# Appendix A-5: Data Abstraction Tool: Unexpected Complications in Term Newborns (NEWB-3)

**INSTRUCTIONS**: Hospitals must refer to the appropriate version of data dictionary for abstraction guidelines that apply to this measure. Updated text throughout this tool is marked by the use of the Emphasis font style. The capital letters in parenthesis represent the field name that corresponds to the data element name.

1. Provider Name (PROVNAME) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Provider ID (PROVIDER-ID) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (AlphaNumeric)
3. First Name(FIRST-NAME)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Last Name(LAST-NAME)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Birthdate (BIRTHDATE)\_\_\_ \_\_\_ -\_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_
6. Sex (SEX)

* 1 Male
* 2 Assigned/Designated Male at Birth
* 3 Female
* 4 Assigned/Designated Female at Birth
* 5 LGBTQ
* 6 Unknown

1. Race Code - (MHRACE) (Select One Option)

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

1. Hispanic Indicator- (ETHNIC)

* Yes
* No

1. Patient ID (i.e. Medical Record Number) (PATIENT-ID)\_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_(Alpha/Numeric)
2. Admission Date (ADMIT-DATE) \_\_\_ \_\_\_-\_\_\_ \_\_\_-\_\_\_ \_\_\_ \_\_\_ \_\_\_
3. Discharge Date (DISCHARGE-DATE) \_\_\_ \_\_\_-\_\_\_ \_\_\_-\_\_\_ \_\_\_ \_\_\_ \_\_\_
4. What was the patient’s discharge disposition on the day of discharge? (DISCHARGDISP)  
   (Select One Option)

* 01 = Home
* 02 = Hospice- Home
* 03 = Hospice- Health Care Facility
* 04 = Acute Care Facility
* 05 = Other Health Care Facility
* 06 = Expired
* 07 = Left Against Medical Advice / AMA
* 08 = Not Documented or Unable to Determine (UTD)

1. What is the patient's primary source of Medicaid payment for care provided? (PMTSRCE)

|  |  |
| --- | --- |
| * 103 | MassHealth FFS Network, MassHealth Limited Plans |
| * 103 | Primary Care Clinician Management (PCCM) Plan |
| * 118 | Medicaid Managed Care: Massachusetts Behavioral Health Partnership |
| * 103 | Medicaid Managed Care: Other (not listed elsewhere) |
| * 288 | Medicaid Managed Care: WellSense Health Plan |
| * 7 | Medicaid Managed Care: Tufts Health Plan |
| * 311 | Medicaid Other ACO |
| * 4 | Fallon Health-Atrius Health Care Collaborative |
| * 4 | Berkshire Fallon Health Collaborative |
| * 4 | Fallon 365 Care |
| * 24 | Be Healthy Partnership with Health New England |
| * 288 | East Boston Neighborhood Health WellSense Alliance |
| * 288 | WellSense Beth Israel Lahey Health (BILH) Performance Network ACO |
| * 288 | WellSense Boston Children’s ACO |
| * 288 | WellSense Care Alliance |
| * 288 | WellSense Community Alliance |
| * 288 | WellSense Mercy Alliance |
| * 288 | WellSense Signature Alliance |
| * 288 | WellSense Southcoast Alliance |
| * 320 | Community Care Cooperative |
| * 322 | Mass General Brigham Health Plan with Mass General Brigham ACO |
| * 323 | Steward Health Choice (ACO) |
| * 7 | Tufts Health Together with UMass Memorial Health |
| * 7 | Tufts Health Together with Cambridge Health Alliance |
| * 328 | Tufts Medicine (ACO) |

1. What is the patient’s MassHealth Member ID? (MHRIDNO)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(All alpha characters must be upper case)

1. ICD-10-CM Principal or Other Diagnosis Codes (Table 11.30, 11.31, 11.32)

* At least one on Table 11.30, 11.31, or 11.32 (Review Ends)
* None on Table 11.30, 11.31, or 11.32

1. What was the patient’s discharge disposition on the day of discharge? (DISCHARGDISP)  
   (Select One Option)

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* 08 = Not Documented or Unable to Determine (UTD)

1. What was the weight of the newborn at delivery?

* \_\_\_\_\_\_\_\_\_\_ grams (150-8165 grams)

*(<2500 grams= Review Ends)*

*(>=2500 grams= continue to Term Newborn)*

* UTD (Unable to Determine) (*Review Ends)*

1. Term Newborn

* 1 = Yes, there is documentation that the newborn was at term or greater than or equal to 37 completed weeks of gestation at the time of birth.
* 2 = No, there is documentation that the newborn was not at term or >= 37 completed weeks of gestation at the time of birth.
* 3 = UTD, unable to determine from medical record documentation.