

APPENDIX A-1:

Data Abstraction Tool: Intrapartum Antibiotic Prophylaxis for GBS (MAT-1)

INSTRUCTIONS: Hospitals must refer to the appropriate version of data dictionary for abstraction guidelines that apply to this measure. Use of *italic and underlined font* throughout this tool indicates updated text has been inserted. The capital letters in parenthesis represents the field name that corresponds to the data element name.

1. Provider Name (PROVNAME) _____
2. Provider ID (PROVIDER-ID) _____ (AlphaNumeric)
3. First Name (FIRST-NAME) _____
4. Last Name (LAST-NAME) _____
5. Birthdate (BIRTHDATE) ____ - ____ - ____
6. Sex (SEX) Female Male Unknown
7. Postal Code What is the postal code of the patient's residence? (POSTAL-CODE) _____
(Five or nine digits, HOMELESS, or Non-US)
8. Race Code - (MHRACE) (Select One Option)
 - R1 American Indian or Alaska Native
 - R2 Asian
 - R3 Black/African American
 - R4 Native Hawaiian or other Pacific Islander
 - R5 White
 - R9 Other Race
 - UNKNOW Unknown/not specified
9. Ethnicity Code - (ETHNICODE) _____
(Alpha 6 characters, numeric is 5 numbers with – after 4th number)
10. Hispanic Indicator- (ETHNIC)
 - Yes
 - No
11. Hospital Bill Number (HOSPBILL#) _____
(Alpha/Numeric – field size up to 20)
12. Patient ID (i.e. Medical Record Number) (PATIENT-ID) _____ (Alpha/Numeric)
13. Admission Date (ADMIT-DATE) ____ - ____ - ____
14. Discharge Date (DISCHARGE-DATE) ____ - ____ - ____
15. Was the patient involved in a clinical trial during this hospital stay relevant to the measure set for this admission? (CLNCLTRIAL)
 - Yes (Review Ends)
 - No

APPENDIX A-1:

Data Abstraction Tool: Intrapartum Antibiotic Prophylaxis for GBS (MAT-1)

16. What was the patient's discharge disposition on the day of discharge? (DISCHARGDISP)

(Select One Option)

- 01 = Home
- 02 = Hospice- Home
- 03 = Hospice- Health Care Facility
- 04 = Acute Care Facility
- 05 = Other Health Care Facility
- 06 = Expired
- 07 = Left Against Medical Advice / AMA
- 08 = Not Documented or Unable to Determine (UTD)

17. What is the patient's primary source of Medicaid payment for care provided? (PMTSRCE)

<input type="checkbox"/> 103	Medicaid (includes MassHealth)	<input type="checkbox"/> <u>282</u>	<i><u>BMC- MassHealth CarePlus</u></i>
<input type="checkbox"/> 104	Medicaid Managed Care – Primary Care Clinician (PCC) Plan	<input type="checkbox"/> <u>283</u>	<i><u>Fallon- MassHealth CarePlus</u></i>
<input type="checkbox"/> 108	MCD Managed Care - Fallon Community Health Plan	<input type="checkbox"/> <u>284</u>	<i><u>NHP- MassHealth CarePlus</u></i>
<input type="checkbox"/> 110	MCD Managed Care - Health New England	<input type="checkbox"/> <u>285</u>	<i><u>Network Health- MassHealth CarePlus</u></i>
<input type="checkbox"/> 113	MCD – Neighborhood Health Plan	<input type="checkbox"/> <u>286</u>	<i><u>Celticare- MassHealth CarePlus</u></i>
<input type="checkbox"/> 118	MCD Managed Care - Mass Behavioral Health Partnership Plan	<input type="checkbox"/> <u>287</u>	<i><u>MassHealth CarePlus</u></i>
<input type="checkbox"/> <u>207/274</u>	MCD Managed Care- Network Health (Cambridge Health Alliance)	<input type="checkbox"/> 119	Medicaid Managed Care Other
<input type="checkbox"/> 208	MCD Managed Care - HealthNet (Boston Medical Center)	<input type="checkbox"/> 178	Children's Medical Security Plan (CMSP)

18. What is the patient's MassHealth Member ID? (MHRIDNO) (All alpha characters must be upper case)

19. Does this case represent part of a sample? (SAMPLE)

- Yes
- No

20. What was the infant's gestational age at the time of delivery? (GESTAGE)

_____ If < = 24 weeks gestation (Review Ends)

(in completed weeks; do not round up) (enter 2 digit numeric value with no leading 0, or UTD)

21. At what time was the mother admitted to the labor and delivery unit? (TIMEADMLABDEL)

__ __: __ __ (military format – HH:MM or UTD)

22. Did the patient receive an IV antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to delivery? (PRENINFANTIB)

- Yes (Review Ends)
- No

23. Was a Cesarean Delivery prior to onset of labor with intact membranes performed? (CDELIVERY)

- Yes (Review Ends)
- No

APPENDIX A-1:

Data Abstraction Tool: Intrapartum Antibiotic Prophylaxis for GBS (MAT-1)

24. On what date was the infant delivered? (INFDELDATE) ____-____-____ (MM-DD-YYYY or UTD)

25. At what time was the infant delivered? (INFDELTIME) ____:____ (military format – HH:MM or UTD)

26. Did the mother deliver a live newborn? (DELLIVENEB)

- Yes
- No (Review Ends)

27. Previous infant with invasive GBS disease? (PREVINFGBS)

- Yes (go to question # 30)
- No

28. Did the mother have GBS bacteriuria at any time during this pregnancy? (GBSBACTPREG)

- Yes (go to question # 30)
- No

29. The result of the mother's vaginal and rectal screening culture for GBS at 35-37 weeks gestation or within 5 weeks prior to birth was? (GBSRSLTS)

Select One

- Positive (go to question # 30)
- Negative (Review Ends)
- Unknown (If selected, proceed to i)
 - i. Gestational age at delivery was < 37 weeks? (GESTAGEWEEKS)
 - Yes (go to question # 30)
 - No
 - ii. Were the amniotic membranes ruptured for 18 or more hours? (AMNMEMBRUPT)
 - Yes (go to question # 30)
 - No
 - iii. Did the mother have an intrapartum temperature of ≥ 100.4 ($\geq 38.0C$)? (INTRAPARTTEMP)
 - Yes
 - No (Review Ends)

30. Was an IV antibiotic administered to the mother in the intrapartum period for GBS prophylaxis? (ABXINTRAPARTUM)

- Yes
- No (Review Ends)

31. Which IV antibiotic was administered? (NAMEABX) (Select One Option)

- 1 - Ampicillin
 - 2 - Cefazolin
 - 3 - Clindamycin
 - 5 - Penicillin
 - 6 - Vancomycin
 - 7 – Other (if chosen, answer maternal allergy question # 32)
- } (go to question #33)

APPENDIX A-1:

Data Abstraction Tool: Intrapartum Antibiotic Prophylaxis for GBS (MAT-1)

Note: (4= Erythromycin has been removed as a recommended choice for prophylaxis)

32. Did the patient have any allergies, sensitivities, or intolerances to any of the recommended antibiotic classes for this measure? (ANTIALLERGY)
- Yes
 - No (Review Ends)
33. On what date was the antibiotic administered?(DTABX) ____ - ____ - ____ (MM-DD-YYYY or UTD)
34. At what time was the antibiotic administered? (TMABX) ____:____ (military format – HH:MM or UTD)