

Commonwealth of Massachusetts
Executive Office Health and Human Services

RY2023 EOHHS Manual Release Notes
(Version 16.1)



Supplement to:
RY2023 EOHHS Technical Specifications Manual for Acute
Hospital Quality Measures (v16.0)

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Introduction

A. Purpose

The EOHHS Release Notes provide hospitals with interim updates on MassHealth Acute Hospital Pay-for-Performance (P4P) Program quality data collection and reporting requirements applicable to the current rate year EOHHS Technical Specifications Manual content posted on Mass.Gov website.

- 1) **Program Update.** The EOHHS Acute Hospital RFA2023 Section 7.B introduced a new MassHealth Clinical Quality Incentive (CQI) Program that expands on Section 7 measure reporting requirements. This Release Notes (16.1) provides advanced notice on instruction for hospitals to implement data collection and reporting on select chart-based measures. Additional Release Notes on other CQI measures are forthcoming.
- 2) **New Program Measure Specifications:**
 - a. **Unexpected Complication in Term Newborn (NEWB-3) Measure.** Pursuant to the MassHealth CQI program “*Specialty Perinatal Quality Domain* (Table 7B-2)” the newly introduced NEWB-3 measure (referred to as PC-06) shall be collected and reported on all Medicaid payer data. This document provides detailed instruction on MassHealth specific measure specifications and data tools that will apply to collection and reporting.
 - b. **Alcohol Use Brief Intervention Provided or Offered (SUB-2) Measure:** Pursuant to the MassHealth CQI program “*Care of Acute and Chronic Conditions Core Quality Domain* (Table 7B-1)” the newly introduced SUB-2 measure shall be collected and reported on all Medicaid payer data. This document provides detailed instruction on MassHealth specific measure specifications and data tools that apply to collection and reporting.
 - c. **Alcohol & Other Drug Use Disorder Treatment Provided/Offered at Discharge (SUB-3) Measure:** Pursuant to the MassHealth CQI program “*Care of Acute and Chronic Conditions Core Quality Domain* (Table 7B-1)” the newly introduced SUB-3 measure shall be collected and reported on all Medicaid payer data. This document provides detailed instruction on MassHealth specific measure specifications and data tools that apply to collection and reporting.
- 3) **Effective Date:** The MassHealth CQI Program reporting on the above chart-based measures will begin with Q1-2023 discharges (Jan 1–March 31, 2023) for a submission cycle deadline to be announced in Acute RFA23 Section 7B amendment.

B. EOHHS Manual Versions. The Release Notes version 16.1 document should be used in conjunction with the RY2023 EOHHS Technical Specifications Manual (v16.0). Hospitals must use the appropriate versions of EOHHS Manual and Appendix data tools that apply to quarterly data periods being collected and submitted. Failure to adhere to the appropriate versions of data collection tools will result in MassQEX portal rejecting data files.

C. Release Notes Guideline. Updates in the EOHHS Release Notes are organized to supplement the EOHHS Manual table of content core sections and appendices using the following headings:

- 1) **Key Impact** – identifies the EOHHS manual section that is impacted by the change listed (i.e.: measure specifications, data tools, dictionary, etc.). A key impact is defined as information that will substantively affect data collection and reporting file requirements.
- 2) **Description of Change** – identifies the specific content within the manual section where the change was made. (i.e.: measure specifications, flowcharts, data format, reporting values, etc.).
- 3) **Rationale** – a brief statement on the reason why the change was made.

Contact MassQEX Helpdesk at massqexhelp@telligen.com if have any questions about the contents of this Release Notes document.

Section I: Changes in Release Notes v 16.1

This section summarizes the key impact, description of change and rationale for the updated requirements referenced in Table 2-6 in Section 2.E of the RY2023 EOHHS Technical Specifications Manual (v16.0).

A. New Measure Specifications. Updates to data reporting specifications are summarized in the following table.

Table A – New Data Reporting Specifications

Key Impact	Description of Change	Rationale
Section 3. MassHealth Specific Measure Specifications	<ul style="list-style-type: none"> New measure description and flowchart for NEWB-3. <u>Remove box overlay and underlying text on flowchart section (page 9 and 10).</u> New measure descriptions and flowcharts for the SUB-2 and SUB-3. 	<ul style="list-style-type: none"> Provide data specifications for upcoming collection and reporting requirements in this document. <u>Clarify flowchart data text sequence.</u>
Section 6.B Data Validation Scoring	<ul style="list-style-type: none"> List specific data elements to be scored for data validation on the NEWB-3 measure. List specific data elements to be scored for data validation on SUB-2 and SUB-3 measures. 	<ul style="list-style-type: none"> Update Table 6.1 list of data elements that will impact hospitals overall validation score in this document.
Appendix A-3: Data Abstraction Tool	<ul style="list-style-type: none"> Add data element abstraction tool for the NEWB-3 measure. <u>Correct allowable values for item 26 (page 35).</u> Add data element abstraction tools for the SUB-2 and SUB-3 measures 	<ul style="list-style-type: none"> Provide new data abstraction tools for collection and reporting of new measures in this document. <u>Align item 26 with Appendix A-4 XML schema file (16.1)</u>
Appendix A-4: XML Schema MassHealth Specific File (v16.1)	<ul style="list-style-type: none"> Add XML data elements and field requirements for the NEWB-3 measure. Add XML data elements and field requirements for the SUB-2 and SUB-3 measures. 	<ul style="list-style-type: none"> Provide new specific data element file format requirements for NEWB-3, SUB-2 and SUB-3 measures.
Appendix A-5: XML MassHealth Data Deletion Request File (v16.1)	<ul style="list-style-type: none"> Add NEWB-3 measure to XML element “episode of care”. Add SUB-2 and SUB-3 measures to XML element “episode of care”. 	<ul style="list-style-type: none"> Provide new specific file format to allow removal of measure files for NEWB-3, SUB-2, and SUB-3 measures.
Appendix A-6: MassHealth Data Dictionary	<ul style="list-style-type: none"> Add data element definitions applicable for the NEWB-3 measures. Add data element definitions for the applicable SUB-2 and SUB-3 measure 	<ul style="list-style-type: none"> Provide new data element definitions applicable to the NEWB-3, SUB-2 and SUB-3 measures in this document.

B. Technical Manual Versions

- EOHHS Manual (16.0):** The new data specifications noted in Table A should be used in conjunction with instructions in Sections 2, 4, 6 of the EOHHS Manual and the MassHealth Data Dictionary (16.0).
- The “Specifications Manual for Joint Commission National Quality Measures v2023A” and Release Notes v2023A ” were used to develop EOHHS Release Notes (v16.1) contents and data tools. Hospital Users of the ‘TJC Specifications Manual’ are responsible for updating their software and associated documentation based on the Joint Commission published manual production timelines
- Appendix Tool Versions:** Updates to RY23 EOHHS Manual (v16.0) Table 2.4 appendix tool versions applicable to new measures listed in this document are summarized below.
 - Use Appendix A-4: XML Schema MassHealth Specific File (v16.1) as of Q1-2023 reporting
 - Use Appendix A-5: XML MassHealth Data Deletion Request File (v16.1) as of Q1-2023 reporting.
- Submission Deadline:** The CY2023 NEWB-3, SUB-2 and SUB-3 measures data reporting deadline will be clarified in upcoming Acute RFA23 Section 7B amendment.

Contact the MassQEX Help Desk massqexhelp@telligen.com or (844) 546-1343 for questions regarding collection and reporting on new measures described in this document.

Section II: New MassHealth Specific Measure Specifications

This section includes new measure specifications and flowcharts for the NEWB-3, SUB-3 and SUB-3 chart-based measures that will be required for the CQI program.

Measure Name: Unexpected Complications in Term Newborns (NEWB-3)

Description: Unexpected complications among full term newborns with no preexisting conditions. Severe complications include neonatal death, transfer to another hospital for higher level of care, severe birth injuries such as intracranial hemorrhage or nerve injury, neurologic damage, severe respiratory and infectious complications such as sepsis. Moderate complications include diagnoses or procedures that raise concern but at a lower level than the list for severe e.g. use of CPAP or bone fracture. Examples include less severe respiratory complications e.g. Transient Tachypnea of the Newborn, or infections with a longer length of stay not including sepsis, infants who have a prolonged length of stay of over 5 days.

Numerator Statement: Newborns with severe complications and moderate complications.

Included Populations:

Severe Complications:

- Death
- Transfer to another acute care facility for higher level of care
- ICD-10-CM Principal Diagnosis Code, ICD-10-CM Other Diagnosis Codes, ICD-10-PCS Principal
- Procedure Code or ICD-10-PCS Other Procedure Codes for Severe Morbidities as defined in
- Appendix A, Tables:
 - 11.36 Severe Birth Trauma
 - 11.37 Severe Hypoxia/Asphyxia
 - 11.38 Severe Shock and Resuscitation
 - 11.39 Neonatal Severe Respiratory Complications
 - 11.40 Neonatal Severe Infection
 - 11.41 Neonatal Severe Neurological Complications
 - 11.42 Severe Shock and Resuscitation Procedures
 - 11.43 Neonatal Severe Respiratory Procedures
 - 11.44 Neonatal Severe Neurological Procedures
- Patients with Length of Stay greater than 4 days AND an ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for Sepsis as defined in Appendix A, Table 11.45 Neonatal Severe Septicemia

Moderate Complications:

- ICD-10-CM Principal Diagnosis Code, ICD-10-CM Other Diagnosis Codes, ICD-10-PCS Principal
- Procedure Code or ICD-10-PCS Other Procedure Codes for moderate complications as defined in Appendix A, Tables:
 - 11.46 Moderate Birth Trauma
 - 11.47 Moderate Respiratory Complications
 - 11.48 Moderate Respiratory Complications Procedures
- ICD-10-CM Principal Diagnosis Code for single liveborn newborn as defined in Appendix A, Table 11.20.2 Single Liveborn Newborn-Vaginal AND Length of Stay greater than 2 days OR ICD-10-CM Principal Diagnosis Code for single liveborn newborn as defined in Appendix A, Table Single Liveborn Newborn-Cesarean AND Length of Stay greater than 4 days AND ANY ICD-10-CM Principal Diagnosis Code, ICD-10-CM Other Diagnosis Codes, ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for moderate complications as defined in Appendix A, Tables:
 - 11.49 Moderate Birth Trauma with LOS
 - 11.50 Moderate Respiratory Complications with LOS
 - 11.51 Moderate Neurological Complications with LOS Procedures
 - 11.52 Moderate Respiratory Complications with LOS Procedures
 - 11.53 Moderate Infection with LOS

- Patients with Length of Stay greater than 5 days and NO ICD-10-CM Principal Diagnosis Code, ICD-10-CM Other Diagnosis Codes, ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for jaundice or social indications as defined in Appendix A, Tables:
 - 11.33 Neonatal Jaundice
 - 11.34 Phototherapy
 - 11.35 Social Indications

Excluded Populations: None

Data Elements:

- *Admission Date*
- *Discharge Date*
- *Discharge Disposition*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *ICD-10-PCS Other Procedure Codes*
- *ICD-10-PCS Principal Procedure Code*

Denominator Statement: Liveborn single term newborns 2500 gm or over in birth weight.

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

Excluded Populations:

- Patients who are not born in the hospital or are part of multiple gestation pregnancies, with no ICD-10-CM Principal Diagnosis Code for single liveborn newborn as defined in Appendix A, Table Number 11.20.1: Single Liveborn Newborn
- Birth Weight < 2500 gm
- Patients who are not term or with < 37 weeks gestation completed
- Patients whose term status or gestational age is missing and birthweight < 3000 gm
- ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for congenital malformations and genetic diseases as defined in Appendix A, Table 11.30 Congenital Malformations
- ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for pre-existing fetal conditions as defined in Appendix A, Table 11.31 Fetal Conditions
- ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for maternal drug use exposure in-utero as defined in Appendix A, Table 11.32 Maternal Drug Use

Data Elements:

- *Birth Weight*
- *Birthdate*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *ICD-10-PCS Other Procedure Codes*
- *ICD-10-PCS Principal Procedure Code*
- *Term Newborn*

Risk Adjustment: No.

Type Of Measure: Outcome

Improvement Noted As: Decrease in the rate

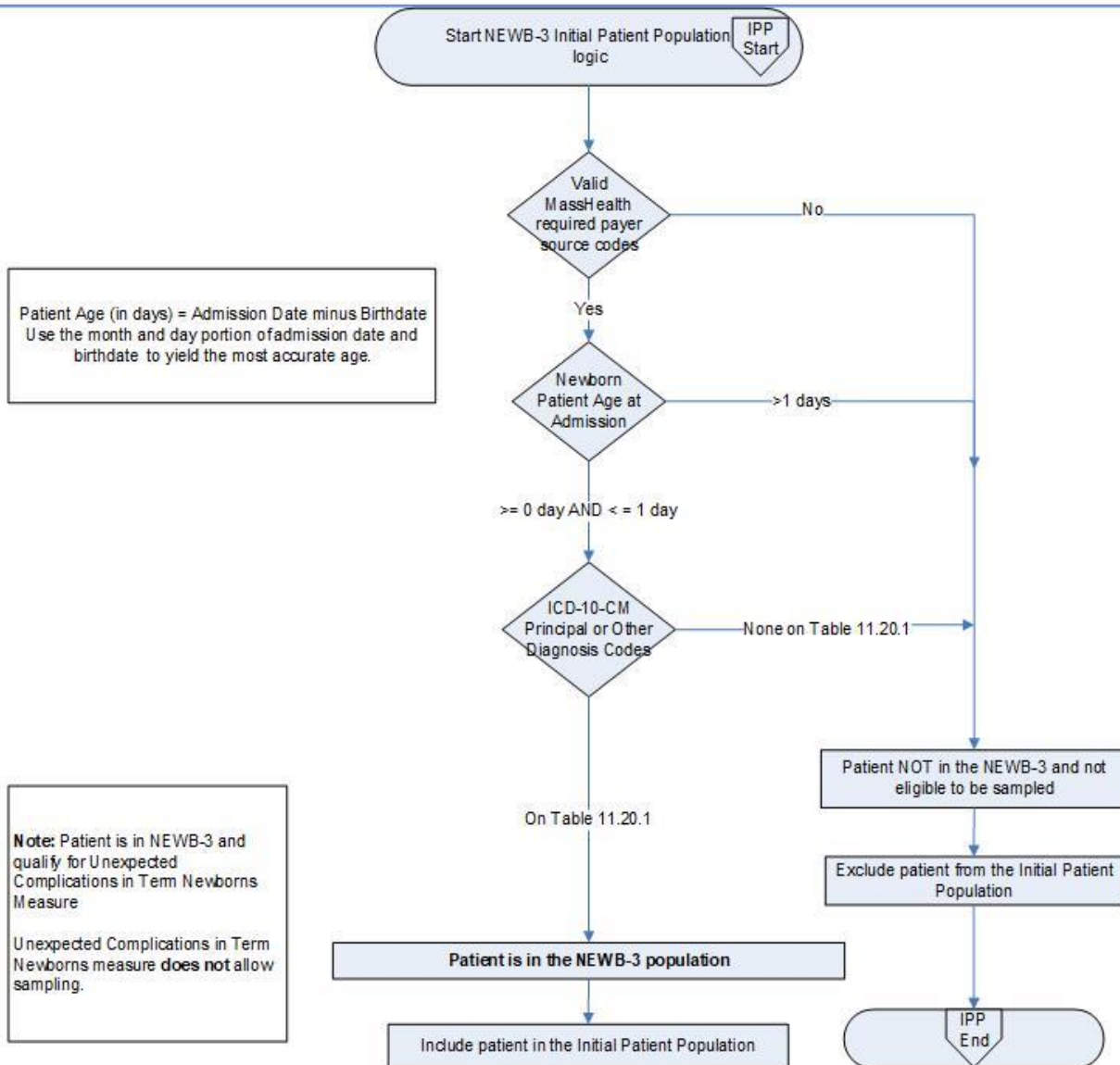
Data Collection Approach: See TJC Core Specifications Manual v 2023A for detail that apply.

Data Accuracy: See TJC Core Specifications Manual v 2023A for detail that apply.

Sampling: No. Include all discharged infants where MassHealth is the primary and only payment source.

Data Reported As: Aggregate rate generated from count data reported as a rate per 1000 livebirths.

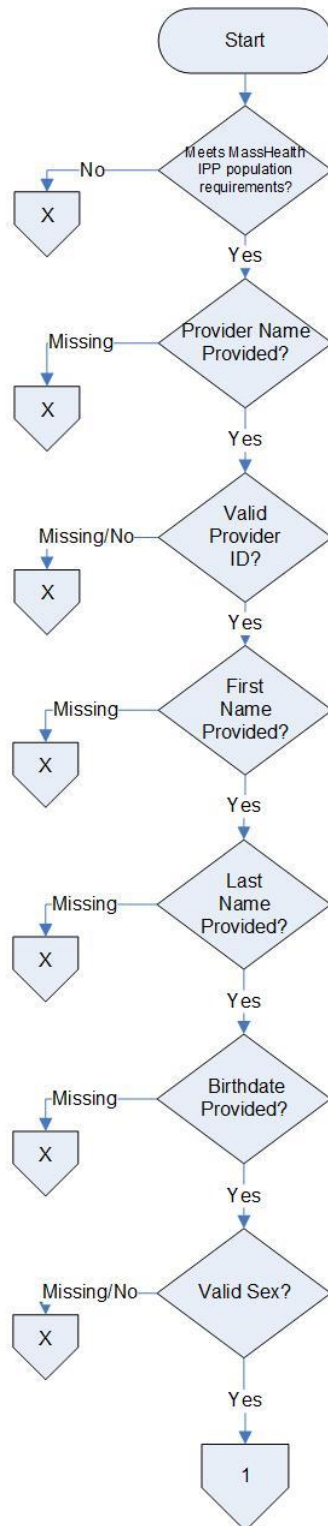
Initial Patient Population Algorithm Newborn Population (NEWB-3)



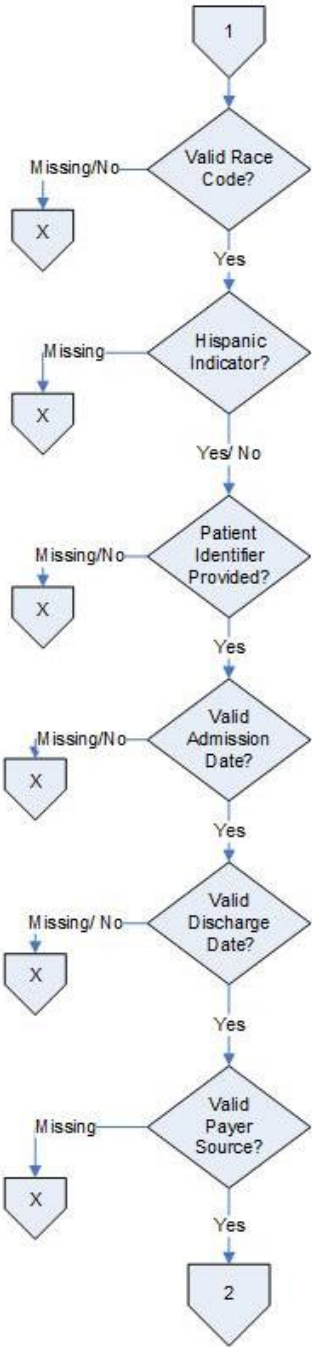
Unexpected Complications in Term Newborns (NEWB-3)

***Numerator:** Newborns with severe complications and moderate complications.

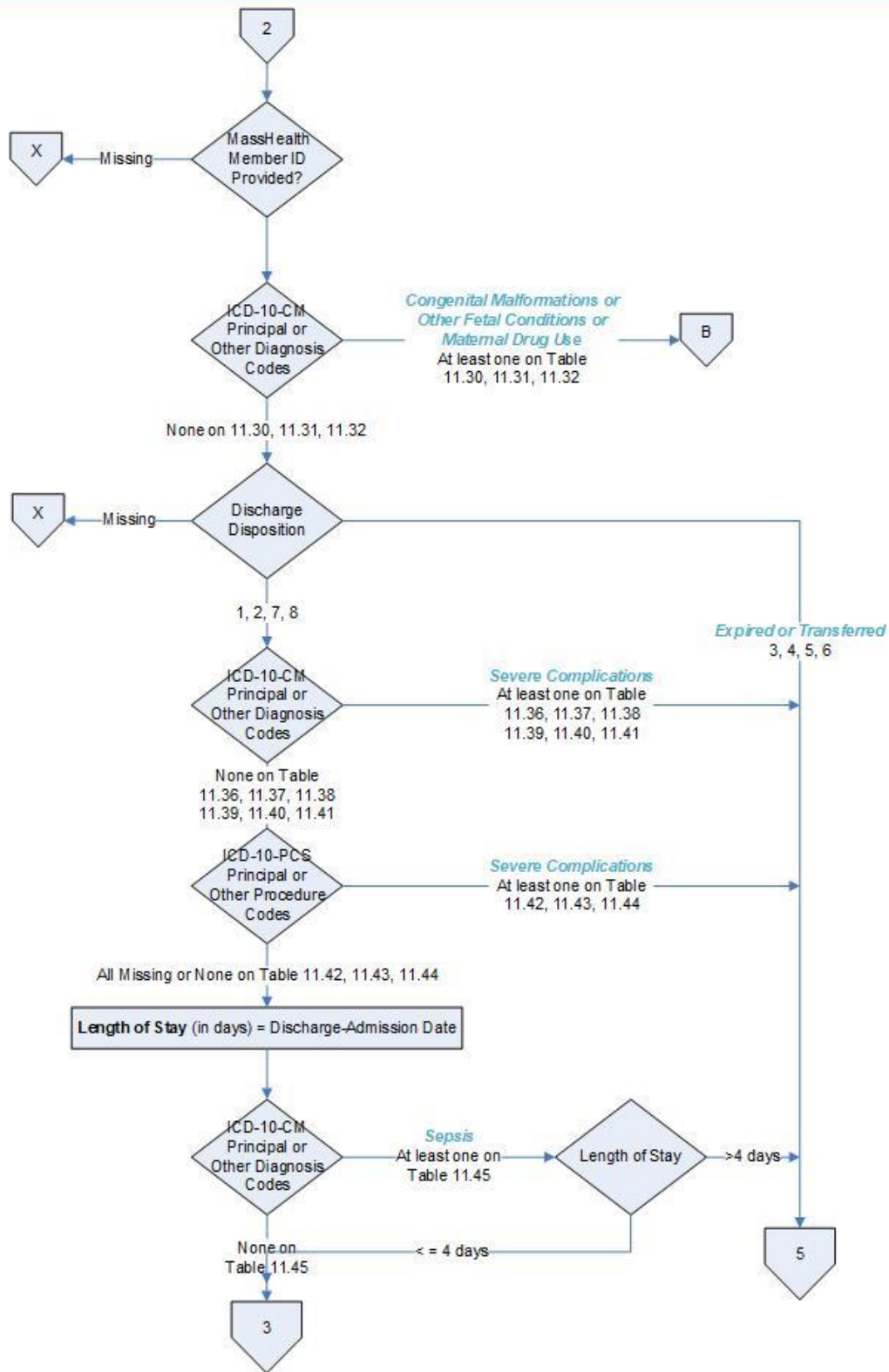
***Denominator:** Live single term newborns 2500 grams or over in birth weight.



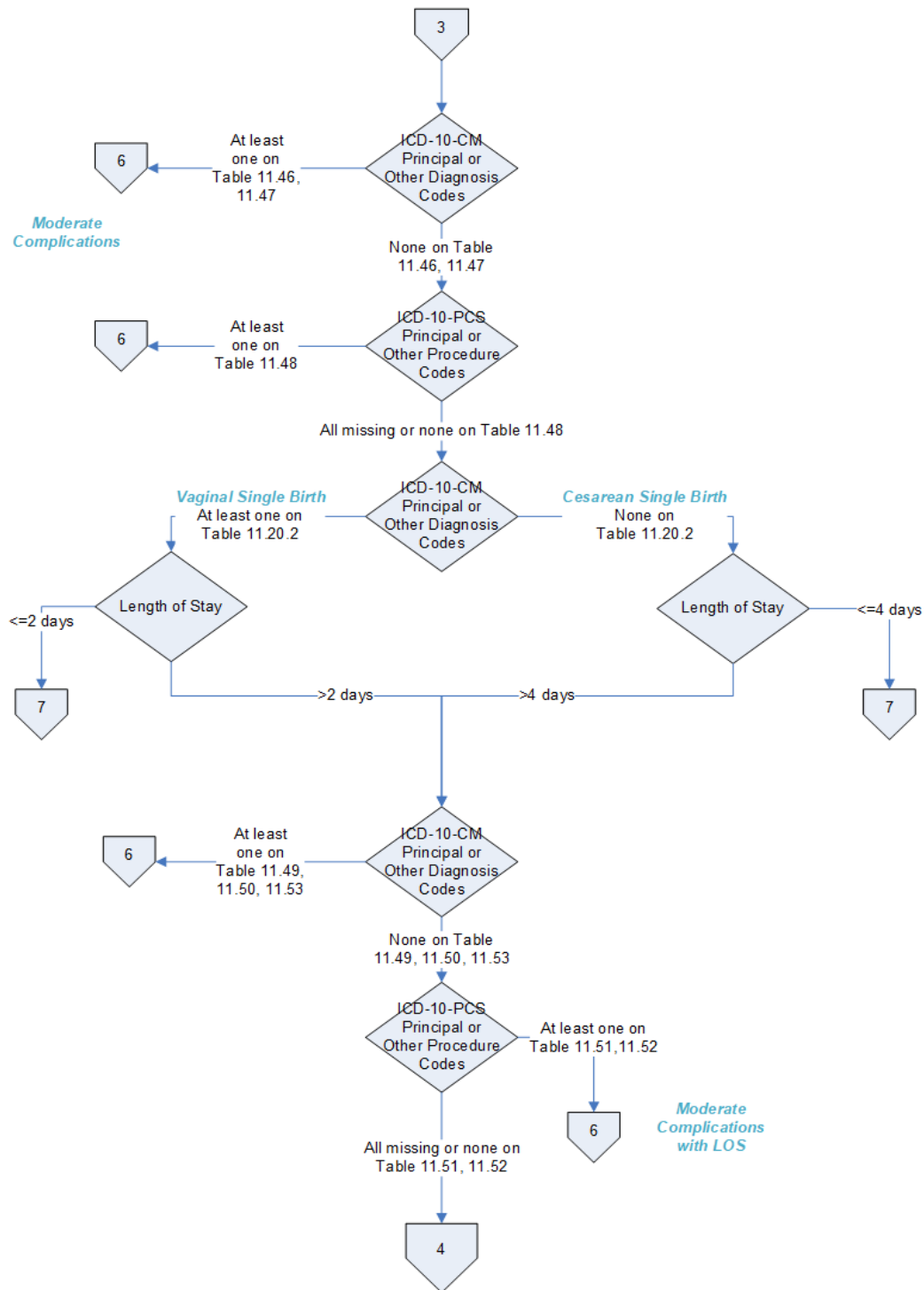
Unexpected Complications in Term Newborns (NEWB-3)



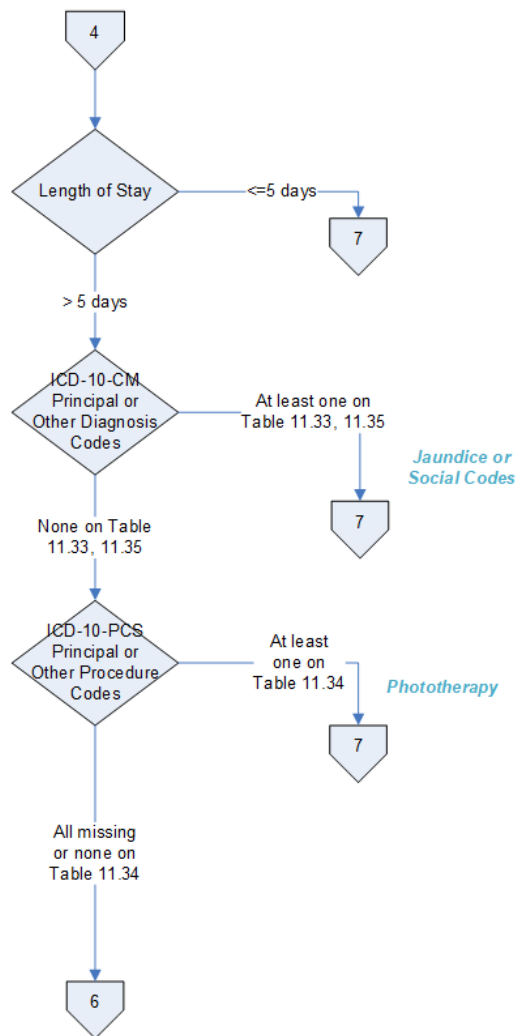
Unexpected Complications in Term Newborns (NEWB-3)



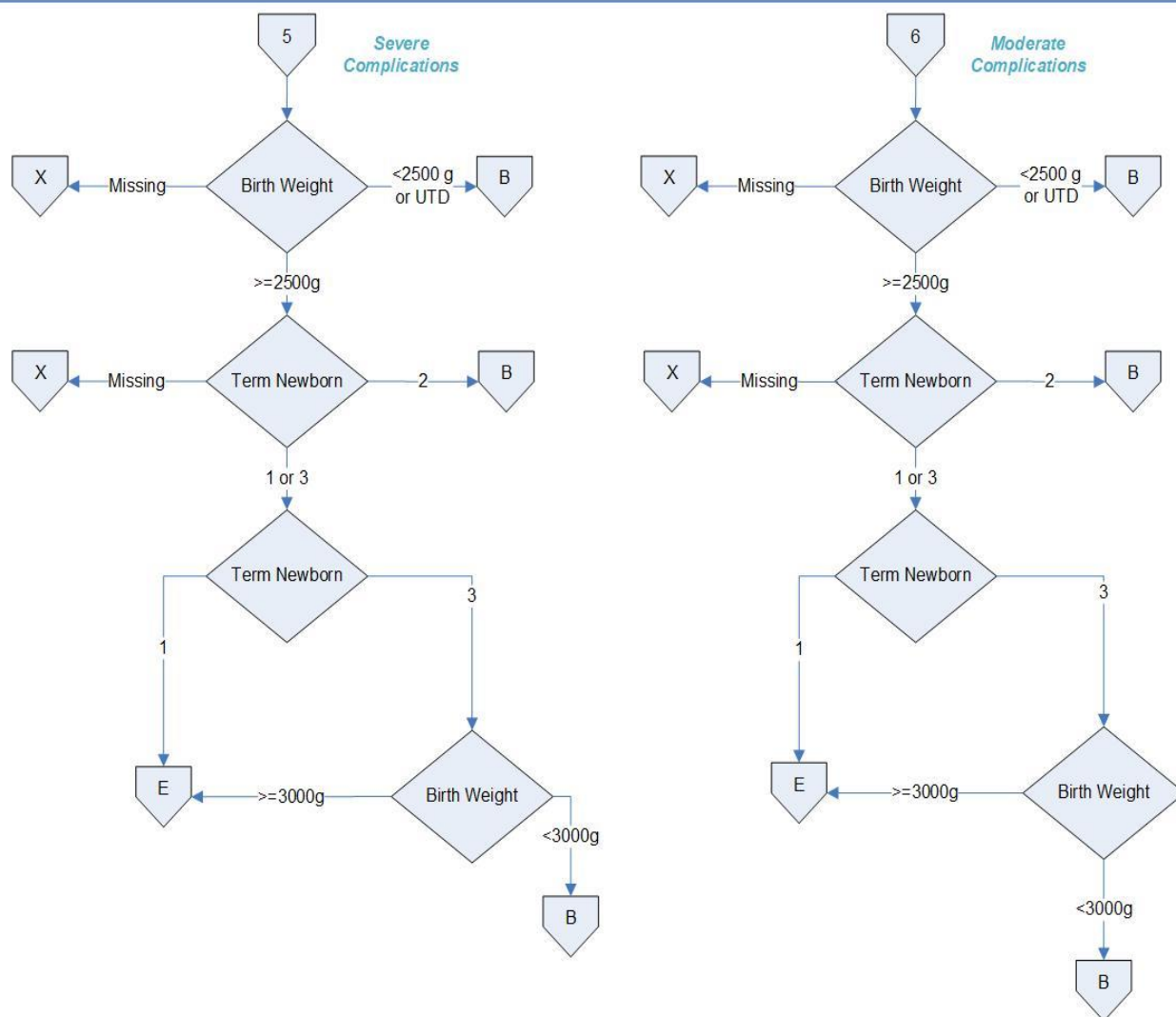
Unexpected Complications in Term Newborns (NEWB-3)



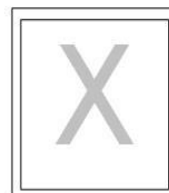
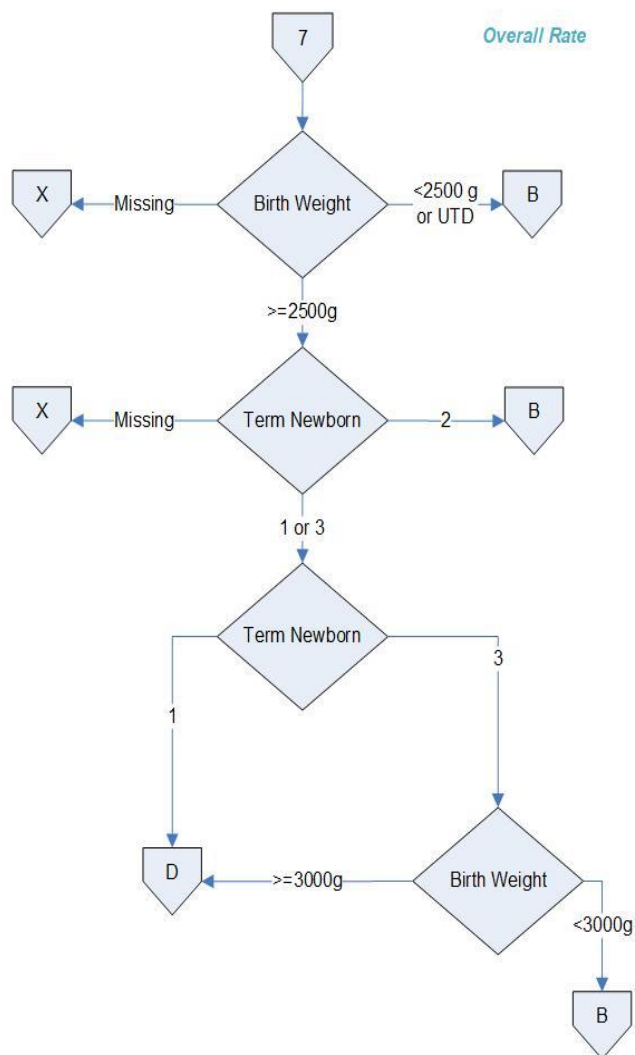
Unexpected Complications in Term Newborns (NEWB-3)



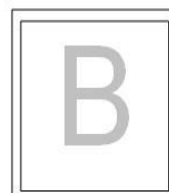
Unexpected Complications in Term Newborns (NEWB-3)



Unexpected Complications in Term Newborns (NEWB-3)



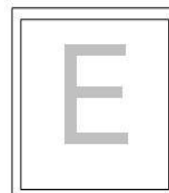
Review Ended
Not in Measure Population Missing or Invalid Data Case will be Rejected



Review Ended
Not in Measure Population Excluded from Numerator and Denominator



Review Ended
In Measure Population Excluded from Numerator Included in Denominator



Measure Met
In Measure Population Included in Numerator and Denominator

Measure Name: Alcohol Use Brief Intervention Provided or Offered (SUB-2)

For MassHealth reporting purposes, the “Initial Patient Population” (also termed ICD population) for the Alcohol Use treatment measures shall include all Medicaid patients discharged from any acute inpatient care setting (medical, surgical, obstetrical, rehab, psychiatric, etc.) that received care for a given condition. Measure collection is required for all acute care hospitals with or without a behavioral health unit.

Description: This measure is reported as an overall rate which includes all patients to whom a brief intervention was provided or offered and refused. The SUB-2 rate describes the patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay.

Numerator Statement: Patients who received or refused a brief intervention.

Included in Population: Patients who refuse/decline the offered brief intervention

Excluded Population: None

Data Elements:

- *Brief Intervention*

Denominator Statement: The number of hospitalized inpatients 18 years of age and older who screened positive for unhealthy alcohol use or an alcohol use disorder (alcohol abuse or alcohol dependence).

Included Population: Not applicable

Excluded Population

- Patients less than 18 years of age
- Patients who are cognitively impaired
- Patients who refused screening for Alcohol Use status during the hospital stay
- Patients who have a duration of stay less than or equal to one day or greater than 120 days
- Patients receiving *Comfort Measures Only* documented

Data Elements:

- *Admission Date*
- *Alcohol Use Status*
- *Birthdate*
- *Comfort Measures Only*
- *Discharge Date*

Risk Adjustment: No.

Type of Measure: Process

Improvement Noted as: Increase in rate

Data Collection Approach: See TJC Core Specifications Manual v 2023A for detail that apply.

Data Accuracy: See TJC Core Specifications Manual v 2023A for detail that apply.

Measure Analysis Suggestions: None

Sampling: Yes. *Global sampling does not apply.* See EOHHS Manual (Section 4) for MassHealth sampling requirements.

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

Measure Name: Alcohol & Other Drug Use Disorder Treatment Provided/Offered at Discharge (SUB-3)
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Description: The measure is reported as an overall rate which includes all patients to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge.

Numerator Statement - The number of patients who received or refused at discharge a prescription for medication for treatment of alcohol or drug use disorder OR received or refused a referral for addictions treatment.

Included Populations: Patients who refused a prescription for FDA-approved medication for treatment of an alcohol or drug dependence. Patients who refused a referral for addictions treatment

Excluded Populations: none

Data Elements:

- *Prescription for Alcohol or Drug Disorder Medication*
- *Referral for Addictions Treatment*

Denominator Statement - The number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder

Included Population

- Patients with ICD-10-CM Principal or Other Diagnosis Code for alcohol or drug use disorder listed on Table 13.1 and 13.2
- Patients with a Principal or Other ICD-10-PCS Procedure Code listed on Table 13.3

Excluded Population

- Patients less than 18 years of age
- Patient drinking at unhealthy levels who do not meet criteria for an alcohol use disorder
- Patients who are cognitively impaired
- Patients who expire
- Patients discharged to another hospital
- Patients who left against medical advice
- Patients discharged to another healthcare facility
- Patients discharged to home or another healthcare facility for hospice care
- Patients who have a duration of stay less than or equal to one day or greater than 120 days
- Patients who do not reside in the United States
- Patients receiving *Comfort Measures Only* documented

Data Elements:

- *Admission Date*
- *Alcohol Use Status*
- *Birthdate*
- *Comfort Measures Only*
- *Discharge Date*
- *Discharge Disposition*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *ICD-10-PCS Other Procedure Codes*
- *ICD-10-PCS Principal Procedure Code*

Risk Adjustment: No.

Type of Measure: Process

Improvement Noted as: Increase in rate

Data Collection Approach: See TJC Core Specifications Manual v 2023A for detail that apply.

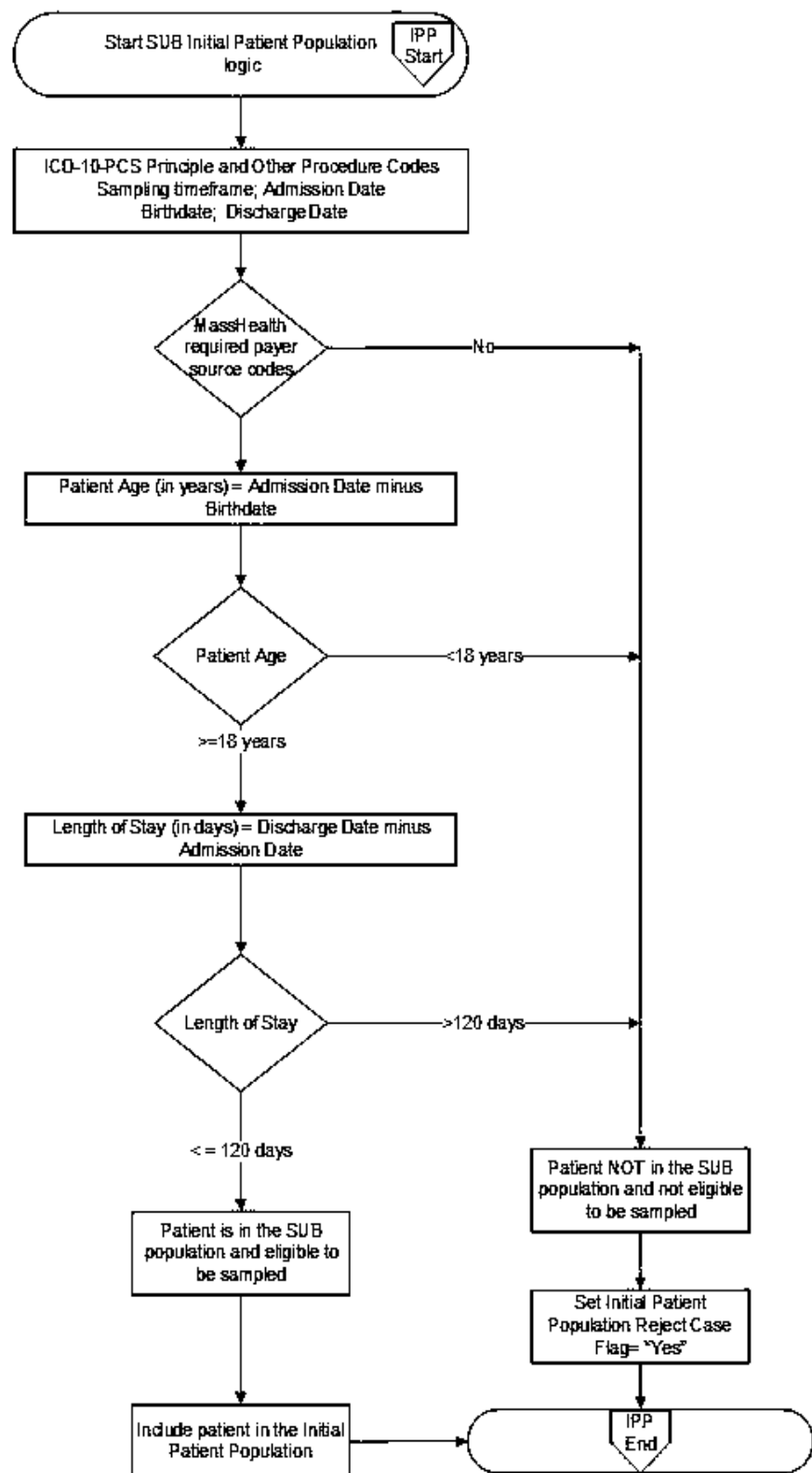
Data Accuracy: See TJC Core Specifications Manual v 2023A for detail that apply.

Measure Analysis Suggestions: See TJC Core Specifications Manual v 2023A for detail that apply.

Sampling: Yes. *Global sampling does not apply*. See EOHHS manual (Section 4) for MassHealth sampling requirements.

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

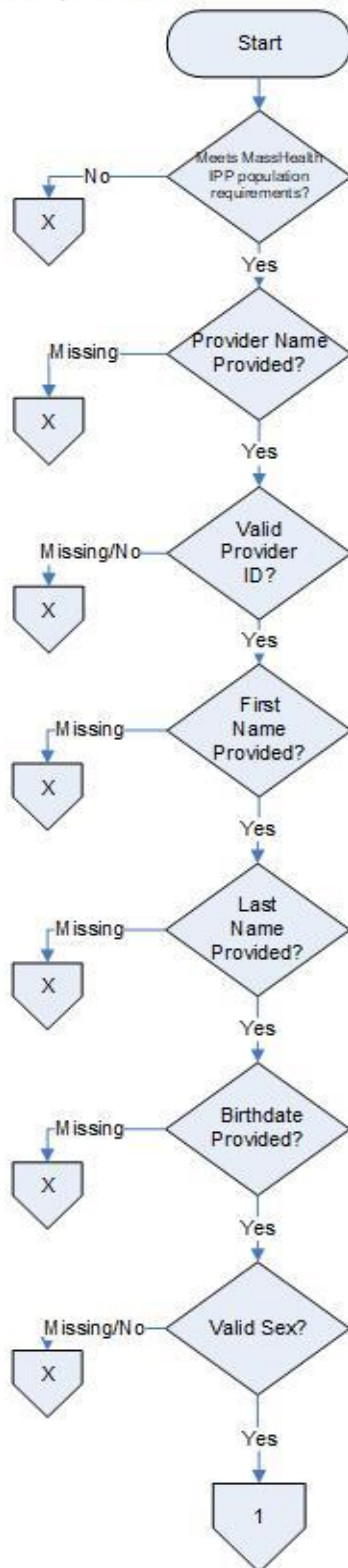
Initial Patient Population Algorithm Substance Use Measure (SUB-2, SUB-3)



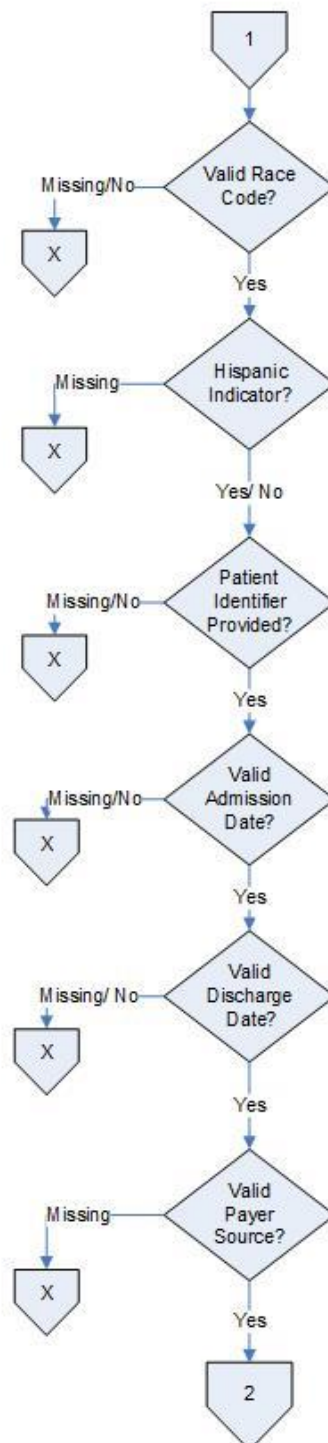
Alcohol Use-Brief Intervention Provided or Offered (SUB-2)

***Numerator:** The number of patients who received or refused a brief intervention

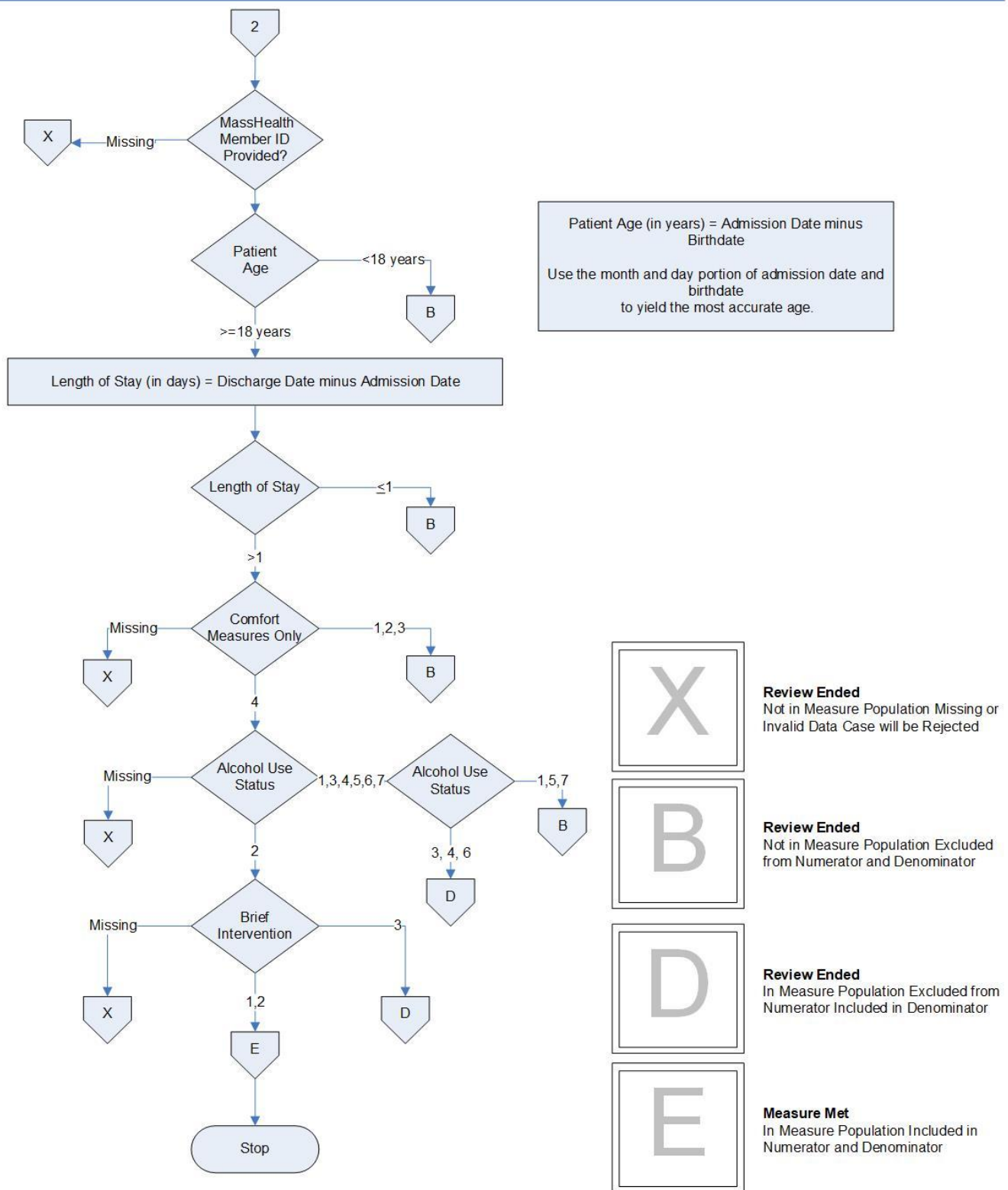
***Denominator:** The number of hospitalized inpatients 18 years of age and older who screen positive for unhealthy alcohol use or an alcohol use disorder (alcohol abuse or alcohol dependence).



Alcohol Use-Brief Intervention Provided or Offered (SUB-2)



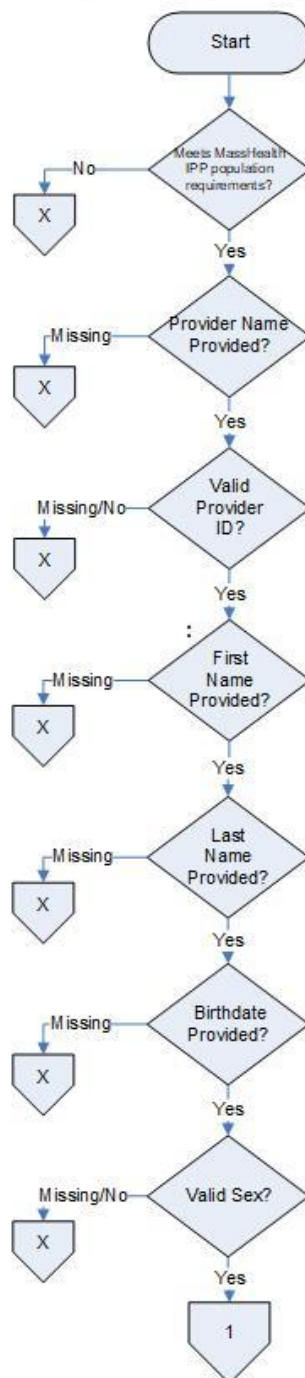
Alcohol Use-Brief Intervention Provided or Offered (SUB-2)



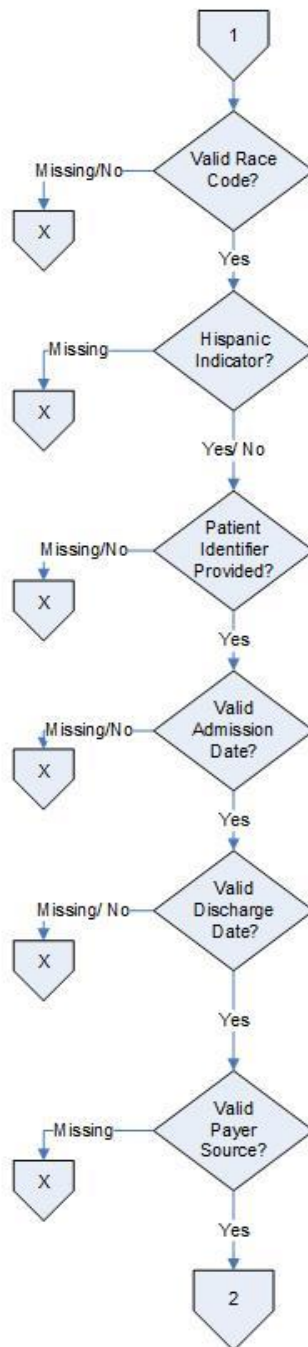
Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge (SUB-3)

***Numerator:** The number of patients who received or refused at discharge a prescription for medication for treatment of alcohol or drug use disorder OR received or refused a referral for addictions treatment.

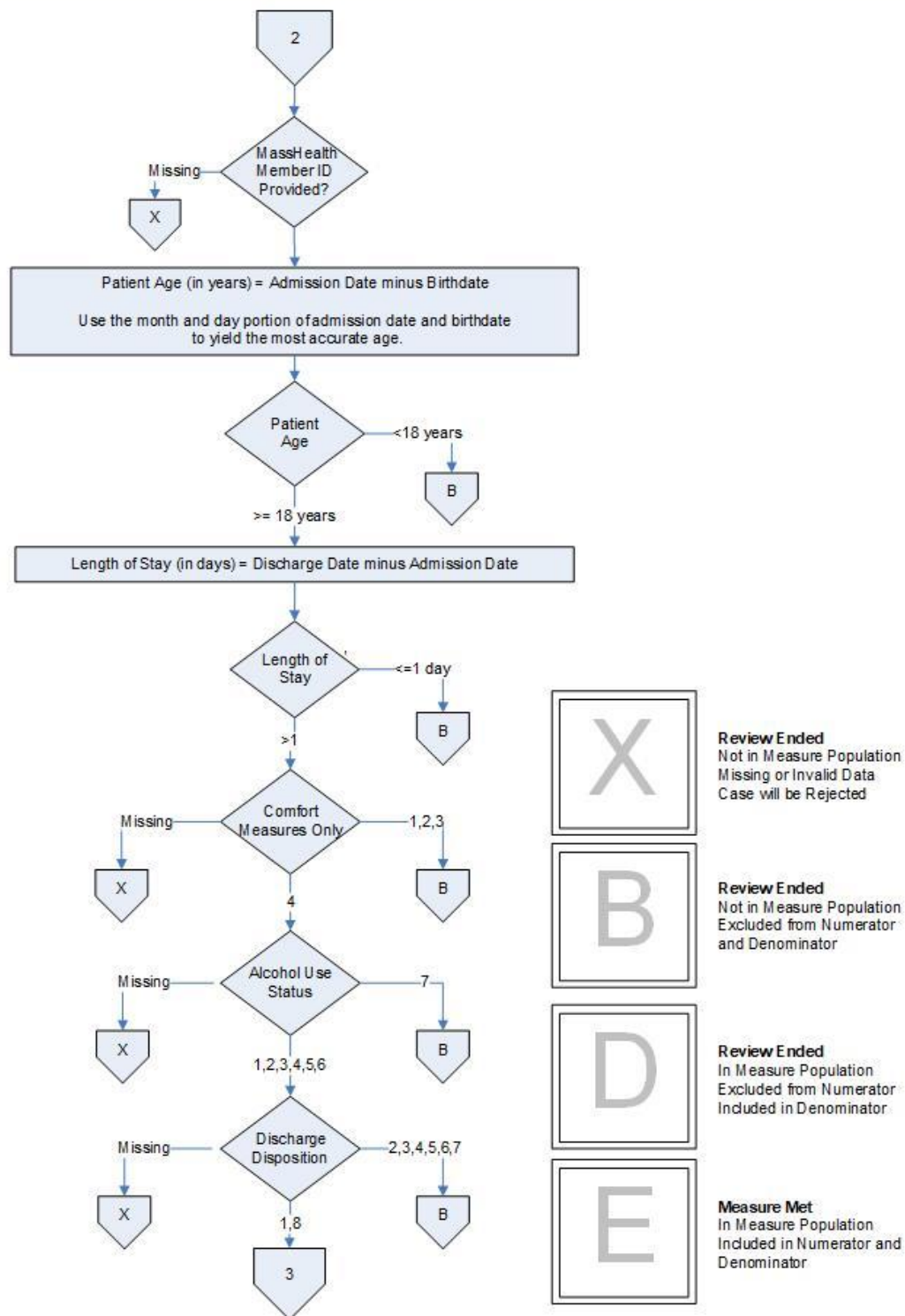
***Denominator:** The number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder.



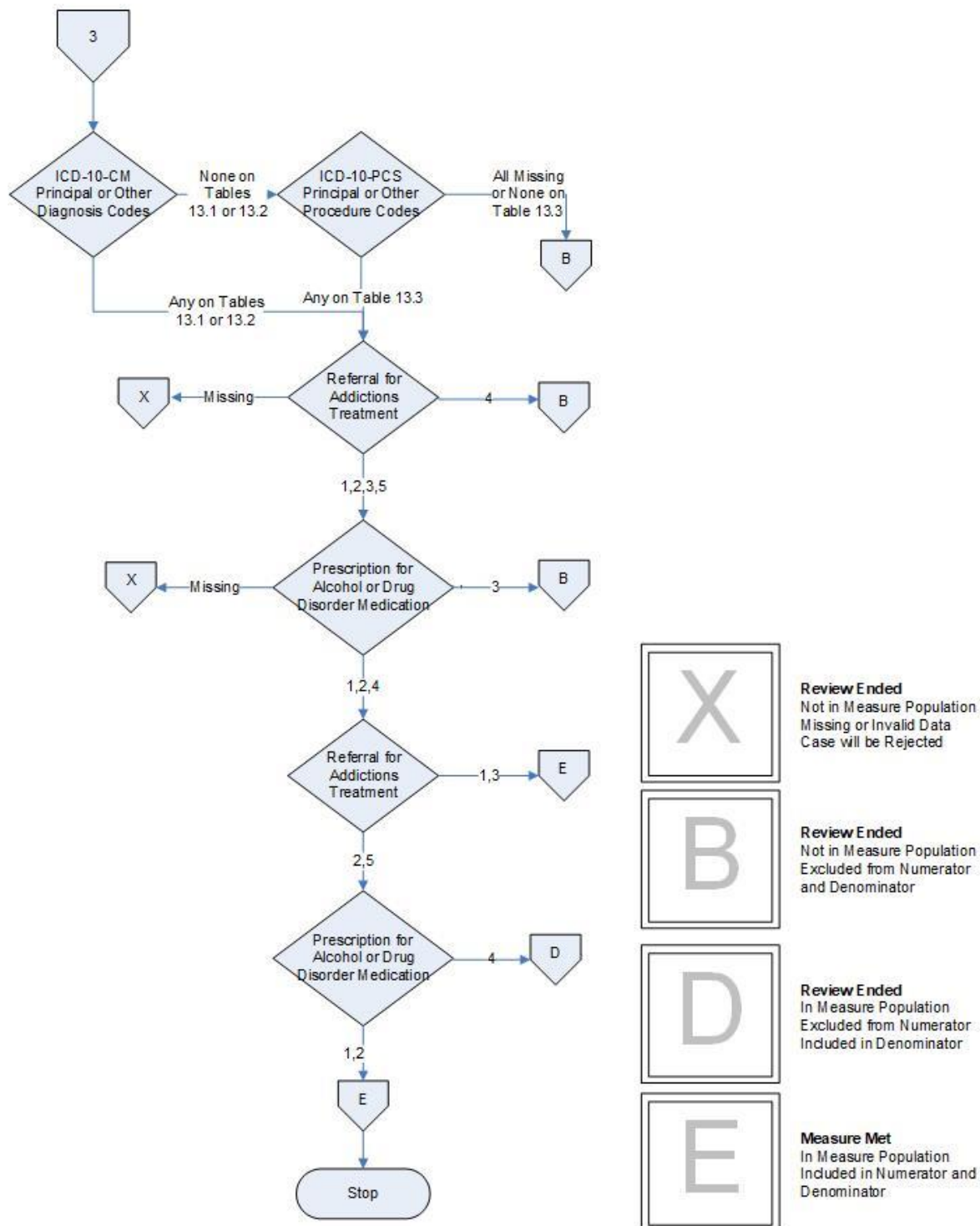
Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge (SUB-3)



Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge (SUB-3)



Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge (SUB-3)



ACKNOWLEDGEMENT: Hospitals are responsible for accessing and adhering to data collection guidelines specifications for nationally reported hospital quality measures using the appropriate versions of the “*Specifications Manual for Joint Commission National Quality Measures v2023A*” and *Release Notes v2023A*. Hospital Users of the ‘TJC Specifications Manual’ are responsible for updating their software and associated documentation based on the Joint Commission published manual production timelines

Section III: Updates to MassHealth Data Dictionary (v16.0)

This section adds complete data element definitions that apply to the specific SUB-2, SUB-3 and NEWB-3 measures reporting that should be used in conjunction with Appendix A-6: MassHealth Data Dictionary (v16.0).

Data Element Name: Alcohol Use Status

Collected For: SUB-2, SUB-3

Definition: Documentation of the adult patient's alcohol use status using a validated screening questionnaire for unhealthy alcohol use within the first day of admission (by end of Day 1). A validated screening questionnaire is an instrument that has been psychometrically tested for reliability (the ability of the instrument to produce consistent results), validity (the ability of the instrument to produce true results), and sensitivity (the probability of correctly identifying a patient with the condition). Validated screening questionnaires can be administered by pencil and paper, by computer or verbally. The screening questionnaire should be at a comprehension level or reading level appropriate for the patient population and in the appropriate language for non-English speaking patients. An example of a validated questionnaire for alcohol screening is the 10 item Alcohol Use Disorder Identification Tests (AUDIT). The first three questions of the AUDIT, the AUDIT-C, ask about alcohol consumption, and can be used reliably and validly to identify unhealthy alcohol use. The four-item CAGE questionnaire is generally inappropriate for screening general populations, as it aims to identify only severely alcohol dependent patients.

Suggested Data Collection Question: What is the patient's alcohol use status?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

- 1 The patient was screened with a validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates no or low risk of alcohol related problems.
- 2 The patient was screened with a validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.
- 3 The patient was screened with a non-validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates no or low risk of alcohol related problems.
- 4 The patient was screened with a non-validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.
- 5 The patient refused the screen for alcohol use within the first day of admission (by end of Day 1).
- 6 The patient was not screened for alcohol use within the first day of admission (by end of Day 1) or unable to determine from medical record documentation.
- 7 The patient was not screened for alcohol use within the first day of admission (by end of Day 1) because of cognitive impairment.

Notes for Abstraction:

- The alcohol use status screening must have occurred within the first day of admission (by end of Day 1). This includes the day of admission which is defined as Day 0 and the day after admission which is defined as Day 1.
EXCEPTION:
If the screening was performed within 3 days prior to admission, i.e., at the transferring facility, in another inpatient hospital unit, emergency department or observation unit, the screening documentation must be present in the current medical record.
- If patient has a blood alcohol test with a result of .08 g/dL or greater or the clinician documents the patient was acutely intoxicated per blood alcohol test results, select Value "2."
 - The 0.08 limit is a blood alcohol concentration (BAC) reported in g/dL. If results are given in mg/dL, convert to g/dL by moving the decimal point 3 places to the left.

Examples:

- A 100 mg/dL serum ethanol level is equivalent to a 0.10 g/dL BAC.
- An 80 mg/dL serum ethanol level is equivalent to a 0.08 g/dL BAC.

- Screening may be done with a “validated” Single Alcohol Screening Question (SASQ) in order to identify those patients with no risk or low risk or who do not drink. Further screening should be done with a validated tool for those patients with a positive result to determine if there is need for a brief intervention.
- Examples** of SASQs include:
- “On any single occasion during the past 3 months, have you had more than 5 drinks containing alcohol?” (“Yes” response is considered positive.)
 - “When was the last time you had more than X drinks in 1 day?” (X = 4 for women and 5 for men) (Within the last 3 months is considered positive.)
 - “How many times in the past year have you had X or more drinks in a day?” (X = 5 men and 4 women) (Response of >1 is considered positive.)
 - How often have you had 6 or more drinks on one occasion in the past year? (Ever in the past year considered positive.)
 - How often do you have X or more drinks on one occasion? (X = 4 for women and 5 for men) (Ever in the past year considered positive.)
- Refer to the Inclusion Guidelines for examples of commonly used validated screening tools; note that the CAGE, although a validated tool, is not recommended for this measure set.
 - If there is documentation in the medical record indicating the patient drinks alcohol and conflicting documentation indicating the patient does not drink alcohol, select Value “6” since alcohol use status is unable to be determined.

EXCEPTION:

If there is documentation of a validated questionnaire for alcohol screening completed within the first day of admission, select the appropriate Value 1 or 2 regardless of conflicting documentation.

- When there is conflicting information in the record with regard to risk, for instance, the results from a validated screening tool are documented as both low AND moderate/high risk, select Value “2” indicating the highest risk.
- Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set is related to documentation that the patient cannot be screened for alcohol use due to the impairment (e.g., comatose, obtunded, confused, memory loss) within the first day of admission (by end of Day 1).
- If there is documentation within the first day of admission (by end of Day 1) that the patient was psychotic, symptoms of psychosis, e.g., hallucinating, non-communicative, catatonic, etc., must also be documented for the patient to be considered cognitively impaired.
- If there is documentation to “rule out” a condition/diagnosis related to cognitive impairment, Value “7” cannot be selected unless there is documentation of symptoms.

Examples:

- Patient actively hallucinating, rule out psychosis. (Select Value “7”).
- Rule out psychosis. (Cannot select Value “7”).
- If there is documentation within the first day of admission (by end of Day 1) of any of the examples below, select Value “7” regardless of conflicting documentation.

Examples of cognitive impairment include:

- Altered Level of Consciousness (LOC)
- Altered Mental Status
- Cognitive impairment
- Cognitively impaired
- Cognitive impairment due to acute substance use, overdose, acute intoxication
- Confused
- Dementia
- Intubation and patient is intubated through the end of Day 1
- Memory loss
- Mentally handicapped
- Obtunded
- Psychotic/psychosis with documented symptoms
- Sedation
- Documentation of cognitive impairment overrides documentation of an alcohol use screen and therefore would not be considered “conflicting documentation.” Even if the family or others tell staff the patient uses alcohol, the patient could not be appropriately screened and subsequently counseled due to cognitive impairment. Select Value “7.”

Suggested Data Sources:

- Consultation notes
- Emergency department record
- History and physical

- Nursing admission assessment
- Nursing Admission Notes
- Physician Progress Notes

Guidelines for Abstraction:

Inclusion	Exclusion
Validated Screening Tools for Unhealthy Alcohol Use: This list is not ALL Inclusive <ul style="list-style-type: none"> • AUDIT • AUDIT-C • ASSIST • CRAFFT • G-MAST • MAST • TWEAK 	Any tool which specifically screens for alcohol use disorder, alcohol dependency or alcohol abuse. Examples include, but are not limited to: <ul style="list-style-type: none"> • CAGE • SASSI • S2BI

Data Element Name: Birth Weight

Collected For: NEWB-3

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

Note:

453.5 grams = 1 pound

28.35 grams = 1 ounce

It is recommended to enter birth weight in either grams or pounds. However, all birth weights must be converted to grams prior to indicator calculation.

Suggested Data Collection Question: What was the weight of the newborn at delivery?

Format:

Length: 4 or UTD

Type: Alphanumeric

Occurs: 1

Allowable Values:

150 through 8165 grams

UTD = Unable to Determine

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

Notes for Abstraction:

- Newborns with birth weights less than 150 grams need to be verified that the baby was live born and for data quality purposes. Birth weights greater than 8165 grams need to be verified for data quality. Abstractors should review all of the suggested data sources to verify the accuracy of the data.
- If the birth weight is unable to be determined from medical record documentation, enter "UTD".
- The medical record must be abstracted as documented (taken at "face value"). When the value documented is not a valid number/value per the definition of this data element and no other documentation is found that provides this information, the abstractor should select "UTD."
- Example:
- Documentation indicates the Birth Weight was 0 grams. No other documentation in the medical record provides a valid value. Since the Birth Weight is not a valid value, the abstractor should select "UTD."
- The NICU admission assessment or notes should be reviewed first for the birth weight. In the absence of admission to the NICU, the delivery record or operating room record should be reviewed next for the birth weight. In cases where there is conflicting data, use the document recording the birth weight closest to the time of delivery.
- It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the

medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the suggested data sources listed below.

- For newborns received into the hospital as a transfer, the admission birth weight may be used if the original birth weight is not available.
- If the birth weight is recorded in pounds and ounces and also in grams, abstract the value for grams.

Suggested Data Sources:

In Order of Priority:

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

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: [Brief Intervention](#)

Collected For: SUB-2

Definition: A brief intervention is a single session or multiple sessions conducted by a qualified healthcare professional or trained peer support person, following a positive screen for unhealthy alcohol use. The intervention includes motivational discussion focused on increasing insight and awareness regarding alcohol use and motivation toward behavioral change. Brief interventions can be tailored for variance in population or setting and can be used as a stand-alone treatment for those at risk as well as a vehicle for engaging those in need of more extensive levels of care.

A brief intervention focuses on increasing the patient's understanding of the impact of substance use on his or her health and motivating the patient to change risky behaviors. The components of the intervention include feedback concerning the quantity and frequency of alcohol consumed by the patient in comparison with national norms; a discussion of negative physical, emotional, and occupational consequences; and a discussion of the overall severity of the problem. The qualified health care professional engages the patient in a joint decision-making process regarding alcohol use and plans for follow-up are discussed and agreed to.

Suggested Data Collection Question: Did patients with a positive screening result for unhealthy alcohol use or alcohol use disorder (abuse or dependence) receive a brief intervention prior to discharge?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

- 1 The patient received the components of a brief intervention
- 2 The patient refused/declined the brief intervention
- 3 Brief counseling was not offered to the patient during the hospital stay or Unable to Determine (UTD) if a brief intervention was provided from medical record documentation

Notes for Abstraction:

- A qualified healthcare professional may be defined as a physician, nurse, certified addictions counselor, psychologist, social worker, or health educator with training in brief intervention.
- A peer support person who has received specialized training in brief intervention may perform the brief intervention in lieu of a qualified healthcare professional.
- If there is no documentation that a brief intervention was given to the patient, select allowable 3

- Select value "3" if the documentation provided is not explicit enough to determine if the intervention provided contained the specific components or if the intervention meets the intent of the measures.
- A brief intervention includes, at a minimum, the following three components:
 - Concern that the patient is drinking at unhealthy levels known to increase his/her risk of alcohol-related health problems
 - Feedback linking alcohol use and health, including:
 - Personalized feedback (i.e., explaining how alcohol use can interact with patient's medical concerns [hypertension, depression/anxiety, insomnia, injury, congestive heart failure (CHF), diabetes mellitus (DM), breast cancer risk, interactions with medications])
 - OR
 - General feedback on health risks associated with drinking.
 - Advice:
 - To abstain (if there are contraindications to drinking)
 - OR
 - To drink below recommended limits (specified for patient).

Suggested Data Sources:

- Consultation notes
- Nursing notes
- Progress notes
- Physical Progress Notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Comfort Measures Only

Collected For: SUB-2, SUB-3,

Definition: Comfort Measures Only refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. Comfort Measures Only is commonly referred to as "comfort care" by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

Suggested Data Collection Question: When is the earliest physician/APN/PA documentation of comfort measures only?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

- 1 **Day 0 or 1:** The earliest day the physician/APN/PA documented comfort measures only was the day of arrival (Day 0) or day after arrival (Day 1).
- 2 **Day 2 or after:** The earliest day the physician/APN/PA documented comfort measures only was two or more days after arrival day (Day 2+).
- 3 **Timing unclear:** There is physician/APN/PA documentation of comfort measures only during this hospital stay, but whether the earliest documentation of comfort measures only was on day 0 or 1 OR after day 1 is unclear.
- 4 **Not Documented/UTD:** There is no physician/APN/PA documentation of comfort measures only, or unable to determine from medical record documentation.

Notes for Abstraction:

- **Only accept terms identified in the list of inclusions. No other terminology will be accepted.**
- Physician/APN/PA documentation of comfort measures only (hospice, comfort care, etc.) mentioned in the following contexts suffices:
 - Comfort measures only recommendation
 - Order for consultation or evaluation by a hospice care service
 - Patient or family request for comfort measures only
 - Plan for comfort measures only
 - Referral to hospice care service
 - Discussion of comfort measures
- Determine the earliest day comfort measures only (CMO) was DOCUMENTED by the physician/APN/PA. If any of the inclusion terms are documented by the physician/APN/PA, select value “1,” “2,” or “3” accordingly.
Examples:
"Discussed comfort care with family on arrival" noted in day 2 progress note — Select “2.”"
- **State-Authorized Portable Orders (SAPOs).**
 - SAPOs are specialized forms or identifiers authorized by state law that translate a patient’s preferences about specific end-of-life treatment decisions into portable medical orders
Examples:
 - DNR-Comfort Care form
 - MOLST (Medical Orders for Life-Sustaining Treatment)
 - POLST (Physician Orders for Life-Sustaining Treatment)
 - Out-of-Hospital DNR (OOH DNR)
 - If there is a SAPO in the record that is dated and signed prior to arrival with an option in which an inclusion term is found that is checked, select value “1.”
 - If a SAPO lists different options for CMO and any CMO option is checked, select value “1,” “2,” or “3” as applicable.
 - If one or more dated SAPOs are included in the record (and signed by the physician/APN/PA), use only the most recent one. Disregard undated SAPOs.
 - For cases where there is a SAPO in the record with a CMO option selected: If the SAPO is dated prior to arrival and there is documentation on the day of arrival or the day after arrival that the patient does not want CMO, and there is no other documentation regarding CMO found in the record, disregard the SAPO.
Example:
Patient has a POLST dated prior to arrival in his chart and ED physician states in current record “Patient is refusing comfort measures, wants to receive full treatment and be a full code.”
- Documentation of an inclusion term in the following situations should be **disregarded**. Continue to review the remaining physician/APN/PA documentation for acceptable inclusion terms. If the **ONLY** documentation found is an inclusion term in the following situations, select value “4.”
 - Documentation (other than SAPOs) that is dated prior to arrival or documentation which refers to the pre-arrival time period.
Examples:
 - Comfort measures only order in previous hospitalization record.
 - “Pt. on hospice at home” in MD ED note.
 - Inclusion term clearly described as negative or conditional.
Examples:
 - “No comfort care”
 - “Not appropriate for hospice care”
 - “Comfort care would also be reasonable - defer decision for now”
 - “DNRCCA” (Do Not Resuscitate — Comfort Care Arrest)
 - “Family requests comfort measures only should the patient arrest.”
 - Documentation of “CMO” should be disregarded if documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., “hx dilated CMO” — Cardiomyopathy context).
 - If there is physician/APN/PA documentation of an inclusion term in one source that indicates the patient is Comfort Measures Only, AND there is physician/APN/PA documentation of an inclusion term in another source that indicates the patient is NOT CMO, the source that indicates the patient is CMO would be used to select value “1,” “2,” or “3” for this data element.
Examples:
 - Physician documents in progress note on day 1 “The patient has refused Comfort Measures” AND then on day 2 the physician writes an order for a Hospice referral. Select value “2.”

- ED physician documents in a note on day of arrival “Patient states they want to be enrolled in Hospice” AND then on day 2 there is a physician progress note with documentation of “Patient is not a Hospice candidate.” Select value “1.”

Suggested Data Sources:

PHYSICIAN/APN/PA DOCUMENTATION ONLY IN THE FOLLOWING ONLY ACCEPTBLE SOURCES:

- Consultation notes
- Discharge summary
- DNR/MOLST/POLST forms
- Emergency department record
- History and physical
- Physician orders
- Progress notes

Excluded Data Sources:

- Restraint order sheet

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none"> ▪ Brain dead ▪ Brain death ▪ Comfort care ▪ Comfort focused treatment ▪ Comfort measures ▪ Comfort measures only (CMO) ▪ Comfort only ▪ DNR-CC ▪ End of life care ▪ Hospice ▪ Hospice care ▪ Organ harvest ▪ Terminal care ▪ Terminal extubation 	None

Data Element Name: [Prescription for Alcohol or Drug Disorder Medication](#)

Collected For: SUB-3

Definition: Documentation that an FDA-approved medication for alcohol or drug disorder was prescribed at hospital discharge

Suggested Data Collection Question: Was one of the FDA approved medications for alcohol or drug disorder prescribed at discharge?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

- 1 A prescription for an FDA-approved medication for alcohol or drug disorder was given to the patient at discharge
- 2 A prescription for an FDA-approved medication for alcohol or drug disorder was offered at discharge and the patient refused
- 3 The patient:
 - is being discharged to a residence outside the USA
 - is released to a court hearing and does not return
 - is being discharged to jail/law enforcement
- 4 A prescription for an FDA-approved medication for alcohol or drug disorder was not offered at discharge; or unable to determine from medical record documentation.

Notes for Abstraction:

- In determining whether a medication for alcohol or drug disorder was prescribed at discharge, it is not uncommon to see conflicting documentation among different medical record sources. For example, the discharge summary may list Disulfiram but this is not included in any of the other discharge medications sources, e.g., discharge orders. All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
- In cases where there is a medication for alcohol or drug disorder in one source and it is not mentioned on other sources, it should be interpreted as a discharge medication, select value "1" unless documentation elsewhere in the medical record suggests that it was not prescribed at discharge.
- If documentation is contradictory (physician noted "d/c Antabuse" or "hold Antabuse" in the discharge orders, but Antabuse is listed in the discharge summary's discharge medication list), or after careful examination of circumstances, context, timing, etc, documentation raises enough questions, the case should be deemed unable to determine, select value "4"
- If the patient does not have a residence in the USA, Value "3" must be selected.

Suggested Data Sources:

- Discharge summary
- Transfer sheet
- Discharge Instruction Sheet
- Medication Reconciliation Form
- Nursing Discharge notes
- Physician Order Sheets

Inclusion	Exclusion
Refer to Appendix C, Table 9.2 for a comprehensive list of FDA-approved medications for alcohol and drug dependence	None

Data Element Name: [Referral for Addictions Treatment](#)

Collected For: SUB-3

Definition: Documentation that a referral was made at discharge for addictions treatment by a physician or non-physician (such as nurse, psychologist, or counselor). A referral is defined as an appointment made by the provider either through telephone contact, fax or e-mail. The referral may be to an addictions treatment program, to a mental health program or mental health specialist for follow-up for substance use or addiction treatment, or to a medical or health professional for follow-up for substance use or addiction.

Suggested Data Collection Question: Was a referral for addictions treatment made for the patient prior to discharge?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

- 1 The referral to addictions treatment was made by the healthcare provider or health care organization at any time prior to discharge.
- 2 Referral information was given to the patient at discharge, but the appointment was not made by the provider or health care organization prior to discharge.
- 3 The patient refused the referral for addictions treatment and the referral was not made.
- 4 The patient:
 - is being discharged to a residence outside the USA
 - is released to a court hearing and does not return
 - is being discharged to jail/law enforcement
- 5 A referral for addictions treatment was not offered any time prior to discharge or Unable to Determine (UTD) from the medical record documentation

Notes for Abstraction:

- If a patient is referred to an addictions treatment provider that does not schedule appointments and the patient was given a specific date and time to present for addictions treatment, select Value “1.”
- If the patient does not have a residence in the USA, Value “4” must be selected.
- A referral to Alcoholics Anonymous (AA) or similar mutual support groups does not meet the intent of the measure. Select Value “5.”
- Select Value “5” if:
 - it cannot be determined that a referral for addictions treatment was made or;
 - it is unclear that the absence of the referral was due to a patient refusal or because the referral was not offered.

Suggested Data Sources:

- Discharge summary
- Transfer sheet
- Discharge Instruction Sheet
- Nursing Discharge Notes
- Physician Order Sheet

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none"> • Group counseling • Individual counseling <ul style="list-style-type: none"> ○ Addictions counselor ○ Personal physician ○ Psychiatrist ○ Psychologist 	<ul style="list-style-type: none"> • Self help interventions in the form of printed/electronic/digital media • Support groups that are not considered treatment such as Alcoholics Anonymous (AA)

Data Element Name: [Term Newborn](#)

Collected For: NEWB-3

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
<ul style="list-style-type: none"> • Gestational age of 37 weeks or more • Early term • Full term • Late term • Post term • Term 	<ul style="list-style-type: none"> • Gestational age of 36 weeks or less • Preterm • Early preterm • Late preterm

ACKNOWLEDGEMENT: Hospitals are responsible for accessing and adhering to data collection guidelines specifications for nationally reported hospital quality measures using the appropriate versions of the “*Specifications Manual for Joint Commission National Quality Measures v2023A*” and *Release Notes v2023A*. Hospital Users of the ‘TJC Specifications Manual’ are responsible for updating their software and associated documentation based on the Joint Commission published manual production timelines

Section IV: MassHealth Data Abstraction Tools

This section provides data abstraction tools for the NEWB-3, SUB-2 and SUB-3 measures collection and reporting.

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 represents 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)
 - ☐ Female
 - ☐ Male
 - ☐ Unknown
7. 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
8. Hispanic Indicator- (ETHNIC)
 - ☐ Yes
 - ☐ No
9. Patient ID (i.e. Medical Record Number) (PATIENT-ID) _____ (Alpha/Numeric)
10. Admission Date (ADMIT-DATE) ____ - ____ - ____
11. Discharge Date (DISCHARGE-DATE) ____ - ____ - ____
12. 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
 - ☐ 147 Medicaid Managed Care: Other (not listed elsewhere)
 - ☐ 288 Medicaid Managed Care: Boston Medical Center HealthNet Plan
 - ☐ 7 Medicaid Managed Care: Tufts Health Together Plan
 - ☐ 311 Medicaid Other ACO
 - ☐ 4 Fallon 365 Care

- ☐ 24 Be Healthy Partnership with Health New England
- ☐ 4 Berkshire Fallon Health Collaborative
- ☐ 288 Well Sense Community Alliance (former BMC Health Net Community Alliance)
- ☐ 288 Well Sense Mercy Alliance (former BMC Health Net Mercy Alliance)
- ☐ 288 Well Sense Signature Alliance (former BMC Health Net Signature Alliance)
- ☐ 288 Well Sense Southcoast Alliance (former BMC Health Net Southcoast Alliance)
- ☐ 320 Community Care Cooperative
- ☐ 322 MGB Healthcare Choice (former Partners Healthcare Choice)
- ☐ 323 Steward Health Choice
- ☐ 910 My Care Family - Always Health Partners
- ☐ 7 Tufts Health Together with Atrius Health
- ☐ 7 Tufts Health Together with BIDCO
- ☐ 7 Tufts Health Together with Boston Children's
- ☐ 7 Tufts Health Together with Cambridge Health Alliance
- ☐ 328 Tufts Medicine Care Plan (former Tufts Wellforce Care Plan)

13. What is the patient's MassHealth Member ID? (MHRIDNO)

(All alpha characters must be upper case)

14. 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

15. 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)

16. ICD-10-PCS Principal or Other Diagnosis Codes (Table 11.36, 11.37, 11.38, 11.39, 11.40, 11.41)

- ☐ At least one on Table 11.36, 11.37, 11.38, 11.39, 11.40, or 11.41
- ☐ None on Table 11.36, 11.37, 11.38, 11.39, 11.40, or 11.41

17. ICD-10-CM Principal or Other Diagnosis Codes (Table 11.42, 11.43, 11.44)

- ☐ At least one on Table 11.42, 11.43, or 11.44
- ☐ All missing or none on Table 11.42, 11.43, or 11.44

18. ICD-10-CM Principal or Other Diagnosis Codes (Table 11.45)

- ☐ At least one on Table 11.45
- ☐ None on Table 11.45

19. ICD-10-CM Principal or Other Diagnosis Codes (Table 11.46, 11.47)

- ☐ At least one on Table 11.46 or 11.47
- ☐ None on Table 11.46 or 11.47

20. ICD-10-CM Principal or Other Diagnosis Codes (Table 11.48)

- ☐ At least one on Table 11.48

☐ None on Table 11.48

21. ICD-10-CM Principal or Other Diagnosis Codes (Table 11.20.2)

☐ At least one on Table 11.20.2

☐ None on Table 11.20.2

22. ICD-10-CM Principal or Other Diagnosis Codes (Table 11.49, 11.50, 11.53)

☐ At least one on Table 11.49, 11.50, or 11.53

☐ None on Table 11.49, 11.50, or 11.53

23. ICD-10-CM Principal or Other Diagnosis Codes (Table 11.51, 11.52)

☐ At least one on Table 11.51 or 11.52

☐ None on Table 11.51 or 11.52

24. ICD-10-CM Principal or Other Diagnosis Codes (Table 11.33, 11.35)

☐ At least one on Table 11.33 or 11.35

☐ None on Table 11.33 or 11.35

25. ICD-10-CM Principal or Other Diagnosis Codes (Table 11.34)

☐ At least one on Table 11.34

☐ None on Table 11.34

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

☐ _____ grams (150-8165 grams)

☐ UTD (Unable to Determine)

27. 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 \geq 37 completed weeks of gestation at the time of birth.

☐ 3 = UTD, unable to determine from medical record documentation.

Data Abstraction Tool: Alcohol Use Brief Intervention Provided or Offered (SUB-2)

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 represents 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)

- ☐ Female
- ☐ Male
- ☐ Unknown

7. 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

8. Hispanic Indicator- (ETHNIC)

- ☐ Yes
- ☐ No

9. Patient ID (i.e. Medical Record Number) (PATIENT-ID) _____ (Alpha/Numeric)

10. Admission Date (ADMIT-DATE) _____ - _____ - _____

11. Discharge Date (DISCHARGE-DATE) _____ - _____ - _____

12. 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
- ☐ 147 Medicaid Managed Care: Other (not listed elsewhere)
- ☐ 288 Medicaid Managed Care: Boston Medical Center HealthNet Plan
- ☐ 7 Medicaid Managed Care: Tufts Health Together Plan
- ☐ 311 Medicaid Other ACO
- ☐ 4 Fallon 365 Care
- ☐ 24 Be Healthy Partnership with Health New England
- ☐ 4 Berkshire Fallon Health Collaborative
- ☐ 288 *Well Sense Community Alliance (former BMC Health Net Community Alliance)*
- ☐ 288 *Well Sense Mercy Alliance (former BMC Health Net Mercy Alliance)*
- ☐ 288 *Well Sense Signature Alliance (former BMC Health Net Signature Alliance)*
- ☐ 288 *Well Sense Southcoast Alliance (former BMC Health Net Southcoast Alliance)*
- ☐ 320 Community Care Cooperative
- ☐ 322 *MGB Healthcare Choice (former Partners Healthcare Choice)*
- ☐ 323 Steward Health Choice
- ☐ 910 My Care Family - MGB Health Plan (former Allways Health Partners)
- ☐ 7 Tufts Health Together with Atrius Health
- ☐ 7 Tufts Health Together with BIDCO
- ☐ 7 Tufts Health Together with Boston Children's
- ☐ 7 Tufts Health Together with Cambridge Health Alliance
- ☐ 328 *Tufts Medicine Care Plan (former Tufts Wellforce Care Plan)*

13. What is the patient's MassHealth Member ID? (MHRIDNO)

(All alpha characters must be upper case)

14. When is the earliest physician/APN/PA documentation of comfort measures only?

- ☐ **1. Day 0 or 1:** The earliest day the physician/APN/PA documented comfort measures only was the day of arrival (Day 0) or day after arrival (Day 1). (Review ends)
- ☐ **2. Day 2 or after:** The earliest day the physician/APN/PA documented comfort measures only was two or more days after arrival day (Day 2+). (Review ends)
- ☐ **3. Timing unclear:** There is physician/APN/PA documentation of comfort measures only during this hospital stay, but whether the earliest documentation of comfort measures only was on day 0 or 1 OR after day 1 is unclear. (Review ends)
- ☐ **4. Not Documented/UTD:** There is no physician/APN/PA documentation of comfort measures only, or unable to determine from medical record documentation.

15. What is the patient's alcohol use status?

- ☐ 1. The patient was screened with a validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates no or low risk of alcohol related problems. (Review Ends)
- ☐ 2. The patient was screened with a validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.
- ☐ 3. The patient was screened with a non-validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates no or low risk of alcohol related problems. (Review Ends)
- ☐ 4. The patient was screened with a non-validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.
- ☐ 5. The patient refused the screen for alcohol use within the first day of admission (by end of Day 1). (Review Ends)
- ☐ 6. The patient was not screened for alcohol use within the first day of admission (by end of Day 1) or unable to determine from medical record documentation. (Review Ends)
- ☐ 7. The patient was not screened for alcohol use within the first day of admission (by end of Day 1) because of cognitive impairment. (Review Ends)

16. Did patients with a positive screening result for unhealthy alcohol use or alcohol use disorder (abuse or dependence) (alcohol use status =2) receive a brief intervention prior to discharge?

- ☐ 1. The patient received the components of a brief intervention
- ☐ 2. The patient refused/declined the brief intervention
- ☐ 3. Brief counseling was not offered to the patient during the hospital stay or Unable to Determine (UTD) if a brief intervention was provided from medical record documentation

Data Abstraction Tool: Alcohol & Other Drug Use Disorder Treatment Provided/Offered at Discharge (SUB-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 represents 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)
 - ☐ Female
 - ☐ Male
 - ☐ Unknown
7. 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
8. Hispanic Indicator- (ETHNIC)
 - ☐ Yes
 - ☐ No
9. Patient ID (i.e. Medical Record Number) (PATIENT-ID) _____ (Alpha/Numeric)
10. Admission Date (ADMIT-DATE) ____ - ____ - ____
11. Discharge Date (DISCHARGE-DATE) ____ - ____ - ____
12. 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)
13. 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
- ☐ 147 Medicaid Managed Care: Other (not listed elsewhere)
- ☐ 288 Medicaid Managed Care: Boston Medical Center HealthNet Plan
- ☐ 7 Medicaid Managed Care: Tufts Health Together Plan
- ☐ 311 Medicaid Other ACO
- ☐ 4 Fallon 365 Care
- ☐ 24 Be Healthy Partnership with Health New England
- ☐ 4 Berkshire Fallon Health Collaborative
- ☐ 288 Well Sense Community Alliance (former BMC Health Net Community Alliance)
- ☐ 288 Well Sense Mercy Alliance (former BMC Health Net Mercy Alliance)
- ☐ 288 Well Sense Signature Alliance (former BMC Health Net Signature Alliance)
- ☐ 288 Well Sense Southcoast Alliance (former BMC Health Net Southcoast Alliance)
- ☐ 320 Community Care Cooperative
- ☐ 322 MGB Healthcare Choice (former Partners Healthcare Choice)
- ☐ 323 Steward Health Choice
- ☐ 910 My Care Family - MGB Health Plan (former Allways Health Partners)
- ☐ 7 Tufts Health Together with Atrius Health
- ☐ 7 Tufts Health Together with BIDCO
- ☐ 7 Tufts Health Together with Boston Children's
- ☐ 7 Tufts Health Together with Cambridge Health Alliance
- ☐ 328 Tufts Medicine Care Plan (former Tufts Wellforce Care Plan)

14. What is the patient's MassHealth Member ID? (MHRIDNO)

(All alpha characters must be upper case)

15. When is the earliest physician/APN/PA documentation of comfort measures only?

- ☐ **1. Day 0 or 1:** The earliest day the physician/APN/PA documented comfort measures only was the day of arrival (Day 0) or day after arrival (Day 1). (Review Ends)
- ☐ **2. Day 2 or after:** The earliest day the physician/APN/PA documented comfort measures only was two or more days after arrival day (Day 2+). (Review Ends)
- ☐ **3. Timing unclear:** There is physician/APN/PA documentation of comfort measures only during this hospital stay, but whether the earliest documentation of comfort measures only was on day 0 or 1 OR after day 1 is unclear. (Review Ends)
- ☐ **4. Not Documented/UTD:** There is no physician/APN/PA documentation of comfort measures only, or unable to determine from medical record documentation.

16. What is the patient's alcohol use status?

- ☐ 1. The patient was screened with a validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates no or low risk of alcohol related problems.
- ☐ 2. The patient was screened with a validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.
- ☐ 3. The patient was screened with a non-validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates no or low risk of alcohol related problems.
- ☐ 4. The patient was screened with a non-validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.

- ☐ 5. The patient refused the screen for alcohol use within the first day of admission (by end of Day 1).
- ☐ 6. The patient was not screened for alcohol use within the first day of admission (by end of Day 1) or unable to determine from medical record documentation.
- ☐ 7. The patient was not screened for alcohol use within the first day of admission (by end of Day 1) because of cognitive impairment. (Review Ends)

17. ICD-10-CM Principal or Other Diagnosis Codes (Table 13.1)

- ☐ At least one on Table 13.1
- ☐ None on Table 11.09

18. ICD-10-CM Principal or Other Diagnosis Codes (Table 13.2)

- ☐ At least one on Table 13.2
- ☐ None on Table 13.2

19. ICD-10-PCS Principal or Other Diagnosis Codes (Table 13.3)

- ☐ At least one on Table 13.3
- ☐ None on Table 13.2

-If All Missing or None on Tables 13.1, 13.2, and 13.3, Review Ends-

23. Was a referral for addictions treatment made for the patient prior to discharge?

- ☐ 1. The referral to addictions treatment was made by the healthcare provider or health care organization at any time prior to discharge.
- ☐ 2. Referral information was given to the patient at discharge, but the appointment was not made by the provider or health care organization prior to discharge.
- ☐ 3. The patient refused the referral for addictions treatment and the referral was not made.
- ☐ 4. The patient: is being discharged to a residence outside the USA, is released to a court hearing and does not return, or is being discharged to jail/law enforcement. (Review Ends)
- ☐ 5. A referral for addictions treatment was not offered any time prior to discharge or Unable to Determine (UTD) from the medical record documentation.

24. Was one of the FDA approved medications for alcohol or drug disorder prescribed at discharge?

- ☐ 1. A prescription for an FDA-approved medication for alcohol or drug disorder was given to the patient at discharge.
- ☐ 2. A prescription for an FDA-approved medication for alcohol or drug disorder was offered at discharge and the patient refused.
- ☐ 3. The patient: is being discharged to a residence outside the USA, is released to a court hearing and does not return, or is being discharged to jail/law enforcement.
- ☐ 4. A prescription for an FDA-approved medication for alcohol or drug disorder was not offered at discharge; or unable to determine from medical record documentation.

Section IV: New Data Validation Scored Elements

This section provides a list of the specific data elements that will be validated for the new upcoming CQI Program measure requirements listed in this EOHHS Release Notes v16.1.

Updates to Table 6.1 in EOHHS Manual (16.0) that apply to the calculation of the overall validation rate for the new chart-based measures data reporting as of Q1-2023 are summarized in the following table.

Table 6-1: Data Elements Scored for New Measures

Scored Data Elements	Non-Scored Data Elements
NEWB-3 Measure: Birth Weight, Discharge Disposition, Term Newborn, Race, Hispanic indicator	<ul style="list-style-type: none">• Admission Date• Admission Time• Birth Date• Discharge Date (scored for CCM-3 only)• Discharge Disposition (scored for NEWB-3, SUB-3, CCM)
SUB-2 Measure: Alcohol Use Status, Brief Intervention, Comfort Measures Only, Race, Hispanic indicator	<ul style="list-style-type: none">• Episode of Care• First Name• Hospital Patient ID #• ICD-CM Diagnosis Codes• ICD-PCS Procedure Codes
SUB-3 Measure: Alcohol Use Status, Comfort Measures Only, Discharge Disposition, Prescription for Alcohol or Drug Disorder Medication, Referral for Addictions Treatment, Race, Hispanic indicator	<ul style="list-style-type: none">• Last Name• Member ID Number• Payer Source• Provider ID• Provider Name• Sex

Medical Record Request

- The addition of the MassHealth specific NEWB-3, SUB-2 and SUB-3 chart-based measures will likely increase the number of medical records that will be requested for CY23 data validation for each quarter to ensure reliability of data.
- Changes to CY23 chart validation requirements will be further clarified in the upcoming Acute RFA23 Section 7B amendment.

Please contact MassQEX Help Desk at massqexhelp@telligen.com if you have questions about the contents of this document.