Appendix A-6:
Data Dictionary for MassHealth Specific Measures

RY2022 Technical Specifications Manual Release Notes (Version 15.1)

Effective with Q1-2022 discharges (01/01/22)

Table of Contents

Enhancements to Data Dictionary iii
Admission Date 1
Admission to NICU 2
Advance Care Plan 3
Birthdate 5
Contact Information 24hrs/ 7 days 6
Contact Information for Studies Pending at Discharge 8
Current Medication List 9
Discharge Date 10
Discharge Diagnosis 11
Discharge Disposition 12
Episode of Care 15
Exclusive Breast Milk Feeding 16
First Name 18
Gestational Age 19
Hispanic Indicator 21
ICD-10-CM Other Diagnosis Codes 22
ICD-10-PCS Other Procedure Codes 23
ICD-10-PCS Other Procedure Dates 24
ICD-10-CM Principal Diagnosis Code 25
ICD-10-PCS Principal Procedure Code 26
ICD-10-PCS Principal Procedure Date 27
Last Name 28
MassHealth Member ID 29
Medical Procedures and Tests & Summary of Results 30
National Provider ID 32
Patient Identifier 33
Patient Instructions 34
Patient Refusal of Transmission 35
Payer Source 36
Plan for Follow-up Care 38
Previous Live Births 40
Primary Physician or Other Health Care Professional for Follow-up Care 42

Provider ID....44
Provider Name....45
Race....46
Reason for Inpatient Admission....48
Reconciled Medication List....49
Sex....51
Studies Pending at Discharge....52
Term Newborn....53
Transition Record....55
Transmission Date (of Transition Record)....57

Enhancements to Data Dictionary (v 15.1)

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

This version of the data dictionary contains changes to definitions for existing data elements and introduces new data elements effective with Q1-2022 data. These changes are summarized in table below.

Updates to Data Dictionary (version 15.1)

Change to Data Element	Maternity and Newborn Measures (MAT-4) and (NEWB-1)	Care Coordination Measures (CCM-1, 2, 3)	All MassHealth Records
Existing	N/A	▪ *Advance Care Plan* ▪ *Patient Refusal of Transmission* ▪ *Reconciled Medication List*	N/A
Add New	N/A	N/A	*Payer Source code 207*
Retired	N/A	N/A	*Payer source code 116*

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

Data Dictionary Format and Terms

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

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

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

Data Element Name: Admission Date

Collected For: All MassHealth Records

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

Suggested Data Collection Question: What is the date the patient was admitted to acute inpatient care?

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

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

Notes for Abstraction: The intent of this data element is to determine the date that the patient was actually admitted to acute inpatient care. Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.

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 dated 4-6-20xx with an order to admit Inpatient.
Postoperative orders dated 5-1-20xx, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 5-1-20xx. The admission date would be abstracted as 5-1-20xx.

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 would be the date the baby was born.

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

Guidelines for Abstraction:

Inclusion	Exclusion
None	Admit to observation Arrival date

Data Element Name: Admission to NICU

Collected For: NEWB-1

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

Suggested Data Collection 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. There is no time limit for admission to observation.

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.

If your hospital does not have a NICU, you must always select Value “no” regardless of any reason a newborn is admitted to a nursery.

Suggested Data Sources:
Nursing notes
Discharge summary
Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Advance Care Plan

Collected For: CCM-2

Definition: An Advance Care Plan refers to a written statement of patient instructions or wishes regarding future use of life sustaining medical treatment. An Advance Care Plan may include: an advance directive, living will, healthcare proxy or surrogate decision maker, or power of attorney. *(Reference to DNR removed)*

Additional information about Massachusetts regulations regarding Advance Care Plans may be found at the following sources:
https://www.mass.gov/files/documents/2017/12/18/130cmr450.pdf
https://www.mass.gov/info-details/massachusetts-legal-forms-for-subjects-e-h#health-care-proxy-/-living-will-.

A transition record that included documentation of the presence of an Advance Care Plan or a documented reason for not providing an advance care plan.

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

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) The transition record includes documentation of the presence of an Advance Care Plan or a documented reason for not providing an advance care plan.

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

Notes for Abstraction: The presence of an advance care plan must be documented on the transition record for all patients 18 years and over.

A checkbox or documentation of the presence of an advance directive, health care proxy, surrogate decision maker, power of attorney, etc. must be documented. *(Reference to DNR or full code status removed)*

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

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

- The care plan was discussed but the patient did not wish or was not able to name a health care proxy or surrogate decision maker
- The patient was not able to provide an advance care plan
- Documentation as appropriate that the patient's cultural and/ or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician patient relationship
- The patient was < 18 years of age (calculated from Date of Birth and Admission Date)

Patient refusal of advance care plan information or decision for an advance care plan, select Y(Yes)

Documentation in the medical record that there is no advance care plan without a reason does not meet the requirement.

The physician decision not to address the Advance Care Plan topic with the patient does not meet the requirement.

In the event the patient is transferred to another site of care and the advance care plan information is provided to the next site of care, this data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

A copy of an Advance Care Plan document within the medical record does not meet the requirement. The Transition Record must have documentation of the presence of an Advance Care Plan.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
Advance Directive Power of Attorney Health care proxy Living Will Medical Orders for Life-Sustaining Treatment (MOLST)	Patients < 18 years of age *Do Not Resuscitate – DNR etc* *Documentation of code status: Full Code*

Data Element Name: Birthdate

Collected For: All MassHealth Records

Definition: The month, day, and year the patient was born.

NOTE: Patient's age (in years) is calculated by *Admission Date* minus *Birthdate.* The algorithm to calculate age must use the month and day portion of admission date and birthdate to yield the most accurate age**.**

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

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

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

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

Suggested Data Sources:
Emergency department record
Face sheet
Registration form

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Contact Information 24hrs/ 7 days
Collected For:	CCM-2
Definition:	Contact information 24hrs/ 7 days refers to any phone number that is listed for the patient to call for questions, concerns, or emergencies that is answered 24 hours a day, 7 days a week. A transition record that included documentation on 24 hr/ 7 day Contact Information for questions, concerns, or emergencies related to the inpatient stay.
Suggested Data Collection Question:	Does the Transition Record include 24 hr/ 7 day Contact Information for questions, concerns, or emergencies related to the inpatient stay?
Format:	**Length:** 1 **Type:** Alphanumeric **Occurs:** 1
Allowable Values:	Y (Yes) The transition record includes 24 hr/ 7 day Contact Information for questions, concerns, or emergencies related to the inpatient stay. N (No) The transition record does not include 24 hr/ 7 day Contact Information for questions, concerns, or emergencies related to the inpatient stay.
Notes for Abstraction:	Any number listed that is answered 24 hours a day, 7 days a week. Must be clear to the patient that this is the number to call for questions, concerns, or emergencies. Examples: • For any questions, please call your PCP at … • Discharging unit phone number provided on Transition Record • 24/7 Contact Information: Emergency Department phone number is ____ • Call 911 if chest pain For the inpatient psychiatric population, contact information for the physician, healthcare team member, or other healthcare personnel who have access to medical records and other information concerning the inpatient stay and who could be contacted regarding emergencies related to the stay is accepted and the abstractor may select Yes. In the event the patient is transferred to another site of care, this data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site of care.
Suggested Data Sources:	Transition Record Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
• Call 911 • Emergency Room Phone Number • Primary Care Physician Phone Number • Specialist Phone Number • Discharging Unit Phone Number • Hospital phone number	None

Data Element Name: Contact Information for Studies Pending at Discharge

Collected For: CCM-2

Definition: Contact information for studies pending refers to the name and/or phone number of a contact person that will provide information on tests when results are pending at discharge.

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

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

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) The transition record includes Contact Information for Studies Pending at Discharge or documentation that there were no studies pending at discharge.

N (No) The transition record does not include Contact Information for Studies Pending at Discharge or documentation that there were no studies pending at discharge.

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

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

In the event of a transfer to another site of care, this element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

See also data element Studies Pending at Discharge

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
• Primary Care Physician • Name of Next Provider or Site of Care • Specialist Office • Hospital Lab or Radiology Department	None

Data Element Name: Current Medication List

Collected For: CCM-2

Definition: A Current Medication List is a list of all medications (continued and new) to be taken by the patient after discharge.

A transition record that included a Current Medication List given to the patient at the time of inpatient discharge.

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

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) The Transition Record includes a current medication list at the time of discharge or documentation of no medications.

N (No) The Transition Record does not include a current medication list at the time of discharge or documentation of no medications.

Notes for Abstraction: If there are no current medications at discharge, there must be documentation of "none" or "N/A" in order for the abstractor to select Y(Yes).

A reconciled medication list given to the patient at discharge meets the requirement for Current Medication List.

In the event the patient is transferred to another site of care and a listing of current medications is provided to the next site of care, this data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

Suggested Data Sources:
Transition Record
Discharge Instructions
Discharge Medication Reconciliation Form

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Discharge Date

Collected For: All MassHealth Records

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

Suggested Data Collection Question: What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay?

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

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

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

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

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Discharge Diagnosis

Collected For: CCM-2

Definition: The discharge diagnosis is defined as the diagnosis determined at discharge, after procedures and tests were administered, to be chiefly responsible for resulting in the patient being admitted for inpatient hospital care.

A transition record that included the Discharge Diagnosis.

Suggested Data Collection Question: Does the Transition Record include the Discharge Diagnosis?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) The transition record includes the Discharge Diagnosis.

N (No) The transition record does not include the Discharge Diagnosis.

Notes for Abstraction: The discharge diagnosis must be specifically documented as the discharge diagnosis and differentiated from the Reason for Inpatient Admission.

Discharge instructions with a title of the patient's condition does not meet the requirement for documentation of the patient's discharge diagnosis. Examples: Postpartum discharge instructions, Knee Replacement discharge instructions.

A discharge diagnosis of "Postpartum" does not meet the requirement. The delivery type must be specified. For example: vaginal delivery, spontaneous vaginal delivery (SVD), Cesarean section etc.

If the admission and discharge diagnosis are the same, documentation of "Same" for the discharge diagnosis will be accepted. The abstractor should select Y (Yes). For example, a patient's admission diagnosis is pneumonia and the documented discharge diagnosis is pneumonia.

In the event the patient is transferred to another site of care and the discharge diagnosis is provided to the next site of care, this data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
• Discharge diagnosis • Final diagnosis • Primary diagnosis at discharge • Principal diagnosis • Working diagnosis	Post-op diagnosis Secondary diagnosis

Data Element Name: Discharge Disposition

Collected For: All MassHealth Records

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

Suggested Data Collection Question: What was the patient's discharge disposition on the day of discharge?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 Home

2 Hospice- Home

3 Hospice- Health Care Facility.

4 Acute Care Facility

5 Other Health Care Facility

6 Expired

7 Left Against Medical Advice / AMA

8 Not Documented or Unable to Determine (UTD)

Notes for Abstraction:

- Only use documentation 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".

- 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.

Example:
- 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 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 patient is being discharged to assisted living care or an assisted living facility (ALF) that is located within a skilled nursing facility, and documentation in the medical record also includes nursing home, intermediate care or skilled nursing facility, select Value "1" ("Home").
- If the medical record states the patient is being discharged to nursing home, intermediate care or skilled nursing facility without mention of assisted living care or assisted living facility (ALF), select Value "5" ("Other Health 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:

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

Excluded Data Source: Any documentation prior to the last two days of hospitalization.

Guidelines for Abstraction:

Inclusion	Exclusion
For 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, 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 For Value 2: • Hospice in the home (or other "Home" setting as above in Value 1) For Value 3: • Hospice- General Inpatient and Respite • Hospice- Residential and Skilled Facilities • Hospice- Other Health Care Facilities For Value 4: • Acute Short Term General and Critical Access Hospitals • Cancer and Children's Hospitals • Department of Defense and Veteran's Administration Hospitals For Value 5: • Extended or Immediate Care Facility (ECF/ICF) • Long Term Acute Care Hospital (LTACH) • Nursing Home or Facility including Veteran's Administration Nursing Facility • Psychiatric Hospital or Psychiatric Unit of a Hospital • Rehabilitation Facility including but not limited to: Inpatient Rehabilitation Facility/ Hospital, Rehabilitation Unit of a Hospital, Chemical Dependency/Alcohol Rehabilitation Facility • Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed • Transitional Care Unit (TCU) • Veterans Home	None

Data Element Name: Episode of Care

Collected For: All MassHealth Records

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

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

Format:
Length: 22
Type: Alphanumeric
Occurs: 1

Allowable Values:

CCM	Care Coordination (includes CCM-1, CCM-2, & CCM-3)
MAT-4	Cesarean Delivery
NEWB-1	Exclusive Breast Milk Feeding

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Exclusive Breast Milk Feeding

Collected For: NEWB -1

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.

Suggested Data Collection 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”.

If the newborn received IV fluids this is the same as a medication and not a feeding.

If dextrose or glucose 40% gel is given it is considered a medication not a feeding. This should be reflected as such in the documentation.

Actual feedings must be abstracted from the only acceptable data sources regardless of any documentation about feeding plans and changes to feeding plans which mention inclusion of formula.

Suggested Data Sources: **Only Acceptable Sources:**
Diet Flow Sheets
Feeding flow sheets
Intake and output sheets

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: First Name

Collected For: All MassHealth Records

Definition: The patient's first name.

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

Format:
Length: 30
Type: Alphanumeric
Occurs: 1

Allowable Values: Enter the patient's first name.

Notes for Abstraction: None

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

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Gestational Age

Collected For: MAT-4

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).

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

Format:

Length:	3 or UTD
Type:	Alphanumeric
Occurs:	1

Allowable Values: UTD= Unable to Determine
1-50

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.

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.

The delivery or operating room record should be reviewed first for gestational age; documentation of a valid number should be abstracted.

If the gestational age in the delivery or operating room record is missing, obviously incorrect (in error, e.g. 3.6), or there is conflicting data, then continue to review the following data sources, starting with the document completed closest to or at the time of the delivery until a positive finding for gestational age is found:

- History and physical
- Clinician admission progress note
- Prenatal forms

Gestational age documented closest to or at the time of delivery (not including the newborn exam) should be abstracted.

The phrase "estimated gestational age" is an acceptable descriptor for gestational age.

If no gestational age was documented (e.g. the patient has not received prenatal care), select allowable value UTD.

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)
- 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:

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

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Hispanic Indicator

Collected For: All MassHealth Records

Definition: The patient self-reported as Hispanic, Latino, or Spanish as defined by Massachusetts regulation noted in Section 2 of this EOHHS manual.

The definition of the "Hispanic" data element in the Massachusetts regulation differs from the CMS National Hospital Inpatient Quality Measures reporting requirement.

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

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

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

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

Notes for Abstraction: As noted in Section 2, Table 2.3 comparison chart, the Massachusetts regulation valid entry codes and allowable values for the "Hispanic" data element differs from CMS reporting requirement. Hospitals must use the Massachusetts regulation definition and allowable values when preparing all MassHealth data files for submission.

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

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

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

Guidelines for Abstraction:

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

Data Element Name: ICD-10-CM Other Diagnosis Codes

Collected For: All MassHealth Records

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

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

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

Allowable Values: Any valid diagnosis code as per the CMS ICD-10-CM master code table (Code Descriptions in Tabular Order): https://www.cms.gov/Medicare/Coding/ICD10/index.html

Notes for Abstraction: None

Suggested Data Sources: Discharge summary
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: ICD-10-PCS Other Procedure Codes

Collected For: All MassHealth Records

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

Suggested Data Collection 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)
Type: Character (upper or lower case)
Occurs: 24

Allowable Values: Any valid procedure code as per the CMS ICD-10-PCS master code table (PCS Long and Abbreviated Titles):
https://www.cms.gov/Medicare/Coding/ICD10/index.html

Notes for Abstraction: None

Suggested Data Sources: Discharge summary
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: ICD-10-PCS Other Procedure Dates

Collected For: All MassHealth Records

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

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

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

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

Notes for Abstraction:

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

  Examples:
  - Documentation indicates the ICD-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 records 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 abstractor should select "UTD"

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

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: ICD-10-CM Principal Diagnosis Code

Collected For: All MassHealth Records

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

Suggested Data Collection 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)
Type: Character (upper or lower case)
Occurs: 1

Allowable Values: Any valid diagnosis code as per the CMS ICD-10-CM master code table (Code Descriptions in Tabular Order): https://www.cms.gov/Medicare/Coding/ICD10/index.html

Notes for Abstraction: None

Suggested Data Sources: Discharge summary
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: ICD-10-PCS Principal Procedure Code

Collected For: All MassHealth 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.

Suggested Data Collection 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)
Type: Character (upper or lower case)
Occurs: 1

Allowable Values: Any valid procedure code as per the CMS ICD-10-PCS master code table (PCS Long and Abbreviated Titles): https://www.cms.gov/Medicare/Coding/ICD10/index.html

Notes for Abstraction: None

Suggested Data Sources: Discharge summary
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: ICD-10-PCS Principal Procedure Date

Collected For: All MassHealth Records

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

Suggested Data Collection Question: What was the date the principal procedure was performed?

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

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

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

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

- Documentation indicates the ICD-10-PCS Principal Procedure Date was 02-42-20xx. No other documentation n 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".

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

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Last Name

Collected For: All MassHealth Records

Definition: The patient's last name.

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

Format:
Length: 60
Type: Alphanumeric
Occurs: 1

Allowable Values: Enter the patient's last name.

Notes for Abstraction: None

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

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: MassHealth Member ID

Collected For: All MassHealth Records

Definition: The patient's MassHealth Member ID.

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

Format:
Length: 20
Type: Alphanumeric
Occurs: 1

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

Notes for Abstraction:

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

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

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

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

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

Suggested Data Sources:
Emergency department record
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Medical Procedures and Tests & Summary of Results

Collected For: CCM-2

Definition: Medical procedures and tests performed refer to procedures and tests performed during the acute inpatient hospitalization to help establish the diagnosis at discharge and course of treatment. Summary of results refers to the results of the medical procedures and tests performed.

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

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

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

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

Notes for Abstraction: Hospitals determine which procedures or tests are relevant to the care of the specific patient. Not all procedures and tests should be documented.

Some examples of procedures and tests are:

Procedures: Cesarean section, vaginal delivery, appendectomy, heart catheterization with stent, knee replacement

Tests: Urine cultures, blood cultures, Imaging Studies (x-rays, CT scan)

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

Examples of documentation for Summary of Results: “Results discussed with physician,” “Within normal limits,” “Contact your physician with any questions regarding your results,” should accompany the specific medical procedure or tests listed. Documentation of actual test results such as: “CT negative for pulmonary emboli” or “Echocardiogram shows your heart is enlarged” also meet the requirement.

If there is documentation of “No procedures or tests/ None/ N/A”, the abstractor should select Y (Yes).

In the event of a transfer to another site of care, if a summary or listing of medical procedures and tests performed during inpatient stay is provided with the patient to the receiving site, this element may be documented as Y (Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
Normal/ Abnormal Within normal limits Results to be discussed with physician	None

Data Element Name: National Provider ID

Collected For: All MassHealth Records

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

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

Format:
Length: 10
Type: Alphanumeric
Occurs: 1

Allowable Values: Any valid ten digit national provider ID.

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

Suggested Data Sources: Administrative record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Patient Identifier

Collected For: All MassHealth Records

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

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

Format:
Length: 40
Type: Alphanumeric
Occurs: 1

Allowable Values: Up to 40 letters and / or numbers

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

Suggested Data Sources: Administrative record
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Patient Instructions

Collected For: CCM-2

Definition: Patient Instructions refers to information that is associated with the diagnosis, treatment, and plan of care specific to the patient's inpatient stay that should be followed by the patient after discharge from inpatient care.

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

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

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) The transition record includes Patient Instructions.

N (No) The transition record does not include Patient Instructions.

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

If the patient instructions given to the patient are on a separate page from the transition record and not retained in the permanent medical record, there must be a reference listing the patient instructions given to the patient.

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

In the event the patient is transferred to another site where the patient instructions will be determined at the time of discharge from that site of care, this data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site of care.

Suggested Data Sources: Transition Record
Patient Instructions (may be pre-printed forms)
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Patient Refusal of Transmission

Collected For: *CCM-3*

Definition: Documentation in the medical record of the patient's or caregiver's refusal of transmission of the patient's healthcare information to include the Transition Record to the next site of care, physician, or other health care professional designated for follow-up care

Suggested Data Collection Question: Is there documentation in the medical record of patient refusal of transmission to the next site of care, physician, or other health care professional designated for follow-up care?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) The medical record includes documentation of patient refusal of transmission to the next site of care, physician, or other health care professional designated for follow-up care.

N (No) The medical record does not include documentation of patient refusal of transmission to the next site of care, physician, or other health care professional designated for follow-up care.

Notes for Abstraction:

Patient refusal of transmission of the transition record may occur at any point during the inpatient stay.

Documentation requirements may be met by the following:

- patient signature indicating refusal of transfer of medical record information
- nursing note stating patient refusal
- other health care provider documentation of refusal

TRANSFER- In the event the patient is transferred to another site of care where the plan for follow-up care will be determined at the time of discharge from that site, patient refusal is abstracted as No. The discharge date should be used as the Transmission Date. Documentation of the discharge date also applies to patients discharged and admitted within the same site.

Suggested Data Sources: Admission Consent Forms
Nursing notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Payer Source

Collected For: All MassHealth Records

Definition: The definition of Medicaid payer source as defined by the Massachusetts regulations noted in Section 2 of this EOHHS manual.

The definition of the Medicaid payer source data element differs from the CMS National Hospital Inpatient Quality Measures reporting requirement.

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

Format:
Length: 3
Type: Alphanumeric
Occurs: 1

Allowable Values: Payment source code values assigned by Massachusetts regulations include:

103	Medicaid: Includes MassHealth FFS and MassHealth Limited
104	Medicaid: Primary Care Clinician (PCC) Plan
208	Medicaid Managed Care – Boston Medical Center HealthNet Plan
274,*207*	Medicaid Managed Care – Tufts Health Together Plan
118	Medicaid Mental Health & Substance Abuse Plan - Mass Behavioral Health Partnership
119	Medicaid Managed Care - Other (not listed elsewhere)
312	Medicaid: Fallon 365 Care (ACO)
313	Medicaid: Be Healthy Partnership with Health New England (ACO)
314	Medicaid: Berkshire Fallon Health Collaborative (ACO)
315	Medicaid: BMC HealthNet Plan Community Alliance (ACO)
316	Medicaid: BMC HealthNet Plan Mercy Alliance (ACO)
317	Medicaid: BMC HealthNet Plan Signature Alliance (ACO)
318	Medicaid: BMC HealthNet Plan Southcoast Alliance (ACO)
321	Medicaid: My Care Family with Allways Health Partners (ACO)
324	Medicaid: Tufts Health Together with Atrius Health (ACO)
325	Medicaid: Tufts Health Together with BIDCO (ACO)
326	Medicaid: Tufts Health Together with Boston Children's (ACO)
327	Medicaid: Tufts Health Together with CHA (ACO)
328	Medicaid: Wellforce Care Plan (ACO)
320	Medicaid: Community Care Cooperative (ACO)
322	Medicaid: Partners Healthcare Choice (ACO)
323	Medicaid: Steward Health Choice (ACO)
311	Medicaid: Other ACO

Notes for Abstraction: As noted in Section 2.C.1 (Table 2.2) a revised list of included and excluded Medicaid payer codes resulting from Affordable Care Act requirements apply. The Massachusetts regulations outline the payer data reporting definitions and codes for Medicaid payment sources required when preparing MassHealth data files for submission.

Primary source of payment is a MassHealth insurance program:
- If Medicaid is the only payer listed (see payer codes above);
- If Medicaid is primary and another secondary insurance is listed.

Primary source of payment is NOT a MassHealth insurance program:
- If Medicare is the only payer listed;
- If Medicare is primary and lists Medicaid as secondary (ex: dual eligible)
- If HMO/Commercial Plan is primary and lists Medicaid as secondary (TPL)

Suggested Data Sources: Face sheet (Emergency Department / Inpatient)
UB-04, file location, 50A, B, C
MassHealth Eligibility Verification System (EVS)
http://www.mass.gov/eohhs/provider/insurance/masshealth/claims/eligibility-verification/

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Plan for Follow-up Care

Collected For: CCM-2

Definition: Plan for Follow-up Care refers to a document that describes further action to be taken after the patient is discharged that is shared with patient/family caregiver. The purpose of a plan for follow-up care is to track and monitor progress toward patient goals.

A transition record that included a Plan for Follow-up Care related to the inpatient stay or documentation by a physician of no follow-up care required.

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

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

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

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

Notes for Abstraction: The Plan for follow-up care may include:

- Any post discharge therapy needed (ex. physical, occupational, home health visits, VNA)
- Any durable medical equipment needed
- Family psychosocial resources available for patient support, self-care instructions (e.g. counseling)
- Follow up appointments
- Follow-up for medical issues, social work and benefits follow-up, pending legal issues, and peer support (e.g. Alcoholics Anonymous, Narcotics Anonymous, and/or home-based services)

A scheduled appointment or specific instructions for the patient to call within a certain timeframe to make an appointment with a physician/ health care professional will be accepted.
Example: Call Dr Jackson for appointment in 1 week
Primary Care Physician to call patient with appointment date/time
Follow up with Dr Jackson as needed
Call OB for appointment in 1 week
Appointment scheduled with Cardiology in 2 days

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

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

In the event the patient is transferred to another site of care where the plan for follow-up care will be determined at the time of discharge from that site, this

data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

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

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
• Instruction for patient to call physician / health care professional or site of care such as a clinic to schedule appointment within a specific time frame • OB/Pediatric follow-up appointments • A scheduled appointment • Oxygen therapy • Physical therapy • Occupational therapy • DME • VNA • Social work and benefits follow-up • References for pending legal issues • Peer support (e.g. Alcoholics Anonymous, Narcotics Anonymous, and/or home-based services	None

Data Element Name: Previous Live Births

Collected For: MAT-4

Definition: Documentation that the patient experienced a live birth prior to current hospitalization.

Suggested Data Collection Question: Did the patient experience a live birth prior to current hospitalization?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) There is documentation that the patient experienced one or more live births prior to the current hospitalization.

N (No) There is no documentation that the patient experienced one or more live births prior to the current hospitalization OR unable to determine from medical record documentation.

Notes for Abstraction:

The delivery or operating room record should be reviewed first for the number of previous live births. If documentation of previous live births is not present or is conflicting in the delivery or operating room record, then continue to review the data sources in the following order: history and physical, clinician admission progress note, prenatal forms, and discharge summary until a positive finding for the number of previous live births is found.

If there is conflicting documentation throughout the acceptable sources and it cannot be determined from the medical record if there were previous live births, select No.

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.

Parity may be used in the absence of documentation of the number of previous live births. If the number for parity documented is "one" and includes the delivery for the current hospitalization, do not include the current delivery to determine previous live births.

A string of three or more numbers without the alpha designation of “p” preceding the second number cannot be used to determine parity. Example: 321 When GTPAL terminology is documented, G= Gravida, T= Term, P= Preterm, A= Abortions, L= Living, P does not equal parity.

Suggested Data Sources:

ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE

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

Guidelines for Abstraction:

Inclusion	Exclusion
Select Yes: • Number of previous live births is greater than 0 • Parity is greater than 0 • Term is greater than 0 • Preterm is greater than 0 • Living is greater than 0 • Documentation of multiparous	Select No: • Number of previous live births equals 0 • Parity equals 0 • Gravidity equals 1 • Documentation of primigravida or nulliparous

Data Element Name: Primary Physician or Other Health Care Professional for Follow-up Care

Collected For: CCM-2

Definition: Primary Physician refers to the physician responsible for overseeing the continued care of the patient immediately after discharge/ post-discharge (ex: Internist, Pediatrician, or Psychiatrist). Other Health Care Professional refers to any other medical specialist that may be involved in the continued care process (ex: surgeon, cardiologist, nurse practitioner etc).

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

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

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) The transition record includes the name of the Primary Physician or other Health Care Professional or site designated for follow-up care.

.

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

Notes for Abstraction: The primary physician or other health care provider's name must be specified. The exception is for a site of care such as a nursing home when the physician name may not be known. In this case the site name must be documented.

The VNA or home health agency is not acceptable as a Primary Care Physician or other Health Care Professional designated for follow-up care.

If the patient is transferred to the next site of care and the physician designated for follow-up is unknown, "site physician" or site of care name will be accepted, and this element may be documented as Y (Yes).

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

In the case of a patient declining assignment of a PCP or clinic, the patient may be referred to the Emergency Room for follow up care.

If it is determined and documented by the physician that the patient requires no follow-up care, the name of the patient's primary physician or other health care professional or site designated for care must be documented.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
• Specific physician name • Specific health care professional • Clinic or site name • Transferred • Emergency Room	• "PCP" "Primary Care Physician" • VNA

Data Element Name: Provider ID

Collected For: All MassHealth Records

Definition: The provider's ten-digit acute care Medicaid or six-digit Medicare provider.

Suggested Data Collection Question: What is the provider's ten-digit acute care Medicaid or six-digit Medicare ID?

Format:
Length: 10
Type: Alphanumeric
Occurs: 1

Allowable Values: Any valid ten-digit Medicaid or six-digit Medicare provider ID.

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

Suggested Data Sources: Administrative record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Provider Name

Collected For: All MassHealth Records

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

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

Format:
Length: 60
Type: Alphanumeric
Occurs: 1

Allowable Values: Provider name

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

Suggested Data Sources: Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Race

Collected For: All MassHealth Records

Definition: The patient's self-reported race as defined by the Massachusetts regulation noted in Section 2 of this EOHHS manual.

The definition of "Race" data element categories in the Massachusetts regulation differ from the CMS National Hospital Inpatient Quality Measures reporting requirement.

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

Format:

Length: 6
Type: Alphanumeric
Occurs: 1

Allowable Values: Select one:

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

Notes for Abstraction: As noted in Section 2, Table 2.3 comparison chart, the Massachusetts regulation codes and allowable values for the "Race" data element differ from CMS reporting requirement. Hospitals must use the Massachusetts regulation race codes and allowable values when preparing all MassHealth data files for submission.

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

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

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

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

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

Guidelines for Abstraction:

Inclusions	Exclusion
(OMB definitions) • American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliations or community attachment, e.g. any recognized tribal entity in North and South America (including Central America), Native American. • 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. • Black / African American: A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro”, can be used in addition to “Black or African American”. • Native Hawaiian or Other Pacific Islander: A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. • White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa, e.g., Caucasian, Iranian, White. • Other Race: A person having an origin other than what has been listed above. • Unknown: Unable to determine the patient’s race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).	None

Data Element Name: Reason for Inpatient Admission

Collected For: CCM-2

Definition: The reason for inpatient admission describes the patient's chief complaint, reason for admission, or diagnosis at time of admission.

A transition record that included the Reason for Inpatient Admission.

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

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

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

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

Notes for Abstraction: The reason for admission may be a short synopsis or listing of the triggering or precipitating event prior to the patient's admission to the hospital.

Documentation of a diagnosis, symptoms, or procedure is acceptable for Reason for Admission. The Reason for Inpatient Admission must be documented and differentiated from the Discharge Diagnosis on the Transition Record.

For the inpatient psychiatric population, it is recommended to document the events the patient experienced prior to this hospitalization; the reason for hospitalization as a short synopsis describing or listing the triggering or precipitating event.

In the event the patient is transferred to another site of care and the reason for admission is provided to the next site of care, this data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
This list is not all-inclusive • Reason for Admission • Admission diagnosis • Primary diagnosis • Chief complaint	None

Data Element Name: Reconciled Medication List

Collected For: CCM-1

Definition: A Reconciled Medication List is the result of the formal process of identifying all medications to create the most complete and accurate list and comparing the list to those in the patient's record or medication orders at the time of discharge.

The Transition Record included the reconciled list received by the patient/caregiver(s) including new, continued, and discontinued medications as applicable to the patient at the time of discharge.

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

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

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

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

Notes for Abstraction: The reconciled list should address medications taken prior to inpatient stay (to be continued or active), started during inpatient stay or upon discharge (new) and medications to discontinue at discharge. If the patient has no home medications and is discharged with no medications, the abstractor should select "Yes".

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

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

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

All 3 categories of continued, new, and discontinued must be addressed for the patient but do not need to be labeled separately. For instance, a medication reconciliation form with the category title "medications to take" is acceptable documentation for the continued and new categories.

A reconciled medication form that does not list discontinued medications must state clearly to the patient that "medications not listed should be discontinued" or "only medications listed should be taken".

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

Prescribed dosage, instructions, and *intended duration* must be included for each continued and new prescription and non-prescription medication.

A generalized statement regarding intended duration, such as a blanket statement indicating that the patient should continue the medications until told to stop, would be acceptable for routine medications.

In the event the patient is transferred to another site of care where the medication reconciliation will be determined at the time of discharge from that site, this data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

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

Oxygen should not be considered a medication.

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

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

If the patient was given written discharge medication instructions only in the form of written prescriptions, select N(No).

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

Guidelines for Abstraction:

Inclusion	Exclusion
None	Prenatal Vitamins

Data Element Name: Sex

Collected For: All MassHealth Records

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

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

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
M = Male
F = Female
U = Unknown

Notes for Abstraction: Collect the documented patient's sex at admission or the first documentation after arrival

Consider the sex to be unable to determine and select "Unknown" if:

- The patient refuses to provide their sex
- Documentation is contradictory
- Documentation indicates the patient is a transsexual
- Documentation indicates the patient is a hermaphrodite

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

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Studies Pending at Discharge

Collected For: CCM-2

Definition: Studies pending at discharge refers to any medical tests performed during hospitalization, but whose final results were unavailable at the time the patient was discharged, and therefore could not be reviewed by clinicians prior to hospital discharge.

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

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

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) The transition record includes documentation of studies pending at discharge or documentation that no studies were pending.

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

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

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

Studies pending do not include tests scheduled to be performed after discharge from inpatient care.

In the event of a transfer to another site of care, if documentation of tests or procedures with pending results was provided with the patient to the receiving site, this element may be documented as Y (Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

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

Data Element Name: Term Newborn

Collected For: NEWB-1

Definition: Documentation that the newborn was at term or >= 37 completed weeks of gestation at the time of birth.

Suggested Data Collection 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:

1. Y (Yes) There is documentation that the newborn was at term or >= 37 completed weeks of gestation at the time of birth.

2. N (No) There is no documentation that the newborn was at term or >= 37 completed weeks of gestation at the time of birth.

3. UTD, 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, including a range of numbers that are 37 weeks or greater, e.g.,37-38 weeks gestation.

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.

In cases when there is conflicting documentation, e.g., both term and a gestational age of 36 weeks are documented, the gestational age takes precedence.

In cases where there are two different values documented for gestational age and one is determined by examination and the other is determined by the best obstetrical estimate (OE) based on dates, abstract the value determined by dates.

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

Discharge summary

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

Data Element Name: Transition Record
Collected For: CCM-2

Definition: A transition record refers to a document (or set of documents), as defined by the hospital, that must contain the minimum core set of information relevant to the patient's diagnosis, treatment, and plan of care. The core set of required information data elements are as follows.

Core set of Required Elements (11):

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

Suggested Data Collection Question: Did the patient/ caregiver(s) or the next site of care for a transfer receive a transition record at the time of discharge?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) The patient/caregiver(s) or the next site of care for a transfer received a transition record at the time of discharge.

N (No) The patient/caregiver(s) or the next site of care for a transfer did not receive a transition record at the time of discharge.

Notes for Abstraction: For a transition record that included any or all of the required elements received by the patient/ family caregiver at the time of hospital inpatient discharge, select Y(Yes).

If the Transition Record is offered to the patient at discharge and the patient/caregiver refuses, select Y(Yes) if there is documentation in the medical record of patient/caregiver refusal.

The required data elements in a Transition Record may be found on a single source document or multiple sources but these sources must be provided to the patient/ caregiver or the next site of care in the case of a transfer.

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

- Transition Record
- Discharge Instructions
- Transfer Forms
- Any document given to the patient/ family caregiver that includes ANY or ALL of the required data elements
- Any document given to the next site of care for a patient transfer that includes ANY or ALL of the required data elements
- Physician Discharge Summary ONLY if given to the patient/ family caregiver or the next site of care in the case of a transfer.

In the event the patient is transferred to another site of care and the transition record, that included any or all of the required elements, is given to the next site of care, the Transition Record may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site of care.

PATIENT PORTAL- Notification to the patient of the availability of a patient portal which gives access to ANY or ALL of the required data elements does not meet the requirement for Transition Record. There must be documentation in the medical record that the patient has elected to access the patient portal for the post discharge Transition Record information. Abstractors may then select Y(Yes) for data elements available to the patient within the portal. Documentation of the required data elements located in the patient portal must be provided for records selected for validation.

Documentation of evidence the patient/ family caregiver received the Transition Record includes:

- Patient/ family caregiver signature on Transition Record
- Nursing documentation of patient receipt of Transition Record
- Physician/ Nurse signature on Transition Record

The caregiver is defined as the patient's family or any other person over age 18 who will assume responsibility for managing the care of the patient after discharge. The caregiver term is differentiated from other health care professional entities that may assist in the care of the patient.

Suggested Data Sources: Transition Record
Discharge Instructions
Transfer Forms

Guidelines for Abstraction:

Inclusion	Exclusion
None	Physician Discharge Summary: Do not abstract information from the physician discharge summary for CCM-2 (unless a copy of the physician discharge summary is given to the patient/caregiver or the patient is a transfer)

Data Element Name: Transmission Date (of Transition Record)

Collected For: CCM-3

Definition: The Transmission Date refers to the month, day and year the Transition Record data elements were transmitted to the next site of care, physician, or other health care professional designated for follow-up care.

Transmission methods may occur via fax, secure email, mail, via mutual access of an electronic medical record (EMR), or by CEHRT transmission. The transmission date may be the day of discharge or within the following two days.

Suggested Data Collection Question: What was the date documented in the medical record that the Transition Record was transmitted?

Format:

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

Allowable Values:

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

Notes for Abstraction: There must be a Transmission of the Transition Record data elements to the next provider or site of care. A physician or site of care listed as "cc" on the discharge summary or transition record is not enough to meet the measure.

Documentation of the date of Transmission must be provided for validation.

EMR -In the case of Electronic Medical Records (EMR), there must be documentation in the medical record or on the transition record by discharging staff of the date the information has been transmitted to the next provider of care. This includes transmission by CEHRT (certified electronic health record technology).

MUTUAL ACCESS- In the case of mutual access, there must be documentation in the medical record or on the transition record of the date of notification to the provider that the patient has been discharged and the transition record elements are ready for review. The next provider of care having access to the EMR without documentation of notification is not enough to pass this measure.

NEXT PROVIDER NOT IDENTIFIED- If the Emergency Room of the hospital is documented as the referral for follow-up care, EMR mutual access is the assumed answer and the date of discharge may be documented for the Transmission Date.

If there is documentation of "Unknown MD/PCP" on the transmission documentation or no MD/PCP/next site of care is identified on the Transition Record and the Emergency Room is NOT designated for follow up, UTD must be selected for transmission date.

TRANSFER- In the event the patient is transferred to another site of care where the plan for follow-up care will be determined at the time of discharge from that site, the discharge date should be used as the Transmission Date.

Documentation of the discharge date also applies to patients discharged and admitted within the same site.

FAX- In the case of a fax transmission, there must be documentation in the medical record or on the transition record of the date the fax was sent to the next provider.

MAIL- If the transition record is sent by mail, the date of the mailing may be documented in the medical record or on the transition record as the Transmission Date.

HAND DELIVERY- A transition record given to the patient to hand carry to a physician is not acceptable.

If the discharging physician is also the physician designated for follow up care, transmission of the Transition Record to the provider or provider practice is still required.

Any documentation used to complete the Transition Record must be transmitted with the Transition Record (ex. Medication Reconciliation Form, Discharge Instructions).

The transition record should be transmitted to the next provider even if there is no follow-up care required.

Suggested Data Sources:

Transition Record
Discharge Instructions
Physician Discharge Summary
Administrative Records or Screen Shots
Information Systems Reports
Health Information Management (HIM) Reports

Guidelines for Abstraction:

Inclusion	Exclusion
• Faxed • Secure Email • Mail • Electronic Medical Record (EMR) or Electronic Health Record (EHR) with proper documentation of notification to next provider of care • CEHRT Transmission	• Hand carried by patient • Transmission to the VNA