**REVSTAT**

REVIEW STATUS (calculated)

- 0. Abstraction has not begun
- 1. Abstraction in progress
- 2. Abstraction completed w/o errors
- 3. TVG failure (exclusion)
- 4. Record contains missing required answers (error record)
- 5. Administrative Exclusion

**DCDT** (Global Measures)

Discharge date (rcvd on pull list and may not be modified)

**ADMDT** (Global Measures)

Admission date:

**BIRTHDT** (Global Measures)

Patient date of birth

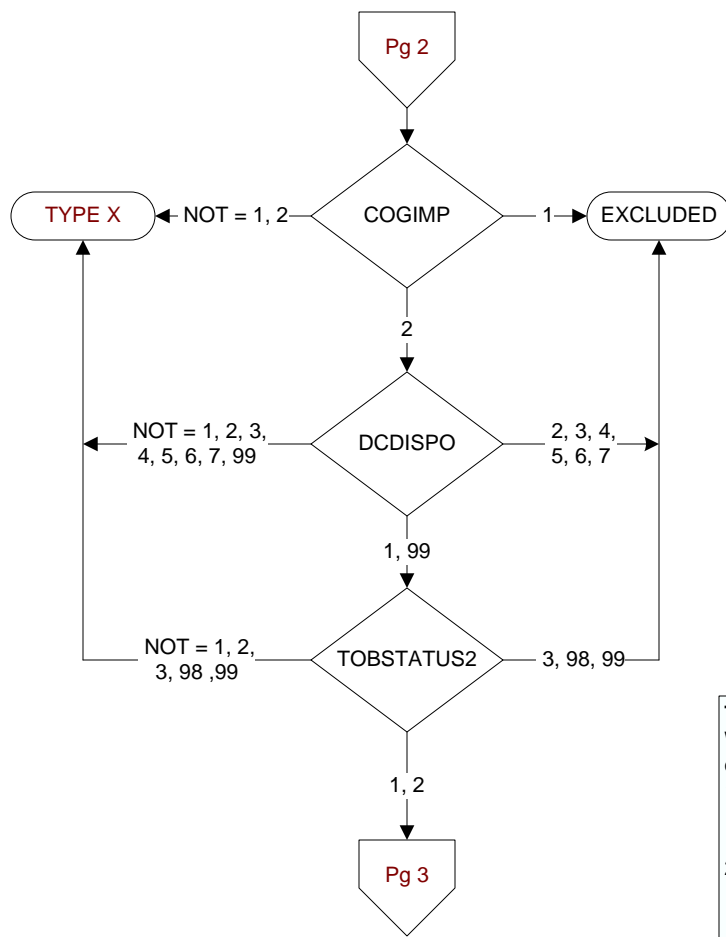
**AGE** (Calculated)

ADMDT - BIRTHDT

**COMFORT** (Global Measures)

When is the earliest physician, APN, or PA documentation of comfort measures only?

- 1. Day of arrival (day 0) or day after arrival (day 1)
- 2. Two or more days after arrival (day 2 or greater)
- 3. Comfort measures only documented during hospital stay, but timing unclear
- 99. Comfort measures only was not documented by the physician/APN/PA or unable to determine

**COGIMP** (Global Measures)

Is there documentation in the medical record that indicates the patient is cognitively impaired?

1. Yes
2. No

**TOBSTATUS2** (Global Measures)

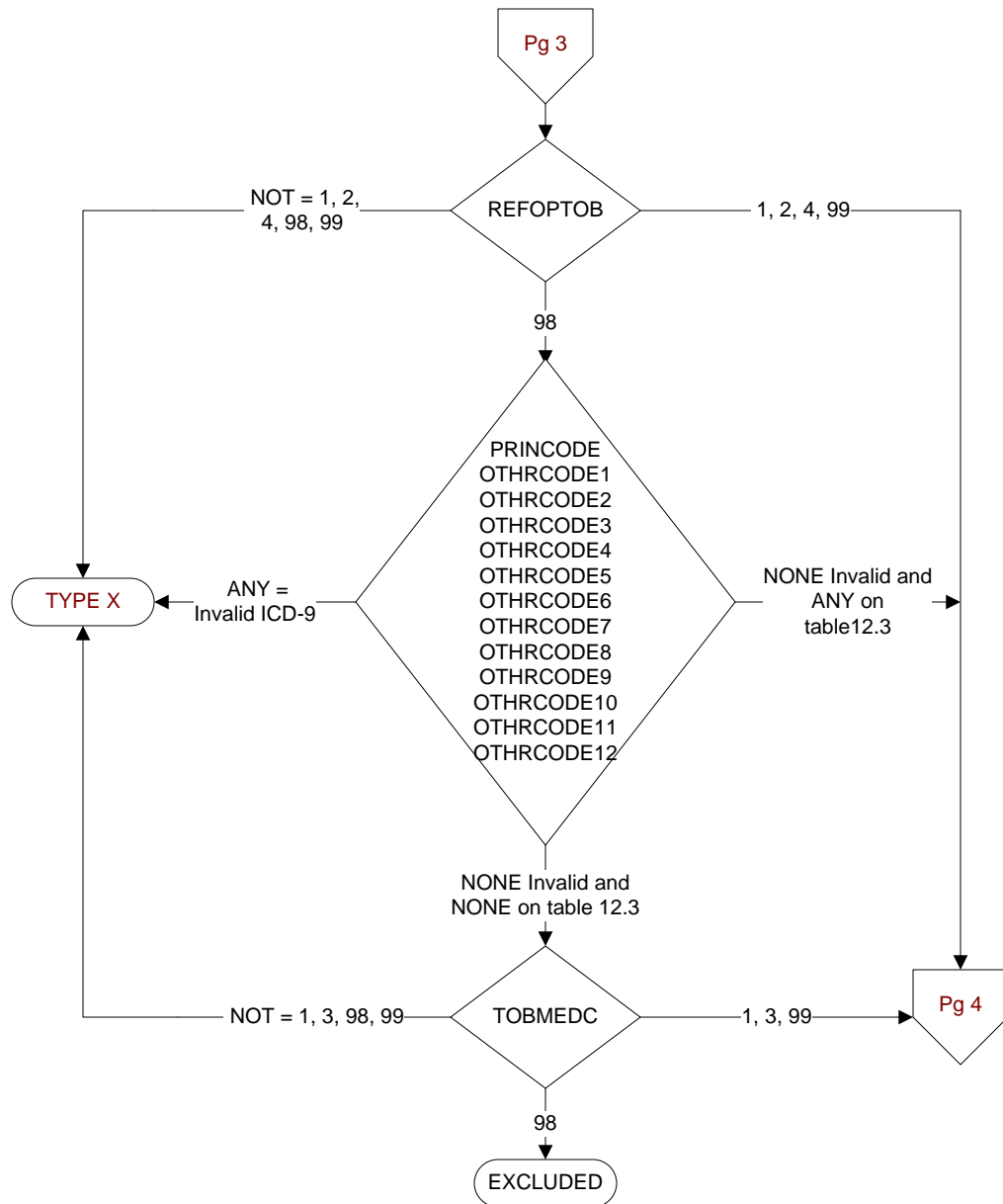
What is the patient's tobacco use status documented within the first three days of admission?

1. The patient has smoked cigarettes daily on average in a volume of five or more cigarettes ( $\geq \frac{1}{4}$  pack) per day and/or cigars daily and/or pipes daily during the past 30 days
2. The patient has smoked cigarettes daily on average in a volume of four or less cigarettes ( $< \frac{1}{4}$  pack) per day and/or used smokeless tobacco and/or smoked cigarettes but not daily and/or cigars but not daily and/or pipes but not daily during the past 30 days
3. The patient has not used any forms of tobacco in the past 30 days
98. The patient refused the tobacco use screen
99. The patient was not screened for tobacco use within the first three days of admission or unable to determine the patient's tobacco use status from medical record documentation

**DCDISPO** (Global Measures)

What was the patient's discharge disposition on the day of discharge?

1. Home
  - Assisted Living Facilities (ALFs) - includes assisted living care at nursing home/facility
  - Court/Law Enforcement – includes detention facilities, jails, and prison
  - Home – includes board and care, domiciliary, 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
2. Hospice – Home (or other home setting as listed in #1 above)
3. Hospice – Health Care Facility
  - General Inpatient and Respite, Residential and Skilled Facilities, and Other Health Care Facilities
4. Acute Care Facility
  - Acute Short Term General and Critical Access Hospitals
  - Cancer and Children's Hospitals
  - Department of Defense and Veteran's Administration Hospitals
5. Other Health Care Facility
  - 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 Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
  - Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed
  - Transitional Care Unit (TCU)
  - Veteran's Home
6. Expired
7. Left Against Medical Advice/AMA
99. Not documented or unable to determine

**REFOPTOB** (Global Measures)

Did the patient receive a referral for Outpatient Tobacco Cessation Counseling?

1. The referral to outpatient tobacco cessation counseling treatment was made by the healthcare provider prior to discharge.
2. Referral information was given to the patient at discharge but the appointment was not made by the provider prior to discharge.
4. The referral for outpatient tobacco cessation counseling treatment was not offered because the patient's residence is not in the USA.
98. Patient refused the referral for outpatient tobacco cessation counseling treatment and the referral was not made.
99. The referral for outpatient tobacco cessation counseling treatment was not offered at discharge or unable to determine from the medical record documentation.

**PRINCODE** (Global Measures)

Enter the ICD-9-CM principal diagnosis code.

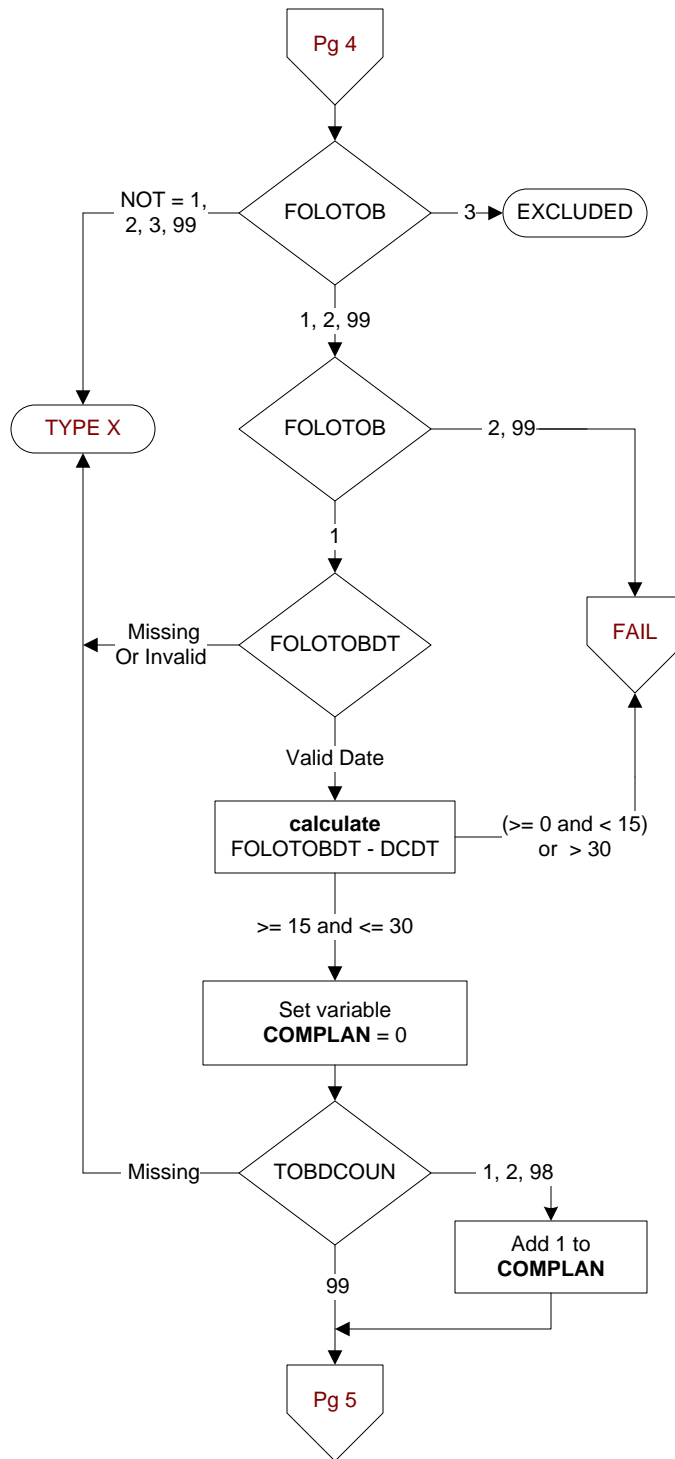
**OTHRCODE1-12** (Global Measures)

Enter the ICD-9-CM other diagnosis codes:

**TOBMEDC** (Global Measures)

Was an FDA-approved tobacco cessation medication prescribed at discharge?

1. A prescription for an FDA-approved tobacco cessation medication was given to the patient at discharge.
3. A prescription for an FDA-approved tobacco cessation medication was not offered because the patient's residence is not in the USA.
98. A prescription for an FDA-approved tobacco cessation medication was offered at discharge and the patient refused.
99. A prescription for an FDA-approved tobacco cessation medication was not offered at discharge or unable to determine from medical record documentation.

**FOLOTOB** (Global Measures)

Was contact made with the patient relative to tobacco use status between 15 and 30 days post discharge?

1. A follow-up contact was made between 15 and 30 days post discharge relative to the patient's tobacco use status.
2. A follow-up contact relative to the patient's tobacco use status was made, but not between 15 and 30 days post discharge, or follow-up contact was made during specified timeframe with a family member only
3. A follow-up contact was not made within 30 days post discharge because the patient's residence is not in the USA, the patient was incarcerated, contact number was no longer valid, the patient had no phone, or the patient was re-admitted to the hospital within 30 days post discharge, or at least 3 unsuccessful attempts to contact the patient were documented.

99. A follow-up contact relative to the patient's tobacco use status was not made post discharge or unable to determine from medical record documentation.

**FOLOTOBDT** (Global Measures)

Enter the date the follow-up contact was made with the patient to assess tobacco use post discharge.

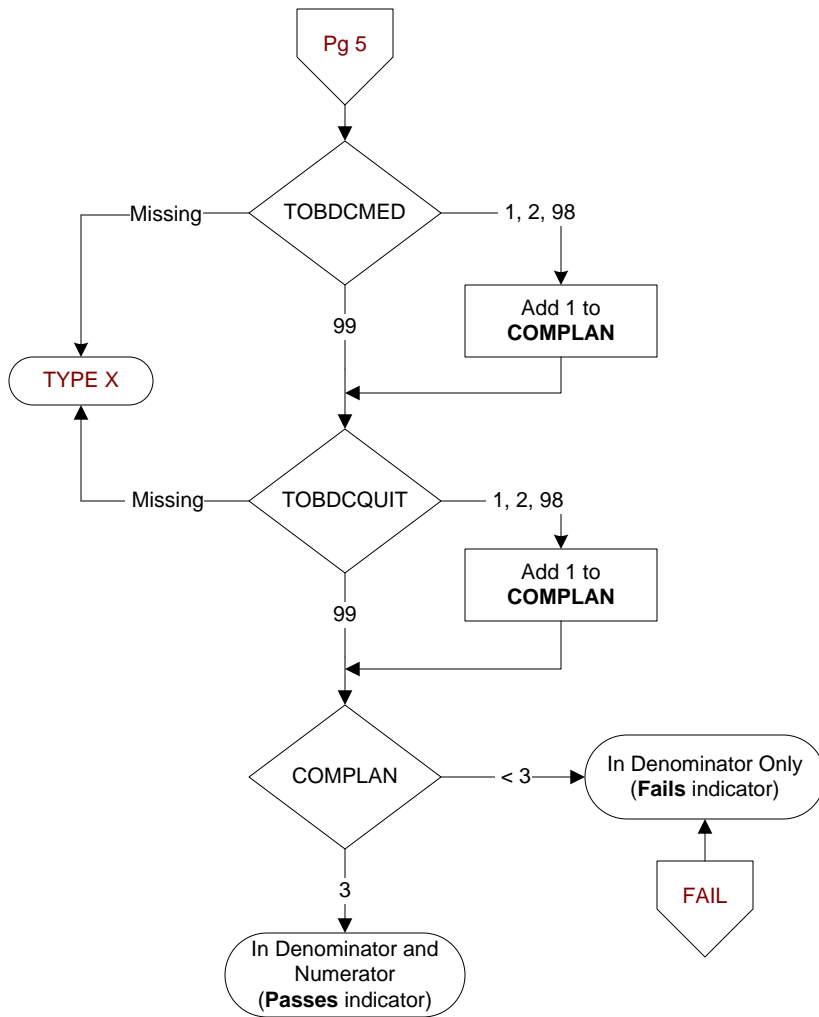
**TOBDCOUN** (Global Measures)

Is the patient attending outpatient tobacco cessation counseling post discharge?

1. The patient is attending outpatient tobacco cessation counseling post discharge.
2. The patient is not attending outpatient tobacco cessation counseling post discharge.

98. Patient refused to provide information relative to post discharge counseling attendance.

99. Not documented or unable to determine from follow-up information.

**TOBDCMED** (Global Measures)

Is the patient taking the recommend tobacco cessation medication post discharge?

1. The patient is taking the recommended tobacco cessation medication post discharge.
2. The patient is not taking the recommended tobacco cessation medication post discharge.
98. Patient refused to provide information relative to tobacco cessation medication use post discharge.
99. Not documented or unable to determine from follow-up information.

**TOBDCQUIT** (Global Measures)

Has the patient quit using tobacco products post discharge?

1. The patient has quit using tobacco products post discharge
2. The patient has not quit using tobacco products post discharge.
98. Patient refused to provide information relative to tobacco use status at the follow-up contact.
99. Not documented or unable to determine from follow-up information collected.