

**Document Links:**

[Global Measures Instrument](#)

**CATNUM** (rcvd on pull list)  
Sample category number  
70 = Global Measures

**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

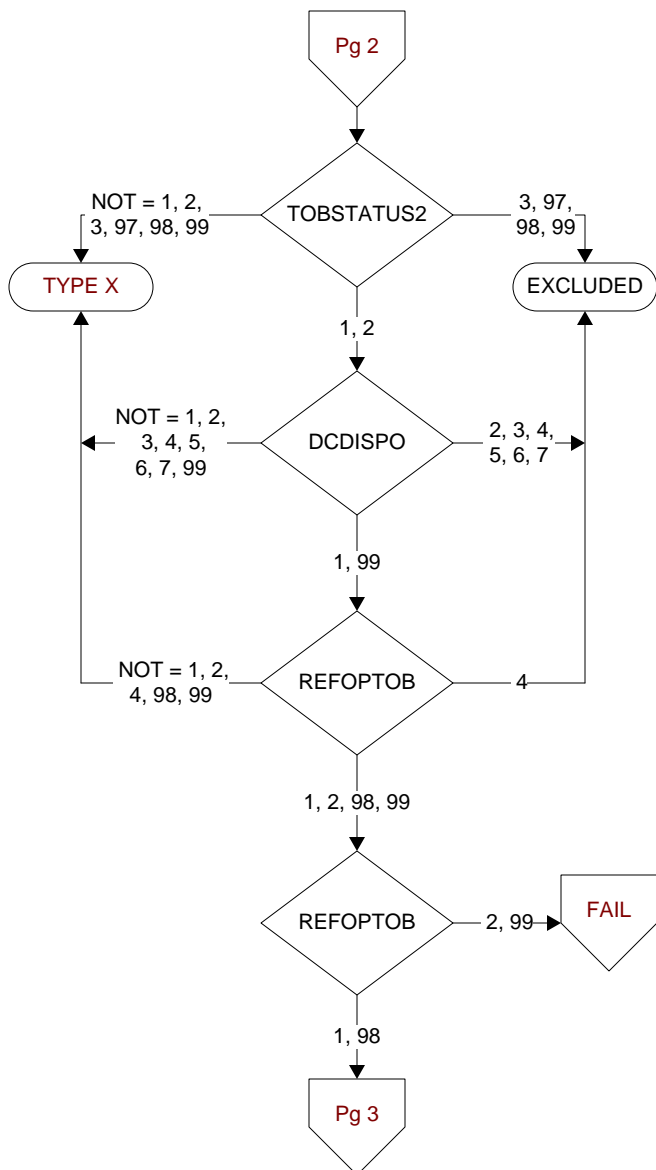
**DCDT** (Global Measures)  
Discharge date (rcvd on pull list and may not be modified)

**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



**TOBSTATUS2** (Global Measures)

What is the patient's tobacco use status documented within the first day of admission (**by the end of Day1**)?

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
97. The patient was not screened for tobacco use during the first day of admission (**by the end of Day1**) because of cognitive impairment
98. The patient refused the tobacco use screen
99. The patient was not screened for tobacco use within the first day of admission (**by the end of Day1**) or unable to determine the patient's tobacco use status from medical record documentation

**DCDISPO** (Global Measures)

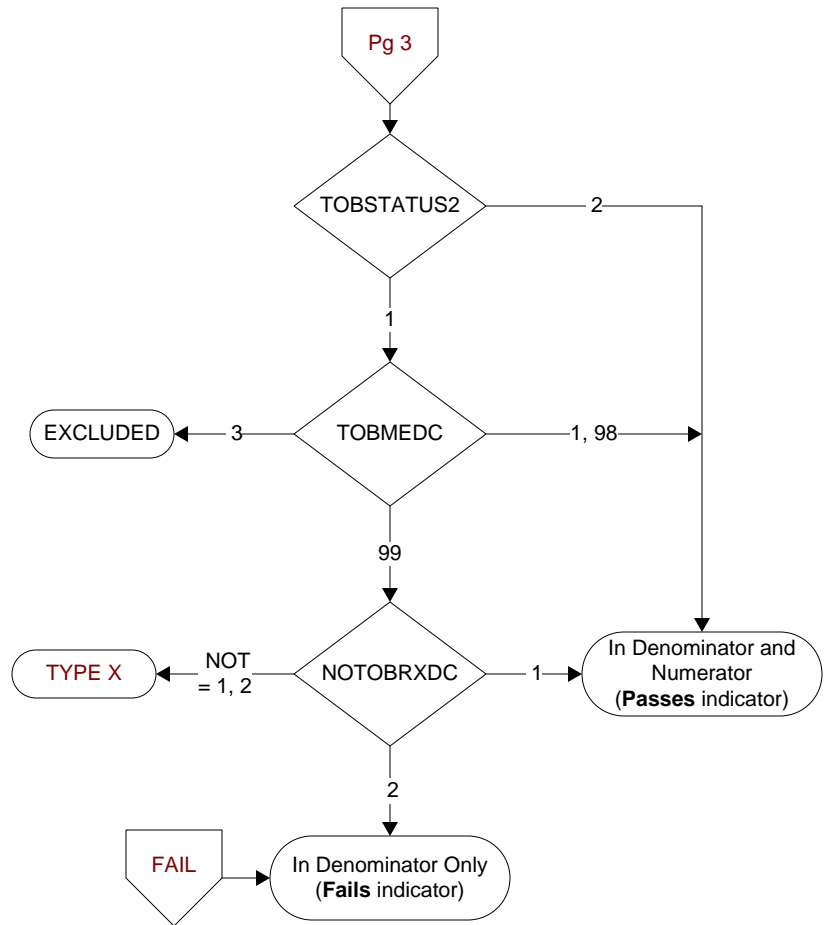
What was the patient's discharge disposition on the day of discharge?

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/facility staff 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/facility staff at any time prior to discharge.
4. The patient is:
  - being discharged to a residence outside the USA
  - released to a court hearing and does not return
  - being discharged to jail/law enforcement
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.



**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. The patient is:

- being discharged to a residence outside the USA
- released to a court hearing and does not return
- being discharged to jail/law enforcement

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.

**NOTOBRXDC** (Global Measures)  
 Is there documentation of a reason for not prescribing one of the FDA-approved tobacco cessation medications at discharge?

- Allergy to all of the FDA-approved tobacco cessation medications.
- Drug interaction (for all of the FDA-approved medications) with other drugs the patient is currently taking.
- Patient is pregnant
- Other reasons documented by physician/APN/PA or pharmacist.

1. Yes  
 2. No