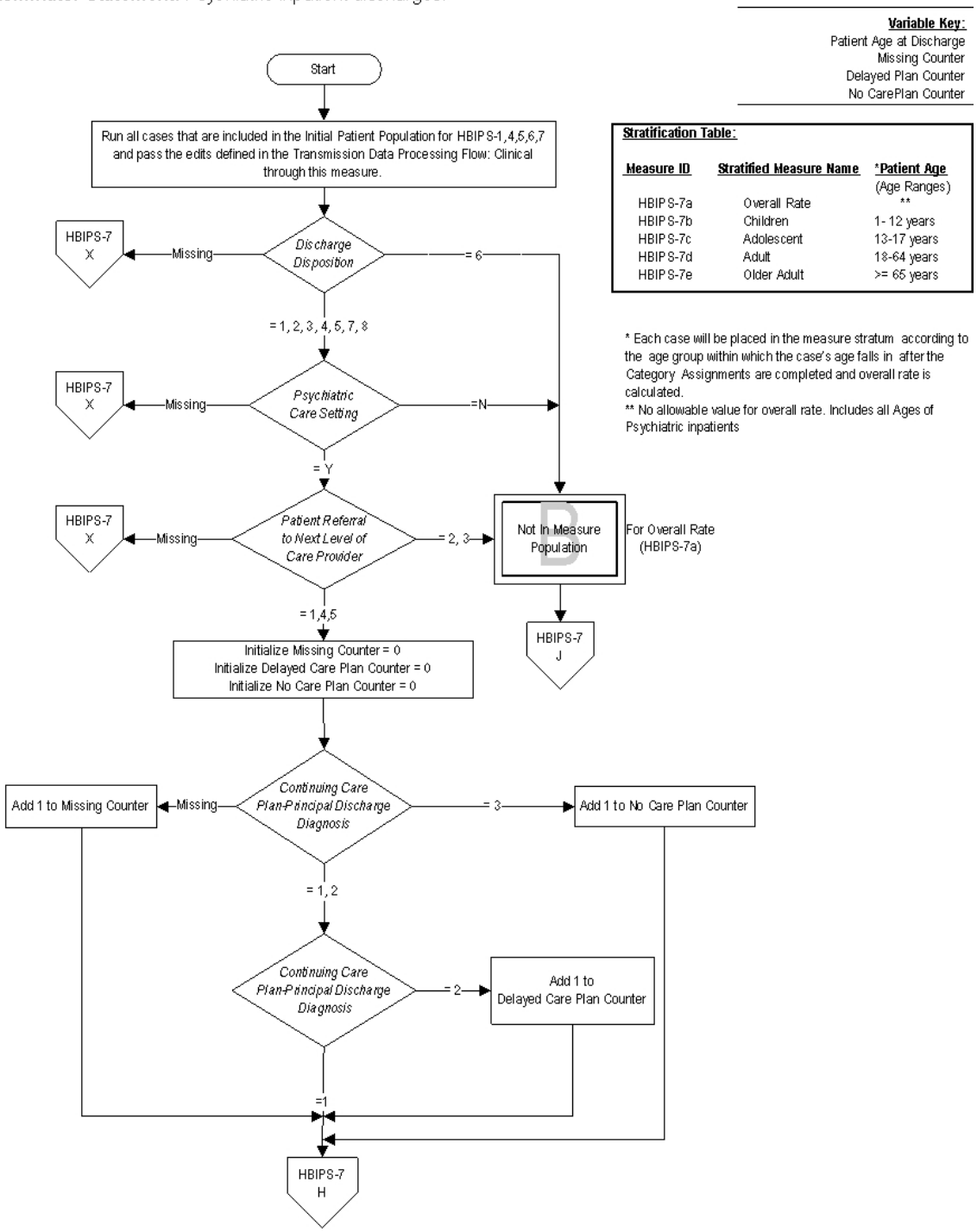
Adopted for CMS Inpatient Psychiatric Facility Quality Reporting Program FY 2014

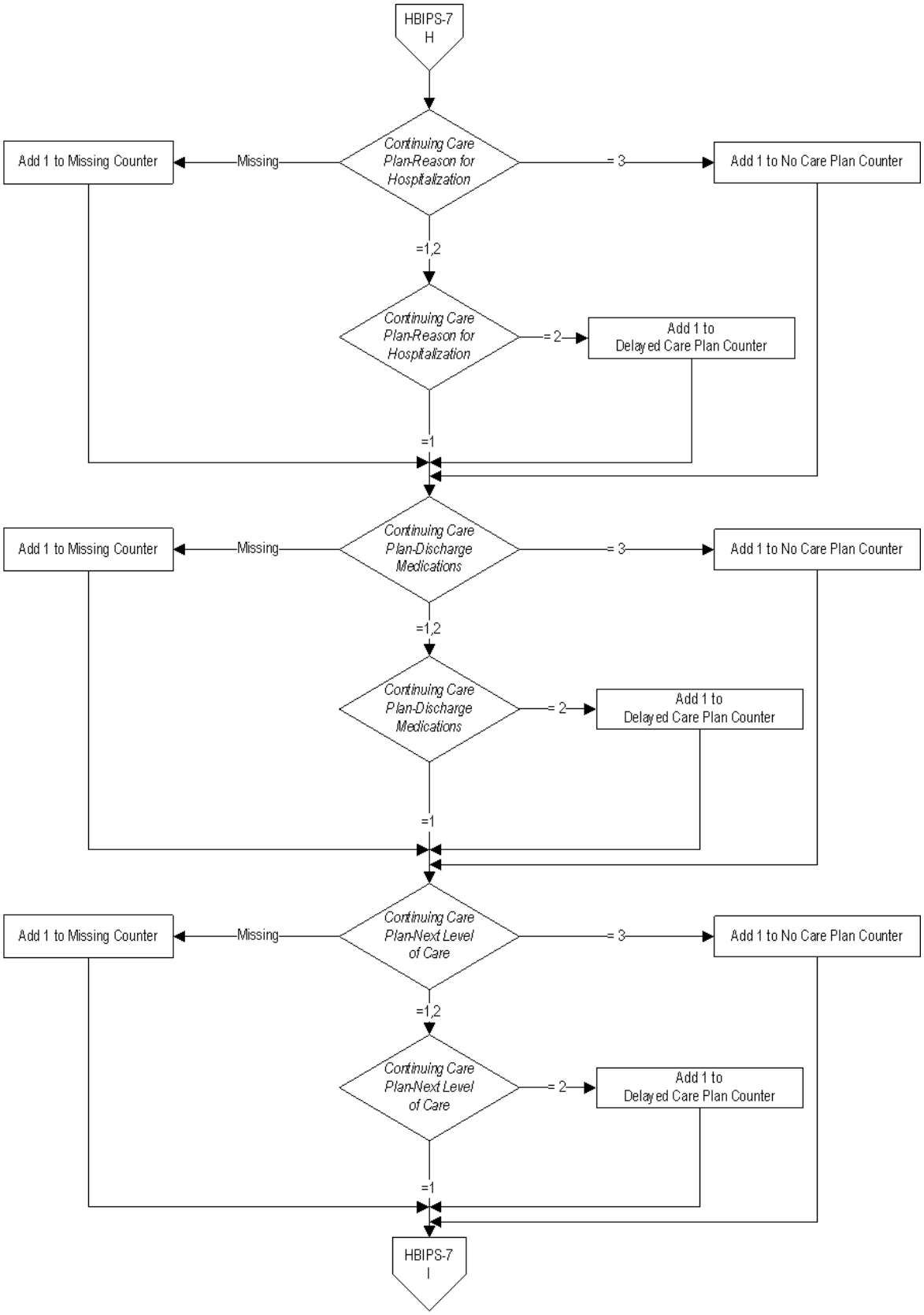
Measure Algorithm:

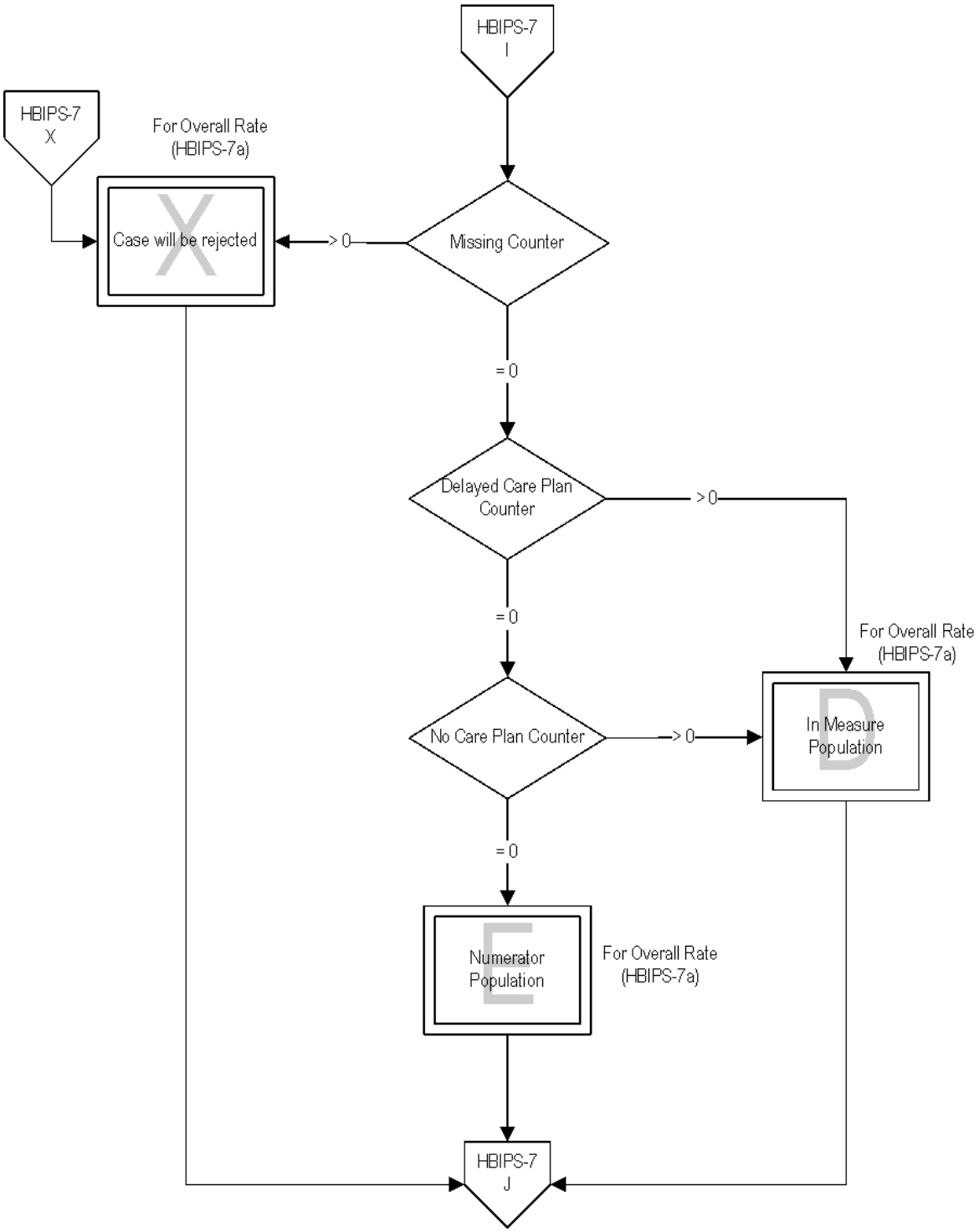
HBIPS-7: Post Discharge Continuing Care Plan Transmitted To Next Level Of Care Provider Upon Discharge

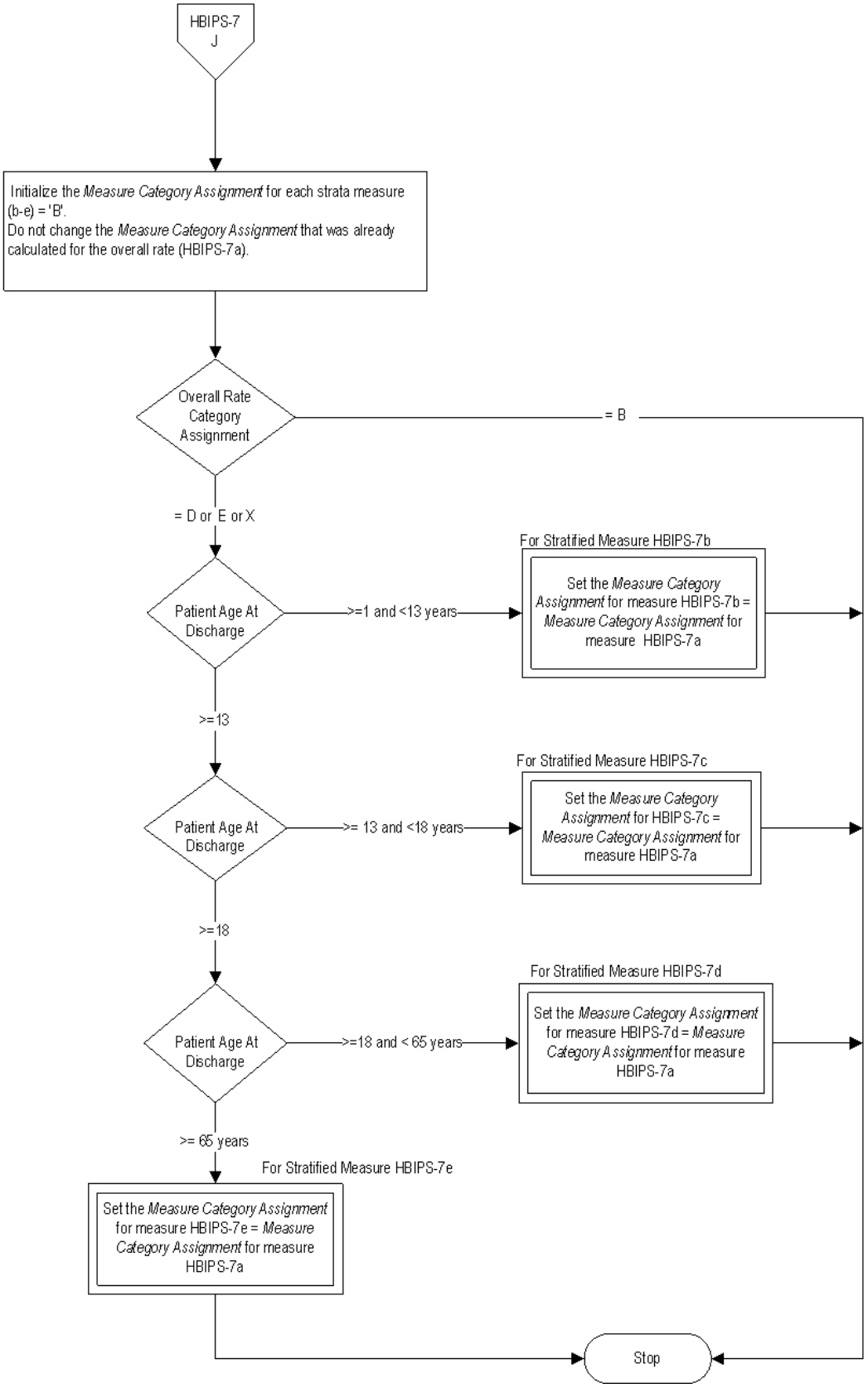
Numerator Statement: Psychiatric inpatients for whom the post discharge continuing care plan was transmitted to the next level of care.

Denominator Statement: Psychiatric inpatient discharges.




HBIPS-7
H
Continuing Care Plan-Reason for Hospitalization
Missing
Add 1 to Missing Counter
= 3
Add 1 to No Care Plan Counter
=1,2
Continuing Care Plan-Reason for Hospitalization
= 2
Add 1 to Delayed Care Plan Counter
=1
Continuing Care Plan-Discharge Medications
Missing
Add 1 to Missing Counter
= 3
Add 1 to No Care Plan Counter
=1,2
Continuing Care Plan-Discharge Medications
= 2
Add 1 to Delayed Care Plan Counter
=1
Continuing Care Plan-Next Level of Care
Missing
Add 1 to Missing Counter
= 3
Add 1 to No Care Plan Counter
=1,2
Continuing Care Plan-Next Level of Care
= 2
Add 1 to Delayed Care Plan Counter
=1
HBIPS-7
I


HBIPS-7
I
HBIPS-7
X
For Overall Rate
(HBIPS-7a)
X
Case will be rejected
> 0
Missing Counter
= 0
Delayed Care Plan
Counter
> 0
= 0
For Overall Rate
(HBIPS-7a)
No Care Plan Counter
> 0
D
In Measure
Population
= 0
E
Numerator
Population
For Overall Rate
(HBIPS-7a)
HBIPS-7
J


HBIPS-7
J
Initialize the *Measure Category Assignment* for each strata measure (b-e) = 'B'.
Do not change the *Measure Category Assignment* that was already calculated for the overall rate (HBIPS-7a).
Overall Rate Category Assignment
= B
= D or E or X
Patient Age At Discharge
>=1 and <13 years
For Stratified Measure HBIPS-7b
Set the *Measure Category Assignment* for measure HBIPS-7b = *Measure Category Assignment* for measure HBIPS-7a
>=13
Patient Age At Discharge
>= 13 and <18 years
For Stratified Measure HBIPS-7c
Set the *Measure Category Assignment* for HBIPS-7c = *Measure Category Assignment* for measure HBIPS-7a
>=18
Patient Age At Discharge
>=18 and < 65 years
For Stratified Measure HBIPS-7d
Set the *Measure Category Assignment* for measure HBIPS-7d = *Measure Category Assignment* for measure HBIPS-7a
>= 65 years
For Stratified Measure HBIPS-7e
Set the *Measure Category Assignment* for measure HBIPS-7e = *Measure Category Assignment* for measure HBIPS-7a
Stop

Perinatal Care (PC)

Set Measures

Set Measure ID	Measure Short Name
PC-01	Elective Delivery
PC-02	Cesarean Birth
PC-03	Antenatal Steroids
PC-04	Health Care-Associated Bloodstream Infections in Newborns
PC-05	Exclusive Breast Milk Feeding

General Data Elements

Element Name	Collected For
Admission Date	All Records,
Birthdate	All Records,
CMS Certification Number	Hospital Clinical Data File, Optional for All Records,
Discharge Date	All Records, Not collected for HBIPS-2 and HBIPS-3
Health Care Organization Identifier	All Records, Patient Population Data File, Hospital Clinical Data File,
Hispanic Ethnicity	All Records,
ICD-10-CM Other Diagnosis Codes	All Records, Optional for HBIPS-2, HBIPS-3
ICD-10-CM Principal Diagnosis Code	All Records, Optional for HBIPS-2, HBIPS-3
ICD-10-PCS Other Procedure Codes	All Records, Optional for All HBIPS Records
ICD-10-PCS Other Procedure Dates	All Records, Optional for All HBIPS Records
ICD-10-PCS Principal Procedure Code	All Records, Optional for All HBIPS Records
ICD-10-PCS Principal Procedure Date	All Records, Optional for All HBIPS Records
Payment Source	All Records, Optional for HBIPS-2 and HBIPS-3
Race	All Records,
Sex	All Records,

Algorithm Output Data Elements

Element Name	Collected For
Measure Category Assignment	Calculation, Transmission, Hospital Clinical Data File

Measure Set Specific Data Elements

Element Name	Collected For
Admission to NICU	PC-05,
Antenatal Steroids Initiated	PC-03,
Birth Weight	PC-04,
Bloodstream Infection Confirmed	PC-04,
Bloodstream Infection Present on Admission	PC-04,
Clinical Trial	PC,
Discharge Disposition	PC-04, PC-05,
Exclusive Breast Milk Feeding	PC-05,
Gestational Age	PC-01, PC-02, PC-03,
Labor	PC-01,
Number of Previous Live Births	PC-02,
Prior Uterine Surgery	PC-01,
Reason for Not Initiating Antenatal Steroids	PC-03,
Term Newborn	PC-05,

Related Materials

	Document Name	
	Acknowledgment and Conditions of Use	
	Appendix A - ICD-10 Code Tables	
	Appendix C - Medication Tables	
	Appendix D - Glossary of Terms	
	Appendix E - Overview of Measure Information Form and Flowchart Formats	
	Appendix G - Resources	
	Appendix H - Miscellaneous Tables	
	b. Data Dictionary	

	Document Name	
	Cover Page for the Joint Commission Manual	
	Introduction to the Manual	
	Missing and Invalid Data	
	Sampling	
	Table of Contents	
	Transmission Alpha Data Dictionary	
	Transmission Data Processing Flow: Clinical	
	Transmission Data Processing Flow: Population and Sampling	
	Transmission of Data	
	Using the The Joint Commission's National Measure Specifications Manual	

Perinatal Care (PC) Initial Patient Population

The PC measure set is unique in that there are two distinct Initial Patient Populations within the measure set, mothers and newborns.

Mothers
The population of the PC-Mother measures (PC-01, 02, and 03) are identified using 4 data elements:

- *Admission Date*
- *Birthdate*
- *Discharge Date*
- *ICD-10-CM Principal or Other Diagnosis Code*

Patients admitted to the hospital for inpatient acute care are included in the PC Mother Initial sampling group if they have: ICD-10-PCS Principal or Other Procedure Codes as defined in Appendix A, Tables 11.01.1, a Patient Age (Admission Date Birthdate) >= 8 years and < 65 and a Length of Stay (Discharge Date - Admission Date) ≤ 120 days.

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

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

- *Admission Date*
- *Birthdate*
- *Discharge Date* (PC-05 only)
- *ICD-10-CM Principal or Other Diagnosis Code*
- *ICD-10-PCS Principal or Other Procedure Code*

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

Measures	Initial Patient Population definition
PC-04	The count of all patients in PC-Newborns with BSI
PC-05	The count of all patients in PC-Newborns with Breast Feeding

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

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

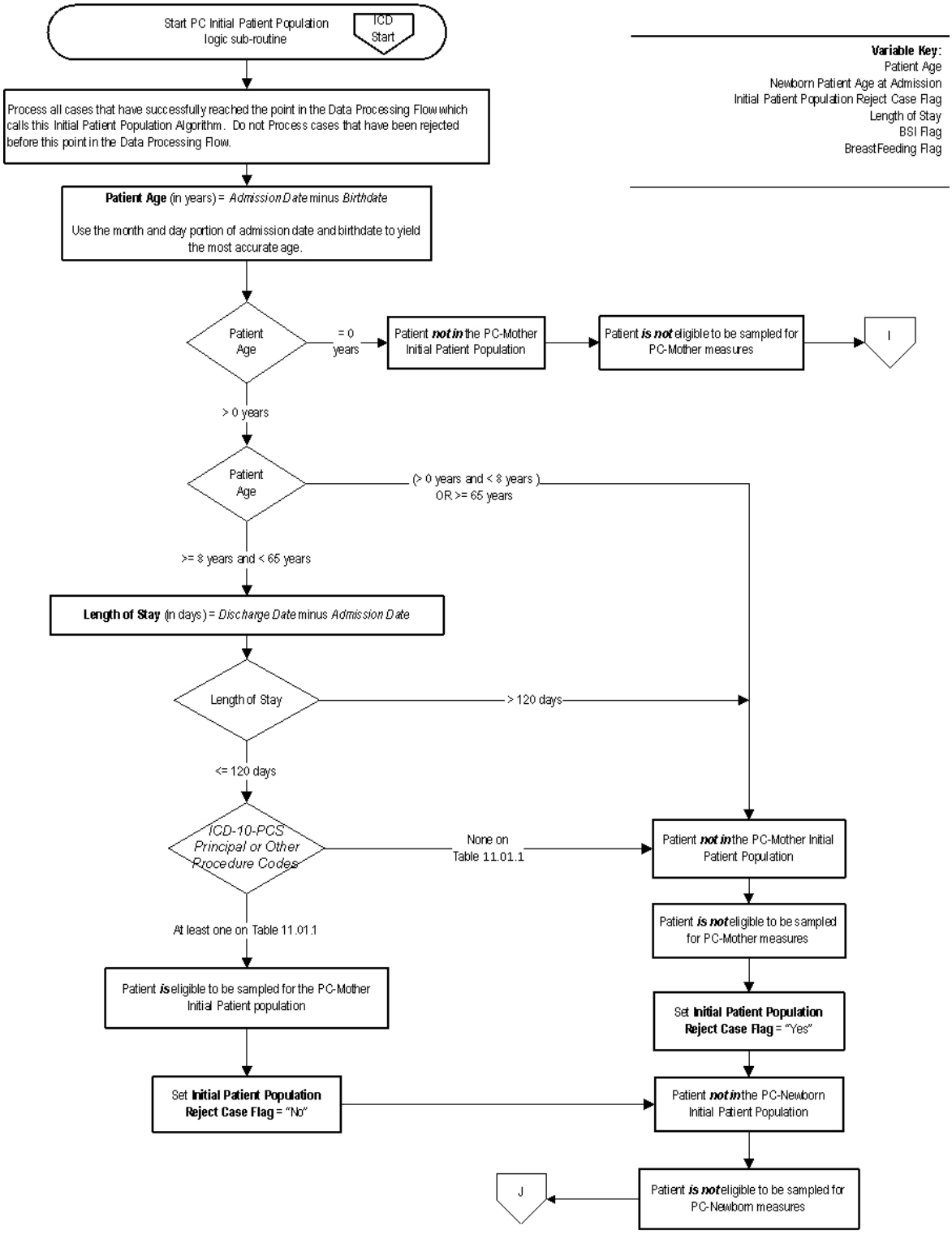
1. **NO** *ICD-10-CM Principal Diagnosis Code* as defined in Appendix A, Table 11.10.2,
2. **ONE** of the following:
    - an *ICD-10-CM Other Diagnosis Code* as defined in Appendix A, Tables 11.12, 11.13, 11.14 Or *Birth Weight* >= 500g and <= 1499g
    - an *ICD-10-CM Other Diagnosis Code* as defined in Appendix A, Tables 11.15, 11.16, Or *Birth Weight* >=1500g with **ANY** OF THE FOLLOWING:
        - an *ICD-10-PCS-Principal* or *Other Procedure Code* as defined in Appendix A, Tables 11.18 or 11.19
        - *Discharge Disposition* of 6 (expired) or a Missing *Discharge Disposition*
        - **NO** *ICD-10-CM Principal Diagnosis Code* as defined in Appendix A, Table 11.10.3
    - *Birth Weight* Missing or Unable To Determine (UTD).
3. **NO** *ICD-10-CM Other Diagnosis Code* as defined in Appendix A, Table 11.20 Or *Birth Weight* < 500g

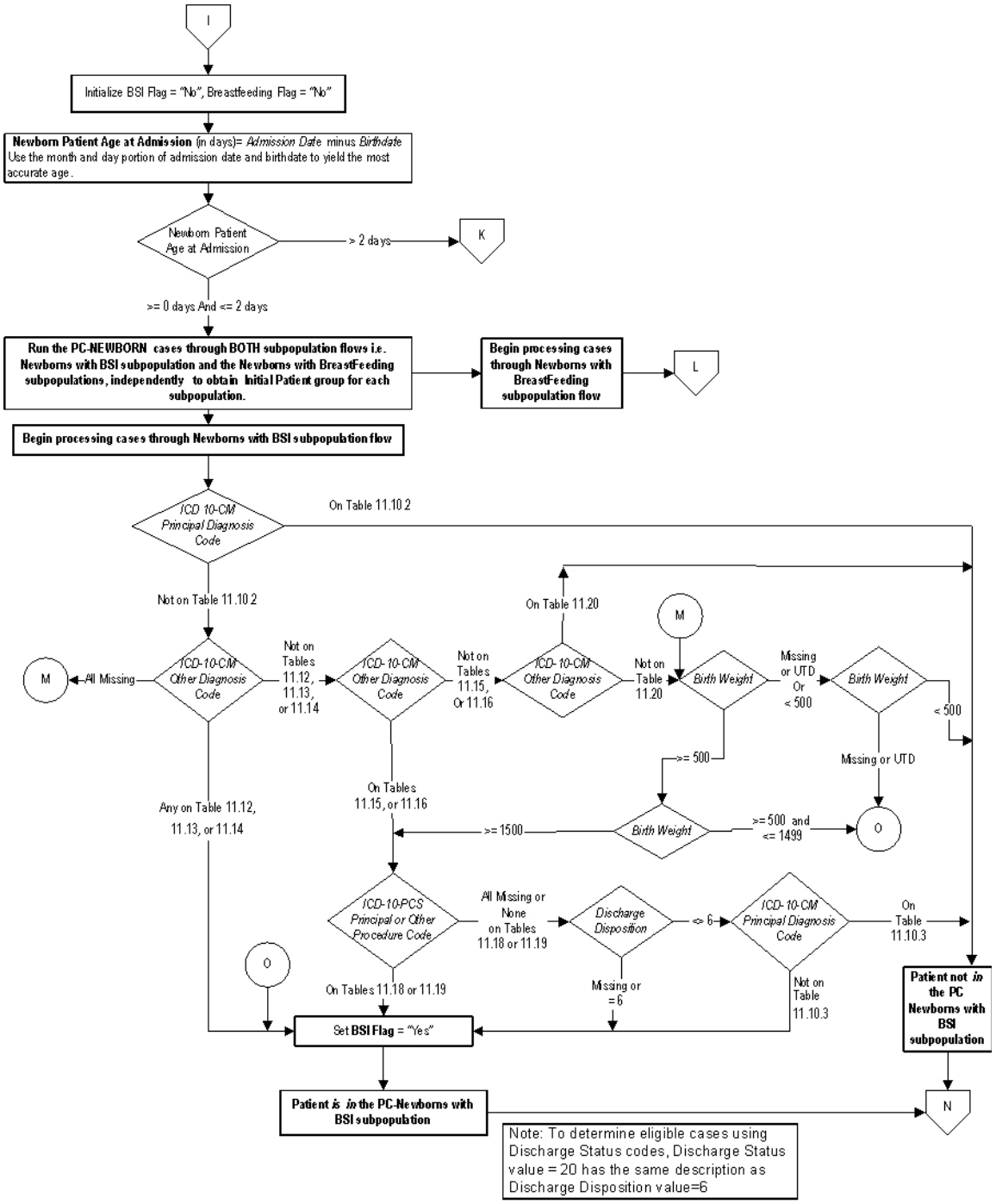
There is NO sampling for this measure.

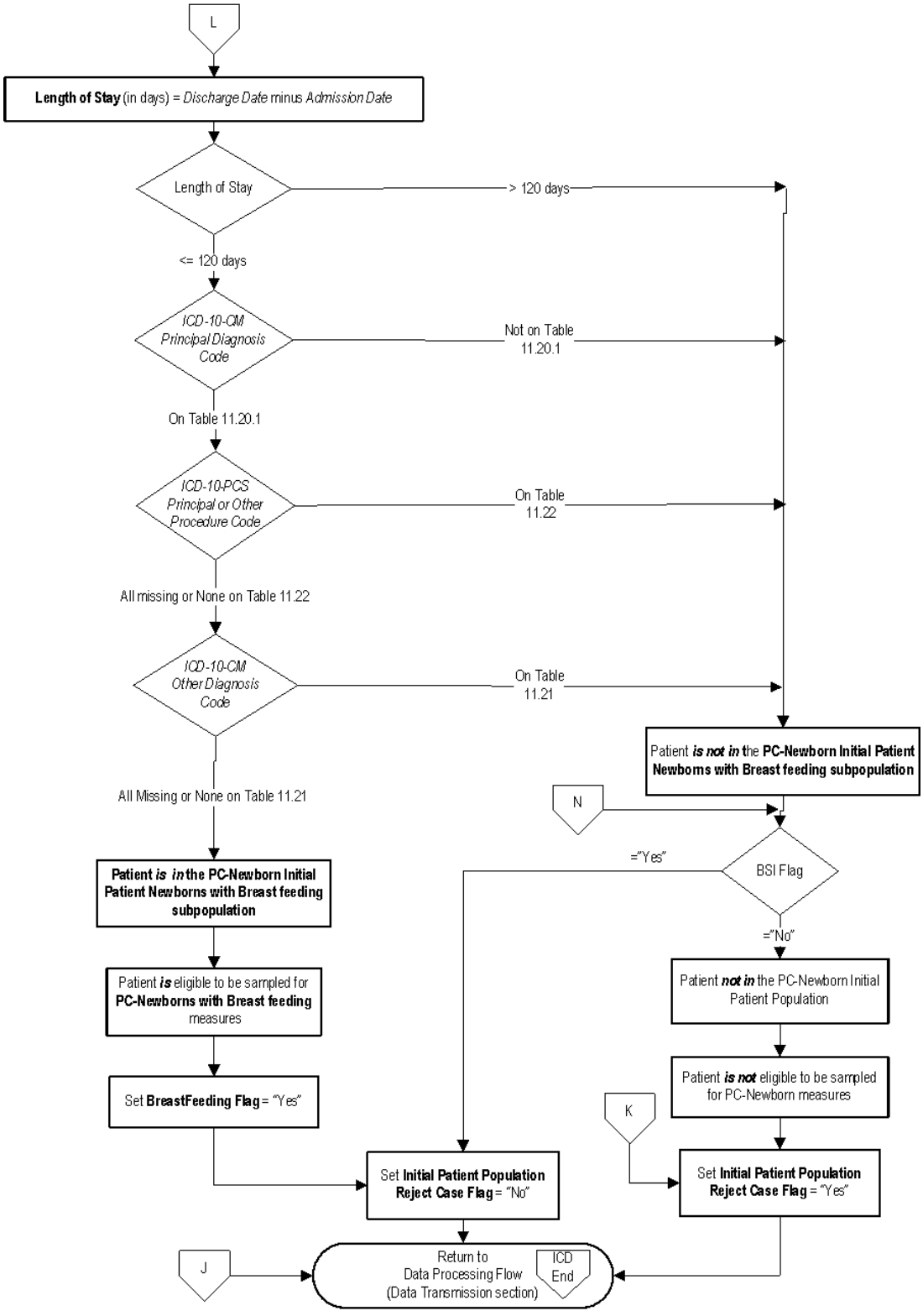
Newborns with Breast Feeding - Patient Age at admission (*Admission Date Birthdate*) ≤ 2 days, Length of Stay (*Discharge Date - Admission Date*) ≤ 120 days, an *ICD-10-CM Principal Diagnosis Code* as defined in Appendix A, Table 11.20.1, **NO** *ICD-10-CM Other Diagnosis Codes* as defined in Appendix A, Table 11.21, **NO** *ICD-10-PCS-Principal* or *Other Procedure Code* as defined in Appendix A, Table 11.22 are included in this subpopulation and are eligible to be sampled.

Initial Patient Population Algorithm

PC Initial Patient Population Algorithm




I
Initialize BSI Flag = "No", Breastfeeding Flag = "No"
Newborn Patient Age at Admission (in days)= Admission Date minus Birthdate
Use the month and day portion of admission date and birthdate to yield the most accurate age.
Newborn Patient Age at Admission
> 2 days
K
>= 0 days And <= 2 days
Run the PC-NEWBORN cases through BOTH subpopulation flows i.e. Newborns with BSI subpopulation and the Newborns with BreastFeeding subpopulations, independently to obtain Initial Patient group for each subpopulation.
Begin processing cases through Newborns with BreastFeeding subpopulation flow
L
Begin processing cases through Newborns with BSI subpopulation flow
ICD-10-CM Principal Diagnosis Code
On Table 11.10.2
Not on Table 11.10.2
M
All Missing
ICD-10-CM Other Diagnosis Code
Not on Tables 11.12, 11.13, or 11.14
ICD-10-CM Other Diagnosis Code
Not on Tables 11.15, Or 11.16
ICD-10-CM Other Diagnosis Code
On Table 11.20
Not on Table 11.20
M
Birth Weight
Missing or UTD Or < 500
Birth Weight
< 500
Missing or UTD
>= 500
Any on Table 11.12, 11.13, or 11.14
On Tables 11.15, or 11.16
Birth Weight
>= 1500
>= 500 and <= 1499
O
ICD-10-PCS Principal or Other Procedure Code
All Missing or None on Tables 11.18 or 11.19
Discharge Disposition
<> 6
ICD-10-CM Principal Diagnosis Code
On Table 11.10.3
O
On Tables 11.18 or 11.19
Missing or = 6
Not on Table 11.10.3
Patient not in the PC Newborns with BSI subpopulation
Set BSI Flag = "Yes"
Patient is in the PC-Newborns with BSI subpopulation
N
Note: To determine eligible cases using Discharge Status codes, Discharge Status value = 20 has the same description as Discharge Disposition value=6



Sample Size Requirements

Hospitals that choose to sample have the option of sampling quarterly or sampling monthly. A hospital may choose to

use a larger sample size than is required. Hospitals whose Initial Patient Population size is less than the minimum number of cases per quarter/month for the sampling group cannot sample that sampling group. Hospitals that have five or fewer discharges for the three combined PC sampling groups (both Medicare and non-Medicare combined) in a quarter are not required to submit PC patient level data to the Joint Commissions Data Warehouse.

A hospital may choose to use vital records to identify the PC-Mother Initial Patient Population as given in the Population section earlier. If a hospital uses this method to identify the initial patient population, then the hospital is encouraged to submit all the records of the initial population rather than using sampling to identify the cases for submission. Submitting all the initial patient population provides a more precise estimate of the performance rate for the measures.

Regardless of the option used, hospital samples must be monitored to ensure that sampling procedures consistently produce statistically valid and useful data. Due to exclusions and contraindications, hospitals selecting sample cases MUST submit AT LEAST the minimum required sample size.

The following sample size tables for each option automatically build in the number of cases needed to obtain the required sample sizes. For information concerning how to perform sampling, refer to the Population and Sampling Specifications section in this manual.

Quarterly Sampling
A modified sampling procedure is required for hospitals performing quarterly sampling for PC. Hospitals selecting sample cases must ensure that each individual sampling group Initial Patient Population and sample size meet the following conditions:

- *Select within the two individual measure sampling groups (mothers and babies).*
- *Select independently from each of the Newborn subpopulation.*

Hospitals selecting sample cases for the **PC-Mothers** must ensure that the Initial Patient Population and sample size for this PC sampling group meets the following conditions:

Quarterly Sample Size
Based on Initial Patient Population for Mothers

Hospital's Measure	
Average Quarterly Initial Patient Sample Group Size N	**Minimum Required Sampling Group Sample Size n**
>= 1501	301
376 1500	20% of the Initial Patient Population size
75 375	75
< 75	No sampling; 100% of the Initial Patient Population required

Within the **PC-Newborn** population, there are two subpopulations each identified by Patient Age at admission and a specific group of diagnosis and procedure codes or lack thereof:

- The PC-Newborns with BSI subpopulation *is not eligible* for sampling and will use the entire Newborns with BSI Initial Patient subpopulation for reporting.
- Hospitals sampling for the PC-Newborns with Breast Feeding must ensure the sample size calculations should be based on the **newborns with breast feed subpopulation count ONLY**. Hospitals selecting cases for the PC-Newborns with Breastfeeding must ensure that the patient population size for this subpopulation meets the following conditions:

Quarterly Sample Size Based on Initial Patient Population for PC-Newborns with Breastfeeding

Hospital's Measure	
Average Quarterly Initial Patient Sample Group Size N	**Minimum Required Sample Size n**
>= 541	109
136 540	20% of the Initial Patient Population size
27 135	27
< 27	No sampling; 100% of Initial Patient Population required

Monthly Sampling

Hospitals selecting sample cases for the **Mothers** must ensure that the Initial Patient Population and sample size for this sampling group meets the following conditions:

Monthly Sample Size
Based on Initial Patient Population for Mothers

Hospital's Measure	
Average Monthly Initial Patient Sample Group Size N	**Minimum Required Sampling Group Sample Size n**
>= 501	101
126 500	20% of the Initial Patient Population
25 125	25
< 25	No sampling; 100% Initial Patient Population required

Within the **PC-Newborn** population, there are two sampling groups each identified by Patient Age at admission and a specific group of diagnosis codes, or lack there of:

- The PC-Newborns with BSI subpopulation *is not eligible* for sampling and will use the entire Newborns with BSI Initial Patient subpopulation for reporting.
- Hospitals sampling for the PC-Newborns with Breast Feeding must ensure the sample size calculations should be based on the **newborns with breast feed subpopulation count ONLY**. Hospitals selecting cases for the PC-Newborns with Breastfeeding must ensure that the patient population size for this subpopulation meets the following conditions:

Monthly Sample Size Based on Initial Patient Population for Newborns with Breast Feeding

Hospital's Measure	
Average Monthly Initial Patient Sample Group Size N	**Minimum Required Sampling Group Sample Size n**
>= 181	37
46 180	20% of the Initial Patient Population

Hospital's Measure	
Average Monthly Initial Patient Sample Group Size N	**Minimum Required Sampling Group Sample Size n**
9 45	9
< 9	No sampling; 100% Initial Patient Population required

Sample Size Examples
Note: PC-Mothers: All sampling groups in PC-Mother population should be used in the calculation of all PC-Mother measures. All of the PC measures' specific exclusion criteria are used to filter out cases that do not belong in the measure denominator. **PC-Newborns**: Cases falling within each newborns subpopulation should be run through the respective Newborn measures only. Cases falling in the Newborns with BSI subpopulation ONLY will flow through the PC-04 measure and cases falling in the Newborns with Breast Feeding subpopulation ONLY will flow through the PC-05 measure only. Cases may fall in both subpopulations and in such scenarios will be processed through both measures. It should be noted that cases should be processed independently through each of newborn initial subpopulation flows to obtain cases for sampling and abstraction.

Quarterly Sampling
Mother Population

- A hospital's Mother Population size is 2300 cases during the second quarter. Using the quarterly sampling table for the Mother population, the sample size required is 301 cases for the quarter.
- A hospital's Mother Population size is 1500 cases during the second quarter. Using the quarterly sampling table for the Mother population, the sample size required is 20% of this sub-population or 300 cases for the quarter.
- A hospital's Mother Population size is 300 cases during the second quarter. Using the quarterly sampling table for the Mother population, the sample size required 75 cases for the quarter.
- A hospital's Mother Population size is 72 cases during the second quarter. Using the quarterly sampling table for the Mother population, the sample size is less than the minimum required quarterly sample size, so 100% of this sub-population or all 72 cases are sampled.

Newborns with Breast Feeding

- A hospital's Newborns with Breast Feeding Population size is 600 cases during the second quarter. Using the quarterly sampling table for the Newborns with Breast Feeding population, the sample size required is 109 cases.
- A hospital's Newborns with Breast Feeding Population size is 350 cases during the second quarter. Using the quarterly sampling table for the Newborns with Breast Feeding population, the sample size required is 20% of this sub-population or 70 cases for the quarter .
- A hospital's Newborns with Breast Feeding Population size is 99 cases during the second quarter. Using the quarterly sampling table for the Newborns with Breast Feeding population, the sample size required 27 cases for the quarter.
- A hospital's Newborns with Breast Feeding Population size is 25 cases during the second quarter. Using the quarterly sampling table for the Newborns with Breast Feeding population, the sample size is less than the minimum required quarterly sample size, so 100% of this sub-population or all 25 cases are sampled.

Newborns with BSI The Newborns with BSI population *is not eligible* for sampling and will use the entire Newborns with BSI Initial Patient sampling group for reporting.

Monthly Sampling
Mother Population

- A hospital's Mother Population size is 510 cases during March. Using the monthly sampling table for the Mother population, the sample size required is 101 cases for the month.
- A hospital's Mother Population size is 400 cases during March. Using the monthly sampling table for the Mother population, the sample size required is 20% of this sub-population or 80 cases for the month.
- A hospital's Mother Population size is 125 cases during March. Using the monthly sampling table for the Mother population, the sample size required is 25 cases for the month.
- A hospital's Mother Population size is 20 cases during March. Using the quarterly sampling table for the Mothers population, the sample size is less than the minimum required quarterly sample size, so 100% of this sub-population or all 20 cases are sampled.

Newborns with Breast Feeding

- A hospital's Newborns with Breast Feeding Population size is 200 cases for the month of March. Using the monthly sampling table for the Newborns with Breast Feeding population, the sample size required is 37 cases.
- A hospital's Newborns with Breast Feeding Population size is 100 cases for the month of March. Using the monthly sampling table for the Newborns with Breast Feeding population, the sample size required is 20% of this sub-population or 20 cases for the month.
- A hospital's Newborns with Breast Feeding Population size is 30 cases for the month of March. Using the monthly sampling table for the Newborns with Breast Feeding population, the sample size required 9 cases for the month.
- A hospital's Newborns with Breast Feeding Population size is 8 cases during the second quarter. Using the monthly sampling table for the Newborns with Breast Feeding population, the sample size is less than the minimum required monthly sample size, so 100% of this sub-population or all 8 cases are sampled.

Newborns with BSI The Newborns with BSI population *is not eligible* for sampling and will use the entire Newborns with BSI Initial Patient sampling group for reporting.

Measure Information Form

Measure Set: Perinatal Care (PC)

Measure ID: PC-01

Name: Elective Delivery

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

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

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

Type Of Measure: Process

Improvement Noted As: Decrease in the rate

Numerator Statement: Patients with elective deliveries

> **Included Populations:** *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for one or more of the following:
>
> - Medical induction of labor as defined in Appendix A, Table 11.05 while not in *Labor* prior to the procedure
> - Cesarean birth as defined in Appendix A, Table 11.06 and all of the following:
>   - not in *Labor*
>   - no history of a *Prior Uterine Surgery*
>
> **Excluded Populations:** None
>
> **Data Elements:**
>
> - *ICD-10-PCS Other Procedure Codes*
> - *ICD-10-PCS Principal Procedure Code*
> - *Labor*
> - *Prior Uterine Surgery*

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

> **Included Populations:**
>
> - *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined

in Appendix A, Table 11.01.1

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

Excluded Populations:

- *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of stay > 120 days
- Enrolled in clinical trials
- *Gestational Age* < 37 or >= 39 weeks or UTD

Data Elements:

- *Admission Date*
- *Birthdate*
- *Clinical Trial*
- *Discharge Date*
- *Gestational Age*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*

Risk Adjustment: No.

Data Accuracy: Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: In order to identify areas for improvement, hospitals may want to review results based on specific ICD-10 codes or patient populations. Data could be analyzed further to determine specific patterns or trends to help reduce elective deliveries.

Sampling: Yes. For additional information see the Sampling Section.

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

Selected References:

- American Academy of Family Physicians. (2000). Tips from Other Journals: Elective induction doubles cesarean delivery rate, 61, 4.Retrieved December 29, 2008 at: http://www.aafp.org/afp/20000215/tips/39.html.
- American College of Obstetricians and Gynecologists. (November 1996). ACOG Educational Bulletin.
- Clark, S., Miller, D., Belfort, M., Dildy, G., Frye, D., & Meyers, J. (2009). Neonatal and maternal outcomes associated with elective delivery. [Electronic Version]. *Am J Obstet Gynecol*. 200:156.e1-156.e4.
- Glantz, J. (Apr.2005). Elective induction vs. spontaneous labor associations and outcomes. [Electronic Version]. *J Reprod Med*. 50(4):235-40.
- Tita, A., Landon, M., Spong, C., Lai, Y., Leveno, K., Varner, M, et al. (2009). Timing of elective repeat cesarean delivery at term and neonatal outcomes. [Electronic Version]. *NEJM*. 360:2, 111-120.

Original Performance Measure Source / Developer:
Hospital Corporation of America-Women's and Children's Clinical Services

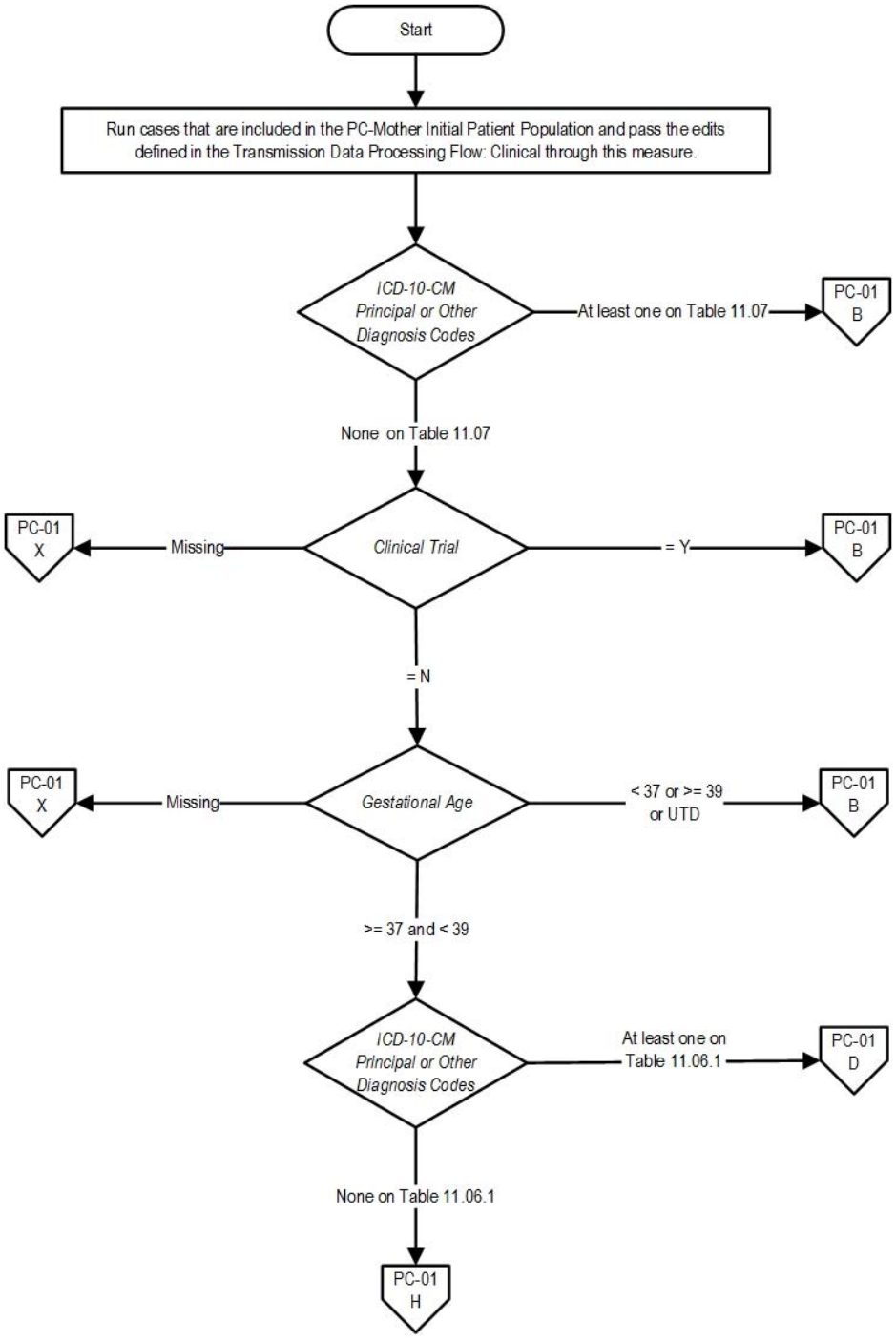
Adopted for CMS Hospital Inpatient Quality Reporting Program FY 2015 and Stage 2 Medicare and Medicaid EHR Incentive Program

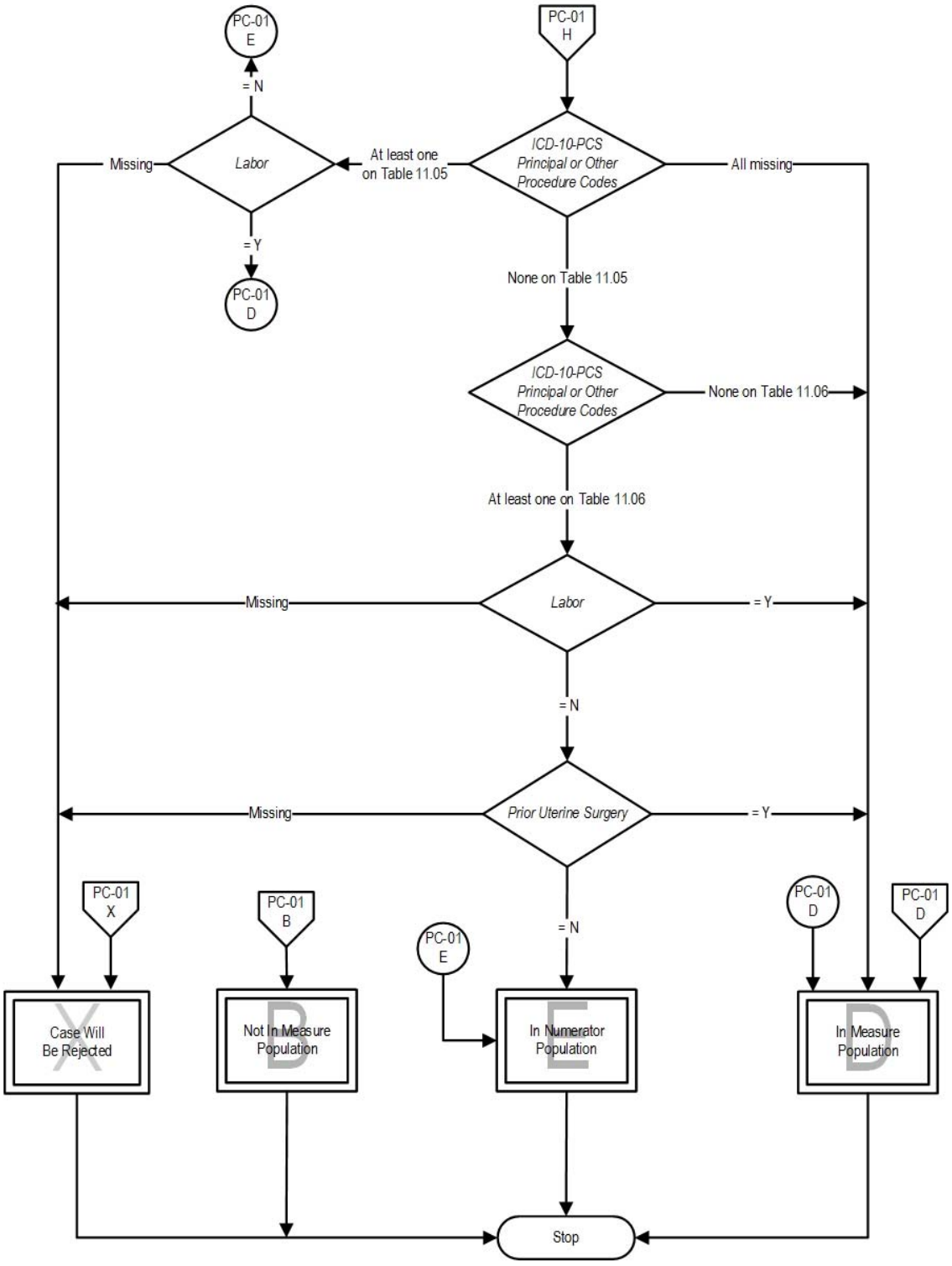
Measure Algorithm:

PC-01: Elective Delivery

Numerator: Patients with elective deliveries

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




PC-01 E
= N
Missing
Labor
= Y
PC-01 D
At least one on Table 11.05
PC-01 H
ICD-10-PCS Principal or Other Procedure Codes
All missing
None on Table 11.05
ICD-10-PCS Principal or Other Procedure Codes
None on Table 11.06
At least one on Table 11.06
Missing
Labor
= Y
= N
Missing
Prior Uterine Surgery
= Y
PC-01 X
PC-01 B
PC-01 E
= N
PC-01 D
PC-01 D
Case Will Be Rejected
Not In Measure Population
In Numerator Population
In Measure Population
Stop

Measure Information Form

Measure Set: Perinatal Care (PC)

Measure ID: PC-02

Name: Cesarean Birth

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

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

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

Type Of Measure: Outcome

Improvement Noted As: Decrease in the rate

Numerator Statement: Patients with cesarean births

> **Included Populations:** *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for cesarean birth as defined in Appendix A, Table 11.06
>
> **Excluded Populations:** None
>
> **Data Elements:**
>
> - *ICD-10-PCS Other Procedure Codes*
> - *ICD-10-PCS Principal Procedure Code*

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

> **Included Populations:**
>
> - *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1
> - Nulliparous patients with *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for outcome of delivery as defined in Appendix A, Table 11.08 and with a delivery of a newborn with 37 weeks or more of gestation completed

Excluded Populations:

- *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for multiple gestations and other presentations as defined in Appendix A, Table 11.09
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of Stay >120 days
- Enrolled in clinical trials
- *Gestational Age* < 37 weeks or UTD

Data Elements:

- *Admission Date*
- *Birthdate*
- *Clinical Trial*
- *Discharge Date*
- *Gestational Age*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *Number of Previous Live Births*

Risk Adjustment: Yes. Applied through direct standardization. This section has been moved to the ORYX Risk Adjustment Guide. This guide is available to the public on the Joint Commissions website and, in addition, it is available to performance measurement systems via the Joint Commissions extranet site for measurement systems (PET)

Data Elements

- *Birthdate*

Data Accuracy: Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: In order to identify areas for improvement, hospitals may want to review results based on specific ICD-10 codes or patient populations. Data could then be analyzed further determine specific patterns or trends to help reduce cesarean births.

Sampling: Yes. For additional information see the Sampling Section.

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

Selected References:

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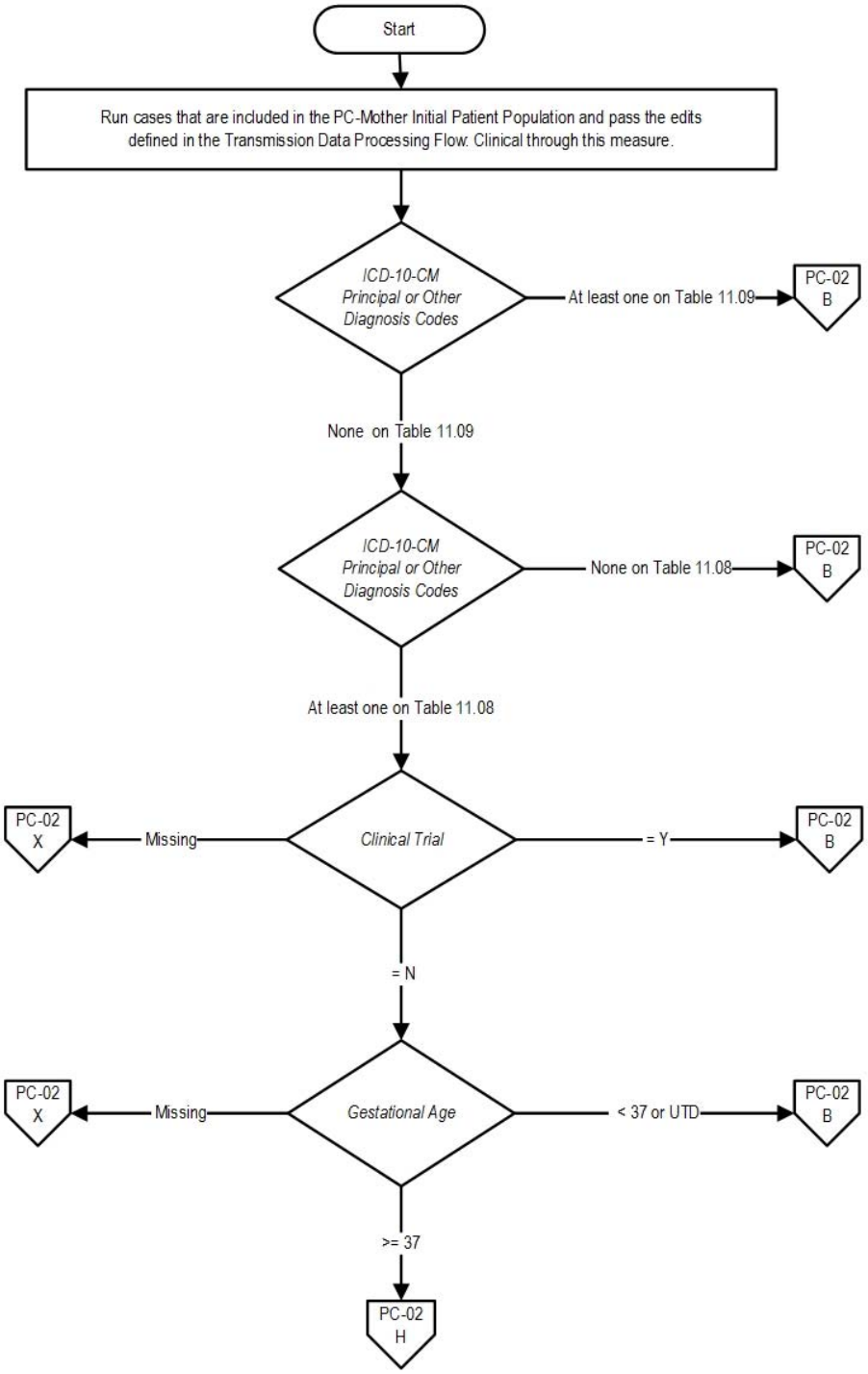
Original Performance Measure Source / Developer:
California Maternal Quality Care Collaborative

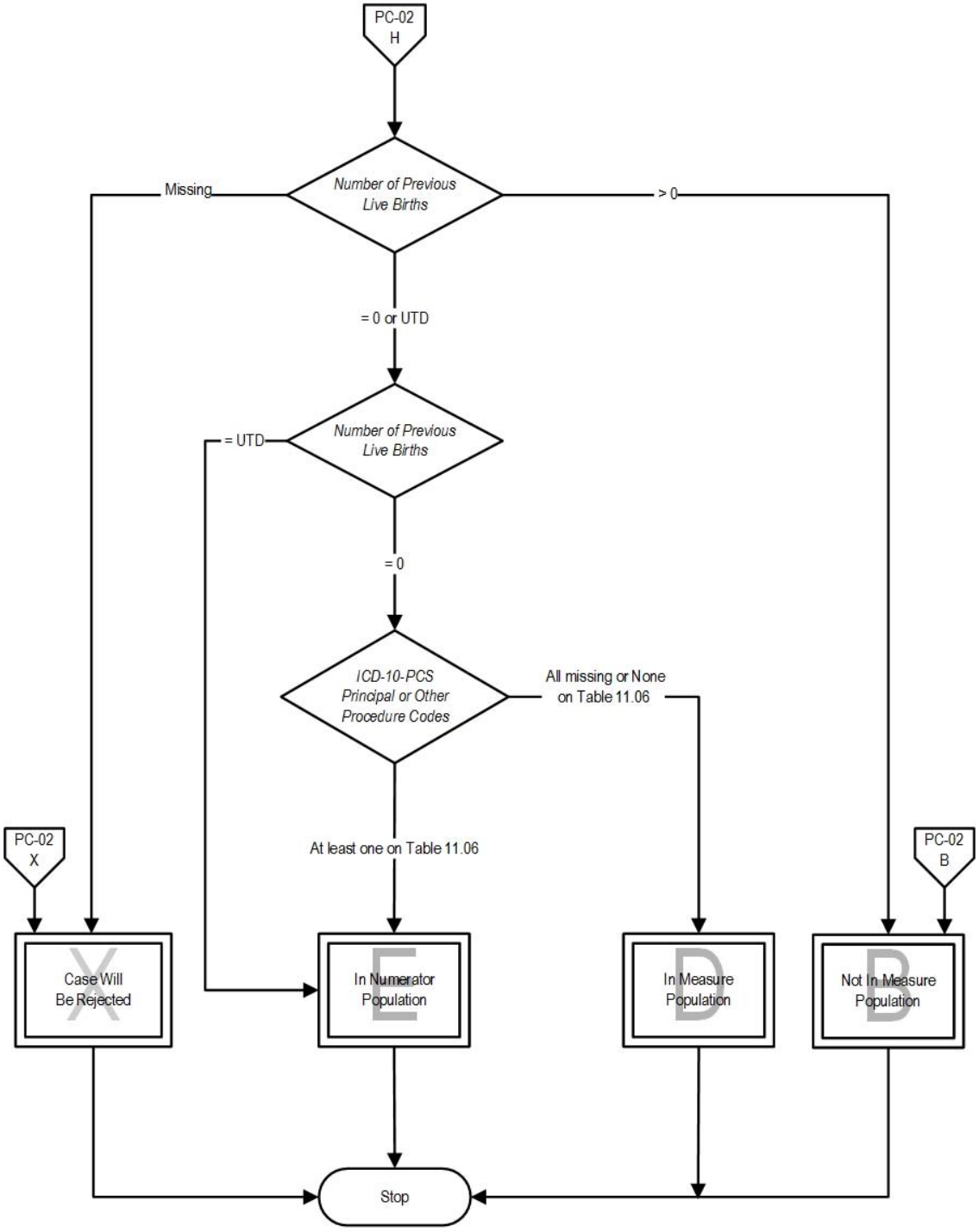
Measure Algorithm:

PC-02: Cesarean Birth

Numerator: Patients with cesarean births

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




PC-02
H
Number of Previous Live Births
Missing
> 0
= 0 or UTD
Number of Previous Live Births
= UTD
= 0
ICD-10-PCS Principal or Other Procedure Codes
All missing or None on Table 11.06
At least one on Table 11.06
PC-02
X
PC-02
B
X
Case Will Be Rejected
E
In Numerator Population
D
In Measure Population
B
Not In Measure Population
Stop

Measure Information Form

Measure Set: Perinatal Care (PC)

Measure ID: PC-03

Name: Antenatal Steroids

Description: Patients at risk of preterm delivery at >=24 and <34 weeks gestation receiving antenatal steroids prior to delivering preterm newborns

Rationale: The National Institutes of Health 1994 recommendation is to give a full course of corticosteroids to all pregnant women between 24 weeks and 34 weeks of gestation who are at risk of preterm delivery. Repeated corticosteroid courses should not be used routinely, because clinical trials show decreased brain size, decreased birth weight, and adrenal insufficiency in newborns exposed to repeated doses. Treatment should consist of two doses of 12 mg of betamethasone given intramuscularly 24 hours apart or four doses of 6 mg dexamethasone given intramuscularly every 12 hours.

A single course of corticosteroids should be given at 24 0/7 to 33 6/7 weeks gestation (NIH, 2000). A Cochrane meta-analysis reinforces the beneficial effect of this therapy regardless of membrane status and further concludes for all preterm deliveries the single course of corticosteroids should be routinely administered (Roberts & Dalziel, 2006).

Type Of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Patients with antenatal steroids initiated prior to delivering preterm newborns

> **Included Populations:** Antenatal steroids initiated (refer to Appendix C, Table 11.0, antenatal steroid medications)
>
> **Excluded Populations:** None
>
> **Data Elements:**
>
> - *Antenatal Steroids Initiated*

Denominator Statement: Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed

> **Included Populations:**
>
> - *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1
>
> **Excluded Populations:**
>
> - Less than 8 years of age
> - Greater than or equal to 65 years of age
> - Length of Stay >120 days
> - Enrolled in clinical trials
> - Documented *Reason for Not Initiating Antenatal Steroids*
> - *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for fetal demise as defined in Appendix A, Table 11.09.1
> - *Gestational Age* < 24 or >= 34 weeks or UTD

Data Elements:

- *Admission Date*
- *Birthdate*
- *Clinical Trial*
- *Discharge Date*
- *Gestational Age*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *Reason for Not Initiating Antenatal Steroids*

Risk Adjustment: No.

Data Accuracy: Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.

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

Sampling: Yes. For additional information see the Sampling Section.

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

Selected References:

- American College of Obstetricians and Gynecologists. (ACOG). (2013). Practice Bulletin: Clinical Management Guidelines for Obstetrician-Gynecologists for Premature rupture of membranes.
- Lockwood, C.J., ed. & Lemons, J.A., ed. (2007). Guidelines for Perinatal Care, Sixth Edition, *American Academy of Pediatrics and the American College of Obstetricians and Gynecologists*, ISBN 978-1-58110-270-3; ISBN 978-1-932328-36-3, pp. 178-181.
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- NIH Consensus Statement: *Antenatal corticosteroids revisited: repeat courses*.2000. 17(2)1-18.
- Roberts, D. & Dalziel, S.R. (2010) *Antenatal corticosteroids for accelerating fetal lung maturation for women at risk of preterm birth (Review)*. The Cochrane Collaboration. Issue 9.

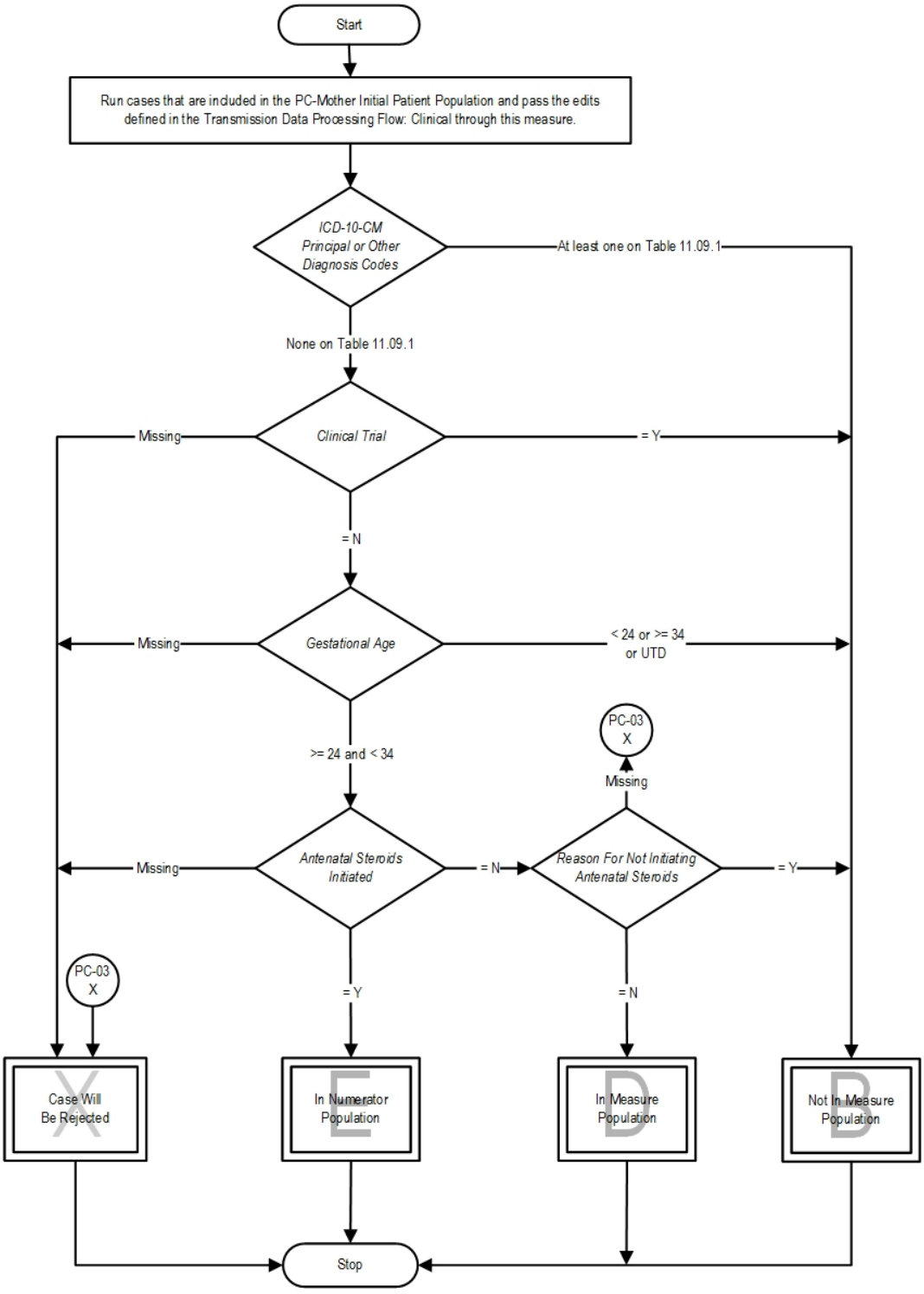
Original Performance Measure Source / Developer:
Providence St Vincents Hospital/Council of Women and Infants Specialty Hospitals

Measure Algorithm:

PC-03: Antenatal Steroids

Numerator: Patients with antenatal steroids initiated prior to delivering preterm newborns

Denominator: Patients delivering live preterm newborns with >= 24 and < 34 weeks gestation completed



Measure Information Form

Measure Set: Perinatal Care (PC)

Measure ID: PC-04

Name: Health Care-Associated Bloodstream Infections in Newborns

Description: Staphylococcal and gram negative septicemias or bacteremias in high-risk newborns

Rationale: Health care-associated bacteremia is significant problem for infants admitted into neonatal intensive care units (NICUs) and other hospital units. This is especially true for very low birth weight infants who are at high risk for these infections due to their immature immune systems and need for invasive monitoring and supportive care (Adams-Chapman & Stoll, 2002; Bloom et al., 2003; Clark et al., 2004a; Clark et al., 2004b; Gaynes et al., 1996; Payne et al., 2004; Sohn et al., 2001; Stoll et al., 2002). Reported health care-associated infection rates range from 6% to 33%, but the rate varies widely among different centers (Adams-Chapman & Stoll, 2002; Bloom et al.,2003; Clark et al.,2004b ; Sohn et al.,2001; Stoll et al.,2002). Mortality rates are high and infections result in increased length of stay as well as increased hospital costs and charges (Adams-Chapman & Stoll, 2002; Bloom et al.,2003; Clark et al., 2004b; Horbar et al., 2001; Kilbride et al., 2003a; Sohn et al.,2001; Stoll et al., 2002).

The incidence of health care-associated bacteremia increases with decreasing birth weight. Other risk factors include central venous catheter use, prolonged time using parenteral nutrition, prolonged time on mechanical ventilation, use of H2-blocking agents, and overcrowding or heavy staff loads (Adams-Chapman & Stoll, 2002; Barton et al., 1999; Gaynes et al., 1996; Stoll et al., 2002). The most common causative organisms are coagulase-negative staphylococci, Staphylococcus aureus, enterococci, Enterobacter sp, and Escherichia coli (Adams-Chapman & Stoll, 2002; Clark et al., 2004b; Gaynes et al., 1996; Horbar et al., 2001; Payne et al., 2004; Sohn et al., 2001; Stoll et al., 2002).

Effective preventive measures range from simple hand-washing protocols or closed medication delivery systems to more elaborate multidisciplinary quality improvement plans involving hand-washing, nutrition, skin care, respiratory care, vascular access, and diagnostic practices. All of these interventions have been shown to substantially reduce infection rates, albeit in nonrandomized studies using historical or concurrent control units (Adams-Chapman & Stoll, 2002; Aly et al., 2005; Bloom et al., 2003; Clark et al., 2004a; Clark et al., 2004b; Horbar et al., 2001; Lam et al., 2004; Kilbride et al., 2003a; Kilbride et al., 2003b; Ng et al., 2004; Schelonka et al., 2006). For example, six Vermont Oxford Network NICUs reduced their rates of coagulase-negative staphylococcus infections from 22.0% in 1994 to 16.6% in 1996 after implementing a quality improvement model (versus a much smaller decrease from 15.4% to 14.5% at 66 comparison NICUs) (Horbar et al., 2001). A similar reduction from 24.6% to 16.4% was achieved with a multi-modality, multi-hospital intervention focusing on hand hygiene with an effective agent before and after every patient contact, eliminating hand jewelry and artificial nails, using maximal barrier precautions during central venous catheter insertion, decreasing the number of skin punctures, reducing the duration of intravenous lipid and deep line use, and improving the diagnosis of health care-associated infections. (Kilbride et al., 2003a; Kilbride et al., 2003b).

Given the fragility and susceptibility of the patient population, a baseline level of health care-associated infections will be expected, even with good protocols in place. However, those centers that have prevention protocols, and are able to encourage health care workers to adhere to these protocols, will probably have success in reducing their rates of health care-associated bacteremia in their neonatal population. Indeed, several quasi-experimental studies have demonstrated that NICUs can lower their infection rates (based on positive blood cultures) from as high as 13.5 per 1,000 patient days to as low as 3.0 per 1,000 patient days(Adams-Chapman & Stoll, 2002; Aly et al., 2005; Bloom et al. ,2003; Clark et al., 2004a; Clark et al., 2004b; Horbar et al., 2001; Lam et al., 2004; Kilbride et al., 2003a; Kilbride et al., 2003b; Ng et al., 2004; Schelonka et al., 2006).

Type Of Measure: Outcome

Improvement Noted As: Decrease in the rate

Numerator Statement: Newborns with septicemia or bacteremia

Included Populations:

- *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

- *ICD-10-CM Other Diagnosis Codes* for sepsis as defined in Appendix A, Table 11.10.1 with a *Bloodstream Infection Confirmed*

Excluded Populations: None

Data Elements:

- *Bloodstream Infection Confirmed*
- *ICD-10-CM Other Diagnosis Codes*

Denominator Statement: Liveborn newborns

Included Populations:

- 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

Excluded Populations:

- *ICD-10-CM Principal Diagnosis Code* for septicemias or bacteremias as defined in Appendix A, Table 11.10.2
- *ICD-10-CM Other Diagnosis Codes* for septicemias or bacteremias as defined in Appendix A, Table 11.10.2 or *ICD-10-CM Principal or Other Diagnosis Codes* for newborn septicemia or bacteremia as defined in Appendix A, Table 11.10 with a *Bloodstream Infection Present on Admission*
- *ICD-10-CM Other Diagnosis Codes* for birth weight < 500g as defined in Appendix A, Table 11.20 OR Birth Weight < 500g
- Enrolled in clinical trials
- Length of Stay < 2 days

Data Elements:

- *Admission Date*

- *Birth Weight*
- *Birthdate*
- *Bloodstream Infection Present on Admission*
- *Clinical Trial*
- *Discharge Date*
- *Discharge Disposition*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *ICD-10-PCS Other Procedure Dates*
- *ICD-10-PCS Principal Procedure Code*

Risk Adjustment: Yes. This section has been moved to the *ORYX Risk Adjustment Guide*. This guide is available to the public on the Joint Commissions website and, in addition, it is available to performance measurement systems via the Joint Commissions extranet site for measurement systems (PET).

Data Elements:

- *Birth Weight*
- *Discharge Disposition*
- *ICD-10-CM Principal Diagnosis Code*
- *ICD-10-CM Other Diagnosis Codes*

Data Accuracy:

- Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.
- 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.
- It is important to ensure that all weight conversions from pounds and ounces to grams are accurate and concise. Birth Weight should not be rounded off i.e., when converting from pounds and ounces to grams, do not round to the nearest pound before converting the weight to grams.
- Discrepancies can occur between Birth Weights obtained from labor and delivery vs. nursery departments. Organizations should determine which is the most reliable source for this data element value and consistently obtain it from that source.

Measure Analysis Suggestions: In order to identify areas for improvement, hospitals may want to review results based on specific ICD-10 codes or patient populations. Data could then be analyzed further determine specific patterns or trends to help reduce bloodstream infections.

Sampling: No. For additional information see the Sampling Section.

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

Selected References:

- Adams-Chapman, I. & Stoll, B.J. (2002). Prevention of nosocomial infections in the neonatal intensive care unit. *Current Opinion in Pediatrics*.14 (2):157-64.
- Aly, H., Herson, V., Duncan, A., et al. (2005). Is bloodstream infection preventable among premature infants? A tale of two cities. *Pediatrics*. 115(6):1513-8.
- Barton, L., Hodgman, J.E., & Pavlova, Z. (1999). Causes of death in the extremely low birth weight infant. *Pediatrics*. 103(2):446-51.

- Bloom, B.T., Craddock, A., Delmore, P.M., et al. (2003). Reducing acquired infections in the NICU: observing and implementing meaningful differences in process between high and low acquired infection rate centers. *Journal of Perinatology*. 23(6):489-92.
- Clark, R., Powers, R., White, R., Bloom, B., Sanchez, P., & Benjamin, D.K., Jr. (2004a). Prevention and treatment of nosocomial sepsis in the NICU. *Journal of Perinatology*. 4; 24(7):446-53.
- Clark, R., Powers, R., White, R., Bloom, B., Sanchez, P., & Benjamin, D.K., Jr. (2004b). Nosocomial infection in the NICU: a medical complication or unavoidable problem? *Journal of Perinatology*. 24(6):382-8.
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- Horbar, J.D., Rogowski, J., Plsek, P.E., et al. (2001). Collaborative quality improvement for neonatal intensive care. NIC/Q Project Investigators of the Vermont Oxford Network. *Pediatrics*. 107(1):14-22.
- Kilbride, H.W., Wirtschafter, D.D., Powers, R.J., & Sheehan, M.B. (2003a). Implementation of evidence-based potentially better practices to decrease nosocomial infections. *Pediatrics*. 111(4 Pt 2):e519-33.
- Kilbride, H.W., Powers, R., Wirtschafter, D.D., et al. (2003b). Evaluation and development of potentially better practices to prevent neonatal nosocomial bacteremia. *Pediatrics*. 111(4 Pt 2):e504-18.
- Lam, B.C., Lee, J., & Lau, Y.L. (2004). Hand Hygiene Practices in a Neonatal Intensive Care Unit: A Multimodal Intervention and Impact on Nosocomial Infection. *Pediatrics*.114 (5):e565.
- Ng, P.C., Wong, H.L., Lyon, D.J., et al. (2004). Combined use of alcohol hand rub and gloves reduces the incidence of late onset infection in very low birthweight infants. Archives of Disease in Childhood Fetal & Neonatal Edition. 89(4):F336-40.
- Payne, N.R., Carpenter, J.H., Badger, G.J., Horbar, J.D., & Rogowski, J. (2004). Marginal increase in cost and excess length of stay associated with nosocomial bloodstream infections in surviving very low birth weight infants. *Pediatrics*. 114(2):348-55.
- Schelonka, R.L., Scruggs, S., Nichols, K., Dimmitt, R.A., & Carlo, W.A. (2006). Sustained reductions in neonatal nosocomial infection rates following a comprehensive infection control intervention. *Journal of Perinatology*. 26(3):176-9.
- Sohn, A.H., Garrett, D.O., Sinkowitz-Cochran, R.L., et al. (2001). Prevalence of nosocomial infections in neonatal intensive care unit patients: Results from the first national point-prevalence survey. *Journal of Pediatrics*. 139(6):821-7.
- Stoll, B.J., Hansen, N., Fanaroff, A.A., et al. (2002). Late-onset sepsis in very low birth weight neonates: the experience of the NICHD Neonatal Research Network. *Pediatrics*. 110(2 Pt 1):285-91.

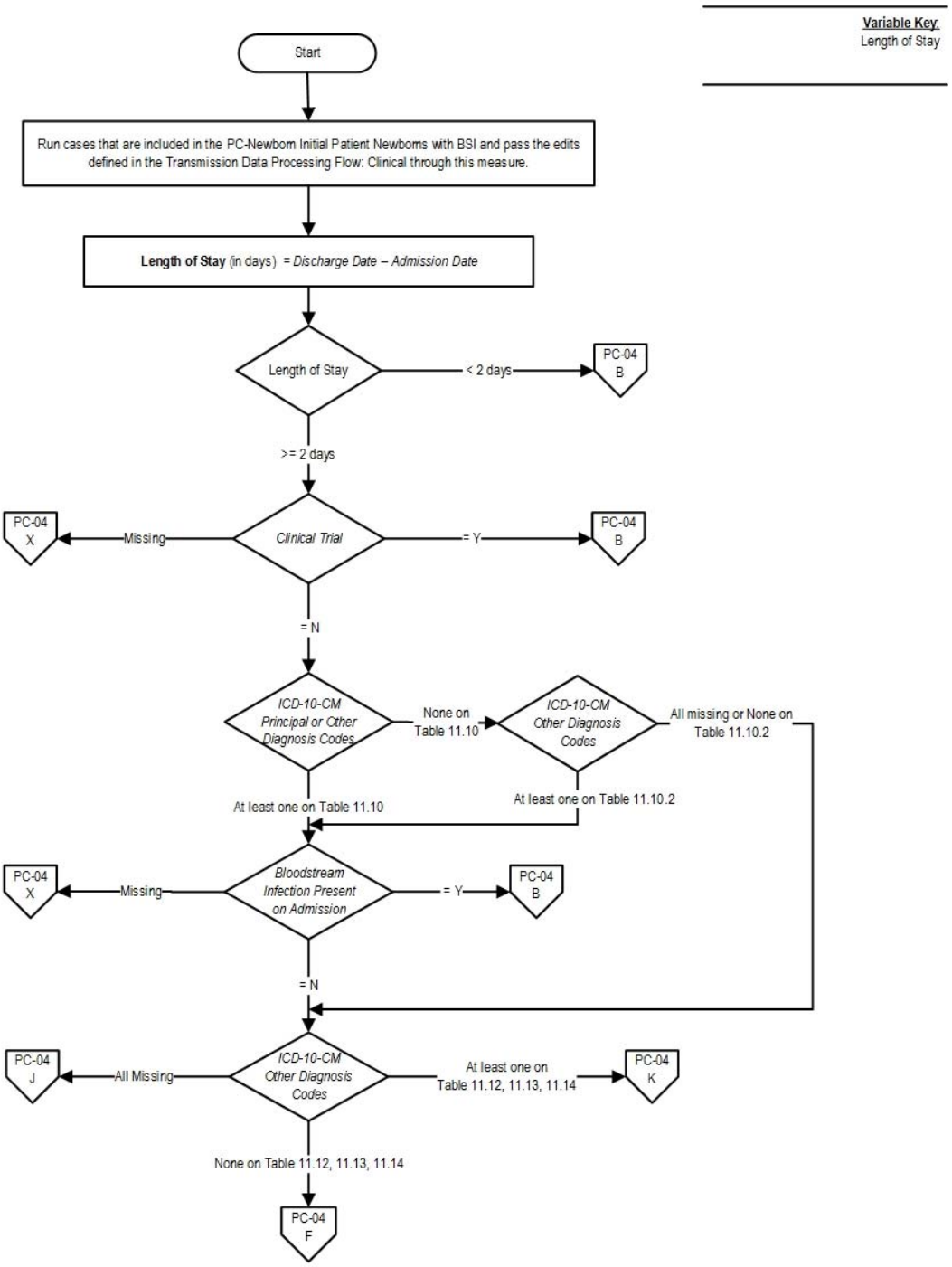
Original Performance Measure Source / Developer:
Agency for Healthcare Research and Quality

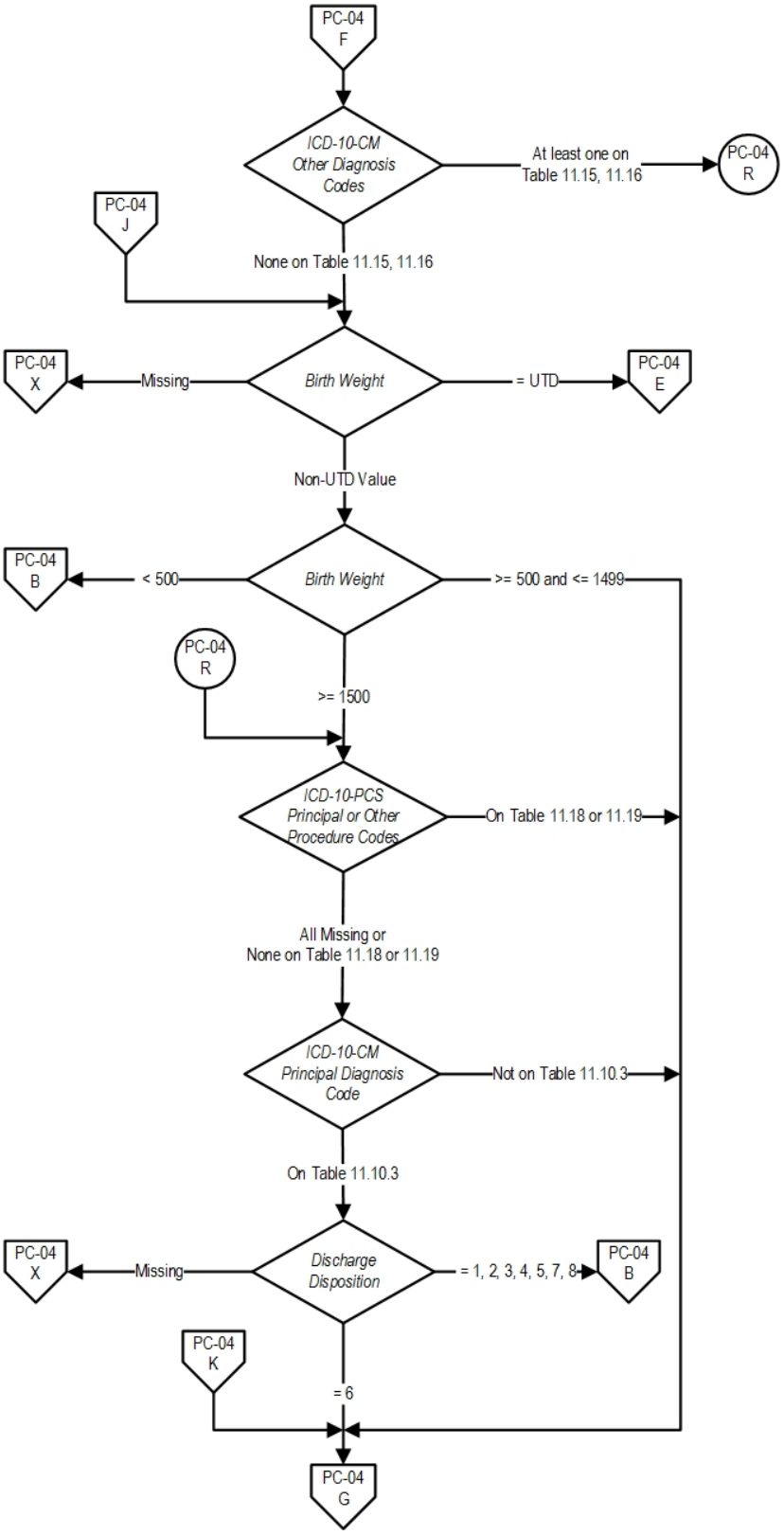
Measure Algorithm:

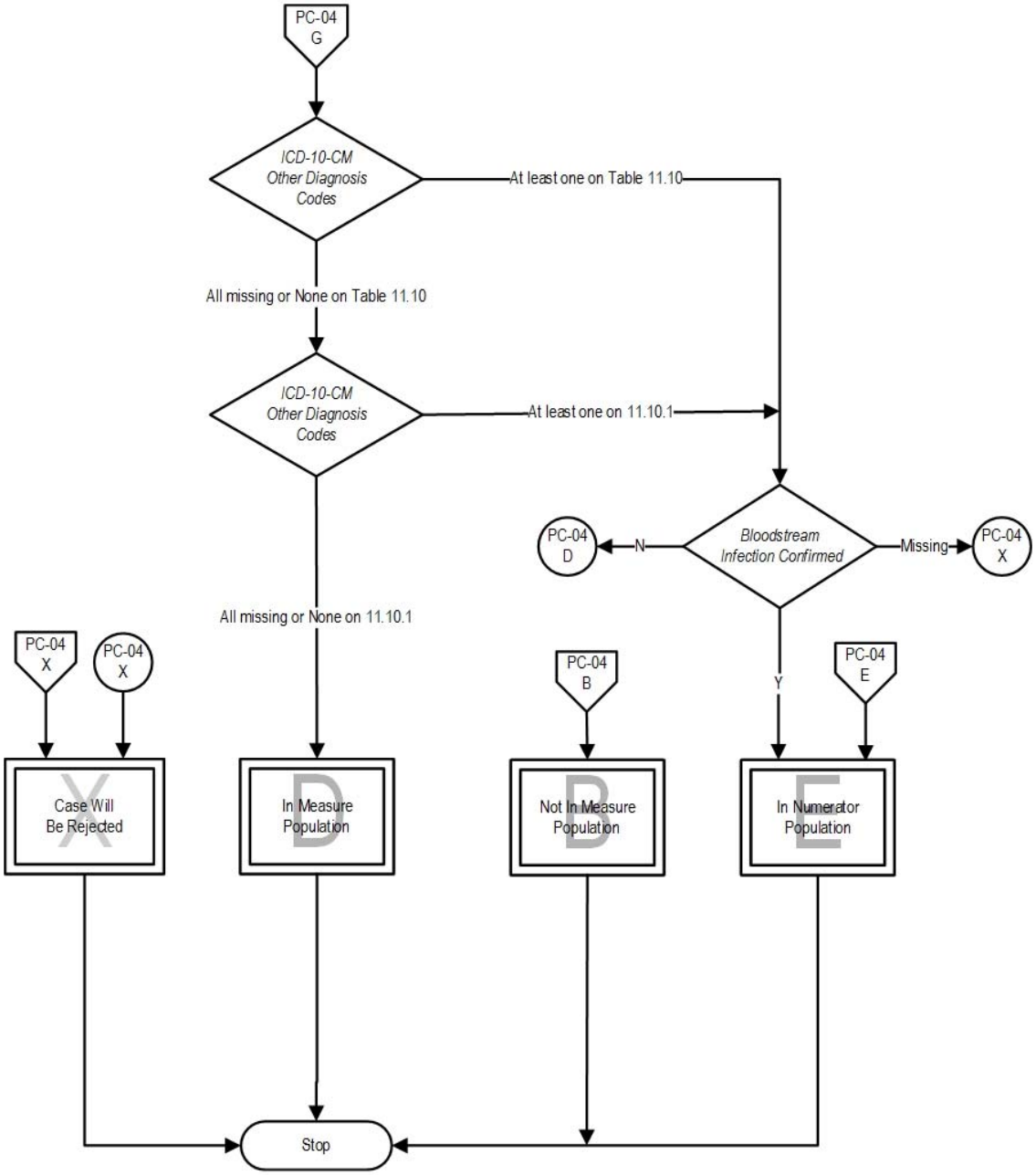
PC-04: Health Care-Associated Bloodstream Infections in Newborns

Numerator: Newborns with septicemia or bacteremia

Denominator: Live-born newborns




PC-04 F
ICD-10-CM Other Diagnosis Codes
At least one on Table 11.15, 11.16
PC-04 R
PC-04 J
None on Table 11.15, 11.16
PC-04 X
Missing
Birth Weight
= UTD
PC-04 E
Non-UTD Value
PC-04 B
< 500
Birth Weight
>= 500 and <= 1499
PC-04 R
>= 1500
ICD-10-PCS Principal or Other Procedure Codes
On Table 11.18 or 11.19
All Missing or None on Table 11.18 or 11.19
ICD-10-CM Principal Diagnosis Code
Not on Table 11.10.3
On Table 11.10.3
PC-04 X
Missing
Discharge Disposition
= 1, 2, 3, 4, 5, 7, 8
PC-04 B
PC-04 K
= 6
PC-04 G


PC-04
G
ICD-10-CM
Other Diagnosis
Codes
At least one on Table 11.10
All missing or None on Table 11.10
ICD-10-CM
Other Diagnosis
Codes
At least one on 11.10.1
Bloodstream
Infection Confirmed
N
PC-04
D
Missing
PC-04
X
All missing or None on 11.10.1
Y
PC-04
X
PC-04
X
PC-04
B
PC-04
E
X
Case Will
Be Rejected
D
In Measure
Population
B
Not In Measure
Population
E
In Numerator
Population
Stop

Measure Information Form

Measure Set: Perinatal Care (PC)

Measure ID: PC-05

Name: Exclusive Breast Milk Feeding

Description: Exclusive breast milk feeding during the newborn's entire hospitalization

The measure is reported as an overall rate which includes all newborns that were exclusively fed breast milk during the entire hospitalization.

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

Type Of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Newborns that were fed breast milk only since birth

Included Populations: Not applicable

Excluded Populations: None

Data Elements:

- *Exclusive Breast Milk Feeding*

Denominator Statement: Single term newborns discharged alive from the hospital

Included Populations: Liveborn newborns with *ICD-10-CM Principal Diagnosis Code* for single liveborn newborn as defined in Appendix A, Table 11.20.1

Excluded Populations:

- Admitted to the Neonatal Intensive Care Unit (NICU) at this hospital during the hospitalization
- *ICD-10-CM Other Diagnosis Codes* for galactosemia as defined in Appendix A, Table 11.21
- *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for parenteral nutrition as defined in Appendix A, Table 11.22
- Experienced death
- Length of Stay >120 days
- Enrolled in clinical trials
- Patients transferred to another hospital
- Patients who are not term or with < 37 weeks gestation completed

Data Elements:

- *Admission Date*
- *Admission to NICU*
- *Birthdate*
- *Clinical Trial*
- *Discharge Date*
- *Discharge Disposition*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *ICD-10-PCS Other Procedure Codes*
- *ICD-10-PCS Principal Procedure Code*
- *Term Newborn*

Risk Adjustment: No.

Data Accuracy: Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.

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

Sampling: Yes. For additional information see the Sampling Section.

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

Selected References:

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- 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.
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- US Department of Health and Human Services. (2007). Healthy People 2010 Midcourse Review. Washington, DC: US Department of Health and Human Services. Available at: http://www.healthypeople.gov /data/midcourse.
- World Health Organization. (1991). Indicators for assessing breastfeeding practices. Geneva, Switzerland: World Health Organization. Available at: http://www.who.int/child-adolescent-health/new_publications/nutrition /who_cdd_ser_91.14.pdf.

Original Performance Measure Source / Developer:
California Maternal Quality Care Collaborative

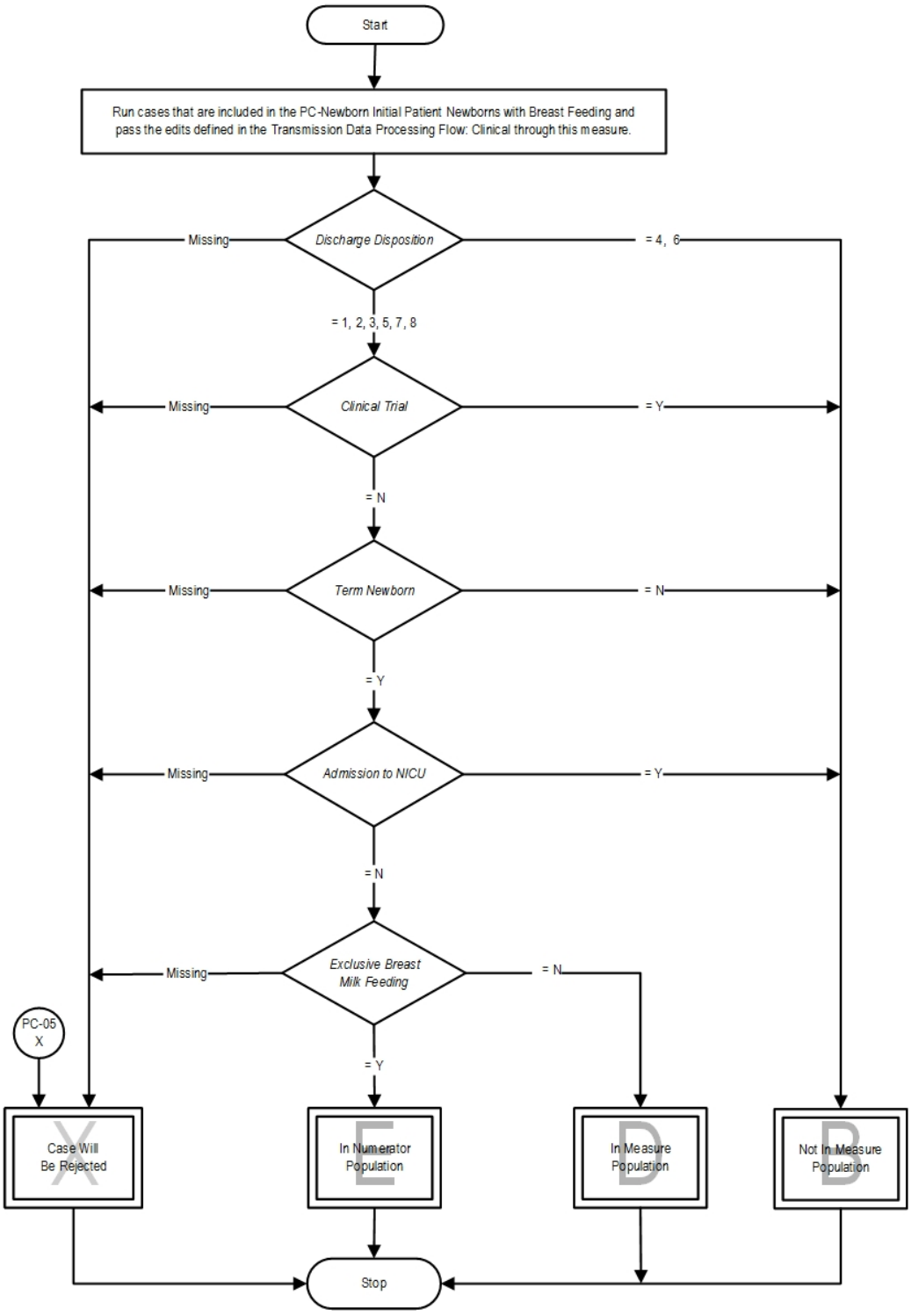
Adopted for Stage 2 Medicare and Medicaid EHR Incentive Program

Measure Algorithm:

PC-05: Exclusive Breast Milk Feeding

Numerator: Newborns that were fed breast milk only since birth

Denominator: Single term newborns discharged alive from the hospital



Data Dictionary Introduction

Introduction

This section of the manual describes the data elements required to calculate category assignments and measurements for The Joint Commission's National Quality Measures. It includes information necessary for defining and formatting the data elements, as well as the allowable values for each data element. This information is intended to assist in processing patient level data elements for The Joint Commission's National Quality Core Measures.

It is of primary importance that all health care organizations using The Joint Commission's National Quality Core Measures gather and utilize the data elements as defined in this section. This will ensure that the data are standardized and comparable across organizations.

Regardless of which measure sets are selected by a hospital, certain general data elements must be collected by the hospital and submitted for **every** patient that falls into **any** of the selected Initial Patient Populations. These data elements are considered "general" to each patient's episode of care.

These data elements include:

- *Admission Date*
- *Birthdate*
- *Health Care Organization Identifier* [2]
- *Hispanic Ethnicity*
- *Measure Set* [1,2]
- *Performance Measure Identifier* [1,2]
- *Race*
- *Sample* [1]
- *Sex*
- *Vendor Tracking ID* [1,2]

Data elements that are general for every patient that fall into measures that are reported at time of discharge include:

- *Discharge Date*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-PCS Other Procedure Codes* (Optional for all HBIPS measures)
- *ICD-10-PCS Other Procedure Dates* (Optional for all HBIPS measures)
- *ICD-10-CM Principal Diagnosis Code*
- *ICD-10-PCS Principal Procedure Code* (Optional for all HBIPS measures)
- *ICD-10-PCS Principal Procedure Date* (Optional for all HBIPS measures)
- *Payment Source*

Data elements that are general for every patient that falls into measures that are reported at the time of the event include:

- *Event Date* (HBIPS measures only)
- *Event Type* (HBIPS measures only)
- *Psychiatric Care Setting* (HBIPS measures only)

Data elements that are general for every patient that falls into specific measures that are reported at the time of discharge include:

- *Discharge Disposition*

[1] Transmission Data Element

[2] These data elements are defined in the Transmission Data Dictionary within the Joint Commission National Quality Core Measures Data Transmission section of this manual

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Episode of Care

An Episode of Care (EOC) is defined as the health care services given during a certain period of time, usually during a hospital stay (e.g., from the day of arrival or admission to the day of discharge). The medical record should be abstracted as it was billed. In the event that there are multiple ED visits within the inpatient medical record, for the same episode of care, it is recommended that the ED visit resulting in the admission to observation or inpatient status be utilized for the purposes of abstraction.

If a patient is transferred from an acute care hospital to another acute care hospital, which is within the same healthcare system and shares the same Joint Commission *Health Care Organization Identifier* (HCO ID), this should be abstracted as one episode of care.

Data integrity

Editing Zero Values

Verification mechanisms are necessary to assure that zero is the intended data value rather than an initialization value for those data elements which have an allowable value of zero (i.e., 0.0, 0000, 0).

Missing and Invalid Data

Each data element that is applicable per the algorithm for each of the measures within a topic must be touched by the abstractor. While this is the expectation, it is recognized that in certain situations information may not be available (e.g., dates, times, codes, etc.). After due diligence in reviewing all allowable data sources within the medical record, if the abstractor determines that a value is not documented, i.e. missing, or is unable to determine if a value is documented, the abstractor should select the UTD - Unable to Determine, value. The data elements *Admission Date*, *Discharge Date* and *Birthdate* require an actual date for submission of discharge measure information into the Joint Commissions Data Warehouse, and UTD cannot be selected as an allowable value. For Yes/No values the allowable value No incorporates the UTD into the definition. For data elements containing more than two categorical values and for numerical data elements (i.e., dates, times, etc.), a UTD option is included as an allowable value and is classified in the same category as not documented. Files that contain any invalid and/or missing data will be rejected from the Joint Commissions Data Warehouse. For additional details on the proper handling of missing and/or invalid data, please refer to the Missing and Invalid Data section of this manual.

Interpreting Data Element Definitions and Allowable Values

Every attempt has been made to comprehensively define The Joint Commission's National Quality Core Measure data elements and allowable values in a manner that obviates the need for interpretation. If, after reviewing the General Abstraction Guidelines, the data element definition, including the notes and guidelines for abstraction, an abstractor cannot clearly assign an allowable value, refer to the Resource section of this manual for additional contact information.

Interpretation of Data Dictionary Terms

Data elements fall into three broad categories in order to support a specific measure set. They include:

- *General Data Elements* data elements that must be collected by health care organizations for each patient record
    - data elements required for each episode of care (EOC) record submitted

    - data elements used to identify the health care organization on each patient record required for each patient-level record submitted
    - patient demographic data required for each episode of care record submitted and used for risk adjustment analysis (where applicable)
- *Measure-Specific Data Elements* data elements used by one specific measure or several measures in one specific measure set, such as in the HBIPS measures
- *Algorithm Output Data Elements* Refer to ORYX® Technical guide

Data Element Dictionary Terms

Term	Definition
Data Element Name:	A short phrase identifying the data element. For each of identification the data element name is *italicized*.
Collected For:	Identifies the measure(s) that utilize this data element or specifies that the data element is used for data transmission or verification.
Definition:	A detailed explanation of the data element. *A vendor may include this information in data collection software*.
Suggested Data Collection Question:	A suggested wording for a data element question in a data abstraction tool.
Format:	**Length** = number of characters or digits allowed for the data element **Type** = 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:	Provided to assist abstractor in the selection of appropriate value for a data element
Suggested Data Sources:	Source document from which data can be identified such as administrative or medical record. Some data elements also list excluded data sources that are unacceptable sources for collecting information.
Guidelines for Abstraction:	Designed to assist abstractors in determining how a data element should be answered **Note:** Element specific notes and guidelines should take precedence over the General Abstraction Guidelines.

General Abstraction Guidelines

The intent of abstraction is to use only documentation that was part of the medical record during the hospitalization (is present upon discharge) and that is present at the time of abstraction. There are instances where an addendum or late entry is added after discharge. This late entry or addendum can be used, for abstraction purposes, as long as it has been added within 30 days of discharge, [Refer to the Medicare Conditions of Participation for Medical Records, 42CFR482.24(c)(2)(viii)], unless otherwise specified in the data element. Documents containing amendments, corrections, or delayed entries must employ the following widely accepted record keeping principles (CMS Medicare Program Integrity Manual Chapter 3, Section 3.3.2.4):

- Clearly and permanently identify any amendments, corrections or addenda;

- Clearly indicate the date and author of any amendments, corrections, or addenda; and
- Clearly identify all original content.

Prenatal forms which are available during the hospitalization and become a permanent part of the patients medical record (electronic health record/EHR or paper) for the current hospitalization may be used for abstraction. It is not the intent to have documentation added at the time of abstraction to ensure the passing of a measure.

Medical Record Documentation

The intent of abstraction is to use only documentation that was part of the medical record during the hospitalization (is present upon discharge) and that is present at the time of abstraction. There are instances where an addendum or late entry is added after discharge. This late entry or addendum can be used, for abstraction purposes, as long as it has been added within 30 days of discharge, unless otherwise specified in the data element. It is not the intent to have documentation added at the time of abstraction to ensure the passing of a measure.

Important Note: There are several data elements where abstraction of data from documentation dated/timed after discharge is restricted, and these exceptions are published on the respective data element pages of the data dictionary. Data element specific notes and guidelines always take precedence over the General Abstraction Guidelines.

All documentation in the medical record must be legible and must be timed, dated and authenticated. However, documentation that is not timed, dated or authenticated may still be used for abstraction if not required by the specific data element. When abstracting a medical record, if a handwritten document is determined to be not legible, other documentation should be reviewed in an attempt to obtain the answer. If no other source document is able to verify the handwritten documentation, only then is the abstractor to answer unable to determine from the medical record documentation, unless otherwise specified in the data element. Authentication may include written signatures, initials, computer key, or other codes.

Data element information should be retrieved from the current medical record, covering the admission and discharge date, or reporting period for event measures being abstracted. Information ascertainable from previous history (e.g., failed trials of monotherapy) AND determined to be part of the current medical record may be used in abstraction. For example, if the patient had previously failed three or more trials of monotherapy and this information is available in the current chart being abstracted (e.g., a note made in the continuing care plan), this information should be used. Previous history information used in abstraction should be information that was part of the medical record during hospitalization, when care was being delivered.

The medical record must be abstracted as documented (taken at face value). When the value documented is obviously in error (not a valid format/range or outside of the parameters for the data element) **and** no other documentation is found that provides this information, the abstractor should select UTD. Example:

- Patient expires on 02-12-20XX and documentation indicates the Event Date was 03-12-20XX. Other documentation in the medical record supports the date of death as being accurate. Since the Event Date is after the Discharge Date (death), it is outside of the parameter of care and the abstractor should select UTD.

Note: Hospitals should use abbreviations according to their policy. Frequently flow sheets or other documentation contain a key or legend that explains what the abbreviation or symbol stands for, especially if unique to that facility.

Suggested Data Sources

- Suggested Data Sources are listed in alphabetical order, NOT priority order, unless otherwise specified in the data element.
- Suggested Data Sources are designed to provide guidance to the abstractor as to the locations/sources where the information needed to abstract a data element will likely be found. However, the abstractor is not limited to these sources for abstracting the information and must review the entire medical record unless otherwise specified in the data element.
- In some instances, a data element may restrict the sources that may be used to gain the information, list a

priority in which the sources should be used or may restrict documentation by only physician/advanced practice nurse/physician assistant. If so, these sources will be identified and labeled as Excluded Data Sources. "ONLY ACCEPTABLE SOURCES", "Priority Source", or "PHYSICIAN/APN/PA DOCUMENTATION ONLY".

- If, after due diligence, the abstractor determines that a value is not documented or is not able to determine the answer value, the abstractor must select Unable to Determine (UTD) as the answer.
- Hospitals often label forms and reports with unique names or titles. Suggested Data Sources are listed by commonly used titles; however, information may be abstracted from any source that is equivalent to those listed.
    - **Example:**
      If the nursing admission assessment is listed as a suggested source, an acceptable alternative might be titled nurses initial assessment or nursing data base.
      Note:
      Element specific notes and guidelines should take precedence over the General Abstraction Guidelines.

Inclusions/Exclusions

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

Physician/Advanced Practice Nurse/ Physician Assistant Documentation

- Advanced Practice Nurse (APN, APRN) titles may vary among state and clinical specialties. Some common titles that represent the advanced practice nurse role are:
    - Nurse Practitioner (NP)
    - Certified Registered Nurse Anesthetist (CRNA)
    - Clinical Nurse Specialist (CNS)
    - Certified Nurse Midwife (CNM)
- When a physician/advanced practice nurse/ physician assistant (physician/APN/PA) signs a form or report (e.g., ED sheet with triage and nursing information and a physician/APN/PA has signed somewhere on the form), information on that form/report should be considered physician/APN/PA documentation.
- Rubber stamped physician/advanced practice nurse/physician assistant (physician/APN/PA) signatures are not acceptable on any document within the medical record. Handwritten, electronic signatures, facsimiles of original written or electronic signatures are acceptable.
- Resident and intern notes should be considered physician documentation. Medical student notes must be co-signed by a physician.
- For the purposes of abstraction, telephone or verbal physician/APN/PA orders (TO/VO) in the medical record are considered physician/APN/PA documentation at the time they were written regardless of whether or not they were authenticated by the physician/APN/PA at the time of abstraction.

Pharmacist Documentation

Pharmacist titles may vary. Some common titles that represent the pharmacist role are:

- Doctor of Pharmacy (Pharm.D. or D.Ph.)

- Registered Pharmacist (R.Ph.)

Medications:

- The approved medication tables contained in the dictionaries may not be inclusive lists of all available therapeutic agents acceptable for a particular data element. Discrepancies must be reported. See Appendix F (resource section) of this manual for contact information.
- Whether or not a medication has been administered to a patient is often clear when using medical record sources such as medication administration records, but documentation can be more ambiguous in other sources, namely, physician orders, ED records, and ambulance records. To make a determination using these sources, use the following criteria:
    - For EHRs only accept documentation that reflects the actual administration of the medication in the context of the chart.
    - If a medication in the physician orders has been initialed and signed off with a time, do NOT presume that the medication was administered. The documentation MUST indicate that the medication was actually given.
    - For an ED or ambulance record, there is no need for documentation indicating that the medication was actually given.
        - **Example:**
          If the ED or ambulance record reflects ASA 325mg po 13:00 and no other documentation exists indicating that the medication was actually given (e.g., given or administered), this is acceptable documentation to abstract.

- When determining whether or not a patient was discharged on a specific medication (e.g., antipsychotic medication):
    - If discharge medications are noted using only references such as continue home meds, continue previous medications, resume other meds, same medications, or continue meds, rather than lists of the names of the discharge medications, the abstractor should include the medication in the count if the patient was on the medication in question prior to arrival, unless documentation suggests otherwise.
    - If discharge medications are noted using only references such as continue current medications or continue present meds rather than lists of the names of the discharge medications, the abstractor should include the medication in the count if the medication in question was listed as a medication on the day of discharge, unless documentation indicates it was to be discontinued at discharge or suggests otherwise
    - If discharge medications are noted using general references such as continue home meds, continue previous medications, continue current meds, continue present meds, resume other meds, or continue meds, but a list of the names of the discharge medications also in the record gives conflicting information about what medications the patient was actually discharged on, the abstractor should consider the list most accurate and use only the list in determining whether or not a patient was discharged on a specific medication.
- Hospitals may allow a patient (or his or her caregiver/support person where appropriate) to self-administer both hospital-issued medications and the patients own medications brought into the hospital. Hospitals must document the administration of each medication, as reported by the patient (or the patients caregiver/support person where appropriate), in the patients medical record [42CFR482.23(c)(6)].

Nursing Care Plans, Standing Orders and Protocols

- Per Medicare Conditions of Participation [42CFR482.23(b)(4)] hospitals have the option of having a stand-alone nursing care plan or a single interdisciplinary care plan that addresses nursing and other disciplines.
- Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders if such orders and protocols are dated, timed, and authenticated promptly in the patients medical record by the ordering practitioner responsible for the care of the patient [42CFR482.24(c)(3)].

Diagnostic/Laboratory Tests
Whether or not a diagnostic or laboratory test has been done is usually clear when using medical record sources such as diagnostic test reports, laboratory reports, or progress notes (where a physician might note test findings), but documentation can be more ambiguous in other sources, namely, physician orders and ED records. To make a determination using these sources, use the following criteria:

- If a test in the physician orders has been initialed and signed off with a time, do NOT presume that the test was done. The documentation MUST indicate that the test was actually done (e.g., accompanied by a word such as done).
- For an ED record, there is no need for explicit documentation indicating that the test was actually done. For example, if an ED record notes Lipid profile, and this is followed by a signature and/or a time, the abstractor should presume the test was performed.

Grids
Instructions for reading values recorded on grids: Measure from the midpoint of the symbol, number and letter. If the value falls between two lines on the grid, abstract the earliest value.

Alphabetical List of All Data Elements

Data Element Name	Collection Notes	Associated Measures
Admission Date	All Records	ACHF-01, ACHF-02, ACHF-03, ACHF-04, ACHF-05, ACHF-06, AMI-10, AMI-2, CAH-01.1, CAH-02.1, CAH-03, CAH-04, CAH-05, CAH-06, CAH-08.1, CAH-09.1, CAH-10.1, CSTK, HBIPS, HF-3, Osteo, PBM, PC, PN-3a, SCA-03, SUB, TOB
Admission to NICU		PC-05
Antenatal Steroids Initiated		PC-03
Appropriate Justification for Multiple Antipsychotic Medications		HBIPS-5
Birth Weight	Risk Adjustment	PC-04
Birthdate	All Records	ACHF, ACHFOP, AMI, CAH, CSTK, HBIPS, HF, Osteo, PBM, PC, PN, SCA, SUB, TOB
Bloodstream Infection Confirmed		PC-04
Bloodstream Infection Present on Admission		PC-04
CMS Certification Number	Hospital Clinical Data File, Optional for All Records	HBIPS, PC
Clinical Trial		ACHF-01, ACHF-02, ACHF-03, ACHF-06, ACHFOP-01, ACHFOP-02, ACHFOP-03, ACHFOP-04, ACHFOP-05, CSTK-04, CSTK-06, PC
Continuing Care Plan-Discharge Medications		HBIPS-6, HBIPS-7

Data Element Name	Collection Notes	Associated Measures
Continuing Care Plan-Next Level of Care		HBIPS-6, HBIPS-7
Continuing Care Plan-Principal Discharge Diagnosis		HBIPS-6, HBIPS-7
Continuing Care Plan-Reason for Hospitalization		HBIPS-6, HBIPS-7
Discharge Date	All Records	ACHF-01, ACHF-02, ACHF-03, ACHF-04, ACHF-05, ACHF-06, AMI, CAH-01.1, CAH-02.1, CAH-03, CAH-04, CAH-05, CAH-06, CAH-08.1, CAH-09.1, CAH-10.1, CSTK, HBIPS-1, HBIPS-4, HBIPS-5, HBIPS-6, HBIPS-7, HF, Osteo, PBM, PC, PICU-03, PN, PSCIP, SCA, SUB, TOB
Discharge Disposition		ACHF-01, ACHF-02, ACHF-03, ACHF-04, ACHF-05, ACHF-06, CSTK-02, HBIPS-4, HBIPS-5, HBIPS-6, HBIPS-7, PC-04, PC-05
Event Date		HBIPS-2, HBIPS-3
Event Type		HBIPS-2, HBIPS-3
Exclusive Breast Milk Feeding		PC-05
Gestational Age		PC-01, PC-02, PC-03
Health Care Organization Identifier	All Records, Patient Population Data File, Hospital Clinical Data File	HBIPS, PC
Hispanic Ethnicity	All Records	ACHF, AMI, CAC, CAH, CSTK, HBIPS, HF, Osteo, PC, PN, PR, SCA, SCIP, STK
ICD-10-CM Other Diagnosis Codes	All Records	HBIPS-1, HBIPS-4, HBIPS-5, HBIPS-6, HBIPS-7, PC
ICD-10-CM Principal Diagnosis Code	All Records	HBIPS-1, HBIPS-4, HBIPS-5, HBIPS-6, HBIPS-7, PC
ICD-10-PCS Other Procedure Codes	All Records	HBIPS, PC
ICD-10-PCS Other Procedure Dates	All Records	HBIPS, PC
ICD-10-PCS Principal Procedure Code	All Records	HBIPS, PC
ICD-10-PCS Principal Procedure Date	All Records	HBIPS, PC
Initial Patient Population Size Medicare Only	Transmission, Patient Population Data File	HBIPS, PC
Initial Patient Population Size Non-Medicare Only	Transmission, Patient Population	HBIPS, PC

Data Element Name	Collection Notes	Associated Measures
	Data File	
Labor		PC-01
Measure Category Assignment	Calculation, Transmission, Hospital Clinical Data File	AMI, HBIPS, HF, PBM, PC, PN
Measure Set	Transmission, Patient Population Data File, Hospital Clinical Data File	HBIPS, PC
Measurement Value	Calculation, Transmission, Hospital Clinical Data File	HBIPS, PC
Minutes of Physical Restraint		HBIPS-2
Minutes of Seclusion		HBIPS-3
National Provider Identifier	Transmission	HBIPS, PC
Number of Antipsychotic Medications Prescribed at Discharge		HBIPS-4, HBIPS-5
Number of Previous Live Births		PC-02
Patient Referral to Next Level of Care Provider		HBIPS-4, HBIPS-5, HBIPS-6, HBIPS-7
Patient Strengths		HBIPS-1
Payment Source	All Records	AMI, CSTK, HBIPS, HF, PC, PN
Predicted Value	Transmission, Risk Adjustment, Hospital Clinical Data File	PC
Prior Uterine Surgery	Joint Commission Only	PC-01
Psychiatric Care Setting	All Records	HBIPS-1, HBIPS-2, HBIPS-3, HBIPS-4, HBIPS-5, HBIPS-6, HBIPS-7
Psychiatric Inpatient Days - Medicare Only		HBIPS-2, HBIPS-3
Psychiatric Inpatient Days-Non-Medicare Only		HBIPS-2, HBIPS-3
Psychological Trauma History		HBIPS-1
Race	All Records	ACHF, AMI, CAC, CAH, CSTK, HBIPS, HF, Osteo, PC, PN, PR, SCA, SCIP, STK
Reason for Not Initiating Antenatal Steroids		PC-03

Data Element Name	Collection Notes	Associated Measures
Sample	Transmission, Hospital Clinical Data File	HBIPS, PC
Sample Size Medicare Only	Transmission, Patient Population Data File	HBIPS, PC
Sample Size Non-Medicare Only	Transmission, Patient Population Data File	HBIPS, PC
Sampling Frequency	Transmission, Patient Population Data File	HBIPS, PC
Sex	All Records	ACHF, AMI, BCC, BCS, CAH, CSTK, HBIPS, HF, Osteo, PBM, PC, PICU, PN, PSCIP, SCA
Substance Use		HBIPS-1
Term Newborn		PC-05
Total Leave Days - Medicare Only		HBIPS-2, HBIPS-3
Total Leave Days-Non-Medicare Only		HBIPS-2, HBIPS-3
Vendor Tracking Identifier	Transmission, Hospital Clinical Data File	HBIPS, PC
Violence Risk to Others		HBIPS-1
Violence Risk to Self		HBIPS-1

Name: *Admission Date*

Collected For:

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

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 (20xx)

Notes for Abstraction:

- The intent of this data element is to determine the date that the patient was actually admitted to acute inpatient care. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.
- If using claim information, the 'Statement Covers Period' is not synonymous with the 'Admission Date' and should not be used to abstract this data element. These are two distinctly different identifiers:
  - The Admission Date is purely the date the patient was admitted as an inpatient to the facility.
  - The Statement Covers Period ("From" and "Through" dates) identifies the span of service dates included in a particular claim. The "From" Date is the earliest date of service on the claim.
- For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.

Example: Medical record documentation reflects that the patient was admitted to observation on 04-05-20xx. On 04-06-20xx the physician writes an order to admit to acute inpatient effective 04-05-20xx. The *Admission Date* would be abstracted as 04-06-20xx; the date the determination was made to admit to acute inpatient care and the order was written.

- The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.

Example: Preoperative Orders are dated as 04-06-20xx with an order to admit to Inpatient. Postoperative Orders, dated 05-01-20xx, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 05-01-20xx. The *Admission Date* would be abstracted 05-01-20xx.

- If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.
- For newborns that are born within this hospital, the *Admission Date* is the date the baby was born.

Suggested Data Sources:

ONLY ALLOWABLE SOURCES

- Physician orders
- Face sheet

- UB-04

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

Excluded Data Sources

- UB-04, "From" and "Through" dates

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• Admit to observation • Arrival date

Name: *Admission to NICU*

Collected For: PC-05, ,

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

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

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) There is documentation that the newborn was admitted to the NICU at this hospital at any time during the hospitalization.

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

Notes for Abstraction: A NICU is defined as a hospital unit providing critical care services which is organized with personnel and equipment to provide continuous life support and comprehensive care for extremely high-risk newborn infants and those with complex and critical illness (source: American Academy of Pediatrics). Names of NICUs may vary from hospital to hospital. Level designations and capabilities also vary from region to region and cannot be used alone to determine if the nursery is a NICU.

If the newborn is admitted to the NICU for observation or transitional care, select allowable value no. Transitional care is defined as a stay of 4 hours or less in the NICU.

If an order to admit to the NICU is not found in the medical record, there must be supporting documentation present in the medical record indicating that the newborn received critical care services in the NICU in order to answer yes. Examples of supporting documentation include, but are not limited to the NICU admission assessment and NICU flow sheet.

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

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Name: *Antenatal Steroids Initiated*

Collected For: PC-03, ,

Definition: Documentation that antenatal steroids were initiated before delivery.

Initial antenatal steroids are 12mg betamethasone IM or 6mg dexamethasone IM.

Question: Is there documentation that antenatal steroids were initiated before delivery?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

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.

Notes for Abstraction: 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".

Suggested Data Sources:

- History and physical
- Progress notes
- Medication administration record (MAR)
- Prenatal forms

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix C, Table 11.0 Antenatal Steroid Medications	None

Name: *Appropriate Justification for Multiple Antipsychotic Medications*

Collected For: HBIPS-5, ,

Definition: Documentation in the medical record of appropriate justification for discharging the patient on two or more routine antipsychotic medications.

Question: Is there documentation in the medical record of appropriate justification for the patient being discharged on two or more antipsychotic medications?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The medical record contains documentation of a history of a minimum of three failed multiple trials of monotherapy.

2 The medical record contains documentation of a recommended plan to taper to monotherapy due to previous use of multiple antipsychotic medications OR documentation of a cross-taper in progress at the time of discharge.

3 The medical record contains documentation of augmentation of Clozapine.

4 The medical record contains documentation of a justification other than those listed in Allowable Values 1-3.

5 The medical record does not contain documentation supporting the reason for being discharged on two or more antipsychotic medications OR unable to determine from medical record documentation.

Notes for Abstraction: If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital or at the time of final discharge from the psychiatric unit.

The recommended plan to taper to monotherapy must appear in the continuing care plan transmitted to the next level of care provider. If an addendum about the recommended plan to taper to monotherapy is added to the continuing care plan within the medical record, it must occur within 5 days after discharge or prior to transmission of the continuing care plan. All other justifications may be documented anywhere in the medical record.

"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.

Only allowable values 1, 2 and 3 are supported by an evidence base which will allow the case to pass the measure. Allowable value 4 can be used as part of an internal performance improvement activity, but the case will not pass the measure.

Suggested Data Sources:
- Aftercare discharge plan
- Continuing care plan
- Discharge plan

- Final discharge summary
- History and physical
- Interim discharge summary
- Medication reconciliation form
- Physician discharge orders
- Physician progress notes
- Referral form

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Name: *Birth Weight*

Collected For: PC-04, Risk Adjustment,

Definition: The weight (in grams) of a newborn at the time of delivery.

Note:

453.5 grams = 1 pound

28.35 grams = 1 ounce

It is recommended that each ORYX Vendor provide the ability to enter birth weight in either grams or pounds. However, all birth weights must be converted to grams prior to indicator calculation.

Question: What was the weight of the newborn at delivery?

Format:
Length: 4 or UTD
Type: Alphanumeric
Occurs: 1

Allowable Values:

150 through 8165 grams
UTD = Unable to Determine

Note: When converting from pounds and ounces to grams, do not round to the nearest pound before converting the weight to grams. Round to the nearest whole number after the conversion to grams.

Notes for Abstraction:

- Newborns with birth weights less than 150 grams need to be verified that the baby was live born and for data quality purposes. Birth weights greater than 8165 grams need to be verified for data quality. Abstractors should review all of the suggested data sources to verify the accuracy of the data.
- If the birth weight is unable to be determined from medical record documentation, enter "UTD".
- The medical record must be abstracted as documented (taken at face value). When the value documented is not a valid number/value per the definition of this data element **and** no other documentation is found that provides this information, the abstractor should select UTD.
  Example:
  Documentation indicates the *Birth Weight* was 0 grams. No other documentation in the medical record provides a valid value. Since the *Birth Weight* is not a valid value, the abstractor should select UTD.
  Note:
  Transmission of a case with an invalid value as described above will be rejected from the Joint Commissions Data Warehouse. Use of UTD for *Birth Weight* allows the case to be accepted into the warehouse.
- The NICU admission assessment or notes should be reviewed first for the birth weight. In the absence of admission to the NICU, the delivery record or operating room record should be reviewed next for the birth weight. In cases where there is conflicting data, use the document recording the birth weight closest to the time of delivery.
- 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 suggested data sources listed below.
- For newborns received into the hospital as a transfer, the admission birth weight may be used if the original birth weight is not available.
- If the birth weight is recorded in pounds and ounces and also in grams, abstract the

value for grams.

Suggested Data Sources:

In Order of Priority:

- NICU admission assessment or notes
- Delivery record
- Operating room record
- History and physical
- Nursing notes
- Nursery record
- Physician progress notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Name: *Birthdate*

Collected For:

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.
- For HBIPS discharge measures, i.e., HBIPS-1, 4, 5, 6, 7, patient's age (in years) is calculated by *Discharge Date* minus *Birthdate*. For event measures, i.e., HBIPS-2, 3, patient's age at time of event (in years) is calculated by *Event Date* minus *Birthdate*. The algorithm to calculate age must use the month and day portion of birthdate, and discharge date or event, as appropriate to yield the most accurate age.

Question: What is the patients 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-Current Year)

Notes for Abstraction: Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct 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
- UB-04

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Name: *Bloodstream Infection Confirmed*

Collected For: PC-04, ,

Definition: Documentation in the medical record that the bloodstream infection (BSI) is confirmed after the first 48 hours after 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 with a course of antibiotics for 7 days or longer 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.

Question: Is there documentation after the first 48 hours after admission that the patient has a bloodstream infection and was receiving a course of antibiotics for 7 days or longer for a suspected bloodstream infection or septicemia?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) There is documentation that the bloodstream infection (BSI) is confirmed after the first 48 hours after admission and is being treated with a course of antibiotics for 7 days or longer for the condition.

N (No) There is no documentation that the bloodstream infection (BSI) is confirmed after the first 48 hours after admission and is being treated with a course of antibiotics for 7 days or longer for the condition or unable to determine from medical record documentation.

Notes for Abstraction: Confirmation of BSI is based on criteria from the Centers for Disease Control and Prevention (CDC) available at: http://www.cdc.gov/nhsn/inpatient-rehab/clabsi/

Suggested Data Sources:
- History and physical
- Laboratory report
- Nursing notes
- Progress notes
- Microbiology report
- NICU notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	• Suspected, presumed or rule out bloodstream infection without a positive blood culture • Receiving a course of antibiotics primarily for the following conditions: ○ Diagnosis of necrotizing enterocolitis (NEC) ○ Diagnosis of urosepsis ○ Skin infections confirmed as the primary source of the BSI ○ Diagnosis of pneumonia

Name: *Bloodstream Infection Present on Admission*

Collected For: PC-04, ,

Definition: 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.

Question: Is there documentation within the first 48 hours after admission that the patient had a bloodstream infection present on admission or is receiving treatment for a suspected bloodstream infection or septicemia on admission?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) There is documentation within the first 48 hours after admission that the patient had a bloodstream infection present on admission or is receiving treatment for a suspected bloodstream infection or septicemia on admission.

N (No) There is no documentation within the first 48 hours after admission that the patient had a bloodstream infection present on admission or is receiving treatment for a suspected bloodstream infection or septicemia present on admission or unable to determine from medical record documentation.

Notes for Abstraction: The admission assessment and the NICU admission assessment or NICU notes should be reviewed first for documentation of a suspected or confirmed bloodstream infection present on admission or within the first 48 hours after admission. Documentation of the suspected bloodstream infection being present on admission should be taken at face value regardless of the blood culture results.

Routine work up for sepsis for high risk newborns admitted to the NICU should not be considered a suspected bloodstream infection in the absence of positive blood culture results. There must be documentation from the clinician specifically stating that the newborn appeared septic or was showing signs and symptoms of sepsis in order to answer yes. Signs and symptoms of sepsis include but are not limited to: body temperature changes, respiratory difficulty, diarrhea, hypoglycemia, reduced movements, reduced sucking, seizures, bradycardia, swollen/distended abdomen, vomiting and/or jaundice.

The results of the initial blood cultures drawn within the first 48 hours of admission which are reported after the first 48 hours may be used to determine if the bloodstream infection was present on admission.

Birth is considered the same as admission for patients who were born in the reporting hospital. If the present on admission (POA) indicator is present with the diagnosis code for septicemia or bacteremia, answer yes to bloodstream infection present on admission.

If there is documentation that a course of antibiotics was started within the first 48 hours after admission which lasted less than 7days, select allowable value “no”.

Suggested Data Sources:

- History and physical
- Laboratory report
- Nursing notes
- Nursing admission assessment
- Progress notes

- Admission assessment
- Microbiology report
- NICU admission assessment or notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• Suspected bloodstream infection • Positive blood culture • Inconclusive blood culture under treatment • Staphylococcal septicemia • Staphylococcal bacteremia • Gram negative septicemia • Gram negative bacteremia	• Rule out sepsis • R/O sepsis • Work up for sepsis • Negative blood culture under treatment • Evaluation for sepsis

Name: *Clinical Trial*

Collected For: PC, ,

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 (i.e. AMI, CAC, PC, SCIP, STK, VTE).

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 (i.e. AMI, CAC, PC, SCIP, STK, VTE)?

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 (i.e. AMI, CAC, PC, SCIP, STK, VTE).

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 (i.e. AMI, CAC, PC, SCIP, STK, VTE), or unable to determine from medical record documentation.

Notes for Abstraction:

- To select "Yes" to this data element, BOTH of the following must be true:
  1. **There must be a signed consent form for clinical trial.** For the purposes of abstraction, a clinical trial is defined as an **experimental study** in which research subjects are recruited and assigned a treatment/intervention and their outcomes are measured based on the intervention received. Treatments/interventions most often include use of drugs, surgical procedures, and devices. Often a control group is used to compare with the treatment/intervention. Allocation of different interventions to participants is usually randomized.
  2. **There must be documentation on the signed consent form that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AMI, CAC, PC, SCIP, STK, VTE).** Patients may either be newly enrolled in a clinical trial during the hospital stay or enrolled in a clinical trial prior to arrival and continued active participation in that clinical trial during this hospital stay.
- In the following situations, select "No:"
  1. **There is a signed patient consent form for an observational study only.** Observational studies are non-experimental and involve no intervention (e.g., registries). Individuals are observed (perhaps with lab draws, interviews, etc.), data is collected, and outcomes are tracked by investigators. Although observational studies may include the assessment of the effects of an intervention, the study participants are not allocated into intervention or control groups.
  2. **It is not clear whether the study described in the signed patient consent form is experimental or observational.**
  3. **It is not clear which study population the clinical trial is enrolling.** Assumptions should not be made if it is not specified.

AMI: Only capture patients enrolled in clinical trials studying patients with acute myocardial infarction (AMI), ST-elevation myocardial infarction (STEMI), Non ST-elevation MI (NSTEMI), heart attack, or acute coronary syndrome (ACS).

CAC: Only capture patients enrolled in clinical trials studying children with asthma.

PC: Only capture patients enrolled in clinical trials studying pregnant patients or

newborns. For Perinatal Care measures **ONLY**, it is appropriate for the ORYX® Vendor to default the data element to "No" unless a diagnosis code for clinical trial is present. If a code is present, or the organization knows via some other electronic method that the patient is participating in a clinical trial, default the data element to "Yes". Hospital abstractors may change defaulted value of "No" based on hospital participation in clinical trial.

SCIP: The clinical trial should be relevant to one or more of the SCIP measures. Some examples may include but are not limited to:

- The clinical trial involved the use of antibiotics.
- The clinical trial involved testing a new beta-blocker.
- The clinical trial involved the use of VTE prophylaxis.

STK: Only capture patients enrolled in clinical trials studying patients with stroke.

VTE: Only capture patients enrolled in clinical trials studying patients with VTE (prevention or treatment interventions).

Suggested Data Sources:

ONLY ACCEPTABLE SOURCES:
Signed consent form for clinical trial

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *CMS Certification Number*

Collected For: HBIPS, PC, Hospital Clinical Data File, Optional for All Records,

Definition: Hospital's six digit acute care CMS Certification Number (CCN).

Note: This data element is optional. If data is transmitted in Hospital Clinical Data (HCD) or Population and Sampling (PaS) all edits and rules associated to this data element will be applied to the data.

Question: What is the hospitals six digit acute care CMS Certification Number?

Format:
Length: 6
Type: Character
Occurs: 1

Allowable Values:
Any valid six digit CMS Certification Number.

The first two digits are the numeric state code. The third digit of zero represents an acute facility. The third digit of 1 and fourth digit of 3 represents a Critical Access Hospital (CAH).

Notes for Abstraction: None

Suggested Data Sources: None

Additional Notes: None

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *Continuing Care Plan-Discharge Medications*

Collected For: HBIPS-6, HBIPS-7, ,

Definition: 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.**

Question: 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?**

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

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.

Notes for Abstraction: **All** medications must have the names, dosage and indication for use listed in the continuing care plan. The indication for use can be as short as one to two words, but must be present for all medications, not just psychotropic medications.

If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital or at the time of final discharge from the psychiatric unit.

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.

A continuing care plan may consist of one document or several documents which could be considered a continuing care packet. The hospital must be able to identify which document(s) make up the continuing care plan and the hospital must identify what specific documents are transmitted to the next level of care provider.

The first post-discharge day is defined as the day after 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.

Medications are defined as any prescription medications, sample medications, herbal remedies, vitamins, nutriceuticals, over-the-counter drugs and any product designated by

the Food and Drug Administration (FDA) as a drug (Taken from the 2009 *Comprehensive Accreditation Manual for Hospitals: The Official Handbook (CAMH)*).

If an addendum about the discharge medications is added to continuing care plan within the medical record, it must occur within 5 days after discharge or prior to transmission of the continuing care plan.

If more than one list of medications is included in the continuing care plan documents and the lists do not match, select allowable value "3" which would capture unable to determine. As there is a conflict between two separate documents, a receiving practitioner would not be able to determine the accurate medication regimen.

Suggested Data Sources:

- Aftercare discharge plan
- Continuing care plan
- Discharge plan
- Final discharge summary
- Interim discharge summary
- Medication reconciliation form
- Physician discharge orders
- Physician progress notes
- Referral form

Additional Notes:

The next level of care providers include the follow-up prescribing inpatient or outpatient clinician, prescribing inpatient or outpatient entity, the treating inpatient or outpatient clinician or the treating inpatient or outpatient entity as described below. If the patient has referrals to more than one clinician or entity for follow-up, the prescribing clinician or entity is considered to be the primary next level of care provider. The order of precedence for transmission of the continuing care plan is listed below.

- The follow-up prescribing inpatient or outpatient clinician or entity is the clinician, hospital or clinic that is responsible for managing the patients medication regime after hospital discharge.
- The treating inpatient or outpatient clinician or entity is the clinician, hospital or clinic that is responsible for the primary treatment of the patient in the absence of medications.
- Some examples of inpatient or outpatient clinicians include, but are not limited to: primary care physician, psychiatrist, advanced practice nurse (APN), physician assistant (PA) Master of Social Work (MSW) and psychologist. Titles of qualified psychiatric practitioners vary from state to state.

Guidelines for Abstraction:

Inclusion	Exclusion
• Routinely scheduled medications • PRN medications	• None

Name: *Continuing Care Plan-Next Level of Care*

Collected For: HBIPS-6, HBIPS-7, ,

Definition: Documentation in the medical record of a continuing care plan which includes next level of care recommendations. Such documentation should be transmitted to the next level of care provider by the **fifth post-discharge day.**

Question: Is there documentation in the medical record of a continuing care plan which includes next level of care recommendations AND was the continuing care plan including next level of care recommendations transmitted to the next level of care provider no later than the **fifth post-discharge day?**

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The medical record contains a continuing care plan which includes next level of care recommendations 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 next level of care recommendations but it 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 next level of care recommendations OR unable to determine from medical record documentation.

Notes for Abstraction: If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital or at the time of final discharge from the psychiatric unit.

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.

A continuing care plan may consist of one document or several documents which could be considered a continuing care packet. The hospital must be able to identify which document(s) make up the continuing care plan and the hospital must identify what specific documents are transmitted to the next level of care provider.

The first post-discharge day is defined as the day after 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.

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.

If an addendum about the next level of care recommendations is added to continuing care plan within the medical record, it must occur within 5 days after discharge or prior to transmission of the continuing care plan.

Suggested Data Sources:
- Aftercare discharge plan
- Continuing care plan
- Discharge plan
- Final discharge summary
- Interim discharge summary

- Medication reconciliation form
- Physician discharge orders
- Physician progress notes
- Referral form

Additional Notes: The next level of care providers include the follow-up prescribing inpatient or outpatient clinician, prescribing inpatient or outpatient entity, the treating inpatient or outpatient clinician or the treating inpatient or outpatient entity as described below. If the patient has referrals to more than one clinician or entity for follow up, the prescribing clinician or entity is considered to be the primary next level of care provider. The order of precedence for transmission of the continuing care plan is listed below.

- The follow-up prescribing inpatient or outpatient clinician or entity is the clinician, hospital or clinic that is responsible for managing the patients medication regime after hospital discharge.
- The treating inpatient or outpatient clinician or entity is the clinician, hospital or clinic that is responsible for the primary treatment of the patient in the absence of medications.
- Some examples of inpatient or outpatient clinicians include, but are not limited to: primary care physician, psychiatrist, advanced practice nurse (APN), physician assistant (PA) Master of Social Work (MSW) and psychologist. Titles of qualified psychiatric practitioners vary from state to state.

Guidelines for Abstraction:

Inclusion	Exclusion
Next level of care recommendations may include, but are not limited to: • Appointment with outpatient clinician or entity • Medical follow-up • Social work and benefits follow-up • Pending legal issues, e.g., follow-up with probation officer • Peer support, i.e., Alcoholics Anonymous, Narcotics Anonymous • Home-based services	• None

Name: *Continuing Care Plan-Principal Discharge Diagnosis*

Collected For: HBIPS-6, HBIPS-7, ,

Definition: Documentation in the medical record of a continuing care plan which includes the principal discharge diagnosis. Such documentation should be transmitted to the next level of care provider by the **fifth post-discharge day.**

Question: Is there documentation in the medical record of a continuing care plan which includes the principal discharge diagnosis AND was the continuing care plan including the principal discharge diagnosis transmitted to the next level of care provider no later than the **fifth post-discharge day?**

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The medical record contains a continuing care plan which includes the principal discharge diagnosis 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 the principal discharge diagnosis 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 the principal discharge diagnosis or unable to determine from medical record documentation.

Notes for Abstraction: If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital or at the time of final discharge from the psychiatric unit.

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.

A continuing care plan may consist of one document or several documents which could be considered a continuing care packet. The hospital must be able to identify which document(s) make up the continuing care plan and the hospital must identify what specific documents are transmitted to the next level of care provider within the required timeframe.

The first post-discharge day is defined as the day after 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.

If an addendum about the principal discharge diagnosis is added to continuing care plan within the medical record, it must occur within 5 days after discharge or prior to transmission of the continuing care plan.

Suggested Data Sources:

- Aftercare discharge plan
- Continuing care plan
- Discharge plan
- Final discharge summary
- Interim discharge summary
- Medication reconciliation form
- Physician discharge orders
- Physician progress notes

- Referral form

Additional Notes: The next level of care providers include the follow-up prescribing inpatient or outpatient clinician, prescribing inpatient or outpatient entity, the treating inpatient or outpatient clinician or the treating inpatient or outpatient entity as described below. If the patient has referrals to more than one clinician or entity for follow up, the prescribing clinician or entity is considered to be the primary next level of care provider. The order of precedence for transmission of the continuing care plan is listed below.

- The follow-up prescribing inpatient or outpatient clinician or entity is the clinician, hospital or clinic that is responsible for managing the patients medication regime after hospital discharge.
- The treating inpatient or outpatient clinician or entity is the clinician, hospital or clinic that is responsible for the primary treatment of the patient in the absence of medications.
- Some examples of inpatient or outpatient clinicians include, but are not limited to: primary care physician, psychiatrist, advanced practice nurse (APN), physician assistant (PA) Master of Social Work (MSW) and psychologist. Titles of qualified psychiatric practitioners vary from state to state.

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Name: *Continuing Care Plan-Reason for Hospitalization*

Collected For: HBIPS-6, HBIPS-7, ,

Definition: Documentation in continuing care plan includes the reason for hospitalization. Such documentation should be transmitted to the next level of care provider by the **fifth post-discharge day.**

Question: Is there documentation in the medical record of a continuing care plan which includes the reason for hospitalization AND was the continuing care plan including the reason for hospitalization transmitted to the next level of care provider no later than the **fifth post-discharge day**?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The medical record contains a continuing care plan which includes the reason for hospitalization 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 the reason for hospitalization 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 the reason for hospitalization or unable to determine from medical record documentation.

Notes for Abstraction: If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital or at the time of final discharge from the psychiatric unit.

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.

A continuing care plan may consist of one document or several documents which could be considered a continuing care packet. The hospital must be able to identify which document(s) make up the continuing care plan and the hospital must identify what specific documents are transmitted to the next level of care provider.

The first post-discharge day is defined as the day after 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.

The reason for hospitalization should be a short synopsis describing the events the patient experienced prior to this hospitalization. The reason for hospitalization may be listed as the triggering or precipitating event.

If an addendum about the reason for hospitalization is added to continuing care plan within the medical record, it must occur within 5 days after discharge or prior to transmission of the continuing care plan.

Suggested Data Sources:

- Aftercare discharge plan
- Continuing care plan
- Discharge plan
- Final discharge summary
- Interim discharge summary

- Medication reconciliation form
- Physician discharge orders
- Physician progress notes
- Referral form

Additional Notes: The next level of care providers include the follow-up prescribing inpatient or outpatient clinician, prescribing inpatient or outpatient entity, the treating inpatient or outpatient clinician or the treating inpatient or outpatient entity as described below. If the patient has referrals to more than one clinician or entity for follow-up, the prescribing clinician or entity is considered to be the primary next level of care provider. The order of precedence for transmission of the continuing care plan is listed below.

- The follow-up prescribing inpatient or outpatient clinician or entity is the clinician, hospital or clinic that is responsible for managing the patients medication regime after hospital discharge.
- The treating inpatient or outpatient clinician or entity is the clinician, hospital or clinic that is responsible for the primary treatment of the patient in the absence of medications.
- Some examples of inpatient or outpatient clinicians include, but are not limited to: primary care physician, psychiatrist, advanced practice nurse (APN), physician assistant (PA) Master of Social Work (MSW) and psychologist. Titles of qualified psychiatric practitioners vary from state to state.

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Name: *Discharge Date*

Collected For: Not collected for HBIPS-2 and HBIPS-3

Definition: The month, day, and year the patient was discharged from acute care, left against medical advice, or expired during this stay.

Question: What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired?

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

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

Notes for Abstraction: Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, 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.

For HBIPS only, if the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital.

Suggested Data Sources:
- Face sheet
- Progress notes
- Physician orders
- Discharge summary
- Nursing discharge notes
- Transfer note
- UB-04

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Name: *Discharge Disposition*

Collected For: HBIPS-4, HBIPS-5, HBIPS-6, HBIPS-7, PC-04, PC-05, ,

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

Question: What was the patients discharge disposition on the day of discharge?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 Home

2 Hospice - Home

3 Hospice - Health Care Facility

4 Acute Care Facility

5 Other Health Care Facility

6 Expired

7 Left Against Medical Advice/AMA

8 Not Documented or Unable to Determine (UTD)

Notes for Abstraction:

- **Only use documentation written on the day prior to discharge through 30 days after discharge** when abstracting this data element.

Example: Documentation in the Discharge Planning notes on 04-01-20xx state that the patient will be discharged back home. On 04-06-20xx the physician orders and nursing discharge notes on the day of discharge reflect that the patient was being transferred to skilled care. The documentation from 04-06-20xx would be used to select value “5” (Other Health Care Facility).

- The medical record must be abstracted as documented (taken at "face value"). Inferences should not be made based on internal knowledge.
- If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract. If documentation is contradictory, use the latest documentation.

Examples:

- ○ Discharge summary dictated 2 days after discharge states patient went home. Physician note on day of discharge further clarifies that the patient will be going home with hospice. Select value "2" (Hospice - Home).
  - ○ Discharge planner note from day before discharge states XYZ Nursing Home. Discharge order from day of discharge states Discharge home. Contradictory documentation, use latest. Select value "1" (Home).
  - ○ Physician order on discharge states Discharge to ALF. Discharge instruction sheet completed after the physician order states patient discharged to SNF. Contradictory documentation, use latest. Select value "5" (Other Health Care Facility).
- If documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. See Inclusion lists for examples.
  - ○ Acute Care Facility
  - ○ Hospice - Health Care Facility
  - ○ Hospice - Home
  - ○ Other Health Care Facility
  - ○ Home
- Hospice (values "2" and "3") includes discharges with hospice referrals and

evaluations.

- If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select value "4" (Acute Care Facility).
- If the medical record identifies the facility the patient is being discharged to by name only (e.g., Park Meadows), and does not reflect the type of facility or level of care, select value "5" (Other Health Care Facility).
- If the medical record states only that the patient is being discharged and does not address the place or setting to which the patient was discharged, select value "1" (Home).
- When determining whether to select value "7" (Left Against Medical Advice/AMA):
  - Explicit "left against medical advice" documentation is not required. E.g., Patient is refusing to stay for continued care - Select value "7".
  - Documentation suggesting that the patient left before discharge instructions could be given does not count.
  - A signed AMA form is not required, for the purposes of this data element.
  - Do not consider AMA documentation and other disposition documentation as contradictory. If any source states the patient left against medical advice, select value "7", regardless of whether the AMA documentation was written last. E.g., AMA form signed and discharge instruction sheet states Discharged home with belongings - Select "7".

Suggested Data Sources:

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

Excluded Data Sources

- Any documentation prior to the last two days of hospitalization
- Coding documents
- UB-04

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
Home (Value 1): • Assisted Living Facilities (ALFs) - Includes ALFs and assisted living care at nursing home, intermediate care, and skilled nursing facilities • Court/Law Enforcement - includes detention facilities, jails, and prison • Home - includes board and care, foster or residential care, group or personal care homes, retirement communities, and homeless shelters • Home with Home Health Services • Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs and Partial Hospitalization	None

Hospice - Home (Value 2): • Hospice in the home (or other Home setting as above in Value 1) **Hospice Health Care Facility (Value 3)**: • Hospice - General Inpatient and Respite • Hospice - Residential and Skilled Facilities • Hospice - Other Health Care Facilities **Acute Care Facility (Value 4)**: • Acute Short Term General and Critical Access Hospitals • Cancer and Childrens Hospitals • Department of Defense and Veterans Administration Hospitals **Other Health Care Facility (Value 5)**: • Extended or Intermediate Care Facility (ECF/ICF) • Long Term Acute Care Hospital (LTACH) • Nursing Home or Facility including Veterans Administration Nursing Facility • Psychiatric Hospital or Psychiatric Unit of a Hospital • Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital • Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed • Transitional Care Unit (TCU) • Veterans Home	

Name: *Event Date*

Collected For: HBIPS-2, HBIPS-3, , Not collected for HBIPS-1, 4, 5, 6 and 7

Definition: The date the associated event type occurred.

Question: What is the date recorded in the medical record that the associated event type occurred?

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

Allowable Values:

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

Notes for Abstraction: Medical record documentation only should be used to collect this data element.

This information is abstracted once for each day on which an event (*Event Type*) occurs during the patients hospitalization. A patient may have multiple events during the hospitalization.

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.

Suggested Data Sources:
- Licensed independent practitioner orders
- Nursing notes
- Nursing flow sheet
- Observation sheets
- Physician orders
- Progress notes
- Psychiatrist notes
- Restraint monitoring form
- Therapist notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Name: *Event Type*

Collected For: HBIPS-2, HBIPS-3, , Not collected for HBIPS-1, 4, 5, 6 and 7

Definition: The measure-related event being identified.

Question: What is the identified measure-related event?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1. Physical Restraint
2. Seclusion

Notes for Abstraction: This information is abstracted once for each type of event that occurs on a specific day (*Event Date*) during the patients hospitalization. A patient may have multiple events during the hospitalization.

A physical restraint is any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely when it is used as a restriction to manage a patients behavior or restrict the patients freedom of movement and is not a standard treatment for the patients medical or psychiatric condition.[1] Refer to the data element *Minutes of Physical Restraint* for a list of inclusions and exclusions.

Seclusion is the involuntary confinement of a patient alone in a room or an area where the patient is physically prevented from leaving.[1] Refer to the data element *Minutes of Seclusion* for a list of inclusions and exclusions.

[1] 42 CFR Part 482, Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients Rights

Suggested Data Sources: None

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Name: *Exclusive Breast Milk Feeding*

Collected For: PC-05, ,

Definition: Documentation that the newborn was exclusively fed breast milk during the entire hospitalization.

Exclusive breast milk feeding is defined as a newborn receiving only breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals, or medicines.

Question: Is there documentation that the newborn was exclusively fed breast milk during the entire hospitalization?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) There is documentation that the newborn was exclusively fed breast milk during the entire hospitalization.

N (No) There is no documentation that the newborn was exclusively fed breast milk during the entire hospitalization OR unable to determine from medical record documentation.

Notes for Abstraction: If the newborn receives any other liquids including water during the entire hospitalization, select allowable value "No".

Exclusive breast milk feeding includes the newborn receiving breast milk via a bottle or other means beside the breast.

Sweet-Ease® or a similar 24% sucrose and water solution given to the newborn for the purpose of reducing discomfort during a painful procedure is classified as a medication and is not considered a supplemental feeding.

If the newborn receives donor breast milk, select allowable value "Yes".

If breast milk fortifier is added to the breast milk, select allowable value "Yes".

In cases where there is conflicting documentation and both exclusive breast milk feeding and formula supplementation is documented, select allowable value "No".

If the newborn received drops of water or formula dribbled onto the mother's breast to stimulate latching and not an actual feeding, select yes.

Suggested Data Sources:

- Discharge summary
- Feeding flow sheets
- Individual treatment plan
- Intake and output sheets
- Nursing notes
- Physician progress notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *Gestational Age*

Collected For: PC-01, PC-02, PC-03, ,

Definition: 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).

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

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

Allowable Values:

1-50

UTD=Unable to Determine

Notes for Abstraction: Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks.

The delivery or operating room record should be reviewed first for gestational age. If gestational age is not recorded in the delivery or operating room record, then continue to review the data sources in the following order: history and physical, prenatal forms,clinician admission progress note and discharge summary until a positive finding for gestational age is found. In cases where there is conflicting data, the gestational age found in the first document according to the order listed above should be used. The phrase "estimated gestational age" is an acceptable descriptor for gestational age.

If the patient has not received prenatal care and no gestational age was documented, select allowable value UTD.

When the admission date is different from the delivery date, use documentation of the gestational age completed closest to the delivery date.

Gestational age should be documented by the clinician as a numeric value between 1-50. 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.

If the gestational age entered by the clinician in the first document listed above is obviously incorrect (in error) but it is a valid number or two different numbers are listed in the first document and the correct number can be supported with documentation in the other acceptable data sources in the medical record, the correct number may be entered.

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

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

sources listed below.

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.

Suggested Data Sources:

ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE:

- Delivery record, note or summary
- Operating room record, note or summary
- History and physical
- Prenatal forms
- Admission clinician progress notes
- Discharge summary

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *Health Care Organization Identifier*

Collected For:

Definition: A unique number, assigned by The Joint Commission, to identify the health care organization that is accredited by The Joint Commission. This number is used to identify and group a health care organization's HCO-Level performance measure data.

Question: What is the Joint Commissions unique identification number for the provider?

Format:
Length: 6
Type: Numeric
Occurs: 1

Allowable Values: 1 through 999,999

Notes for Abstraction: None

Suggested Data Sources: Does not apply, assigned by The Joint Commission.

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *Hispanic Ethnicity*

Collected For:

Definition: Documentation that the patient is of Hispanic ethnicity or Latino.

Question: Is the patient of Hispanic ethnicity or Latino?

Format:
Length: 1
Type: Character
Occurs: 1

Allowable Values:

Y (Yes) Patient is of Hispanic ethnicity or Latino.

N (No) Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation.

Notes for Abstraction: The data element, *Race* , is required in addition to this data element.

Suggested Data Sources:
- Emergency department record
- History and physical
- Face sheet
- Nursing admission assessment
- Progress notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term Spanish origin can be used in addition to Hispanic or Latino. Examples: • Black-Hispanic • Chicano • H • Hispanic • Latin American • Latino/Latina • Mexican-American • Spanish • White-Hispanic	• None

Name: *ICD-10-CM Other Diagnosis Codes*

Collected For: Optional for HBIPS-2, HBIPS-3

Definition: The other or secondary (ICD-10-CM) codes associated with the diagnosis for this hospitalization.

Question: What were the ICD-10-CM other diagnosis codes selected for this medical record?

Format:
Length: 3-7 (without decimal point or dot; upper or lower case)
Type: Character
Occurs: 24

Allowable Values: 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

Notes for Abstraction: None

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

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *ICD-10-CM Principal Diagnosis Code*

Collected For: Optional for HBIPS-2, HBIPS-3

Definition: The ICD-10-CM diagnosis code that is primarily responsbile for the admission of the patient to the hospital for care during this hospitalization.

Question: What was the ICD-10-CM code selected as the principal diagnosis for this record?

Format:
Length: 3-7 (without decimal point or dot; upper or lower case)
Type: Character
Occurs: 1

Allowable Values: 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

Notes for Abstraction: None

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

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *ICD-10-PCS Other Procedure Codes*

Collected For: Optional for All HBIPS Records

Definition: The other or secondary (ICD-10-PCS) codes identifying all significant procedures other than the principal procedure.

Note: If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, *ICD-10-PCS Other Procedure Date* exists, etc.) will apply.

Question: What were the ICD-10-PCS code(s) selected as other procedure(s) for this record?

Format:
Length: 3-7 (without decimal point or dot; upper or lower case)
Type: Character
Occurs: 24

Allowable Values: 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

Notes for Abstraction: None

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

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *ICD-10-PCS Other Procedure Dates*

Collected For: Optional for All HBIPS Records

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

Note: If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, *ICD-10-PCS Other Procedure Codes* exists, etc.) will apply.

Question: What were the date(s) the other procedure(s) were performed?

Format:
Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 24

Allowable Values:

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

Notes for Abstraction:

- If the procedure date for the associated procedure is unable to be determined from medical record documentation, select "UTD."
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care [after *Discharge Date*]) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Examples:
  - Documentation indicates the *ICD-10-PCS Other Procedure Dates* was 02-**42**-20xx. No other documentation in the medical record provides a valid date. Since the *ICD-10-PCS 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-10-PCS Other Procedure Dates* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *ICD-10-PCS Other Procedure Dates* is after the *Discharge Date* (death), it is outside of the parameters 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-10-PCS Other Procedure Dates* 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
- UB-04

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *ICD-10-PCS Principal Procedure Code*

Collected For: Optional for All HBIPS Records

Definition: The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

Note: If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, *ICD-10-PCS Principal Procedure Date* exists, etc.) will apply.

Question: What was the ICD-10-PCS code selected as the **principal** procedure for this record?

Format:
Length: 3-7 (without decimal point or dot; upper or lower case)
Type: Character
Occurs: 1

Allowable Values: 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

Notes for Abstraction: None

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

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *ICD-10-PCS Principal Procedure Date*

Collected For: Optional for All HBIPS Records

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

Note: If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, *ICD-10-PCS Principal Procedure Code* exists, etc.) will apply.

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 (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- If the principal procedure date is unable to be determined from medical record documentation, select "UTD."
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid date/format or is outside of the parameters of care [after *Discharge Date*]) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Examples:
  - Documentation indicates the *ICD-10-PCS Principal Procedure Date* was 02-**42**-20xx. No other documentation in the medical record provides a valid date. Since the *ICD-10-PCS 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-10-PCS Principal Procedure Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *ICD-10-PCS 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-10-PCS Principal Procedure Date* 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
- UB-04

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *Initial Patient Population Size Medicare Only*

Collected For: HBIPS, PC, Transmission, Patient Population Data File,

Definition: Indicates the number of episode of care (EOC) records identified for a hospital with Medicare listed as a payment source prior to the application of data integrity filters, measure exclusions, and/or sampling methodology for the specified time period.

The data element is based on the hospital's initial identification of Medicare EOC records for a measure set, stratum, or sub-population. Initial Patient Population Size Medicare Only includes all patients that are billed under Medicare or Title 18. Medicare can be listed as a primary, secondary, teritary or lower on the list of payment sources for the patient. In addition, patients who are participating as a member of a Medicare HMO/Medicare Advantage are included in the Medicare counts, e.g., Medicare Blue, Humana Gold, Secure Horizons, AARP, Coventry Advantra, etc. This initial data pull utilizes administrative data such as ICD-10-CM diagnosis and ICD-10-PCS procedure codes, admission date, and birthdate.

For the discharge measures (eg. HBIPS-1, 4, PC-01), refer to the Initial Patient Population discussion in the Measure Information section of this manual for more information.

For the HBIPS event measures (HBIPS-2 and 3), the Initial Patient Population Size Medicare Only is equal to those EOC records in the census data identified as being Medicare EOC records. The HBIPS census data are calculated by (Psychiatric Inpatient Days-Medicare Only - Total Leave Days-Medicare Only). Initial Patient Population Size Medicare Only is not derived from those cases that pass through the Initial Patient Population algorithm.

Note:
If the hospitals data has been sampled, this field contains the population from which the sample was originally drawn, NOT the sample size.

Question: Not Applicable

Format:
Length: 6
Type: Numeric
Occurs:

Non-stratified Measure Sets:

One Initial Patient Population Size Medicare Only per hospitals measure set (e.g., AMI, CAC and STK).

Stratified Measure Sets:

One Initial Patient Population Size Medicare Only per measure set stratum or sub-population the hospital is participating in:
* The PC measure set has three occurrences, one for the mother sub-population and two for the newborn sub-populations.
* The HBIPS measure set has four occurrences, one for each age stratum.

Note:
Refer to the appropriate version of the Specifications Manual for National Quality Inpatient Measures for the number of occurrences for the VTE measure set.

Allowable Values: 0 through 999,999

Notes for Abstraction: *Initial Patient Population Size-Medicare Only* must contain the actual number of patients in the population even if the hospital has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter and has decided to not submit patient level data.

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *Initial Patient Population Size Non-Medicare Only*

Collected For: HBIPS, PC, Transmission, Patient Population Data File,

Definition: Indicates the number of episode of care (EOC) records identified for a hospital with Medicare NOT listed as a payment source prior to the application of data integrity filters, measure exclusions, and/or sampling methodology for the specified time period.

The data element is based on the hospital's initial identification of non-Medicare EOC records for a measure set, stratum, or sub-population. This initial data pull utilizes administrative data such as ICD-10-CM diagnosis and ICD-10-PCS procedure codes, admission date, and birthdate.

For the discharge measures (eg. HBIPS-1, 4, PC-01), refer to the Initial Patient Population discussion in the Measure Information section of this manual for more information.

For the HBIPS event measures (HBIPS-2 and 3), the Initial Patient Population Size Non-Medicare Only is equal to those EOC records in the census data identified as not having Medicare listed as a payment source. The HBIPS census data are calculated by (Psychiatric Inpatient Day-Non-Medicare Only - Total Leave Days-Non-Medicare Only). Initial Patient Population Size Non-Medicare Only is not derived from those cases that pass through the Initial Patient Population algorithm.

Note:
If the hospitals data has been sampled, this field contains the population from which the sample was originally drawn, NOT the sample size.

Question: Not Applicable

Format:

Length: 6
Type: Numeric
Occurs:

Non-stratified Measure Sets:

One Initial Patient Population Size Non-Medicare Only per hospitals measure set (e.g., AMI, and STK).

Stratified Measure Sets:

One Initial Patient Population Size Non-Medicare Only per measure set stratum or sub-population the hospital is participating in:
* The PC measure set has three occurrences, one for the mother sub-population and two for the newborn sub-populations.
* The HBIPS measure set has four occurrences, one for each age stratum.

Note:
Refer to the appropriate version of the Specifications Manual for National Quality Inpatient Measures for the number of occurrences for the VTE measure set.

Allowable Values: 0 through 999,999

Notes for Abstraction: *Initial Patient Population Size-Non-Medicare* Only must contain the actual number of patients in the population even if the hospital has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter and has decided to not submit patient level data.

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *Labor*

Collected For: PC-01, ,

Definition: Documentation by the clinician that the patient was in labor prior to induction and/or cesarean birth.

Question: Is there documentation by the clinician that the patient was in labor prior to induction and/or cesarean birth?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

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.

Notes for Abstraction:

- A clinician is defined as a physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN).
- Documentation of labor by the clinician should be abstracted at face value. There is no requirement for acceptable descriptors to be present in order to answer "yes" to labor.
- Documentation of regular contractions with or without cervical change; i.e., dilation, effacement without mention of labor may be used to answer "yes" to labor.
- 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.

Suggested Data Sources:

- History and physical
- Nursing notes
- Medication administration record (MAR)
- Physician progress notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
The following are acceptable descriptors for labor: • Active • Early • Spontaneous	The following are not acceptable descriptors for labor: • Latent • Prodromal

Name: *Measure Category Assignment*

Collected For: HBIPS, PC, Calculation, Transmission, Hospital Clinical Data File, Used in calculation of the Joint Commissions aggregate data and in the transmission of the Hospital Clinical Data file. Informational ONLY for PBM.

Notes:

- Episode of care records that calculate with a *Measure Category Assignment* of X (missing data) for one or more measures will be rejected by the Joint Commissions Data Warehouse. Refer to the Missing and Invalid Data section in this manual for more information.
- All hospital measures use this data element. The ORYX Vendor's calculated *Measure Category Assignment* will be transmitted to The Joint Commission on a quarterly basis with the associated hospital clinical data. These measure results will be used in the Joint Commissions data quality analysis and continuous measure verification process. ORYX Vendors can refer to the Joint Commissions *ORYX Data Quality Manual* for more information.
- *Measure Category Assignment* must be transmitted to The Joint Commission but cannot be transmitted to CMS. Files transmitted to the QIO Clinical Warehouse that contain *Measure Category Assignment* will be rejected.

Definition: Calculated measures results for each episode of care (EOC) that is processed through a measure algorithm.

Used to summarize the outcome for an EOC that is processed through a specific measure algorithm.

Question: Not Applicable

Format:
Length: 1
Type: Character
Occurs: One *Measure Category Assignment* per EOC is expected for every measure that a hospital is participating in.

Allowable Values:

B **Category B - Not in Measure Population**
For rate-based and continuous variable measures:
EOC record is not a member of a measure's population.

For rate-based-ratio measures:
Does not apply.

D **Category D - In Measure Population**
For rate-based measures:
EOC record is a member of the measure's population and there has not been an occurrence of the measure.

For rate-based-ratio measures:
Does not apply.

For continuous variable measures:
EOC record is a member of the measure's population and has sufficient accurate and valid data to compute the measurement.

Note: For measures for which better quality is associated with a lower score or numerator, i.e.,HBIPS-4,PC-01, PC-02, PC-04, a Measure Category Assignment of D means that the appropriate care was provided and the intent of the measure was met. For aggregate data, the EOC record will be included in the measure denominator only.

Note:
For continuous variable measures, EOC records that have a *Measure Category Assignment* of D **will** have an associated *Measurement Value*.

E **Category E - In Numerator Population**
For rate-based measures:
EOC record is a member of the measure's population and there has been an occurrence of the measure.

For rate-based-ratio measures:
Event record is a member of the measure's population and there has been an occurrence of the measure.

For continuous variable measures:
Does not apply.

Note: For measures for which better quality is associated with a lower score or numerator, i.e., HBIPS-4, PC-01, PC-02, PC-04, a Measure Category Assignment of E means that the appropriate care was not provided and the intent of the measure was not met. For aggregate data, the EOC record will be included in both the measure numerator and denominator.

U **Category U Not In Numerator Population**

For rate-based-proportion measures:
Does not apply

For rate-based-ratio measures:
Event record is a member of the measure's population; however, it contains a data element whose allowable value excludes it from the numerator.

For continuous variable measures:
Does not apply.

X **Category X Data Are Missing**
For rate-based and continuous variable measures:
Data are missing that is required to calculate the measure. The record will be rejected by the QIO Clinical Warehouse and the Joint Commissions Data Warehouse.

Y **Category Y UTD Allowable Value Does Not Allow Calculation of The Measure**
For rate-based measures:
Does not apply.

For rate-based-ratio measures: Event record contains a Date, Time, or Numeric data element with a value of UTD.

For continuous variable measures:
EOC record contains a Date, Time, or Numeric data element with a value of UTD.

Note:
For continuous variable measures, EOC records that have a *Measure Category Assignment* of Y **will not** have an associated *Measurement Value*.

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Name: *Measure Set*

Collected For: HBIPS, PC, Transmission, Patient Population Data File, Hospital Clinical Data File,

Definition: Indicates which measure set (topic) is being transmitted for a hospital.

Question: Not Applicable

Format:
Length: 10
Type: Character
Occurs: Hospital Clinical Data file: 1
Hospital Initial Patient Population Data file: 1 9

Allowable Values: Refer to the Hospital Clinical Data XML File Layout and the Hospital Initial Patient Population Data XML File Layout in the Transmission section of this manual.

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *Measurement Value*

Collected For: HBIPS, PC, Calculation, Transmission, Hospital Clinical Data File, Used in the calculation of the Joint Commissions aggregate data, Continuous Variable Measures and in the transmission of the Hospital Clinical Data file

Note:

- The ORYX Vendor's calculated *Measurement Value* will be transmitted to The Joint Commission on a quarterly basis with the associated hospital clinical data. These measure results will be used in the Joint Commissions data quality analysis and continuous measure verification process. ORYX Vendors can refer to the Joint Commissions *ORYX Data Quality Manual* for more information.
- *Measurement Value* must be transmitted to The Joint Commission but cannot be transmitted to CMS. Files transmitted to the CMS Clinical Warehouse that contain *Measurement Value* will be rejected.

Definition: This data element is used to store the calculated results of the measurements that are outputs from continuous variable measure algorithms.

Note:
Used in conjunction with *Measure Category Assignment* when its allowable value = D (In Measure Population).

Question: Not Applicable

Format:
Length: 6
Type: Numeric
Occurs: One *Measurement Value* is expected per EOC for every continuous variable measure that a hospital is participating in.

Allowable Values: Any valid number

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Name: *Minutes of Physical Restraint*

Collected For: HBIPS-2, ,

Definition: The total minutes recorded in the medical record that a patient was maintained in *Event Type* 1 (physical restraint(s)) for the associated *Event Date*.

Question: What was the total number of minutes recorded in the medical record that the patient was maintained in *Event Type* 1 (physical restraint) for the *Event Date*?

Format:
Length: 4 or UTD
Type: Alphanumeric
Occurs: 1

Allowable Values:

1-1440
UTD= Unable to Determine

Notes for Abstraction: *Event Type* 1 (physical restraint(s)) should be reported in whole minutes. Events less than or equal to 60 seconds should be reported as 1 minute (i.e., event duration of 2 minutes 5 seconds is reported as 3 minutes).

For each patient enter the *Minutes of Physical Restraint* that corresponds with the *Event Date* and *Event Type*.

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)).

Select unable to determine when either the start or stop time **OR** the total number of minutes of *Event Type* 1 (physical restraint) event is missing from the medical record and the total *Minutes of Physical Restraint* can not be calculated for the associated *Event Date*.

See the guidelines for abstraction for definition of an *Event Type* 1 (physical restraint).

When an *Event Type* 1 (physical restraint) starts at school or during an off-campus outing; this event should be reported.

Suggested Data Sources:
- Licensed independent practitioner orders
- Nursing flow sheet
- Nursing notes
- Observation sheets
- Physician orders
- Progress notes
- Psychiatrist notes
- Restraint monitoring form
- Therapist notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
A physical restraint is any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely when it is used as a restriction to manage a patients behavior or	• Devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets • Methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests

restrict the patients freedom of movement and is not a standard treatment for the patients medical or psychiatric condition.[1] Examples of physical restraint includes but is not limited to:: • 2 point restraint • 4 point restraint • 5 point restraint • Body nets • Mittens for the purpose of preventing intentional self-harm • Wrist-to-waist restraints • Soft wrist restraints • Manual holds • Stapling • Jarvis • Leather restraints • Devices that serve multiple purposes such as a Geri chair or side rails, when they have the effect of restricting a patients movement and cannot be easily removed by the patient, constitute a restraint. [2] [12] ,[3] 42 CFR Part 482, Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients Rights	• Methods that protect a patient from falling out of bed • Methods that permit the patient to participate in activities without the risk of physical harm (does not include a physical escort)[3] • Restraint uses that are forensic or correctional restrictions applied and used by outside law enforcement • Restraint uses that are forensic or correctional restrictions applied and used by designated hospital security personnel for the purpose of transporting the patient to court off the locked unit.

Name: *Minutes of Seclusion*

Collected For: HBIPS-3, ,

Definition: The total minutes recorded in the medical record that a patient was held in *Event Type* 2 (seclusion) during the associated *Event Date*.

Question: What was the total number of minutes recorded in the medical record that the patient was held in *Event Type* 2 (seclusion) during the *Event Date*?

Format:
Length: 4 or UTD
Type: Alphanumeric
Occurs: 1

Allowable Values:

1-1440
UTD= Unable to Determine

Notes for Abstraction: *Event Type* 2 (seclusion(s)) should be reported in whole minutes. Events less than or equal to 60 seconds should be reported as 1 minute (i.e., event duration of 2 minutes 5 seconds is reported as 3 minutes).

For each patient enter the *Minutes of Seclusion* that corresponds with the *Event Date* and *Event Type*.

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).

Select unable to determine when either the start or stop time **OR** the total number of minutes of *Event Type* 2 (seclusion) event is missing from the medical record and the total *Minutes of Seclusion* can not be calculated for the associated *Event Date*.

See guidelines for abstraction for definition of an *Event Type* 2 (seclusion).

When an *Event Type* 2 (seclusion) starts at school or during an off-campus outing; this event should be reported.

Suggested Data Sources:
- Licensed independent practitioner orders
- Nursing flow sheet
- Nursing notes
- Observation sheets
- Physician orders
- Progress notes
- Psychiatrist notes
- Seclusion monitoring form
- Therapist notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
Seclusion is the involuntary confinement of a patient alone in a room or an area where the patient is physically prevented from leaving. This includes but is not limited to [1]: • Manually or electronically locked doors • One-way doors	• Time-out • Quarantine due to infectious disease

• The presence of staff proximal to the room preventing exit or the threat of consequences if the patient leaves the room [1] 42 CFR Part 482, Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients Rights	

Name: *National Provider Identifier*

Collected For: HBIPS, PC, Transmission, Optional for All Records

Definition: All Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered healthcare providers must obtain a National Provider Identifier (NPI). The NPI may be provided in addition to the Medicare provider number.

Question: What is the NPI for this provider?

Format:
Length: 10
Type: Character
Occurs: 1

Allowable Values:
Any valid 10 digit NPI number.

The 10th digit is a numeric check digit based off the first 9 digits.

Notes for Abstraction: None

Suggested Data Sources: UB-04, Field Location: 56

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *Number of Antipsychotic Medications Prescribed at Discharge*

Collected For: HBIPS-4, HBIPS-5, ,

Definition: The number of routinely scheduled antipsychotic medications prescribed to the patient at discharge as documented in the medical record.

Question: What is the documented number of antipsychotic medications prescribed for the patient at discharge?

Format:
Length: 2 or UTD
Type: Alphanumeric
Occurs: 1

Allowable Values:

0-99
UTD= Unable to Determine

Notes for Abstraction: An antipsychotic medication is defined as any of a group of drugs, such as the phenothiazines, butyrophenones or serotonin-dopamine antagonists, which are used to treat psychosis. An antipsychotic medication is also called neuroleptic (refer to Appendix C, Table 10.0- Antipsychotic Medications).

All antipsychotic medications should be counted regardless of the indication for use or the reason documented for prescribing the antipsychotic medication.

If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital.

If the patient is on two forms of the same medication i.e., po and IM, this would be counted as one antipsychotic medication.

Only use Antipsychotic NOS in the following situation:
- For new antipsychotics that are not yet listed in Table 10.0 in Appendix C.

It is acceptable to use data derived from pharmacy reports 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 suggested data sources listed below.

Suggested Data Sources:
- Aftercare discharge plan
- Continuing care plan
- Discharge plan
- Final discharge summary
- Interim discharge summary
- Medication reconciliation form
- Physician discharge orders
- Physician progress notes
- Referral form

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• Refer to Appendix C, Table 10.0- Antipsychotic Medications	• PRN antipsychotic medications • Short-acting intramuscular antipsychotic medications (refer to Appendix C, Table 10.1- Short-Acting

	Intramuscular Antipsychotic Medications)

Name: *Number of Previous Live Births*

Collected For: PC-02, ,

Definition: The number of deliveries resulting in a live birth the patient experienced prior to current hospitalization.

Question: How many deliveries resulting in a live birth did the patient experience prior to current hospitalization?

Format:
Length: 2 or UTD
Type: Alphanumeric
Occurs: 1

Allowable Values:
0-50

UTD=Unable to Determine

Notes for Abstraction: 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.

Suggested Data Sources:
ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE:
- Delivery record, note or summary
- Operating room record, note or summary
- History and physical
- Prenatal forms
- Admission clinician progress note
- Discharge summary

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Name: *Patient Referral to Next Level of Care Provider*

Collected For: HBIPS-4, HBIPS-5, HBIPS-6, HBIPS-7, ,

Definition: Documentation in the medical record that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting.

Question: Is there documentation in the medical record that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The medical record contains documentation that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting.

2 The medical record contains documentation of one of the following:

- the patient or guardian refused the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting
- the patient or guardian refused to authorize release of information
- the patient was readmitted to the same facility within 5 days after discharge

3 The medical record contains documentation of one of the following:

- the patient eloped and was discharged
- the patient failed to return from leave and was discharged
- the patient has not yet been discharged from the hospital
- the patient was discharged from the hospital to another level of care outside of the hospital system from a setting other than a *Psychiatric Care Setting*
- the patient's residence is not in the USA, and they are returning to another country after discharge

4 The medical record contains documentation that the patient was not referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting for a reason other than above.

5 The medical record does not contain documentation that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting OR unable to determine from medical record documentation.

Notes for Abstraction: If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital.

When a patient checks himself out of a hospital against the advice of his doctor (AMA) this is not the same as an elopement. The patient should still be offered a referral to a next level of care provider. If the patient refuses the referral, select allowable value 2.

When a patient is released from a psychiatric inpatient stay directly after a court hearing, select allowable value 3.

When allowable value 2 or 3 is selected, creation and transmission of a continuing care plan is not required.

A referral to attend support groups, i.e., Alcoholics Anonymous (AA), Narcotics Anonymous (NA), etc. after discharge is not a referral to a next level of care provider. A referral to support groups is a next level of care recommendation.

Suggested Data Sources:

- Aftercare discharge plan
- Continuing care plan
- Discharge plan
- Final discharge summary
- Interim discharge summary
- Medication reconciliation form
- Physician discharge orders
- Physician progress notes
- Referral form

Additional Notes:

The next level of care providers include the follow-up prescribing inpatient or outpatient clinician, prescribing inpatient or outpatient entity, the treating inpatient or outpatient clinician or the treating inpatient or outpatient entity as described below:

- The follow-up prescribing inpatient or outpatient clinician is the clinician who is responsible for managing the patients medication regimen after hospital discharge.
- The prescribing inpatient or outpatient entity is the hospital or clinic that is responsible for managing the patients medication regimen after hospital discharge.
- The treating inpatient or outpatient clinician is the clinician who is responsible for the primary treatment of the patient in the absence of medications.
- The treating inpatient or outpatient entity is the hospital or clinic that is responsible for the primary treatment of the patient in the absence of medications.
- Some examples of inpatient or outpatient clinicians include, but are not limited to: primary care physician, psychiatrist, advanced practice nurse (APN), physician assistant (PA) Master of Social Work (MSW) and psychologist. Titles of qualified psychiatric practitioners vary from state to state.

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Name: *Patient Strengths*

Collected For: HBIPS-1, ,

Definition: Documentation in the medical record that an admission screening for a minimum of **two** patient strengths was performed within the first three days of admission.

Question: Is there documentation in the medical record that the patient was screened for a minimum of **two** patient strengths within the first three days of admission?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) Documentation in the medical record includes a screening for a minimum of **two** patient strengths performed within the first three days of admission.

N (No) Documentation in the medical record does not include a screening for a minimum of **two** patient strengths 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 a minimum of **two** patient strengths cannot be completed due to the patients inability or unwillingness to answer screening questions within the first three days of admission OR patient has a previous admission to the psychiatric unit during a single hospitalization.

Notes for Abstraction: A screening for patient strengths must be completed by a qualified psychiatric practitioner, e.g., psychiatrist, psychologist, registered nurse (RN), physicians assistant (PA) or Master of Social Work (MSW) within the first three days of admission. The titles of qualified psychiatric practitioners may vary from state to state.

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.

The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day. An admission screen performed in an ambulatory setting, i.e. emergency department, crisis center which results in an admission to an inpatient psychiatric care setting can be used if the screen becomes a permanent part of the medical record.

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.

Suggested Data Sources:

- Biopsychosocial assessment
- Emergency department record
- Functional skills assessment
- History and physical
- Individual plan of service
- Initial assessment form
- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form
- Referral packet
- School report
- Social worker assessment

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
Examples of adult and older adult patient strengths may include but are not limited to: • Assessment of patient optimism that change can occur • Motivation and readiness for change • Setting and pursuing goals • Attempting to realize ones potential • Managing surrounding demands and opportunities • Exercising self-direction • Vocational interests, i.e., hobbies • Interpersonal relationships and supports,i.e., family, friends, peers • Cultural/spiritual/religious and community involvement • Access to housing/residential stability • Steady employment • Financial stability • Awareness of substance use issues • Knowledge of medications Examples of children and adolescent patient strengths may include but are not limited to: • Stable and supportive family • Presence of friends • School engagement • Parent involvement in school • Favorable relationships with teachers • Assessment of self-esteem, motivation and achievement • Refrain from alcohol, drugs, sexual activity • Engagement in hobbies, sports, arts and clubs	• None

Name: *Payment Source*

Collected For: Optional for HBIPS-2 and HBIPS-3

Definition: The source of payment for this episode of care.

Question: What is the patient's source of payment for this episode of care?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 Source of payment is Medicare.

2 Source of payment is NonMedicare.

Notes for Abstraction:

- If Medicare is listed as the primary, secondary, tertiary, or even lower down on the list or payers, select "1".
- If the patient has Medicaid only or Medicaid and another insurance type, other than Medicare, select "2". If the patient has Medicaid and Medicare, select "1".
- If the patient is an Undocumented Alien or Illegal immigrant select "1". Undocumented Alien: Section 1011 of the Medicare Modernization Act of 2003 allows for reimbursement for services rendered to patients who are: Undocumented or illegal aliens (immigrants), Aliens who have been paroled into a United States port of entry and Mexican citizens permitted to enter the United States on a laser visa.

Suggested Data Sources:

- Face sheet
- UB-04

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
Medicare includes, but is not limited to: • Medicare Fee for Service (includes DRG or PPS) • Black Lung • End Stage Renal Disease (ESRD) • Railroad Retirement Board (RRB) • Medicare Secondary Payer • Medicare HMO/Medicare Advantage	• None

Name: *Predicted Value*

Collected For: PC, Transmission, Risk Adjustment, Hospital Clinical Data File, Used in the calculation of the Joint Commissions aggregate data for Risk Adjusted Measures **(PC-02, PC-04)** and in the Transmission section of the Hospital Clinical Data file.

Note:

- The ORYX Vendors calculated *Predicted Value* will be transmitted to The Joint Commission on a quarterly basis with the associated hospital clinical data. These measure results will be used in the Joint Commissions data quality analysis and continuous measure verification process. ORYX Vendors can refer to the Joint Commissions *ORYX Data Quality Manual* and *ORYX Risk Adjustment Guide* for more information.

Definition: This data element is used to store the calculated predicted value that results from applying the appropriate Joint Commission risk model to the data.

Note:
Used in conjunction with Measure Category Assignment when its allowable value = D (In Measure Population) or E (In Numerator Population).

Question: Not Applicable

Format:
Length: 2-9 (including decimal)
Type: Numeric
Occurs: One Predicted Value is expected per EOC for every risk-adjusted measure that a hospital is participating in.

Allowable Values:
0.00000001 0.99999999

JOINT COMMISSION NOTE TO PROGRAMMERS:

- Round to 8 decimal places.
- Use only the twenty four ICD-10-CM Diagnosis Codes that are transmitted as part of the patient record when evaluating the patient against the risk model. Do not use additional ICD-10-CM Diagnosis Codes that may be available in the medical record or from the UB download.

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *Prior Uterine Surgery*

Collected For: PC-01, Joint Commission Only,

Definition: Documentation that the patient had undergone prior uterine surgery.

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

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) The medical record contains documentation that the patient had undergone prior uterine surgery.

N (No) The medical record does not contain documentation that the patient had undergone a prior uterine surgery OR unable to determine from medical record documentation.

Notes for Abstraction:

Suggested Data Sources:

- History and physical
- Nursing admission assessment
- Progress notes
- Physicians notes
- Prenatal forms

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
The **only** prior uterine surgeries considered for the purposes of the measure are: • Prior classical cesarean birth which is defined as a vertical incision into the upper uterine segment • Prior myomectomy • Prior uterine surgery resulting in a perforation of the uterus due to an accidental injury • History of a uterine window or thinning or defect of the uterine wall noted during prior uterine surgery or during a past or current ultrasound • History of uterine rupture requiring surgical repair • History of a cornual ectopic pregnancy • History of transabdominal cerclage	• Prior low transverse cesarean birth • Prior cesarean birth without specifying prior classical cesarean birth • History of an ectopic pregnancy without specifying cornual ectopic pregnancy • History of a cerclage without specifying transabdominal cerclage

Name: *Psychiatric Care Setting*

Collected For:

Definition: Documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e., a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital.

Question: Did the patient receive care in an inpatient psychiatric setting?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) The patient received care in an inpatient psychiatric setting.

N (No) The patient did not receive care in an inpatient psychiatric setting.

Programming Note: The allowable value for *Psychiatric Care Setting* may be determined electronically using a source such as an Electronic Record (EHR/EMR) or hospital billing system. Hospitals must document the specific data source (field and application) that is used and make this information available to their vendor. This information must be made available to The Joint Commission upon request.

Notes for Abstraction: Example 1 - Chemical Dependency Units that treat patients primarily for substance use disorders and occasionally psychiatric diagnoses are excluded from the HBIPS measures.

Example 2 - Psychiatric Units that treat dual diagnosis patients (patients with **both** substance use disorders and psychiatric diagnoses) are included in the HBIPS measures.

Suggested Data Sources:
- Emergency department record
- Face sheet
- Physician orders
- Discharge summary
- Registration form

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• Patients with a psychiatric diagnosis who received care in an inpatient unit other than a psychiatric unit within an acute-care hospital or a free-standing psychiatric hospital.

Name: *Psychiatric Inpatient Days - Medicare Only*

Collected For: HBIPS-2, HBIPS-3, ,

Definition: The sum of the number of days each Medicare patient was included in the psychiatric inpatient census during the month (includes clients on leave status).

This data element is used to calculate the *Initial Patient Population Size Medicare Only* data element and the denominator for HBIPS-2 and 3. ORYX vendors can refer to the Joint Commissions *ORYX Technical Implementation Guide* for more information.

Question: What is the sum of the number of days each Medicare patient was included in the psychiatric inpatient census during the month?

Format:
Length: 6
Type: Numeric
Occurs: 5 (Overall rate and once per sub-strata)

Allowable Values:

0-999999

Programming Note: The value of the *Initial Patient Population Size Medicare Only* may be determined electronically using a source such as an Electronic Record (EHR/EMR) or hospital billing system. Hospitals must document the specific data source (field and application) that is used and make this information available to their vendor. This information must be made available to The Joint Commission upon request.

Notes for Abstraction:

- For the purposes of calculating inpatient days, the admission day (*Admission Date*) but not the discharge day (*Discharge Date*) should be counted. The only exception will be for patients who are admitted and discharged on the same day. Such patients will contribute one inpatient day to the calculation.
- If Medicare is listed as the primary, secondary, tertiary, or even lower down on the list of payers, the patient should be counted in the Medicare inpatient days.
- If the patient is an Undocumented Alien or Illegal immigrant, the patient should be counted in the Medicare inpatient days: Section 1011 of the Medicare Modernization Act of 2003 allows for reimbursement for services rendered to patients who are: Undocumented or illegal aliens (immigrants), Aliens who have been paroled a United States port of entry and Mexican citizens to enter the United States on a laser visa.

Suggested Data Sources:

- Admissions/ discharges/ transfers (ADT) system
- Daily census log that is completed on the same time each day

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	• Discharge date

Name: *Psychiatric Inpatient Days-Non-Medicare Only*

Collected For: HBIPS-2, HBIPS-3, ,

Definition: The sum of the number of days each Non-Medicare patient was included in the psychiatric inpatient census during the month (includes clients on leave status).

This data element is used to calculate the *Initial Patient Population Size Non-Medicare Only* data element and the denominator for HBIPS-2 and 3. ORYX vendors can refer to the Joint Commissions *ORYX Technical Implementation Guide for more information*.

Question: What is the sum of the number of days each Non-Medicare patient was included in the psychiatric inpatient census during the month?

Format:
Length: 6
Type: Numeric
Occurs: 5 (Overall rate and once per sub-strata)

Allowable Values:

0-999999

Programming Note: The value of the *Initial Patient Population Size Non-Medicare Only* may be determined electronically using a source such as an Electronic Record (EHR/EMR) or hospital billing system. Hospitals must document the specific data source (field and application) that is used and make this information available to their vendor. This information must be made available to The Joint Commission upon request.

Notes for Abstraction:

- For the purposes of calculating inpatient days, the admission day (*Admission Date*) but not the discharge day (*Discharge Date*) should be counted. The only exception will be for patients who are admitted and discharged on the same day. Such patients will contribute one inpatient day to the calculation.
- If Medicare is **not** listed as the primary, secondary, tertiary, or even lower down on the list of payers, the patient should be counted in the Non-Medicare inpatient days.

Suggested Data Sources:

- Admissions/ discharges/transfers (ADT) system
- Daily census log that is completed on the same time each day

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	• Discharge date

Name: *Psychological Trauma History*

Collected For: HBIPS-1, ,

Definition: Documentation in the medical record that an admission screening for a psychological trauma history was performed within the first three days of admission.

Question: Is there documentation in the medical record that the patient was screened for a psychological trauma history performed within the first three days of admission?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) Documentation in the medical record includes a screening for a psychological trauma history performed within the first three days of admission.

N (No) Documentation in the medical record does not include a screening for a psychological trauma history 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 a psychological trauma history can not be completed due to the patients inability or unwillingness to answer screening questions within the first three days of admission OR patient has a previous admission to the psychiatric unit during a single hospitalization.

Notes for Abstraction: A screening for a psychological trauma history 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. The titles of qualified psychiatric practitioners may vary from state to state.

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.

Traumatic life experiences are defined as those that result in responses to life stressors characterized by significant fear, anxiety, panic, terror, dissociation, feelings of complete powerless or strong emotions that have long term effects on behaviors and coping skills[1].

[1]American Psychiatric Association. (1994). *Diagnostic and statistical manual or mental disorders, Fourth Ed*. Washington, DC: APA.

The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day. An admission screen performed in an ambulatory setting, i.e. emergency department, crisis center which results in an admission to an inpatient psychiatric care setting can be used if the screen becomes a permanent part of the medical record.

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.

Suggested Data Sources:

- Biopsychosocial assessment
- Emergency department record
- Functional skills assessment
- History and physical
- Individual plan of service
- Initial assessment form
- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form

- Referral packet
- School report
- Social worker assessment

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
Examples of psychological trauma may include but are not limited to: • physical abuse • sexual abuse • emotional abuse • Severe childhood neglect • victimization, e.g., disasters, criminal activities, crime stigma, identity theft • combat experiences • witnessing others being harmed or victimized • any significant injury or life-threatening disease • significant psycho/social loss, e.g., bankruptcy, traumatic family loss	• None

Name: *Race*

Collected For:

Definition: Documentation of the patients race.

Question: What is the patients race?

Format:
Length: 1
Type: Character
Occurs: 1

Allowable Values:

Select one:

1 **White:** Patients race is White or the patient has origins in Europe, the Middle East, or North Africa.

2 **Black or African American:** Patients race is Black or African American.

3 **American Indian or Alaska Native:** Patients race is American Indian/Alaska Native.

4 **Asian:** Patients race is Asian.

5 **Native Hawaiian or Pacific Islander:** Patients race is Native Hawaiian/Pacific Islander.

6 **RETIRED VALUE** (effective 07-01-05 discharges)

7 **UTD:** Unable to determine the patients race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).

Notes for Abstraction:

- The data element *Hispanic Ethnicity* is required in addition to this data element.
- If documentation indicates the patient has more than one race (e.g., Black-White, Indian-White), select the first listed race.
- Although the terms Hispanic and Latino are actually descriptions of the patients ethnicity, it is not uncommon to find them referenced as race. If the patients race is documented only as Hispanic/Latino, select White. If the race is documented as mixed Hispanic/Latino with another race, use whatever race is given (e.g., Black-Hispanic select Black). Other terms for Hispanic/Latino include Chicano, Cuban, H (for Hispanic), Latin American, Latina, Mexican, Mexican-American, Puerto Rican, South or Central American, and Spanish.

Suggested Data Sources:

- Emergency department record
- History and physical
- Face sheet
- Nursing admission assessment
- Progress notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
Black or 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. **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 maintains tribal affiliation or community	• None

attachment (e.g., any recognized tribal entity in North and South America [including Central America], Native American.) **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. **White** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., Caucasian, Iranian, White). **Native Hawaiian or Pacific Islander** A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	

Name: *Reason for Not Initiating Antenatal Steroids*

Collected For: PC-03, ,

Definition: 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.

Question: Is there documentation in the medical record of reasons for not initiating antenatal steroids before delivery?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

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.

Notes for Abstraction: 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).

Suggested Data Sources:

PHYSICIAN/APN/PA/CNM DOCUMENTATION ONLY

- History and physical
- Physician progress notes
- Prenatal forms

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *Sample Size Medicare Only*

Collected For: HBIPS, PC, Transmission, Patient Population Data File, Used in transmission of the Hospital Initial Patient Population Data file.

Note:
For more information refer to the Population and Sampling Specifications section and Hospital Initial Patient Population Data XML File Layout in the Transmission section of this manual.

Definition: Indicates the number of episode of care (EOC) records identified for a hospital with Medicare listed as a payment source for a hospital to perform data abstraction on. This count is after the appropriate sampling methodology, if any, has been applied for the specific time period.

Notes for discharge measures (eg. HBIPS-1, 4, PC-01):

- If the hospital is sampling the discharge measures, then the Sample Size Medicare Only should be equal or less than the Initial Patient Population Size Medicare Only for the set, stratum, or sub-population.
- If the hospital is not sampling the discharge measures, then the Sample Size Medicare Only will equal the Initial Patient Population Size Medicare Only for the set, stratum, or sub-population.

Notes for HBIPS event measures (HBIPS-2 and 3):

- Hospitals may not sample the HBIPS event measures. For these two measures, the Sample Size Medicare Only equals the Initial Patient Population Size Medicare Only for the set, stratum, or sub-population.

Question: Not Applicable

Format:
Length: 6
Type: Numeric
Occurs:

Non-stratified Measure Sets:

One Sample Size Medicare Only per hospitals measure set (e.g., AMI, and STK).

Stratified Measure Sets:

One Sample Size Medicare Only per measure set stratum or sub-population the hospital is participating in:
* The PC measure set has three occurrences, one for the mother sub-population and two for the newborn sub-populations.
* The HBIPS measure set has four occurrences, one for each age stratum.

Note:
Refer to the appropriate version of the Specifications Manual for National Quality Inpatient Measures for the number of occurrences for the VTE measure set.

Allowable Values: 0 through 999,999

Notes for Abstraction: For Discharge measures (eg. HBIPS-1,PC-01), when Sampling Frequency = N/A because the hospital has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter and has decided to not submit patient level data, Sample Size Medicare Only should equal zero.

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *Sample Size Non-Medicare Only*

Collected For: HBIPS, PC, Transmission, Patient Population Data File, Used in transmission of the Hospital Initial Patient Population Data file.

Note:
- For more information, refer to the Population and Sampling Specifications section and Hospital Initial Patient Population Data XML File Layout in the Transmission section of this manual.

Definition: Indicates the number of episode of care (EOC) records identified for a hospital with Medicare NOT listed as a payment source for a hospital to perform data abstraction on. This count is after the appropriate sampling methodology, if any, has been applied for the specific time period.

Notes for discharge measures (eg HBIPS-1, 4, PC-01):
- If the hospital is sampling the HBIPS discharge measures, then the Sample Size Non-Medicare Only should be equal or less than the Initial Patient Population Size Non-Medicare Only for the set, stratum, or sub-population.
- If the hospital is not sampling the discharge measures, then the Sample Size Non-Medicare Only will equal the Initial Patient Population Size Non-Medicare Only for the set, stratum, or sub-population.

Notes for HBIPS event measures (HBIPS-2 and 3):
- Hospitals may not sample the HBIPS event measures. For these two measures, the Sample Size Non-Medicare Only equals the Initial Patient Population Size Non-Medicare Only for the set, stratum, or sub-population.

Question: Not Applicable

Format:
Length: 6
Type: Numeric
Occurs:

Non-stratified Measure Sets:

One Sample Size Non Medicare Only per hospitals measure set (e.g., AMI, and STK).

Stratified Measure Sets:

One Sample Size Non Medicare Only per measure set stratum or sub-population the hospital is participating in:
* The PC measure set has three occurrences, one for the mother sub-population and two for the newborn sub-populations.
* The HBIPS measure set has four occurrences, one for each age stratum.

Note:
Refer to the appropriate version of the Specifications Manual for National Quality Inpatient Measures for the number of occurrences for the VTE measure set.

Allowable Values: 0 through 999,999

Notes for Abstraction: For Discharge measures (eg. HBIPS-1, 4, PC-01), when Sampling Frequency = N/A because the hospital has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter and has decided to not submit patient level data, Sample Size Non-Medicare Only should equal zero.

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *Sample*

Collected For: HBIPS, PC, Transmission, Hospital Clinical Data File,

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

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 performing 100 percent of the discharges eligible for this topic.

Notes for Abstraction: When *Sampling Frequency* equals '3' (No, the hospital is not sampling) or '4' (N/A, submission of patient level data is not required), then abstract *Sample* as "No".

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Name: *Sampling Frequency*

Collected For: HBIPS, PC, Transmission, Patient Population Data File, Used in transmission of the Hospital Initial Patient Population Data file.

Note:
Refer to the Population and Sampling Specifications section and Hospital Initial Patient Population Data XML File Layout in the Transmission section of this manual.

Definition: Indicates if the data being transmitted for a hospital has been sampled (either monthly or quarterly), or represents an entire population for the specified time period.

Question: Not Applicable

Format:
Length: 1
Type: Character
Occurs:

Non-stratified Measure Sets:

One Sampling Frequency per hospitals measure set (e.g., AMI, CAC and STK).

Stratified Measure Sets:

One Sampling Frequency per measure set stratum or sub-population the hospital is participating in:
* The PC measure set has three occurrences, one for the mother sub-population and two for the newborn sub-populations.
* The HBIPS measure set has four occurrences, one for each age stratum.

Note:
Refer to the appropriate version of the Specifications Manual for National Quality Inpatient Measures for the number of occurrences for the VTE, and SCIP measure sets.

Allowable Values:

1 Yes, the hospital is sampling data monthly.

2 Yes, the hospital is sampling data quarterly.

3 No, the hospital is not sampling.

4 N/A, submission of patient level data is not required.

Notes for Abstraction:

- Sampling Frequency must be consistent across a discharge time period.
  Example:
  If the Sampling Frequency for April is monthly, then the Sampling Frequency for May and June must be monthly.
- For Discharge measures (e.g., HBIPS-1, 4, PC-01): Hospitals with five or fewer discharges (both Medicare and Non-Medicare combined) in a quarter are not required to submit patient level data.
- For Event measures (eg., HBIPS-2 and 3): This data element will always be equal to 3 (No, the hospital is not sampling).

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *Sex*

Collected For:

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

Question: What is the patients sex on arrival?

Format:
Length: 1
Type: Character
Occurs: 1

Allowable Values:

M = Male
F = Female
U = Unknown

Notes for Abstraction:

- Collect the documented patients sex at admission or the first documentation after arrival.
- Consider the sex to be unable to be determined and select Unknown if:
  - The patient refuses to provide their sex.
  - Documentation is contradictory.
  - Documentation indicates the patient is a Transexual.
  - Documentation indicates the patient is a Hermaphrodite.

Suggested Data Sources:

- Consultation notes
- Emergency department record
- History and physical
- Face sheet
- Progress notes
- Nursing admission notes
- UB-04

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Name: *Substance Use*

Collected For: HBIPS-1, ,

Definition: 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.

Question: 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?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

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.

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.
- 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.
- The intent of this data element is to screen the patient for substance use within the 12 months prior to admission. Documentation of substance use must at a minimum state over the past 12 months. Documentation of a past history of substance use should differentiate the use being either within the past 12 months or prior to the 12 month time frame.
- Documentation of "no history" cannot be used, unless it is associated with a time frame. For example:
  - “No history of substance use within the past 12 months.”
    Or
  - “History of substance use 2 years ago.”
- The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day. An admission screen performed in an ambulatory setting, i.e. emergency department, crisis center which results in an admission to an inpatient psychiatric care setting can be used if the screen becomes a permanent part of the medical record.
- Substance use is defined as the use of psychoactive or mood altering substances, i.e.,

prescription medications, over the counter medications, inhalants, organic substances, illegal substances and street drugs.

- 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.
- 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.

Suggested Data Sources:

- Biopsychosocial assessment
- Emergency department record
- Functional skills assessment
- History and physical
- Individual plan of service
- Initial assessment form
- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form
- Referral packet
- School report
- Social worker assessment

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
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	• None

Name: *Term Newborn*

Collected For: PC-05, ,

Definition: Documentation that the newborn was at term or >= 37 completed weeks of gestation at the time of birth.

Question: Is there documentation that the newborn was at term or >= 37 completed weeks of gestation at the time of birth?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) There is documentation that the newborn was at term or >= 37 completed weeks of gestation at the time of birth.

N (No) There is no documentation that the newborn was at term or >= 37 completed weeks of gestation at the time of birth OR unable to determine from medical record documentation.

Notes for Abstraction: Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks. Estimated gestational age (EGA) may be used to determine gestational age.

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

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

Suggested Data Sources:

- History and physical
- Nursing notes
- Nursing admission assessment
- Progress notes
- Physicians notes
- Discharge summary

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• Gestational age of 37 weeks or more • Early term • Full term • Late term • Post term • Term	• Gestational age of 36 weeks or less • Preterm • Early preterm • Late preterm

Name: *Total Leave Days - Medicare Only*

Collected For: HBIPS-2, HBIPS-3, ,

Definition: Total leave days-Medicare only is the aggregate number of leave days for Medicare patients during the month. A leave day-Medicare only is defined as an authorized or unauthorized absence of a Medicare patient from a psychiatric care setting, excluding discharges, during which the patient is absent from the psychiatric care setting at the time of the daily census and is not under the direct supervision of psychiatric care setting staff while absent.

This data element is used to calculate the *Initial Patient Population Size Medicare Only* data element and the denominator for HBIPS-2 and 3. ORYX vendors can refer to the Joint Commissions *ORYX Technical Implementation Guide* for more information.

Question: What is the sum of the number of days each Medicare patient was absent from the facility?

Format:
Length: 6
Type: Numeric
Occurs: 5 (Overall rate and once per sub-strata)

Allowable Values:

0-999999

Programming Note: The value of the *Total Leave Days-Medicare Only* may be determined electronically using a source such as an Electronic Record (EHR/EMR) or hospital billing system. Hospitals must document the specific data source (field and application) that is used and make this information available to their vendor. This information must be made available to The Joint Commission upon request.

Notes for Abstraction:

- If Medicare is listed as the primary, secondary, tertiary, or even lower down on the list of payers, the patient should be counted in the Medicare inpatient days.
- If the patient is an Undocumented Alien or Illegal immigrant, the patient should be counted in the Medicare inpatient days: Section 1011 of the Medicare Modernization Act of 2003 allows for reimbursement for services rendered to patients who are: Undocumented or illegal aliens (immigrants), Aliens who have been paroled a United States port of entry and Mexican citizens to enter the United States on a laser visa.

Suggested Data Sources:

- Nursing notes
- Progress notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
Therapeutic pass	None

Name: *Total Leave Days-Non-Medicare Only*

Collected For: HBIPS-2, HBIPS-3, ,

Definition: Total leave days-Non-Medicare only is the aggregate number of leave days for Non-Medicare patients during the month. A leave day-Non-Medicare only is defined as an authorized or unauthorized absence of a Non-Medicare patient from a psychiatric care setting, excluding discharges, during which the patient is absent from the psychiatric care setting at the time of the daily census and is not under the direct supervision of psychiatric care setting staff while absent.

This data element is used to calculate the the *Initial Patient Population Size Non-Medicare Only* data element and denominator for HBIPS-2 and 3. ORYX vendors can refer to the Joint Commissions *ORYX Technical Implementation Guide* for more information.

Question: What is the sum of the number of days each Non-Medicare patient was absent from the facility?

Format:
Length: 6
Type: Numeric
Occurs: 5 (Overall rate and once per sub-strata)

Allowable Values:
0-999999

Programming Note: The value of the *Total Leave Days-Non-Medicare Only* may be determined electronically using a source such as an Electronic Record (EHR/EMR) or hospital billing system. Hospitals must document the specific data source (field and application) that is used and make this information available to their vendor. This information must be made available to The Joint Commission upon request.

Notes for Abstraction: If Medicare is **not** listed as the primary, secondary, tertiary, or even lower down on the list of payers, the patient should be counted in the Non-Medicare total leave days.

Suggested Data Sources:
- Nursing notes
- Progress notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
Therapeutic pass	None

Name: *Vendor Tracking Identifier*

Collected For: HBIPS, PC, Transmission, Hospital Clinical Data File,

Definition: An ORYX Vendor® -generated identifier that uniquely identifies this patients stay or episode of care. It is a fictitious identifier generated by the ORYX Vendor to differentiate between individual patient records in each hospital.

This identifier cannot be derived from or related to information about the patient in such a way that it is possible to identify the patient via a review or manipulation of the data.

Since this identifier is transmitted to The Joint Commission, ORYX Vendors must be able to link this tracking identifier to the original record (patient) in the event that data quality issues arise. Any data that require correction and re-transmission must use the same tracking identifier as that used in the original transmission or a duplication of data within the Joint Commissions database will occur.

This identifier is linked to a patients episode of care, not to a specific event that occurs during the episode of care. The Vendor Tracking ID must be the same each time data for a unique patients episode of care is transmitted; regardless of whether this is the second or thirty-second record being transmitted for the patient.

Question: Not applicable, this data element is not data entered.

Format:
Length: 100
Type: Character
Occurs: 1

Allowable Values:

Up to 100 letters, numbers, and/or special characters can be entered.

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

The identifier cannot be left blank or be the patients social security number, Medicare number, driver license number, medical record number, account number, or other identifier assigned to the patient for purposes other than transmission of data to The Joint Commission. In addition, this identifier cannot be a combination of data in which one portion of the data directly identifies the patient or the combination of data identifies the patient.

Notes for Abstraction: For each patient episode of care, the *Vendor Tracking ID* should match for each *Measure Set* that is submitted. For example, if the hospital submits a separate XML file for PC, ED, and TOB, the *Vendor Tracking ID* should be the same in each XML file.

Suggested Data Sources: Unique ORYX Vendor generated identifier

NOTE TO PROGRAMMERS:

- An ORYX Vendor may have its own case identifier. We are not requesting that ORYX Vendors change their internal processes; rather, this tracking identifier is needed for transmission of the hospital clinical data to The Joint Commission.

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Name: *Violence Risk to Others*

Collected For: HBIPS-1, ,

Definition: 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.

Question: Is there documentation in the medical record that the patient was screened for violence risk to others over the past six months was performed within the first three days of admission?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) Documentation in the medical record includes a screening for violence risk to others over the past six months performed within the first three days of admission.

N (No) Documentation in the medical record does not include a screening for violence risk to others over the past six 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 violence risk to others over the past six months can not 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 the psychiatric unit during a single hospitalization.

Notes for Abstraction:

- A screening for violence risk to others 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.
- The intent of this data element is to screen the patient for being a violence risk to others within the 6 months prior to admission. Documentation of violence risk must at a minimum state over the past 6 months. Documentation of a past history of violence risk should differentiate the risk being either within the past 6 months or prior to the 6 month time frame.
- Documentation of "no history" cannot be used, unless it is associated with a time frame. For example:
  - “No history of violence risk to others within the past 6 months.”
    Or
  - “History of violence risk to others over a year ago.”
- 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.
- The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day. An admission screen performed in an ambulatory setting, i.e. emergency department, crisis center which results in an admission to an inpatient psychiatric care setting can be used if the screen becomes a permanent part of the medical record.

- Some examples of violence risk to others include but are not limited to the following: thoughts of harm to others, intentional infliction of harm on someone else by the patient, homicidal thoughts by the patient and thoughts of harming someone else by the patient.
- 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.

Suggested Data Sources:

- Biopsychosocial assessment
- Emergency department record
- Functional skills assessment
- History and physical
- Individual plan of service
- Initial assessment form
- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form
- Referral packet
- School report
- Social worker assessment

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
• None	• None

Name: *Violence Risk to Self*

Collected For: HBIPS-1, ,

Definition: 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.

Question: Is there documentation in the medical record that the patient was screened for violence risk to self over the past six months within the first three days of admission?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) Documentation in the medical record includes a screening for violence risk to self over the past six months was performed within the first three days of admission.

N (No) Documentation in the medical record does not include a screening for risk to self over the past six 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 risk of violence to self over the past six months can not 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.

Notes for Abstraction:

- A screening for risk of violence to self and others 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.
- The intent of this data element is to screen the patient for being a violence risk to self within the 6 months prior to admission. Documentation of violence risk must at a minimum state over the past 6 months. Documentation of a past history of violence risk should differentiate the risk being either within the past 6 months or prior to the 6 month time frame.
- Documentation of "no history" cannot be used, unless it is associated with a time frame. For example:
  - “No history of violence risk to self within the past 6 months.”
    Or
  - “History of violence risk to self over a year ago.”
- 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.
- The admission screening must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day. An admission screen performed in an ambulatory setting, i.e. emergency department, crisis center which results in an admission to an inpatient psychiatric care setting can be used if the screen becomes a permanent part of the medical record.
- Some examples of violence to self include but are not limited to: past suicide attempts by the patient, intentional cutting, burning, bruising or damaging of self by the patient, inappropriate substance use, suicidal thoughts in the past six months by the patient,

specific suicidal plan in the past six months by the patient and past suicide attempts by anyone in patients family.

- 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.

Suggested Data Sources:

- Biopsychosocial assessment
- Emergency department record
- Functional skills assessment
- History and physical
- Individual plan of service
- Initial assessment form
- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form
- Referral packet
- School report
- Social worker assessment

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
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,	• None

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	

Missing and Invalid Data

Introduction

Missing data refers to data elements, required for calculating a national hospital quality measure, that have no values present for one or more episodes of care (EOC) or event records. Invalid data refers to data element values, required for calculating a national hospital quality measure, that fall outside of the range of allowable values defined by The Joint Commission for that data element.

Reducing missing and invalid data minimizes the bias to a measure rate, because episodes of care with missing or invalid data cannot be included in the calculation of the observed measure rate. A measures observed rate may not accurately reflect the patient population, if the excluded EOC and event records differ significantly from the EOCs and events with no missing data that were included in the measure calculation.

Data Collection and the Unable to be Determined (UTD) Allowable Value

Abstractors must touch and provide an answer to every data element that is applicable per the combined skip logic of all of the measures in a topic. While there is an expectation that all data elements are collected, it is recognized that in certain situations information may not be available (dates, times, codes, etc.). If, after due diligence, the abstractor determines that a value is not documented or is not able to determine the answer value, the abstractor must select Unable to Determine (UTD) as the answer. The UTD allowable value is used as follows:

- *Admission Date*, *Birthdate*, *Discharge Date*, *Event Date*, *Event Type*, *ICD-10-CM Principal and Other Diagnosis Codes*, *ICD-10-PCS Principal and Other Procedure Codes*, *Psychiatric Care Setting*, *Psychiatric Inpatient Days-Medicare Only*, *Psychiatric Inpatient Days-Non-Medicare Only*, *Total Leave Days-Medicare Only*, and *Total Leave Days-Non-Medicare Only* do not have an UTD allowable value for transmission to The Joint Commission. EOC and event records containing UTD for any of these data elements are rejected when submitted to the Joint Commissions Data Warehouse.
- Date, time, and numeric data elements, other than those listed above have an UTD allowable value option.
    - Rate-based proportion algorithms evaluate EOC records to a *Measure Category Assignment* = D or "E" (failed) depending on the desired direction improvement of the associated measure when a date, time, or numeric data element containing an allowable value of UTD is evaluated. When the direction of the improvement is an increase in rate, the algorithm will evaluate the EOC records to a *Measure Category Assignment* = "D". When the direction of improvement is a decrease in rate, the algorithm will evaluate the EOC record to a *Measure Category Assignment* = "E".
    - Continuous variable and rate-based ratio algorithms evaluate EOC records to a *Measure Category Assignment* = Y (UTD value exists) when a date, time, or numeric data element containing an allowable value of UTD is evaluated.
    - The method by which data collection software collects UTD information is determined by each software vendor; except the **software cannot automatically default an UTD answer.** The decision to enter an UTD for each data element is up to the abstractor, not the software.
    - There are specific requirements pertaining to the transmission of this value. Refer to the Transmission section in this manual for more information.
- Yes/No data elements: The allowable value No incorporates UTD into the definition. Refer to the measure algorithms in which each Yes/No data element is used to determine how the EOC and event records are treated.
- Data elements containing two or more categorical values: The UTD value is either classified as a separate allowable value or included in the same category as None of the above/Not documented. Refer to the measure algorithms in which each categorical data element is used to determine how the EOC record is treated.

Missing and Invalid Episode of Care (EOC) and Event Data

The Joint Commissions Data Warehouse evaluates patient data using the missing, invalid and data integrity edits. Refer to the Edit Feedback Messages documents located on Joint Commission PET, in Manuals and Guides tab,

Data Transmission Technical Documentation page, Hospital Clinical Data (HCD) link, for a complete listing of all critical and informational edits.

Rejected data must be corrected and resubmitted before the transmission deadline in order for it to be accepted by the Joint Commissions Data Warehouse.

- The majority of general data elements that are missing data cause the EOC and event records to be rejected. These data elements for *Discharge measure* include but not limited to *Admission Date*, *Birthdate*, *Discharge Date*, and *ICD-10-CM Principal Diagnosis Codes*. For *Event measures* such general data elements include but not limited to *event-type*, *event-date*, *Admission Date*, and *Birthdate*. Refer to the Introduction to the Data Dictionary in this manual for the complete list of general data elements.
    - Not all patients have an ICD-10-CM Other Diagnosis Code or an ICD-10-PCS Principal and Other Procedure Codes. Records will be accepted with missing data for this data element.
- Measure-specific data elements that are missing data cause the EOC and event records to be rejected if any measure algorithm results in a *Measure Category Assignment* = X (missing data). If no measure evaluates to a category assignment of X, the EOC record will be accepted.
- General and measure specific data elements that contain invalid data cause the EOC and events record to be rejected.

Abstraction Software Skip Logic and Missing Data

Skip logic allows hospitals and vendors to minimize abstraction burden by using vendor software edit logic to bypass abstraction of data elements not utilized in the measure algorithm. However, these bypassed elements also negatively impact data quality when elements are incorrectly abstracted and subsequent data elements are bypassed and left blank.

The use of skip logic by hospitals and ORYX vendors is optional and not required by The Joint Commission. Hospitals should be aware the potential impact of skip logic on data quality and abstraction burden. Vendors and hospitals utilizing skip logic should closely monitor the accuracy rate of abstracted data elements, particularly data elements placed higher in the algorithm flow.

Note:
*A missing value occurs when the abstractor does not select an answer for a data element (leaves it blank) or the software incorrectly transmits a null instead of the correct value for a data element. An UTD allowable value is not considered missing data.

Missing, Invalid, UTD Data Summary:

Missing Data	Invalid Data	UTD
No data element value is present. (blank or null)	The data element value falls outside of the range of defined allowable values.	The allowable value of UTD is present for the data element.

Population and Sampling Specifications

Introduction

Population

Defining the population is the first step to estimate a hospitals performance. A population is generally defined as a collection of patients sharing a common set of universally measured characteristics, such as an ICD-10-CM Principal Diagnosis or ICD-10-PCS Procedure Code. The Initial Patient Population and diagnosis codes meet this description for the national quality measures. For the purpose of measuring national quality core measures, the term Initial Patient Population is defined below:

- An Initial Patient Population refers to all patients (Medicare and non-Medicare) who share a common set of specified, administratively derived data elements. This may include ICD-10-CM diagnosis codes or other population characteristics such as age. For example, the population for the HBIPS discharge measures (e.g., HBIPS-1, 4, 5, 6, and 7) includes all patients having a principal or secondary psychiatric diagnosis code from Appendix A, Table 10.01.

Cases identified as being in the Initial Patient Population for the measure set, or strata (e.g., HBIPS), or sampling group (e.g., PC-Mother and PC-Breast Feeding) are eligible to be sampled. For the definition of the Initial Patient Population(s) for each measure set, refer to the appropriate Initial Patient Population discussion in the Measure Information section of this manual.

Sampling

Sampling is a process of selecting a representative part of a population in order to estimate the hospitals performance, without collecting data for its entire population. Using a statistically valid sample, a hospital can measure its performance in an effective and efficient manner. Sampling is a particularly useful technique for performance measures that require primary data collection from a source such as the medical record. Sampling should not be used unless the hospital has a large number of cases in the Initial Patient Population because a fairly large number of sample cases are needed to achieve a representative sample of the population. For the purpose of sampling national quality measures, the terms sample and case are defined as below:

- The sample is the fraction of the population that is selected for further study.
- A case refers to a single record (or an episode of care [EOC] or event) within the population. For example, during the first quarter a hospital may have 100 patients who had principal or secondary psychiatric diagnosis code associated to the HBIPS-1, 4, 5, 6, and 7 measures. The hospitals Initial Patient Population would include 100 cases or 100 patient records for these measures during the first quarter.

To obtain statistically valid sample data, the sample size should be carefully determined and the sample cases should be randomly selected in such a way that the individual cases in the population have an equal chance of being selected. Only when the sample data truly represent the whole population can the sample-based performance measure data be meaningful and useful.

Each hospital is ultimately responsible that sampling techniques applied for their hospital adhere to the sampling requirements outlined in this manual. ORYX® Vendors are responsible for ensuring that the sampling techniques are applied consistently across their client hospitals.

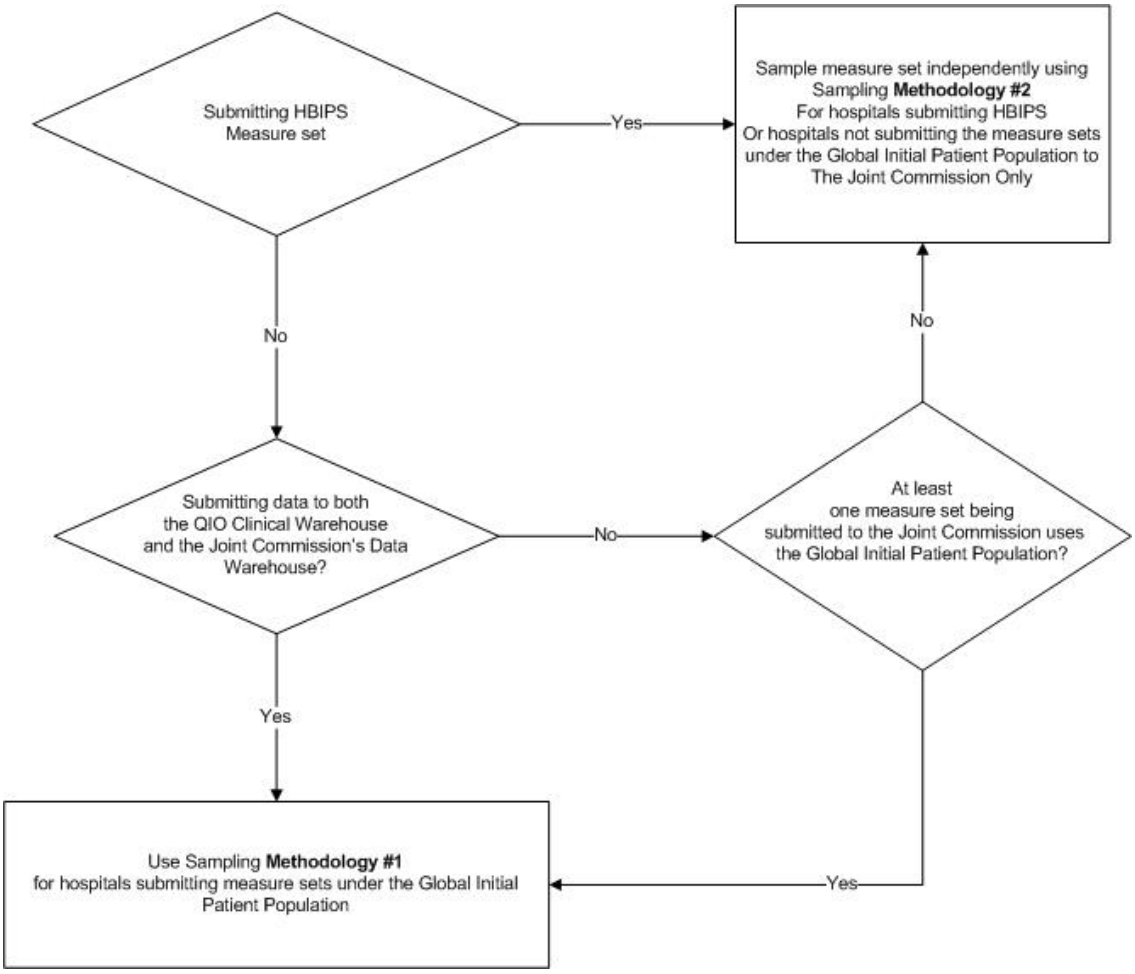
Sampling is done by national quality inpatient measure set; however, for Perinatal Care (PC), and Hospital-Based Inpatient Psychiatric Services (HBIPS) are done by strata or sampling group. For measures requiring medical record abstraction, sampling must be done using available databases that contain all discharges for the transmission quarter.

Note:
Hospitals are NOT required to sample their data. If sampling offers minimal benefit (i.e., a hospital has 80 cases for the quarter and must select a sample of 76 cases) the hospital may choose to use all cases.

Order of Data Flow

The sampling methodology defined in the *Specifications Manual for National Hospital Inpatient Quality Measures* requires hospitals submitting data for any measure set, except HBIPS, that utilizes the Global Initial Patient Population to use the associated sampling methodology for all measure sets being submitted. This requirement includes the PC measure set. Hospitals submitting data for HBIPS are not required to utilize Global sampling methodology even if they are submitting Global measure sets.

- If the hospital is submitting data to both the CMS Warehouse and the Joint Commissions Data Warehouse, use sampling methodology number one.
- If the hospital is submitting data to only The Joint Commission:
    - If the hospital is submitting at least one measure set that uses the Global Initial Patient Population, use sampling methodology number one.
    - If the hospital is not submitting any of the measure sets that uses the Global Initial Patient Population, sample each measure set independently using sampling methodology number two.
    - If the hospital is submitting HBIPS, sample independently using sampling methodology number two



1. Hospitals Submitting Measure Sets Under the Global Initial Patient Population to Both the CMS Warehouse and The Joint Commissions Data Warehouse

For the submission of the Global Initial Patient Population and associated measure sets (i.e., ED, IMM, TOB, and/or SUB) the following data flow or process steps should be used to identify the data for all measure sets or stratum that are transmitted to the Joint Commissions Data Warehouse, including PC, however excluding HBIPS. These process steps are:

Identify Global Cases To Be Abstracted (ED, IMM, SUB, TOB)

- Identify the Global Initial Patient Population. The Global Initial Patient Population is used for the ED, IMM, TOB, and SUB measure sets. This data pull utilizes administrative data such as admission date and discharge date. This identification process must be completed prior to the application of data integrity filter, measure exclusions, and the application of sampling methodology. For specific Global Initial Patient Population definitions, refer to the Global Initial Patient Population discussion in the Measure Information section of the *Specifications Manual for National Hospital Inpatient Quality Measures*. This data pull is completed once for each hospital. This is not performed for each measure set that utilizes the Global population.
    - If the hospital is sampling, use the Global Initial Patient Population identified above and pull the sample of medical records for the ED, IMM, TOB, and/or SUB measure sets using the Sample Size Requirements defined in the Global Initial Patient Population Information section of the *Specifications Manual for National Hospital Inpatient Quality Measures*. Note: This is completed once for each hospital. This is not performed for each measure set that utilizes the Global population.
- Collect or abstract from the identified medical records the general and measure specific data elements that are needed for the measure set. Run the data through the algorithms for the measure sets under the Global Initial Patient Population (ED, IMM, SUB and/or TOB). The count of the number of cases used in this step is collected in the Global Initial Patient Population and Sample Size data elements.
- If the hospital is only submitting the measure sets under the Global Initial Patient Population (i.e., ED, IMM, SUB or TOB), the process is complete.

Identify Cases To Be Abstracted For The Remaining Measure Sets, Strata, and Sub-populations (PC, AMI, CAC, SCIP, STK, VTE)

- Identify the Initial Patient Population for the other measure sets (AMI, STK, CAC, SCIP) strata or sub-populations (PC, VTE). This data pull utilizes administrative data such as ICD-10-CM diagnosis and ICD-10-PCS procedure codes, admission date, and birthdate. All ICD-10-CM diagnosis and ICD-10-PCS procedure codes included in the Initial Patient Population definition must be applied. This identification process must be completed prior to the application of data integrity filter, measure exclusions, and the application of sampling methodology. For specific PC measure set definitions, refer to the Initial Patient Population discussion in the Measure Information section of this manual. For all other measures, refer to the Initial Patient Population discussion in the Measure Information section of the *Specifications Manual for National Hospital Inpatient Quality Measures*. The number of cases in the Initial Patient Population of each measure set, strata, and sub-population are collected in the appropriate Initial Patient Population Size data elements.
    - If the hospital is not sampling, collect or abstract from the identified medical records the general and measure specific data elements that are needed for the measure set(s), strata or sub-populations. The count of the number of cases used in this step is collected in the Sample Size data elements.
    - If the hospital is sampling, use the Initial Patient Population (*N*) identified above and pull the sample of medical records for the measure set, strata or sub-population using the Sample Size Requirements in the appropriate sampling discussion in the Measure Information section of this manual for PC. For all other measures, refer to the Sample Size Requirements in the appropriate sampling discussion in the Measure Information section of the *Specifications Manual for National Hospital Inpatient Quality Measures*.
- Using the Global Initial Patient Population identified above, identify and count the number of cases that are also in the other Measure Sets (e.g., AMI, CAC, SCIP and STK), strata, or sub-populations (e.g., PC or VTE) Initial Patient Population(s).Determine the number of cases that need to be sampled (*n*) from the cases in the other measure set(s) or stratum(s) Initial Patient Population (*N*). Use the Sample Size Requirements in the appropriate sampling discussion in the Measure Information section of this manual for PC and HBIPS. For all other measures, refer to the Sample Size Requirements in the appropriate sampling discussion in the Measure Information section of the *Specifications Manual for National Hospital Inpatient Quality Measures*.
    - If there are enough Initial Patient Population cases in the Global sample pull to meet the specific initial patient population and sampling requirements for the measure set(s), strata, or sub-populations, then no additional sampling is required. Collect or abstract from the identified medical records the general and measure specific data elements that are needed for the measure set(s), strata, or sub-populations.

The count of the number of cases used in this step is collected in the *Sample Size* data elements.

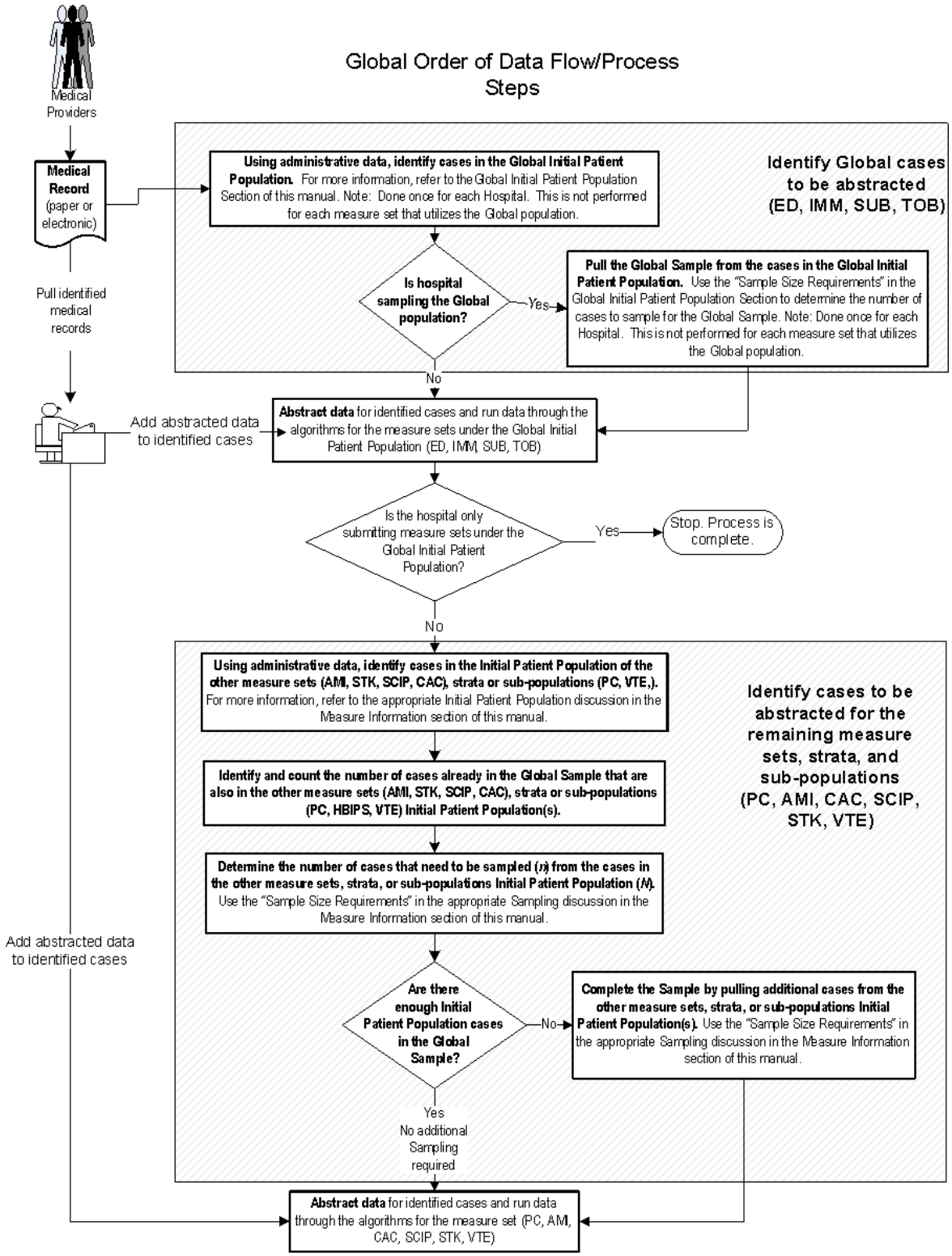
- If there are not enough Initial Patient Population cases in the Global sample pull to meet the specific initial patient population and sampling requirements for the measure set(s), strata or sub-populations, complete the sample by pulling additional cases from the other measure set(s), strata or sub-populations Initial Patient Population(s). Use the Sample Size Requirements in the appropriate Sampling discussion in the Measure Information section of this manual for PC. For all other measures, refer to the Sample Size Requirements in the appropriate sampling discussion in the Measure Information section of the *Specifications Manual for National Hospital Inpatient Quality Measures*. Collect or abstract from the identified medical records the general and measure specific data elements that are needed for the measure set(s). The count of the number of cases used in this step is collected in the *Sample Size* data elements.

Example: For 4th quarter the Global Initial Patient Population is 1550, 100 for AMI, 250 for PC-Mothers, and 300 for PC-Newborns with Breast Feeding. If the hospital is sampling, the minimum number of cases that would be required to be sampled would be 306 for Global (ED, IMM, TOB, and/or SUB), 78 for AMI, 75 for PC-Mothers, and 37 for PC-Newborns with Breast Feeding.

The hospital would pull 306 cases for the Global sample. From those 306 cases the hospital would determine how many of those cases were also AMI, PC-Mothers, PC-Newborns with Breast Feeding cases that met the initial patient population criteria for the specific measure set. If there are enough AMI, PC-Mothers, and PC-Newborns with Breast Feeding cases in the Global sample pull to meet the minimum sampling requirements for those measure sets, then no additional sample pull is needed.

If there are not enough cases in the Global sample pull to meet the other measure sets minimum sampling requirements then an additional sample pull is needed. For example, from the Global sample pull there were 72 AMI, 20 PC-Mothers, and 5 PC-Newborns with Breast Feeding cases identified that met the initial population criteria for the specific measure set. As the minimum sample requirements for AMI is 78, 6 additional AMI cases would need to be pulled from the AMI Initial Patient Population. As the minimum sample requirements for PC-Mothers is 75, an additional 55 cases would need to be pulled from the PC-Mothers Initial Patient Population. As the minimum sample requirements for PC-Newborns with Breast Feeding is 37, an additional 32 cases would need to be pulled from the PC-Newborns with Breast Feeding Initial Patient Population.

Note: PC-Newborns with BSI are not eligible for sampling and will use the entire Initial Patient sampling group, as appropriate, for reporting.



2. Hospitals Submitting HBIPS or Hospitals Not Submitting the Measure Sets Under the Global Initial Patient Population to The Joint Commission Only

For hospitals submitting HBIPS or hospitals not submitting the measure sets under the Global Initial Patient Population to The Joint Commission only, an independent sample pull should be used to pull the sample for the applicable measure sets (i.e., PC, HBIPS, AMI, CAC, SCIP, STK and VTE).

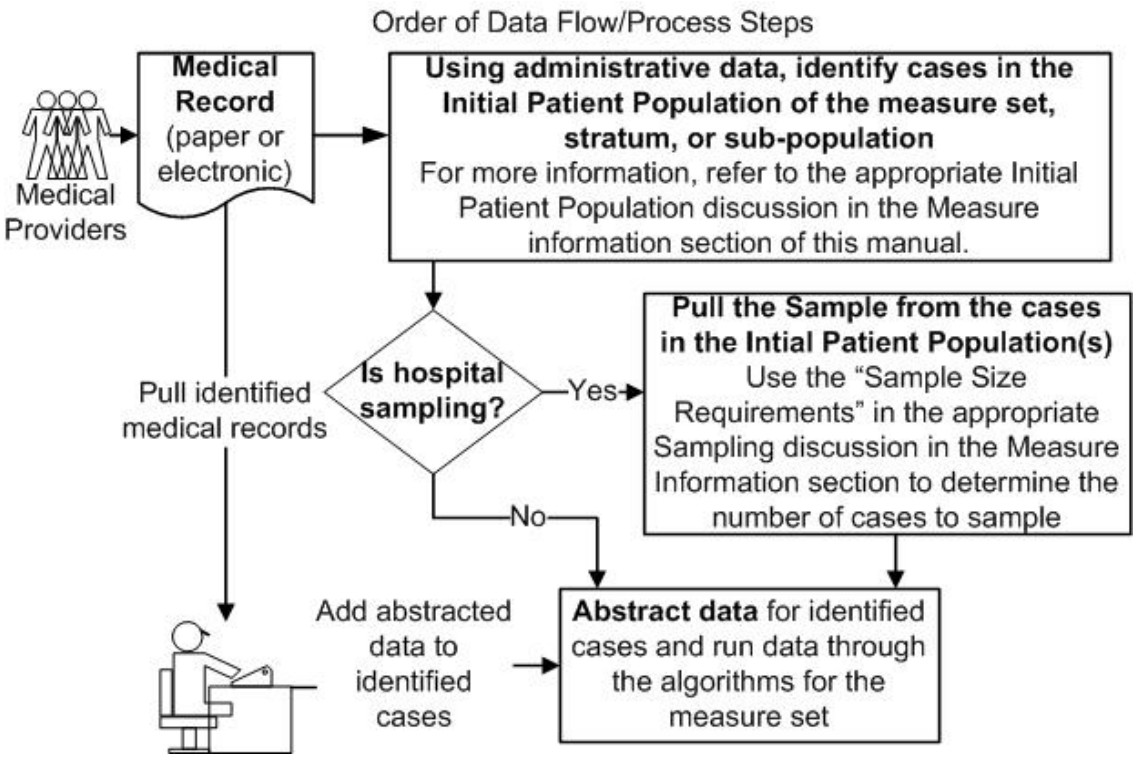
Each measure set, stratum, or sub-population has a unique definition of Initial Patient Population and sample size requirement. However, the same data flow or process steps can be used to identify the data that is transmitted to the Joint Commission's Data Warehouse. These process steps are:

- First, identify the Initial Patient Population for the measure set. An Initial Patient Population is defined for each measure set, stratum, and sampling group and the count is collected in the Initial Patient Population Size data elements.

All data elements in the appropriate Initial Patient Population definition, including ICD-10-CM Diagnosis Codes when appropriate, must be applied. This identification process must be completed prior to the application of data integrity filter, measure exclusions, and the application of sampling methodology.

For specific measure set, stratum, and sampling group definitions, refers to the appropriate Initial Patient Population discussion in the Measure Information section of this manual for PC and HBIPS. For all other measures, refer to the Sample Size Requirements in the appropriate sampling discussion in the Measure Information section of the *Specifications Manual for National Hospital Inpatient Quality Measures*.

- Second, if the measure allows sampling and the hospital is sampling, use the Initial Patient Population identified above and pull the sample of medical records for each measure set, stratum, or sub-population using the Sample Size Requirements defined in the appropriate Measure Information section of this manual for PC and HBIPS. For all other measures, refer to the Sample Size Requirements in the appropriate sampling discussion in the Measure Information section of the *Specifications Manual for National Hospital Inpatient Quality Measures*.
- Third, collect or abstract from the identified medical records the general and measure specific data elements that are needed for the measure set. The count of the number of cases used in this step is collected in the *Sample Size* data elements.
    - If the hospital is not sampling, use the medical records identified in the first data pull.
    - If the measure allows sampling and the hospital is sampling, use the medical records from the cases in the identified sample.



Sample Size Requirements

Hospitals that choose to sample have the option of sampling quarterly or sampling monthly. The sample size requirements for each of these options are described in turn. Hospitals need to use the next highest whole number when determining their required sample size. See below for rounding examples. For each measure sets sample size requirements, refer to the appropriate measure sets Measure Information section in this manual.

Hospitals selecting sample cases for measure sets that are not stratified must ensure that its Initial Patient Population(s) and sample size(s) meet the conditions stated in the measure sets Sample Size Requirements.

For hospitals selecting sample cases for stratified measure sets or measure sets with sampling groups (e.g., HBIPS and PC), a modified sampling procedure is required. Hospitals selecting samples cases for these sets must ensure that each individual stratum's Population/sampling group and sample size meets the conditions stated in the measure set's Sample Size Requirements.

Regardless of the option used, hospital samples must be monitored to ensure that sampling procedures consistently produce statistically valid and useful data. Due to exclusions and contraindications, hospitals selecting sample cases MUST submit AT LEAST the minimum required sample size. The sample size tables for each option automatically build the number of cases needed to obtain the required sample sizes.

Hospitals that sample, should sample by their Joint Commissions *Health Care Organization Identifier*. All data that are sampled must be transmitted to The Joint Commission.

A hospital may choose to use a larger sample size than is required. Hospitals whose Initial Patient Population size is less than the minimum number of cases per quarter/month for the stratum cannot sample. For the Discharge measures (e.g., HBIPS-1, 4, 5, 6, 7, and PC), hospitals that have five or fewer discharges (both Medicare and non-Medicare combined) are not required to submit patient level data to the Joint Commission's Data Warehouse. For the event measures (e.g., HBIPS-2, and 3), hospitals must submit patient level data to The Joint Commission regardless of the number of discharges or events they have each quarter. Refer to the Sample Size Requirement tables provided in the Measure Information section to determine the minimum number of cases that need to be sampled for each HBIPS measure set.

Quarterly Sampling Examples

Quarterly Example 1: Measure set is Not Stratified

Hospitals selecting sample cases for measure set ABC, which is not stratified, must ensure that its Initial Patient Population and quarterly sample size meet the following conditions:

Quarterly Sample Size
Based on Initial Patient Population for the ABC Measure set

Hospital's Measures	
Average Quarterly Initial Patient Population N	**Minimum Required Sample Size n**
≥ 1551	311
391 - 1550	20% of the Initial Patient Population
78-390	78
6 - 77	No sampling; 100% of the Initial Patient Population is required
0 - 5	Submission of patient level data is not required; if submission occurs, 100% Initial Patient Population required.

Examples

- A hospitals ABC Initial Patient Population is 77 patients during the first quarter. Using the above table, no sampling is allowed 100% of the population is required.
- A hospitals ABC Initial Patient Population is 100 patients during the second quarter. Using the above table, the required sample size is seen to be a minimum of 78 ABC patients for this quarter.
- A hospitals ABC Initial Patient Population is 401 patients during the third quarter. Using the above table, the required sample size is seen to be 20% of the population, or 81 cases for the quarter (twenty percent of 401 equals 80.2 rounded to the next whole number = 81).
- A hospitals ABC Initial Patient Population is 5 patients during the first quarters. Using the above table, submission of patient level data is not required. If the hospital chooses to submit patient level data, the required quarterly sample size would be 100% of the patient population or 5 cases for the quarter.

Quarterly Example 2: Measure set is stratified

For hospitals selecting sample cases for measure set XYZ which contains 8 strata, a modified sampling procedure is required. Hospitals selecting sample cases for these sets must ensure that each individual stratums population and quarterly sample size meets the following conditions.

- *Select within each of the seven individual measure stratum and the 8th XYZ stratum*.

Quarterly Sample Size
Based on Initial Patient Population for the XYZ measure set

Hospital's Measures	
Average Quarterly Stratum Initial Patient Population N	**Minimum Required Stratum Sample Size n**
≥ 471	48
161 - 470	10% of the Initial Patient Population

Hospital's Measures	
Average Quarterly Stratum Initial Patient Population N	**Minimum Required Stratum Sample Size n**
16 - 160	16
< 16	No sampling; 100% of the Initial Patient Population is required

Example

- The XYZ Initial Patient Population sizes for a hospital are 5, 50, 15, 140, 35, 201, 3, and 481 patients respectively per stratum for the quarter. Since the total Initial Patient Population for XYZ is 930, the hospital must submit patient level data. The required quarterly sample sizes for each stratum would be 5, 16, 15, 16, 16, 21, 3, and 48.
    - The 1st, 3rd, and 7th strata are less than the minimum required quarterly sample size, so 100% of each of these strata are sampled.
    - The 2nd, 4th, and 5th strata each require 16 cases to be sampled.
    - The 6th stratum has 201 patients per quarter, which requires a 10% sample size, or 21 cases (twenty percent of 201 equals 20.1 rounded to the next whole number = 21).
    - The 8th stratum is more than the maximum required quarterly sample size, so this stratum requires 48 cases to be sampled.

- The XYZ Initial Patient Population sizes for a hospital 1, 1, 0, 0, 1, 0, 1, and 1 patients respectively per stratum for the quarter. Since the total Initial Patient Population for XYZ is 5, the hospital may choose to not submit patient level data. If the hospital chooses to submit patient level data, the required quarterly sample sizes for each stratum would be 1, 1, 0, 0, 1, 0, 1, and 1.
- The 1st, 2nd, 5th, 7th, and 8th strata are less than the minimum required quarterly sample size, so 100% of each of these strata are sampled.
- There is no data to sample for the 3rd, 4th, and 6th strata.

Quarterly Example 3: Measure set has sub-populations
For hospitals selecting sample cases for measure set DEF which contains 3 independent sub-populations a modified sampling procedure is required. The three sub-populations must be sampled independently from each other.

1-Hospitals selecting sample cases for sub-population 1 must ensure that the Initial Patient Population and sample size for the sub-population 1 meet the following conditions:

Quarterly Sample Size
Based on Initial Patient Population for the Patient Sub-Population 1

Hospital's Measures	
Average Quarterly Initial Patient Sub-Population Size N	**Minimum Required Sub-Population Sample Size n**
≥ 896	180
226 - 895	20% of the Initial Patient Population Size
45 - 225	45
< 45	No sampling; 100% of the Initial Patient Population required

Hospital's Measures	
Average Quarterly Initial Patient Sub-Population Size N	**Minimum Required Sub-Population Sample Size n**
0 - 45	Submission of patient level data is not required; if submission occurs, 100% Initial Patient Population required.

2 - Hospitals selecting sample cases for sub-population 2 must ensure that the initial Patient Population and sample size for sub-population 2 meet the following conditions:

Quarterly Sample Size
Based on Initial Patient Population Size for the
Patient Sub-Population 2

Hospital's Measures	
Average Quarterly Initial Patient Sub-Population Size N	**Minimum Required Sub-Population Sample Size n**
≥ 1796	360
451 - 1795	20% of the Initial Patient Population
90 - 450	90
< 90	No sampling; 100% of the Initial Patient Population required

3 - Sub-population 3 *is not eligible* for sampling and will use the entire Initial Patient Population for reporting.

Example
1. Quarterly sampling for sub-population 1:

- A hospital's sub-population 1 is 752 during the second quarter. Using the quarterly sampling table for sub-population 1, the sample size required is 20% of this sub-population, or 151 cases for the quarter (twenty percent of 752 equals 150.4 rounded up to the next whole number = 151).
- A hospital's sub-population 1 is 5 during the first quarter. Using the quarterly sampling table for sub-population 1, the sample size is less than the minimum required quarterly sample size, so 100% of this sub-population is sampled.
- A hospital's sub-population 1 is 99 during the third quarter. The required quarterly sample is 45 cases.

2. Quarterly sampling for sub-population 2:

- A hospital's sub-population 2 is 511 during the second quarter. Using the quarterly sampling table for sub-population 2, the sample size required is 20% of this sub-population, or 103 cases for the quarter (twenty percent of 511 equals 102.2 rounded up to the next whole number = 103).
- A hospital's sub-population 2 is 3 during the first quarter. Using the quarterly sampling table for sub-population 2, the sample size is less than the minimum required quarterly sample size, so 100% of this sub-population is sampled.
- A hospital's sub-population 2 is 300 during the third quarter. The required quarterly sample is 90 cases.

3. Quarterly sampling for sub-population 3:

- Sub-population *is not eligible* for sampling and will use the entire initial Patient Sub-Population for reporting.

Quarterly Example 4: Measure set has Sampling Groups
For hospitals selecting sample cases for measure set HGI which contains 3 independent sampling groups a modified sampling procedure is required. The three sampling groups are sampled independently from each other. A patient falls into multiple sampling groups but may not actually be sampled for all the groups for which the patient is eligible.

1-Hospitals selecting sample cases for sampling group 1 must ensure that the Initial Patient Population and sample size for the sampling group 1 meet the following conditions:

Quarterly Sample Size
Based on Initial Patient Population Size for the
Patient Sampling Group 1

Hospital's Measures	
Average Quarterly Initial Patient Sampling Group Size N	**Minimum Required Sampling Group Sample Size n**
≥ 801	161
201 - 800	20% of the Initial Patient Population Size
40 - 200	40
< 40	No sampling; 100% Initial Patient Population required

2 - Hospitals selecting sample cases for sampling group 2 must ensure that the initial Patient Population and sample size for the sampling group 2 meet the following conditions:

Quarterly Sample Size
Based on Initial Patient Population Size for the
Patient Sampling Group 2

Hospital's Measures	
Average Quarterly Initial Patient Sampling Group Size N	**Minimum Required Sampling Group Sample Size n**
≥ 2001	401
501 - 2000	20% of the Initial Patient Population
100 - 500	100
< 100	No sampling; 100% Initial Patient Population required

3 - Hospitals selecting sample cases for sampling group 3 must ensure that the Initial Patient Population and sample size for the sampling group 3 meet the following conditions:

Quarterly Sample Size
Based on Initial Patient Population Size for the
Patient Sampling Group 3

Hospital's Measures

Average Quarterly Initial Patient Sampling Group Size N	Minimum Required Sampling Group Sample Size n
≥ 2001	401
501 - 2000	20% of the Initial Patient Population
100 - 500	100
< 100	No sampling; 100% Initial Patient Population required

Example

1. A Hospital's sampling group 1 size 347 during the second quarter. The required sample size is 20% of the patient population or 70 cases for the quarter (twenty percent of 347 equals 69.4 rounded up to the next highest whole number is 70.)
2. A Hospital's sampling group 2 size is 250 patients during the second quarter. The required sample size is seen to be 100 patients for this quarter.
3. A Hospital's sampling group 3 size is 700 patients during the second quarter. The required sample size is seen to be 140 patients for this quarter.

Monthly Sampling Examples

Monthly Example 1: Measure set is Not Stratified
Hospitals selecting sample cases for ABC measure set must ensure that its Initial Patient Population and effective monthly sample size meet the following conditions:

Monthly Sample Size
Based on Initial Patient Population for the ABC measure set

Hospital's Measures	
Average Monthly Initial Patient Population N	**Minimum Required Sample Size n**
≥ 516	104
131 515	20% of the Initial Patient Population
26 130	26
< 26	No sampling; 100% of the Initial Patient Population is required

Examples

- A hospitals ABC Initial Patient Population is 25 patients during January. Using the above table, no sampling is allowed 100% of the population is required.
- A hospitals ABC Initial Patient Population is 130 patients during February. Using the above table, the required sample size is seen to be a minimum of 26 ABC patients for this month.
- A hospitals ABC Initial Patient Population is 301 patients during March. Using the above table, the required sample size is seen to be 20% of the population, or 61 cases for the month (twenty percent of 301 equals = 60.2 rounded to the next whole number = 61.
- A hospitals ABC Initial Patient Population is 516 patients during April. Using the above table, the required sample size is seen to be a minimum of 104 ABC patients for this month.

Monthly Example 2: Measure set is Stratified

For hospitals selecting sample cases for the XYZ measure set, a modified sampling procedure is required. Hospitals selecting sample cases for this set must ensure that each individual strata population and effective monthly sample size meets the following conditions:

- *Select within each of the seven individual measure stratum and the 8th XYZ stratum*.

Monthly Sample Size
Based on Initial Patient Population for the XYZ measure set

Hospital's Measures	
Average Monthly Stratum Initial Patient Population N	**Minimum Required Stratum Sample Size n**
≥ 151	16
61 - 150	10% of the Initial Patient Population
6 - 60	6
< 6	No sampling; 100% of the Initial Patient Population is required

Example

- The XYZ Initial Patient Population sizes for a hospital are 5, 50, 15, 141, 35, 201, 3, and 481 patients respectively in June. The required monthly sample sizes would be 5, 6, 6, 15, 6, 16, 3, and 16.
    - The 1st and 7th strata are less than the minimum required monthly sample size, so 100% of each of these strata is sampled.
    - The 2nd, 3rd, and 5th strata each require 6 cases to be sampled.
    - The 4th stratum has 141 patients per month, which requires a 10% sample size, or 15 cases (twenty percent of 141 equals 14.1 rounded to the next whole number = 15).
    - The 6th and 8th strata are each more than the maximum required monthly sample size, so this stratum requires 16 cases to be sampled.

Monthly Example 3: Measure set has sub-populations

For hospitals selecting sample cases for measure set DEF which contains 3 independent sub-populations a modified sampling procedure is required. The three sub-populations must be sampled independently from each other.

1 - Hospitals selecting sample cases for sub-population 1 must ensure that the Initial Patient Population and sample size for sub-population and sample size for sub-population 1 meet the following conditions:

Monthly Sample Size
Based on Initial Patient Population Size for the
Patient Sub-Population 1

Hospital's Measures	
Average Monthly Initial Patient Sub-Population Size N	**Minimum Required Sub-Population Sample Size n**
≥ 296	60
76 - 295	20% of the Initial Patient Population
15 - 75	15

Hospital's Measures	
Average Monthly Initial Patient Sub-Population Size N	**Minimum Required Sub-Population Sample Size n**
< 15	No sampling; 100% of the Initial Patient Population is required

2 - Hospitals selecting sample cases for sub=population 2 must ensure that the Initial Patient Population and sample size for sub-population and sample size for sub-population 2 meet the following conditions:

Monthly Sample Size
Based on Initial Patient Population Size for the
Patient Sub-Population 2

Hospital's Measures	
Average Monthly Initial Patient Sub-Population Size N	**Minimum Required Sub-Population Sample Size n**
≥ 596	120
151 - 595	20% of the Initial Patient Population
30 - 150	30
< 30	No sampling; 100% of the Initial Patient Population is required

3 - Sub-population 3 *is not eligible* for sampling and will use the entire Initial Patient Sub-Population for reporting.

Example
1. Monthly sampling for sub-population 1:

- A hospital's sub-population 1 is 81 during March. Using the monthly sampling table for sub-population 1, the sample size required is 20% of this sub-population, or 17 cases for the month (twenty percent of 81 equals 16.2 rounded up to the next whole number = 17).
- A hospital's sub-population 1 is 5 during February. Using the monthly sampling table for sub-population 1, the sample size is less than the minimum required monthly sample size, so 100% of this sub-population is sampled.
- A hospital's sub-population 1 is 45 during January. The required monthly sample is 15 cases.

2. Monthly sampling for sub-population 2:

- A hospital's sub-population is 387 during March. Using the monthly sampling table for sub-population 2, the sample size required is 20% of this sub-population, or 78 cases for the month (twenty percent of 387 equals 77.4 rounded up to the next whole number = 78).
- A hospital's sub-population 2 is 3 during February. Using the monthly sampling table for sub-population 2, the sample size is less than the minimum required monthly sample size, so 100% of this sub-population is sampled.
- A hospital's sub-population 2 is 47 during January. The required monthly sample is 30 cases.

3. Monthly sampling for sub-population 3:

- Sub-population 3 *is not eligible* for sampling and will use the entire initial Patient Sub-Population for reporting.

Monthly Example 4: Measure set has Sampling Groups

1 - Hospitals selecting sample cases for sampling group 1 must ensure that the Initial Patient Population and sample size for the sampling group 1 meet the following conditions:

Monthly Sample Size
Based on Initial Patient Population Size for the
Patient Sampling Group 1

Hospital's Measures	
Average Monthly Initial Patient Sampling Group Size N	**Minimum Required Sampling Group Sample Size n**
≥ 201	41
51 - 200	20% of the Initial Patient Population Size
10 - 50	10
< 50	No sampling; 100% Initial Patient Population required

2 - Hospitals selecting sample cases for sampling group 2 must ensure that the initial Patient Population and sample size for the sampling group 2 meet the following conditions:

Monthly Sample Size
Based on Initial Patient Population Size for the
Patient Sampling Group 2

Hospital's Measures	
Average Monthly Initial Patient Sampling Group Size N	**Minimum Required Sampling Group Sample Size n**
≥ 501	101
126 - 500	20% of the Initial Patient Population
25 - 125	25
< 25	No sampling; 100% Initial Patient Population required

3 - Hospitals selecting sample cases for sampling group 3 must ensure that the Initial Patient Population and sample size for the sampling group 3 meet the following conditions:

Monthly Sample Size
Based on Initial Patient Population Size for the
Patient Sampling Group 3

Hospital's Measures	
Average Monthly Initial Patient Sampling Group Size N	**Minimum Required Sampling Group Sample Size n**

Hospital's Measures	
Average Monthly Initial Patient Sampling Group Size N	**Minimum Required Sampling Group Sample Size n**
≥ 501	101
126 - 500	20% of the Initial Patient Population
25 - 125	25
< 25	No sampling; 100% Initial Patient Population required

Example
1. Monthly sampling for sampling group 1:

- A hospital's sampling group 1 is 81 during March. Using the monthly sampling table for sampling group 1, the sample size required is 20% of this sampling group, or 17 cases for the month (twenty percent of 81 equals 16.2 rounded up to the next whole number = 17).
- A hospital's sampling group 1 is 5 during February. Using the monthly sampling table for sub-population 1, the sample size is less than the minimum required monthly sample size, so 100% of this sampling group is sampled.
- A hospital's sampling group 1 is 45 during January. The required monthly sample is 10 cases.

2. Monthly sampling for sampling group 2:

- A hospital's sampling group is 2 is 387 during March. Using the monthly sampling table for sampling group 2, the sample size required is 20% of this sampling group, or 78 cases for the month (twenty percent of 387 equals 77.4 rounded up to the next whole number = 78).
- A hospital's sampling group 2 is 3 during February. Using the monthly sampling table for sampling group 2, the sample size is less than the minimum required monthly sample size, so 100% of this sampling group is sampled.
- A hospital's sampling group 2 is 47 during January. The required monthly sample is 25 cases.

3. Monthly sampling for sampling group 3:

- A hospital's sampling group 3 is 125 during January. The required monthly sample is 25 cases.

Sampling Approaches

As previously stated in this section, hospitals have the option to sample from their population, or submit their entire population. Hospitals that choose to sample must ensure that the sampled data represent their Initial Patient Population by using either the simple random sampling or systematic random sampling methods and that the sampling techniques are applied consistently within a quarter. For example, monthly samples for a measure set, stratum, or sampling group must use consistent sampling techniques across the quarterly submission period.

- Simple random sampling - selecting a sample size *(n)* from a population of size *(N)* in such a way that every case has the same chance of being selected.
- Systematic random sampling - selecting every kth record from a population of size N in such a way that a sample size of n is obtained, where k ≤ N/n. The first sample record (i.e., the starting point) must be randomly selected before taking every kth record. This is a two-step process: a) Randomly select the starting point by choosing a number between one and k using a table of random numbers or a computer-generated random

number; and b) Then select every kth record thereafter until the selection of the sample size is completed.

Each hospital is ultimately responsible that sampling techniques applied for their hospital adhere to the sampling requirements outlined in this manual. ORYX Vendors are responsible for ensuring that the sampling techniques are applied consistently across their client hospitals.

Sampling Approach Examples

For a hospital with an Initial Patient Population size of 350 ABC measure set discharges per quarter, the sample size would be 78. To select a random sample of 78 ABC patients:

- Simple random sampling:
    1. Generate random numbers for individual ABC patient records from a random number function using a statistical software package or computer programming language.
    2. Sort data by the random numbers either in an increasing or decreasing order.
    3. Select the first 78 ABC patient records as the random sample.

- Systematic random sampling:
    1. In this example, the hospitals Initial Patient Population size= 350 and the sample size = 78. Divide the Initial Patient Population size by the sample size and take the quotient (i.e., the integer portion) as the sampling interval k. The sampling interval k = 350/78 = 4.5. Thus, every 4th ABC patient record will be selected from the Initial Patient Population until 78 cases are selected.
    2. To ensure that each ABC patient has an equal chance of being selected, the starting point must be randomly determined before selecting every 4th ABC patient record. This can be done using a computer random number generator or a random number table to randomly choose a number between 1 and 4 as the starting point.

Transmission of Initial Patient Population and Sample Data Elements

The Joint Commission requires transmission of Initial Patient Population and sample count data. Transmission of Initial Patient Population and sample count data elements are used to assist in evaluating completeness of submission in accordance with The Joint Commission sampling requirements.

The Initial Patient Population Size refers to all patients (Medicare and non-Medicare) who share common payment sources which can be identified by utilizing administrative data such as the UB-04. All ICD-10-CM diagnosis and ICD-10-PCS procedure codes included in the appropriate Initial Patient Population definition must be applied. This identification process must be completed prior to the application of data integrity filter, measure exclusions, and the application of sampling methodology. For specific measure set and strata definitions, refer to the appropriate Initial Patient Population discussion in the Measure Information section of this manual.

The Initial Patient Population and sample data elements are:

- *Initial Patient Population Size Medicare Only*
- *Initial Patient Population Size Non-Medicare Only*
- *Sampling Frequency*
- *Sample Size Medicare Only*
- *Sample Size Non-Medicare Only*

These elements are transmitted in the Population and Sampling (PaS) data file. Refer to the Hospital ICD Population XML Layout File Layout in the Transmission section of this manual.

Sample indicates whether or not the hospital has sampled data for the specified time period. *Sampling Frequency* indicates if the hospital has sampled using the monthly or quarterly methodology, or whether the entire population was used for the specified time period or the hospital had five or fewer discharges for the discharge quarter and did not submit patient level data.

Initial Patient Population Size Medicare Only includes all patients that are billed under Medicare or Title 18. Medicare

can be listed as a primary, secondary, tertiary or lower on the list of payment sources for the patient. In addition, patients who are participating as a member of a Medicare HMO/Medicare Advantage are included in the Medicare counts, e.g., Medicare Blue, Humana gold, Secure Horizons, AARP, Coventry Advantra, etc.

Initial Patient Population and Sample Size Examples

Example 1 Hospital does not sample
A hospital uses the Initial Patient Population(s) for the ABC measure set to identify 120 cases in the ABC Initial Patient Population during the second quarter. The hospital does not sample the ABC measure set, so data for all 120 cases are collected and used to calculate the hospitals rate for each ABC measure. 40 of the 120 cases in the ABC Initial Patient Population are Medicare patients.

Note: Sampling Frequency = 3 (not sampling) is the only valid value for HBIPS event measures (HBIPS-2 and 3).

The breakdown of data by month and Medicare / Non-Medicare is:

	April	May	June	Total
Initial Patient Population Medicare patients	10	15	15	**40**
Initial Patient Population Non-Medicare patients	20	30	30	**80**
Total Initial Patient Population Size	**30**	**45**	**45**	**120**
Sample Size Medicare patients	10	15	15	**40**
Sample Size Non-Medicare patients	20	30	30	**80**
Total Sample Size	**30**	**45**	**45**	**120**

The following is transmitted for each month in the quarter:

	April	May	June
Initial Patient Population Size Medicare Only	10	15	15
Initial Patient Population Size Non-Medicare Only	20	30	30
Sampling Frequency (3 = not sampling)	3	3	3
Sample Size Medicare Only	10	15	15
Sample Size Non-Medicare Only	20	30	30

Example 2 Hospital samples monthly
A hospital uses the Initial Patient Population(s) for the ABC measure set to identify 120 cases in the ABC Initial Patient Population during the second quarter. From these 120 cases, the hospital uses the monthly sample size requirements and randomly selects a sample of 26 cases for each month. Data for these 26 cases are collected and used to calculate the hospitals rate for each ABC measure. 40 of the 120 cases in the ABC Initial Patient Population are Medicare patients and 24 of these cases were included in the sample.

Note: *Sampling Frequency* = 1 (sampling data monthly) is not valid for HBIPS event measures (HBIPS-2 and 3).

The breakdown of data by month and Medicare / Non-Medicare is:

	April	May	June	Total
Initial Patient Population Medicare patients	10	15	15	**40**
Initial Patient Population Non-Medicare patients	20	30	30	**80**
Total Initial Patient Population Size	**30**	**45**	**45**	**120**

	April	May	June	Total
Initial Patient Population Medicare patients	10	15	15	**40**
Sample Size Medicare patients	8	9	7	**24**
Sample Size Non-Medicare patients	18	17	19	**54**
Total Sample Size	**26**	**26**	**26**	**78**

The following is transmitted for each month in the quarter:

	April	May	June
Initial Patient Population Size Medicare Only	10	15	15
Initial Patient Population Size Non-Medicare Only	20	30	30
Sampling Frequency (1 = sampling data monthly)	1	1	1
Sample Size Medicare Only	8	9	7
Sample Size Non-Medicare Only	18	17	19

Example 3 Hospital samples quarterly
A hospital uses the Initial Patient Population(s) for the ABC measure set to identify 120 cases in the ABC Initial Patient Population during the second quarter. From these 120 cases, the hospital uses the quarterly sample size requirements and randomly selects a sample of 78 cases. Data for these 78 cases are collected and are then used to calculate the hospitals rate for each ABC measure. 40 of the 120 cases in the ABC Initial Patient Population are Medicare patients and 20 of these cases were included in the sample.

Note: *Sampling Frequency* = 2 (sampling data quarterly) is not valid for HBIPS event measures (HBIPS-2 and 3).

The breakdown of data by month and Medicare / Non-Medicare is:

	April	May	June	Total
Initial Patient Population Medicare patients	10	15	15	**40**
Initial Patient Population Non-Medicare patients	20	30	30	**80**
Total Initial Patient Population Size	**30**	**45**	**45**	**120**
Sample Size Medicare patients	5	10	5	**20**
Sample Size Non-Medicare patients	10	20	28	**58**
Total Sample Size	**15**	**30**	**33**	**78**

The following is transmitted for each month in the quarter:

	April	May	June
Initial Patient Population Size Medicare Only	10	15	15
Initial Patient Population Size Non-Medicare Only	20	30	30
Sampling Frequency (2 = sampling data quarterly)	2	2	2
Sample Size Medicare Only	5	10	5
Sample Size Non-Medicare Only	10	20	28

Example 4 Hospital has five or fewer discharges and chooses not to submit patient level data
Note: This example is only valid for the HBIPS Discharge measures (HBIPS-1, 4, 5, 6, 7, and 8). This is not valid for the HBIPS Event measures (HBIPS-2 and 3) since all data must be submitted for these measures regardless of the number of discharges or events that occur during the quarter.

A hospital uses the Initial Patient Population(s) for the ABC measure set to identify 5 cases in the ABC Initial Patient Population for the entire measure set during the second quarter. Since the total Initial Patient Population for ABC is 5, the hospital chooses to not submit patient level data.

Note: *Sampling Frequency* = 4 (N/A, submission of patient level data is not required) is not valid for HBIPS event measures (HBIPS-2 and 3).

The breakdown of data by month and Medicare / Non-Medicare is:

	April	May	June	Total
Initial Patient Population Medicare patients	1	0	2	**3**
Initial Patient Population Non-Medicare patients	0	1	1	**2**
Total Initial Patient Population Size	**1**	**1**	**3**	**5**
Sample Size Medicare patients	0	0	0	**0**
Sample Size Non-Medicare patients	0	0	0	**0**
Total Sample Size	**0**	**0**	**0**	**0**

The following is transmitted for each month in the quarter:

	April	May	June
Initial Patient Population Size Medicare Only	1	0	2
Initial Patient Population Size Non-Medicare Only	0	1	1
Sampling Frequency (2 = sampling data quarterly)	4	4	4
Sample Size Medicare Only	0	0	0
Sample Size Non-Medicare Only	0	0	0

Example 5 Hospital has five or fewer discharges and chooses to submit patient level data
Note: This example is only valid for the HBIPS Discharge measures (HBIPS-1, 4, 5, 6, 7, and 8). This is not valid for the HBIPS Event measures (HBIPS-2 and 3) since all data must be submitted for these measures regardless of the number of discharges or events that occur during the quarter.

A hospital uses the Initial Patient Population(s) for the ABC measure set to identify 5 cases in the ABC Initial Patient Population for the entire measure set during the second quarter. Even though the total Initial Patient Population for

ABC is 5, the hospital chooses to submit patient level data.

Note: *Sampling Frequency* = 4 (N/A, submission of patient level data is not required) is not valid for HBIPS event measures (e.g., HBIPS-2 and 3).

The breakdown of data by month and Medicare / Non-Medicare is:

	April	May	June	Total
Initial Patient Population Medicare patients	1	0	2	**3**
Initial Patient Population Non-Medicare patients	0	1	1	**2**
Total Initial Patient Population Size	**1**	**1**	**3**	**5**
Sample Size Medicare patients	1	0	2	**3**
Sample Size Non-Medicare patients	0	1	1	**2**
Total Sample Size	**1**	**1**	**3**	**5**

The following is transmitted for each month in the quarter:

	April	May	June
Initial Patient Population Size Medicare Only	1	0	2
Initial Patient Population Size Non-Medicare Only	0	1	1
Sampling Frequency (2 = sampling data quarterly)	3	3	3
Sample Size Medicare Only	1	0	2
Sample Size Non-Medicare Only	0	1	1

The Joint Commission National Quality Core Measures

Data Transmission

Introduction

This section of the manual is provided to highlight the unique data transmission specifications for The Joint Commission national quality core measure data.

This section is divided into four parts: National Quality Core Measure Data Transmission, Guidelines for Submission of Data, Transmission Alphabetical Data Dictionary, and Transmission Data Processing Flows.

The Data Transmission section provides information related to the transmission of national quality core measure data to the Joint Commissions Data Warehouse.

The Guidelines for Submission of Data includes an overview of the data required to be submitted to the Joint Commissions Data Warehouse, as well as the Hospital Clinical Data XML file layout and the Hospital Initial Patient Population Data XML file Layout.

The Transmission Alphabetical Data Dictionary describes the data elements that are either used to identify the hospital and measure set associated to the transmitted data or are calculated by the vendor using the hospitals patient-level data and measure results. These data elements are not used in the Initial Patient Population Algorithms or Measure Algorithms.

The Transmission Data Processing Flows contain information regarding the order in which the Joint Commissions Data Warehouse evaluates the national hospital quality measures and the associated population and sampling data. In addition, it highlights the decision points as to when cases are rejected from the warehouse. Refer to the Edit Message documents located on The Joint Commission PET, in Manuals and Guides tab, Data Transmission Technical Documentation page, Hospital Clinical Data (HCD) link for a complete listing of all critical and informational edits.

The Joint Commission National Quality Core Measure Data Transmission

Overview

The Joint Commission requires two different data transmissions related to the national quality core measure data. All of these transmissions are submitted by ORYX® Vendors and follow the same data transmission schedule used to submit ORYX data to The Joint Commission. The most significant items related to the transmission of national quality core measure data are listed here, but this is not an exhaustive list. Refer to the appropriate documents as detailed below for more information.

Download File Layouts

- Download Hospital Clinical Data XML File Layout (MS Excel)
- Download ICD Population XML File Layout (MS Excel)

Hospital Initial Patient Population Data

The Joint Commission collects Initial Patient Population and sampling information by *Measure Set*. This data is required to be submitted to The Joint Commission on a quarterly basis. All Initial Patient Population and sampling data will be submitted in an XML file that adheres to the *Hospital Initial Patient Population Data XML File Layout* specifications and guidelines provided later in this section. Each file may contain data for only one provider.

Hospital Clinical Data

Hospital clinical data is required to be submitted to The Joint Commission no less than on a quarterly basis. All patient-level data submitted to The Joint Commission must adhere to the *Hospital Clinical Data XML File Layout* specifications and guidelines provided later in this section. The hospital clinical data submitted to The Joint

Commission is anonymous because no direct patient identifiers are included in the *Hospital Clinical Data XML File*.

Each case must have a separate XML file. For example, if 12 records have been abstracted, there must be 12 separate XML files. If a patient has also been sampled for a different national hospital quality measure set, then a separate XML file must be created for the additional measure set. Each measure set can only be abstracted once for the same medical record. Refer to the applicable version of the *Specifications Manual for National Hospital Inpatient Quality Measures* for information on how to create and transmit the data for the other measure sets which are not presented in The Joint Commission Only Manual such as STK, ED.

Each HBIPS discharge case and event case must have a separate XML file. For example:
Example #1: During the quarter, 10 patients are discharged (*Discharge Date*) and no restraint or seclusion events occurred for any patient (not just those discharged). Ten (10) separate XML files are created and transmitted, one for each discharged patient.

Example #2: During the quarter, no patients are discharged (*Discharge Date*) and 4 unique patients have restraint or seclusion events for a total of 11 events. Eleven (11) separate XML files are created and transmitted, one for each event (*Event Date*). Multiple events (*Event Date*) for a patient **cannot** be combined into one XML file. If the same patient is restrained and seclude (*Event Type*) on the same day (*Event Date*), the two events must be transmitted in separate XML files.

Example #3: During the quarter, 1 patient is discharged (*Discharge Date*) and 1 unique patient has a restraint event and a seclusion event (*Event Date*) for a total of 2 events. The patient with the events is the same patient that was discharged. Three (3) separate XML files are created and transmitted, one for the patients discharge information (*Discharge Date*) and one for each event (*Event Date and Event Type*). A patients discharge information and event information **cannot** be combined into the same XML file.

Additional information:

For more information concerning the *Performance Measurement System Identifier*, refer to the *ORYX Technical Implementation Guide* . For more information concerning the *Vendor Tracking ID* and *Health Care Organization Identifier*, refer to the Transmission Alpha Data Dictionary in this manual.

- **Unique Key Identifier for Discharge Measures (e.g., HBIPS-1, PC-01)**:
  - *Performance Measurement System Identifier* - not part of the file, captured at the point the file is uploaded to The Joint Commission
  - *Vendor Tracking ID* - fictitious identifier generated by the measurement system to differentiate between individual patient records from each hospital
  - *Admission Date*
  - *Discharge Date*
  - *Measure Set*
  - *Health Care Organization Identifier*

- **Unique Key Identifier for Event Measures (e.g., HBIPS-2 and HBIPS-3)**:
  - *Performance Measurement System Identifier* - not part of the file, captured at the point the file is uploaded to The Joint Commission
  - *Vendor Tracking ID* - fictitious identifier generated by the ORYX Vendor to differentiate between individual patient records from each hospital
  - *Admission Date*
  - *Event Date*
  - *Event Type*
  - *Measure Set*
  - *Health Care Organization Identifier*

- **Transaction Processing:** Data can be added, replaced, and deleted during the current reporting quarter using the Action-Code in the XML file. In order to replace or delete an existing file at The Joint Commission, the files must match on the unique key data elements as defined above. In order to update a key element in an existing file, the file must be deleted and a new file must be submitted. If the element to update is not a key element,

then the file can be resubmitted using the Add Action-Code; there is no need to delete the file first as long as the file matches on the unique key data elements.

- **Measure Selection:** Data that passes all edits and contains all data required to calculate the measures will be accepted as long as the hospital (identified by the *Health Care Organization Identifier*) has selected the measure set for the reporting quarter with the ORYX Vendor that is submitting the data.

- **Sample:** All EOC and event records included in the sample, or if the hospital is not sampling the Initial Patient Population, must be transmitted to The Joint Commission. This is true regardless of whether or not any measure for the record calculates to a *Measure Category Assignment* = X. **Note** the HBIPS event measures (HBIPS-2 and 3) do not allow sampling, all data in the Initial Patient Population of these two measures must be transmitted.

- **Data Elements Not Accepted by The Joint Commission:** The following data elements may be transmitted to the Centers for Medicare and Medicaid Services (CMS) for the aligned national hospital quality measures but cannot be transmitted to The Joint Commission for any measure because the data transmitted to The Joint Commission are anonymous. For information concerning these data elements, refer to the applicable version of the *Specifications Manual for National Hospital Inpatient Quality Measures*. Files transmitted to The Joint Commission that contain the following data will be rejected:
  - *Patient Identifier*
  - *Patient HIC #*
  - *First Name*
  - *Last Name*
  - *Postal Code*

- **Data Elements Required by The Joint Commission:** In order to support the Joint Commissions data quality analysis and continuous measure verification process the following data elements are required to be transmitted for each measure in the measure set.
  - *Measure Category Assignment*
  - *Measurement Value* (Note: Currently there is no active Continuous Variable measure in The Joint Commission Manual that uses this data element)
  - *Predicted Value*
  - *Vendor Tracking ID*

    Note *Vendor Tracking ID* is a fictitious identifier that is generated by the ORYX Vendor to differentiate between individual patient records from each hospital because the Joint Commissions data are blinded as to whom the patient is. *Vendor Tracking ID* data element is used to transmit this fictitious identifier. This identifier is unique to a patient.

- **For each patient episode of care the following patient identifiers should match for each *Measure Set* that is submitted for Discharge Measures (e.g., HBIPS-1, PC-01).**
  - *Vendor Tracking ID*
  - *Admission Date*
  - *Discharge Date*
  - *Birthdate*
  - *Health Care Organization Identifier*

    For example, if the hospital submits a separate XML file for AMI, PC, HBIPS, and TOB, the above identifiers should be the same in each of the discharge XML files.

- **For HBIPS records, if the patient has multiple events(e.g., HBIPS-2 and HBIPS-3), the following patient identifiers should match for each event record transmitted.**
  - *Vendor Tracking ID*
  - *Admission Date*
  - *Birthdate*

- *Health Care Organization Identifier*

  In addition, the discharge record must also be transmitted with the same identifiers.

- **HBIPS Specific Data Elements Not Accepted by The Joint Commission As Part of HCD:** The following data elements will not be transmitted to The Joint Commission in the Hospital Clinical Data (HCD) file. These data are aggregated at the hospital level and are not patient specific data. Files transmitted to The Joint Commission that contain the following data will be rejected:
  - *Psychiatric Inpatient Days - Medicare Only*
  - *Psychiatric Inpatient Days - Non-Medicare Only*
  - *Total Leave Days - Medicare Only*
  - *Total Leave Days - Non-Medicare Only*

Data Re-transmission

- The Joint Commission acknowledges that it is appropriate to allow ORYX data to be updated. We are interested in assuring the best possible data quality, especially in light of public reporting. With each regularly scheduled transmission deadline, we routinely accept retransmission of up to four quarters of Hospital Clinical data (HCD) and Population and Sampling data (PaS). In addition, we accept retransmission of up to four quarters of aggregate non-core measure data. The purposes of the accepting the retransmitted data is to update the data for the ORYX Performance Measure Reports, national comparison group data, and the health care organization Quality Report postings. These retransmitted data may be inclusive of updated data previously submitted and/or data that may have been erroneously omitted.

  ORYX Vendors are required to correct their recognized data integrity issues and retransmit up to four quarters of updated HCD and PaS data for national quality core measures and aggregate non-core measure data by the next regularly scheduled quarterly transmission deadline. Retransmission of corrected data from issues emanating at the client health care organization-level is encouraged whenever feasible. It is the responsibility of the ORYX Vendor to notify their clients that updated data were retransmitted to The Joint Commission, and that the subsequent Quality Report posting and future ORYX Performance Measure Reports will reflect these data. It is important to note, these retransmitted data will refresh the *following quarters* ORYX Performance Measure Reports and Quality Report (core only), and update the national comparison group rates (core only).

  Refer to the ORYX Performance Measurement System Agreement, ORYX Data Retransmission Process, for further details and associated fees that apply. ORYX Vendor inquires related to the retransmission of ORYX data should be directed to http://manual.jointcommission.org.

Information The Joint Commission Provides To Core ORYX Vendors

Risk Adjustment: The Joint Commission will provide ORYX Vendors with risk adjustment model information for the active national quality core measures (e.g., PC) that require risk adjustment. ORYX Vendors must apply the risk model information to their patient-level data. Additional specifics include:

- ORYX Vendors will have access to current national quality core measure risk model information files through the Performance Measurement System Extranet Track (PET).
- Details related to the risk model information file, its usage by ORYX Vendors and a list of significant risk factors are provided in the *ORYX Risk Adjustment Guide*. This guide is available to the public on the Joint Commissions website and, in addition, it is available to ORYX Vendors via the Joint Commissions extranet site for ORYX Vendors (PET).
- National quality core measure risk models must not be used for any purposes other than calculating risk-adjusted data elements.
- For assistance with the national quality core measure risk model information, please contact the ORYX statistical support staff at http://manual.jointcommission.org and click on Statistical Support.

National Comparison Group: The Joint Commission will provide ORYX Vendors participating in the ORYX national

quality core measure initiative with national comparison group data. ORYX Vendors may use this information to prepare feedback reports for client organizations. Additional details in regard to this process include:

- ORYX Vendors will have access to national comparison group data through the Performance Measurement System Extranet Track (PET).
- Refer to the *ORYX Data Quality Manual* for the list of national comparison group data elements, how ORYX Vendors may utilize this data, and related information.
- For assistance with the national quality core measure national comparison group, please contact the ORYX statistical support staff at http://manual.jointcommission.org and click on Statistical Support.

Joint Commission Guidelines for Submission of Data

Overview

The below guidelines are for the submission of Hospital Clinical Data and Hospital Initial Patient Population Data to The Joint Commission. Additionally, for the Joint Commissions Hospital Clinical Data Edit and Algorithm Error Feedback Messages, please refer to the Joint Commissions extranet for measurement systems (PET).

- Error Messages provide feedback regarding submitted data, file structure and data integrity that either cause the case to be rejected from the warehouse (Critical) or ask for further verification (Informational). Cases with any critical error messages will not be processed or stored in the warehouse. For cases to be accepted into the warehouse all critical errors must be corrected and the case resubmitted. Informational errors are feedback that warn of potential issues and ask for verification. Cases that receive no error messages or that receive informational messages only will be processed as per the measure algorithm.
- Missing Messages are critical edits that will cause the case to be rejected from the warehouse due to missing data, as per the measure algorithms, resulting in a measure outcome of X (Data are Missing).
- Measure Messages provide feedback related to the outcome of the case, as per the measure algorithm, resulting in any other measure outcome, i.e., B (Not in Measure Population/Excluded), D (In Measure Population/Failed), E (In Numerator Population/Passed), or Y (Unable to Determine Allowable Value Does Not Allow Calculation of the Measure/UTD).

Joint Commission Guidelines for Submission of Hospital Clinical Data

Minimum Data Requirements Prior to processing measure outcomes all data will be verified according to the rules in the data transmission section and the Feedback Messages documents. Cases submitted to the the Joint Commission’s Data Warehouse that does not meet the requirements outlined in these documents will be rejected.

Allowable Measure Set Combination per Patient Episode of Care A patient episode of care might be qualified to be submitted for multiple measure sets. However, the population definition of the measure sets dictate which measure sets combination is possible and they could be reported for a single episode of care and which combination of measure sets are not possible and therefore are not allowed to be submitted for the same episode of care. 'TJC Allowable Measure Set Combinations' file provides guidance on allowable Measure Set combinations that are acceptable into The Joint Commission’s Data Warehouse. Refer to TJC Allowable Measure Set Combinations file for further guidance.

- Download TJC_Allowable_Measure_Sets_Combination (MS Excel)

Requirements for XML Tags and Associated Data
Do not put spaces between XML tags and associated data. Cases with inappropriate spaces will be rejected from the Joint Commission’s Data Warehouse.

Export File Character Limitations
ORYX Vendors should refer to the ORYX Technical Implementation Guide for guidelines related to file naming for submission of data to the Joint Commission’s Data Warehouse.

Missing Data Policy
All cases submitted to The Joint Commission’s Data Warehouse must have all data required to calculate the

measures. Files submitted which are missing data required to calculate measures (any case that would result in a Measure Category “X” assignment) will be rejected. These cases should be reviewed by the provider and resubmitted with an allowable value indicated for any data element that was missing. Please refer to the Missing and Invalid Data Section for additional information.

* If the abstractor, after due diligence, is not able to determine an answer, a value of “UTD” must be selected for the applicable data element. This includes ICD-10-PCS Principal Procedure Date and ICD-10-PCS Other Procedure Dates, which are required data elements if ICD-10-PCS Principal Procedure Code and ICD-10-PCS Other Procedure Codes are submitted for the case. Please see the data element definitions for further details on allowable values. If the case is missing the corresponding allowable answer value, the case will be rejected from the Joint Commission’s Data Warehouse.

Data Elements Not Accepted by The Joint Commission
The following data elements are transmitted to CMS, but cannot be transmitted to The Joint Commission. Files transmitted to The Joint Commission that contain the following data will be rejected:

- Patient HIC #
- Patient Identifier
- First Name
- Last Name
- Postal Code

Data Elements Required by the Joint Commission In order to support the Joint Commission’s data quality analysis and continuous measure verification process the following data elements are required to be transmitted for each measure in the measure set.

- Measure Category Assignment
- Measurement Value (Note: Currently there is no active Continuous Variable measure which uses this data element)
- Predicted Value

Unique Record Key (What fields make a record unique?)

Discharge Measures: Performance Measurement System Identifier , Vendor Tracking Identifier , Admission Date , Discharge Date , Health Care Organization Identifier , and Measure Set

For each patient episode of care the following patient identifiers should match for each Measure Set that is submitted for Discharge Measures (e.g., HBIPS-1, PC-01). For example, if the hospital submits a separate XML file for AMI, PC, HBIPS, and TOB, the above identifiers should be the same in each of the discharge XML files.

1. Vendor Tracking ID
2. Admission Date
3. Discharge Date
4. Birthdate
5. Health Care Organization Identifier

For Event Measures: Performance Measurement System Identifier , Vendor Tracking Identifier , Admission Date , Event Date , Event Type , Health Care Organization Identifier , and Measure Set

For HBIPS records, if the patient has multiple events (e.g., HBIPS-2 and HBIPS-3), the following patient identifiers should match for each event record transmitted. In addition, the discharge record must also be transmitted with the same identifiers.

1. Vendor Tracking ID
2. Admission Date
3. Birthdate
4. Health Care Organization Identifier

Refer to the Transmission Alpha Data Dictionary for more information concerning the Vendor Tracking ID and Health Care Organization Identifier.

Note: Refer to the ORYX Technical Implementation Guide for more information concerning the Performance Measurement System Identifier.

Principal and Other Diagnosis and Procedure Codes Effective March 1, 2007, The National Uniform Billing Committee has implemented a Present on Admission indicator for Principal and Other Diagnosis codes. Data submitted to the Joint Commission's Data Warehouse must have the Present on Admission Indicator removed prior to submission. Failure to remove the indicator will result in cases being rejected from both warehouses.

Patient-Level Clinical Data XML File Layout
The XML File Layout is divided into the following five main sections (Please refer to Hospital Clinical Data XML File Layout for details).

Submission

1. Type – Describes the setting for which the data is being collected (Hospital)
2. Data – Describes the type of data being submitted (Clinical).
3. Version – Describes the version of the XML file layout.
4. Action-Code – Describes the action intended with the submission of the file. Options include:
    a. Add (applicable to a file submitted for the first time for the hospital/time period or to a file being submitted as an update/replacement of an existing file already submitted for a provider).
    b. Delete (utilize when the file is submitted for the purpose of deleting a file already submitted to the Joint Commission's Data Warehouse.)

Note: In order to replace or delete an existing file utilizing the Add or Delete action codes, the files must match on the following fields in the Joint Commission's Data Warehouse: Performance Measurement System Identifier*, Vendor Tracking ID, Admission Date, Discharge Date, Measure Set, and Health Care Organization Identifier.

File Audit Data
Note: This section is not required

1. Create-Date – Indicates the date the file was created.
2. Create-Time – Indicates the time the file was created.
3. Create-By – Indicates who created the file.
4. Version – Indicates the version of the file being submitted.
5. Create-by-Tool – Indicates the software tool utilized to create the file.

Abstraction Audit Data
Note: This section is not required

1. Abstraction-Date – Indicates the date the file was abstracted.
2. Abstractor-id – Indicates the person who abstracted the file.
3. Total-Abstraction-Time – Indicates the time required to abstract the file (in seconds).
4. Comments – Area for entry of any comments regarding the abstraction.

Provider
Data elements in this section of the XML file relate to Provider identification. These data elements include:

1. CMS Certification Number - Hospital's six digit acute CMS Certification Number (CCN), which is allowed and is optional for The Joint Commission.
2. NPI - National Provider Identifier as assigned by CMS, optional for The Joint Commission.
3. HCOID - Identifies the healthcare organization that is accredited by The Joint Commission and is required as a key element of the patient file for The Joint Commission.

Patient

Data elements in this section of the XML file relate to patient demographic information such as Birthdate and Sex. For algorithms that calculate the patient age, Admission Date minus the Birthdate, use the month and day portion of admission date and birthdate to yield the most accurate age. The traditional approach of counting months or years by the birthday date or the first day of the next month, when the exact date does not exist in the calendar for the end point, must be used when calculating the patient age. For example, if calculating the age by year, a patient born on March 31st turns one year older on March 31st. A patient born on February 29th, in a leap year, has a birthday on February 29th on all leap years, and March 1st in all non-leap years. Or if calculating age by month, if a patient is born on March 31st the patient turns 6 months on October 1st and not on September 30th. Since the date 31 does not exist in September, you would move to the first day of the next month, which would be October 1st, to add one month to the patient age.

Episode of Care

Data in this section of the XML file relate to the acute inpatient stay and clinical data associated with the stay. Examples of associated data elements include:

1. Admission Date
2. Discharge Date (discharge measures)
3. Event Date (event measures)
4. Event Type (event measures)
5. Vendor Tracking Identifier
6. Measure Set
7. Clinical Questions and answer codes

The Joint Commission

Data in this section of the XML file support the Joint Commission's data quality analysis and continuous measure verification process of ORYX Vendors. The following data elements are required to be transmitted to The Joint Commission for each measure in the measure set.

1. Measure Category Assignment
2. Measurement Value (Note: Currently there is no active Continuous Variable measure which uses this data element)
3. Predicted Value

Please refer to the data dictionary for further definition of these data elements.

Abstraction Software Skip Logic and Missing Data

Skip logic allows hospitals and vendors to minimize abstraction burden by using vendor software edit logic to bypass abstraction of data elements not utilized in the measure algorithm. However, these bypassed elements also negatively impact data quality when elements are incorrectly abstracted and subsequent data elements are bypassed and left blank.

The use of skip logic by hospitals and ORYX vendors is optional and not required by The Joint Commission. Hospitals should be aware the potential impact of skip logic on data quality and abstraction burden. Vendors and hospitals utilizing skip logic should closely monitor the accuracy rate of abstracted data elements, particularly data elements placed higher in the algorithm flow.

Joint Commission Guidelines for Submission of Hospital Initial Patient Population Data

Hospitals must submit to The Joint Commission on a quarterly basis the aggregate population and sample counts for Medicare and non-Medicare discharges for each of the measure sets. If the aggregate population count is zero, the hospital is still required to submit the Hospital Initial Inpatient Population Data file and would submit zero as the population and sample counts. In addition, The Hospital Initial Inpatient Population Data file must be transmitted to the Joint Commission's Data Warehouse even if the hospital has elected to not report the patient data for the Discharge measures (e.g., HBIPS1, 4, PC-01) when they have five or fewer cases for an appropriate measure set during the quarter.

Hospital Initial Patient Population Data XML File Layout

The XML File Layout is divided into the following five main sections (Please refer to Hospital Initial Patient Population Data XML File Layout for details).

Submission

1. Type Describes the setting for which the data is being collected (Hospital)
2. Data Describes the type of data being submitted (Population).
3. Version Describes the version of the XML file layout.
4. Action-Code Describes the action intended with the submission of the file. The Add action-code is required for all initial patient population files submitted.

Note: In order to replace an existing file at the utilizing the Add action code, the files must match on:
Health Care Organization ID, Time-Period and Measure-Set
In order to replace an existing file all XML tags must be present, however, only the XML tags mentioned above (Health Care Organization ID, Time-Period, and Measure-Set) need to be submitted with values.

File Audit Data

Note: This section is not required

1. Create-Date Indicates the date the file was created.
2. Create-Time Indicates the time the file was created.
3. Create-By Indicates who created the file.
4. Version Indicates the version of the file being submitted.
5. Create-by-Tool Indicates the software tool utilized to create the file.

Provider Data

Data elements in this section of the XML file relate to Provider identification. These data elements include:

1. *Provider-Id* - Hospital's six digit acute care CMS Certification Number (CCN), which is allowed and it's optional for The Joint Commission.
2. *NPI* - National Provider Identifier as assigned by CMS, and is optional for The Joint Commission.
3. *HCOID* - Identifies the healthcare organization that is accredited by The Joint Commission and is required as a key element of the patient file.

Time Period

Time-Period- Dates in this field should reflect the discharge time period related to the data being submitted. Time period start and end dates must reflect full month increments, and may not be greater than one month. Files submitted to the Joint Commissions Data Warehouse are required to contain a three monthly time periods which comprise the calendar quarter for which data is being submitted.
Example: If the Hospital Initial Patient Population File is being submitted for fourth quarter 2008, the file must contain the following time periods and appropriate associated data (including all data elements is the Population Details section that follows):
October 2008
November 2008
December 2008

Files submitted with time periods that do not meet the above requirements will be rejected from the Joint Commissions Data Warehouse.

Population Details

1. Measure-Set Indicates the Measure Set for which the data is being submitted.
2. Stratum Indicates the stratum (e.g., HBIPS) or sub-population (e.g., PC) related to the data being submitted.

Additional data elements include *Initial Patient Population Size Medicare, Initial Patient Population Size Non-Medicare, Sampling Frequency, Sample Size Medicare, and Sample Size Non-Medicare*. Please refer to the Transmission Data Dictionary for further definition of these data elements. Please refer to Hospital Initial Patient Population Data XML File Layout for further information on details of the XML file format. All data elements are based on discharges or events that occurred during the associated time period.

Transmission Alphabetical Data Dictionary

These data elements are either used to identify the hospital and measure set associated to the transmitted data or are calculated by the vendor using the hospitals patient-level data and measure results. These data elements are not used in the Initial Patient Population Algorithms or Measure Algorithms.

Data Element Name	Collected For
CMS Certification Number	Hospital Clinical Data File, Optional for All Records
Health Care Organization Identifier	All Records, Patient Population Data File, Hospital Clinical Data File
Initial Patient Population Size Medicare Only	Transmission, Patient Population Data File
Initial Patient Population Size Non-Medicare Only	Transmission, Patient Population Data File
Measure Set	Transmission, Patient Population Data File, Hospital Clinical Data File
Measurement Value	Calculation, Transmission, Hospital Clinical Data File
National Provider Identifier	Transmission
Predicted Value	Transmission, Risk Adjustment, Hospital Clinical Data File
Sample	Transmission, Hospital Clinical Data File
Sample Size Medicare Only	Transmission, Patient Population Data File
Sample Size Non-Medicare Only	Transmission, Patient Population Data File
Sampling Frequency	Transmission, Patient Population Data File
Vendor Tracking Identifier	Transmission, Hospital Clinical Data File

Go to: Alphabetical List of all Data Elements

Transmission Data Processing Flow: Clinical

Introduction

This section contains information regarding the order in which the Joint Commissions Data Warehouse evaluates the Joint Commission national quality core measures.

The transmission data processing flow ensures that only valid data are used in the measure algorithms. Each case that is rejected by the process will be listed on a report along with a brief description of the problem. Vendors will access the Joint Commission's HCD Report via the Performance Measurement System Extranet Track (PET).

Transmission Data Processing Flow for The Joint Commission

Note: HBIPS contains two Initial Patient Populations, discharges and events. Discharge information and event information are transmitted in separate XML files. All events of the same type occurring on the same day are transmitted in one XML file. However, different types of events occurring on the same day are transmitted in separate XML files. PC measure set contains 3 sub-populations, PC-Mother, PC-BSI and PC-Breast Feeding sub-populations. Each PC Mother case needs to be reported in one xml file, and each PC-Baby case needs to be reported in one xml. If the PC-Baby case belongs to both Baby-BSI and Baby Breast Feeding sub-populations and is sampled for Baby-Breast Feeding, it should report both PC-04 and PC-05 measures in the same xml file.

All data transmitted pass through the following process:

1. If appropriate, files are verified to be proper zip and XML files.
    - If the files are invalid, reject the file(s) and stop processing.
    - If the files are valid, continue processing.

2. The data are verified that no unexpected protected health information (PHI) (e.g., Patient HIC#, and Postal Code) is present.
    - If unexpected PHI exists, reject the file(s) and stop processing.
    - If **no** unexpected PHI exists, continue processing.

    Starting with this step, processing is per case (individual XML file):
3. Data are evaluated to ensure the quarter associated to the *Discharge Date* or *Event Date* is open for data transmission.
    - If the Data Collection quarter is closed, reject the XML file and stop processing.
    - If the Data Collection quarter is open, continue processing.

4. Data are evaluated to ensure the *Measure Set* is expected from the submitter for the time frame (*Discharge Date* or *Event Date*) and the *Healthcare Organization Identifier* in question.
    - If the data are not expected, reject the XML file and stop processing.
    - If the data are expected, continue processing.

5. Check the action-code
    - If the action-code = ADD, continue with step #6.
    - If the action-code = DELETE, continue with step #14.

6. The general data elements, as defined in the Introduction to the Data Dictionary section, are evaluated to ensure they exist and contain valid allowable values. The HBIPS measure set is unique in that it has three different groups of general data elements. The first group is "general" for all measures in the set. The second group is only "general" for the HBIPS discharge measures. The third group is only "general" for the HBIPS event measures.

    In addition, HBIPS data elements may be "measure set specific" for one type of HBIPS measure and "general"

for the other type. For example, *Psychiatric Care Setting* is a "measure set specific" data element for the discharge measures and a "general" data element for the event measures. See #8 for information concerning the processing of "measure set specific" data elements.
    - If any general data elements fall outside of the data integrity checks, reject the XML file and stop processing.
    - If any general data element is missing or invalid, reject the XML file and stop processing.
    - If all general data elements exist and contain valid allowable values, continue processing.

7. The Initial Patient Population Algorithm associated to the *Measure Set* is evaluated to ensure that the data is in the population of the set. Refer to the appropriate *Measure Set* Data Element List for the algorithm.
    - If the Initial Patient Population Algorithm returns an **Initial Patient Population Reject Case Flag** = Yes (case is not in the Initial Patient Population), reject the XML file and stop processing.
    - If the Initial Patient Population Algorithm returns an **Initial Patient Population Reject Case Flag** = No (case is in the Initial Patient Population), continue processing.

8. The *Measure Set* specific data elements are evaluated to ensure they contain valid allowable values. This step does not evaluate for missing data because that is performed by the measure algorithms.
    - If any measure set specific data elements fall outside of the data integrity checks, reject the XML file and stop processing.
    - If any measure set specific data elements are invalid, reject the XML file and stop processing.
    - If all measure set specific data elements contain valid allowable values, continue processing.

9. If appropriate for the *Measure Set*, grid data elements are evaluated to ensure each row does not contain missing data. This step does not ensure that the entire grid is empty because that evaluation is performed by the measure algorithms.
    - If any row of the grid is missing data, reject the XML file and stop processing.
    - If the grid is empty or all data elements exist in each row, continue processing.

10. Each XML file is evaluated for unexpected data. While a case may be in the population of more than one measure set, each XML file is associated to only one set.
    - If any data exists that is not expected for the *Measure Set*, reject the XML file and stop processing.
    - If no unexpected data for the *Measure Set* exists, continue processing.

11. Each XML file is evaluated to ensure that it and existing data in the database for the patient does not create an incorrect measure set combinations. For example if *Measure Set* = HBIPS for a patient less than 18 years old and a record for the same patient has previously been accepted by the Warehouse for the *Measure Set* of STK or AMI, then the new record will create an incorrect measure set combination. Refer to the Joint Commission Guidelines for Submission of Data in the Data Transmission section, for list of invalid measure set combinations.
    - If this record will create an incorrect measure set combination, reject the XML file and stop processing.
    - If this record will not create an incorrect measure set combination, continue processing.

12. Execute each measure algorithm associated to the measures the hospital has selected for the *Measure Set*. Refer to the appropriate Measure Information Forms for the *Measure Set* for the measure algorithms.
    - If any measure evaluates with a *Measure Category Assignment* = X, reject the XML file and stop processing.
    - If all measures evaluate with *Measure Category Assignments* = B, D, E, "U", and/or Y, continue processing.

13. The case is accepted into the Joint Commissions Data Warehouse. If any of the measures in the measure set are Risk Adjusted:
    - If yes, then execute the measure risk model on xml file and then stop processing.
    - If no, stop processing.

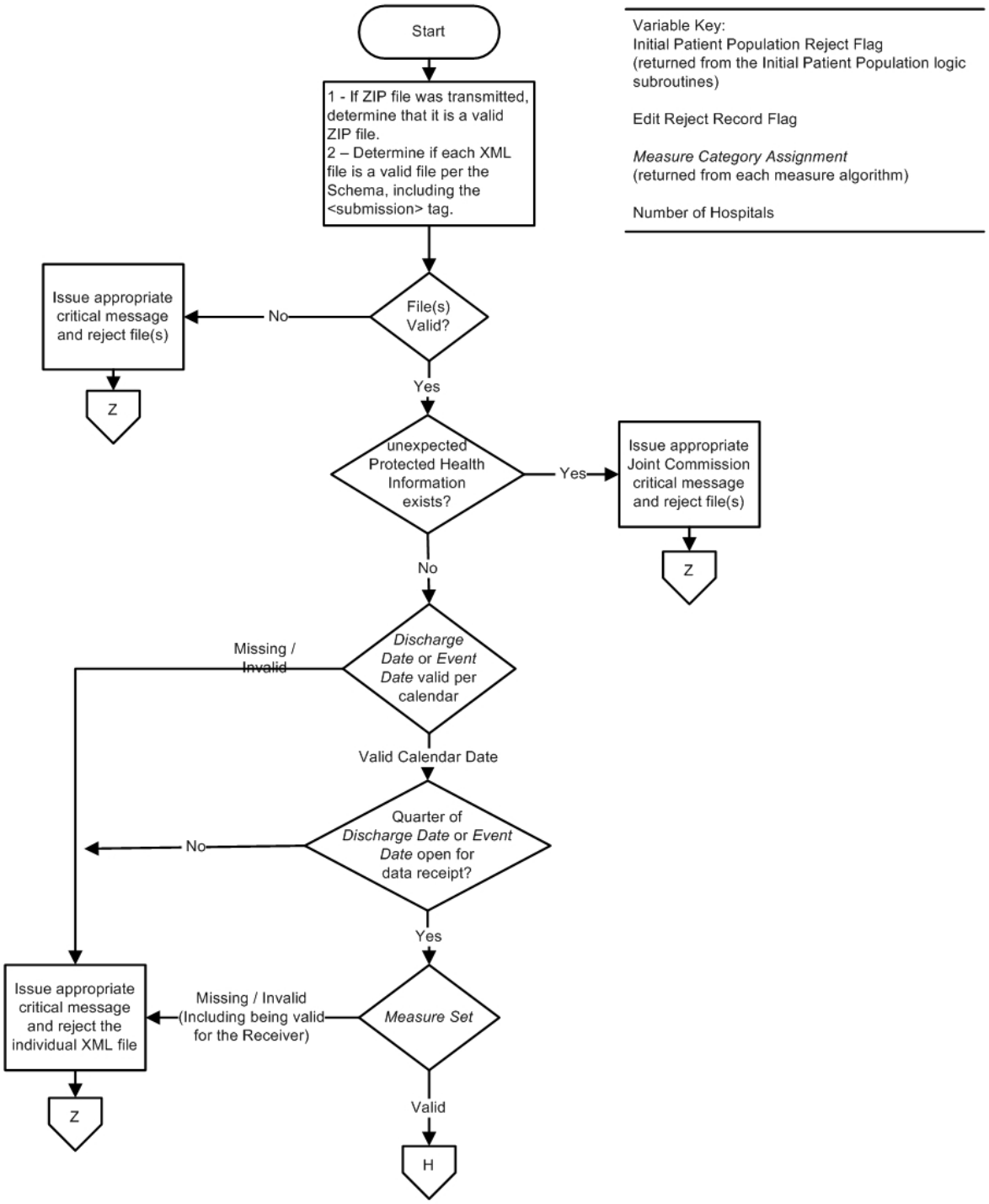
The following steps are performed if the records action-code = DELETE:

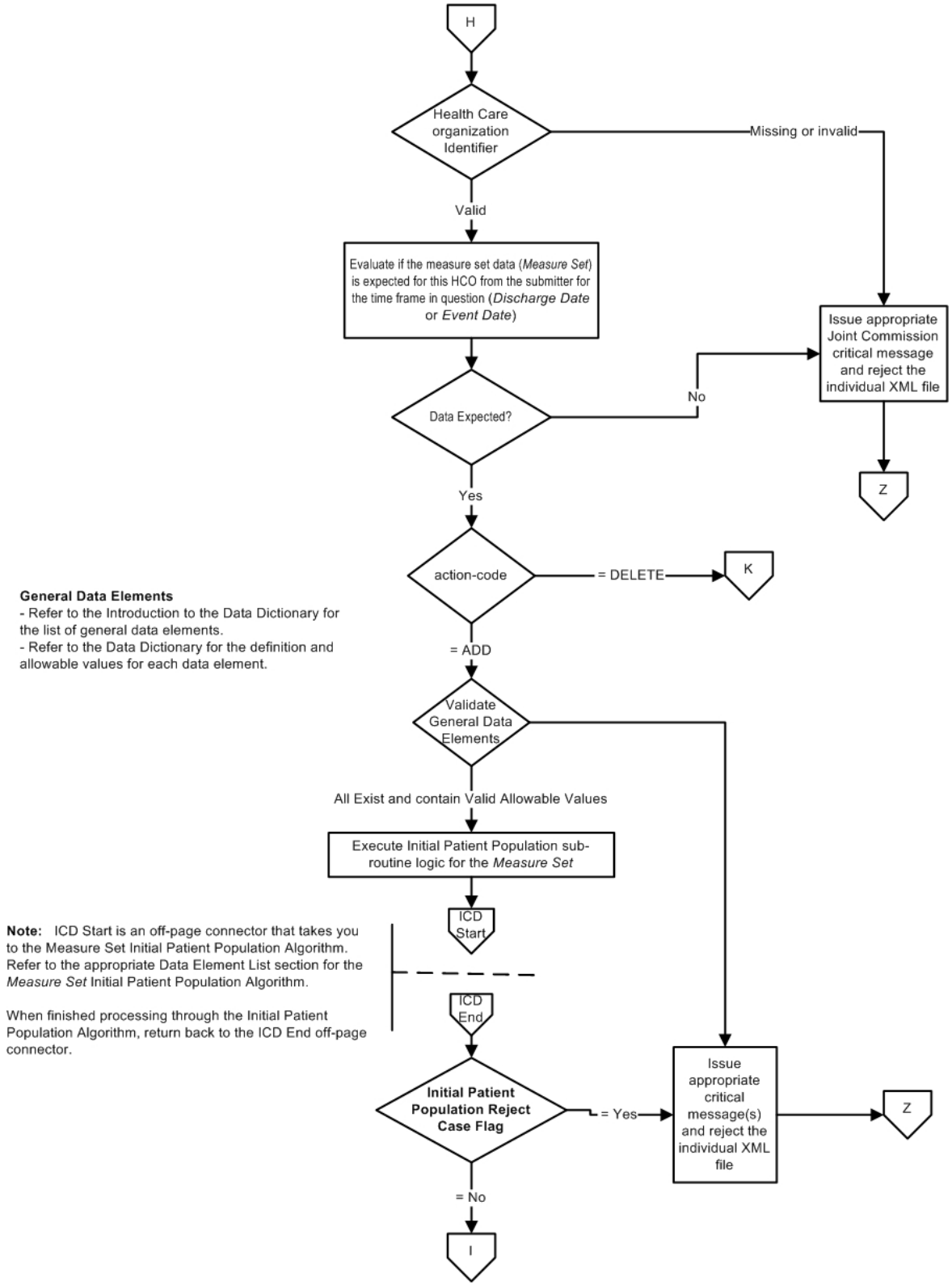
14. The remaining data elements that are part of the Unique Record Key, as defined in the Joint Commission Guidelines for Submission of Hospital Clinical Data in the Data Transmission section, are evaluated to ensure they exist and contain valid allowable values. These data elements are required for all *Measure Sets*.
    - If any Unique Record Key data element is missing or invalid, reject the XML file and stop processing.
    - If all Unique Record Key data elements exist and contain valid allowable values, continue processing.

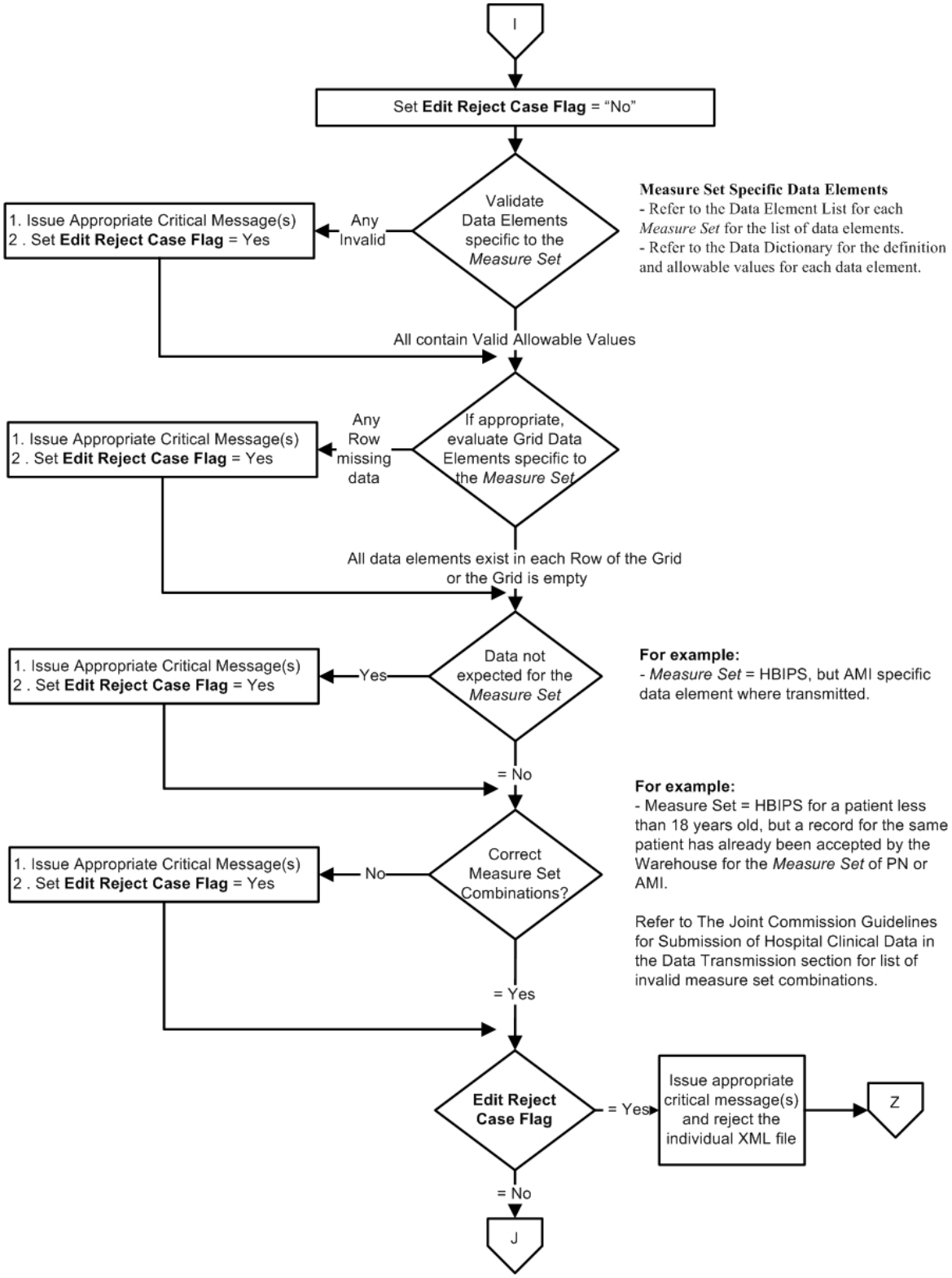
15. The database is checked to see if a record with the same Unique Record Key already exists.
    - If the case does not already exist in the database, then the transmitted DELETE record is rejected.
    - If the record already exists in the database, it is deleted.

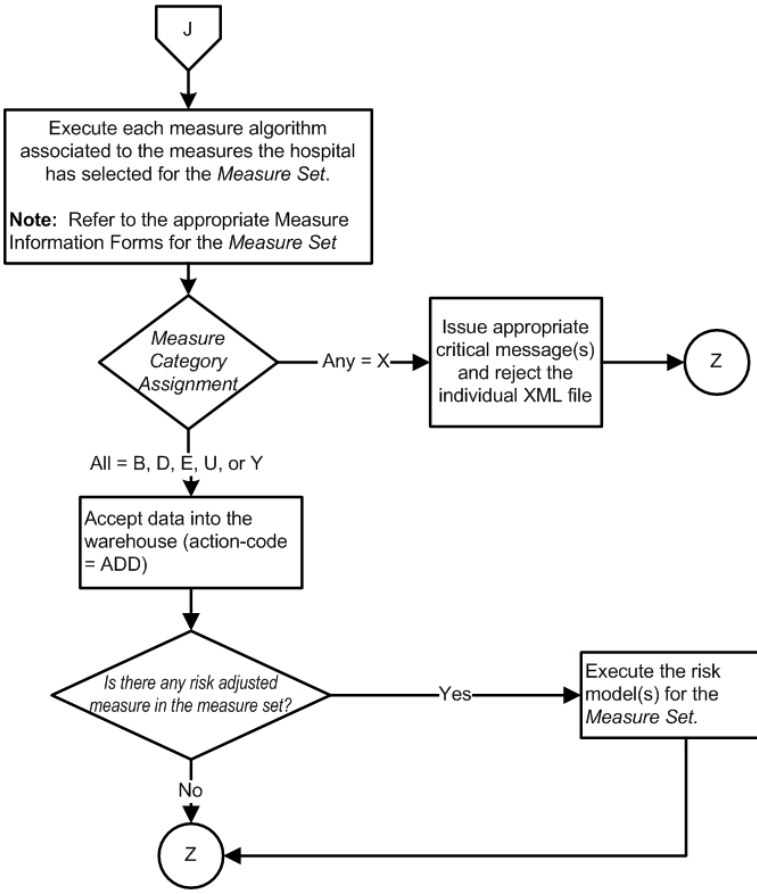
Transmission Data Processing Flow: Clinical Algorithm

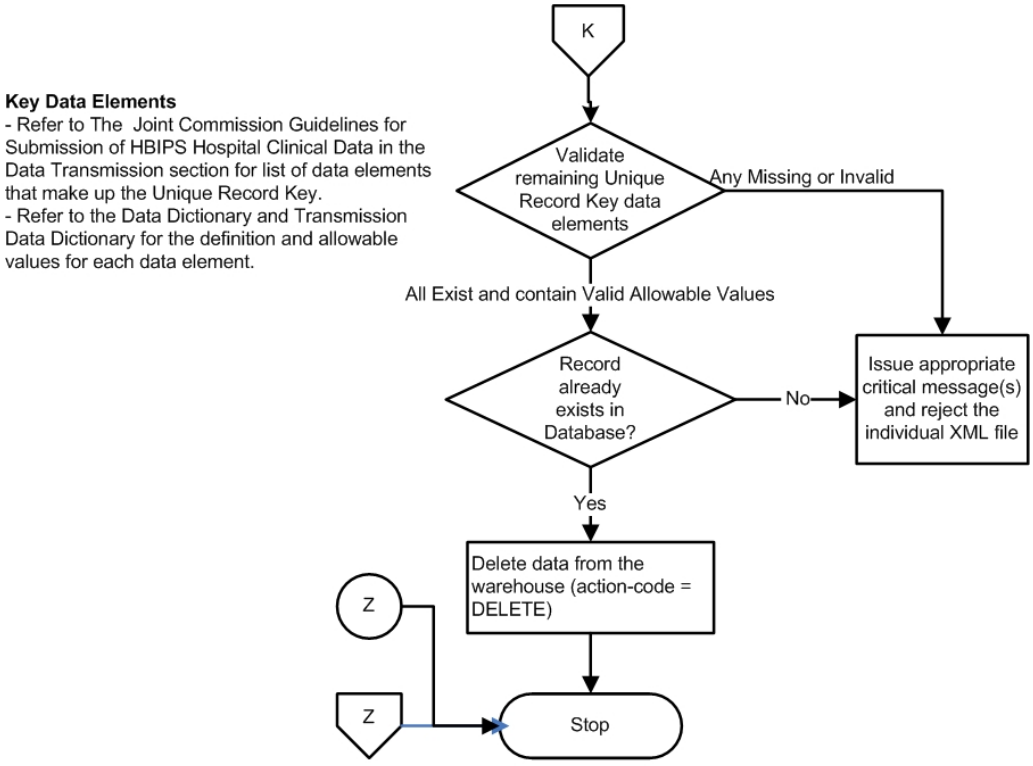
Transmission Data Processing Flow: Clinical for The Joint Commission




H
Health Care organization Identifier
Missing or invalid
Valid
Evaluate if the measure set data (*Measure Set*) is expected for this HCO from the submitter for the time frame in question (*Discharge Date* or *Event Date*)
Issue appropriate Joint Commission critical message and reject the individual XML file
Data Expected?
No
Z
Yes
action-code
= DELETE
K
= ADD
General Data Elements
- Refer to the Introduction to the Data Dictionary for the list of general data elements.
- Refer to the Data Dictionary for the definition and allowable values for each data element.
Validate General Data Elements
All Exist and contain Valid Allowable Values
Execute Initial Patient Population sub-routine logic for the *Measure Set*
ICD Start
Note: ICD Start is an off-page connector that takes you to the Measure Set Initial Patient Population Algorithm. Refer to the appropriate Data Element List section for the *Measure Set* Initial Patient Population Algorithm.
When finished processing through the Initial Patient Population Algorithm, return back to the ICD End off-page connector.
ICD End
Initial Patient Population Reject Case Flag
= Yes
Issue appropriate critical message(s) and reject the individual XML file
Z
= No
I


I
Set Edit Reject Case Flag = "No"
Validate Data Elements specific to the Measure Set
Any Invalid
1. Issue Appropriate Critical Message(s)
2 . Set Edit Reject Case Flag = Yes
Measure Set Specific Data Elements
- Refer to the Data Element List for each Measure Set for the list of data elements.
- Refer to the Data Dictionary for the definition and allowable values for each data element.
All contain Valid Allowable Values
If appropriate, evaluate Grid Data Elements specific to the Measure Set
Any Row missing data
1. Issue Appropriate Critical Message(s)
2 . Set Edit Reject Case Flag = Yes
All data elements exist in each Row of the Grid or the Grid is empty
Data not expected for the Measure Set
Yes
1. Issue Appropriate Critical Message(s)
2 . Set Edit Reject Case Flag = Yes
For example:
- Measure Set = HBIPS, but AMI specific data element where transmitted.
= No
Correct Measure Set Combinations?
No
1. Issue Appropriate Critical Message(s)
2 . Set Edit Reject Case Flag = Yes
For example:
- Measure Set = HBIPS for a patient less than 18 years old, but a record for the same patient has already been accepted by the Warehouse for the Measure Set of PN or AMI.
Refer to The Joint Commission Guidelines for Submission of Hospital Clinical Data in the Data Transmission section for list of invalid measure set combinations.
= Yes
Edit Reject Case Flag
= Yes
Issue appropriate critical message(s) and reject the individual XML file
Z
= No
J


J
Execute each measure algorithm associated to the measures the hospital has selected for the *Measure Set*.
Note: Refer to the appropriate Measure Information Forms for the *Measure Set*
Measure Category Assignment
Any = X
Issue appropriate critical message(s) and reject the individual XML file
Z
All = B, D, E, U, or Y
Accept data into the warehouse (action-code = ADD)
Is there any risk adjusted measure in the measure set?
Yes
Execute the risk model(s) for the *Measure Set*.
No
Z


Key Data Elements
- Refer to The Joint Commission Guidelines for Submission of HBIPS Hospital Clinical Data in the Data Transmission section for list of data elements that make up the Unique Record Key.
- Refer to the Data Dictionary and Transmission Data Dictionary for the definition and allowable values for each data element.
K
Validate remaining Unique Record Key data elements
Any Missing or Invalid
All Exist and contain Valid Allowable Values
Record already exists in Database?
No
Issue appropriate critical message(s) and reject the individual XML file
Yes
Delete data from the warehouse (action-code = DELETE)
Z
Z
Stop

Transmission Data Processing Flow: Population and Sampling

Introduction

This section contains information regarding the order in which the Joint Commissions Data Warehouse evaluate submitted files, which contain aggregate population and sampling counts. Transmission of population and sampling counts are used to assist in evaluating completeness of submission in accordance with The Joint Commission's sampling requirements.

Each case that is rejected by the process will be listed on a report along with a brief description of the problem. Vendors will access the Joint Commission's HCD Reports via the Performance Measurement System Extranet Track (PET).

Transmission Data Processing Flow

All data transmitted pass through the following process:

1. If appropriate, files are verified to be proper zip and XML files.
    - If the files are invalid, reject the file(s) and stop processing.
    - If the files are valid, continue processing.

    Starting with this step, processing is per XML file:
2. Data are evaluated to ensure that three individual time periods, which make up a calendar quarter, exist within the file.
    - If the data are not expected, reject the XML file and stop processing.
    - If the data are expected, continue processing.

3. The *Measure Set* /Stratum is evaluated to ensure a valid value is submitted.
    - If the data are not expected, reject the XML file and stop processing.
    - If the data are expected, continue processing.

4. Data are evaluated to ensure the quarter for Time Periods is open for data submission.
    - If the Data Collection quarter is closed, reject the XML file and stop processing.
    - If the Data Collection quarter is open, continue processing.

5. If the files are submitted to The Joint Commission: The *Health Care Organization Identifier* is evaluated to ensure a valid value is submitted.
    - If the data are not expected, reject the XML file and stop processing.
    - If the data are expected, continue processing.

6. If the files are submitted to The Joint Commission: Data are evaluated to ensure the Measure Set(s) or Strata are expected from the submitter.
    - If the data are not expected, set the reject 'Pending Database' flag = Yes, continue processing.
    - If the data are expected, set the reject 'Pending Database' flag = No, continue processing.

7. Check the action-code
    - If action-code equals Add, continue with processing.
    - If the action-code is missing or invalid, reject the XML file and stop processing..

8. The transmission data elements, as defined in the Transmission Alphabetical Data Dictionary, are evaluated to ensure they exist and contain valid allowable values. These transmission data elements are required for all submitted files.
    - If any transmission data elements fall outside of the data integrity checks, reject the XML file and stop processing.

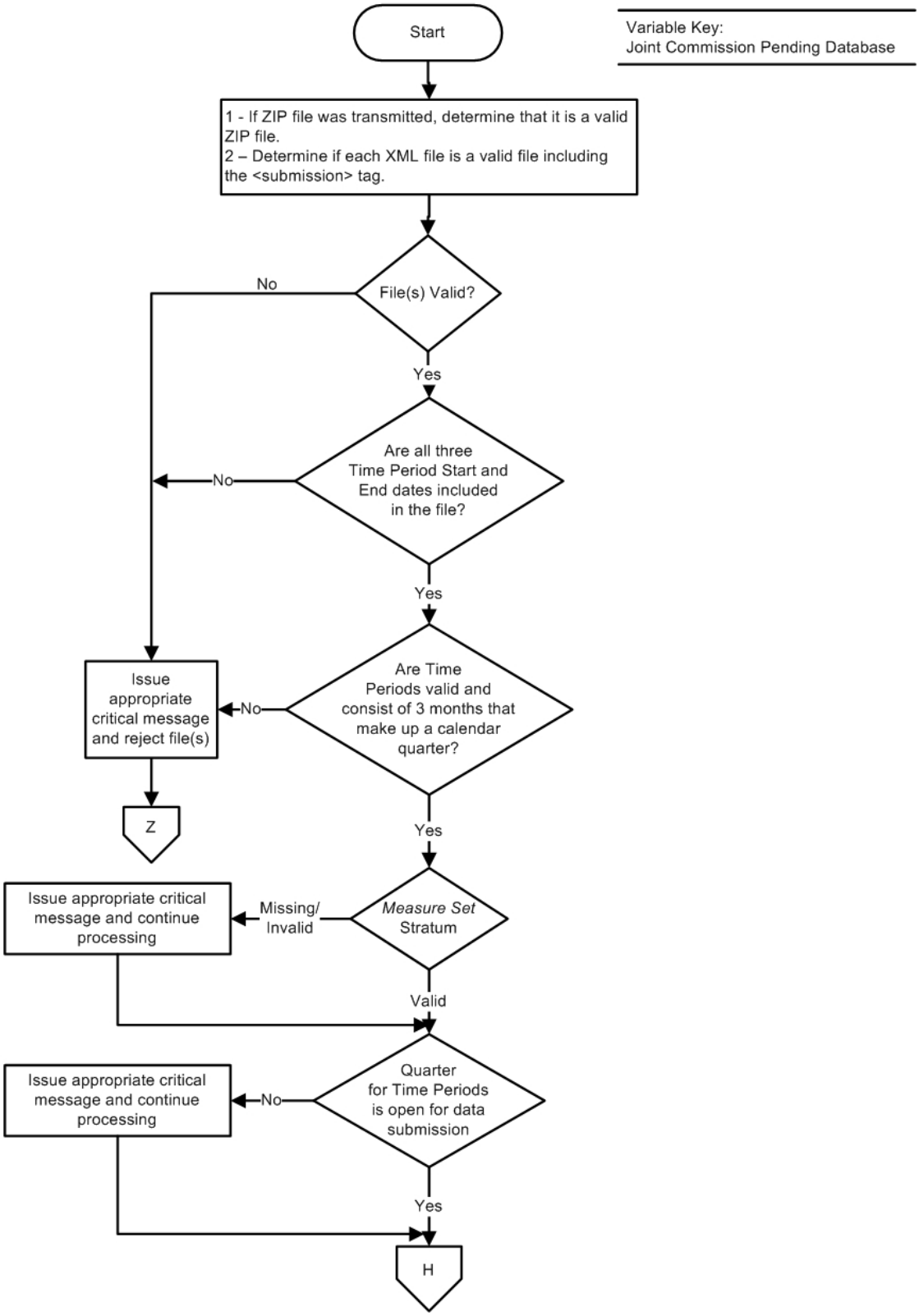
- If any transmission data element is missing or invalid, reject the XML file and stop processing.
- If all transmission data elements exist and contain valid allowable values, continue processing.

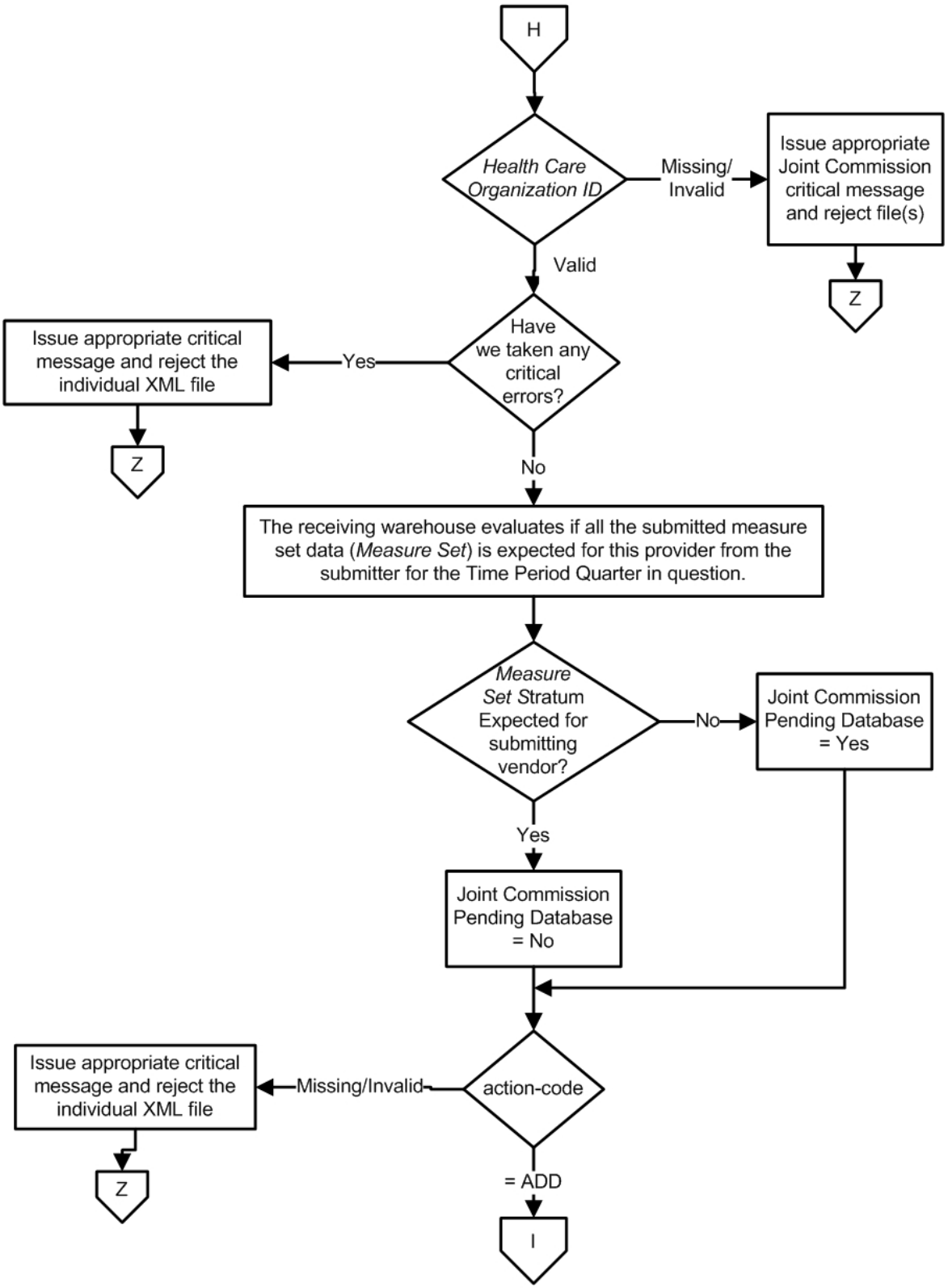
9. Data are evaluated to ensure that the sample size fulfills the required specifications. *Sample Frequency* must be consistent across all three time periods within a calendar quarter.
    - If the data are not expected, informational messages generated, continue processing.
    - If the data are expected, continue processing.

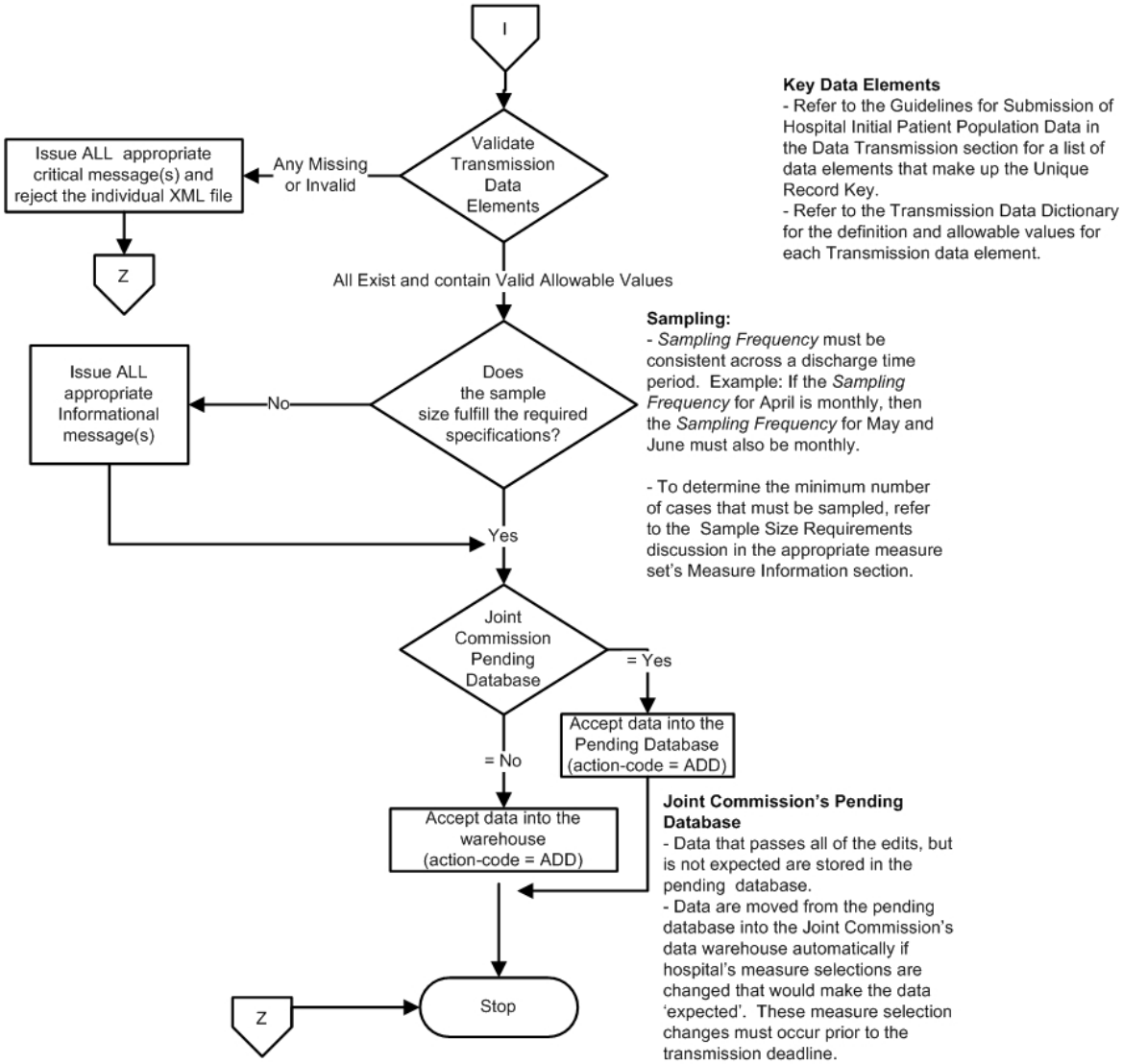
10. a. Check the Pending Database Flag
    - If the Pending Database flag = No, the case is accepted into the Joint Commission's Data Warehouse.
    - If the Pending Database flag = Yes, the case is accepted into the Joint Commission's Data Warehouse automatically if hospital's measure selections are changed that would make the data 'expected' (refer to step #6b above). These measure selection changes must occur prior to the transmission deadline.

Transmission Data Processing Flow Algorithm

Transmission Data Processing Flow: Population and Sampling for The Joint Commission




H
Health Care Organization ID
Missing/ Invalid
Issue appropriate Joint Commission critical message and reject file(s)
Z
Valid
Have we taken any critical errors?
Yes
Issue appropriate critical message and reject the individual XML file
Z
No
The receiving warehouse evaluates if all the submitted measure set data (Measure Set) is expected for this provider from the submitter for the Time Period Quarter in question.
Measure Set Stratum Expected for submitting vendor?
No
Joint Commission Pending Database = Yes
Yes
Joint Commission Pending Database = No
action-code
Missing/Invalid
Issue appropriate critical message and reject the individual XML file
Z
= ADD
I


I
Validate Transmission Data Elements
Any Missing or Invalid
Issue ALL appropriate critical message(s) and reject the individual XML file
Z
All Exist and contain Valid Allowable Values
Does the sample size fulfill the required specifications?
No
Issue ALL appropriate Informational message(s)
Yes
Joint Commission Pending Database
= Yes
Accept data into the Pending Database (action-code = ADD)
= No
Accept data into the warehouse (action-code = ADD)
Stop
Z
Key Data Elements
- Refer to the Guidelines for Submission of Hospital Initial Patient Population Data in the Data Transmission section for a list of data elements that make up the Unique Record Key.
- Refer to the Transmission Data Dictionary for the definition and allowable values for each Transmission data element.
Sampling:
- Sampling Frequency must be consistent across a discharge time period. Example: If the Sampling Frequency for April is monthly, then the Sampling Frequency for May and June must also be monthly.
- To determine the minimum number of cases that must be sampled, refer to the Sample Size Requirements discussion in the appropriate measure set's Measure Information section.
Joint Commission's Pending Database
- Data that passes all of the edits, but is not expected are stored in the pending database.
- Data are moved from the pending database into the Joint Commission's data warehouse automatically if hospital's measure selections are changed that would make the data 'expected'. These measure selection changes must occur prior to the transmission deadline.

Appendix A

ICD-10 Code Tables

- Download Code Tables (includes 11.18)

Table Number 10.01: Mental Disorders

Code	Shortened Description
F0150	Vascular dementia without behavioral disturbance
F0151	Vascular dementia with behavioral disturbance
F0280	Dementia in other diseases classified elsewhere without behavioral disturbance
F0281	Dementia in other diseases classified elsewhere with behavioral disturbance
F0390	Unspecified dementia without behavioral disturbance
F0391	Unspecified dementia with behavioral disturbance
F04	Amnestic disorder due to known physiological condition
F05	Delirium due to known physiological condition
F060	Psychotic disorder with hallucinations due to known physiological condition
F061	Catatonic disorder due to known physiological condition
F062	Psychotic disorder with delusions due to known physiological condition
F0630	Mood disorder due to known physiological condition, unspecified
F0631	Mood disorder due to known physiological condition with depressive features
F0632	Mood disorder due to known physiological condition with major depressive-like episode
F0633	Mood disorder due to known physiological condition with manic features
F0634	Mood disorder due to known physiological condition with mixed features
F064	Anxiety disorder due to known physiological condition
F068	Other specified mental disorders due to known physiological condition
F070	Personality change due to known physiological condition
F0781	Postconcussional syndrome
F0789	Other personality and behavioral disorders due to known physiological condition
F079	Unspecified personality and behavioral disorder due to known physiological condition
F09	Unspecified mental disorder due to known physiological condition
F10121	Alcohol abuse with intoxication delirium
F1014	Alcohol abuse with alcohol-induced mood disorder

Code	Shortened Description
F10150	Alcohol abuse with alcohol-induced psychotic disorder with delusions
F10151	Alcohol abuse with alcohol-induced psychotic disorder with hallucinations
F10159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified
F10180	Alcohol abuse with alcohol-induced anxiety disorder
F10181	Alcohol abuse with alcohol-induced sexual dysfunction
F10182	Alcohol abuse with alcohol-induced sleep disorder
F10188	Alcohol abuse with other alcohol-induced disorder
F1019	Alcohol abuse with unspecified alcohol-induced disorder
F10221	Alcohol dependence with intoxication delirium
F10230	Alcohol dependence with withdrawal, uncomplicated
F10231	Alcohol dependence with withdrawal delirium
F10232	Alcohol dependence with withdrawal with perceptual disturbance
F10239	Alcohol dependence with withdrawal, unspecified
F1024	Alcohol dependence with alcohol-induced mood disorder
F10250	Alcohol dependence with alcohol-induced psychotic disorder with delusions
F10251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
F10259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F1026	Alcohol dependence with alcohol-induced persisting amnestic disorder
F1027	Alcohol dependence with alcohol-induced persisting dementia
F10280	Alcohol dependence with alcohol-induced anxiety disorder
F10281	Alcohol dependence with alcohol-induced sexual dysfunction
F10282	Alcohol dependence with alcohol-induced sleep disorder
F10288	Alcohol dependence with other alcohol-induced disorder
F1029	Alcohol dependence with unspecified alcohol-induced disorder
F10920	Alcohol use, unspecified with intoxication, uncomplicated
F10921	Alcohol use, unspecified with intoxication delirium
F10929	Alcohol use, unspecified with intoxication, unspecified
F1094	Alcohol use, unspecified with alcohol-induced mood disorder
F10950	Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions
F10951	Alcohol use, unspecified with alcohol-induced psychotic disorder with hallucinations

Code	Shortened Description
F10959	Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
F1096	Alcohol use, unspecified with alcohol-induced persisting amnestic disorder
F1097	Alcohol use, unspecified with alcohol-induced persisting dementia
F10980	Alcohol use, unspecified with alcohol-induced anxiety disorder
F10981	Alcohol use, unspecified with alcohol-induced sexual dysfunction
F10982	Alcohol use, unspecified with alcohol-induced sleep disorder
F10988	Alcohol use, unspecified with other alcohol-induced disorder
F1099	Alcohol use, unspecified with unspecified alcohol-induced disorder
F11121	Opioid abuse with intoxication delirium
F11122	Opioid abuse with intoxication with perceptual disturbance
F1114	Opioid abuse with opioid-induced mood disorder
F11150	Opioid abuse with opioid-induced psychotic disorder with delusions
F11151	Opioid abuse with opioid-induced psychotic disorder with hallucinations
F11159	Opioid abuse with opioid-induced psychotic disorder, unspecified
F11181	Opioid abuse with opioid-induced sexual dysfunction
F11182	Opioid abuse with opioid-induced sleep disorder
F11188	Opioid abuse with other opioid-induced disorder
F1119	Opioid abuse with unspecified opioid-induced disorder
F11220	Opioid dependence with intoxication, uncomplicated
F11221	Opioid dependence with intoxication delirium
F11222	Opioid dependence with intoxication with perceptual disturbance
F11229	Opioid dependence with intoxication, unspecified
F1123	Opioid dependence with withdrawal
F1124	Opioid dependence with opioid-induced mood disorder
F11250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11281	Opioid dependence with opioid-induced sexual dysfunction
F11282	Opioid dependence with opioid-induced sleep disorder
F11288	Opioid dependence with other opioid-induced disorder

Code	Shortened Description
F1129	Opioid dependence with unspecified opioid-induced disorder
F11920	Opioid use, unspecified with intoxication, uncomplicated
F11921	Opioid use, unspecified with intoxication delirium
F11922	Opioid use, unspecified with intoxication with perceptual disturbance
F11929	Opioid use, unspecified with intoxication, unspecified
F1193	Opioid use, unspecified with withdrawal
F1194	Opioid use, unspecified with opioid-induced mood disorder
F11950	Opioid use, unspecified with opioid-induced psychotic disorder with delusions
F11951	Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations
F11959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified
F11981	Opioid use, unspecified with opioid-induced sexual dysfunction
F11982	Opioid use, unspecified with opioid-induced sleep disorder
F11988	Opioid use, unspecified with other opioid-induced disorder
F1199	Opioid use, unspecified with unspecified opioid-induced disorder
F12120	Cannabis abuse with intoxication, uncomplicated
F12121	Cannabis abuse with intoxication delirium
F12122	Cannabis abuse with intoxication with perceptual disturbance
F12129	Cannabis abuse with intoxication, unspecified
F12150	Cannabis abuse with psychotic disorder with delusions
F12151	Cannabis abuse with psychotic disorder with hallucinations
F12159	Cannabis abuse with psychotic disorder, unspecified
F12180	Cannabis abuse with cannabis-induced anxiety disorder
F12188	Cannabis abuse with other cannabis-induced disorder
F1219	Cannabis abuse with unspecified cannabis-induced disorder
F12220	Cannabis dependence with intoxication, uncomplicated
F12221	Cannabis dependence with intoxication delirium
F12222	Cannabis dependence with intoxication with perceptual disturbance
F12229	Cannabis dependence with intoxication, unspecified
F12250	Cannabis dependence with psychotic disorder with delusions
F12251	Cannabis dependence with psychotic disorder with hallucinations

Code	Shortened Description
F12259	Cannabis dependence with psychotic disorder, unspecified
F12280	Cannabis dependence with cannabis-induced anxiety disorder
F12288	Cannabis dependence with other cannabis-induced disorder
F1229	Cannabis dependence with unspecified cannabis-induced disorder
F12920	Cannabis use, unspecified with intoxication, uncomplicated
F12921	Cannabis use, unspecified with intoxication delirium
F12922	Cannabis use, unspecified with intoxication with perceptual disturbance
F12929	Cannabis use, unspecified with intoxication, unspecified
F12950	Cannabis use, unspecified with psychotic disorder with delusions
F12951	Cannabis use, unspecified with psychotic disorder with hallucinations
F12959	Cannabis use, unspecified with psychotic disorder, unspecified
F12980	Cannabis use, unspecified with anxiety disorder
F12988	Cannabis use, unspecified with other cannabis-induced disorder
F1299	Cannabis use, unspecified with unspecified cannabis-induced disorder
F13121	Sedative, hypnotic or anxiolytic abuse with intoxication delirium
F13129	Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
F1314	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder
F13150	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13151	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13181	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13182	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sleep disorder
F13188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder
F1319	Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder
F13220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium
F13229	Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified

Code	Shortened Description
F13230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium
F13232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance
F13239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified
F1324	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder
F13250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F1326	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
F1327	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
F13280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13281	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13282	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder
F13288	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder
F1329	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder
F13920	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, uncomplicated
F13921	Sedative, hypnotic or anxiolytic use, unspecified with intoxication delirium
F13929	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, unspecified
F13930	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, uncomplicated
F13931	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal delirium
F13932	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal with perceptual disturbances
F13939	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, unspecified
F1394	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder
F13950	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13951	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13959	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified

Code	Shortened Description
F1396	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
F1397	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia
F13980	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13981	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13982	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sleep disorder
F13988	Sedative, hypnotic or anxiolytic use, unspecified with other sedative, hypnotic or anxiolytic-induced disorder
F1399	Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder
F14121	Cocaine abuse with intoxication with delirium
F14122	Cocaine abuse with intoxication with perceptual disturbance
F14129	Cocaine abuse with intoxication, unspecified
F1414	Cocaine abuse with cocaine-induced mood disorder
F14150	Cocaine abuse with cocaine-induced psychotic disorder with delusions
F14151	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations
F14159	Cocaine abuse with cocaine-induced psychotic disorder, unspecified
F14180	Cocaine abuse with cocaine-induced anxiety disorder
F14181	Cocaine abuse with cocaine-induced sexual dysfunction
F14182	Cocaine abuse with cocaine-induced sleep disorder
F14188	Cocaine abuse with other cocaine-induced disorder
F1419	Cocaine abuse with unspecified cocaine-induced disorder
F14220	Cocaine dependence with intoxication, uncomplicated
F14221	Cocaine dependence with intoxication delirium
F14222	Cocaine dependence with intoxication with perceptual disturbance
F14229	Cocaine dependence with intoxication, unspecified
F1423	Cocaine dependence with withdrawal
F1424	Cocaine dependence with cocaine-induced mood disorder
F14250	Cocaine dependence with cocaine-induced psychotic disorder with delusions
F14251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
F14259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified

Code	Shortened Description
F14280	Cocaine dependence with cocaine-induced anxiety disorder
F14281	Cocaine dependence with cocaine-induced sexual dysfunction
F14282	Cocaine dependence with cocaine-induced sleep disorder
F14288	Cocaine dependence with other cocaine-induced disorder
F1429	Cocaine dependence with unspecified cocaine-induced disorder
F14920	Cocaine use, unspecified with intoxication, uncomplicated
F14921	Cocaine use, unspecified with intoxication delirium
F14922	Cocaine use, unspecified with intoxication with perceptual disturbance
F14929	Cocaine use, unspecified with intoxication, unspecified
F1494	Cocaine use, unspecified with cocaine-induced mood disorder
F14950	Cocaine use, unspecified with cocaine-induced psychotic disorder with delusions
F14951	Cocaine use, unspecified with cocaine-induced psychotic disorder with hallucinations
F14959	Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified
F14980	Cocaine use, unspecified with cocaine-induced anxiety disorder
F14981	Cocaine use, unspecified with cocaine-induced sexual dysfunction
F14982	Cocaine use, unspecified with cocaine-induced sleep disorder
F14988	Cocaine use, unspecified with other cocaine-induced disorder
F1499	Cocaine use, unspecified with unspecified cocaine-induced disorder
F15121	Other stimulant abuse with intoxication delirium
F15122	Other stimulant abuse with intoxication with perceptual disturbance
F15129	Other stimulant abuse with intoxication, unspecified
F1514	Other stimulant abuse with stimulant-induced mood disorder
F15150	Other stimulant abuse with stimulant-induced psychotic disorder with delusions
F15151	Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations
F15159	Other stimulant abuse with stimulant-induced psychotic disorder, unspecified
F15180	Other stimulant abuse with stimulant-induced anxiety disorder
F15181	Other stimulant abuse with stimulant-induced sexual dysfunction
F15182	Other stimulant abuse with stimulant-induced sleep disorder
F15188	Other stimulant abuse with other stimulant-induced disorder
F1519	Other stimulant abuse with unspecified stimulant-induced disorder

Code	Shortened Description
F15220	Other stimulant dependence with intoxication, uncomplicated
F15221	Other stimulant dependence with intoxication delirium
F15222	Other stimulant dependence with intoxication with perceptual disturbance
F15229	Other stimulant dependence with intoxication, unspecified
F1523	Other stimulant dependence with withdrawal
F1524	Other stimulant dependence with stimulant-induced mood disorder
F15250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions
F15251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations
F15259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
F15280	Other stimulant dependence with stimulant-induced anxiety disorder
F15281	Other stimulant dependence with stimulant-induced sexual dysfunction
F15282	Other stimulant dependence with stimulant-induced sleep disorder
F15288	Other stimulant dependence with other stimulant-induced disorder
F1529	Other stimulant dependence with unspecified stimulant-induced disorder
F15920	Other stimulant use, unspecified with intoxication, uncomplicated
F15921	Other stimulant use, unspecified with intoxication delirium
F15922	Other stimulant use, unspecified with intoxication with perceptual disturbance
F15929	Other stimulant use, unspecified with intoxication, unspecified
F1593	Other stimulant use, unspecified with withdrawal
F1594	Other stimulant use, unspecified with stimulant-induced mood disorder
F15950	Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions
F15951	Other stimulant use, unspecified with stimulant-induced psychotic disorder with hallucinations
F15959	Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified
F15980	Other stimulant use, unspecified with stimulant-induced anxiety disorder
F15981	Other stimulant use, unspecified with stimulant-induced sexual dysfunction
F15982	Other stimulant use, unspecified with stimulant-induced sleep disorder
F15988	Other stimulant use, unspecified with other stimulant-induced disorder
F1599	Other stimulant use, unspecified with unspecified stimulant-induced disorder
F16121	Hallucinogen abuse with intoxication with delirium
F16122	Hallucinogen abuse with intoxication with perceptual disturbance

Code	Shortened Description
F16129	Hallucinogen abuse with intoxication, unspecified
F1614	Hallucinogen abuse with hallucinogen-induced mood disorder
F16150	Hallucinogen abuse with hallucinogen-induced psychotic disorder with delusions
F16151	Hallucinogen abuse with hallucinogen-induced psychotic disorder with hallucinations
F16159	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified
F16180	Hallucinogen abuse with hallucinogen-induced anxiety disorder
F16183	Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)
F16188	Hallucinogen abuse with other hallucinogen-induced disorder
F1619	Hallucinogen abuse with unspecified hallucinogen-induced disorder
F16220	Hallucinogen dependence with intoxication, uncomplicated
F16221	Hallucinogen dependence with intoxication with delirium
F16229	Hallucinogen dependence with intoxication, unspecified
F1624	Hallucinogen dependence with hallucinogen-induced mood disorder
F16250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
F16251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
F16259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
F16288	Hallucinogen dependence with other hallucinogen-induced disorder
F1629	Hallucinogen dependence with unspecified hallucinogen-induced disorder
F16920	Hallucinogen use, unspecified with intoxication, uncomplicated
F16921	Hallucinogen use, unspecified with intoxication with delirium
F16929	Hallucinogen use, unspecified with intoxication, unspecified
F1694	Hallucinogen use, unspecified with hallucinogen-induced mood disorder
F16950	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with delusions
F16951	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with hallucinations
F16959	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder, unspecified
F16980	Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder
F16983	Hallucinogen use, unspecified with hallucinogen persisting perception disorder (flashbacks)
F16988	Hallucinogen use, unspecified with other hallucinogen-induced disorder

Code	Shortened Description
F1699	Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder
F18120	Inhalant abuse with intoxication, uncomplicated
F18121	Inhalant abuse with intoxication delirium
F18129	Inhalant abuse with intoxication, unspecified
F1814	Inhalant abuse with inhalant-induced mood disorder
F18150	Inhalant abuse with inhalant-induced psychotic disorder with delusions
F18151	Inhalant abuse with inhalant-induced psychotic disorder with hallucinations
F18159	Inhalant abuse with inhalant-induced psychotic disorder, unspecified
F1817	Inhalant abuse with inhalant-induced dementia
F18180	Inhalant abuse with inhalant-induced anxiety disorder
F18188	Inhalant abuse with other inhalant-induced disorder
F1819	Inhalant abuse with unspecified inhalant-induced disorder
F18220	Inhalant dependence with intoxication, uncomplicated
F18221	Inhalant dependence with intoxication delirium
F18229	Inhalant dependence with intoxication, unspecified
F1824	Inhalant dependence with inhalant-induced mood disorder
F18250	Inhalant dependence with inhalant-induced psychotic disorder with delusions
F18251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations
F18259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
F1827	Inhalant dependence with inhalant-induced dementia
F18280	Inhalant dependence with inhalant-induced anxiety disorder
F18288	Inhalant dependence with other inhalant-induced disorder
F1829	Inhalant dependence with unspecified inhalant-induced disorder
F18920	Inhalant use, unspecified with intoxication, uncomplicated
F18921	Inhalant use, unspecified with intoxication with delirium
F18929	Inhalant use, unspecified with intoxication, unspecified
F1894	Inhalant use, unspecified with inhalant-induced mood disorder
F18950	Inhalant use, unspecified with inhalant-induced psychotic disorder with delusions
F18951	Inhalant use, unspecified with inhalant-induced psychotic disorder with hallucinations
F18959	Inhalant use, unspecified with inhalant-induced psychotic disorder, unspecified

Code	Shortened Description
F1897	Inhalant use, unspecified with inhalant-induced persisting dementia
F18980	Inhalant use, unspecified with inhalant-induced anxiety disorder
F18988	Inhalant use, unspecified with other inhalant-induced disorder
F1899	Inhalant use, unspecified with unspecified inhalant-induced disorder
F19121	Other psychoactive substance abuse with intoxication delirium
F19122	Other psychoactive substance abuse with intoxication with perceptual disturbances
F19129	Other psychoactive substance abuse with intoxication, unspecified
F1914	Other psychoactive substance abuse with psychoactive substance-induced mood disorder
F19150	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions
F19151	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations
F19159	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified
F1916	Other psychoactive substance abuse with psychoactive substance-induced persisting amnestic disorder
F1917	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia
F19180	Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder
F19181	Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction
F19182	Other psychoactive substance abuse with psychoactive substance-induced sleep disorder
F19188	Other psychoactive substance abuse with other psychoactive substance-induced disorder
F1919	Other psychoactive substance abuse with unspecified psychoactive substance-induced disorder
F1921	Other psychoactive substance dependence, in remission
F19220	Other psychoactive substance dependence with intoxication, uncomplicated
F19221	Other psychoactive substance dependence with intoxication delirium
F19222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19229	Other psychoactive substance dependence with intoxication, unspecified
F19230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19231	Other psychoactive substance dependence with withdrawal delirium
F19232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
F19239	Other psychoactive substance dependence with withdrawal, unspecified
F1924	Other psychoactive substance dependence with psychoactive substance-induced mood disorder
F19250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions

Code	Shortened Description
F19251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations
F19259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified
F1926	Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder
F1927	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction
F19282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder
F19288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
F1929	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder
F19920	Other psychoactive substance use, unspecified with intoxication, uncomplicated
F19921	Other psychoactive substance use, unspecified with intoxication with delirium
F19922	Other psychoactive substance use, unspecified with intoxication with perceptual disturbance
F19929	Other psychoactive substance use, unspecified with intoxication, unspecified
F19930	Other psychoactive substance use, unspecified with withdrawal, uncomplicated
F19931	Other psychoactive substance use, unspecified with withdrawal delirium
F19932	Other psychoactive substance use, unspecified with withdrawal with perceptual disturbance
F19939	Other psychoactive substance use, unspecified with withdrawal, unspecified
F1994	Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder
F19950	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with delusions
F19951	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations
F19959	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder, unspecified
F1996	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting amnestic disorder
F1997	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia
F19980	Other psychoactive substance use, unspecified with psychoactive substance-induced anxiety disorder
F19981	Other psychoactive substance use, unspecified with psychoactive substance-induced sexual dysfunction
F19982	Other psychoactive substance use, unspecified with psychoactive substance-induced sleep disorder

Code	Shortened Description
F19988	Other psychoactive substance use, unspecified with other psychoactive substance-induced disorder
F1999	Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F2081	Schizophreniform disorder
F2089	Other schizophrenia
F209	Schizophrenia, unspecified
F21	Schizotypal disorder
F22	Delusional disorders
F23	Brief psychotic disorder
F24	Shared psychotic disorder
F250	Schizoaffective disorder, bipolar type
F251	Schizoaffective disorder, depressive type
F258	Other schizoaffective disorders
F259	Schizoaffective disorder, unspecified
F28	Other psychotic disorder not due to a substance or known physiological condition
F29	Unspecified psychosis not due to a substance or known physiological condition
F3010	Manic episode without psychotic symptoms, unspecified
F3011	Manic episode without psychotic symptoms, mild
F3012	Manic episode without psychotic symptoms, moderate
F3013	Manic episode, severe, without psychotic symptoms
F302	Manic episode, severe with psychotic symptoms
F303	Manic episode in partial remission
F304	Manic episode in full remission
F308	Other manic episodes
F309	Manic episode, unspecified
F310	Bipolar disorder, current episode hypomanic

Code	Shortened Description
F3110	Bipolar disorder, current episode manic without psychotic features, unspecified
F3111	Bipolar disorder, current episode manic without psychotic features, mild
F3112	Bipolar disorder, current episode manic without psychotic features, moderate
F3113	Bipolar disorder, current episode manic without psychotic features, severe
F312	Bipolar disorder, current episode manic severe with psychotic features
F3130	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F3131	Bipolar disorder, current episode depressed, mild
F3132	Bipolar disorder, current episode depressed, moderate
F314	Bipolar disorder, current episode depressed, severe, without psychotic features
F315	Bipolar disorder, current episode depressed, severe, with psychotic features
F3160	Bipolar disorder, current episode mixed, unspecified
F3161	Bipolar disorder, current episode mixed, mild
F3162	Bipolar disorder, current episode mixed, moderate
F3163	Bipolar disorder, current episode mixed, severe, without psychotic features
F3164	Bipolar disorder, current episode mixed, severe, with psychotic features
F3170	Bipolar disorder, currently in remission, most recent episode unspecified
F3171	Bipolar disorder, in partial remission, most recent episode hypomanic
F3172	Bipolar disorder, in full remission, most recent episode hypomanic
F3173	Bipolar disorder, in partial remission, most recent episode manic
F3174	Bipolar disorder, in full remission, most recent episode manic
F3175	Bipolar disorder, in partial remission, most recent episode depressed
F3176	Bipolar disorder, in full remission, most recent episode depressed
F3177	Bipolar disorder, in partial remission, most recent episode mixed
F3178	Bipolar disorder, in full remission, most recent episode mixed
F3181	Bipolar II disorder
F3189	Other bipolar disorder
F319	Bipolar disorder, unspecified
F320	Major depressive disorder, single episode, mild
F321	Major depressive disorder, single episode, moderate
F322	Major depressive disorder, single episode, severe without psychotic features

Code	Shortened Description
F323	Major depressive disorder, single episode, severe with psychotic features
F324	Major depressive disorder, single episode, in partial remission
F325	Major depressive disorder, single episode, in full remission
F328	Other depressive episodes
F329	Major depressive disorder, single episode, unspecified
F329	Major depressive disorder, single episode, unspecified
F330	Major depressive disorder, recurrent, mild
F331	Major depressive disorder, recurrent, moderate
F332	Major depressive disorder, recurrent severe without psychotic features
F333	Major depressive disorder, recurrent, severe with psychotic symptoms
F3340	Major depressive disorder, recurrent, in remission, unspecified
F3341	Major depressive disorder, recurrent, in partial remission
F3342	Major depressive disorder, recurrent, in full remission
F338	Other recurrent depressive disorders
F339	Major depressive disorder, recurrent, unspecified
F340	Cyclothymic disorder
F341	Dysthymic disorder
F348	Other persistent mood [affective] disorders
F349	Persistent mood [affective] disorder, unspecified
F39	Unspecified mood [affective] disorder
F4000	Agoraphobia, unspecified
F4001	Agoraphobia with panic disorder
F4002	Agoraphobia without panic disorder
F4010	Social phobia, unspecified
F4011	Social phobia, generalized
F40210	Arachnophobia
F40218	Other animal type phobia
F40220	Fear of thunderstorms
F40228	Other natural environment type phobia
F40230	Fear of blood

Code	Shortened Description
F40231	Fear of injections and transfusions
F40232	Fear of other medical care
F40233	Fear of injury
F40240	Claustrophobia
F40241	Acrophobia
F40242	Fear of bridges
F40243	Fear of flying
F40248	Other situational type phobia
F40290	Androphobia
F40291	Gynephobia
F40298	Other specified phobia
F408	Other phobic anxiety disorders
F409	Phobic anxiety disorder, unspecified
F410	Panic disorder [episodic paroxysmal anxiety] without agoraphobia
F411	Generalized anxiety disorder
F413	Other mixed anxiety disorders
F418	Other specified anxiety disorders
F419	Anxiety disorder, unspecified
F42	Obsessive-compulsive disorder
F430	Acute stress reaction
F4310	Post-traumatic stress disorder, unspecified
F4311	Post-traumatic stress disorder, acute
F4312	Post-traumatic stress disorder, chronic
F4320	Adjustment disorder, unspecified
F4321	Adjustment disorder with depressed mood
F4321	Adjustment disorder with depressed mood
F4322	Adjustment disorder with anxiety
F4323	Adjustment disorder with mixed anxiety and depressed mood
F4324	Adjustment disorder with disturbance of conduct
F4325	Adjustment disorder with mixed disturbance of emotions and conduct

Code	Shortened Description
F4329	Adjustment disorder with other symptoms
F438	Other reactions to severe stress
F439	Reaction to severe stress, unspecified
F440	Dissociative amnesia
F441	Dissociative fugue
F442	Dissociative stupor
F444	Conversion disorder with motor symptom or deficit
F445	Conversion disorder with seizures or convulsions
F446	Conversion disorder with sensory symptom or deficit
F447	Conversion disorder with mixed symptom presentation
F4481	Dissociative identity disorder
F4489	Other dissociative and conversion disorders
F449	Dissociative and conversion disorder, unspecified
F450	Somatization disorder
F451	Undifferentiated somatoform disorder
F4520	Hypochondriacal disorder, unspecified
F4521	Hypochondriasis
F4522	Body dysmorphic disorder
F4529	Other hypochondriacal disorders
F4541	Pain disorder exclusively related to psychological factors
F4542	Pain disorder with related psychological factors
F458	Other somatoform disorders
F459	Somatoform disorder, unspecified
F481	Depersonalization-derealization syndrome
F482	Pseudobulbar affect
F488	Other specified nonpsychotic mental disorders
F489	Nonpsychotic mental disorder, unspecified
F5000	Anorexia nervosa, unspecified
F5001	Anorexia nervosa, restricting type
F5002	Anorexia nervosa, binge eating/purging type

Code	Shortened Description
F502	Bulimia nervosa
F508	Other eating disorders
F509	Eating disorder, unspecified
F5101	Primary insomnia
F5102	Adjustment insomnia
F5103	Paradoxical insomnia
F5109	Other insomnia not due to a substance or known physiological condition
F5111	Primary hypersomnia
F5112	Insufficient sleep syndrome
F5119	Other hypersomnia not due to a substance or known physiological condition
F513	Sleepwalking [somnambulism]
F514	Sleep terrors [night terrors]
F515	Nightmare disorder
F518	Other sleep disorders not due to a substance or known physiological condition
F519	Sleep disorder not due to a substance or known physiological condition, unspecified
F520	Hypoactive sexual desire disorder
F521	Sexual aversion disorder
F5221	Male erectile disorder
F5222	Female sexual arousal disorder
F5231	Female orgasmic disorder
F5232	Male orgasmic disorder
F524	Premature ejaculation
F525	Vaginismus not due to a substance or known physiological condition
F526	Dyspareunia not due to a substance or known physiological condition
F528	Other sexual dysfunction not due to a substance or known physiological condition
F529	Unspecified sexual dysfunction not due to a substance or known physiological condition
F53	Puerperal psychosis
F54	Psychological and behavioral factors associated with disorders or diseases classified elsewhere
F59	Unspecified behavioral syndromes associated with physiological disturbances and physical factors
F600	Paranoid personality disorder

Code	Shortened Description
F601	Schizoid personality disorder
F602	Antisocial personality disorder
F603	Borderline personality disorder
F604	Histrionic personality disorder
F605	Obsessive-compulsive personality disorder
F606	Avoidant personality disorder
F607	Dependent personality disorder
F6081	Narcissistic personality disorder
F6089	Other specific personality disorders
F609	Personality disorder, unspecified
F630	Pathological gambling
F631	Pyromania
F632	Kleptomania
F633	Trichotillomania
F6381	Intermittent explosive disorder
F6389	Other impulse disorders
F639	Impulse disorder, unspecified
F641	Gender identity disorder in adolescence and adulthood
F642	Gender identity disorder of childhood
F648	Other gender identity disorders
F649	Gender identity disorder, unspecified
F650	Fetishism
F651	Transvestic fetishism
F652	Exhibitionism
F653	Voyeurism
F654	Pedophilia
F6550	Sadomasochism, unspecified
F6551	Sexual masochism
F6552	Sexual sadism
F6581	Frotteurism

Code	Shortened Description
F6589	Other paraphilias
F659	Paraphilia, unspecified
F66	Other sexual disorders
F6810	Factitious disorder, unspecified
F6811	Factitious disorder with predominantly psychological signs and symptoms
F6812	Factitious disorder with predominantly physical signs and symptoms
F6813	Factitious disorder with combined psychological and physical signs and symptoms
F6813	Factitious disorder with combined psychological and physical signs and symptoms
F688	Other specified disorders of adult personality and behavior
F69	Unspecified disorder of adult personality and behavior
F70	Mild intellectual disabilities
F71	Moderate intellectual disabilities
F72	Severe intellectual disabilities
F73	Profound intellectual disabilities
F78	Other intellectual disabilities
F79	Unspecified intellectual disabilities
F800	Phonological disorder
F801	Expressive language disorder
F802	Mixed receptive-expressive language disorder
F804	Speech and language development delay due to hearing loss
F8081	Childhood onset fluency disorder
F8089	Other developmental disorders of speech and language
F809	Developmental disorder of speech and language, unspecified
F810	Specific reading disorder
F812	Mathematics disorder
F8181	Disorder of written expression
F8189	Other developmental disorders of scholastic skills
F819	Developmental disorder of scholastic skills, unspecified
F82	Specific developmental disorder of motor function
F840	Autistic disorder

Code	Shortened Description
F843	Other childhood disintegrative disorder
F845	Asperger's syndrome
F848	Other pervasive developmental disorders
F849	Pervasive developmental disorder, unspecified
F88	Other disorders of psychological development
F89	Unspecified disorder of psychological development
F900	Attention-deficit hyperactivity disorder, predominantly inattentive type
F901	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F902	Attention-deficit hyperactivity disorder, combined type
F908	Attention-deficit hyperactivity disorder, other type
F908	Attention-deficit hyperactivity disorder, other type
F909	Attention-deficit hyperactivity disorder, unspecified type
F910	Conduct disorder confined to family context
F911	Conduct disorder, childhood-onset type
F912	Conduct disorder, adolescent-onset type
F913	Oppositional defiant disorder
F918	Other conduct disorders
F919	Conduct disorder, unspecified
F930	Separation anxiety disorder of childhood
F938	Other childhood emotional disorders
F939	Childhood emotional disorder, unspecified
F940	Selective mutism
F941	Reactive attachment disorder of childhood
F942	Disinhibited attachment disorder of childhood
F948	Other childhood disorders of social functioning
F949	Childhood disorder of social functioning, unspecified
F950	Transient tic disorder
F951	Chronic motor or vocal tic disorder
F952	Tourette's disorder
F958	Other tic disorders

Code	Shortened Description
F959	Tic disorder, unspecified
F980	Enuresis not due to a substance or known physiological condition
F981	Encopresis not due to a substance or known physiological condition
F9821	Rumination disorder of infancy
F9829	Other feeding disorders of infancy and early childhood
F983	Pica of infancy and childhood
F984	Stereotyped movement disorders
F985	Adult onset fluency disorder
F988	Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F989	Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99	Mental disorder, not otherwise specified
R451	Restlessness and agitation
R452	Unhappiness
R455	Hostility
R456	Violent behavior
R457	State of emotional shock and stress, unspecified
R4581	Low self-esteem
R4582	Worries
R480	Dyslexia and alexia
Z87890	Personal history of sex reassignment

Table Number 11.01.1: Delivery

Code	Shortened Description
10D00Z0	Extraction of Products of Conception, Classical, Open Approach
10D00Z1	Extraction of Products of Conception, Low Cervical, Open Approach
10D00Z2	Extraction of Products of Conception, Extraperitoneal, Open Approach
10D07Z3	Extraction of Products of Conception, Low Forceps, Via Natural or Artificial Opening
10D07Z4	Extraction of Products of Conception, Mid Forceps, Via Natural or Artificial Opening
10D07Z5	Extraction of Products of Conception, High Forceps, Via Natural or Artificial Opening
10D07Z6	Extraction of Products of Conception, Vacuum, Via Natural or Artificial Opening

Code	Shortened Description
10D07Z7	Extraction of Products of Conception, Internal Version, Via Natural or Artificial Opening
10D07Z8	Extraction of Products of Conception, Other, Via Natural or Artificial Opening
10E0XZZ	Delivery of Products of Conception, External Approach

Table Number 11.05: Medical Induction of Labor

Code	Shortened Description
0U7C7DZ	Dilation of Cervix with Intraluminal Device, Via Natural or Artificial Opening
0U7C7ZZ	Dilation of Cervix, Via Natural or Artificial Opening
10900ZC	Drainage of Amniotic Fluid, Therapeutic from Products of Conception, Open Approach
10903ZC	Drainage of Amniotic Fluid, Therapeutic from Products of Conception, Percutaneous Approach
10904ZC	Drainage of Amniotic Fluid, Therapeutic from Products of Conception, Percutaneous Endoscopic Approach
10907ZC	Drainage of Amniotic Fluid, Therapeutic from Products of Conception, Via Natural or Artificial Opening
10908ZC	Drainage of Amniotic Fluid, Therapeutic from Products of Conception, Via Natural or Artificial Opening Endoscopic
3E033VJ	Introduction of Other Hormone into Peripheral Vein, Percutaneous Approach

Table Number 11.06: Cesarean Birth

Code	Shortened Description
10D00Z0	Extraction of Products of Conception, Classical, Open Approach
10D00Z1	Extraction of Products of Conception, Low Cervical, Open Approach
10D00Z2	Extraction of Products of Conception, Extraperitoneal, Open Approach

Table Number 11.06.1: Planned Cesarean Birth in Labor

Code	Shortened Description
O7582	Onset (spontaneous) of labor after 37 completed weeks of gestation but before 39 completed weeks gestation, with delivery by (planned) cesarean section

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

Code	Shortened Description
B20	Human immunodeficiency virus [HIV] disease
K835	Biliary cyst

Code	Shortened Description
K838	Other specified diseases of biliary tract
K87	Disorders of gallbladder, biliary tract and pancreas in diseases classified elsewhere
O09291	Supervision of pregnancy with other poor reproductive or obstetric history, first trimester
O09292	Supervision of pregnancy with other poor reproductive or obstetric history, second trimester
O09293	Supervision of pregnancy with other poor reproductive or obstetric history, third trimester
O09299	Supervision of pregnancy with other poor reproductive or obstetric history, unspecified trimester
O10011	Pre-existing essential hypertension complicating pregnancy, first trimester
O10012	Pre-existing essential hypertension complicating pregnancy, second trimester
O10013	Pre-existing essential hypertension complicating pregnancy, third trimester
O1002	Pre-existing essential hypertension complicating childbirth
O1003	Pre-existing essential hypertension complicating the puerperium
O10111	Pre-existing hypertensive heart disease complicating pregnancy, first trimester
O10112	Pre-existing hypertensive heart disease complicating pregnancy, second trimester
O10113	Pre-existing hypertensive heart disease complicating pregnancy, third trimester
O1012	Pre-existing hypertensive heart disease complicating childbirth
O1013	Pre-existing hypertensive heart disease complicating the puerperium
O10211	Pre-existing hypertensive chronic kidney disease complicating pregnancy, first trimester
O10212	Pre-existing hypertensive chronic kidney disease complicating pregnancy, second trimester
O10213	Pre-existing hypertensive chronic kidney disease complicating pregnancy, third trimester
O1022	Pre-existing hypertensive chronic kidney disease complicating childbirth
O10311	Pre-existing hypertensive heart and chronic kidney disease complicating pregnancy, first trimester
O10312	Pre-existing hypertensive heart and chronic kidney disease complicating pregnancy, second trimester
O10313	Pre-existing hypertensive heart and chronic kidney disease complicating pregnancy, third trimester
O1032	Pre-existing hypertensive heart and chronic kidney disease complicating childbirth
O10411	Pre-existing secondary hypertension complicating pregnancy, first trimester
O10412	Pre-existing secondary hypertension complicating pregnancy, second trimester
O10413	Pre-existing secondary hypertension complicating pregnancy, third trimester
O1042	Pre-existing secondary hypertension complicating childbirth
O1043	Pre-existing secondary hypertension complicating the puerperium
O10911	Unspecified pre-existing hypertension complicating pregnancy, first trimester

Code	Shortened Description
O10912	Unspecified pre-existing hypertension complicating pregnancy, second trimester
O10913	Unspecified pre-existing hypertension complicating pregnancy, third trimester
O1092	Unspecified pre-existing hypertension complicating childbirth
O111	Pre-existing hypertension with pre-eclampsia, first trimester
O111	Pre-existing hypertension with pre-eclampsia, first trimester
O112	Pre-existing hypertension with pre-eclampsia, second trimester
O113	Pre-existing hypertension with pre-eclampsia, third trimester
O1211	Gestational proteinuria, first trimester
O1212	Gestational proteinuria, second trimester
O1213	Gestational proteinuria, third trimester
O1221	Gestational edema with proteinuria, first trimester
O1222	Gestational edema with proteinuria, second trimester
O1223	Gestational edema with proteinuria, third trimester
O131	Gestational [pregnancy-induced] hypertension without significant proteinuria, first trimester
O131	Gestational [pregnancy-induced] hypertension without significant proteinuria, first trimester
O132	Gestational [pregnancy-induced] hypertension without significant proteinuria, second trimester
O133	Gestational [pregnancy-induced] hypertension without significant proteinuria, third trimester
O1402	Mild to moderate pre-eclampsia, second trimester
O1403	Mild to moderate pre-eclampsia, third trimester
O1412	Severe pre-eclampsia, second trimester
O1413	Severe pre-eclampsia, third trimester
O1422	HELLP syndrome (HELLP), second trimester
O1423	HELLP syndrome (HELLP), third trimester
O1492	Unspecified pre-eclampsia, second trimester
O1493	Unspecified pre-eclampsia, third trimester
O1502	Eclampsia in pregnancy, second trimester
O1503	Eclampsia in pregnancy, third trimester
O151	Eclampsia in labor
O152	Eclampsia in the puerperium
O161	Unspecified maternal hypertension, first trimester

Code	Shortened Description
O162	Unspecified maternal hypertension, second trimester
O163	Unspecified maternal hypertension, third trimester
O169	Unspecified maternal hypertension, unspecified trimester
O24011	Pre-existing diabetes mellitus, type 1, in pregnancy, first trimester
O24012	Pre-existing diabetes mellitus, type 1, in pregnancy, second trimester
O24013	Pre-existing diabetes mellitus, type 1, in pregnancy, third trimester
O2402	Pre-existing diabetes mellitus, type 1, in childbirth
O24111	Pre-existing diabetes mellitus, type 2, in pregnancy, first trimester
O24112	Pre-existing diabetes mellitus, type 2, in pregnancy, second trimester
O24113	Pre-existing diabetes mellitus, type 2, in pregnancy, third trimester
O2412	Pre-existing diabetes mellitus, type 2, in childbirth
O24311	Unspecified pre-existing diabetes mellitus in pregnancy, first trimester
O24312	Unspecified pre-existing diabetes mellitus in pregnancy, second trimester
O24313	Unspecified pre-existing diabetes mellitus in pregnancy, third trimester
O2432	Unspecified pre-existing diabetes mellitus in childbirth
O24410	Gestational diabetes mellitus in pregnancy, diet controlled
O24414	Gestational diabetes mellitus in pregnancy, insulin controlled
O24419	Gestational diabetes mellitus in pregnancy, unspecified control
O24420	Gestational diabetes mellitus in childbirth, diet controlled
O24424	Gestational diabetes mellitus in childbirth, insulin controlled
O24429	Gestational diabetes mellitus in childbirth, unspecified control
O24811	Other pre-existing diabetes mellitus in pregnancy, first trimester
O24812	Other pre-existing diabetes mellitus in pregnancy, second trimester
O24813	Other pre-existing diabetes mellitus in pregnancy, third trimester
O2482	Other pre-existing diabetes mellitus in childbirth
O24911	Unspecified diabetes mellitus in pregnancy, first trimester
O24912	Unspecified diabetes mellitus in pregnancy, second trimester
O24913	Unspecified diabetes mellitus in pregnancy, third trimester
O2492	Unspecified diabetes mellitus in childbirth
O26611	Liver and biliary tract disorders in pregnancy, first trimester

Code	Shortened Description
O26612	Liver and biliary tract disorders in pregnancy, second trimester
O26613	Liver and biliary tract disorders in pregnancy, third trimester
O2662	Liver and biliary tract disorders in childbirth
O26831	Pregnancy related renal disease, first trimester
O26832	Pregnancy related renal disease, second trimester
O26833	Pregnancy related renal disease, third trimester
O30001	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, first trimester
O30002	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30003	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O30011	Twin pregnancy, monochorionic/monoamniotic, first trimester
O30012	Twin pregnancy, monochorionic/monoamniotic, second trimester
O30013	Twin pregnancy, monochorionic/monoamniotic, third trimester
O30031	Twin pregnancy, monochorionic/diamniotic, first trimester
O30032	Twin pregnancy, monochorionic/diamniotic, second trimester
O30033	Twin pregnancy, monochorionic/diamniotic, third trimester
O30041	Twin pregnancy, dichorionic/diamniotic, first trimester
O30042	Twin pregnancy, dichorionic/diamniotic, second trimester
O30043	Twin pregnancy, dichorionic/diamniotic, third trimester
O30091	Twin pregnancy, unable to determine number of placenta and number of amniotic sacs, first trimester
O30092	Twin pregnancy, unable to determine number of placenta and number of amniotic sacs, second trimester
O30093	Twin pregnancy, unable to determine number of placenta and number of amniotic sacs, third trimester
O30101	Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, first trimester
O30102	Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30103	Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O30111	Triplet pregnancy with two or more monochorionic fetuses, first trimester
O30112	Triplet pregnancy with two or more monochorionic fetuses, second trimester
O30113	Triplet pregnancy with two or more monochorionic fetuses, third trimester
O30121	Triplet pregnancy with two or more monoamniotic fetuses, first trimester
O30122	Triplet pregnancy with two or more monoamniotic fetuses, second trimester

Code	Shortened Description
O30123	Triplet pregnancy with two or more monoamniotic fetuses, third trimester
O30191	Triplet pregnancy, unable to determine number of placenta and number of amniotic sacs, first trimester
O30192	Triplet pregnancy, unable to determine number of placenta and number of amniotic sacs, second trimester
O30193	Triplet pregnancy, unable to determine number of placenta and number of amniotic sacs, third trimester
O30201	Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, first trimester
O30202	Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30203	Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O30211	Quadruplet pregnancy with two or more monochorionic fetuses, first trimester
O30212	Quadruplet pregnancy with two or more monochorionic fetuses, second trimester
O30213	Quadruplet pregnancy with two or more monochorionic fetuses, third trimester
O30221	Quadruplet pregnancy with two or more monoamniotic fetuses, first trimester
O30222	Quadruplet pregnancy with two or more monoamniotic fetuses, second trimester
O30223	Quadruplet pregnancy with two or more monoamniotic fetuses, third trimester
O30291	Quadruplet pregnancy, unable to determine number of placenta and number of amniotic sacs, first trimester
O30292	Quadruplet pregnancy, unable to determine number of placenta and number of amniotic sacs, second trimester
O30293	Quadruplet pregnancy, unable to determine number of placenta and number of amniotic sacs, third trimester
O30801	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs, first trimester
O30802	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30803	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O30811	Other specified multiple gestation with two or more monochorionic fetuses, first trimester
O30812	Other specified multiple gestation with two or more monochorionic fetuses, second trimester
O30813	Other specified multiple gestation with two or more monochorionic fetuses, third trimester
O30821	Other specified multiple gestation with two or more monoamniotic fetuses, first trimester
O30822	Other specified multiple gestation with two or more monoamniotic fetuses, second trimester
O30823	Other specified multiple gestation with two or more monoamniotic fetuses, third trimester

Code	Shortened Description
O30891	Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs, first trimester
O30892	Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs, second trimester
O30893	Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs, third trimester
O3091	Multiple gestation, unspecified, first trimester
O3092	Multiple gestation, unspecified, second trimester
O3093	Multiple gestation, unspecified, third trimester
O3111X0	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, not applicable or unspecified
O3111X0	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, not applicable or unspecified
O3111X0	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, not applicable or unspecified
O3111X0	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, not applicable or unspecified
O3111X1	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, fetus 1
O3111X1	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, fetus 1
O3111X2	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, fetus 2
O3111X2	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, fetus 2
O3111X3	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, fetus 3
O3111X4	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, fetus 4
O3111X5	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, fetus 5
O3111X9	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, other fetus
O3112X0	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, not applicable or unspecified
O3112X0	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, not applicable or unspecified
O3112X1	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, fetus 1
O3112X1	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, fetus 1
O3112X2	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, fetus 2
O3112X2	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, fetus 2
O3112X3	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, fetus 3

Code	Shortened Description
O3112X4	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, fetus 4
O3112X5	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, fetus 5
O3112X9	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, other fetus
O3113X0	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, not applicable or unspecified
O3113X0	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, not applicable or unspecified
O3113X1	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, fetus 1
O3113X1	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, fetus 1
O3113X2	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, fetus 2
O3113X2	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, fetus 2
O3113X3	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, fetus 3
O3113X4	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, fetus 4
O3113X5	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, fetus 5
O3113X9	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, other fetus
O3121X0	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, not applicable or unspecified
O3121X1	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, fetus 1
O3121X2	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, fetus 2
O3121X3	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, fetus 3
O3121X4	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, fetus 4
O3121X5	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, fetus 5
O3121X9	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, other fetus
O3122X0	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, not applicable or unspecified
O3122X1	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, fetus 1
O3122X2	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, fetus 2
O3122X3	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, fetus 3
O3122X4	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, fetus 4
O3122X5	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, fetus 5
O3122X9	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, other fetus

Code	Shortened Description
O3123X0	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, not applicable or unspecified
O3123X1	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, fetus 1
O3123X2	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, fetus 2
O3123X3	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, fetus 3
O3123X4	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, fetus 4
O3123X5	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, fetus 5
O3123X9	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, other fetus
O3131X0	Continuing pregnancy after elective fetal reduction of one fetus or more, first trimester, not applicable or unspecified
O3131X1	Continuing pregnancy after elective fetal reduction of one fetus or more, first trimester, fetus 1
O3131X2	Continuing pregnancy after elective fetal reduction of one fetus or more, first trimester, fetus 2
O3131X3	Continuing pregnancy after elective fetal reduction of one fetus or more, first trimester, fetus 3
O3131X4	Continuing pregnancy after elective fetal reduction of one fetus or more, first trimester, fetus 4
O3131X5	Continuing pregnancy after elective fetal reduction of one fetus or more, first trimester, fetus 5
O3131X9	Continuing pregnancy after elective fetal reduction of one fetus or more, first trimester, other fetus
O3132X0	Continuing pregnancy after elective fetal reduction of one fetus or more, second trimester, not applicable or unspecified
O3132X1	Continuing pregnancy after elective fetal reduction of one fetus or more, second trimester, fetus 1
O3132X2	Continuing pregnancy after elective fetal reduction of one fetus or more, second trimester, fetus 2
O3132X3	Continuing pregnancy after elective fetal reduction of one fetus or more, second trimester, fetus 3
O3132X4	Continuing pregnancy after elective fetal reduction of one fetus or more, second trimester, fetus 4
O3132X5	Continuing pregnancy after elective fetal reduction of one fetus or more, second trimester, fetus 5
O3132X9	Continuing pregnancy after elective fetal reduction of one fetus or more, second trimester, other fetus
O3133X0	Continuing pregnancy after elective fetal reduction of one fetus or more, third trimester, not applicable or unspecified
O3133X1	Continuing pregnancy after elective fetal reduction of one fetus or more, third trimester, fetus 1
O3133X2	Continuing pregnancy after elective fetal reduction of one fetus or more, third trimester, fetus 2
O3133X3	Continuing pregnancy after elective fetal reduction of one fetus or more, third trimester, fetus 3
O3133X4	Continuing pregnancy after elective fetal reduction of one fetus or more, third trimester, fetus 4
O3133X5	Continuing pregnancy after elective fetal reduction of one fetus or more, third trimester, fetus 5
O3133X9	Continuing pregnancy after elective fetal reduction of one fetus or more, third trimester, other fetus

Code	Shortened Description
O318X10	Other complications specific to multiple gestation, first trimester, not applicable or unspecified
O318X11	Other complications specific to multiple gestation, first trimester, fetus 1
O318X12	Other complications specific to multiple gestation, first trimester, fetus 2
O318X13	Other complications specific to multiple gestation, first trimester, fetus 3
O318X14	Other complications specific to multiple gestation, first trimester, fetus 4
O318X15	Other complications specific to multiple gestation, first trimester, fetus 5
O318X19	Other complications specific to multiple gestation, first trimester, other fetus
O318X20	Other complications specific to multiple gestation, second trimester, not applicable or unspecified
O318X21	Other complications specific to multiple gestation, second trimester, fetus 1
O318X22	Other complications specific to multiple gestation, second trimester, fetus 2
O318X23	Other complications specific to multiple gestation, second trimester, fetus 3
O318X24	Other complications specific to multiple gestation, second trimester, fetus 4
O318X25	Other complications specific to multiple gestation, second trimester, fetus 5
O318X29	Other complications specific to multiple gestation, second trimester, other fetus
O318X30	Other complications specific to multiple gestation, third trimester, not applicable or unspecified
O318X31	Other complications specific to multiple gestation, third trimester, fetus 1
O318X32	Other complications specific to multiple gestation, third trimester, fetus 2
O318X33	Other complications specific to multiple gestation, third trimester, fetus 3
O318X34	Other complications specific to multiple gestation, third trimester, fetus 4
O318X35	Other complications specific to multiple gestation, third trimester, fetus 5
O318X39	Other complications specific to multiple gestation, third trimester, other fetus
O320XX0	Maternal care for unstable lie, not applicable or unspecified
O320XX1	Maternal care for unstable lie, fetus 1
O320XX2	Maternal care for unstable lie, fetus 2
O320XX3	Maternal care for unstable lie, fetus 3
O320XX4	Maternal care for unstable lie, fetus 4
O320XX5	Maternal care for unstable lie, fetus 5
O320XX9	Maternal care for unstable lie, other fetus
O329XX0	Maternal care for malpresentation of fetus, unspecified, not applicable or unspecified
O329XX1	Maternal care for malpresentation of fetus, unspecified, fetus 1

Code	Shortened Description
O329XX2	Maternal care for malpresentation of fetus, unspecified, fetus 2
O329XX3	Maternal care for malpresentation of fetus, unspecified, fetus 3
O329XX4	Maternal care for malpresentation of fetus, unspecified, fetus 4
O329XX5	Maternal care for malpresentation of fetus, unspecified, fetus 5
O329XX9	Maternal care for malpresentation of fetus, unspecified, other fetus
O350XX0	Maternal care for (suspected) central nervous system malformation in fetus, not applicable or unspecified
O350XX1	Maternal care for (suspected) central nervous system malformation in fetus, fetus 1
O350XX2	Maternal care for (suspected) central nervous system malformation in fetus, fetus 2
O350XX3	Maternal care for (suspected) central nervous system malformation in fetus, fetus 3
O350XX4	Maternal care for (suspected) central nervous system malformation in fetus, fetus 4
O350XX5	Maternal care for (suspected) central nervous system malformation in fetus, fetus 5
O350XX9	Maternal care for (suspected) central nervous system malformation in fetus, other fetus
O351XX0	Maternal care for (suspected) chromosomal abnormality in fetus, not applicable or unspecified
O351XX1	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 1
O351XX2	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 2
O351XX3	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 3
O351XX4	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 4
O351XX5	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 5
O351XX9	Maternal care for (suspected) chromosomal abnormality in fetus, other fetus
O353XX0	Maternal care for (suspected) damage to fetus from viral disease in mother, not applicable or unspecified
O353XX1	Maternal care for (suspected) damage to fetus from viral disease in mother, fetus 1
O353XX2	Maternal care for (suspected) damage to fetus from viral disease in mother, fetus 2
O353XX3	Maternal care for (suspected) damage to fetus from viral disease in mother, fetus 3
O353XX4	Maternal care for (suspected) damage to fetus from viral disease in mother, fetus 4
O353XX5	Maternal care for (suspected) damage to fetus from viral disease in mother, fetus 5
O353XX9	Maternal care for (suspected) damage to fetus from viral disease in mother, other fetus
O354XX0	Maternal care for (suspected) damage to fetus from alcohol, not applicable or unspecified
O354XX1	Maternal care for (suspected) damage to fetus from alcohol, fetus 1
O354XX2	Maternal care for (suspected) damage to fetus from alcohol, fetus 2
O354XX3	Maternal care for (suspected) damage to fetus from alcohol, fetus 3

Code	Shortened Description
O354XX4	Maternal care for (suspected) damage to fetus from alcohol, fetus 4
O354XX5	Maternal care for (suspected) damage to fetus from alcohol, fetus 5
O354XX9	Maternal care for (suspected) damage to fetus from alcohol, other fetus
O355XX0	Maternal care for (suspected) damage to fetus by drugs, not applicable or unspecified
O355XX1	Maternal care for (suspected) damage to fetus by drugs, fetus 1
O355XX2	Maternal care for (suspected) damage to fetus by drugs, fetus 2
O355XX3	Maternal care for (suspected) damage to fetus by drugs, fetus 3
O355XX4	Maternal care for (suspected) damage to fetus by drugs, fetus 4
O355XX5	Maternal care for (suspected) damage to fetus by drugs, fetus 5
O355XX9	Maternal care for (suspected) damage to fetus by drugs, other fetus
O356XX0	Maternal care for (suspected) damage to fetus by radiation, not applicable or unspecified
O356XX1	Maternal care for (suspected) damage to fetus by radiation, fetus 1
O356XX2	Maternal care for (suspected) damage to fetus by radiation, fetus 2
O356XX3	Maternal care for (suspected) damage to fetus by radiation, fetus 3
O356XX4	Maternal care for (suspected) damage to fetus by radiation, fetus 4
O356XX5	Maternal care for (suspected) damage to fetus by radiation, fetus 5
O356XX9	Maternal care for (suspected) damage to fetus by radiation, other fetus
O358XX0	Maternal care for other (suspected) fetal abnormality and damage, not applicable or unspecified
O358XX1	Maternal care for other (suspected) fetal abnormality and damage, fetus 1
O358XX2	Maternal care for other (suspected) fetal abnormality and damage, fetus 2
O358XX3	Maternal care for other (suspected) fetal abnormality and damage, fetus 3
O358XX4	Maternal care for other (suspected) fetal abnormality and damage, fetus 4
O358XX5	Maternal care for other (suspected) fetal abnormality and damage, fetus 5
O358XX9	Maternal care for other (suspected) fetal abnormality and damage, other fetus
O360110	Maternal care for anti-D [Rh] antibodies, first trimester, not applicable or unspecified
O360111	Maternal care for anti-D [Rh] antibodies, first trimester, fetus 1
O360112	Maternal care for anti-D [Rh] antibodies, first trimester, fetus 2
O360113	Maternal care for anti-D [Rh] antibodies, first trimester, fetus 3
O360114	Maternal care for anti-D [Rh] antibodies, first trimester, fetus 4
O360115	Maternal care for anti-D [Rh] antibodies, first trimester, fetus 5

Code	Shortened Description
O360119	Maternal care for anti-D [Rh] antibodies, first trimester, other fetus
O360120	Maternal care for anti-D [Rh] antibodies, second trimester, not applicable or unspecified
O360121	Maternal care for anti-D [Rh] antibodies, second trimester, fetus 1
O360122	Maternal care for anti-D [Rh] antibodies, second trimester, fetus 2
O360123	Maternal care for anti-D [Rh] antibodies, second trimester, fetus 3
O360124	Maternal care for anti-D [Rh] antibodies, second trimester, fetus 4
O360125	Maternal care for anti-D [Rh] antibodies, second trimester, fetus 5
O360129	Maternal care for anti-D [Rh] antibodies, second trimester, other fetus
O360130	Maternal care for anti-D [Rh] antibodies, third trimester, not applicable or unspecified
O360131	Maternal care for anti-D [Rh] antibodies, third trimester, fetus 1
O360132	Maternal care for anti-D [Rh] antibodies, third trimester, fetus 2
O360133	Maternal care for anti-D [Rh] antibodies, third trimester, fetus 3
O360134	Maternal care for anti-D [Rh] antibodies, third trimester, fetus 4
O360135	Maternal care for anti-D [Rh] antibodies, third trimester, fetus 5
O360139	Maternal care for anti-D [Rh] antibodies, third trimester, other fetus
O360910	Maternal care for other rhesus isoimmunization, first trimester, not applicable or unspecified
O360911	Maternal care for other rhesus isoimmunization, first trimester, fetus 1
O360912	Maternal care for other rhesus isoimmunization, first trimester, fetus 2
O360913	Maternal care for other rhesus isoimmunization, first trimester, fetus 3
O360914	Maternal care for other rhesus isoimmunization, first trimester, fetus 4
O360915	Maternal care for other rhesus isoimmunization, first trimester, fetus 5
O360919	Maternal care for other rhesus isoimmunization, first trimester, other fetus
O360920	Maternal care for other rhesus isoimmunization, second trimester, not applicable or unspecified
O360921	Maternal care for other rhesus isoimmunization, second trimester, fetus 1
O360922	Maternal care for other rhesus isoimmunization, second trimester, fetus 2
O360923	Maternal care for other rhesus isoimmunization, second trimester, fetus 3
O360924	Maternal care for other rhesus isoimmunization, second trimester, fetus 4
O360925	Maternal care for other rhesus isoimmunization, second trimester, fetus 5
O360929	Maternal care for other rhesus isoimmunization, second trimester, other fetus
O360930	Maternal care for other rhesus isoimmunization, third trimester, not applicable or unspecified

Code	Shortened Description
O360931	Maternal care for other rhesus isoimmunization, third trimester, fetus 1
O360932	Maternal care for other rhesus isoimmunization, third trimester, fetus 2
O360933	Maternal care for other rhesus isoimmunization, third trimester, fetus 3
O360934	Maternal care for other rhesus isoimmunization, third trimester, fetus 4
O360935	Maternal care for other rhesus isoimmunization, third trimester, fetus 5
O360939	Maternal care for other rhesus isoimmunization, third trimester, other fetus
O361110	Maternal care for Anti-A sensitization, first trimester, not applicable or unspecified
O361111	Maternal care for Anti-A sensitization, first trimester, fetus 1
O361112	Maternal care for Anti-A sensitization, first trimester, fetus 2
O361113	Maternal care for Anti-A sensitization, first trimester, fetus 3
O361114	Maternal care for Anti-A sensitization, first trimester, fetus 4
O361115	Maternal care for Anti-A sensitization, first trimester, fetus 5
O361119	Maternal care for Anti-A sensitization, first trimester, other fetus
O361120	Maternal care for Anti-A sensitization, second trimester, not applicable or unspecified
O361121	Maternal care for Anti-A sensitization, second trimester, fetus 1
O361122	Maternal care for Anti-A sensitization, second trimester, fetus 2
O361123	Maternal care for Anti-A sensitization, second trimester, fetus 3
O361124	Maternal care for Anti-A sensitization, second trimester, fetus 4
O361125	Maternal care for Anti-A sensitization, second trimester, fetus 5
O361129	Maternal care for Anti-A sensitization, second trimester, other fetus
O361130	Maternal care for Anti-A sensitization, third trimester, not applicable or unspecified
O361131	Maternal care for Anti-A sensitization, third trimester, fetus 1
O361132	Maternal care for Anti-A sensitization, third trimester, fetus 2
O361133	Maternal care for Anti-A sensitization, third trimester, fetus 3
O361134	Maternal care for Anti-A sensitization, third trimester, fetus 4
O361135	Maternal care for Anti-A sensitization, third trimester, fetus 5
O361139	Maternal care for Anti-A sensitization, third trimester, other fetus
O361910	Maternal care for other isoimmunization, first trimester, not applicable or unspecified
O361911	Maternal care for other isoimmunization, first trimester, fetus 1
O361912	Maternal care for other isoimmunization, first trimester, fetus 2

Code	Shortened Description
O361913	Maternal care for other isoimmunization, first trimester, fetus 3
O361914	Maternal care for other isoimmunization, first trimester, fetus 4
O361915	Maternal care for other isoimmunization, first trimester, fetus 5
O361919	Maternal care for other isoimmunization, first trimester, other fetus
O361920	Maternal care for other isoimmunization, second trimester, not applicable or unspecified
O361921	Maternal care for other isoimmunization, second trimester, fetus 1
O361922	Maternal care for other isoimmunization, second trimester, fetus 2
O361923	Maternal care for other isoimmunization, second trimester, fetus 3
O361924	Maternal care for other isoimmunization, second trimester, fetus 4
O361925	Maternal care for other isoimmunization, second trimester, fetus 5
O361929	Maternal care for other isoimmunization, second trimester, other fetus
O361930	Maternal care for other isoimmunization, third trimester, not applicable or unspecified
O361931	Maternal care for other isoimmunization, third trimester, fetus 1
O361932	Maternal care for other isoimmunization, third trimester, fetus 2
O361933	Maternal care for other isoimmunization, third trimester, fetus 3
O361934	Maternal care for other isoimmunization, third trimester, fetus 4
O361935	Maternal care for other isoimmunization, third trimester, fetus 5
O361939	Maternal care for other isoimmunization, third trimester, other fetus
O364XX0	Maternal care for intrauterine death, not applicable or unspecified
O364XX1	Maternal care for intrauterine death, fetus 1
O364XX2	Maternal care for intrauterine death, fetus 2
O364XX3	Maternal care for intrauterine death, fetus 3
O364XX4	Maternal care for intrauterine death, fetus 4
O364XX5	Maternal care for intrauterine death, fetus 5
O364XX9	Maternal care for intrauterine death, other fetus
O365110	Maternal care for known or suspected placental insufficiency, first trimester, not applicable or unspecified
O365111	Maternal care for known or suspected placental insufficiency, first trimester, fetus 1
O365112	Maternal care for known or suspected placental insufficiency, first trimester, fetus 2
O365113	Maternal care for known or suspected placental insufficiency, first trimester, fetus 3
O365114	Maternal care for known or suspected placental insufficiency, first trimester, fetus 4

Code	Shortened Description
O365115	Maternal care for known or suspected placental insufficiency, first trimester, fetus 5
O365119	Maternal care for known or suspected placental insufficiency, first trimester, other fetus
O365120	Maternal care for known or suspected placental insufficiency, second trimester, not applicable or unspecified
O365121	Maternal care for known or suspected placental insufficiency, second trimester, fetus 1
O365122	Maternal care for known or suspected placental insufficiency, second trimester, fetus 2
O365123	Maternal care for known or suspected placental insufficiency, second trimester, fetus 3
O365124	Maternal care for known or suspected placental insufficiency, second trimester, fetus 4
O365125	Maternal care for known or suspected placental insufficiency, second trimester, fetus 5
O365129	Maternal care for known or suspected placental insufficiency, second trimester, other fetus
O365130	Maternal care for known or suspected placental insufficiency, third trimester, not applicable or unspecified
O365131	Maternal care for known or suspected placental insufficiency, third trimester, fetus 1
O365132	Maternal care for known or suspected placental insufficiency, third trimester, fetus 2
O365133	Maternal care for known or suspected placental insufficiency, third trimester, fetus 3
O365134	Maternal care for known or suspected placental insufficiency, third trimester, fetus 4
O365135	Maternal care for known or suspected placental insufficiency, third trimester, fetus 5
O365139	Maternal care for known or suspected placental insufficiency, third trimester, other fetus
O365910	Maternal care for other known or suspected poor fetal growth, first trimester, not applicable or unspecified
O365911	Maternal care for other known or suspected poor fetal growth, first trimester, fetus 1
O365912	Maternal care for other known or suspected poor fetal growth, first trimester, fetus 2
O365913	Maternal care for other known or suspected poor fetal growth, first trimester, fetus 3
O365914	Maternal care for other known or suspected poor fetal growth, first trimester, fetus 4
O365915	Maternal care for other known or suspected poor fetal growth, first trimester, fetus 5
O365919	Maternal care for other known or suspected poor fetal growth, first trimester, other fetus
O365920	Maternal care for other known or suspected poor fetal growth, second trimester, not applicable or unspecified
O365921	Maternal care for other known or suspected poor fetal growth, second trimester, fetus 1
O365922	Maternal care for other known or suspected poor fetal growth, second trimester, fetus 2
O365923	Maternal care for other known or suspected poor fetal growth, second trimester, fetus 3
O365924	Maternal care for other known or suspected poor fetal growth, second trimester, fetus 4
O365925	Maternal care for other known or suspected poor fetal growth, second trimester, fetus 5

Code	Shortened Description
O365929	Maternal care for other known or suspected poor fetal growth, second trimester, other fetus
O365930	Maternal care for other known or suspected poor fetal growth, third trimester, not applicable or unspecified
O365931	Maternal care for other known or suspected poor fetal growth, third trimester, fetus 1
O365932	Maternal care for other known or suspected poor fetal growth, third trimester, fetus 2
O365933	Maternal care for other known or suspected poor fetal growth, third trimester, fetus 3
O365934	Maternal care for other known or suspected poor fetal growth, third trimester, fetus 4
O365935	Maternal care for other known or suspected poor fetal growth, third trimester, fetus 5
O365939	Maternal care for other known or suspected poor fetal growth, third trimester, other fetus
O401XX0	Polyhydramnios, first trimester, not applicable or unspecified
O401XX1	Polyhydramnios, first trimester, fetus 1
O401XX2	Polyhydramnios, first trimester, fetus 2
O401XX3	Polyhydramnios, first trimester, fetus 3
O401XX4	Polyhydramnios, first trimester, fetus 4
O401XX5	Polyhydramnios, first trimester, fetus 5
O401XX9	Polyhydramnios, first trimester, other fetus
O402XX0	Polyhydramnios, second trimester, not applicable or unspecified
O402XX1	Polyhydramnios, second trimester, fetus 1
O402XX2	Polyhydramnios, second trimester, fetus 2
O402XX3	Polyhydramnios, second trimester, fetus 3
O402XX4	Polyhydramnios, second trimester, fetus 4
O402XX5	Polyhydramnios, second trimester, fetus 5
O402XX9	Polyhydramnios, second trimester, other fetus
O403XX0	Polyhydramnios, third trimester, not applicable or unspecified
O403XX1	Polyhydramnios, third trimester, fetus 1
O403XX2	Polyhydramnios, third trimester, fetus 2
O403XX3	Polyhydramnios, third trimester, fetus 3
O403XX4	Polyhydramnios, third trimester, fetus 4
O403XX5	Polyhydramnios, third trimester, fetus 5
O403XX9	Polyhydramnios, third trimester, other fetus
O4101X0	Oligohydramnios, first trimester, not applicable or unspecified

Code	Shortened Description
O4101X1	Oligohydramnios, first trimester, fetus 1
O4101X2	Oligohydramnios, first trimester, fetus 2
O4101X3	Oligohydramnios, first trimester, fetus 3
O4101X4	Oligohydramnios, first trimester, fetus 4
O4101X5	Oligohydramnios, first trimester, fetus 5
O4101X9	Oligohydramnios, first trimester, other fetus
O4102X0	Oligohydramnios, second trimester, not applicable or unspecified
O4102X1	Oligohydramnios, second trimester, fetus 1
O4102X2	Oligohydramnios, second trimester, fetus 2
O4102X3	Oligohydramnios, second trimester, fetus 3
O4102X4	Oligohydramnios, second trimester, fetus 4
O4102X5	Oligohydramnios, second trimester, fetus 5
O4102X9	Oligohydramnios, second trimester, other fetus
O4103X0	Oligohydramnios, third trimester, not applicable or unspecified
O4103X1	Oligohydramnios, third trimester, fetus 1
O4103X2	Oligohydramnios, third trimester, fetus 2
O4103X3	Oligohydramnios, third trimester, fetus 3
O4103X4	Oligohydramnios, third trimester, fetus 4
O4103X5	Oligohydramnios, third trimester, fetus 5
O4103X9	Oligohydramnios, third trimester, other fetus
O411010	Infection of amniotic sac and membranes, unspecified, first trimester, not applicable or unspecified
O411011	Infection of amniotic sac and membranes, unspecified, first trimester, fetus 1
O411012	Infection of amniotic sac and membranes, unspecified, first trimester, fetus 2
O411013	Infection of amniotic sac and membranes, unspecified, first trimester, fetus 3
O411014	Infection of amniotic sac and membranes, unspecified, first trimester, fetus 4
O411015	Infection of amniotic sac and membranes, unspecified, first trimester, fetus 5
O411019	Infection of amniotic sac and membranes, unspecified, first trimester, other fetus
O411020	Infection of amniotic sac and membranes, unspecified, second trimester, not applicable or unspecified
O411021	Infection of amniotic sac and membranes, unspecified, second trimester, fetus 1
O411022	Infection of amniotic sac and membranes, unspecified, second trimester, fetus 2

Code	Shortened Description
O411023	Infection of amniotic sac and membranes, unspecified, second trimester, fetus 3
O411024	Infection of amniotic sac and membranes, unspecified, second trimester, fetus 4
O411025	Infection of amniotic sac and membranes, unspecified, second trimester, fetus 5
O411029	Infection of amniotic sac and membranes, unspecified, second trimester, other fetus
O411030	Infection of amniotic sac and membranes, unspecified, third trimester, not applicable or unspecified
O411031	Infection of amniotic sac and membranes, unspecified, third trimester, fetus 1
O411032	Infection of amniotic sac and membranes, unspecified, third trimester, fetus 2
O411033	Infection of amniotic sac and membranes, unspecified, third trimester, fetus 3
O411034	Infection of amniotic sac and membranes, unspecified, third trimester, fetus 4
O411035	Infection of amniotic sac and membranes, unspecified, third trimester, fetus 5
O411039	Infection of amniotic sac and membranes, unspecified, third trimester, other fetus
O411210	Chorioamnionitis, first trimester, not applicable or unspecified
O411211	Chorioamnionitis, first trimester, fetus 1
O411212	Chorioamnionitis, first trimester, fetus 2
O411213	Chorioamnionitis, first trimester, fetus 3
O411214	Chorioamnionitis, first trimester, fetus 4
O411215	Chorioamnionitis, first trimester, fetus 5
O411219	Chorioamnionitis, first trimester, other fetus
O411220	Chorioamnionitis, second trimester, not applicable or unspecified
O411221	Chorioamnionitis, second trimester, fetus 1
O411222	Chorioamnionitis, second trimester, fetus 2
O411223	Chorioamnionitis, second trimester, fetus 3
O411224	Chorioamnionitis, second trimester, fetus 4
O411225	Chorioamnionitis, second trimester, fetus 5
O411229	Chorioamnionitis, second trimester, other fetus
O411230	Chorioamnionitis, third trimester, not applicable or unspecified
O411231	Chorioamnionitis, third trimester, fetus 1
O411232	Chorioamnionitis, third trimester, fetus 2
O411233	Chorioamnionitis, third trimester, fetus 3
O411234	Chorioamnionitis, third trimester, fetus 4

Code	Shortened Description
O411235	Chorioamnionitis, third trimester, fetus 5
O411239	Chorioamnionitis, third trimester, other fetus
O411410	Placentitis, first trimester, not applicable or unspecified
O411411	Placentitis, first trimester, fetus 1
O411412	Placentitis, first trimester, fetus 2
O411413	Placentitis, first trimester, fetus 3
O411414	Placentitis, first trimester, fetus 4
O411415	Placentitis, first trimester, fetus 5
O411419	Placentitis, first trimester, other fetus
O411420	Placentitis, second trimester, not applicable or unspecified
O411421	Placentitis, second trimester, fetus 1
O411422	Placentitis, second trimester, fetus 2
O411423	Placentitis, second trimester, fetus 3
O411424	Placentitis, second trimester, fetus 4
O411425	Placentitis, second trimester, fetus 5
O411429	Placentitis, second trimester, other fetus
O411430	Placentitis, third trimester, not applicable or unspecified
O411431	Placentitis, third trimester, fetus 1
O411432	Placentitis, third trimester, fetus 2
O411433	Placentitis, third trimester, fetus 3
O411434	Placentitis, third trimester, fetus 4
O411435	Placentitis, third trimester, fetus 5
O411439	Placentitis, third trimester, other fetus
O42011	Preterm premature rupture of membranes, onset of labor within 24 hours of rupture, first trimester
O42012	Preterm premature rupture of membranes, onset of labor within 24 hours of rupture, second trimester
O42013	Preterm premature rupture of membranes, onset of labor within 24 hours of rupture, third trimester
O4202	Full-term premature rupture of membranes, onset of labor within 24 hours of rupture
O42111	Preterm premature rupture of membranes, onset of labor more than 24 hours following rupture, first trimester
O42112	Preterm premature rupture of membranes, onset of labor more than 24 hours following rupture, second trimester

Code	Shortened Description
O42113	Preterm premature rupture of membranes, onset of labor more than 24 hours following rupture, third trimester
O4212	Full-term premature rupture of membranes, onset of labor more than 24 hours following rupture
O42911	Preterm premature rupture of membranes, unspecified as to length of time between rupture and onset of labor, first trimester
O42912	Preterm premature rupture of membranes, unspecified as to length of time between rupture and onset of labor, second trimester
O42913	Preterm premature rupture of membranes, unspecified as to length of time between rupture and onset of labor, third trimester
O4292	Full-term premature rupture of membranes, unspecified as to length of time between rupture and onset of labor
O43011	Fetomaternal placental transfusion syndrome, first trimester
O43012	Fetomaternal placental transfusion syndrome, second trimester
O43013	Fetomaternal placental transfusion syndrome, third trimester
O4401	Placenta previa specified as without hemorrhage, first trimester
O4402	Placenta previa specified as without hemorrhage, second trimester
O4403	Placenta previa specified as without hemorrhage, third trimester
O4411	Placenta previa with hemorrhage, first trimester
O4412	Placenta previa with hemorrhage, second trimester
O4413	Placenta previa with hemorrhage, third trimester
O45001	Premature separation of placenta with coagulation defect, unspecified, first trimester
O45002	Premature separation of placenta with coagulation defect, unspecified, second trimester
O45003	Premature separation of placenta with coagulation defect, unspecified, third trimester
O45011	Premature separation of placenta with afibrinogenemia, first trimester
O45012	Premature separation of placenta with afibrinogenemia, second trimester
O45013	Premature separation of placenta with afibrinogenemia, third trimester
O45021	Premature separation of placenta with disseminated intravascular coagulation, first trimester
O45022	Premature separation of placenta with disseminated intravascular coagulation, second trimester
O45023	Premature separation of placenta with disseminated intravascular coagulation, third trimester
O45091	Premature separation of placenta with other coagulation defect, first trimester
O45092	Premature separation of placenta with other coagulation defect, second trimester
O45093	Premature separation of placenta with other coagulation defect, third trimester

Code	Shortened Description
O458X1	Other premature separation of placenta, first trimester
O458X2	Other premature separation of placenta, second trimester
O458X3	Other premature separation of placenta, third trimester
O4591	Premature separation of placenta, unspecified, first trimester
O4592	Premature separation of placenta, unspecified, second trimester
O4593	Premature separation of placenta, unspecified, third trimester
O46001	Antepartum hemorrhage with coagulation defect, unspecified, first trimester
O46002	Antepartum hemorrhage with coagulation defect, unspecified, second trimester
O46003	Antepartum hemorrhage with coagulation defect, unspecified, third trimester
O46011	Antepartum hemorrhage with afibrinogenemia, first trimester
O46012	Antepartum hemorrhage with afibrinogenemia, second trimester
O46013	Antepartum hemorrhage with afibrinogenemia, third trimester
O46021	Antepartum hemorrhage with disseminated intravascular coagulation, first trimester
O46022	Antepartum hemorrhage with disseminated intravascular coagulation, second trimester
O46023	Antepartum hemorrhage with disseminated intravascular coagulation, third trimester
O46091	Antepartum hemorrhage with other coagulation defect, first trimester
O46092	Antepartum hemorrhage with other coagulation defect, second trimester
O46093	Antepartum hemorrhage with other coagulation defect, third trimester
O468X1	Other antepartum hemorrhage, first trimester
O468X2	Other antepartum hemorrhage, second trimester
O468X3	Other antepartum hemorrhage, third trimester
O4691	Antepartum hemorrhage, unspecified, first trimester
O4692	Antepartum hemorrhage, unspecified, second trimester
O4693	Antepartum hemorrhage, unspecified, third trimester
O480	Post-term pregnancy
O666	Obstructed labor due to other multiple fetuses
O670	Intrapartum hemorrhage with coagulation defect
O678	Other intrapartum hemorrhage
O679	Intrapartum hemorrhage, unspecified
O68	Labor and delivery complicated by abnormality of fetal acid-base balance

Code	Shortened Description
O690XX0	Labor and delivery complicated by prolapse of cord, not applicable or unspecified
O690XX1	Labor and delivery complicated by prolapse of cord, fetus 1
O690XX2	Labor and delivery complicated by prolapse of cord, fetus 2
O690XX3	Labor and delivery complicated by prolapse of cord, fetus 3
O690XX4	Labor and delivery complicated by prolapse of cord, fetus 4
O690XX5	Labor and delivery complicated by prolapse of cord, fetus 5
O690XX9	Labor and delivery complicated by prolapse of cord, other fetus
O694XX0	Labor and delivery complicated by vasa previa, not applicable or unspecified
O694XX1	Labor and delivery complicated by vasa previa, fetus 1
O694XX2	Labor and delivery complicated by vasa previa, fetus 2
O694XX3	Labor and delivery complicated by vasa previa, fetus 3
O694XX4	Labor and delivery complicated by vasa previa, fetus 4
O694XX5	Labor and delivery complicated by vasa previa, fetus 5
O694XX9	Labor and delivery complicated by vasa previa, other fetus
O7102	Rupture of uterus before onset of labor, second trimester
O7103	Rupture of uterus before onset of labor, third trimester
O76	Abnormality in fetal heart rate and rhythm complicating labor and delivery
O99111	Other diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism complicating pregnancy, first trimester
O99112	Other diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism complicating pregnancy, second trimester
O99113	Other diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism complicating pregnancy, third trimester
O9912	Other diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism complicating childbirth
O9913	Other diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism complicating the puerperium
O99411	Diseases of the circulatory system complicating pregnancy, first trimester
O99411	Diseases of the circulatory system complicating pregnancy, first trimester
O99412	Diseases of the circulatory system complicating pregnancy, second trimester
O99412	Diseases of the circulatory system complicating pregnancy, second trimester
O99413	Diseases of the circulatory system complicating pregnancy, third trimester

Code	Shortened Description
O99413	Diseases of the circulatory system complicating pregnancy, third trimester
O9942	Diseases of the circulatory system complicating childbirth
O9942	Diseases of the circulatory system complicating childbirth
O9943	Diseases of the circulatory system complicating the puerperium
O9943	Diseases of the circulatory system complicating the puerperium
O99810	Abnormal glucose complicating pregnancy
O99814	Abnormal glucose complicating childbirth
O99815	Abnormal glucose complicating the puerperium
Z21	Asymptomatic human immunodeficiency virus [HIV] infection status
Z371	Single stillbirth
Z7901	Long term (current) use of anticoagulants

Table Number 11.08: Outcome of Delivery

Code	Shortened Description
Z370	Single live birth

Table Number 11.09: Multiple Gestations and Other Presentations

Code	Shortened Description
O30001	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, first trimester
O30002	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30003	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O30011	Twin pregnancy, monochorionic/monoamniotic, first trimester
O30012	Twin pregnancy, monochorionic/monoamniotic, second trimester
O30013	Twin pregnancy, monochorionic/monoamniotic, third trimester
O30031	Twin pregnancy, monochorionic/diamniotic, first trimester
O30032	Twin pregnancy, monochorionic/diamniotic, second trimester
O30033	Twin pregnancy, monochorionic/diamniotic, third trimester
O30041	Twin pregnancy, dichorionic/diamniotic, first trimester
O30042	Twin pregnancy, dichorionic/diamniotic, second trimester
O30043	Twin pregnancy, dichorionic/diamniotic, third trimester

Code	Shortened Description
O30091	Twin pregnancy, unable to determine number of placenta and number of amniotic sacs, first trimester
O30092	Twin pregnancy, unable to determine number of placenta and number of amniotic sacs, second trimester
O30093	Twin pregnancy, unable to determine number of placenta and number of amniotic sacs, third trimester
O30101	Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, first trimester
O30102	Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30103	Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O30111	Triplet pregnancy with two or more monochorionic fetuses, first trimester
O30112	Triplet pregnancy with two or more monochorionic fetuses, second trimester
O30113	Triplet pregnancy with two or more monochorionic fetuses, third trimester
O30121	Triplet pregnancy with two or more monoamniotic fetuses, first trimester
O30122	Triplet pregnancy with two or more monoamniotic fetuses, second trimester
O30123	Triplet pregnancy with two or more monoamniotic fetuses, third trimester
O30191	Triplet pregnancy, unable to determine number of placenta and number of amniotic sacs, first trimester
O30192	Triplet pregnancy, unable to determine number of placenta and number of amniotic sacs, second trimester
O30193	Triplet pregnancy, unable to determine number of placenta and number of amniotic sacs, third trimester
O30201	Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, first trimester
O30202	Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30203	Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O30211	Quadruplet pregnancy with two or more monochorionic fetuses, first trimester
O30212	Quadruplet pregnancy with two or more monochorionic fetuses, second trimester
O30213	Quadruplet pregnancy with two or more monochorionic fetuses, third trimester
O30221	Quadruplet pregnancy with two or more monoamniotic fetuses, first trimester
O30222	Quadruplet pregnancy with two or more monoamniotic fetuses, second trimester
O30223	Quadruplet pregnancy with two or more monoamniotic fetuses, third trimester
O30291	Quadruplet pregnancy, unable to determine number of placenta and number of amniotic sacs, first trimester
O30292	Quadruplet pregnancy, unable to determine number of placenta and number of amniotic sacs, second trimester
O30293	Quadruplet pregnancy, unable to determine number of placenta and number of amniotic sacs, third trimester

Code	Shortened Description
O30801	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs, first trimester
O30802	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30803	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O30811	Other specified multiple gestation with two or more monochorionic fetuses, first trimester
O30812	Other specified multiple gestation with two or more monochorionic fetuses, second trimester
O30813	Other specified multiple gestation with two or more monochorionic fetuses, third trimester
O30821	Other specified multiple gestation with two or more monoamniotic fetuses, first trimester
O30822	Other specified multiple gestation with two or more monoamniotic fetuses, second trimester
O30823	Other specified multiple gestation with two or more monoamniotic fetuses, third trimester
O30891	Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs, first trimester
O30892	Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs, second trimester
O30893	Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs, third trimester
O3091	Multiple gestation, unspecified, first trimester
O3092	Multiple gestation, unspecified, second trimester
O3093	Multiple gestation, unspecified, third trimester
O3111X0	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, not applicable or unspecified
O3111X1	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, fetus 1
O3111X2	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, fetus 2
O3111X3	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, fetus 3
O3111X4	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, fetus 4
O3111X5	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, fetus 5
O3111X9	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, other fetus
O3112X0	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, not applicable or unspecified
O3112X1	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, fetus 1
O3112X2	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, fetus 2

Code	Shortened Description
O3112X3	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, fetus 3
O3112X4	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, fetus 4
O3112X5	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, fetus 5
O3112X9	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, other fetus
O3113X0	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, not applicable or unspecified
O3113X1	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, fetus 1
O3113X2	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, fetus 2
O3113X3	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, fetus 3
O3113X4	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, fetus 4
O3113X5	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, fetus 5
O3113X9	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, other fetus
O3121X0	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, not applicable or unspecified
O3121X1	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, fetus 1
O3121X2	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, fetus 2
O3121X3	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, fetus 3
O3121X4	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, fetus 4
O3121X5	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, fetus 5
O3121X9	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, other fetus
O3122X0	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, not applicable or unspecified
O3122X1	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, fetus 1
O3122X2	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, fetus 2
O3122X3	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, fetus 3
O3122X4	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, fetus 4
O3122X5	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, fetus 5
O3122X9	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, other fetus
O3123X0	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, not applicable or unspecified
O3123X1	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, fetus 1
O3123X2	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, fetus 2

Code	Shortened Description
O3123X3	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, fetus 3
O3123X4	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, fetus 4
O3123X5	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, fetus 5
O3123X9	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, other fetus
O318X10	Other complications specific to multiple gestation, first trimester, not applicable or unspecified
O318X11	Other complications specific to multiple gestation, first trimester, fetus 1
O318X12	Other complications specific to multiple gestation, first trimester, fetus 2
O318X13	Other complications specific to multiple gestation, first trimester, fetus 3
O318X14	Other complications specific to multiple gestation, first trimester, fetus 4
O318X15	Other complications specific to multiple gestation, first trimester, fetus 5
O318X19	Other complications specific to multiple gestation, first trimester, other fetus
O318X20	Other complications specific to multiple gestation, second trimester, not applicable or unspecified
O318X21	Other complications specific to multiple gestation, second trimester, fetus 1
O318X22	Other complications specific to multiple gestation, second trimester, fetus 2
O318X23	Other complications specific to multiple gestation, second trimester, fetus 3
O318X24	Other complications specific to multiple gestation, second trimester, fetus 4
O318X25	Other complications specific to multiple gestation, second trimester, fetus 5
O318X29	Other complications specific to multiple gestation, second trimester, other fetus
O318X30	Other complications specific to multiple gestation, third trimester, not applicable or unspecified
O318X31	Other complications specific to multiple gestation, third trimester, fetus 1
O318X32	Other complications specific to multiple gestation, third trimester, fetus 2
O318X33	Other complications specific to multiple gestation, third trimester, fetus 3
O318X34	Other complications specific to multiple gestation, third trimester, fetus 4
O318X35	Other complications specific to multiple gestation, third trimester, fetus 5
O318X39	Other complications specific to multiple gestation, third trimester, other fetus
O321XX0	Maternal care for breech presentation, not applicable or unspecified
O321XX1	Maternal care for breech presentation, fetus 1
O321XX2	Maternal care for breech presentation, fetus 2
O321XX3	Maternal care for breech presentation, fetus 3
O321XX4	Maternal care for breech presentation, fetus 4

Code	Shortened Description
O321XX5	Maternal care for breech presentation, fetus 5
O321XX9	Maternal care for breech presentation, other fetus
O322XX0	Maternal care for transverse and oblique lie, not applicable or unspecified
O322XX1	Maternal care for transverse and oblique lie, fetus 1
O322XX2	Maternal care for transverse and oblique lie, fetus 2
O322XX3	Maternal care for transverse and oblique lie, fetus 3
O322XX4	Maternal care for transverse and oblique lie, fetus 4
O322XX5	Maternal care for transverse and oblique lie, fetus 5
O322XX9	Maternal care for transverse and oblique lie, other fetus
O323XX0	Maternal care for face, brow and chin presentation, not applicable or unspecified
O323XX1	Maternal care for face, brow and chin presentation, fetus 1
O323XX2	Maternal care for face, brow and chin presentation, fetus 2
O323XX3	Maternal care for face, brow and chin presentation, fetus 3
O323XX4	Maternal care for face, brow and chin presentation, fetus 4
O323XX5	Maternal care for face, brow and chin presentation, fetus 5
O323XX9	Maternal care for face, brow and chin presentation, other fetus
O328XX0	Maternal care for other malpresentation of fetus, not applicable or unspecified
O328XX1	Maternal care for other malpresentation of fetus, fetus 1
O328XX2	Maternal care for other malpresentation of fetus, fetus 2
O328XX3	Maternal care for other malpresentation of fetus, fetus 3
O328XX4	Maternal care for other malpresentation of fetus, fetus 4
O328XX5	Maternal care for other malpresentation of fetus, fetus 5
O328XX9	Maternal care for other malpresentation of fetus, other fetus
O329XX0	Maternal care for malpresentation of fetus, unspecified, not applicable or unspecified
O329XX1	Maternal care for malpresentation of fetus, unspecified, fetus 1
O329XX2	Maternal care for malpresentation of fetus, unspecified, fetus 2
O329XX3	Maternal care for malpresentation of fetus, unspecified, fetus 3
O329XX4	Maternal care for malpresentation of fetus, unspecified, fetus 4
O329XX5	Maternal care for malpresentation of fetus, unspecified, fetus 5
O329XX9	Maternal care for malpresentation of fetus, unspecified, other fetus

Code	Shortened Description
O3421	Maternal care for scar from previous cesarean delivery
O364XX0	Maternal care for intrauterine death, not applicable or unspecified
O364XX1	Maternal care for intrauterine death, fetus 1
O364XX2	Maternal care for intrauterine death, fetus 2
O364XX3	Maternal care for intrauterine death, fetus 3
O364XX4	Maternal care for intrauterine death, fetus 4
O364XX5	Maternal care for intrauterine death, fetus 5
O364XX9	Maternal care for intrauterine death, other fetus
O6012X0	Preterm labor second trimester with preterm delivery second trimester, not applicable or unspecified
O6012X1	Preterm labor second trimester with preterm delivery second trimester, fetus 1
O6012X2	Preterm labor second trimester with preterm delivery second trimester, fetus 2
O6012X3	Preterm labor second trimester with preterm delivery second trimester, fetus 3
O6012X4	Preterm labor second trimester with preterm delivery second trimester, fetus 4
O6012X5	Preterm labor second trimester with preterm delivery second trimester, fetus 5
O6012X9	Preterm labor second trimester with preterm delivery second trimester, other fetus
O6013X0	Preterm labor second trimester with preterm delivery third trimester, not applicable or unspecified
O6013X1	Preterm labor second trimester with preterm delivery third trimester, fetus 1
O6013X2	Preterm labor second trimester with preterm delivery third trimester, fetus 2
O6013X3	Preterm labor second trimester with preterm delivery third trimester, fetus 3
O6013X4	Preterm labor second trimester with preterm delivery third trimester, fetus 4
O6013X5	Preterm labor second trimester with preterm delivery third trimester, fetus 5
O6013X9	Preterm labor second trimester with preterm delivery third trimester, other fetus
O6014X0	Preterm labor third trimester with preterm delivery third trimester, not applicable or unspecified
O6014X1	Preterm labor third trimester with preterm delivery third trimester, fetus 1
O6014X2	Preterm labor third trimester with preterm delivery third trimester, fetus 2
O6014X3	Preterm labor third trimester with preterm delivery third trimester, fetus 3
O6014X4	Preterm labor third trimester with preterm delivery third trimester, fetus 4
O6014X5	Preterm labor third trimester with preterm delivery third trimester, fetus 5
O6014X9	Preterm labor third trimester with preterm delivery third trimester, other fetus
O6022X0	Term delivery with preterm labor, second trimester, not applicable or unspecified

Code	Shortened Description
O6022X1	Term delivery with preterm labor, second trimester, fetus 1
O6022X2	Term delivery with preterm labor, second trimester, fetus 2
O6022X3	Term delivery with preterm labor, second trimester, fetus 3
O6022X4	Term delivery with preterm labor, second trimester, fetus 4
O6022X5	Term delivery with preterm labor, second trimester, fetus 5
O6022X9	Term delivery with preterm labor, second trimester, other fetus
O6023X0	Term delivery with preterm labor, third trimester, not applicable or unspecified
O6023X1	Term delivery with preterm labor, third trimester, fetus 1
O6023X2	Term delivery with preterm labor, third trimester, fetus 2
O6023X3	Term delivery with preterm labor, third trimester, fetus 3
O6023X4	Term delivery with preterm labor, third trimester, fetus 4
O6023X5	Term delivery with preterm labor, third trimester, fetus 5
O6023X9	Term delivery with preterm labor, third trimester, other fetus
O632	Delayed delivery of second twin, triplet, etc.
O641XX0	Obstructed labor due to breech presentation, not applicable or unspecified
O641XX0	Obstructed labor due to breech presentation, not applicable or unspecified
O641XX1	Obstructed labor due to breech presentation, fetus 1
O641XX2	Obstructed labor due to breech presentation, fetus 2
O641XX3	Obstructed labor due to breech presentation, fetus 3
O641XX4	Obstructed labor due to breech presentation, fetus 4
O641XX5	Obstructed labor due to breech presentation, fetus 5
O641XX9	Obstructed labor due to breech presentation, other fetus
O642XX0	Obstructed labor due to face presentation, not applicable or unspecified
O642XX1	Obstructed labor due to face presentation, fetus 1
O642XX2	Obstructed labor due to face presentation, fetus 2
O642XX3	Obstructed labor due to face presentation, fetus 3
O642XX4	Obstructed labor due to face presentation, fetus 4
O642XX5	Obstructed labor due to face presentation, fetus 5
O642XX9	Obstructed labor due to face presentation, other fetus
O643XX0	Obstructed labor due to brow presentation, not applicable or unspecified

Code	Shortened Description
O643XX1	Obstructed labor due to brow presentation, fetus 1
O643XX2	Obstructed labor due to brow presentation, fetus 2
O643XX3	Obstructed labor due to brow presentation, fetus 3
O643XX4	Obstructed labor due to brow presentation, fetus 4
O643XX5	Obstructed labor due to brow presentation, fetus 5
O643XX9	Obstructed labor due to brow presentation, other fetus
O648XX0	Obstructed labor due to other malposition and malpresentation, not applicable or unspecified
O648XX1	Obstructed labor due to other malposition and malpresentation, fetus 1
O648XX2	Obstructed labor due to other malposition and malpresentation, fetus 2
O648XX3	Obstructed labor due to other malposition and malpresentation, fetus 3
O648XX4	Obstructed labor due to other malposition and malpresentation, fetus 4
O648XX5	Obstructed labor due to other malposition and malpresentation, fetus 5
O648XX9	Obstructed labor due to other malposition and malpresentation, other fetus
O661	Obstructed labor due to locked twins
O666	Obstructed labor due to other multiple fetuses
P015	Newborn (suspected to be) affected by multiple pregnancy
Z371	Single stillbirth
Z372	Twins, both liveborn
Z373	Twins, one liveborn and one stillborn
Z374	Twins, both stillborn
Z3750	Multiple births, unspecified, all liveborn
Z3751	Triplets, all liveborn
Z3752	Quadruplets, all liveborn
Z3753	Quintuplets, all liveborn
Z3754	Sextuplets, all liveborn
Z3759	Other multiple births, all liveborn
Z3760	Multiple births, unspecified, some liveborn
Z3761	Triplets, some liveborn
Z3762	Quadruplets, some liveborn
Z3763	Quintuplets, some liveborn

Code	Shortened Description
Z3764	Sextuplets, some liveborn
Z3769	Other multiple births, some liveborn
Z377	Other multiple births, all stillborn

Table Number 11.09.1: Fetal Demise

Code	Shortened Description
O364XX0	Maternal care for intrauterine death, not applicable or unspecified

Table Number 11.10: Newborn Septicemia or Bacteremia

Code	Shortened Description
P360	Sepsis of newborn due to streptococcus, group B
P3610	Sepsis of newborn due to unspecified streptococci
P3619	Sepsis of newborn due to other streptococci
P362	Sepsis of newborn due to Staphylococcus aureus
P3630	Sepsis of newborn due to unspecified staphylococci
P3639	Sepsis of newborn due to other staphylococci
P364	Sepsis of newborn due to Escherichia coli
P365	Sepsis of newborn due to anaerobes
P368	Other bacterial sepsis of newborn
P369	Bacterial sepsis of newborn, unspecified
R7881	Bacteremia

Table Number 11.10.1: Sepsis

Code	Shortened Description
A021	Salmonella sepsis
A227	Anthrax sepsis
A267	Erysipelothrix sepsis
A327	Listerial sepsis
A400	Sepsis due to streptococcus, group A
A401	Sepsis due to streptococcus, group B
A403	Sepsis due to Streptococcus pneumoniae

Code	Shortened Description
A403	Sepsis due to Streptococcus pneumoniae
A408	Other streptococcal sepsis
A409	Streptococcal sepsis, unspecified
A4101	Sepsis due to Methicillin susceptible Staphylococcus aureus
A4102	Sepsis due to Methicillin resistant Staphylococcus aureus
A411	Sepsis due to other specified staphylococcus
A412	Sepsis due to unspecified staphylococcus
A413	Sepsis due to Hemophilus influenzae
A414	Sepsis due to anaerobes
A4150	Gram-negative sepsis, unspecified
A4151	Sepsis due to Escherichia coli [E. coli]
A4152	Sepsis due to Pseudomonas
A4153	Sepsis due to Serratia
A4159	Other Gram-negative sepsis
A4181	Sepsis due to Enterococcus
A4189	Other specified sepsis
A419	Sepsis, unspecified organism
A427	Actinomycotic sepsis
A5486	Gonococcal sepsis
B377	Candidal sepsis
R6520	Severe sepsis without septic shock
R6521	Severe sepsis with septic shock
R7881	Bacteremia
T8112XA	Postprocedural septic shock, initial encounter

Table Number 11.10.2: Septicemias or Bacteremias

Code	Shortened Description
A021	Salmonella sepsis
A227	Anthrax sepsis
A267	Erysipelothrix sepsis

Code	Shortened Description
A327	Listerial sepsis
A400	Sepsis due to streptococcus, group A
A401	Sepsis due to streptococcus, group B
A403	Sepsis due to Streptococcus pneumoniae
A408	Other streptococcal sepsis
A409	Streptococcal sepsis, unspecified
A4101	Sepsis due to Methicillin susceptible Staphylococcus aureus
A4102	Sepsis due to Methicillin resistant Staphylococcus aureus
A411	Sepsis due to other specified staphylococcus
A412	Sepsis due to unspecified staphylococcus
A413	Sepsis due to Hemophilus influenzae
A414	Sepsis due to anaerobes
A4150	Gram-negative sepsis, unspecified
A4151	Sepsis due to Escherichia coli [E. coli]
A4152	Sepsis due to Pseudomonas
A4153	Sepsis due to Serratia
A4159	Other Gram-negative sepsis
A4181	Sepsis due to Enterococcus
A4189	Other specified sepsis
A419	Sepsis, unspecified organism
A427	Actinomycotic sepsis
A4901	Methicillin susceptible Staphylococcus aureus infection, unspecified site
A5486	Gonococcal sepsis
B377	Candidal sepsis
B952	Enterococcus as the cause of diseases classified elsewhere
B9561	Methicillin susceptible Staphylococcus aureus infection as the cause of diseases classified elsewhere
B957	Other staphylococcus as the cause of diseases classified elsewhere
B958	Unspecified staphylococcus as the cause of diseases classified elsewhere
B961	Klebsiella pneumoniae [K. pneumoniae] as the cause of diseases classified elsewhere
B9620	Unspecified Escherichia coli [E. coli] as the cause of diseases classified elsewhere

Code	Shortened Description
B9621	Shiga toxin-producing Escherichia coli [E. coli] (STEC) O157 as the cause of diseases classified elsewhere
B9622	Other specified Shiga toxin-producing Escherichia coli [E. coli] (STEC) as the cause of diseases classified elsewhere
B9623	Unspecified Shiga toxin-producing Escherichia coli [E. coli] (STEC) as the cause of diseases classified elsewhere
B9629	Other Escherichia coli [E. coli] as the cause of diseases classified elsewhere
B965	Pseudomonas (aeruginosa) (mallei) (pseudomallei) as the cause of diseases classified elsewhere
B9689	Other specified bacterial agents as the cause of diseases classified elsewhere
R571	Hypovolemic shock
R578	Other shock
R6520	Severe sepsis without septic shock
R6521	Severe sepsis with septic shock
R7881	Bacteremia
T8110XA	Postprocedural shock unspecified, initial encounter

Table Number 11.10.3: Liveborn Newborn

Code	Shortened Description
Z3800	Single liveborn infant, delivered vaginally
Z3801	Single liveborn infant, delivered by cesarean
Z381	Single liveborn infant, born outside hospital
Z382	Single liveborn infant, unspecified as to place of birth
Z3830	Twin liveborn infant, delivered vaginally
Z3831	Twin liveborn infant, delivered by cesarean
Z384	Twin liveborn infant, born outside hospital
Z385	Twin liveborn infant, unspecified as to place of birth
Z3861	Triplet liveborn infant, delivered vaginally
Z3862	Triplet liveborn infant, delivered by cesarean
Z3863	Quadruplet liveborn infant, delivered vaginally
Z3864	Quadruplet liveborn infant, delivered by cesarean
Z3865	Quintuplet liveborn infant, delivered vaginally
Z3866	Quintuplet liveborn infant, delivered by cesarean

Code	Shortened Description
Z3868	Other multiple liveborn infant, delivered vaginally
Z3869	Other multiple liveborn infant, delivered by cesarean
Z387	Other multiple liveborn infant, born outside hospital
Z388	Other multiple liveborn infant, unspecified as to place of birth

Table Number 11.12: Birth Weight 500-749 Grams

Code	Shortened Description
P0502	Newborn light for gestational age, 500-749 grams
P0512	Newborn small for gestational age, 500-749 grams
P052	Newborn affected by fetal (intrauterine) malnutrition not light or small for gestational age
P059	Newborn affected by slow intrauterine growth, unspecified
P0702	Extremely low birth weight newborn, 500-749 grams

Table Number 11.13: Birth Weight 750-999 Grams

Code	Shortened Description
P0503	Newborn light for gestational age, 750-999 grams
P0513	Newborn small for gestational age, 750-999 grams
P052	Newborn affected by fetal (intrauterine) malnutrition not light or small for gestational age
P059	Newborn affected by slow intrauterine growth, unspecified
P0703	Extremely low birth weight newborn, 750-999 grams

Table Number 11.14: Birth Weight 1000-1499 Grams

Code	Shortened Description
P0504	Newborn light for gestational age, 1000-1249 grams
P0505	Newborn light for gestational age, 1250-1499 grams
P0514	Newborn small for gestational age, 1000-1249 grams
P0515	Newborn small for gestational age, 1250-1499 grams
P052	Newborn affected by fetal (intrauterine) malnutrition not light or small for gestational age
P059	Newborn affected by slow intrauterine growth, unspecified
P0714	Other low birth weight newborn, 1000-1249 grams
P0715	Other low birth weight newborn, 1250-1499 grams

Table Number 11.15: Birth Weight 1500-1999 Grams

Code	Shortened Description
P0506	Newborn light for gestational age, 1500-1749 grams
P0507	Newborn light for gestational age, 1750-1999 grams
P0516	Newborn small for gestational age, 1500-1749 grams
P0517	Newborn small for gestational age, 1750-1999 grams
P052	Newborn affected by fetal (intrauterine) malnutrition not light or small for gestational age
P059	Newborn affected by slow intrauterine growth, unspecified
P0716	Other low birth weight newborn, 1500-1749 grams
P0717	Other low birth weight newborn, 1750-1999 grams

Table Number 11.16: Birth Weight 2000-2499

Code	Shortened Description
P0508	Newborn light for gestational age, 2000-2499 grams
P0518	Newborn small for gestational age, 2000-2499 grams
P052	Newborn affected by fetal (intrauterine) malnutrition not light or small for gestational age
P059	Newborn affected by slow intrauterine growth, unspecified
P0718	Other low birth weight newborn, 2000-2499 grams

Table Number 11.18: Major Surgery

Please download Excel file at top which includes 11.18 codes

Table Number 11.19: Mechanical Ventilation

Code	Shortened Description
5A1935Z	Respiratory Ventilation, Less than 24 Consecutive Hours
5A1945Z	Respiratory Ventilation, 24-96 Consecutive Hours
5A1955Z	Respiratory Ventilation, Greater than 96 Consecutive Hours

Table Number 11.20: Birth weight less than 500 g

Code	Shortened Description
P0501	Newborn light for gestational age, less than 500 grams
P0511	Newborn small for gestational age, less than 500 grams

Code	Shortened Description
P052	Newborn affected by fetal (intrauterine) malnutrition not light or small for gestational age
P059	Newborn affected by slow intrauterine growth, unspecified
P0701	Extremely low birth weight newborn, less than 500 grams

Table Number 11.20.1: Single Liveborn Newborn

Code	Shortened Description
Z3800	Single liveborn infant, delivered vaginally
Z3801	Single liveborn infant, delivered by cesarean

Table Number 11.21: Galactosemia

Code	Shortened Description
E7420	Disorders of galactose metabolism, unspecified
E7421	Galactosemia
E7429	Other disorders of galactose metabolism

Table Number 11.22: Parenteral Nutrition

Code	Shortened Description
3E0336Z	Introduction of Nutritional Substance into Peripheral Vein, Percutaneous Approach
3E0436Z	Introduction of Nutritional Substance into Central Vein, Percutaneous Approach
3E0536Z	Introduction of Nutritional Substance into Peripheral Artery, Percutaneous Approach
3E0636Z	Introduction of Nutritional Substance into Central Artery, Percutaneous Approach

Appendix C

Medication Tables

- Download Medication Tables (MS Excel)

Table Number 10.0: Antipsychotic Medications *(Ver. 2015B)*

Medication	Generic
Abilify Discmelt	Aripiprazole
Abilify Maintena	Aripiprazole
Abilify Oral Solution	Aripiprazole
Abilify Tablets	Aripiprazole
Antipsychotic Not Otherwise Specified (NOS)	Antipsychotic Not Otherwise Specified (NOS)
Aripiprazole Oral Solution	Aripiprazole
Aripiprazole Tablets	Aripiprazole
Asenapine	Asenapine
Chlorpromazine Oral Solution	Chlorpromazine
Chlorpromazine Oral Syrup	Chlorpromazine
Chlorpromazine Tablets	Chlorpromazine
Clozapine Tablets	Clozapine
Clozaril Tablets	Clozapine
Etrafon	Amitriptyline + Perphenazine
Fanapt	Iloperidone
FazaClo Orally Disintegrating Tablets	Clozapine
Fluphenazine	Fluphenazine
Fluphenazine Decanoate Injectable	Fluphenazine
Fluphenazine HCL Oral Solution	Fluphenazine
Fluphenazine HCL Tablets	Fluphenazine
Geodon Capsules	Ziprasidone
Haldol Decanoate Injectable-Long Acting	Haloperidol
Haldol Oral Solution	Haloperidol
Haldol Tablets	Haloperidol
Haloperidol Decanoate Injectable Long-Acting	Haloperidol

Medication	Generic
Haloperidol Oral Solution	Haloperidol
Haloperidol Tablets	Haloperidol
Iloperidone	Iloperidone
Invega Sustenna Injectable	Paliperidone Palmitate
Invega Tablets	Paliperidone
Latuda	Lurasidone
Loxapine Capsules	Loxapine
Loxitane Capsules	Loxapine
Lurasidone	Lurasidone
Mellaril Tablets	Thioridazine
Mesoridazine	Mesoridazine
Navane Capsules	Thiothixene
Olanzapine + Fluoxetine Capsules	Olanzapine + Fluoxetine
Olanzapine Tablets	Olanzapine
Olanzapine ZYDIS Orally Disintegrating Tablets	Olanzapine
Orap Tablets	Pimozide
Paliperidone Tablets	Paliperidone
Permitril	Fluphenazine
Perphenazine Tablets	Perphenazine
Pimozide Tablets	Pimozide
Prolixin Decanoate Injectable- Long Acting	Fluphenazine
Prolixin Oral Solution	Fluphenazine
Prolixin Tablets	Fluphenazine
Quetiapine Fumarate	Quetiapine
Quetiapine Tablets	Quetiapine
Risperal Consta Injectable- Long Acting	Risperidone
Risperdal M-Tab Orally Disintegrating Tablets	Risperidone
Risperdal Oral Solution	Risperidone
Risperdal Tablets	Risperidone
Risperidone Injectable - Long Acting	Risperidone

Medication	Generic
Risperidone M- Tab Orally Disintegrating Tablets	Risperidone
Risperidone Tablets	Risperidone
Saphris	Asenapine
Serentil	Mesoridazine
Seroquel Tablets	Quetiapine
Seroquel XR Tablets	Quetiapine
Stelazine Tablets	Trifluoperazine
Symbyax Capsules	Olanzapine + Fluoxetine
Thioridazine HCL Tablets	Thioridazine
Thiothixene Capsules	Thiothixene
Thorazine Oral Solution	Chlorpromazine
Thorazine Oral Syrup	Chlorpromazine
Thorazine Tablets	Chlorpromazine
Triavil	Amitriptyline + Perphenazine
Trifluroperazine HCL Tablets	Trifluoperazine
Trilafon Tablets	Perphenazine
Ziprasidone HCL Tablets	Ziprasidone
Zyprexa Relprevv Injectable	Olanzapine
Zyprexa Tablets	Olanzapine
Zyprexa ZYDIS Orally Disintegrating Tablets	Olanzapine

Table Number 10.1: Short-Acting Intramuscular Antipsychotic Medications *(Ver. 2010A)*

Medication	Generic
Abilify Injectable- Short Acting	Aripiprazole
Aripiprazole Injectable- Short Acting	Aripiprazole
Chlorpromazine Injectable- Short Acting	Chlorpromazine
Geodon Injectable- Short Acting	Ziprasidone
Haldol Injectable- Short Acting	Haloperidol
Haloperidol Injectable- Short Acting	Haloperidol
Olanzapine Injectable- Short Acting	Olanzapine

Medication	Generic
Prolixin Injectable- Short Acting	Fluphenazine
Thorazine Injectable- Short Acting	Chlorpromazine
Ziprasidone Mesylate Injectable- Short Acting	Ziprasidone
Zyprexa Injectable- Short Acting	Olanzapine

Table Number 11.0: Antenatal Steroid Medications *(Ver. 2010A)*

Medication	Generic
Betamethasone	Betamethasone
Betamethasone Sodium Phosphate	Betamethasone Sodium Phosphate
Betamethasone Sodium Phosphate and Betamethasone Acetate	Betamethasone Sodium Phosphate and Betamethasone Acetate
Celestone	Betamethasone
Celestone Phosphate	Betamethasone Sodium Phosphate
Celestone Soluspan	Betamethasone Sodium Phosphate and Betamethasone Acetate
Cortastat	Dexamethasone Sodium Phosphate
Dalalone	Dexamethasone Sodium Phosphate
Dalalone DP	Dexamethasone Acetate
Dalalone LA	Dexamethasone Acetate
Decadron	Dexamethasone
Decadron LA	Dexamethasone Acetate
Decadron Phosphate	Dexamethasone Sodium Phosphate
Decadron w/Xylocaine	Dexamethasone Sodium Phosphate with Lidocaine HCL
Decaject	Dexamethasone Sodium Phosphate
Decaject LA	Dexamethasone Sodium Phosphate
Dexamethasone	Dexamethasone
Dexamethasone Acetate	Dexamethasone Acetate
Dexamethasone Intensol	Dexamethasone
Dexamethasone Sodium Phosphate	Dexamethasone Sodium Phosphate
Dexamethasone Sodium Phosphate with Lidocaine	Dexamethasone Sodium Phosphate with Lidocaine
Dexamethasone Sodium Phosphate with Lidocaine HCL	Dexamethasone Sodium Phosphate with Lidocaine HCL

Medication	Generic
Dexasone	Dexamethasone Sodium Phosphate
Dexasone LA	Dexamethasone Acetate
Dexone	Dexamethasone
Dexone LA	Dexamethasone Acetate
Hexadrol	Dexamethasone
Hexadrol Phosphate	Dexamethasone Sodium Phosphate
Solurex	Dexamethasone Sodium Phosphate
Solurex LA	Dexamethasone Acetate

Appendix D

General Glossary of Terms

AMA (Against Medical Advice) When a patient checks himself out of a hospital against the advice of his doctor.

accuracy (of data) The extent to which data are free of identifiable errors.

acute hemorrhagic stroke A non-traumatic intracerebral hemorrhage, subarachnoid hemorrhage or hemorrhagic infarction.

acute ischemic stroke A measurable neurological deficit of sudden onset, presumed secondary to focal cerebral ischemia, and not otherwise attributable to intracerebral hemorrhage (ICH) or another disease process. Cerebrovascular disorder caused by deprivation of blood flow to an area of the brain, generally as a result of thrombosis, embolism, or reduced blood pressure.

acute myocardial infarction (AMI) Death of heart muscle resulting from insufficient blood supply to the heart.

administrative/billing data (data source) Administrative data are patient-identifiable data used for administrative, regulatory, and payment (financial) purposes. Administrative data that generally reflect the content of discharge abstracts (for example, demographic information on patients such as age, sex, zip code; information about the episode of care such as admission source, length of stay, charges, discharge status; and ICD-10-CM diagnostic and ICD-10-PCS procedure codes). Namely, the Uniform Hospital Discharge Data Set and the Uniform Bill of the Health Care Financing Administration (UB-04) provides specifications for the abstraction of administrative/billing data.

Agency for Healthcare Research and Quality (AHRQ) The Agency for Healthcare Research and Quality (AHRQ) is the health services research arm of the U.S. Department of Health and Human Services (HHS), complementing the biomedical research mission of its sister agency, the National Institutes of Health. AHRQ is a home to research centers that specialize in major areas of health care research such as quality improvement and patient safety, outcomes and effectiveness of care, clinical practice and technology assessment, and health care organization and delivery systems.

aftercare (see next level of care) Inpatient or outpatient care that the patient will receive after discharge from the hospital.

aggregate (hospital data) Aggregate data elements derived for a specific hospital from the results of each measure's algorithm over a given time period (e.g., monthly, quarterly). These data are transmitted to The Joint Commission by ORYX® Vendors.

aggregate risk-adjusted data elements Aggregate data elements derived from episode of care (EOC) records that result from the application of risk adjustment models by ORYX® Vendors for transmission to The Joint Commission.

algorithm An ordered sequence of data element retrieval and aggregation through which numerator and denominator events or continuous variable values are identified by a measure. The algorithms are depicted using flowcharting symbols.

allowable value A list of acceptable responses for a data element.

angioplasty Reconstruction of blood vessels damaged by disease or injury.

ANSI X12 The American National Standards Institutes standard for transmitting data electronically, or electronic data interchange (EDI).

antenatal steroids Steroids given before birth.

antithrombotic therapy Pharmacologic agents (oral or parenteral) preventing or interfering with the formation of a thrombus or blood coagulation.

atherosclerosis Common disorder characterized by yellowish plaques of cholesterol, other lipids, and cellular debris in the inner layers of the walls of arteries.

atrial fibrillation Cardiac arrhythmia characterized by disorganized electrical activity in the atria accompanied by an irregular ventricular response that is usually rapid. The atria quiver instead of pumping in an organized fashion, resulting in compromised ventricular filling and reduced stroke volume. Stasis of left atrial flow increases the risk of

stroke.

atrial flutter Type of atrial tachycardia characterized by contraction rates between 230/min and 380/min.

augmentation of clozapine The addition of a second antipsychotic medication for patients receiving clozapine.

binary outcome Events or conditions that occur in one or two possible states often labeled 0 or 1. Such data are frequently encountered in medical research. Common examples include dead or alive, and improved or not improved.

calculation model A description of the steps or statistical calculations (computations) used to derive the numerator and denominator or continuous variable values required for a measure. Measure Information Forms in this manual will include either an algorithm or calculation model.

cardiac module A set of evidence-based process measures designed to prevent cardiac complications in surgical patients.

caregiver The patients family or any other person who will be responsible for care of the patient after discharge.

central tendency A property of the distribution of a variable, usually measured by statistics such as the mean, median, and mode.

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.

chemotherapy For purposes of the PN and IMM measure sets, chemotherapy is defined as antineoplastic agents used to treat cancer. Types include targeted agents, alkylating agents, antimetabolites, plant alkaloids and terpenoids, topoisomerase inhibitors, antitumor antibiotics, monoclonal antibodies, and biologics and related agents. Hormonal therapies are not included.

childrens asthma care (CAC) Asthma is defined as a lung disorder marked by breathing difficulty, wheezing, or coughing. For purposes of this measure set, the population is defined as children equal or greater than 2 through 17 years of age.

clinical chorioamnionitis Usually includes otherwise unexplained fever (at or above 38 degree C (100.4F)) with one or more of the following: uterine tenderness and/or irritability, leukocytosis, fetal tachycardia, maternal tachycardia or malodorous vaginal discharge.

clinical measures Measures designed to evaluate the processes or outcomes of care associated with the delivery of clinical services; allow for intra- and interorganizational comparisons to be used to continuously improve patient health outcomes; may focus on the appropriateness of clinical decision making and implementation of these decisions; must be condition specific, procedure specific, or address important functions of patient care (e.g., medication use, infection control, patient assessment, etc.).

comparison group The group of health care organizations to which an individual health care organization is compared. (ORYX® Vendors transmit aggregated comparison group data for non-core measures. The Joint Commission will aggregate health care organization-level data to create the comparison group for each core measure.)

confounding factors Intervening variables that distort the true relationship between/among the variables of interest. They are related to the outcome of interest, but extraneous to the study question and are non-randomly distributed among the groups being compared. They can hide a true correlation or give the appearance of a correlation when none actually exists.

continuous variable An aggregate data measure in which the value of each measurement can fall anywhere along a continuous scale (e.g., the time [in minutes] from hospital arrival to administration of thrombolysis).

continuous variable data elements Those data elements required to construct the measure as stated in the section labeled Continuous Variable Statement.

controllers Controllers are long term control medications for asthma. Controllers reduce airway inflammation and prevent asthma exacerbations. Inhaled corticosteroids are the preferred medications for controlling mild, moderate, and severe persistent asthma. Refer to Appendix C, Table 6.1 for a listing of controller medications.

corticosteroids Any of the hormones produced by the adrenal cortex or their synthetic equivalents, used to achieve quick relief of asthma exacerbations or long term control of the swelling, inflammation and mucus production that

occurs when the airway are irritated. Corticosteroids are available in inhaled, topical, oral, and intravenous forms.

critical access hospital (CAH) A facility that meets the following criteria may be designated by CMS as a CAH:

- Is located in a State that has established with CMS a Medicare rural hospital flexibility program; and
- Has been designated by the State as a CAH; and
- Is currently participating in Medicare as a rural public, non-profit or for-profit hospital; or was a participating hospital that ceased operation during the 10-year period from November 29, 1989 to November 29, 1999; or is a health clinic or health center that was downsized from a hospital; and
- Is located in a rural area or is treated as rural; and Is located more than a 35-mile drive from any other hospital or CAH (in mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles); and
- Maintains no more than 25 inpatient beds; and
- Maintains an annual average length of stay of 96 hours per patient for acute inpatient care; and
- Complies with all CAH Conditions of Participation, including the requirements to make available 24-hour emergency care services 7 days per week.
- A CAH may also be granted swing-bed approval to provide post-hospital Skilled Nursing Facility-level care in its inpatient beds. In the case of hospice care, a hospice may contract with a CAH to provide the Medicare hospice hospital benefit. Reimbursement from Medicare is made to the hospice. The CAH may dedicate beds to the hospice, but the beds must be counted toward the 25-bed maximum. However, the hospice patient is not included in the calculation of the 96-hour annual average length of stay. The hospice patient can be admitted to the CAH for any care involved in their treatment plan or for respite care. The CAH negotiates reimbursement through an agreement with the hospice. In addition to the 25 inpatient CAH beds, a CAH may also operate a psychiatric and/or a rehabilitation distinct part unit of up to 10 beds each. These units must comply with the Hospital Conditions of Participation.

data collection The act or process of capturing raw or primary data from a single or number of sources. Also called data gathering.

data collection effort The availability and accessibility of the required data elements, the relative effort required, and associated cost of abstracting or collecting the data.

data element A discrete piece of data, such as patient birthdate or principal diagnosis. See also *denominator data elements, numerator data elements, continuous variable data elements*, and *risk adjustment data elements*.

data entry The process by which data are transcribed or transferred into an electronic format.

data quality The accuracy and completeness of measure data on performance in the context of the analytic purposes for which they will be used.

data transmission The process by which data are electronically sent from one organization to another. For example, a hospital sending patient-level data to their selected ORYX® Vendor, and the vendor sending measure-level data to The Joint Commission or patient-level data to the QIO Clinical Warehouse.

denominator The lower part of a fraction used to calculate a rate, proportion, or ratio. Also the population for a rate based measure.

denominator data elements Those data elements required to construct the denominator.

depilatories Chemical-based lotions or creams used to dissolve hair at the skins surface.

disaster medical assistance team (DMAT) Provides emergency medical assistance following a catastrophic disaster or other major emergency.

discrete variable See *rate-based measure*.

elective carotid endarterectomy Surgical procedure performed by choice, involving excision of atheromatous segments of the endothelium and tunica media of the carotid artery, leaving a smooth tissue lining and facilitating blood flow through the vessel; surgery done to prevent stroke.

elective carotid intervention Surgery (i.e., carotid endarterectomy) and other procedures (e.g., carotid angioplasty, stenting) involving the carotid artery, performed due to the patients choice.

elective delivery Delivery of a newborn(s) when the mother was not in active labor or presented with spontaneous ruptured membranes prior to medical induction and/or cesarean section.

electrocardiogram (ECG) A graphic tracing of the hearts electrical impulses.

electronic data interchange (EDI) An instance of data being sent electronically between parties, normally according to predefined industry standards.

elopement When a patient wanders away, walks away, runs away, escapes, or otherwise leaves the hospital unsupervised, unnoticed, and/or prior to their scheduled discharge.

emergency department (ED) A portion of the hospital where emergency diagnosis and treatment of illness or injury is provided.

emergency medical system (EMS) Network of services coordinated to provide aid and medical assistance from primary response to definitive care, involving personnel trained in the rescue, stabilization, transportation, and advanced treatment of traumatic or medical emergencies.

empiric antibiotic therapy Antibiotic treatment based on the clinicians judgment and the patients signs and symptoms and offered before a diagnosis has been confirmed.

episode of care (EOC) An Episode of Care (EOC) is defined as the health care services given during a certain period of time, usually during a hospital stay (e.g., from the day of arrival or admission to the day of 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).

excluded populations Detailed information describing the populations that should not be included in the indicator. For example, specific age groups, ICD-10-PCS procedure or ICD-10-CM diagnostic codes, or certain time periods could be excluded from the general population drawn upon by the indicator.

extranet A private network using the Internet protocol to securely share business information or operations with vendors, customers, and/or other businesses. The Joint Commission Connect TM is the name given to the Joint Commissions extranet site.

event An occurrence of physical restraint or seclusion. Events that occur during the patient's stay do not define new episodes of care.

fibrinolytic therapy Administration of a pharmacological agent intended to cause lysis of a thrombus (destruction or dissolution of a blood clot). Refer to Appendix C, Table 1.5 for a listing of fibrinolytic agents.

format Specifies the character length of a specific data element; the type of information the data element contains: numeric, decimal, number, date, time, character, or alphanumeric; and the frequency with which the data element occurs.

general data elements Data elements that must be collected by hospitals for each patient record. These data are patient demographic data, hospital identifiers, and patient identifiers.

global Global is an umbrella term for all measure sets that share the same Initial Patient Population definition.

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.

health care-associated infection A localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s). There must be no evidence that the infection was present or incubating at the time of admission to the care setting.

health care organization (HCO) The business entity which is participating in an ORYX Vendor (e.g., health care organization level data describes information about the business entity).

health care organization (HCO) level data Aggregation of patient level data to summarize the performance of an individual health care organization on a performance measure. This data is transmitted to The Joint Commission by the hospitals ORYX Vendor.

heart failure (HF) A clinical syndrome characterized by signs and symptoms resulting from disturbances in cardiac

output or from increased venous pressure, including fatigue, shortness of breath, or leg swelling.

hospital According to the American Hospital Association, hospitals are licensed institutions with at least six beds whose primary function is to provide diagnostic and therapeutic patient services for medical conditions by an organized physician staff, and have continuous nursing services under the supervision of registered nurses.

hospital-based inpatient psychiatric services (HBIPS) The Hospital-Based Inpatient Psychiatric Services (HBIPS) is a national quality partnership of organizations focused on improving quality and performance in impatient psychiatric settings through performance measurement utilizing 5 process measures in 3 separate domains (assessment, patient safety, continuity/transition of care).

Hospital Inpatient Quality Reporting Program The Hospital Inpatient Quality Reporting Program initiative is intended to empower consumers with quality of care information to make more informed decisions about their health care, while encouraging hospitals and clinicians to improve the quality of inpatient care provided to all patients. The hospital quality of care information gathered through the Hospital Inpatient Quality Reporting Program initiative is available to consumers on the Hospital Compare website.

hospitalist A physician whose main practice provides care for hospitalized patients.

ICD-10 Codes The 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization. It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases and procedures.

immunization (IMM) The process by which a person becomes protected against a disease through vaccination or inoculation. For the purposes of this measure set, the population is defined as hospitalized inpatients screened for pneumococcal and seasonal influenza immunization status.

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.

infection module A set of evidence-based process measures designed to prevent postoperative infection in the surgical patient.

initial patient populations Detailed information describing the population(s) that the indicator intends to measure. Details could include such information as specific age groups, diagnoses, ICD-10-CM diagnostic and ICD-10-PCS procedure codes, CPT codes, revenue codes, enrollment periods, insurance and health plan groups, etc.

inpatient mortality Any patient death occurring while admitted as an in-patient in the hospital.

inpatient prospective payment system (IPPS) rule A prospective payment system (PPS) under Medicare for hospital acute inpatient services. Hospitals contract with Medicare to furnish acute inpatient care and are reimbursed through pre-determined payment on a per discharge or per case basis for Medicare beneficiaries with inpatient stays.

inpatient psychiatric services Inpatient psychiatric services include care provided to a patient for a mental disorder while hospitalized in a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital. Services rendered to outpatients or day treatment patients are not considered inpatient psychiatric services.

intermittent pneumatic compression device Device that uses sequential and/or intermittent compression to counteract blood flow stasis by increasing peak flow velocity. As a result, less blood is allowed to pool in veins thus decreasing chances for thrombus formation. In addition compression has an anticlotting effect by increasing fibrolytic activity which in turn stimulates the release of plasminogen activator. These two physiological effects, in combination with the mechanical movement of fluid in a proximal direction make the sequential devices effective in preventing and treating VTE.

intracerebral hemorrhage (ICH) Non-traumatic abrupt onset of headache or altered level of consciousness and/or focal neurological deficit that is associated with a focal collection of blood within the brain parenchyma on CT scan and is not due to trauma or hemorrhagic conversion of a cerebral infarction.

invalid data Values for data elements that are required for calculating and/or risk adjusting a core measure that fall outside of the acceptable range of values defined for that data element. Refer to the Missing and Invalid Data section

for further information.

IV thrombolytic therapy Intravenous administration of a thrombolytic agent, such as tissue plasminogen activator (TPA), to dissolve an arterial clot.

The Joint Commission Connect The name given to the Joint Commissions extranet site, a secured online connection to The Joint Commission.

leave day An authorized or unauthorized absence from a facility, excluding discharges, during which the patient is absent from the facility at the time of the daily census and is not under the direct supervision of facility staff while absent.

low-density lipoprotein (LDL) Plasma protein provided by the liver, carrying relatively more cholesterol and triglycerides than protein. The high cholesterol content may account for its greater atherogenic potential. Also known as bad cholesterol.

mean A measure of central tendency for a continuous variable measure. The mean is the sum of the values divided by the number of observations.

measure data elements Data elements used by one specific measure or several measures in two or more measure sets, such as Clinical Trial.

measure information form Tool to provide specific clinical and technical information on a measure. The information contained includes: measure set, performance measure name, description, rationale, type of measure, improvement noted as, numerator/ denominator/continuous variable statements, included populations, excluded populations, data elements, risk adjustment, data collection approach, data accuracy, measure analysis suggestions, sampling, data reported as, and selected references.

measure of performance See *performance measure*.

measure-specific data elements Data elements used by one specific measure or several measures in one specific measure set, such as *Infection Prior to Anesthesia* in the SCIP measures.

measurement system See *performance measurement system*.

median The value in a group of ranked observations that divides the data into two equal parts.

medical record (data source) Data obtained from the records or documentation maintained on a patient in any health care setting (for example, hospital, home care, long term care, practitioner office). Includes automated and paper medical record systems.

military time A 24 hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

missing data No values present for one or more data elements that are required for calculating and/or risk adjusting a national quality measure. Refer to the Missing and Invalid Data section for further information.

mode The most frequently occurring response for that data element.

module A set of measures under a common group/topic area (e.g., infection module).

monotherapy The use of a single antipsychotic medication.

multiple antipsychotic medications Antipsychotic medications are drugs prescribed to treat certain mental disorders; if two or more of these medications are routinely administered or prescribed this is considered multiple antipsychotic medications.

national hospital inpatient quality measure A standardized performance measure that meets the Centers for Medicare & Medicaid Services and Joint Commission evaluation criteria, has precisely defined specifications, can be uniformly embedded in extant systems, has standardized data collection protocols to permit uniform implementation by health care organizations and permit comparisons of health care organization performance over time through the establishment of a national comparative data base.

national hospital inpatient quality measure set A unique grouping of performance measures carefully selected to provide, when viewed together, a robust picture of the care provided in a given area (e.g., cardiovascular care, pregnancy).

neonatal intensive care unit (NICU) A hospital unit organized with personnel and equipment to provide continuous life support and comprehensive care for extremely high-risk newborn infants and those with complex and critical illness.

newborn A very young child from birth to one year who has not yet begun to walk or talk.

next level of care (see aftercare) Inpatient or outpatient care that the patient will receive after discharge from the hospital.

non-core measure A performance measure defined by the ORYX Vendor that has undergone review against Joint Commission established measure criteria and has been accepted for use in the ORYX initiative.

nulliparous A woman with a parity of zero.

numerator The upper portion of a fraction used to calculate a rate, proportion, or ratio.

numerator data elements Those data elements necessary or required to construct the numerator.

observed rate The observed rate is the measure rate that is based on a hospitals aggregated data for the reporting period. This is calculated as the number of measure numerator cases for the reporting period divided by the number of denominator cases. Observed rates are used to measure hospital performances.

oral antibiotics For the purposes of the SCIP measure set, refers to two different combinations of antibiotics by the PO route, which can be given by mouth, NG tube, or PEG tube. Those combinations are either Neomycin and Erythromycin or Neomycin and Flagyl (also called Metronidazole). These combinations are for use in prophylaxis specifically for colon surgery patients.

ORYX® vendor An entity consisting of an automated database(s), that facilitates performance improvement in health care organizations through the collection and dissemination of process and/or outcome measures of performance. ORYX Vendors must be able to generate internal comparisons of organization performance over time, and external comparisons of performance among participating organizations at comparable times.

outpatient prospective payment system (OPPS) Rule A prospective payment system (PPS) under Medicare for hospital outpatient services, certain Part B services furnished to hospital inpatients that have no Part A coverage, and partial hospitalization services furnished by community mental health centers. All services paid under the PPS are classified into groups called Ambulatory Payment Classifications or APCs. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter.

parenteral Not through the alimentary canal but rather by injection through some other route, as subcutaneous, intramuscular, intraorbital, intracapsular, intraspinal, intrasternal, intravenous, etc.

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

paroxysmal Occurring as sudden or periodic attacks or recurrences of symptoms of a disease; exacerbation.

patient level data Collection of data elements that depict the health care services provided to an individual (patient). Patient level data are aggregated to generate hospital level data and comparison group data.

patient survey (data source) Survey data are exclusively obtained from patients and/or their family members/significant others.

percentile A value on a scale of 100 that indicates the percentage of a distribution that is equal to or below it.

performance measure A quantitative tool (for example, rate, ratio, index, percentage) that provides an indication of an organizations performance in relation to a specified process or outcome. Refer to *process measure* and the *outcome measure* in Appendix E.

performance measurement systems extranet track (PET) An electronic information and message center available to ORYX Vendors. Access to the Internet and a browser are necessary to connect to PET. Access to PET is available by clicking on the Joint Commission Connect button on the Joint Commissions home page (www.jointcommission.org).

perinatal care (PC) The care and management of the fetus and newborn infant in the perinatal period before, during, and after delivery.

physical restraint A physical restraint is any manual method or physical or mechanical device, material, or

equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely when it is used as a restriction to manage a patients behavior or restrict the patients freedom of movement and is not a standard treatment for the patients medical or psychiatric condition.

pneumonia (PN) Pneumonia is defined as an acute infection of the pulmonary parenchyma that is associated with at least some symptoms of acute infection, accompanied by presence of acute infiltrate on chest radiograph or auscultatory findings consistent with pneumonia (such as altered breath sounds and/or localized rales).

post discharge continuing care plan Communication from the hospital to the next level of care provider after a patient is discharged from the hospital. The plan must contain the reason for hospitalization, main diagnosis at discharge, a list of medications at discharge, and recommendations for the next level of care.

predicted value The statistically expected response or outcome for a patient after the risk adjustment model has been applied and the patients unique set of risk factors have been taken into account.

P.R.N. Abbreviation for pro re nata, Latin term for "as needed".

process An interrelated series of events, activities, actions, mechanisms, or steps that transform inputs into outputs.

prophylactic antibiotic An antibiotic used to prevent, rather than treat or cure, disease. For the purposes of SCIP-Inf-1-3, antibiotics given to prevent postoperative infection will be collected. Because the overuse of antibiotics can lead to resistance, antibiotics taken to prevent infection should be used only for a short time.

process measure A measure which focuses on a process which leads to a certain outcome, meaning that a scientific basis exists for believing that the process, when executed well, will increase the probability of achieving a desired outcome.

proportion measure A measure which shows the number of occurrences over the entire group within which the occurrence should take place (e.g., patients delivered by cesarean section over all deliveries).

randomization A technique for selecting or assigning cases such that each case has an equal probability of being selected or assigned. It is done to stimulate chance distribution, reduce the effects of confounding factors, and produce unbiased statistical data.

range A measure of the spread of a data set. The difference between the smallest and largest observation.

rate Derived by dividing the numerator (e.g., cases that meet the criterion for good or poor care) by the denominator (e.g., all cases to which the criterion applies) within a given time frame. In other words, the numerator is a subset of the denominator.

rate based (measure) An aggregate data measure in which the value of each measurement is expressed as a proportion or as a ratio. In a proportion, the numerator is expressed as a subset of the denominator (for example, patients with cesarean section, divided by all patient who deliver). In a ratio, the numerator and denominator measure different phenomena (for example, the number of patients with central lines who develop infections divided by the number of central line days).

ratio A relationship between two counted sets of data, which may have a value of zero or greater. In a ratio, the numerator is not necessarily a subset of the denominator (e.g., pints of blood transfused to number of patients discharged).

reliability The ability of the indicator to accurately and consistently identify the events it was designed to identify across multiple health care settings.

relievers Relievers are used to quickly alleviate bronchoconstriction. Relievers relax the bands of muscle that surround the airways. Relievers are also known as rescue, quick relief, or short-acting medications of choice to quickly relieve asthma exacerbations. Relievers include short acting beta2 agonists and anticholinergics. Refer to Appendix C, Table 6.2 for a listing of reliever medications.

reperfusion Reestablishing blood flow in an obstructed coronary artery. It may be accomplished with thrombolytic therapy or percutaneous coronary intervention.

reporting period The defined time period which describes the patients end-of-service.

risk adjusted measures Measures that are risk adjusted using statistical modeling or stratification methods.

risk adjusted rate A rate that takes into account differences in case mix to allow for more valid comparisons between

groups.

risk adjustment A statistical process for reducing, removing, or clarifying the influences of confounding factors that differ among comparison groups (for example, logistic regression, stratification).

risk adjustment data elements Those data elements used to risk adjust a performance measure (e.g., reduce, remove, or clarify the influences of confounding patient factors that differ among comparison groups). Such data elements may be used exclusively for risk adjustment (e.g., not required to construct the numerator or denominator) or may be required for numerator or denominator construction as well as risk adjustment.

risk adjustment model The statistical algorithm that specifies the numerical values and the sequence of calculations used to risk adjust (e.g., reduce or remove the influence of confounding factors) performance measures.

risk factor A factor that produces or influences a result. In statistics, an independent variable used to identify membership of qualitatively different groups.

risk factor value A specific value assigned to a risk factor for a given episode of care (EOC) record.

risk model The statistical algorithm that specifies the numerical values and the sequence of calculations used to risk adjust (e.g., reduce or remove the influence of confounding factors) performance measures.

routinely scheduled medications Medications prescribed to be taken regularly after discharge from the hospital.

sampling frequency If a hospital chooses to sample, they may sample data on either a monthly or quarterly basis. Refer to the Sample Size Requirements discussion in the Population and Sampling Specifications section for further information.

sampling method Describes the process used to select a sample. Sampling approaches for national hospital inpatient quality measures are simple random sampling and systematic sampling. Refer to the “Sampling Approaches” discussion in the Population and Sampling Specifications section for further information.

sample size The number of individuals or particular patients included in a study. Usually chosen so that the study has a particular statistical power of detecting an effect of a particular size. Refer to the “Sample Size Requirements” discussion in the Population and Sampling Specifications for further information. For measure set specific "Sample Size Requirements" refer to Measure Information section.

score A rating, usually expressed as a number, and based on the degree to which certain qualities or attributes are present (e.g., Glascow coma, ASA scores).

seclusion Seclusion is the involuntary confinement of a patient alone in a room or an area where the patient is physically prevented from leaving.

severity The degree of biomedical risk, or mortality of medical treatment.

simple random sample A process in which a sample of data is selected from the total population in such a way that every case has the same chance of being selected and that the sample size is met. Refer to the Sampling Approaches discussion in the Population and Sampling Specifications section for further information.

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.

standard deviation A measure of variability that indicates the dispersion, spread, or variation in a distribution.

statin A class of pharmaceutical agents that modify LDL-cholesterol by blocking the action of an enzyme in the liver which is needed to synthesize cholesterol, thereby decreasing the level of cholesterol circulating in the blood; HMG-CoA reductase inhibitors.

stent Rod or threadlike device for supporting tubular structures during surgical anastamosis or for holding arteries open during percutaneous angioplasty.

strata See stratified measure.

stratification A form of risk adjustment which involves classifying data into subgroups based on one or more characteristics, variables, or other categories.

stratification based approach for risk adjustment The process of dividing or classifying subgroups known as strata in order to facilitate more valid comparisons. For example, a measures outcome may be divided into type of surgery-

specific categories or strata.

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.

stratum See stratified measure.

stroke (STK) See definitions for acute ischemic stroke and acute hemorrhagic stroke.

subarachnoid hemorrhage (SAH) Non-traumatic abrupt onset of headache or altered level of consciousness that is associated with blood in the subarachnoid space on CT or a clinical history and exam consistent with SAH (sudden onset of severe headache or altered level of consciousness) with xanthochromia and many red blood cells in the cerebrospinal fluid.

sub-population A population that is part of a larger population. For example, the measure set Perinatal Care evaluates the obstetrical population in the hospital. This measure set is broken into two distinct sub-populations, mothers (PC-01, PC-02 and PC-03) and newborns (PC-04 and PC-05).

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.

substance use (SUB) For the purposes of the Substance Use measure set (SUB) substance use includes unhealthy alcohol use and drug abuse or dependence including opioids, sedative/hypnotics, cocaine, cannabis, amphetamines, and hallucinogens.

surgical care improvement project (SCIP) The Surgical Care Improvement Project (SCIP) is a national quality partnership of organizations focused on improving surgical care by significantly reducing surgical complications through performance measurement. Utilizing ten process measures in three separate modules (infection, cardiac, and VTE), the goal is to reduce the incidence of surgical complications nationally.

surgical infection prevention (SIP) In August of 2002, the Centers for Medicare & Medicaid Services and the Centers for Disease Control and Prevention collaborated to develop the Surgical Infection Prevention project. The Medicare Surgical Infection Prevention Project was started with the single objective - to decrease morbidity and mortality associated with postoperative infection in the Medicare patient population. As of July 2006 discharges, the three SIP measures become the first three SCIP infection measures.

systematic random sampling A process in which the starting case is selected randomly, and the next cases are selected according to a fixed interval that is based upon the number of cases in the population. For example, the starting case is the second patient that arrives at the hospital. This patient and every subsequent fifth patient becomes part of the random sample until the sample size is reached. Refer to the Sampling Approaches discussion in the Population and Sampling Specifications section for further information.

systemic corticosteroids Corticosteroids are hormones produced by the adrenal cortex or their synthetic equivalents and are administered orally or intravenous. Corticosteroids are used to achieve quick relief of acute or moderate to severe asthma exacerbations. Oral corticosteroids are also used for long term control of the swelling, inflammation and mucus production in the airways.

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.

thrombolytic therapy See fibrinolytic therapy

time last known well Time at which the patient was last known to be without the signs and symptoms of the current stroke or at his or her prior baseline. Variation may exist if the signs and symptoms are not witnessed.

time-out The restriction of a patient for any period of time to a designated area from which the patient is not physically prevented from leaving and for the purpose of providing the patient an opportunity to regain self-control.

tissue plasminogen activator (TPA) Clot-dissolving substance produced naturally by cells in the walls of blood vessels, and also manufactured synthetically. TPA activates plasminogen to dissolve clots and is used therapeutically to open occluded arteries.

tobacco use (TOB) For the purposes of the Tobacco Treatment measure set (TOB), tobacco use includes cigarettes, pipes, cigars and smokeless tobacco products.

transmission schedule The schedule of dates on which data are expected to be transmitted to The Joint Commission and the QIO Clinical Warehouse.

unable to be determined (UTD) Each data element that is applicable per the algorithm for each of the measures within a topic must be touched by the abstractor. While there is an expectation that all data elements are collected, it is recognized that in certain situations information may not be available (i.e., dates, times, codes, etc.). If, after due diligence, the abstractor determines that a value is not documented or is not able to determine the answer value, the abstractor must select Unable to Determine (UTD) as the answer.

vaccine A vaccine is a suspension of an attenuated (weakened) or killed microorganism, such as bacteria or virus, administered for the prevention, amelioration, or treatment of infectious diseases.

validation The process by which the integrity and correctness of data are established. Validation processes can occur immediately after a data item is collected or after a complete set of data are collected. The Centers for Medicare & Medicaid Services (CMS) chart level validation will validate the data at several levels. There are consistency and internal edit checks to assure the integrity of the submitted data; there are external edit checks to verify expectations about the volume of the data received, and, there will be chart level audits to assure the reliability of the submitted data. Information on these procedures is available on www.qualitynet.org.

validity Ability to identify opportunities for improvement in the quality of care; demonstration that the indicator use results in improvements in outcomes and/or quality of care.

variance Equal to the square of the standard deviation.

venous thromboembolism (VTE) A term that includes deep vein thrombosis and/or pulmonary embolism.

verification The process used to ensure consistent implementation of core measure algorithms specified in this manual across disparate ORYX Vendors .

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.

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Appendix E

Overview of Measure Information Form and Flowchart Formats for collected measures

Measure Information Form Introduction

Measure Set

The specific national hospital quality measure set to which an individual measure belongs (e.g., acute myocardial infarction, stroke).

Set Measure ID

A unique alpha-numeric identifier assigned to a measure. Information associated with a measure is identified by this unique alpha-numeric number.

Performance Measure Name

A brief title that uniquely identifies the measure.

Description

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)

Rationale

The reason for performing a specified process to improve the quality of care outcomes. This may include specific literature references, evidence based information, expert consensus, etc.

Type of Measure

Indicates whether the measure is used to examine a process or an outcome over time.

- **Process:** A measure used to assess a goal directed, interrelated series of actions, events, mechanisms, or steps, such as measure of performance that describes what is done to, for, or by patients, as in performance of a procedure.
- **Outcome:** A measure that indicates the result of performance (or non-performance) of a function(s) or process(es).

Improvement Noted As

Describes how improvement would be indicated by the measure.

- An increase in the rate/score/number of occurrences (for example, immunizations)
- A decrease in the rate/score/number of occurrences (for example, potentially preventable venous thromboembolism)
- Either an increase or a decrease in the rate/score/number of occurrences, depending upon the context of the measure (for example, utilization)

Numerator Statement

Represents the portion of the denominator population that satisfies the conditions of the performance measure to be an indicator event.

Note: If the measure is reported as a rate (proportion or ratio), the Numerator and Denominator Statement are completed. If a performance measure does not have both a numerator and a denominator, then a Continuous Variable Statement is completed.

Included Population in Numerator Specific information describing the population(s) comprising the numerator, not contained in the numerator statement, or not applicable

Excluded Population in Numerator Specific information describing the population(s) that should not be included in the numerator, or none

Data Elements Those data elements necessary or required to determine (or establish) the numerator.

Denominator Statement

Represents the population evaluated by the performance measure.

Note: If measure is reported as a rate (proportion or ratio), the Numerator and Denominator Statement are completed. If a performance measure does not have both a numerator and a denominator, then a Continuous Variable Statement is completed.

Included Population in Denominator Specific information describing the population(s) comprising the denominator, not contained in the denominator statement or not applicable

Excluded Population in Denominator Specific information describing the population(s) that should not be included in the denominator, or none

Data Elements Those data elements required to determine (or establish) the denominator

Continuous Variable Statement

Describes an aggregate data measure in which the value of each measurement can fall anywhere along a continuous scale.

Note: If measure is reported as a central tendency, Continuous Variable Statement is completed. This item is only completed when the performance measure does not have numerator and denominator statements.

Included Population in Continuous Variable Specific information describing the population(s) comprising the performance measure, not contained in the continuous variable statement or not applicable

Excluded Population in Continuous Variable Specific information describing the population(s) that should not be included in the performance measure or none

Date Elements Those data elements required to determine (or establish) the measure for a continuous variable

Risk Adjustment

Indicates whether a measure is subject to the statistical process for reducing, removing, or clarifying the influences of confounding factors to allow more useful comparisons.

Data Collection Approach

Recommended timing for when data should be collected for a measure. Data collection approaches include retrospective, concurrent or prospective data collection. **Retrospective** data collection involves collecting data for events that have already occurred. **Concurrent** data collection is the process of gathering data on how a process works or is working while a patient is in active treatment. **Prospective** data collection is data collection in anticipation of an event or occurrence.

Data Accuracy

Recommendations to reduce identifiable data errors, to the extent possible.

Measure Analysis Suggestions

Recommendations to assist in the process of interpreting data and drawing valid conclusions.

Sampling

Indicates whether or not a measure can be sampled. Sampling is a process of selecting a representative part of a population in order to estimate the organizations performance, without collecting data for the entire population.

Data Reported As

Indicates how data will be reported for a measure.

- Aggregate rate generated from count data reported as a **proportion** (for example, rate-based measures which report summary data generated from the number of Cesarean sections as a proportion of deliveries)
- Aggregate rate generated from count data reported as a **ratio** (e.g., bloodstream infection per 1,000 line days).
- Aggregate measures of **central tendency** (e.g., continuous variables which report means and medians such as length of stay).

Calculation Model

A description of the steps or statistical calculations (computations) used to derive the numerator and denominator or continuous variable values required for a measure. Measure Information Forms in this manual will include either an algorithm or calculation model.

Selected References

Specific literature references that are used to support the importance of the performance measure.

Algorithm Introduction

Each measures initial patient population and the measure is described by a unique algorithm. An algorithm is a predefined set of rules that help to break down complex processes into simple, repetitive steps.

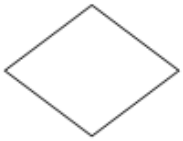
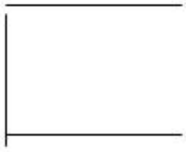
Measure algorithms serve two purposes. First, they evaluate and identify which episode of care (EOC) records contain missing and/or invalid data that will prohibit the ability to properly evaluate the measure. Second, they determine if:

- For rate-based measures, the patients EOC record belongs in the measure population of interest described by the denominator, and if the patient experienced the event described in the numerator.
- For continuous variable measures, the patients EOC record belongs in the patient population described in the measures statement and, if so, to define and calculate the *measurement* value.

This section contains some standard flow-charting conventions used to develop each algorithm:

- **Flow lines** are used to guide the reader to different parts of the algorithm, with arrows denoting the direction of movement. Generally, movement is from the top to the bottom of the chart.
- **Symbols** used in each algorithm flow charts are described later in this section under Flow Chart Symbols.
- **Temporary variables** within the algorithm are noted in the variable key at the top of each page.

Flowchart Symbols

Symbol	Explanation
	Start/Stop denotes the beginning or end of an algorithm
	Diamonds represent "If...Then" decision points for logic tests and comparisons. Two or three flow lines exit the decision point to reflect alternative actions based upon an evaluation of the condition(s) stated around the decision point.
	Rectangles or process boxes show when computation or manipulation of the data are required, such as a calculation or summarization.
	Circle or "On-page: connectors, labeled with a letter, show a link to sections of the algorithm which are continued on the same page.
	Five-sided or "Off-page" connectors, labeled with a letter, show a link to sections of the algorithm which are continued on different pages. *Note: Both circular, On-page, five-sided*, and *Off-page* Connectors containing the letters B, D, E, U, X, or Y lead to *measure Outcome Boxes*.
	Outcome Boxes represent the result of data passed through the algorithm. Connectors extending from outcome boxes lead to the end of the algorithm, or to risk adjustment procedures, where applicable. This symbol is also used to identify the strata within a stratified measure.
	Symbol to represent comments that should be taken into account when programming flowchart.
	This symbol is placed along side the Process box to which they are applicable. Comments are used to expand upon information contained within the process box, such as how to properly calculate age. Comments are never the sole location where processing logic is provided.
	Start/Return denotes the beginning and ending of a sub-routine. Algorithms that use this symbol are called from another algorithm and the data processing flow returns to the calling algorithm when the Return is encountered. See the Initial Patient Population Algorithms and Transmission Data Processing Flows for an example of the usage of this symbol.

Appendix G

Resources

The following are available resources to those using the Specifications Manual for National Quality Core Measures.

Healthcare Organizations
If you are a Joint Commission accredited healthcare organization with questions about National Quality Core Measures, ORYX; requirements, etc., please contact Accreditation and Certification Operations at contact Accreditation and Certification Operations at http://manual.jointcommission.org/

ORYX® Vendors
If you are an ORYX Vendor with questions about Joint Commission National Quality Core Measures, please contact the Division of Quality Measurement and Research at http://manual.jointcommission.org/

Appendix H

Miscellaneous Tables

Table 2.6 Qualifiers and Modifiers Table

Note: These guideleines apply only to those data elements that refer to them in their Guidelines for Abstraction Exclusion list(s)

Qualifiers	Modifiers
Qualifiers are words used as adjectives to indicate some uncertainty about whether or not a condition really exists.	Quantitative modifiers are adjectives that quantitatively describe a condition
The following qualifiers should be abstracted as ***negative findings*** , unless otherwise specified - **Consider this list all-inclusive:** • And/or (+/-; e.g., "ST abnormalities consistent with ischemia and/or injury"), except when comparing only inclusions (e.g., "ST segment elevation and/or STEMI") • Cannot exclude • Cannot rule out • Could be • Could have been • May be • May have • May have had • May indicate • Or, except when comparing only inclusions • Possible • Questionable (?) • Risk of • Rule out (r'd/o, r/o'd) • Suggestive of • Suspect • Suspicious • Vs., except when comparing only inclusions **Example:** If the in-hospital echocardiogram report documents "questionable LVSD", this should be abstracted as a **negative** finding.	The following quantitative modifiers should be abstracted as ***negative findings*** , unless otherwise specified - **Consider this list all-inclusive**: • Borderline • Insignificant • Scant • Slight • Sub-clinical • Subtle • Trace • Trivial