Specifications Manual for National Hospital Inpatient Quality Measures

Guidelines for Using Release Notes
Release Notes 3.2b provide modifications to the Specifications Manual for National Hospital Inpatient Quality Measures. The Release Notes are provided as a reference tool and are 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. Within each topic section, a row represents a change beginning with general changes followed by data elements in alphabetical order. The implementation date is 10-01-2010 unless otherwise specified. The headings are described below:

- **Impacts** - used to identify which portion(s) of the Manual Section is impacted by the change listed. Examples are Alphabetical Data Dictionary, (Measure Set) Data Element List, Measure Information Form (MIF) and Flowchart (Algorithm). The measures that the data element is collected for are identified.
- **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.

**NOTE**: In addition to being called out specifically in the Release Notes document, additions and deletions are listed and additions are pink highlighted in the corresponding document. Exceptions: The additions and changes to the Algorithms are not pink highlighted, and the Hospital Initial Patient Population and Clinical Data XML File Layouts are pink highlighted in the cells that have a change in them and the actual changes are bolded.

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

Data Element Name: *Decision to Admit Date*

**Impacts:** ED-2

**Description of Changes:**

Notes for Abstraction

**Change** in the 1st bullet:

‘abstract’

To

‘select’

Add bullet and sub-bullets:

The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care [after the *Discharge Date*]) and no other documentation is found that provides this information, the abstractor should select “UTD.”

Examples:

- Documentation indicates the *Decision to Admit Date* was 03-42-20XX. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid date. Since the *Decision to Admit Date* is outside of the range listed in the Allowable Values for “Day”, it is not a valid date and the abstractor should select “UTD.”
- Patient expires on 02-12-20XX and all documentation within the ONLY ACCEPTABLE SOURCES indicates the *Decision to Admit Date* was 03-12-20XX. Other documentation in the medical record supports the date of death as being accurate. Since the *Decision to Admit Date* is after the *Discharge Date* (death), it is outside of the parameter of care and the abstractor should select “UTD.”

**Note:** Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse. Use of “UTD” for *Decision to Admit Date* allows the case to be accepted into the warehouse.

Add bullet:

When reviewing ED records do NOT include any documentation from external sources (e.g., ambulance records, physician/advanced practice nurse/physician assistant [physician/APN/PA] office record, laboratory reports or ECGs) obtained prior to arrival. The intent is to utilize any documentation, which reflects processes that occurred in the ED or hospital.

Change in the 6th bullet:

‘abstract’

To

‘select’

**Inclusion Guidelines for Abstraction**

**Remove:**

Bed Request Date
Call for room Date
Add:
None

Rational: Update data element to provide consistency with other date data elements and provide clarity to abstractors.

Data Element Name: Decision to Admit Time

Impacts: ED-2

Description of Changes:
Notes for Abstraction
Change in the 2nd bullet:
‘abstract’
To
‘select’

Add bullet:
The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range) and no other documentation is found that provides this information, the abstractor should select “UTD.”
Example:
Documentation indicates the Decision to Admit Time was 3300. No other documentation in the list of ONLY Acceptable Sources provides a valid time. Since the Decision to Admit Time is outside of the range in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD.”
Note: Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse. Use of “UTD” for Decision to Admit Time allows the case to be accepted into the warehouse.

Add bullet:
When reviewing ED records do NOT include any documentation from external sources (e.g., ambulance records, physician/advanced practice nurse/physician assistant [physician/APN/PA] office record, laboratory reports, or ECGs) obtained prior to arrival. The intent is to utilize any documentation which reflects processes that occurred in the ED or hospital.

Change 4th bullet:
For purposes of this data element “decision to admit time” is the time the physician/APN/PA makes the decision to admit the patient from the emergency department to the hospital as an inpatient. This will not necessarily coincide with the time the patient is officially admitted to inpatient status.
To
For purposes of this data element “decision to admit time” is the time the physician/APN/PA communicates the decision to admit the patient from the emergency department to the hospital as an inpatient. This will not necessarily coincide with the time the patient is officially admitted to inpatient status.
Change 5th bullet:
If the decision to admit the patient is made, but the actual request for a bed is delayed until an inpatient bed is available, record the time the physician/APN/PA made the decision to admit.

To
If the decision to admit the patient is made, but the actual request for a bed is delayed until an inpatient bed is available, record the time the physician/APN/PA communicated the decision to admit.

Change in the 6th bullet:
‘abstract’
To
‘select’

Add bullet:
Do not use admit order time for the Decision to Admit Time unless documentation clearly indicates this is the time the provider made the decision. If the documentation does not clearly indicate this was the time of the decision, do not use and select, “UTD.”

Inclusion Guidelines for Abstraction
Remove:
Bed Request Time
Call for room time

Add:
None

Rational: Update data element to provide consistency with other date data elements and provide clarity to abstractors.

Data Element Name: ED Departure Date

Impacts: ED-1, ED-2

Description of Change:
Notes for Abstraction
Add bullet and sub-bullets:
The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care [after the Discharge Date]) and no other documentation is found that provides this information, the abstractor should select “UTD.”

Examples:
- Documentation indicates the ED Departure Date was 03-42-20XX. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid date. Since the ED Departure Date is outside of the range listed in the Allowable Values for “Day”, it is not a valid date and the abstractor should select “UTD.”
- Patient expires on 02-12-20XX and all documentation within the ONLY ACCEPTABLE SOURCES indicates the ED Departure Date was 03-12-20XX. Other documentation in the medical record supports the date of death as being
accurate. Since the \textit{ED Departure Date} is after the \textit{Discharge Date} (death), it is outside of the parameter of care and the abstractor should select “UTD.”

\textbf{Note:} Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse. Use of “UTD” for \textit{ED Departure Date} allows the case to be accepted into the warehouse.

Change in the 1\textsuperscript{st} bullet:
‘enter’
To
‘select’

Change in the 3\textsuperscript{rd} bullet:
‘abstract’
To
‘select’

\textbf{Inclusion Guidelines for Abstraction}

\textbf{Change:}
ED Leave Time
To
ED Leave Date

\textbf{Rational:} Update data element to provide consistency with other date data elements and provide clarity to abstractors.

\textbf{Data Element Name:} \textit{ED Departure Time}

\textbf{Impacts:} ED-1, ED-2

\textbf{Description of Change:}

Notes for Abstraction

Add bullet:
The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range) and no other documentation is found that provides this information, the abstractor should select “UTD.”

Example:
Documentation indicates the \textit{ED Departure Time} was 3300. No other documentation in the list of ONLY Acceptable Sources provides a valid time. Since the \textit{ED Departure Time} is outside of the range in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD.”

\textbf{Note:} Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse. Use of “UTD” for \textit{ED Departure Time} allows the case to be accepted into the warehouse.

Change in the 3\textsuperscript{rd} bullet:
‘enter’
To
‘select’
**Rational:** Update data element to provide consistency with other date data elements and provide clarity to abstractors.

---

**Data Element Name:** *ICD-9-CM Principal Diagnosis Code*

**Impacts:** ED-1, ED-2

**Description of Change:**

*Collected For*

*Add:*

*CMS Voluntary Only: ED-1, ED-2*

*Inclusion Guidelines for Abstraction*

*Add: ED*

*Exclusion Guidelines for Abstraction*

*Add: ED*

**Rational:** Update data element to provide consistency with other date data elements and provide clarity to abstractors.

---

**Emergency Department (ED) Measure Information Form**

**Impact:** ED Data Element List

**Description of Change:**

*ED Data Element List*

*Change: Extensive changes were made to the ED List – see document for all changes.*

**Rational:** CMS has made the decision to change the ED Measures to Voluntary in order to allow hospitals to begin submitting data for this measure set.

---

**Impacts:** ED-1

**Description of Change:**

*Measure Information Form*

*Change: Extensive changes were made to the ED-1 Measures Information Form – see document for all changes.*

**Rational:** CMS has made the decision to change the ED Measures to Voluntary in order to allow hospitals to begin submitting data for this measure set.

---

**Impacts:** ED-2

**Description of Change:**

*Change: Extensive changes were made to the ED-2 Measures Information Form – see
Rational: CMS has made the decision to change the ED Measures to Voluntary in order to allow hospitals to begin submitting data for this measure set.

Emergency Department (ED) Algorithm

Impact: ED-1

Description of Change:
Algorithm
Change: Extensive changes were made to the ED-1 Algorithm – see document for all changes.

Rationale: CMS has made the decision to change the ED Measures to Voluntary in order to allow hospitals to begin submitting data for this measure set.

Impacts: ED-2

Description of Changes:
Algorithm
Change: Extensive changes were made to the ED-2 Algorithm – see document for all changes.

Rationale: CMS has made the decision to change the ED Measures to Voluntary in order to allow hospitals to begin submitting data for this measure set.

Population and Sampling Specifications

Impacts: N/A

Description of Changes:
Order of Data Flow
Add ED Order of Data Flow/Process Steps. Please refer to the Population and Sampling Specifications section for specific details.

Rationale: To provide guidance regarding the modified data flow or process steps that can be used to determine the population and sample cases if the hospital is voluntarily submitting the ED Measure Set.

Data Transmission

Impacts: N/A

Description of Changes:
CMS and Joint Commission Guidelines for Submission of Hospital Clinical Data
Add to Allowable Measure Set Combination per Patient Episode of Care:
3. QIO Clinical Warehouse Only
   a. AMI and ED for patients age 18 and older
   b. HF and ED for patients age 18 and older
   c. PN and ED for patients age 18 and older
   d. SCIP and ED

Rationale: To provide additional guidance regarding the allowable measure set combinations.

Transmission Alphabetical Data Dictionary

Impacts: Initial Patient Population Size – Medicare Only

Description of Changes:
Format
Add “ED” to the listing of measure sets under the Occurs for Non-stratified Measure Sets

Rationale: Addition of the ED Measure Set.

Impacts: Initial Patient Population Size – Non-Medicare Only

Description of Changes:
Format
Add “ED” to the listing of measure sets under the Occurs for Non-stratified Measure Sets

Rationale: Addition of the ED Measure Set.

Impacts: Measure Set

Description of Changes:
Format
Change the Hospital Initial Patient Population Data file Occurs from 1 – 7 to 1 – 8.

Rationale: Addition of the ED Measure Set.

Impacts: Sample Size – Medicare Only

Description of Changes:
Format
Add “ED” to the listing of measure sets under the Occurs for Non-stratified Measure Sets

Rationale: Addition of the ED Measure Set.
Impacts: Sample Size – Non-Medicare Only

Description of Changes:
Format
Add “ED” to the listing of measure sets under the Occurs for Non-stratified Measure Sets

Rationale: Addition of the ED Measure Set.

Impacts: Sampling Frequency

Description of Changes:
Format
Add “ED” to the listing of measure sets under the Occurs for Non-stratified Measure Sets

Rationale: Addition of the ED Measure Set.

Hospital Initial Patient Population Data XML File

Impacts: <measure-set>

Description of Changes:
Elements
Add ED (CMS Voluntary Only) to the Valid Values

Rationale: Addition of the ED Measure Set.

Impacts: Population Size <medicare>

Description of Changes:
Elements
Add For ED Only: Can be null or left blank to the Valid Values

Rationale: Addition of the ED Measure Set.

Impacts: Population Size <non-medicare>

Description of Changes:
Elements
Add For ED Only: Can be null or left blank to the Valid Values

Rationale: Addition of the ED Measure Set.
Impacts: <sampling-frequency>

Description of Changes:
Elements
Add For ED Only: Can be null or left blank to the Valid Values

Rationale: Addition of the ED Measure Set.

---

Impacts: Sample Size <medicare>

Description of Changes:
Elements
Add For ED Only: Can be null or left blank to the Valid Values

Rationale: Addition of the ED Measure Set.

---

Impacts: Sample Size <non-medicare>

Description of Changes:
Elements
Add For ED Only: Can be null or left blank to the Valid Values

Rationale: Addition of the ED Measure Set.

---

Hospital Clinical Data XML File Layout

Impacts: <episode-of-care>

Description of Changes:
Elements
Add ED (CMS Voluntary Only) to the Valid Values

Rationale: Addition of the ED Measure Set.

---

Impacts: Arrival Date

Description of Changes:
Hospital Clinical Data – Data Elements Information
Add ED-1 to Applicable Measure(s)

Add CMS Voluntary Only: ED-1 to the Programming Notes

Rationale: Addition of the ED Measure Set.
Impacts: Arrival Time

Description of Changes:
Hospital Clinical Data – Data Elements Information
Add ED-1 to Applicable Measure(s)

Add CMS Voluntary Only: ED-1 to the Programming Notes

Rationale: Addition of the ED Measure Set.

---

Impacts:
Decision to Admit Date
Decision to Admit Time
ED Departure Date
ED Departure Time
Observation Services

Description of Changes:
Hospital Clinical Data – Data Elements Information
Add new data elements:
Decision to Admit Date
Decision to Admit Time
ED Departure Date
ED Departure Time
Observation Services

Rationale: Addition of the ED Measure Set.

---

Impacts: ICD-9-CM Principal Diagnosis Code

Description of Changes:
Hospital Clinical Data – Data Elements Information
Add ED-1, ED-2 to Applicable Measure(s)

Add CMS Voluntary Only: ED-1, ED-2 to the Programming Notes

Rationale: Addition of the ED Measure Set.

---

Appendices

Appendix H

Impacts: N/A

Description of Changes:
Table 2.7
Add ED to the Allowable Measure Set Combinations

Add Footnote 2 This measure set is CMS Voluntary Only. The measure set combinations containing this set is only applicable for the transmission of data to the QIO Clinical Warehouse.

Rationale: Addition of the ED Measure Set.