Non-Claims-Based Performance Measure

Standard Reporting Template Data Submissions Guidance Document

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Prepared by Public Consulting Group on behalf of the NJ Department of Health

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Performance Measures Submission: General Guidelines

Required documents:

There are two Standard Reporting Templates (SRTs): 1) An SRT for all measures except M010 and BH12 and 2) An SRT specific to measures M010 and BH12.

Non-Claims-Based Measure SRT

The Non-Claims-Based Measure SRT contains six (6) tabs. Of these, four (4) are for reference and two (2) are for data submission.

Reference tabs (4):

- "Requirement Notes" – lists the requirements for non-claims-based (i.e., chart and/or electronic medical record (EMR)-based, non-MMIS) data submission.
- "EMR_IN DataDictionary" – displays the data dictionary to be used in conjunction with the "EMR_IN Template".
- "NonMMIS Measures List" – details the non-claims-based measures.
- "Data Validation Lists" – details the acceptable lookup values where applicable by measure (hidden tab, do not alter).

Data Submission-Related tabs (2):

- "Sampling Instructions" – allows hospitals to indicate contact information, performance measure-specific sampling, and overall summary data.
- "EMR_IN Template" – details the individual-level data to support each performance measure.
  - Flat-files are strongly preferred, however, hospitals may decide on whether to submit an Excel template, a flat file, or a hybrid of the two.
  - The "EMR_IN Template" may be filled in manually or may be populated by data export into Excel or a flat file; the latter method must adhere to the column names and formatting restrictions as noted in tab "EMR_IN DataDictionary" (detail below).
  - The hospital may include all measures in one file or may provide separate files by measure.
  - At minimum per hospital, two files (one for the "Sampling Instructions" (File Type = "S") and one for the "EMR_IN Template" (File Type = "E")) will be uploaded to the Secure File Transfer Protocol (SFTP).

File Naming Conventions and Formatting:

- Files uploaded to the SFTP (QIP-NJ SFTP User Guide) must adhere to the stated naming conventions to facilitate a manageable process.

- Files must include the **Time Period (MY3)_Hospital Medicaid ID_FileType** as indicated on the attribution roster's "ReadMe" tab (MID) and the type of file (S or E).
    - If sending **one consolidated workbook**, follow this naming convention: MY3_MID_S
        - For example: MY3_3676803_S
    - If sending **multiple workbooks**, follow this naming convention: MY3_MID_E (if there is more than 1 file, indicate this by E1, E2 through En)
        - For example: **MY3_3676803_E1, MY3_3676803_E2, MY3_3676803_E3, etc.**
  - Do not enter any decimal values for ICD codes.
  - Service and other pertinent dates must be in a consistent format with date elements separated by slashes ("/").

Non-Standard Data Elements:

  - Any new variable names must be 8 characters or less in length and must be explicitly pre-approved by the State before inclusion after the last specified column ("EOF_ID").

Flat File Submission:

Hospitals wishing to submit their data in flat file format must meet the following additional requirements**:**

  - Flat files must be pipe-delimited ("|") and follow the "EMR_IN Template" column structure exactly *unless otherwise authorized*.

SRT for measures M010 and BH12

The SRT for measures M010 and BH12 contains two (2) tabs. Of these, one (1) is for reference and one (1) is for data submission.

Reference tab (1):

- "Dictionary" – displays the data dictionary to be used in conjunction with the "Reporting_Template".

Data Submission-Related tabs (1):

- "Reporting_Template" -- details the individual-level data to support each performance measure.
    - Flat-files are strongly preferred, however, hospitals may decide on whether to submit an Excel template, a flat file, or a hybrid of the two.

- The "Reporting_Template" may be filled in manually or may be populated by data export into Excel or a flat file; the latter method must adhere to the column names and formatting restrictions as noted in tab "Dictionary" (detail below).
- The hospital may include both measures (M010 and BH12) in one file or may provide separate files by measure.
- At minimum per hospital, one file (for the "Reporting_Template" (File Type = "E")) will be uploaded to the Secure File Transfer Protocol (SFTP)

File Naming Conventions and Formatting:

- Files uploaded to the SFTP (QIP-NJ SFTP User Guide) must adhere to the stated naming conventions to facilitate a manageable process.
- Files must include the **Time Period (MY3)_Hospital Medicaid ID_FileType** as indicated on the attribution roster's "ReadMe" tab (MID) and the type of file (S or E).
  - If sending **one consolidated workbook**, follow this naming convention: MY3_MID_S
    - For example: MY3_3676803_S
  - If sending **multiple workbooks**, follow this naming convention: MY3_MID_E (if there is more than 1 file, indicate this by E1, E2 through En)
    - For example: **MY3_3676803_E1, MY3_3676803_E2, MY3_3676803_E3, etc.**
- Service and other pertinent dates must be in a consistent format with date elements separated by forward slashes ("/").

Non-Standard Data Elements:

- Any new variable names must be 8 characters or less in length and must be explicitly pre-approved by the State before inclusion after the last specified column ("EOF_ID").

Flat File Submission:

Hospitals wishing to submit their data in flat file format must meet the following additional requirements**:**

- Flat files must be pipe-delimited ("|") and follow the "Reporting_Template" column structure exactly *unless otherwise authorized*.

Performance Measure Submission: FAQ

1. **Q: What documents are required for the submission process?**
    a. **For non-staff training measures** (not M010 nor BH12), hospitals will decide on whether to submit the "Standard Reporting Template" package in Excel or a hybrid of Excel and flat file(s). The "Sampling Instructions" spreadsheet must be submitted in addition to the "EMR_IN Template", which may be submitted in Excel or as a flat file, in accordance with "General Guidelines" outlined in this document. The hospital may choose whether all measures are included in one file for the "EMR_IN Template" or in separate files by measure. Following, the hospital will upload files to the SFTP, confirming submission in a message to QIP-NJ@pcgus.com that states production-ready review for the respective hospital's files may begin by the State.
    b. **For staff training measures (M010 and BH12),** hospitals will decide on whether to submit the "Standard Reporting Template" package in Excel or a hybrid of Excel and flat file(s). The hospital may choose whether both measures are included in one file for the "Reporting_Template" or in separate files by measure. Following, the hospital will upload files to the SFTP, confirming submission in a message to QIP-NJ@pcgus.com that states production-ready review for the respective hospital's files may begin by the State.
2. **Q: How do I know how to fill out column "M_ELEMT"?**
    a. Consult each individual performance measure specification in the Databook for details of what data elements constitute the numerator, denominator, exclusions, and exceptions (exceptions apply only for BH07). Further, consult the "Standard Reporting Template" to understand how to transform the data appropriately. For several measures, presence of an individual in the attribution roster (eligible population) automatically gets the individual into the denominator; however, there may be additional data elements to consider specific to the measure (e.g., age, diagnosis, site of service).
3. **Q: What if our hospital has non-standard data ("homegrown") codes that do not fit within the constraints of column "CODE_VAL"?**
    a. Those encountering these circumstances must contact us as soon as possible to discuss the specific scenario and arrange for mapping of the codes. Any non-standard codes must be mapped to known standard nomenclature after the "EOF Column". The State must approve this prior to submission. When submitting non-standard codes, please describe the application in the Submission Comments on the "Sampling_Instructions" tab. Data submitted without this acknowledgement will not be used in performance measure calculations.
4. **Q: For the "EMR_IN Template" submission is there guidance how to group by patients or by measure?**
    a. The first two sections as referenced in the tab "EMR_IN DataDictionary" (entity tracking and individual data elements) are required to be populated for all individuals. Explicit grouping by measure is helpful though not required.
5. **Q: How do we report individuals who had multiple visits where on the first visit, they met the numerator; however, on the second visit, they did not meet the numerator?**

   a. If an individual has multiple screenings during the measurement year, a follow up must be documented following a positive screen for BH07 on at least one of those encounters to be considered numerator compliant. Report each individual's numerator-specific elements in a new row. In this scenario, one or more rows will display the applicable codes for numerator compliance, including the service date, and the second set of rows will display the applicable codes for numerator non-compliance, including the service date.

6. **Q: Is there a concern that there will be a large volume of data per measure (for example, we know there may be over 20 rows per individual)?**
   a. The option to sample will reduce some volume per measure; however, it is important that the full episode of care is captured for each individual. To further reduce the need for administrative burden on hospitals, the State has decided that *exclusions do not need to be reported unless they are relevant to a pattern* (e.g., if the measure does not meet the minimum denominator).
7. **Q: For reporting the non-claims-based or chart/EHR measures, can hospitals use sampling methodology rather than reporting on all MMC-enrolled individuals served?**
   a. Yes, hospitals may use the Databook's outlined sampling methodology rather than report on all individuals served. The measures that are eligible for sampling are:
      - BH Measure Set: BH07, BH08, BH09, BH10, BH11
      - Maternal Health Measure Set: M002, M003, M006, M007, M008, M009

Sampling may be permitted based upon the volume of attributed individuals. For BH, this is determined by the total number of individuals in the attributed population with an encounter in an appropriate setting during the MY. For maternal health, sampling is determined by the total number of attributed individuals admitted to the hospital for labor and delivery during the MY. When a sample is taken for a measure and exclusions force that population below the 30- patient denominator requirement:

Step 1: Identify the eligible population from the attribution roster and remove all required exclusions based upon the respective measure specifications. All required exclusions must be removed from the final eligible population.

Step 2: Search chart/EHR systems to identify numerator events for all individuals in the eligible population.

Step 3: If applicable, for individuals for whom non-claims-based data do not show a positive numerator event (numerator compliance), search non-claims-based data for an exclusion to the service/procedure being measured.

Step 4: Exclude from the eligible population, individuals from step 3 for whom system data identified an exclusion to the service or procedure being measured. For more information on the Minimum Sample Size for the measure based on the attribution size (denominator) please refer to the Databook on the QIP-NJ Documents & Resources webpage. Hospitals are responsible for ensuring that

all sampling requirements associated with the measure have been met. Each measure reported through a sample must include a description of steps taken to validate that all sampling requirements have been met.

8. **Q: How do we know which clinical codes are acceptable to use as an exception?**
    a. Exceptions are relevant only to BH07 and must be reported in the Standard Reporting Template for consideration. A final decision will be rendered by the State after consideration of the circumstances of the scenario presented. An exception is indicative of an emergent clinical issue or refers to an individual incapable of being screened, usually due to a severe cognitive issue; an ICD-10 diagnosis, procedure code, or other billing code will apply.
9. **Q: For BH09/M006: if the individual is discharged to a nursing home how may the measure be met?**
    a. As long as the individual's record follows him to the designated facility and primary clinician in a verifiable manner (e.g., medical discharge summary in a sealed envelope or electronically transferred with known date of transmission), it is acceptable.
10. **Q: For the instrument-based performance measures, specifically SDOH, could you clarify what is the expectation on reporting? Will there be the same level of scoring scrutiny as with the non-instrument-based measures?**
    a. For the SDOH measures (BH11, M009) the numerator represents those attributed individuals that received a screening using a validated tool with required domains. The denominator are those individuals in the attributed population. To validate the count of screenings that occurred, it is important for the hospital to report all those individuals who were screened out of the total possible individuals (it is acceptable to report this total count in the "Sampling Instructions" comment sections per measure). The State recognizes that there is subjectivity among which questions constitute each of the required domains. Additionally, there is variation across tools and facilities for how raw scores translate to an individual being "at risk" or "not at risk". For this reason, the State places more emphasis on whether "referral made" is chosen. The key takeaway in the evaluation of these measures per hospital is that when an individual is deemed "at risk" there is a "referral made" as needed.
11. **Q: BH12 and M010 are new measures – see several questions below:**
    a. **What is the baseline period for those measures?**
        i. BH12 and M010 were introduced in MY2 (calendar year 2022). Accordingly, the baseline period for those measures is calendar year 2022.
    b. **Has DOH developed tools for Social Determinants of Health and Implicit Bias training?**
        i. DOH has not developed and is not endorsing any specific tools for BH12 and M010. To satisfy the QIP-NJ-specific measures BH12 and M010, hospitals will need to consult the training module requirements, which are described in the QIP-NJ Databook, to ensure any training they implement meets those requirements.
    c. **Is payment tied to these measures?**
        i. BH12 and M010 are <u>pay-for-reporting</u> measures. Hospitals must submit data to comply with this requirement and the program hopes to see directional improvement each year.

d. **Who should be in the denominator for BH12?**

    i. For the measure specification, hospital-employed healthcare professionals and patient-facing support staff that interact with BH patients. ~~Do not include hospital staff that are not in the hospital setting. However,~~ P~~p~~rogrammatically, QIP-NJ encourages hospitals to train all patient-facing staff, even beyond the hospital-setting. At their discretion, hospitals may include hospital-employed, community-based staff in the denominator, however, if community-based staff are included, they must be included in the denominator every year.

e. **Who should be in the denominator for M010?**

    i. For the measure specification, hospital-employed healthcare professionals and patient-facing support staff that interact with maternal patients. ~~. Do not include hospital staff that are not in the hospital setting. However, p~~Programmatically, QIP-NJ encourages hospitals to train all patient-facing staff, even beyond the hospital-setting. At their discretion, hospitals may include hospital-employed, community-based staff in the denominator, however, if community-based staff are included, they must be included in the denominator every year.

f. **Should per diem employees be included in the report/denominator for M010 & BH12?**

    i. Yes, all service-line applicable staff, per diem and non-per diem should be included in the denominators.

g. **Should employees terminated during the MY be included for the denominator?**

    i. Yes.

h. **Should the denominator be employees that were employed the entire MY or anyone employed at any point during the MY regardless of length of employment?**

    i. Employees who worked for any duration during the MY should be included in the denominator(s). Employees hired between Dec 1 – Dec. 31 of the MY may be excluded from the denominator(s).

i. **Our hospital does not have employee IDs, can we provide a unique identifier for each reported staff member?**

    i. Yes, hospitals may report a unique identifier to disambiguate staff members. Hospitals must ensure that, on audit, the Department of Health can identify specific, unique employees based upon the names/IDs provided.

j. **Our hospital assigns IDs to report employees' training. Do we need to use the same IDs across measurement years?**

    i. For QIP-NJ reporting purposes an assigned ID, does not need to be consistent year-over-year, however, hospitals may wish to consider having the ID consistent year-over-year, for their own tracking purposes.

General Guidance for Completing the SRT

- For most measures, an attributed individual will have multiple rows in a submission. For each of the following fields for the individual, we expect all entries to be the same:
  - HOSP_ID
  - M_NBR1
  - M_NBR2
  - M_NBR3
  - M_NBR4
  - M_LNAME
  - M_FNAME
  - M_MI
  - M_DOB
  - M_GENDER
  - M_PROV
- An individual may have multiple encounters per measure (per the measure specification); list each in a new row with the required identifiers and appropriate columns per measure.
- Service date may be a diagnostic date, the ordered date for pharmacy events, survey / screening tool admin date, transfer of file date - depending on measure context (report inpatient admit and discharge dates separately in the specified columns).
- To ensure all clinical elements are captured properly, populate the column “RES_VAL” with the appropriate indicator and include the relevant accompanying code in columns “CODE_VAL” and “RES_VALP” (as necessary). These fields will be validated by the State for accuracy and consistency.
- Only one value should be entered for each row in the SRT. If a patient has more than one diagnosis code, or more than one clinical data value, they should be entered onto separate lines. Reporting more than one value in a cell will cause the row to be excluded from measure calculation and may require resubmission.
- Individuals that are reported as exclusions should be recorded only with rows where M_ELEMT = E. They should not be reported as numerator or denominator eligible patients.
- **PLEASE NOTE:** BH12 and M010 are staff training measures – data elements completed for these measures should refer to staff information, not member/patient information.

Fields that must be completed for all records submitted

Entity tracking data elements

Variable	Description	Submission Guidelines	Example

M_ID	Measure set and #	Hospitals should report the 4 alphanumeric characters appropriate to the measure	BH07, BH08, BH09, BH10, BH11, BH12, M002, M003, M006, M007, M008, M009, M010
M_YR	Measure year	One digit value representing the measurement year Baseline=0, MY1=1, MY2=2, MY3=3, MY4=4, MY5=5	2
HOSP_ID	Hospital entity - Medicaid ID	Unique hospital Medicaid ID. These values must be from the DOH approved list of hospital IDs, such as those indicated on the attribution roster "read me" tab.	Unique hospital 7-digit ID

Member data elements

Variable	Description	Submission Guidelines	Example
M_NBR1	Medicaid Beneficiary ID (eligibility enroll file) - Current	Complete with patient Medicaid ID from either Hospital EHR or attribution roster.[1]	800001999999
M_NBR2	Medicaid Beneficiary ID (eligibility enroll file) – Original	Complete with patient Medicaid ID from either Hospital EHR or attribution roster.[1]	800001999999
M_NBR3	Unique member number - Medicaid Beneficiary ID (eligibility enroll file) - Social security #	Complete with patient social security number from either Hospital EHR or attribution roster.[1]	023232545
M_NBR4	Unique member number - other identifier (e.g., Patient account #)	Complete with other patient ID from either Hospital EHR or attribution roster.[1]	1941165835009
M_LNAME	Member Last Name	Complete with patient last name as reported in the attribution roster or your hospital EHR.	Doe
M_FNAME	Member First Name	Complete with patient first name as reported in the attribution roster or your hospital EHR.	John
M_MI	Member Middle Initial	Complete with patient middle initial as reported in the attribution roster or your hospital EHR.	K
M_DOB	Date of member's birth	Complete with patient date of birth as reported in the attribution roster or your hospital EHR.	1/21/2000
M_GENDER	Member's gender	U = Unknown M = Male F = Female	M

[1] If member IDs are pulled from the hospital EHR or chart, at least one member ID must match the IDs shared in the attribution roster to pass the State data validation check. Records submitted with IDs that do not match may be discarded from measure calculation or may result in non-payment if the submission is deemed non-compliant with measure specifications.

M_PROV	Medicaid Billing Provider NPI	Complete with the billing provider NPI for your facility. These values must be from the DOH approved list of hospital IDs. Note: in future versions of the SRT this will be appropriately listed as an "entity tracking data element".	1043457772
M_SAMP	Member part of sample population	0 = No 1 = Yes	1
M_ELEMT	Data element component	N = Numerator D = Denominator E = Exclusion X = Exception	N
SVC_DT	Service Date[2]	Indicate the date the service was rendered. Please use the "short date" format of MM/DD/YYYY.	11/20/2020

Measure-specific fields

Clinical & diagnostic data elements

Variable	Description	Submission Guidelines	Example
RES_VAL	Result value indicator; matches the code type reported under CODE_VAL	Select the indicator that matches the type of code that is reported in CODE_VAL. C=CPT, D=Discharge Status H=HCPCS I=ICD10CM, J= ICD10PCS, L=LOINC, N= NDC, P(NJ)=POS, R = RXNORM, S=SNOMED, T=(UB)TOB, U=UBREV, Z=OTHER Only ONE value should be reported per row per individual.	H
CODE_VAL	The clinical information from the patient record. This data may be a diagnosis code, billing code, or other clinical information as required by the measure specification.	Code values should match those available in the VSC for that specific measure, unless otherwise noted in guidance. Must be consistent with RES_VAL.	H0019
RES_VALP	Additional component to the code value as required by the measure	If there are additional components to RES_VAL, such as a procedure modifier to accompany a CPT code, enter the modifier here.	PA

[2] Admission date, discharge date, other measure specific date and time elements may also be required. For inpatient measures, unless otherwise stated, the admission date = service date.

Staff data elements for training measures BH12 and M010

Variable	Description	Submission Guidelines	Example
S_LNAME	Staff Last Name	Complete with staff last name	Doe
S_FNAME	Staff First Name	Complete with staff first name	John
S_MI	Staff Middle Initial	Complete with staff middle initial, if available.	K
S_EMPID	Staff Employee ID or unique identifier	Complete with employee ID or unique identifier, no more than 30 characters	12345678

Performance Measures Sample Individual Profiles

The purpose of this section is to provide several illustrative scenarios per performance measure that hospitals may use as guidance for extracting and submitting non-claims-based performance measure data. The examples provided correspond to the individual performance measure-specific prerecorded webinars published to the QIP-NJ Documents & Resources webpage. Although hospitals may approximate their percentage or rate per performance measure with reasonable certainty using the methodology and submission tools, all data will be internally validated thoroughly before final scores are determined. The State reserves the right to request additional data and perform primary source verification as needed.

Examples shown are meant to mimic real-life individuals and encounters; however, they are not based on any living or deceased individuals. Additionally, no examples are shown that are based on hospitals that have "homegrown" codes.

Three scenarios accompany the non-claims-based performance measures, and two scenarios accompany the instrument-based measures (there are no accompanying prerecorded webinars for these latter measures). Although only two or three individuals are shown for demonstration, the expectation is that the hospital will have at least 30 individuals in the denominator unless there are extenuating circumstances (to be detailed in the "Sampling Instructions").

BEHAVIORAL HEALTH

BH07: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (PDS)

General Submission Guidelines

- To be considered denominator compliant, individuals will have 1 row reported for the encounter, including either RES_VAL = C and a relevant CPT code in CODE_VAL for the encounter, or RES_VAL = U and a relevant UBREV code in CODE_VAL for the encounter (VSC table BH07_00). For the SVC_DT field report the date of the encounter.
- Numerator compliant individuals will have at least 1 row reported for each screening event[3], in addition to 1 row indicating denominator compliance for the individual, with the following data elements:
  - RES_VAL = H;
  - CODE_VAL = G8431 or G8510; and
  - The below fields completed[4]:

Variable	Description	Submission Guidelines	Acceptable Values
SVC_DT	Service Date	The date that the screening was administered. Please use the “short date” format of MM/DD/YYYY. Example: “09/01/2020”	MM/DD/YYYY
DEPS_T1[5]	Depression screening tool name (BH07)	Enter the two-digit identifier for the screening tool used. If no tool was used, report 00. If the tool used is not in this list, please report ‘10’ = OTHER, and indicate the tool used in the submission comments on the Sampling_Instructions tab. All tools used must be approved by the QIP-NJ team through the formal process. If your hospital is using a tool that is not captured in this list for this population, you must reach out to the QIP-NJ inbox immediately. **Submission Comments** Please include any comments below. If a required measure is omitted from this submission, please explain. BH07: The following tool XXX is used (10=OTHER) for column DEPS_T1	00 = Refused Screening 1A = BDI 1B = BDI-II 02 = CUDOS 03 = DEPS 04 = HAM-D 05 = MDI 06 = PHQ-2 07 = PHQ-9 08 = T Score 09 = Zung

[3] If more than one screening event is documented for an individual, numerator compliance will be determined by the result most advantageous to the hospital’s performance.

[4] All fields must be completed, even if the screen is negative; may include all screening elements in one row (see scenarios for detail).

[5] Where a tool requires a LOINC to be reported, a separate numerator row is required.

			10 = OTHER 11 = C-SSRS 12 = PSS-3 13 = NIMH-Suicide Risk Screening Tool 14 = EPDS 15 = PHQ-4
DEPS_O1	Result of Screening (BH07)	Enter the two-digit identifier for the outcome of the screening event.	00 = No result recorded 01 = Positive result 02 = Negative result 03 = Indeterminate
DEPS_S1	Screening Score (BH07)	Enter the patient's two-digit score on the screening tool applied. This will be validated against the tool name (DEPS_T1) and result of screening (DEPS_O1) reported for the screening event. If the screening tool has no numeric score refer to the appendix for guidance on how the score should be documented for that specific tool.	Score based upon tool used—must be an approved tool. Report as 2-digit (use leading zero if <10)
DEPS_I1	Follow Up Plan (BH07)	Enter the two-digit identifier for the follow up plan as documented in the patient chart. If no follow up was documented, the patient had a negative or low-risk screen, report 00.	00 = Refused Further Intervention / No Follow-Up Required / No Follow-Up Documented 01 = Additional evaluation for depression **DELETED: "02 = Suicide Risk Assessment"** 03 = Referral to practitioner who is qualified to diagnose and treat depression 04 = Pharmacological interventions 05 = Other interventions or follow-up for the diagnosis or treatment of depression

- Exclusions are reported as a single row.
  - For individuals with an excluded existing diagnosis with a RES_VAL = I and a CODE_VAL of an ICD-10-CM code from VSC table BH07_02a and a RES_VAL = H and a CODE_VAL = G9717.
  - For individuals in hospice, report a RES_VAL (C, H, U, S) and a corresponding CODE_VAL from VSC table BH07_02b.
  - For individuals receiving AMHR services, report a CODE_VAL = H from VSC table BH07_02c and a corresponding RES_VAL (and RES_VALP, if applicable).
- Exceptions will have 2 rows reported, with the following fields completed:
  - All demographic fields as required for all measures;
  - Clinical or diagnostic data elements;
  - Will include one row with RES_VAL = H, CODE_VAL = G8433 AND one row with a valid ICD-10-CM, ICD-10-PCS, or billing code to document why the screening was not administered.

BH07: Sample Individual #1: Profile

An individual that has a prior depression diagnosis noted within the last calendar year; therefore, is an **exclusion** from the measure denominator. *Due to the amended guidelines around exclusions, only the row presenting the exclusion (E) is shown in the accompanying screenshot.*

- Gender: Female
- DOB: 5/14/1998 (Age: 22)
- Encounter Date: October 15, 2020 > column "SVC_DT"
- Revenue Code: 456 > column "RES_VAL" > "U". "CODE_VAL" > "456" (D)
- HCPCS Code: G8510 (N)
- ICD-10 Code: F3011 > column "M_ELEMT" > "E" (E)
- LOINC Code: 89211-7 (N)
- Screening Tool Used: Beck Depression Inventory Fast Screen (N) > column "DEPS_T1" > "01"
    - Score: 10 – negative, no follow up

Figure BH7.1 (Note: certain columns from the "EMR_IN" template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	RES_VAL	CODE_VAL
BH07	0	4136900	5/14/1998	F	0	E	10/15/2020	I	F3011

BH07: Sample Individual #2: Profile

An individual that had a positive screening and a required follow-up documented; therefore, is counted as **numerator compliant** towards the measure

- Gender: Male
- DOB: 1/3/1977 (Age: 43)
- Encounter Date: 9/25/2020
- Screening Date: 9/25/2020
- Revenue Code: 918 (psychiatric / psychological services) (D)
- HCPCS Code: G8431 (N)
- Screening Tool Used: Major Depression Inventory [MDI] (N)
    - Score: 26 – positive, follow-up scheduled with a practitioner (N)

Figure BH7.2 (Note: certain columns from the "EMR_IN" template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	RES_VAL	CODE_VAL	DEPS_T1	DEPS_O1	DEPS_S1	DEPS_I1
BH07	0	4136900	1/3/1977	M	0	D	9/25/2020	U	918				
BH07	0	4136900	1/3/1977	M	0	N	9/25/2020	H	G8431	05	03	26	03

BH07: Sample Individual #3: Profile

An individual that due to emergency circumstances (required CPR), did not have a screening tool administered; however, the reason for the tool not being used was documented. Therefore, is counted as an **exception**[6]

- Gender: Male
- DOB: 11/2/1959 (Age: 61)
- Encounter Date: October 15, 2020
- HCPCS Code: G8433 (X)
- CPT Code: 92950 (CPR administered) (X)
- Screening Tool Used: N/A

Figure 7.3 (Note: certain columns from the "EMR_IN" template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	RES_VAL	CODE_VAL
BH07	0	4136900	11/2/1959	M	0	X	10/15/2020	H	G8433
BH07	0	4136900	11/2/1959	M	0	X	10/15/2020	C	92950

[6] Denominator exceptions are conditions that remove a patient from the denominator only if the numerator criteria are not met (depression screening not completed, reason documented, e.g., medical reason for not performing a screening). Patients meeting the denominator exception criteria should still be reported. They allow for the adjustment of the final calculated score for hospitals exhibiting higher risk populations and are only used in proportional eMeasures. Clinical codes representing what constitute an exception will be evaluated following review of Baseline data and will be made available for MY2.

BH08: Substance Use Screening and Intervention Composite

General Submission Guidelines

- A denominator compliant individual will have 1 row reported, with an eligible outpatient or ED encounter including either RES_VAL = C and a relevant CPT code in CODE_VAL for the encounter, or RES_VAL = U and a relevant UBREV code in CODE_VAL for the encounter from VSC table BH08_00.
- Hospitals should submit as much relevant data as possible, however, to reduce administrative burden, hospitals can choose to report only the ED visit that resulted in the administration of the tool for the 3 components when there are multiple ED visits logged.
- For an individual to be numerator compliant, in addition to a correctly reported denominator row, there must be sufficient rows to identify the screenings were conducted with individual tools for each domain or an inclusive tool covering tobacco, alcohol, and drug use screenings, and that any required follow up is reported.
    - RES_VAL = H or L and CODE_VAL = a valid HCPCS, or LOINC code from BH08_00. All numerator submissions will have a HCPCS code, LOINC codes must be provided in a separate row if appropriate for the tool used. If your hospital has received approval to use another tool that does not have a LOINC code, you may use LOINC code 88888-8.
    - Screenings and interventions (from VSC tab BH08_00) are reported in the following fields:

Variable	Description	Submission Guidelines	Acceptable Values
SVC_DT	Service Date	The date that the screening was administered. Please use the "short date" format of MM/DD/YYYY. Example: "09/01/2020"	MM/DD/YYYY
TOBA_T[7]	Tobacco screening tool (BH08)	Enter the two-digit identifier for the screening tool used. If no tool was used, or an inclusive tool was used, leave blank.	00 = Refused Screening 01 = Fagerstrom Test for Nicotine Dependence (FND) 02 = OTHER
TOBA_S	Tobacco total test score (BH08)	Enter the patient's two-digit score on the screening tool applied. This will be validated against the tool name (TOBA_T). If the screening tool has no numeric score refer to the appendix for guidance on how the score should be documented for that specific tool.	Report as 2-digit (use leading zero if <10)
TOBA_I	Tobacco intervention (BH08)	If the individual received an intervention for a positive tobacco screen indicate it in this field. If 'other' is reported in this field, a submission comment must be entered on the Sampling_Instructions tab. This will also be verified against the CODE_VAL reported in this row as an appropriate	00 = Refused Further Intervention, No Contact 01 = Screening, brief intervention, and referral to treatment (SBIRT) 02 = Other

[7] If more than one screening event is documented for an individual, numerator compliance will be determined by the result most advantageous to the hospital's performance.

		intervention. If no intervention is required as in the case of a negative screening, report 00. Submission Comments Please include any comments below. If a required measure is omitted from this submission, please explain. BH08: For TOBA_I, 02 = Other applies to XXX	
ALCS_T[8]	Alcohol screening tool (BH08)	Enter the two-digit identifier for the screening tool used. If no tool was used, or an inclusive tool was used, leave blank.	00 = Refused Screening 01 = CAGE Questionnaire for Detecting Alcoholism 2A = The Alcohol Use Disorders Identification Test-Concise (AUDIT-C) 2B = The Alcohol Use Disorders Identification Test (AUDIT) 03 = OTHER
ALCS_S	Alcohol total test score (BH08)	Enter the patient's two-digit score on the screening tool applied. This will be validated against the tool name (ALCS_T). If the screening tool has no numeric score refer to the appendix for guidance on how the score should be documented for that specific tool.	Report as 2-digit (use leading zero if <10)
ALCS_I	Alcohol intervention (BH08)	If the individual received an intervention for a positive alcohol screen indicate it in this field. If 'other' is reported in this field, a submission comment must be entered on the Sampling_instructions tab. This will also be verified against the CODE_VAL reported in this row as an appropriate intervention. If no intervention is required as in the case of a negative screening, report '00'. Submission Comments Please include any comments below. If a required measure is omitted from this submission, please explain. BH08: For ALC_I, 02 = Other applies to XXX	00 = Refused Further Intervention, No Contact 01 = Screening, brief intervention, and referral to treatment (SBIRT) 02 = Other
DRUG_T[9]	Illicit drug screening tool (BH08)	Enter the two-digit identifier for the screening tool used. If no tool was used, or an inclusive tool was used, leave blank.	00 = Refused Further Intervention 01 = CAGE-AID Substance Abuse Screening Tool 02 = DAST-10 Prescription and Illicit Drug Use Screening 03 = OTHER
DRUG_S	Illicit drug total test score (BH08)	Enter the patient's two-digit score on the screening tool applied. This will be validated against the tool name (DRUG_T). If the screening tool has no	Report as 2-digit (use leading zero if <10)

[8] If more than one screening event is documented for an individual, numerator compliance will be determined by the result most advantageous to the hospital's performance.
[9] If more than one screening event is documented for an individual, numerator compliance will be determined by the result most advantageous to the hospital's performance.

		numeric score refer to the appendix for guidance on how the score should be documented for that specific tool.	
DRUG_I	Illicit drug intervention (BH08)	If the individual received an intervention for a positive drug screen indicate it in this field. If 'other' is reported in this field, a submission comment must be entered on the Sampling_Instructions tab. This will also be verified against the CODE_VAL reported in this row as an appropriate intervention. If no intervention is required as in the case of a negative screening, report '00'. Submission Comments Please include any comments below. If a required measure is omitted from this submission, please explain BH08: For DRUG_I, 02 = Other applies to XXX	00 = Refused Further Intervention, No Contact 01 = Screening, brief intervention, and referral to treatment (SBIRT) 02 = Other
INCL_T[10]	Inclusive screening tool (BH08)	Enter the two-digit identifier for the screening tool used. If no tool was used, or an inclusive tool was used, leave blank.	00 = Refused Further Intervention 01 = NIDA Quick Screen 02 = NIDA Drug Use Screening Tool (NMASSIST) 03 = Other 04 = TAPS-1
INCL_S	Inclusive total test score (BH08)	Enter the patients two-digit score on the screening tool applied. This will be validated against the tool name (INCL_T). If the screening tool has no numeric score refer to the appendix for guidance on how the score should be documented for that specific tool.	Report as 2-digit (use leading zero if <10)
INCL_I	Inclusive intervention (BH08)	If the individual received an intervention for a positive inclusive screen indicate it in this field. If 'other' is reported in this field, a submission comment must be entered on the Sampling_Instructions tab. This will also be verified against the CODE_VAL reported in this row as an appropriate intervention. If no intervention is required as in the case of a negative screening, report '00'. Submission Comments Please include any comments below. If a required measure is omitted from this submission, please explain. BH08: For INCL_I, 02 = Other applies to XXX	00 = Refused Further Intervention, No Contact 01 = Screening, brief intervention, and referral to treatment (SBIRT) 02 = Other

- For individuals determined to be exclusions, report CODE_VAL = an appropriate UBREV, CPT, SNOMED, or HCPCS code from VSC table BH08_01, or if the individual is an exclusion due to their chronic pain management condition, CODE_VAL = diagnosis leading to the condition, and RES_VALP = OPIOID.

[10] If more than one screening event is documented for an individual, numerator compliance will be determined by the result most advantageous to the hospital's performance.

BH08: Sample Individual #1: Profile

An individual that did not meet the measure criteria (has metastatic breast cancer and is taking opioids for pain management); therefore, is an **exclusion** from the mTAPSeasure denominator. *Due to the amended guidelines around exclusions, only the row presenting the exclusion (E) is shown in the accompanying screenshot.*

- Gender: Female
- DOB: 8/16/1991 (Age: 29)
- Encounter Date: September 1, 2020
- ICD-10-CM Code: C50 (metastatic breast cancer) > column "M_ELEMT" > "E" (E)
- Screening Tool Used: N/A > column "CODE_VAL" > "OPIOID"

Figure BH8.1 (Note: certain columns from the "EMR_IN" template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	RES_VAL	CODE_VAL	RES_VALP
BH8	0	4136900	8/16/1991	F	0	E	9/1/2020	I	C50	OPIOID

BH08: Sample Individual #2: Profile

An individual that attends weekly outpatient group therapy; had two inclusive screening tests administered (the second test was the result of a positive screening on the first test) during latest therapy session, including:

1. NIDA Quick Screen (screened positive, therefore, the NMASSIST was administered)
2. NIDA Drug Use Screening Tool (NMASSIST)

He had appropriate follow up interventions where the score was positive. Therefore, is counted as **numerator compliant** towards the measure.

- Gender: Male
- DOB: 5/20/1965 (Age: 55)
- Encounter Date: 10/9/2020
- Screening Date: 10/9/2020
- Revenue Code: 915 (D)
- Screening Tools Used:

- NIDA Quick Screen (N)
  - HCPCS Code: H0049 (Alcohol and/or drug screening (Medicaid))
  - Score: 4 – positive, SBIRT > column “INCL_T” > “01”, column “INCL_S” > “04”, column “INCL_I” > “01”
- NMASSIST (N)
  - HCPCS Code: H0049 (Alcohol and/or drug screening (Medicaid))
  - Score: 27– positive, SBIRT > column “INCL_T” > “02”, column “INCL_S” > “27”, column “INCL_I” > “01”

Figure BH 8.2 (Note: certain columns from the “EMR_IN” templates are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	RES_VAL	CODE_VAL	INCL_T	INCL_S	INCL_I
BH08	0	4136900	5/20/1965	M	0	D	10/9/2020	U	915			
BH08	0	4136900	5/20/1965	M	0	N	10/9/2020	H	H0049	01	04	01
BH08	0	4136900	5/20/1965	M	0	N	10/9/2020	H	H0049	02	27	01

BH08: Sample Individual #3: Profile

An individual that had psychotherapy; had an annual screening test:

- NIDA Quick Screen

The score was positive; however, no intervention was indicated nor was there the administration of recommended tool, NMASSIST. Therefore, is counted as **numerator non-compliant** towards the measure

- Gender: Male
- DOB: 12/20/1996 (Age: 23)
- Encounter Date: 7/3/2020
- Screening Date: 7/3/2020
- Revenue Code: 914 (psychotherapy) (D)
- Screening Tool Used:
  - NIDA-QS (N)
    - HCPCS Code: G0442 (Annual alcohol misuse screening)

    Score: 2 – positive, no SBIRT documented > column “INCL_T” > “01”, column “INCL_S” > “02”, column “INCL_I” > “00”

Figure BH8.3 (Note: certain columns from the “EMR_IN” template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M-ELEMT	SVC_DT	RES_VAL	CODE_VAL	INCL_T	INCL_S	INCL_I	EOF_ID
BH8	0	4136900	12/20/1996	M	0	D	7/3/2020	U	914				

BH8	0	4136900	12/20/1996	M	0	N	7/3/2020	H	G0442	01	02	00	999999

BH08: Sample Individual #4: Profile

An individual had a visit for psychotherapy; and received screenings in all three domains:

- Fagerstrom test for Nicotine Dependence (FND)
- The Alcohol Use Disorders Identification Test – Concise (AUDIT-C)
- DAST-10 Prescription and Illicit Drug Use Screening

Where the score was positive and was screened in all 3 domains (tobacco, alcohol, and drug), he received appropriate follow up interventions. Therefore, he is counted as **numerator compliant** towards the measure.[11]

- Gender: Male
- DOB: 11/12/1995 (Age: 24)
- Encounter Date: 10/1/2020
- Screening Date: 10/1/2020
- Revenue Code: 914 (D)
- Screening Tools Used:
    - Fagerstrom test for Nicotine Dependence (N)
        - LOINC Code: 11366-2 (History of tobacco use narrative)
        - Score: 4 – negative, no intervention > column "TOBA_T" > "01", column "TOBA_S" > "04", column "TOBA_I" > "00"
    - AUDIT-C (N)
        - LOINC Code: 75626-2
        - Score: 2– negative, no intervention > column "ALCS_T" > "2A", column "ALCS_S" > "02", column "ALCS_I" > "00"
    - DAST-10 (N)
        - LOINC Code: 82667-7
        - Score: 7– positive, SBIRT > column "DRUG_T" > "02", column "DRUG_S" > "07", column "DRUG_I" > "01"

Figure BH 8.4 (Note: certain columns from the "EMR_IN" template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	RES_VAL	CODE_VAL	TOBA_T	TOBA_S	TOBA_I	ALCS_T	ALCS_S	ALCS_I	DRUG_T	DRUG_S	DRUG_I

[11] Note that if the only numerator row reported is the one with the intervention, this individual will be numerator *non-compliant*, because there is no evidence he was screened in all 3 domains.

BH08	0	11/12/1995	M	0	D	10/1/2020	U	914									
BH08	0	11/12/1995	M	0	N	10/1/2020	L	11366-2	01	04	00						
BH08	0	11/12/1995	M	0	N	10/1/2020	L	75626-2				2A	02	00			
BH08	0	11/12/1995	M	0	N	10/1/2020	L	82667-7							02	07	01

BH08: Sample Individual #5: Profile

An individual that had psychotherapy; had an annual screening test:

- NIDA Quick Screen

The score was positive; however, despite several attempts to follow-up with the patient, no contact was established. Therefore, is counted as **numerator non-compliant** towards the measure.

- Gender: Male
- DOB: 12/20/1996 (Age: 23)
- Encounter Date: 7/3/2020
- Screening Date: 7/3/2020
- Revenue Code: 914 (psychotherapy) (D)
- Screening Tool Used:
    - NIDA-QS (N)
        - HCPCS Code: G0442 (Annual alcohol misuse screening)
        - Score: 2 – positive, no SBIRT documented > column “INCL_T” > “01”, column “INCL_S” > “02”, column “INCL_I” > “00”

Figure BH8.5 (Note: certain columns from the “EMR_IN” template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	RES_VAL	CODE_VAL	INCL_T	INCL_S	INCL_I	EOF_ID
BH8	0	4136900	12/20/1996	M	0	D	07/03/2020	U	914				
BH8	0	4136900	12/20/1996	M	0	N	07/03/2020	H	G0442	01	02	00	999999

BH09: Timely Transmission of Transition Record (Behavioral Health)

General Submission Guidelines

- Denominator compliant individuals will have 3 rows reported for each transition of care.

    - An individual's diagnosis will be documented as RES_VAL = I, and CODE_VAL equals an appropriate ICD-10-CM code from VSC table BH09_00.
    - Type of Bill for the individual will be reported as RES_VAL = T, and CODE_VAL equals the appropriate type of bill from VSC table BH09M06_01a. Type of bill can be found on a UB-04 claim as field location = 4.
    - Discharge Status for the individual will be reported as RES_VAL = D, and CODE_VAL equals the appropriate discharge status code from VSC table BH09M06_01b. Discharge status can be found on a UB-04 claim as field location = 17.
- Numerator compliant individuals will have one additional row, where RES_VAL = Z, and CODE_VAL = the patient discharge summary transmission date.
    - For records available to the primary care physician or other health care professional designated for follow-up care through a shared EHR, the date of discharge should be listed as the patient discharge summary transmission date. If the professional designated for follow-up care does not have access to a shared EHR, these patients will require an alternative means of record transmission.
- If a hospital chooses to report an exclusion or is required to report due to minimum denominator requirements, the exclusion will have a single row reported, with RES_VAL = D and an appropriate CODE_VAL from VSC table BH09M06_02.
- Where a single patient has multiple transitions of care in the measurement period, the outcome most advantageous to the hospital will be considered for numerator compliance.

BH09: Sample Individual #1: Profile[12]

An individual that had a principal diagnosis of acute stress reaction and was discharged to home/self-care; the discharge summary was transmitted to her PCP within 24 hours. Therefore, she is **numerator compliant** towards the measure.

- Gender: Female
- DOB: 5/5/1974 (Age: 46)
- Admit Date: July 25, 2020
- Encounter Date: July 25, 2020 > column "ADMT_DT"
- Discharge Date: July 31, 2020 (N) > column "DICH_DT"
- Patient Discharge Summary Transmission Date: July 31, 2020 (N)
- ICD-10-CM Codes:

[12] See M006 for additional profiles within the maternal health attributed population; only two examples are shown for the behavioral health attributed population.

    - F430 (acute stress reaction) (D)
- Bill Type: 0121 (D)
- Discharge Status Code: 01 (D)

Figure BH9.1 (Note: certain columns from the “EMR_IN” template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	ADMT_DT	DICH_DT	RES_VAL	CODE_VAL
BH09	0	4136900	5/1/1974	F	0	D	7/25/2020	7/25/2020	7/31/2021	I	F430
BH09	0	4136900	5/1/1974	F	0	D	7/25/2020	7/25/2020	7/31/2021	T	0121
BH09	0	4136900	5/1/1974	F	0	D	7/25/2020	7/25/2020	7/31/2021	D	01
BH09	0	4136900	5/1/1974	F	0	N	7/25/2020	7/25/2020	7/31/2021	Z	7/31/2021

BH09: Sample Individual #2: Profile

An individual who expired, left against medical advice, or discontinued care is an **exclusion** from the measure denominator. *Due to the amended guidelines around exclusions, only the row presenting the exclusion (E) is shown in the accompanying screenshot.*

- Gender: Female
- DOB: 5/14/1998 (Age: 22)
- Encounter Date: October 15, 2020 > column “SVC_DT”
- Discharge Status Code: 07 (E)

Figure BH9.2 (Note: certain columns from the “EMR_IN” template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	ADT_DT	DICH_DT	RES_VAL	CODE_VAL
BH09	0	4136900	5/14/1998	F	0	E	10/15/2020	10/15/2020	10/17/2020	D	07

Note: no denominator row should be submitted for individuals submitted as exclusions.

BH10: 3-Item Care Transitions Measure (CTM-3)

- General Submission Guidelines: Denominator compliant individuals must have been admitted and discharged to inpatient status within the measurement year and must have also received the survey using CTM-3 or other approved tool.
- Numerator and denominator compliant individuals will have 1 row reported (M_ELEMT = N) for each survey event, with the following fields completed:

- RES_VAL = Z
- CODE_VAL = "ECHO"[13] or "HCAHPS" or "CTM3". If another survey instrument is used, please identify here using up to 10 characters, and provide more detail on the sampling instructions tab of the SRT under "submission comments".
- And the below fields completed:

Variable	Description	Submission Guidelines	Acceptable Values
SVC_DT	Service Date	Report the date of discharge. Please use the "short date" format of MM/DD/YYYY. Example: "09/01/2020"	MM/DD/YYYY
ADMT_DT	Inpatient Admit Date	The date that the individual was admitted to the hospital. Please use the "short date" format of MM/DD/YYYY. Example: "09/01/2020"	MM/DD/YYYY
DICH_DT	Inpatient Discharge Date	The date that the individual was discharged from the hospital. Please use the "short date" format of MM/DD/YYYY. Example: "09/01/2020"	MM/DD/YYYY
DMODE	Survey Administration Method (BH10 and M008)	Enter the two-digit identifier for the screening tool used. If no tool was used, report 00.	01 = Mail-only 02 = Telephone-only 03 = Mixed mode of mail and Telephone 04 = Electronically/Mixed mode of email, text, and phone call
CTMS_I	Standalone or combined with other test	If these questions are asked as part of a stand-alone 3 question survey, report "1". If questions are asked as part of a survey containing other questions (including ECHO and HCAHPS), report "2".	1 = Stand-Alone 2 = Combined
CTMS_E	CTMS Test exclusions	There are several exclusions for this measure. If the patient meets any of these exclusions, report them under CTMS_E. If an exclusion is reported in this column, the CTMS_S column should be left blank and no score should be reported.	01 = Patients under age 18, 02 = Patients who died in the hospital, 03 = Patients who did not stay at least one night in the hospital 04 = Patients over age 64
CTMS_S	Total score of CTMS test (SUM of CTMS 1-3)	**CTM-3 and HCAHPS:** The numeric score of the 3 questions combined, where for each question Q1 and Q2: "Strongly Disagree" = (1)	Numeric score: See Appendix B for scoring range Between 2 and 9 for ECHO

[13] ECHO may only be used for behavioral health population not the maternal health population.

		“Disagree” = (2) “Agree” = (3) “Strongly Agree” = (4) “Don’t Know” options will be scored as zero (0) Q3: Strongly Disagree = (1) Disagree = (2) Agree = (3) Strongly Agree = (4) I was not given any medication when I left the hospital = (5) – this response option is available on the HCAHPS CTM-3 Don’t Know/Don’t Remember/Not Applicable = (0) - this option is only available on the Standalone CTM-3 **ECHO:** The sum of the three questions where for questions 12 and 18: Never = 1 Sometimes = 2 Usually = 3 Always = 4 And for question 22: Yes = 1 No = 0	

- Denominator entries do not need to be reported for this measure, as the denominator is the sum of individuals with a valid CTMS score (CTMS_S) for this measure.
- Exclusions do not need to be reported, however if the hospital chooses to report, or is required to report due to minimum denominator requirements, the exclusion will have a single row reported, with fields RES_VAL, CODE_VAL, DMODE, CTMS_I, and CTMS_E completed. CTMS_S will be left blank.
- Hospitals should make an effort to ensure that the same individual is not surveyed more than once during a measurement period. If more than one survey is reported for a single individual for a MY, only the most recent survey will be counted towards numerator compliance/the score for this measure.

BH10: Sample Individual #1: Profile

The overall hospital score will be derived by summing the “CTMS_S” column per survey type used (CTM-3, HCAHPS or ECHO) and dividing that sum by the number of individuals who received the survey.

An individual that had a completed survey documented is counted as **numerator compliant** towards the measure.

- Gender: Female
- DOB: 5/14/1998 (Age: 22)
- Discharge Date: 10/17/2020
- Screening Tool Used: ECHO (N) > column “RES_VAL” > “Z”, column “CODE_VAL” = “ECHO”, column “D_MODE” > “04” (Electronic), “CTMS_I” > “2” (Combined)
    - Score: 16 > column “CTMS_S” = “16”

Figure BH10.1 (Note: certain columns from the “EMR_IN” template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	ADMT_DT	DICH_DT	RES_VAL	CODE_VAL	DMODE	CTMS_I	CTMS_E	CTMS_S
BH10	0	4136900	5/14/1998	F	1	N	10/17/2020	10/15/2020	10/17/2020	Z	ECHO	04	2		16

BH10: Sample Individual #2: Profile

An individual that did not meet the measure criteria (did not stay at least one night in the hospital); therefore, is an **exclusion** from the measure denominator. *Due to the amended guidelines around exclusions, only the row presenting the exclusion (E) is shown in the accompanying screenshot.*

- Gender: Male
- DOB: 1/3/1978 (Age: 42)
- Discharge Date: 9/2/2020
- Screening Tool Used: HCAHPS (E) > column “RES_VAL” > “Z”, column “CODE_VAL” = “HCAHPS”, column “D_MODE” > “01” (Mail-only), “CTMS_I” > “2” (Combined)
    - Score: N/A > column “CTMS_E” = “03” (Patients who did not stay at least one night in the hospital)

Figure BH10.2 (Note: certain columns from the “EMR_IN” template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	ADMT_DT	DICH_DT	RES_VAL	CODE_VAL	DMODE	CTMS_I	CTMS_E	CTMS_S

BH10	0	4136900	1/3/1978	M	1	E	9/2/2020	9/1/2020	9/2/2020	Z	HCAHPS	01	2	03	

BH11: Use of a Standardized Screening Tool for SDOH

General Submission Guidelines

- Denominator compliant individuals will have 1 row reported to indicate patients sampled. For hospitals not sampling on this measure, the denominator will be all patients included in the attribution roster.
- Numerator compliant individuals will have 1 row reported for each screening event.
  - RES_VAL = Z
  - CODE_VAL = SDOH
  - And the following rows completed:

Variable	Description	Submission Guidelines	Acceptable Values
SVC_DT	Service Date	The date that the screening tool was administered. Please use the "short date" format of MM/DD/YYYY. Example: "09/01/2020"	MM/DD/YYYY
SDOH_T	SDOH Tool Names	Indicate the SDOH screening tool used. If the tool used not the AAFP, PRAPARE or PRA, please report 04 = Other tool, and indicate the tool used in the submission comments on the Sampling_Instructions tab. All tools used must be approved by the QIP-NJ team through the formal process. If your hospital is using a tool that is not captured in this list for this population, you must reach out to the QIP-NJ inbox immediately. **Submission Comments** Please include any comments below. If a required measure is omitted from this submission, please explain. BH11: For SDOH_T, 04 = Tool is XXX	01 = AAFP: SDOH 02 = PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences 03 = PRA* (only allowed for M009 or for obstetric patients) 04 = Other tool (must be pre-approved and identified on the sampling instruction tab under submission comments).
SDOH_E	SDOH Exclusion Reason	Indicate if the patient declined the screening, or the screening was not completed with all required elements populated. Note: This is not an exclusion from the denominator—individuals will be deemed numerator non-compliant.	0 = No Exclusion/Survey Complete 1 = Patient Declined 2 = Screening Incomplete
SDOH_R1	SDOH Response (Domain 1: Housing)	Indicate if the screening identified the patient as at risk in the housing domain.	0 = No Response 1 = At Risk 2 = Not at Risk
SDOH_I1	SDOH Intervention	Indicate the intervention to the patient if they were identified as at risk in SDOH_R1. If a hospital indicates "Other", the intervention must be described on the sampling instruction tab under submission comments.	0= N/A 1= Referral Made 2= No Action Taken 3= Other

		Submission Comments Please include any comments below. If a required measure is omitted from this submission, please explain. BH11: For SDOH_I# "Other" indicates intervention XXX	
SDOH_R2	SDOH Response (Domain 2: Food Security)	Indicate if the screening identified the patient as at risk in the housing security domain.	0 = No Response 1 = At Risk 2 = Not at Risk
SDOH_I2	SDOH Intervention	Indicate the intervention to the patient if they were identified as at risk in SDOH_R2. If a hospital indicates "Other", the intervention must be described on the sampling instruction tab under submission comments.	0= N/A 1= Referral Made 2= No Action Taken 3= Other
SDOH_R3	SDOH Response (Domain 3: Transportation)	Indicate if the screening identified the patient as at risk in the transportation domain.	0 = No Response 1 = At Risk 2 = Not at Risk
SDOH_I3	SDOH Intervention	Indicate the intervention to the patient if they were identified as at risk in SDOH_R3. If a hospital indicates "Other", the intervention must be described on the sampling instruction tab under submission comments.	0= N/A 1= Referral Made 2= No Action Taken 3= Other
SDOH_R4	SDOH Response (Domain 4: Social Supports)	Indicate if the screening identified the patient as at risk in the social supports domain, including "finances", "education", and "employment".	0 = No Response 1 = At Risk 2 = Not at Risk
SDOH_I4	SDOH Intervention	Indicate the intervention to the patient if they were identified as at risk in SDOH_R4. If a hospital indicates "Other", the intervention must be described on the sampling instruction tab under submission comments.	0= N/A 1= Referral Made 2= No Action Taken 3= Other

Note: this measure differs from M009 in that it does not have a "domestic violence" domain. Please ensure that fields SDOH_R5 and SDOH_I5 are completed for maternal health patients.

BH11: Sample Individual #1: Profile

The overall hospital score will be derived by summing the total number of individuals screened divided by the total number of individuals in the attributed population.

An individual that was screened with a required tool; therefore, is counted as **numerator compliant** towards the measure

- Gender: Female

- DOB: 5/14/1998 (Age: 22)
- Encounter Date: 10/15/2020
    - Screening Tool Used: AAFP SDOH (N) > column “RES_VAL” > “Z”, column “CODE_VAL” = “SDOH”, column “SDOH_T” = “01”
    - Scores:
        - Housing - unstable, several problems with home = 5, referral made; column “SDOH_R1” = “1”, column “SDOH_I1” = “1”
        - Food - insecure = 3, referral made; column “SDOH_R2” = “1”, column “SDOH_I2” = “1”
        - Transportation - cannot get to appointments = 3; referral made; column “SDOH_R3” = “1”, column “SDOH_I3” = “1”
        - Social Supports - reports verbal and physical abuse = 15; referral made; column “SDOH_R4” = “1”, column “SDOH_I4” = “1”

Figure BH11.1 (Note: certain columns from the “EMR_IN” template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	RES_VAL	CODE_VAL	SDOH_T	SDOH_E	SDOH_R1	SDOH_I1	SDOH_R2	SDOH_I2	SDOH_R3	SDOH_I3	SDOH_R4	SDOH_I4
BH11	0	5/14/1998	F	1	N	10/15/2020	Z	SDOH	01	0	1	1	1	1	1	1	1	1
BH11	0	5/14/1998	F	1	D	10/15/2020	Z	SDOH										

BH11: Sample Individual #2: Profile

An individual that was not screened with a required tool; therefore, is **numerator non-compliant.**

- Gender: Male
- DOB: 1/3/1978 (Age: 42)
- Encounter Date: 9/1/2020
    - Screening Tool Used: PRAPARE SDOH (E) > column “RES_VAL” > “Z”, column “CODE_VAL” = “SDOH”, column “SDOH_T” = “02”
    - Patient declined; column “SDOH_E” = “1”

Figure BH 11.2 (Note: certain columns from the “EMR_IN” template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	RES_VAL	CODE_VAL	SDOH_T	SDOH_E
BH11	0	1/3/1978	M	1	N	10/15/2020	Z	SDOH	02	1
BH11	0	1/3/1978	M	1	D	10/15/2020	Z	SDOH		

BH12: Reducing Disparities and Improving Patient Experience Through Targeted Training

General Submission Guidelines

- **PLEASE NOTE:**
  - Hospitals must complete the BH12/M010-specific SRT for reporting.
  - BH12 and M010 are staff training measures – data elements completed for these measures should refer to the staff information, not member/patient information.
- Denominator compliant individuals will have 1 row reported to indicate they are a staff member. All health care professionals who provide BH care and all supportive staff members who interact with BH patients (not just those with licensure) will be included.
  - **For M010:** Denominator compliant individuals will have 1 row reported to indicate they are a staff member. All health care professionals who provide perinatal treatment and care to pregnant persons and all supportive staff members who interact with pregnant persons.
- Numerator compliant individuals will have 1 row reported for each training event.
  - And the following rows completed:

Variable	Description	Submission Guidelines	Acceptable Values
SVC_DT	Training Date was received	The date that the training was received. Please use the “short date” format of MM/DD/YYYY. Example: “09/01/2020”	MM/DD/YYYY
TRAINING_CAT	Training category received	Indicate the category of training that was received	IB = Implicit Bias SDOH = Social Determinants of Health
TRAINING	Specific training that was received	Indicate the specific training that was completed	Free text

BH12: Sample Individual #1: Profile

The overall hospital score will be derived by summing the total number of individuals trained in both categories divided by the total number of hospital staff.

An individual that was trained in both categories; therefore, is counted as **numerator compliant** towards the measure.

- Training Date: 11/12/2022
  - Training categories received: IB (Implicit Bias) and SDOH (Social Determinants of Health)

Figure BH12.1

M_ID	M_YR	HOSP_ID	S_LNAME	S_FNAME	S_MI	S_EMPID	M_ELEMT	SVC_DT	TRAINING_CAT	TRAINING
BH12	2	7777777	Doe	John	A	12345678	D			
BH12	2	7777777	Doe	John	A	12345678	N	11/12/2022	IB	Examples: In-person, “XYZ Implicit Training” by Friendly Training Co.; Virtual, “ABC SDOH Training” by Effective Training Consultants
BH12	2	7777777	Doe	John	A	12345678	N	11/12/2022	SDOH	<Name of training and trainer/training entity>

BH12: Sample Individual #2: Profile

An individual that was not trained in both training categories; therefore, is **numerator non-compliant.**

- Training Date: 11/12/2022
  - Training categories received: IB (Implicit Bias)

Figure BH12.2

M_ID	M_YR	HOSP_ID	S_LNAME	S_FNAME	S_MI	S_EMPID	M_ELEMT	SVC_DT	TRAINING_CAT	TRAINING
BH12	2	7777777	Doe	Jane	A	12345678	D			
BH12	2	7777777	Doe	Jane	A	12345678	N	11/12/2022	IB	Examples: In-person, “XYZ Implicit Training” by Friendly Training Co.;

MATERNAL HEALTH

M002: PC-02 Cesarean Birth

General Submission Guidelines

- Denominator compliant individuals will have at least 2 rows reported. Rows will indicate whether the birth was nulliparous, vertex, term and singleton.
    - Singleton births are reported with RES_VAL= I, CODE_VAL = Z370. A list of codes for non-singleton births, an exclusion to the denominator, can be found in VSC table M02_04.
    - Term births are reported with RES_VAL= I, CODE_VAL = Z3A.xx where xx is the completed weeks of pregnancy (VSC table M2_02). Other codes to identify births that were not term are an exclusion to the denominator and can be found in VSC table M02_04. Only births that are > 37 weeks will be deemed denominator compliant.
    - Vertex position can be reported using either RES_VAL = I and CODE_VAL O80 or O82 from VSC table M02_01 OR using the VERTEX column VERTEX = 1.
    - Nulliparous status of the individual must be reported in at least one denominator row, as NULLIP = 1 for an individual to be deemed denominator compliant.

Variable	Description	Submission Guidelines	Acceptable Values
SVC_DT	Service Date	The date that of the delivery. Please use the “short date” format of MM/DD/YYYY. Example: “09/01/2020”	MM/DD/YYYY
ADMT_DT	Inpatient Admit Date - Only populate when part of an inpatient stay	The date that the individual was admitted to the hospital. Please use the “short date” format of MM/DD/YYYY. Example: “09/01/2020”	MM/DD/YYYY
DICH_DT	Inpatient Discharge Date - Only populate when part of an inpatient stay	The date that the individual was discharged from the hospital. Please use the “short date” format of MM/DD/YYYY. Example: “09/01/2020”	MM/DD/YYYY

NULLIP	Cesarean Birth details (M02)	Indicate using one of the three choices if the mother was nulliparous (this was her first live birth). Only individuals where this field = 1 will be included in the denominator.	0 = Unknown[14] 1 = Yes 2 = No
VERTEX	Cesarean Birth details: is baby in vertex position? (M02)	Indicate using one of the three choices if the baby was in the vertex position at the time of delivery. Only individuals where this field = 1 will be included in the denominator.	0 = Unknown[15] 1 = Yes 2 = No

- Numerator compliant individuals will have one row reported to indicate that the delivery was via cesarean.
  - RES_VAL = J
  - CODE_VAL = an appropriate ICD-10-CM code from VSC table M02_03.

M002: Sample Individual #1: Profile

An individual that had all numerator and denominator birth data elements satisfied; therefore, is counted as **numerator compliant** towards the measure.

- Gender: Female
- DOB: 2/3/1989 (Age: 31)
- Admit Date: September 16, 2020
- Encounter Date: September 16, 2020
- Discharge Date: September 19, 2020
- ICD-10-CM Codes:
  - Z370 (live singleton newborn) (D)
  - O80 (vertex presentation), (D) > column “VERTEX”
  - Z3A38 (38th week gestation completed) (D)
- ICD-10-PCS Code: 10D00Z3 (C-section) (N)
- Additional information: nulliparous (data element extracted from EHR) (D) > column “NULLIP”

Figure M2.1 (Note: certain columns from the “EMR_IN” template are hidden to showcase the measure-specific data elements)

[14] Births listed as NULLIP = 0 or NULLIP = 2 will be deemed denominator non-compliant.

[15] Births listed as VERTEX = 0 or VERTEX = 2 will be deemed denominator non-compliant.

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	ADMT_DT	DICH_DT	RES_VAL	CODE_VAL	NULLIP	VERTEX
M002	0	4136900	2/3/1989	F	0	N	9/16/2020	9/16/2020	9/19/2020	J	10D00Z2		
M002	0	4136900	2/3/1989	F	0	D	9/16/2020	9/16/2020	9/19/2020	I	Z370	1	1
M002	0	4136900	2/3/1989	F	0	D	9/16/2020	9/16/2020	9/19/2020	I	Z3A38		

M002: Sample Individual #2: Profile

An individual that did not have all numerator and denominator birth data elements satisfied – in this scenario, the C-section procedure is not specified (rather, one indicating "Division of the female perineum, external approach" is); therefore, is counted as **numerator non-compliant** towards the measure

- Gender: Female
- DOB: 4/3/1977 (Age: 43)
- Admit Date: September 24, 2020
- Encounter Date: September 25, 2020
- Discharge Date: September 28, 2020
- ICD-10-CM Codes:
    - Z370 (live singleton newborn) (D)
    - O82 (vertex presentation), (D) > column "VERTEX"
    - Z3A39 (39th week gestation completed) (D)
- ICD-10-PCS Code: 0KQM0ZZ (which denotes "repair perineum muscle", not C-section) (N)
- Additional information: nulliparous (data element extracted from EHR) (D) > column "NULLIP"

Figure M2.2 (Note: certain columns from the "EMR_IN" template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	ADMT_DT	DICH_DT	RES_VAL	CODE_VAL	NULLIP	VERTEX
M002	0	4136900	4/3/1977	F	0	D	9/25/2020	9/24/2020	9/28/2020	I	Z370	1	1
M002	0	4136900	4/3/1977	F	0	D	9/25/2020	9/24/2020	9/28/2020	I	Z3A39		
M002	0	4136900	4/3/1977	F	0	N	9/25/2020	9/24/2020	9/28/2020	J	0KQM0ZZ		

M002: Sample Individual #3: Profile

An individual that did not have all numerator and denominator birth data elements satisfied – in this scenario, indicated is that there was a twin pregnancy; therefore, is an **exclusion** from the measure denominator. *Due to the amended guidelines around exclusions, only the row presenting the exclusion (E) is shown in the accompanying screenshot.*

- Gender: Female
- DOB: 9/3/1979 (Age: 41)
- Encounter Date: October 15, 2020
- ICD-10-CM Code: O30003 (Twin pregnancy, unspecified number of placenta and…number of amniotic sacs, third trimester) (E)
  - missing (vertex presentation), (D) > column “VERTEX”
  - missing (week gestation completed) (D)
- ICD-10-PCS Code: missing (denotes C-section) (N)
- Additional information: nulliparous (data element extracted from EHR) (D) > column “NULLIP”

Figure M2.3 (Note: certain columns from the “EMR_IN” template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	ADMT_DT	DICH_DT	RES_VAL	CODE_VAL	NULLIP	VERTEX
M002	0	9/3/1979	F	0	E	10/15/2020			I	O30003	1	

M003: Maternal Depression Screening (PDS-E)

General Submission Guidelines

- To be considered denominator compliant, individuals will have at least 1 row reported for the encounter, including either RES_VAL = C and a relevant CPT code in CODE_VAL for the encounter, or RES_VAL = J and a relevant ICD-10-PCS code in CODE_VAL, or a RES_VAL=S and a relevant SNOMED code in the CODE_VAL for the encounter (VSC table M03_Deliveries).
- Numerator compliant individuals will have at least 1 row reported for each screening event[16]with the following data elements:
  - RES_VAL = H
  - CODE_VAL = G8431 or G8510 or G8511, 96127, 90791
  - And the below fields completed[17]:

Variable	Description	Submission Guidelines	Acceptable Values
SVC_DT	Service Date	The date that the screening was administered. Please use the “short date” format of MM/DD/YYYY. Example: “09/01/2020”	MM/DD/YYYY

[16] If more than one screening event is documented for an individual, numerator compliance will be determined by the result most advantageous to the hospital’s performance.

[17] All fields must be completed, even if the screen is negative; may include all screening elements in one row (see scenarios for detail).

ADMT_DT	Inpatient Admit Date - Only populate when part of an inpatient stay	The date that the individual was admitted to the hospital. Please use the "short date" format of MM/DD/YYYY. Example: "09/01/2020"	MM/DD/YYYY
DICH_DT	Inpatient Discharge Date - Only populate when part of an inpatient stay	The date that the individual was discharged from the hospital. Please use the "short date" format of MM/DD/YYYY. Example: "09/01/2020"	MM/DD/YYYY
DEPS_T2[18]	Depression screening tool name (M03)	Enter the two-digit identifier for the screening tool used. If no tool was used, report 00. All tools used must be approved by the QIP-NJ team through the formal process. If your hospital is using a tool that is not captured in this list for this population, you must reach out to the QIP-NJ inbox immediately.	00 = Refused Screening 01 = BDI / BDI-II 02 = CUDOS 03 = DEPS 04 = HAM-D 05 = MDI 06 = PHQ-2 07 = PHQ-9 08 = T Score 09 = Zung 10 = OTHER 11 = EPDS 12 = NIMH-Suicide Risk Screening Tool
DEPS_O2	Result of Screening (M03)	Enter the two-digit identifier for the outcome of the screening event. If the screening could not be completed, please report '00'. Note: we will be verifying this result against the score reported in DEPS_S2.	00 = No result recorded 01 = Positive result 02 = Negative result 03 = Indeterminate
DEPS_S2	Screening Score: will be internally validated against finding of DEPS_O2 (M03)	Enter the patients two-digit score on the screening tool applied. This will be validated against the tool name (DEPS_T2) and result of screening (DEPS_O2) reported for the screening event. If the screening tool has no numeric score refer to the appendix for guidance on how the score should be documented for that specific tool.	Report as 2-digit (use leading zero if <10)
DEPS_I2	Follow Up Plan (M03)	Enter the two-digit identifier for the follow up plan as documented in the patient chart. If no follow up was documented, report 00. Although a follow up plan is **not required for numerator** compliance on this measure, QIP-NJ would like you to report the follow up that	00 = Refused Further Intervention / No Follow-Up Required 01 = Additional evaluation for depression 03 = Referral to practitioner who is qualified to diagnose and treat

[18] Where a tool requires a LOINC to be reported, a separate numerator row is required.

		the patient received to better inform future measurement and learning design for this program.	depression 04 = Pharmacological interventions 05 = Other interventions or follow-up for the diagnosis or treatment of depression

M003: Sample Individual #1: Profile

An individual that had a birth admission and prior to discharge had maternal screening for depression is counted as **numerator compliant** towards the measure.

- Gender: Female
- DOB: 8/8/1991 (Age: 29)
- Encounter Date: 9/16/2020
- Screening Date: 9/16/2020
- CPT Code: 59400 (D)
- HCPCS Code: G8431 (N)
- Screening Tool Used: Beck Depression Inventory [BDI] (N)
  - Score: 30 – positive, follow-up scheduled with a practitioner ("DEPS_T2" column must be populated for M003; others are optional)

Figure M3.1 (Note: certain columns from the "EMR_IN" template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	RES_VAL	CODE_VAL	DEPS_T2	DEPS_O2	DEPS_S2	DEPS_I2
M003	0	4136900	8/8/1991	F	0	D	9/16/2020	C	5940				
M003	0	4136900	8/8/1991	F	0	N	9/16/2020	H	G8431				
M003	0	4136900	8/8/1991	F	0	N	9/16/2020	L	89211-7	01	01	30	03

M003: Sample Individual #2: Profile

An individual that had a birth admission and the depression screening was not documented, reason not given; therefore, is counted as **numerator non-compliant** towards the measure

- Gender: Female
- DOB: 9/1/1977 (Age: 43)

- Encounter Date: 9/16/2020
- Screening Date: 9/16/2020
- SNOMED Code: 25296001 (D)
- HCPCS Code: G8432 (N)

Figure M3.2 (Note: certain columns from the “EMR_IN” template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	RES_VAL	CODE_VAL
M003	0	4136900	9/1/1977	F	0	D	9/25/2020	S	25296001
M003	0	4136900	9/1/1977	F	0	N	9/25/2020	H	G8432

M003: Sample Individual #3: Profile

An individual that had a birth admission; however, she was transferred to another facility before a depression screening could be administered; therefore, is an **exclusion** from the measure denominator. *Due to the amended guidelines around exclusions, only the row presenting the exclusion (E) is shown in the accompanying screenshot.*

- Gender: Female
- DOB: 2/14/1979 (Age: 41)
- Encounter Date: 10/15/2020
- Screening Date: N/A
- Discharge Status Code: 64 (E)

Figure M3.3 (Note: certain columns from the “EMR_IN” template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	RES_VAL	CODE_VAL
M003	0	4136900	2/14/1979	F	0	E	10/15/2020	D	64

Note: no denominator row should be submitted for individuals submitted as exclusions.

M006: Timely Transmission of Transition Record (Maternal Health)

General Submission Guidelines

- Denominator compliant individuals will have 3 rows reported for each transition of care.
  - An individual's birth related diagnosis/procedure will be documented as RES_VAL = I, and CODE_VAL equals an appropriate ICD-10-CM/PCS code:
    - See diagnosis codes on VSC table M06_00 and procedure codes on VSC table M03_Deliveries.
  - Type of Bill for the individual will be reported as RES_VAL = T, and CODE_VAL equals the appropriate type of bill from VSC table BH09M06_01a. Type of bill can be found on a UB-04 claim as field location = 4.
  - Discharge Status for the individual will be reported as RES_VAL = D, and CODE_VAL equals the appropriate discharge status code from VSC table BH09M06_01b. Discharge status can be found on a UB-04 claim as field location = 17.
- Numerator compliant individuals will have one additional row, where RES_VAL = Z, and CODE_VAL = the patient discharge summary transmission date.
  - For records available to the primary care physician or other health care professional designated for follow-up care through a shared EHR, the date of discharge should be listed as the patient discharge summary transmission date. If the professional designated for follow-up care does not have access to a shared EHR, these patients will require an alternative means of record transmission.
- If a hospital chooses to report an exclusion or is required to report due to minimum denominator requirements, the exclusion will have a single row reported, with RES_VAL = D and an appropriate CODE_VAL from VSC table BH09M06_02.
- Where a single patient has multiple transitions of care in the measurement period, the outcome most advantageous to the hospital will be considered for numerator compliance.

M006: Sample Individual #1: Profile

An individual that had a birth admission; however, their discharge code (07) indicates they left AMA. Therefore, is an **exclusion** from the measure denominator. *Due to the amended guidelines around exclusions, only the row presenting the exclusion (E) is shown in the accompanying screenshot.*

- Gender: Female
- DOB: 2/1/1987 (Age: 33)
- Admit Date: September 16, 2020
- Discharge Date: September 19, 2020 (N)

- Discharge Status Code: 07 (E)
- Race: White (Caucasian) > column “RACE”
- Ethnicity: Hispanic > column “ETHNIC”

Figure M6.1 (Note: certain columns from the “EMR_IN” template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	ADMT_DT	DICH_DT	RES_VAL	CODE_VAL	RACE	ETHNIC	E OF_ ID
M006	0	4136900	02/01/1987	F	0	E	9/16/2020	9/19/2020	D	07	01	01	999999

Note: no denominator row should be submitted for individuals submitted as exclusions.

M006: Sample Individual #2: Profile

An individual that had a birth admission and was discharged to home/self-care; however, the record was transmitted 3 days (72 hours) after discharge. Therefore, is counted as **numerator non-compliant** towards the measure.

- Gender: Female
- DOB: 3/5/1987 (Age: 33)
- Admit Date: October 16, 2020
- Discharge Date: October 19, 2020 (N)
- Patient Discharge Summary Transmission Date: October 22, 2020 (N)
- ICD-10-CM Codes:
  - Z3800 (birth admission) (D)
- Bill Type: 0111 (D)
- Discharge Status Code: 01 (D)
- Race: Black / African American (D) > column “RACE”
- Ethnicity: non-Hispanic (D) > column “ETHNIC”

Figure M6.2 (Note: certain columns from the “EMR_IN” template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	M_DOB	M_GENDER	M_SAMP	M_ELEMT	ADMT_DT	DICH_DT	RES_VAL	CODE_VAL	RACE	ETHNIC	EOF_ID
M006	0	3/5/1987	F	0	D	10/16/2020	10/19/2020	I	Z3800	02	01	999999
M006	0	3/5/1987	F	0	D	10/16/2020	10/19/2020	T	0111			999999
M006	0	3/5/1987	F	0	D	10/16/2020	10/19/2020	D	01			999999
M006	0	3/5/1987	F	0	N	10/16/2020	10/19/2020	Z	10/22/2020			999999

M006: Sample Individual #3: Profile

An individual that had a birth admission, was discharged to home/self-care, and the record was transmitted to her PCP within 24 hours; therefore, is counted as **numerator compliant** towards the measure.

- Gender: Female
- DOB: 5/5/1974 (Age: 46)
- Admit Date: July 25, 2020
- Discharge Date: July 31, 2020 (N)
- Patient Discharge Summary Transmission Date: July 31, 2020 (N)
- ICD-10-CM Codes:
    - P0500 (birth admission) (D)
- Bill Type: 0121 (D)
- Discharge Status Code: 01 (D)
- Race: Black / African American (D) > column "RACE"
- Ethnicity: Hispanic (D) > column "ETHNIC"

Figure M6.3 (Note: certain columns from the "EMR_IN" template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	ADMT_DT	DICH_DT	RES_VAL	CODE_VAL	RACE	ETHNIC	EOF_ID
M006	0	4136900	5/5/1974	F	0	D	7/25/2020	7/31/2021	I	P0500	02	01	999999
M006	0	4136900	5/5/1974	F	0	D	7/25/2020	7/31/2021	T	0121			999999
M006	0	4136900	5/5/1974	F	0	D	7/25/2020	7/31/2021	D	01			999999
M006	0	4136900	5/5/1974	F	0	N	7/25/2020	7/31/2021	Z	7/31/2021			999999

M007: Treatment of Severe Hypertension (SHTN)

General Submission Guidelines

- To be considered denominator compliant, individuals must have at least 3 rows reported for the encounter, corresponding to at least two individual blood pressure readings, and a diagnosis of hypertension. For an individual to be included in the denominator, the individual must have at least 2 BP readings, but the hospital may report up to 5 consecutive BP readings.
    - For the diagnosis of hypertension, one row should be completed with:
        - RES_VAL = I
        - CODE_VAL = appropriate ICD-10-CM from VSC table M07_01.
    - For each BP reading row the following fields should be completed:

- RES_VAL = Z
- CODE_VAL = leave blank
- And the below fields completed:

Variable	Description	Submission Guidelines	Acceptable Values
SVC_DT	Service Date	The date that the blood pressure readings and/or treatment were administered. Please use the "short date" format of MM/DD/YYYY. Example: "09/01/2020". **Please ensure dates of BP readings and treatments are accurate for any episodes that occur around midnight.**	MM/DD/YYYY
ADMT_DT	Inpatient Admit Date - Only populate when part of an inpatient stay	The date that the individual was admitted to the hospital. Please use the "short date" format of MM/DD/YYYY. Example: "09/01/2020"	MM/DD/YYYY
DICH_DT	Inpatient Discharge Date - Only populate when part of an inpatient stay	The date that the individual was discharged from the hospital. Please use the "short date" format of MM/DD/YYYY. Example: "09/01/2020"	MM/DD/YYYY
BP_TM	Blood pressure time for SHTN (M07)	Time of blood pressure reading.[19] Time entries should be recorded using military time (24h clock) hhmm, with no separators.	Example: 0300
BP_SYST	Blood Pressure Systolic value (M07)	Enter the 3-digit systolic blood pressure reading that corresponds with the time entered in BP_TM and the diastolic blood pressure reading entered in BP_DIAS. If reading is lower than 100, do not add leading zero.	Example: 160
BP_DIAS	Blood Pressure Diastolic value (M07)	Enter the 3-digit diastolic blood pressure reading that corresponds with the time entered in BP_TM and the systolic blood pressure reading entered in BP_SYST. If reading is lower than 100, do not add leading zero.	Example: 110

- Numerator compliant individuals will have 1 row reported, in addition to their denominator rows. The numerator row will include:
  - RES_VAL = N
  - CODE_VAL = Which clinically-appropriate medication was administered (See VSC table M07_00)
    - 01 = Intravenous Labetalol
    - 02 = Intravenous Hydralazine

- [19] BP readings must be more than 15 min apart and less than 60 minutes apart to be denominator compliant.

- 03 = Immediate-release oral Nifedipine[20]
- And the following fields completed:

Variable	Description	Submission Guidelines	Acceptable Values
BG_TM	Beginning of treatment for SHTN (M07)	Time of administration for first line agent or other mode of treatment. Time entries should be recorded using military time (24h clock) hhmm, with no separators. **Please ensure dates of BP readings and treatments are accurate for any episodes that occur around midnight.**	Example: 0300
ED_TM	Ending of treatment for SHTN (M07)	End time of administration for first line agent or other mode of treatment. Where treatment is a single administration of a first line agent, BG_TM and ED_TM may be the same. Time entries should be recorded using military time (24h clock) hhmm, with no separators. **Note: this field is optional.**	Example: 0300
ED_OTHTX	Was other non-first line agent administered (M07)	Second-line interventions such as anesthesia and magnesium sulfate are rarely used and therefore, not recommended, however if one of these interventions is used, please report it in this field, and document which agent was administered using the submission comments box on the Sampling_Instructions tab of the SRT. Second-line interventions in the absence of a first line agent are not numerator compliant.	1 = Y 2 = N

- Exclusions are not required to be reported for this measure, except in cases where the denominator for the measure would otherwise fall below 30, or there is a pattern of exclusions you would like to raise to the attention of the QIP-NJ Team. To report an exclusion, each excluded patient will have one row, where RES_VAL = I, and CODE_VAL = an appropriate ICD-10-CM code from VSC table M07_02.
- The second line agent(s) must be documented in the submission comments on the Sampling_Instructions tab.

M007: Sample Individual #1: Profile

An individual who had gestational edema in the second trimester; therefore, is an **exclusion** from the measure denominator.

- Gender: Female
- DOB: 1/30/1991 (Age: 29)
- Presents in the emergency room on 9/30/2020

[20] The Society for Maternal Fetal Medicine specifically states that extended release nifedipine is not a standard treatment for SHTN episodes.

- First blood pressure reading is 160/110 at 1600 (D)
- Second blood pressure reading is 160/110 at 1645 (D)
- ICD-10-CM Codes:
  - O1222 (E)
- No drug administered

Figure M7.1 (Note: certain columns from the "EMR_IN" template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	BP_TM	BG_TM	ED_TM	RES_VAL	CODE_VAL	BP_SYST	BP_DIAS
M007	0	1/30/1991	F	0	E	9/30/2020				I	O1222		

M007: Sample Individual #2: Profile

An individual that had a diagnosis of severe pre-eclampsia; however, the clinically-appropriate medication was not documented; therefore, is counted as **numerator non-compliant** towards the measure

- Gender: Female
- DOB: 1/3/1998 (Age: 22)
- Presents in the emergency room on 6/1/2020
- First blood pressure reading is 160/110 at 1400 (D)
- Second blood pressure reading is 160/110 at 1430 (D)
- ICD-10-CM Codes:
  - O1413 (D)
- A treatment is administered at 1450 (N) > column "ED_OTHTX" (Nifedipine)
- Third blood pressure reading is 130/80 at 1515 (D)
- As vital signs are clinically improved, no additional drug is administered (N) > column "ED_TM"

Figure M7.2 (Note: certain columns from the "EMR_IN" template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	BP_TM	BG_TM	ED_TM	RES_VAL	CODE_VAL	BP_SYS	BP_DIAS	ED_OTHTX
M007	0	4136900	1/3/1998	F	0	D	6/1/2020	1400			Z		160	110	
M007	0	4136900	1/3/1998	F	0	D	6/1/2020	1430			Z		160	110	
M007	0	4136900	1/3/1998	F	0	D	6/1/2020				I	O1413			
M007	0	4136900	1/3/1998	F	0	N	6/1/2020		1450		N				2
M007	0	4136900	1/3/1998	F	0	D	6/1/2020	1515			Z		130	80	

M007: Sample Individual #3: Profile

An individual that had a diagnosis of severe pre-eclampsia and treatment with the clinically-appropriate medication is documented; therefore, is counted as **numerator compliant** towards the measure

- Gender: Female
- DOB: 2/3/1998 (Age: 22)
- Presents in the emergency room on 7/15/2020
- First blood pressure reading is 170/120 at 0930 (D)
- Second blood pressure reading is 160/120 at 1020 (D)
- ICD-10-CM Codes:
    - O14.13 (D)
- First-line agent is administered at 1000 (N) > columns “CODE_VAL”, “ED_OTHTX”
- Third blood pressure reading is 120/90 at 1145 (D)
- As vital signs are clinically improved, no additional drug is administered (N) > column “ED_TM”

Figure M7.3 (Note: certain columns from the “EMR_IN” template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	HOSP_ID	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	BP_TM	BG_TM	ED_TM	RES_VAL	CODE_VAL	BP_SYS	BP_DIAS	ED_OTHTX
M007	0	4136900	1/3/1998	F	0	D	7/15/2020	0930			Z		170	120	
M007	0	4136900	1/3/1998	F	0	D	7/15/2020	1020			Z		160	120	
M007	0	4136900	1/3/1998	F	0	D	7/15/2020				I	O1413			
M007	0	4136900	1/3/1998	F	0	N	7/15/2020		1000		N	01			01
M007	0	4136900	1/3/1998	F	0	D	7/15/2020	1145			Z		130	80	

Note: the second line agent must be documented in the submission comments on the Sampling_Instructions tab.

M008: See BH10

M009: Use of a Standardized Screening Tool for SDOH

General Submission Guidelines

- Denominator compliant individuals will have 1 row reported to indicate patients sampled. For hospitals not sampling on this measure, the denominator will be all patients included in the attribution roster.

- Numerator compliant individuals will have 1 row reported for each screening event.
  - RES_VAL = Z
  - CODE_VAL = SDOH
  - And the following rows completed:

Variable	Description	Submission Guidelines	Acceptable Values
SVC_DT	Service Date	The date that the screening tool was administered. Please use the "short date" format of MM/DD/YYYY. Example: "09/01/2020"	MM/DD/YYYY
SDOH_T	SDOH Tool Names	Indicate the SDOH screening tool used. If the tool used not the AAFP, PRAPARE or PRA, please report 04 = Other tool, and indicate the tool used in the submission comments on the Sampling_Instructions tab. All tools used must be approved by the QIP-NJ team through the formal process. If your hospital is using a tool that is not captured in this list for this population, you must reach out to the QIP-NJ inbox immediately. Submission Comments Please include any comments below. If a required measure is omitted from this submission, please explain. BH11: For SDOH_T, 04 = Tool is XXX	01 = AAFP: SDOH 02 = PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences 03 = PRA* 04 = Other tool (must be identified on the sampling instruction tab under submission comments).
SDOH_E	SDOH Exclusion Reason	Indicate if the patient declined the screening, or the screening was not completed with all required elements populated. Note: This is not an exclusion from the denominator—individuals will be deemed numerator non-compliant.	0 = No Exclusion/Survey Complete 1 = Patient Declined 2 = Screening Incomplete
SDOH_R1	SDOH Response (Domain 1: Housing)	Indicate if the screening identified the patient as at risk in the housing domain.	0 = No Response 1 = At Risk 2 = Not at Risk
SDOH_I1	SDOH Intervention	Indicate the intervention to the patient if they were identified as at risk in SDOH_R1. If a hospital indicates "Other", the intervention must be described on the sampling instruction tab under submission comments. Submission Comments Please include any comments below. If a required measure is omitted from this submission, please explain. BH11: For SDOH_I# "Other" indicates intervention XXX	0= N/A 1= Referral Made 2= No Action Taken 3= Other
SDOH_R2	SDOH Response (Domain 2: Food Security)	Indicate if the screening identified the patient as at risk in the housing security domain.	0 = No Response 1 = At Risk 2 = Not at Risk
SDOH_I2	SDOH Intervention	Indicate the intervention to the patient if they were identified as at risk in SDOH_R2. If a hospital indicates "Other", the intervention	0= N/A 1= Referral Made 2= No Action Taken

		must be described on the sampling instruction tab under submission comments.	3= Other
SDOH_R3	SDOH Response (Domain 3: Transportation)	Indicate if the screening identified the patient as at risk in the transportation domain.	0 = No Response 1 = At Risk 2 = Not at Risk
SDOH_I3	SDOH Intervention	Indicate the intervention to the patient if they were identified as at risk in SDOH_R3. If a hospital indicates "Other", the intervention must be described on the sampling instruction tab under submission comments.	0= N/A 1= Referral Made 2= No Action Taken 3= Other
SDOH_R4	SDOH Response (Domain 4: Social Supports)	Indicate if the screening identified the patient as at risk in the social supports domain.	0 = No Response 1 = At Risk 2 = Not at Risk
SDOH_I4	SDOH Intervention	Indicate the intervention to the patient if they were identified as at risk in SDOH_R4. If a hospital indicates "Other", the intervention must be described on the sampling instruction tab under submission comments.	0= N/A 1= Referral Made 2= No Action Taken 3= Other
SDOH_R5[21]	SDOH Response (Domain 5: Domestic Violence)	Indicate if the screening identified the patient as at risk in the domestic violence domain.	0 = No Response 1 = At Risk 2 = Not at Risk
SDOH_I5[20]	SDOH Intervention	Indicate the intervention to the patient if they were identified as at risk in SDOH_R5. If a hospital indicates "Other", the intervention must be described on the sampling instruction tab under submission comments.	0= N/A 1= Referral Made 2= No Action Taken 3= Other

M009: Sample Individual #1: Profile

The overall hospital score will be derived by summing the total number of individuals with a completed screening divided by the total number of individuals in the attributed or sampled population.

An individual that was screened with a required tool; therefore, is counted as **numerator compliant** towards the measure.

- Gender: Female
- DOB: 5/14/1998 (Age: 22)
- Encounter Date: 10/15/2020
  - Screening Tool Used: PRA (N) > column "RES_VAL" > "Z", column "CODE_VAL" = "SDOH", column "SDOH_T" = "03"

[21] **Note: this measure differs from BH11 in that it has an additional domestic violence domain. Please ensure that fields SDOH_R5 and SDOH_I5 are completed for maternal health patients.**

- Scores:
  - Housing - unstable, several problems with home, referral made; column “SDOH_R1” = “1”, column “SDOH_I1” = “1”
  - Food - insecure, referral made; column “SDOH_R2” = “1”, column “SDOH_I2” = “1”
  - Transportation - cannot get to appointments; referral made; column “SDOH_R3” = “1”, column “SDOH_I3” = “1”
  - Social Supports - reports lack of childcare; referral made; column “SDOH_R4” = “1”, column “SDOH_I4” = “1”
  - Domestic Violence – No risk reported; column “SDOH_R5” = “2”, column “SDOH_I5” = “0”

Figure M009.1 (Note: certain columns from the “EMR_IN” template are hidden to showcase the measure-specific data elements)

M_ID	M_YR	M_DOB	M_GENDER	M_SAMP	M_ELEMT	SVC_DT	RES_VAL	CODE_VAL	SDOH_T	SDOH_E	SDOH_R1	SDOH_I1	SDOH_R2	SDOH_I2	SDOH_R3	SDOH_I3	SDOH_R4	SDOH_I4	SDOH_R5	SDOH_I5
M009	0	5/14/1998	F	1	N	10/15/2020	Z	SDOH	03	0	1	1	1	1	1	1	1	1	2	0
M009	0	5/14/1998	F	1	D	10/15/2020	Z	SDOH												

M010: See BH12

Appendix A: CHANGE LOG

In addition to consulting the change log below, hospitals should consult the change log in the Databook and Value Set Compendium.

LOG#	Last Update	Issue	Measure(s) Affected
1	8/10/2021	Amended FAQ regarding multiple positive depression screenings	BH07
2	8/10/2021	Amended FAQ regarding acceptable exceptions	BH07
3	8/10/2021	BH7: SI #1 - modified to have only exclusion row displayed in screenshot	BH07
4	8/10/2021	BH8: SI #2 - modified from Fagerstrom and CAGE to NIDA, NMASSIST (inclusive)	BH08
5	8/10/2021	BH9: SI #1 - added example from BH attributed population	BH09
6	8/10/2021	M007: SI#3 - corrected DOB, screenshot for example	M007
7	8/10/2021	Appendix A: added Change Log to record modifications between v1.0 and v1.1	N/A
8	11/30/2021 (v1.2)	Major changes to format and utility of the SRT guidance. Step by step instructions for filling out the SRT were added for each measure, and patient examples were updated for clarity.	ALL
9	11/30/2021	Appendix B: added to provide anticipated scores for approved tools and surveys.	N/A
10	05/11/2023 (v2.2)	BH10: Clarified denominator-compliant individuals. BH12 and M010: added section provide guidance for new measures	BH10 BH12/M010
11	05/25/2023 (v2.3)	• BH08: Clarified use of '00' versus blank values for numerator reporting • BH07/M03: Removed "Suicide Risk Assessment" – i.e. option "02" as numerator-compliant follow-up for Variable DEPS_I1 and DEPS_I2, respectively. Added approved screening tools from QMC 8. See main text and Appendix B. • BH12/M010: Removed staff gender and date of birth data variable, added employeeID data variable	BH08 BH07/M03 BH12/M010 M06 M07

		• M06: Added reference to procedure codes that may be used for denominator inclusion • M07: Updated numerator reporting of First Line Agents	
12	03/08/2024 (v3.1)	• Clarified PHQ-2/PHQ-9 tool scoring	BH07
		• Added PHQ-4 scoring guidance	BH07
		• Removed "Suicide Risk Assessment" – i.e. option "02" as numerator-compliant follow-up for Variable DEPS_I1 and DEPS_I2, respectively.	BH07
		• Clarified use of '00' versus blank values for numerator reporting	BH07
		• Added reporting and follow-up scoring for TAPS-1 tool	BH08
		• Updated scoring for CTMS_S: Question 3	BH10
		• Removed staff gender and date of birth data variable, added employee ID or other unique employee identifier data variable • Clarified exclusion guidance	BH12/M010
		• Removed "Suicide Risk Assessment" – i.e. option "02" as numerator-compliant follow-up for Variable DEPS_I1 and DEPS_I2, respectively. Added approved screening tools from QMC 8. See main text and Appendix B.	M003
		• Edited "Sample Individual #1: Profile": "An individual that had a birth admission and prior to discharge had maternal screening for depression and is therefore, is counted as numerator compliant towards the measure."	M003
		• Added follow-up scoring for EPDS tool	M003
		• Added codes to postpartum numerator-compliant care, see VSC change log	M004
		• Added reference to procedure codes that may be used for denominator inclusion	M006
		• Removed "Encounter Date" and "Svc_Dt" from examples as those data elements are not related to measure adjudication. **No change to reporting requirement.**	M006
		• Simplified numerator reporting of First Line Agents	M007
		• Added date/time note regarding cases that occur around midnight.	M007
		• Updated guidance to align with ACOG guidelines in Databook	M007

13	05/28/2024 (v3.2)	• Added clarification regarding revision to denominator enabling inclusion of community-based hospital employees. • Added clarification about assigned IDs for year-over-year reporting.	BH12 M010

Appendix B: Scoring for Screening Tools

Section	Tool Code[22]	Tool Name	Score Range	Values	Follow-up Needed[23]
DEPS_T1 (BH07)	00	Refused Screening	N/A	*Leave blank*	N/A
	1A	BDI	00-21	**7 Questions** 4 response options per question with increasing severity. Scored 00-03, 03 being most severe	≥04
	1B	BDI-II	00-63	**21 Questions** 4 response options per question with increasing severity. Scored 00-03, 03 being most severe	≥11
	02	CUDOS	00-72	**Questions 1-16** Not at all true = 00 Rarely true = 01 Sometimes true = 02 Often true = 03 Almost always true = 04 **Question 17**	≥11

[22] All scores should be reported in a two-digit format. This means that if the value of the score is less than ten, there should be a leading zero (e.g., “01”). If the score gets into three digits, it is appropriate to report accordingly (e.g., “123”).
[23] If a hospital believes there is a more clinically appropriate threshold for identifying where follow-up is needed, they should indicate it in their Submission Comments on the Sampling_Instructions tab of the SRT, and the QIP-NJ team will take it under review.

Section	Tool Code[22]	Tool Name	Score Range	Values	Follow-up Needed[23]
				Not at all = 00 A little bit = 01 A moderate amount = 02 Quite a bit = 03 Extremely = 04 **Question 18** Very good = 00 Pretty good = 01 Good and bad are equal = 02 Pretty bad = 03 Very bad = 04	
DEPS_T1 (BH07)	03	DEPS	00-30	**10 Questions** Not at all = 00 A little = 01 Quite a lot = 02 Extremely = 03	≥10
	04	HAM-D	00-53	**17 Questions** 3-5 response options per question with increasing severity. Questions with 3 response options are scored 00-02, with 02 being the most severe. Questions with 5 response options are scored 00-04, with 04 being the most severe.	≥20
	05	MDI	00-50	**12 Questions** All the time = 05 Most of the time = 04 Slightly more than half the time = 03 Slightly less than half the time = 02	≥20

Section	Tool Code[22]	Tool Name	Score Range	Values	Follow-up Needed[23]
				Some of the time = 01 At no time = 00 For questions 8a/8b and 10a/10b, only count the highest score of the pair towards the overall score.	
DEPS_T1 (BH07)	06	PHQ-2	00-06	**2 questions** Not at all = 00 Several days = 01 More than half the days = 02 Nearly Every Day = 03	≥03 Follow-up with PHQ-9 required
	07	PHQ-9	00-27	**9 Questions** Not at all = 00 Several days = 01 More than half the days = 02 Nearly Every Day = 03	≥10
	08	T Score (PROMIS)	37.1-81.1	**8 Questions** Never = 01 Rarely = 02 Sometimes = 03 Often = 04 Always = 05	≥55
	09	Zung	20-80	**Questions 1, 3-4, 7-10, 13, 15, 19** A little of the time = 01 Some of the time = 02 A good part of the time = 03 Most of the time = 04	≥50

Section	Tool Code[22]	Tool Name	Score Range	Values	Follow-up Needed[23]
				Questions 2, 5-6, 11-12, 14, 16-18, 20 A little of the time = 04 Some of the time = 03 A good part of the time = 02 Most of the time = 01	
	10	OTHER		If your hospital has a depression screening tool approved for baseline, you may use this "10 - OTHER" category to indicate the use of your tool	Please use and supply to us the scoring methodology you were asked to provide upon approval of your tool
DEPS_T1 (BH07)	11	C-SSRS[24]	00-03	**Questions 1-2** Yes = Low risk (01) No = No risk (00) **Question 3** Yes = Moderate risk (02) No = No risk (00) **Question 4-5** Yes = High risk (03)	≥02 (If the individual's response indicates moderate or high risk for any question, that is a positive screen. This is not a sum of scores)

[24] If you are using the SAFE-T Protocol version of the C-SSRS, the scoring will be slightly different per question, but should still be recorded as 00 = No risk, 01 = Low risk, 02 = Moderate risk and 03 = High risk

Section	Tool Code[22]	Tool Name	Score Range	Values	Follow-up Needed[23]
				No = No risk (00) **Question 6** Yes = *ask 6b* No = No risk (00) **Question 6b** Yes = High risk (03) No = Moderate risk (02) ***No risk = 00*** ***Low risk = 01*** ***Moderate risk = 02*** ***High risk = 03***	
	12	PSS-3	00-04	**Note: Patient presenting with a current suicide attempt is an automatic 'Yes' on questions 2 and 3.** **Question 2** Yes = 01 No = 00 Patient unable to complete = 00 Patient Refused = 00 **Question 3a (asked if Question 3 was 'yes')** Within past 24 hours (including today) = 03 Within last month (but not today) = 02 Between 1 and 6 months ago = 01 More than 6 months ago = 00 Patient unable to complete = 00	≥01

Section	Tool Code[22]	Tool Name	Score Range	Values	Follow-up Needed[23]
				Patient Refused = 00	
	13	NIMH-Suicide Risk Screening Tool	00-10	**Questions 1 - 5** Yes = 02 Refuse to answer/blank = 01 No = 00	≥01
	14	EPDS	00-30	**10 Questions** 4 response options per question with increasing severity. Hospitals can choose which threshold they would like to use to indicate a positive screen. This must be indicated in the data submission. A score of 13 is considered "a more serious indicator" while a score of 10 is usually used as an indicator or possible depression and a signal that further evaluation is needed.	Please use and supply to QIP-NJ the scoring threshold chosen by hospital, either ≥10 or ≥13
	15	PHQ-4	00-12	**4 Questions** **Not at all = 00** **Several days = 01** **More than half the days = 02** **Nearly every day = 03** ****Only report the cumulative score from questions 3 and 4**	≥03 ONLY REPORT cumulative score from Questions 3 and 4
TOBA_T (BH08)	00	Refused Screening	N/A	*Leave blank*	N/A
	01	Fagerstorm Test for Nicotine Dependence (FND)	00-10	**Question 1** Within 5 minutes = 03 Within 6-30 minutes = 02 Within 31-60 minutes = 01 After 60 minutes = 00	≥05

Section	Tool Code[22]	Tool Name	Score Range	Values	Follow-up Needed[23]
				Question 2 Always = 02 Sometimes = 01 Never = 00 **Question 3** The First one in the morning = 01 All others = 00 **Question 4** More than 3 = 02 Response "2-3" = 01 Response "1" = 00 **Question 5-6** Yes = 01 No = 00	
TOBA_T (BH08)	02	OTHER		If your hospital has a tobacco screening tool approved for baseline, you may use this "02 - OTHER" category to indicate the use of your tool	Please use and supply to us the scoring methodology you were asked to provide upon approval of your tool

Section	Tool Code[22]	Tool Name	Score Range	Values	Follow-up Needed[23]
ALCS_T (BH08)	00	Refused Screening	N/A	*Leave blank*	N/A
	01	CAGE Questionnaire for Detecting Alcoholism	00-04	**4 Questions** Yes = 01 No = 00	≥02
	2A	The Alcohol Use Disorders Identification Test – Concise (AUDIT-C)	00-12	**Question 1** Never = 00 Monthly or less = 01 2-4 times a month = 02 2-3 times a week = 03 4 or more times a week = 04 **Question 2** Response "1 or 2" = 00 Response "3 to 4" = 01 Response "5 to 6" = 02 Response "7 to 9" = 03 Response "10 or more" = 04 **Question 3** Never = 00 Less than monthly = 01 Monthly = 02 Weekly = 3 Daily or almost daily = 4	Men: ≥04 Women: ≥03
ALCS_T (BH08)	2B	The Alcohol Use Disorders	00-40	**Question 1**	≥08

Section	Tool Code[22]	Tool Name	Score Range	Values	Follow-up Needed[23]
		Identification Test (AUDIT)		Never = 00 Monthly or less = 01 2-4 times a month = 02 2-3 times a week = 03 4 or more times a week = 04 **Question 2** Response “1 or 2” = 00 Response “3 or 4” = 01 Response “5 or 6” = 02 Response “7 to 9” = 03 Response “10 or more” = 04 **Questions 3-8** Never = 00 Less than monthly = 01 Monthly = 02 Weekly = 03 Daily or almost daily = 04 **Questions 9-10** No = 00 Yes, but not in the last year = 02 Yes, during the last year = 04	
ALCS_T (BH08)	03	OTHER		If your hospital has an alcohol screening tool approved for baseline, you may use this “03 - OTHER” category to indicate the use of your tool	Please use and supply to us the scoring

Section	Tool Code[22]	Tool Name	Score Range	Values	Follow-up Needed[23]
					methodology you were asked to provide upon approval of your tool
DRUG_T (BH08)	00	Refused Screening	N/A	*Leave blank*	N/A
	01	CAGE-AID Substance Abuse Screening Tool	00-4	**4 Questions** Yes = 01 No = 00	≥02
	02	DAST-10 Prescription and Illicit Drug Use Screen	00-10	**10 Questions** Yes = 01 No = 00	≥03
	03	OTHER		If your hospital has a drug screening tool approved for baseline, you may use this "03 - OTHER" category to indicate the use of your tool	Please use and supply to us the scoring methodology you were asked to provide upon approval of your tool
INCL_T (BH08)	00	Refused Screening	N/A	*Leave blank*	N/A
	01	NIDA Quick Screen	00-16	**4 Questions** Never = 00 Once or Twice = 01	≥01 Follow-up with

Section	Tool Code[22]	Tool Name	Score Range	Values	Follow-up Needed[23]
				Monthly = 02 Weekly = 03 Daily or almost daily = 04	NMASSIST required
	02	NIDA Drug Use Screening Tool (NMASSIST)	00-45	**Question 1** Yes = Move to question 2 No = Remind them NIDA QS indicated there should be at least one positive response and repeat question 1 **Question 2** Never = 00 Once or Twice = 02 Monthly = 03 Weekly = 04 Daily or almost daily = 06 **Question 3** Never = 00 Once or Twice = 03 Monthly = 04 Weekly = 05 Daily or almost daily = 06 **Question 4** Never = 00 Once or Twice = 04 Monthly = 05 Weekly = 06	≥04

Section	Tool Code[22]	Tool Name	Score Range	Values	Follow-up Needed[23]
				Daily or almost daily = 07 **Question 5** Never = 00 Once or Twice = 05 Monthly = 06 Weekly = 07 Daily or almost daily = 08 **Question 6-8** No, never = 00 Yes, but not in the past 3 months = 03 Yes, in the past 3 months = 06	
INCL_T (BH08)	03	OTHER		If your hospital has an inclusive tool approved for baseline, you may use this "03 - OTHER" category to indicate the use of your tool	Please use and supply to us the scoring methodology you were asked to provide upon approval of your tool
	04	TAPS-1		If patient screens negative, report '00'; If patient screens positive, report '01'	≥01
DEPS_T2 (M003)	00	Refused Screening	N/A	*Leave blank*	N/A

Section	Tool Code[22]	Tool Name	Score Range	Values	Follow-up Needed[23]
	1A	BDI	00-21	*See above in the DEPS_T1 section*	No follow-up needed for M003
	1B	BDI-II	00-63	*See above in the DEPS_T1 section*	No follow-up needed for M003
	02	CUDOS	00-72	*See above in the DEPS_T1 section*	No follow-up needed for M003
	03	DEPS	00-30	*See above in the DEPS_T1 section*	No follow-up needed for M003
	04	HAM-D	00-53	*See above in the DEPS_T1 section*	No follow-up needed for M003
	05	MDI	00-50	*See above in the DEPS_T1 section*	No follow-up needed for M003
	06	PHQ-2	00-06	*See above in the DEPS_T1 section*	No follow-up needed for M003
	07	PHQ-9	00-27	*See above in the DEPS_T1 section*	No follow-up needed for M003
	08	T Score	00-	*See above in the DEPS_T1 section*	No follow-up needed for M003
	09	Zung	20-80	*See above in the DEPS_T1 section*	No follow-up needed for M003

Section	Tool Code[22]	Tool Name	Score Range	Values	Follow-up Needed[23]
	10	OTHER		*See above in the DEPS_T1 section*	No follow-up needed for M003
	11	EPDS	00-30	**10 Questions** 4 response options per question with increasing severity. Hospitals can choose which threshold they would like to use to indicate a positive screen that has to be indicated in the data submission. A score of 13 is considered "a more serious indicator" while a score of 10 is usually used as an indicator or possible depression and a signal that further evaluation is needed.	No follow-up needed for M003 Please use and supply to QIP-NJ the scoring threshold chosen by hospital, either ≥10 or ≥13
	12	NIMH-Suicide Risk Screening Tool	00-10	**Questions 1 - 5** **Yes = 02** **Refuse to answer/blank = 01** **No = 00≥01**	No follow-up needed for M003
CTMS (BH10/M 008)		CTMS	00-13	**Questions 1 & 2** Strongly Disagree = 01 Disagree = 02 Agree = 03 Strongly Agree = 04 *I don't know = 00* **Question 3** Strongly Disagree = (1) Disagree = (2)	N/A

Section	Tool Code[22]	Tool Name	Score Range	Values	Follow-up Needed[23]
				Agree = (3) Strongly Agree = (4) Don't Know/Don't Remember/Not Applicable = (0) -this option is only available on the Standalone CTM-3	
		HCAHPS	01-13	**Questions 1 & 2** Strongly Disagree = 01 Disagree = 02 Agree = 03 Strongly Agree = 04 *I don't know = 00* **Question 3** Strongly Disagree = (1) Disagree = (2) Agree = (3) Strongly Agree = (4) I was not given any medication when I left the hospital = (5) – this response option is available on the HCAHPS CTM-3	N/A
		ECHO	02-09	**Questions 12,18** Never = 01 Sometimes = 02 Usually = 03 Always = 04 **Question 22** Yes = 1 No = 0	N/A

Section	Tool Code[22]	Tool Name	Score Range	Values	Follow-up Needed[23]
SDOH_T (BH11/M 009)	01	AAFP: Social Determinants of Health	04-20	Underlined answer options indicate a positive response for a social need for the housing, food, transportation, utilities, child care, employment, education, and finances categories. **Personal Safety Q's** Never = 01 Rarely = 02 Sometimes = 03 Fairly often = 04 Frequently = 05	≥10 for Personal Safety
	02	PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences	00-22	Please see link for PRAPARE scoring methodology	≥01 for any given category
	03	PRA (Only allowed for M09 or for obstetric patients)		**The following is a list of domains and their possible responses with yes/no options** **Housing** Homeless Unstable housing Currently in foster care **Food Security** Nutritional concerns	Anything checked with a "yes" will be counted as at risk and requires a follow-up

Section	Tool Code[22]	Tool Name	Score Range	Values	Follow-up Needed[23]
				Transportation Transportation problems **Social Supports** Inadequate social support **Domestic Violence Status** Domestic violence	
SDOH_T (BH11/M 009)	04	OTHER		If your hospital has an SDOH tool approved for baseline, you may use this "04 - OTHER" category to indicate the use of your homegrown tool	Please use and supply to us the scoring methodology you were asked to provide upon approval of your tool