Guidelines for Using Release Notes
The Release Notes provides modifications to the Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.6. The information in this document is to be used as a reference and is not intended to be used to program abstraction tools. Please refer to the Specifications Manual for National Hospital Inpatient Quality Measures for the complete and current technical specifications and abstraction information.

The notes are organized to follow the order of the Table of Contents. The implementation date is 07/01/2019, unless otherwise specified. The headings are described below:

- **Impacts** - used to identify the impacted measures and portion(s) of the Manual Section, e.g., Alphabetical Data Dictionary, Measure Information Form (MIF) and Flowchart (Algorithm).

- **Description of Changes** - used to identify the section within the document where the change occurs, e.g., Definition, Data Collection Question, Allowable Values, and Denominator Statement - Data Elements.

- **Rationale** - provided for the change being made.

Data elements that cross multiple measures and contain the same changes will be consolidated.

**NOTE**: In addition to being called out specifically in the Release Notes document, additions are yellow highlighted in the corresponding documents. The changes in the Hospital Initial Patient Population and Clinical Data XML File Layouts have yellow highlighted cells with actual changes noted in **bold font**.
Table of Contents

Note: click on any section title in the Release Notes to return to Table of Contents page.

Table of Contents (no updates) ........................................................................................................... 2
Acknowledgement (no updates) ........................................................................................................... 2
Introduction (no updates) ..................................................................................................................... 2
Using the Specifications Manual for National Hospital Inpatient Quality Measures (no updates) ................................................................................................................................................. 2

SECTION 1 – Data Dictionary ............................................................................................................. 2
Introduction to Data Dictionary (no updates) ...................................................................................... 2
Alphabetical Data Dictionary .................................................................................................................. 2

SECTION 2 – Measurement Information ............................................................................................ 11
Subsection 2.1 – Severe Sepsis and Septic Shock (SEP) (no updates) ........................................ 11
Subsection 2.2 – Venous Thromboembolism (VTE) ........................................................................ 11
Subsection 2.4 – Global Initial Patient Population (ED, IMM, TOB, SUB) (no updates) .......... 11
Subsection 2.5 – Emergency Department (ED) ............................................................................. 11
Subsection 2.6 - Prevention .......................................................................................................... 12
  2.6.1 - Immunization (IMM) ........................................................................................................ 12
  2.6.2 - Substance Use (SUB) (no updates) ................................................................................ 12
  2.6.3 - Tobacco Treatment (TOB) (no updates) ....................................................................... 12

SECTION 3 – Missing and Invalid Data (no updates) ....................................................................... 12

SECTION 4 – Population and Sampling Specifications (no updates) ............................................... 12

SECTION 9 – Data Transmission ....................................................................................................... 12
  Transmission Overview (no updates) ............................................................................................. 12
  Transmission Alphabetical Data Dictionary (no updates) .............................................................. 12
  Hospital Clinical Data XML File Layout ....................................................................................... 12
  Hospital Initial Patient Population Data XML File Layout (no updates) .................................. 12

SECTION 10 – CMS Outcome/Inpatient Web-Based Measures ..................................................... 12
  Subsection 10.1 – CMS Outcome Measures (no updates) ......................................................... 12
  Subsection 10.2 – Inpatient Web-Based Measures (no updates) .............................................. 12

APPENDICES ................................................................................................................................. 13
  Appendix A – ICD-10 Code Tables (Word and Excel) (no updates) ....................................... 13
  Appendix C – Medication Tables (Word and Excel) ................................................................. 13
  Appendix D – Glossary of Terms (no updates) ......................................................................... 13
  Appendix E – Overview of Measure Information Form and Flowchart Formats (no updates) ... 13
  Appendix F – Measure Name Crosswalk (no updates) ............................................................... 13
  Appendix G – Resources (no updates) ....................................................................................... 13
  Appendix H – Miscellaneous Tables ........................................................................................... 13
  Appendix P – Preview Section (no updates) ............................................................................. 13
The content below is organized to follow the Table of Contents in the specifications manual.

Table of Contents (no updates)

Acknowledgement (no updates)

Introduction (no updates)

Using the Specifications Manual for National Hospital Inpatient Quality Measures (no updates)

SECTION 1 – Data Dictionary

Introduction to Data Dictionary (no updates)

Alphabetical Data Dictionary

Impacts:
*Administrative Contraindication to Care, Septic Shock*

Rationale: The *Administrative Contraindication to Care, Septic Shock* data element is being updated with new guidance.

Description of Changes:

Notes for Abstraction

Change third bullet point to:

- A more general documentation of refusal of care (e.g. central line, PICC, IO access) or documentation of patient non-compliance with care (e.g., pulling out IV) that would result in the following not being administered within the specified time frame is acceptable.
  - Blood Draws
  - IV or IO fluid administration
  - Vasopressors

Impacts:
*Administrative Contraindication to Care, Severe Sepsis*

Rationale: The *Administrative Contraindication to Care, Severe Sepsis* data element is being updated with new guidance.

Description of Changes:

Notes for Abstraction

Change third bullet point to:

- A more general documentation of refusal of care (e.g. central line, PICC, IO access) or documentation of patient non-compliance with care (e.g., pulling out IV) that would result in the following not being administered within the specified time frame is acceptable.
  - Blood Draws
  - IV or IO fluid administration
  - Vasopressors
Impacts:
*Broad Spectrum or Other Antibiotic Administration Selection*

**Rationale:** The *Broad Spectrum or Other Antibiotic Administration Selection* data element is being updated with new guidance.

**Description of Changes:**

**Notes for Abstraction**

*Change* under fifth bullet point, “Examples” to:

**Example:**

*Change* first sub-bullet point under sixth bullet point to:

There is physician/APN/PA documentation within 24 hours prior to the antibiotic start time identifying the presence of C. difficile. Documentation that C. difficile is suspected or likely is acceptable.

---

Impacts:
*Directive for Comfort Care or Palliative Care, Septic Shock*

**Rationale:** The *Directive for Comfort Care, Septic Shock* data element is being updated with new guidance to further specify that only inclusion terms documented in specific context are acceptable.

**Description of Changes:**

**Notes for Abstraction**

*Change* second bullet point to:

- Only the earliest physician/APN/PA documentation of an inclusion term documented in the following contexts suffices:
  - Comfort measures only recommendation
  - Order for consultation or evaluation by a hospice care service
  - Patient or patient representative request for comfort measures only
  - Plan for comfort measures only
  - Referral to hospice care service

---

Impacts:
*Directive for Comfort Care or Palliative Care, Severe Sepsis*

**Rationale:** The *Directive for Comfort Care, Septic Shock* data element is being updated with new guidance to further specify that only inclusion terms documented in specific context are acceptable.

**Description of Changes:**

**Notes for Abstraction**

*Change* second bullet point to:

- Only the earliest physician/APN/PA documentation of an inclusion term documented in the following contexts suffices:
  - Comfort measures only recommendation
  - Order for consultation or evaluation by a hospice care service
  - Patient or patient representative request for comfort measures only
  - Plan for comfort measures only
  - Referral to hospice care service
Impacts:  
*Discharge Disposition*

**Rationale:** The data element is being updated to provide abstraction guidance regarding documentation related to patient discharge to rehabilitation facilities for chemical and alcohol dependency.

**Description of Changes:**
*Inclusion Guidelines for Abstraction*

Under Other Health Care Facility (Value 5):

**Change** fifth bullet point to:
- Rehabilitation Facility including, but not limited to: Inpatient Rehabilitation Facility/Hospital, Rehabilitation Unit of a Hospital, Chemical Dependency/Alcohol Rehabilitation Facility

---

**Impacts:**  
*Initial Hypotension*

**Rationale:** The *Initial Hypotension* data element is being updated with clarifying guidance.

**Description of Changes:**
*Notes for Abstraction*

**Change** fourth bullet point to:
- Hypotensive BPs obtained within the operating room (OR), interventional radiology, during active delivery, or procedural/conscious sedation **should not be used**.

**Change** seventh bullet point to:
- Documentation of a term that represents or is defined by an SBP <90 mmHg or MAP <65 mmHg is acceptable in place of an abnormal value when documented as normal for the patient, due to a chronic condition, due to a medication, or due to an acute condition that has a non-infectious source/process.
  
  **Example:**
  Hypotension (Systolic blood pressure <90 mmHg).

---

**Impacts:**  
*Persistent Hypotension*

**Rationale:** The *Persistent Hypotension* data element is being updated with clarifying guidance.

**Description of Changes:**
*Notes for Abstraction*

**Change** third bullet point to:
- Hypotensive BPs obtained within the operating room (OR), interventional radiology, during active delivery, or procedural/conscious sedation **should not be used**.

**Add** new sixth bullet point:
- If one or more blood pressures were documented within the time frame and persistent hypotension is unable to be determined but a vasopressor was administered, select Value “1.”

**Change** eighth bullet point to:
- Documentation of a term that represents or is defined by an SBP <90 mmHg or MAP <65 mmHg is acceptable in place of an abnormal value when documented as normal for
the patient, due to a chronic condition, due to a medication, or due to an acute condition that has a non-infectious source/process.

Example:
Hypotension (Systolic blood pressure <90 mmHg).

Remove:
- Acceptable crystalloid fluids are identified in the Crystalloid Fluid Administration data element.
- If the end time of the target ordered volume of crystalloid fluids cannot be determined, select Value “3.”
- If crystalloid fluids were administered but at a volume less than the target ordered volume, choose Value “4.”

Impacts:
Reason for No Administration of VTE Prophylaxis

Rationale: The data element is being updated to provide additional guidance for the abstractor.

Description of Changes:
Notes for Abstraction
Change under second bullet point, third sub-bullet point to:
- For patients receiving anticoagulant therapy, including continuous IV heparin infusion, between arrival and the day before the VTE diagnostic test order date, select “Yes.”

Disregard IV heparin administered to flush/maintain patency of a line or dialysis equipment and IV heparin administered during an interventional procedure, e.g., cardiac cath.

Remove fourth bullet point:
- If the VTE Diagnostic Test was performed the day of or the day after arrival, select “Yes.”

Impacts:
Referral for Addictions Treatment

Rationale: The data element is being updated to provide abstraction guidance regarding documentation related to patient referrals and appointments for addictions treatment.

Description of Changes:
Notes for Abstraction
Change to:
- If a patient is referred to an addictions treatment provider that does not schedule appointments and the patient was given a specific date and time to present for addictions treatment, select Value “1.”
- If the patient does not have a residence in the USA, Value “4” must be selected.
- A referral to Alcoholics Anonymous (AA) or similar mutual support groups does not meet the intent of the measure. Select Value “5.”
- Select Value “5” if:
  - it cannot be determined that a referral for addictions treatment was made or;
  - it is unclear that the absence of the referral was due to a patient refusal or because the referral was not offered.
Impacts:  
**Referral for Outpatient Tobacco Cessation Counseling**

**Rationale:** The data element is being updated to provide abstraction guidance regarding documentation related to patient referrals and appointments for addictions treatment.

**Description of Changes:**

**Notes for Abstraction**

**Change to:**

- If a referral is made to a Quitline, defined as a telephone counseling in which at least some of the contact is initiated by the Quitline counselor to deliver tobacco use interventions, select Value “1.” If the patient directly calls the Quitline during the hospitalization, documentation must reflect that staff was present during the call to verify that an appointment was set.
- If a patient is referred to an outpatient tobacco cessation counseling provider that does not schedule appointments and the patient was given a specific date and time to present for counseling, select Value “1”.
- If the patient is provided with contact information for e-health or internet smoking cessation programs which tailor program content to the tobacco user’s needs (by collecting information from the tobacco user and using algorithms to tailor feedback or recommendations, permitting the user to select from various features including extensive information on quitting, tobacco dependence, and related topics) select Value “2.” Note that if Value “2” is selected, the case will not pass the measure. Value “2” can be used as part of an internal performance improvement activity in order to determine if any type of referral was made rather than no referral.
- If a referral for outpatient tobacco cessation counseling was offered during the hospitalization and the patient refused, select Value “3.” It does not need to be offered again at discharge.
- If the patient does not have a residence in the USA, Value “4” must be selected.
- If the patient is provided with self-help materials that are not tailored to the patient’s needs and do not provide a structured program, select Value “5.”
- Select Value “5” if:
  - it cannot be determined that a referral for outpatient cessation counseling was made or;
  - it is unclear that the absence of the referral was due to a patient refusal or because the referral was not offered.
- If the patient refused practical counseling (Tobacco Use Treatment Practical Counseling) during the hospitalization, a referral for outpatient tobacco cessation counseling must still be offered at the time of discharge. Select Value “5” if a referral for outpatient counseling was not offered at the time of discharge.

**Impacts:**

**Severe Sepsis Present**

**Rationale:** The **Severe Sepsis Present** data element is being updated with new guidance.

**Description of Changes:**

**Notes for Abstraction**

**Change** under second bullet point, eighth bullet point under “C” to:

- INR >1.5 or aPTT >60 sec
If the suggested data source shows the patient was given an anticoagulant medication in Appendix C Table 5.3, an elevated INR or aPTT level should not be used as organ dysfunction. Physician/APN/PA documentation is not required. If only the following is given, the elevated INR or aPTT level should be used:

- Heparin flushes

**Change** fourth bullet point to:

- Documentation of a term that represents or is defined by a SIRS criteria or sign of organ dysfunction is acceptable in place of an abnormal value when documented as normal for the patient, due to a chronic condition, due to a medication, or due to an acute condition that has a non-infectious source/process.

**Examples** include but are not limited to:

- Tachypnea (Respiration >20 per minutes)
- Tachycardia, RVR (Heart rate >90)
- Leukopenia (White blood cell count <4,000)
- Leukocytosis (White blood cell count >12,000)
- Thrombocytopenia (Platelet count <100,000)
- Hypotension (Systolic blood pressure <90 mmHg)

**Change** seventh bullet point to:

- SIRS criteria or a sign of organ dysfunction obtained within the operating room (OR), interventional radiology, during active delivery, or procedural/conscious sedation should not be used.

**Impacts:**

**Septic Shock Present**

**Rationale:** The **Septic Shock Present** data element is being updated with clarifying guidance.

**Description of Changes:**

**Notes for Abstraction**

**Change** “a” under third bullet point to:

a. Severe Sepsis Present

**AND**

**Persistent Hypotension** evidenced by:

- In the hour after the conclusion of the target ordered volume of **Crystalloid Fluid Administration**, two consecutive documented hypotensive blood pressure readings.

**Change** fourth and fifth bullet point to:

- For evaluation of blood pressure parameters to establish whether or not hypotension persists after crystalloid fluid administration, begin abstracting at the time that crystalloid fluid administration concludes (refer to the **Persistent Hypotension** data element); abstract for the time period that follows for the next hour only.

- Hypotensive BPs obtained within the operating room (OR), interventional radiology, during active delivery, or procedural/conscious sedation should not be used.

**Change** ninth bullet point to:

- Documentation of a term that represents or is defined by a SBP <90 mmHg or MAP <65 mmHg is acceptable in place of an abnormal value when documented as normal for the patient, due to a chronic condition, due to a medication, or due to an acute condition that has a non-infectious source/process.
Impacts: 
**VTE Confirmed**

**Rationale:** The data element is being updated to provide additional guidance for the abstractor.

**Description of Changes:**
**Inclusion Guidelines for Abstraction**
*Add* new bullet point:
- Infrarenal IVC

**Exclusion Guidelines for Abstraction**
*Add* new bullet points:
- Amniotic fluid embolism / emboli
- Cement embolism / emboli

---

Impacts: 
**VTE Diagnostic Test**

**Rationale:** The data element is being updated to provide additional guidance for the abstractor.

**Description of Changes:**
**Inclusion Guidelines for Abstraction**
*Change* second bullet point to:
- Venous Ultrasound of lower extremities

*Add* new bullet point:
- CT pulmonary angiogram (CTPA) / CTPA Scan / CT pulmonary embolism (CTPE)

---

Impacts: 
**VTE Present at Admission**

**Rationale:** The data element is being updated to provide additional guidance for the abstractor.

**Description of Changes:**
**Notes for Abstraction**
*Change* to:
- The time frame for this data element includes any documentation dated from hospital arrival to the day after admission. **It is not necessary to review documentation outside of this timeframe to answer this data element.**
- Documentation of suspicion or a diagnosis of a pulmonary embolism (PE) or venous thromboembolism (VTE) in a confirmed location is acceptable. **Only accept terms identified in the list of inclusions.**
  **NOTE:** It is not necessary for a **VTE Diagnostic Test** to be linked with the physician/APN/PA documented diagnosis of PE or VTE.

**Acceptable Examples:**
- A patient arrived on 10/1/20xx with shortness of breath. On 10/2/20XX, there is physician documentation that a PE is suspected, select “Yes.”
- Results of a venous Doppler performed the day after admission are positive for VTE in the common femoral vein, select “Yes.”


- Results of a Doppler are positive for an acute nonocclusive LLE thrombus on the day after admission, select “Yes.”
- Day of admission physician includes PE on the problem list, select “Yes.”
- Patient admitted with a diagnosis of left popliteal deep vein thrombus, select “Yes.”
- Patient arrived on 01/05/20XX with documentation from an outside transferring hospital indicating vascular ultrasound was performed on 01/02/20XX and positive for VTE, select “Yes.”
- Physician documents in H&P on day of admission, “DVT right lower extremity”, select “Yes.”

**Unacceptable Examples:**
- H&P on day of admission notes that the patient has an occlusion of the subclavian vein. Subclavian vein is not a defined location, select “No.”
- A patient arrives to the hospital emergency department with C/O severe headache. Differential diagnosis on the day of arrival includes cerebral venous thrombosis (CVT) versus SAH, select “No.”
- Physician admitting note documents DVT prophylaxis under the treatment plan, select “No.”
- Patient admitted with a diagnosis of left upper extremity deep vein thrombus, select “No.”
- Patient has a CT chest with IV contrast on the day of arrival to R/O PE and test results are negative and received by 2359 the day after admission, select “No.”

### An order for a VTE diagnostic test is acceptable ONLY if it is explicitly documented that VTE/PE is the reason for the test. Only accept terms identified in the list of inclusions. If an acceptable test is ordered for a PE or VTE indication and results are documented as negative by 2359 the day after admission, then suspicion of PE or VTE has been ruled out. Select “No.”

**Acceptable Examples:**
- A patient presents to the hospital emergency department with a chief complaint of pain and swelling in the right calf. A vascular ultrasound of the lower extremities is ordered to R/O DVT, select “Yes.” UNLESS results are negative and received by 2359 the day after admission.
- Bilateral venous Doppler of the lower extremities is ordered on the day after admission for redness and swelling left calf, select “Yes.”
- A patient arrives on 06/01/20XX. Admitting diagnosis is fever. On 06/02/20XX patient admitted and physician documents “if cough continues may require evaluation for PE.” On 06/03/20XX, CTA chest is ordered and positive for PE. Select “Yes.”

**Unacceptable Examples:**
- Physician orders a bilateral lower extremity arterial duplex on the day after admission. Arterial duplex is not an acceptable test. Select "No" for VTE Present on Admission.
- Patient presents to the emergency room with complaints of pain all over after sustaining a fall. ED MD orders multiple tests including a CT of the chest with IV contrast. ED MD documents fall as the reason for the test. No mention of PE/VTE, select “No.”
A patient is admitted after a motor vehicle accident. On arrival, a CT of the abd/pelvis with IV contrast was done to R/O internal injuries. No mention of PE/VTE, select “No.”

Bilateral venous Doppler of the lower extremities is ordered on the day of arrival for redness and swelling left calf. Results returned the same day document no acute VTE in left common femoral vein or popliteal vein, select “No.”

Patients who are under treatment and receiving anticoagulation therapy for PE/VTE at the time of hospital arrival, select “Yes.”

Examples:
- Patient admitted 04/30/20XX. Physician documents on 04/30/20XX that Coumadin was started on 04/20/20XX for a recently diagnosed PE, select “Yes.”
- Patient presents with a documented diagnosis of PE on the day of arrival. Coumadin placed on hold to evaluate for GI bleed, select “Yes.”

Patients on anticoagulation therapy for another condition (e.g., atrial fibrillation, mitral valve replacement) at the time of hospital arrival, select “Yes.”

Examples:
- Patient with a history of stroke and taking dabigatran as a home medication prior to arrival, select “YES.”
- H&P documents chronic VTE. Taking Coumadin, select “Yes.”

EXCEPTION:
Patient on apixaban prior to arrival for a history of atrial fibrillation. Apixaban discontinued on arrival for surgery the day after admission, select “No.”

For patients with only a past history of VTE documented, select “No.”

Example:
- Problem list includes PE 199X, select “No.”

If the patient was admitted and had surgery on day of or day after hospital admission or ICU admission and there was no documentation of diagnosed/suspected VTE prior to surgery, the VTE is not considered present on admission. Select “No.”

Disregard diagnostic procedures performed, e.g., cardiac catheterization, endoscopy, ERCP.

Inclusion Guidelines for Abstraction VTE Confirmed

Add new bullet point:
- Infrarenal IVC

Inclusion Guidelines for Abstraction VTE Diagnostic Test

Change second bullet point to:
- Venous Ultrasound of lower extremities

Add new bullet point:
- CT pulmonary angiogram (CTPA) / CTPA Scan / CT pulmonary embolism (CTPE)
### SECTION 2 – Measurement Information

#### Subsection 2.1 – Severe Sepsis and Septic Shock (SEP) *(no updates)*

#### Subsection 2.2 – Venous Thromboembolism (VTE)

**Impacts:**
VTE Data Element List

**Rationale:** The VTE Data Element List is being updated to remove data elements not collected by The Joint Commission, the current measure steward.

**Description of Changes:**
Remove rows in their entirety:
- First Name
- Last Name
- Patient Identifier
- Physician 1
- Physician 2
- Postal Code

**Impacts:**
Sample Size Requirements
Quarterly Sampling

**Rationale:** This document is being updated to remove the references to CMS.

**Description of Changes:**
Remove from first paragraph and under Quarterly Sampling section:
the CMS Clinical Warehouse or

#### Subsection 2.4 – Global Initial Patient Population (ED, IMM, TOB, SUB) *(no updates)*

#### Subsection 2.5 – Emergency Department (ED)

**Impacts:**
ED-1: Algorithm

**Rationale:** This document is being updated to align with fiscal year (FY) 2019 Inpatient Prospective Payment System (IPPS) final rule and the removal of ED-1 from the Hospital IQR Program.

**Description of Changes:**
Remove the following notes and decision box:
For Overall Measure (ED-1a) For The Joint Commission Only off of the Case Will Be Rejected decision point

Stop here for CMS. CONTINUE for The Joint Commission decision point

Note: X is for The Joint Commission Only
Subsection 2.6 - Prevention

2.6.1 - Immunization (IMM)

Impacts:
IMM Data Element List

Rationale: The IMM Data Element List is being updated to remove data elements not collected by The Joint Commission, the current measure steward.

Description of Changes:
Remove rows in their entirety:
First Name
Last Name
Patient Identifier
Physician 1
Physician 2
Postal Code

2.6.2 - Substance Use (SUB) (no updates)

2.6.3 - Tobacco Treatment (TOB) (no updates)

SECTION 3 – Missing and Invalid Data (no updates)

SECTION 4 – Population and Sampling Specifications (no updates)

SECTION 9 – Data Transmission
Transmission Overview (no updates)

Transmission Alphabetical Data Dictionary (no updates)

Hospital Clinical Data XML File Layout
Impacts:
Data Elements Info

Rationale: Updates are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Change Retired or Deleted Data Elements Effective 07/01/2019 Discharges section to:
No elements retired or deleted.

Hospital Initial Patient Population Data XML File Layout (no updates)

SECTION 10 – CMS Outcome/Inpatient Web-Based Measures
Subsection 10.1 – CMS Outcome Measures (no updates)

Subsection 10.2 – Inpatient Web-Based Measures (no updates)
APPENDICES

Appendix A – ICD-10 Code Tables (Word and Excel) (no updates)

Appendix C – Medication Tables (Word and Excel)

Impacts:
Table 5.2: Vasopressors for Septic Shock

Rationale: Table 5.2 is being updated to include Giapreza (angiotensin II), an injection recently approved by the U.S. Food and Drug Administration to increase blood pressure in adults with septic or other distributive shock.

Description of Changes:
Add row under Generic Name and corresponding Brand Name columns:

"Angiotensin II" to left column
“Giapreza” to right column

Appendix D – Glossary of Terms (no updates)

Appendix E – Overview of Measure Information Form and Flowchart Formats (no updates)

Appendix F – Measure Name Crosswalk (no updates)

Appendix G – Resources (no updates)

Appendix H – Miscellaneous Tables

Impacts:
Table 2.6

Rationale: Table 2.6 is being removed as it is no longer utilized for any of the measure sets.

Description of Changes:
Remove in its entirety:
Table 2.6: Qualifiers and Modifiers Table

Appendix P – Preview Section (no updates)