

**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

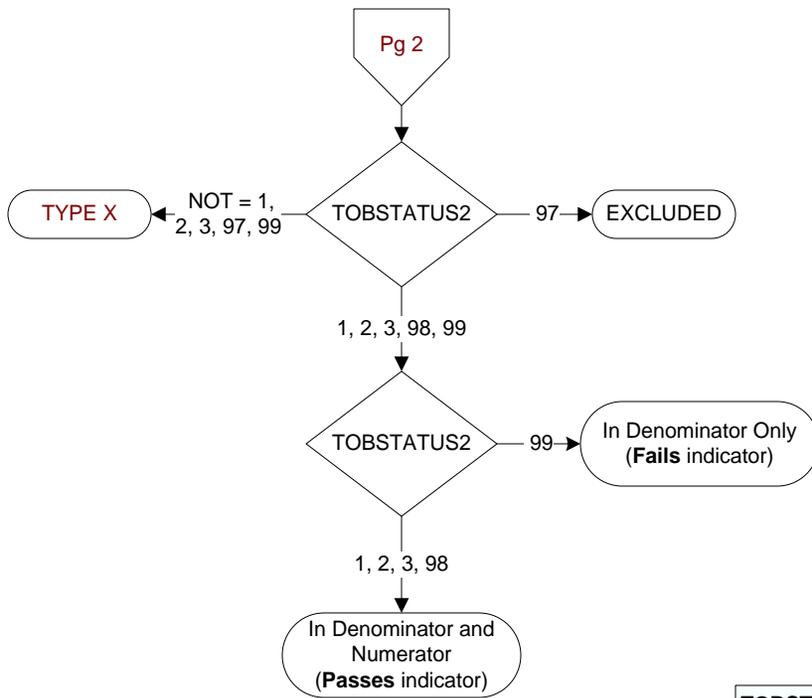
**DCDT** (Global Measures)  
 Discharge date (rcvd on pull list and may not be modified)

**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