Guidelines for Using Release Notes

Release Notes 4.2 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 01-01-2013, 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.
  
  **Note:** In addition to being called out specifically in the Release Notes document, simple additions will be grey highlighted in the Release notes.
- **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 **yellow highlighted** in the corresponding document.

**Exceptions:** The additions and changes to the Algorithms are not yellow highlighted, and the Hospital Initial Patient Population and Clinical Data XML File Layouts are **yellow 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.
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Note: Click on any section header to return to Table of Contents page.

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**Release Notes version 4.2** - The notes in the tables below are organized to follow the Table of Contents in the specifications manual. The **implementation date is 01/01/2013** unless otherwise specified.

**Table of Contents**

No updates in this section.

**Acknowledgement**

No updates in this section.

**Introduction**

**Impacts:**  HAC

  **Data Element(s):**
  N/A

**Rationale:**  Remove reference to hospital reporting program name RHQDAPU.

**Description of Changes:**

**Introduction**

**Remove:**

"formerly known as the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program."

**Using the Manual**

**Impacts:**  Using the Manual Section

**Rationale:**  To provide further clarification as to the initial selection of cases that are intended for the inpatient national quality measures.

**Description of Changes:**

**Change**  last paragraph

**From:**

The initial selection of medical records, intended for data abstraction of the National Hospital Quality Inpatient Measures, must meet the following criteria:

- All "acute inpatient" episodes of care billed under the hospitals acute CMS Certification Number (CCN)
- All payor sources

For measure set specific Initial Patient Populations, refer to Section 2 ("Measurement Information") and Section 4 ("Population and Sampling Specifications") of this manual.

**To:**

The initial selection of medical records, intended for data abstraction of the National Hospital Quality Inpatient Measures, must meet the following criteria:

- All units/areas of the hospital licensed under the hospitals acute CMS Certification Number (CCN). The acute CCN is identified by a 3rd digit of “0” for IPPS hospitals and a 3rd & 4th digit of “13” for Critical Access Hospitals.
- All inpatient episodes of care billed under the hospitals acute CCN
- All payor sources

For measure set specific Initial Patient Populations, refer to Section 2 (“Measurement Information”) and Section 4 (“Population and Sampling Specifications”) of this manual.

### SECTION 1 – Data Dictionary

**Impacts:** Introduction to the Data Dictionary

**Rationale:** As Transmission Alphabetical Data Dictionary and XML Layout file identify specific organizational elements or transmission elements, footnotes are not needed in this document.

**Description of Changes:**

**Introduction**

**Remove** footnotes from all of the general data element listings

---

**Impacts:** Alphabetical Data Dictionary

**Data Element(s)**

- Admission Date

**Measure(s)**

- N/A

**Rationale:** To ensure that the correct Form Locators are being used if the claim/UB is being used to obtain the Admission Date.

**Description of Changes:**

**Notes for Abstraction**

**Add** to the end of the first bullet:

If using claim information, the ‘Statement Covers Period’ is not synonymous with the ‘Admission Date’ and should not be used to abstract this data element. These are two distinctly different identifiers:

- The Admission Date (Form Locator 12) is purely the date the patient was admitted as an inpatient to the facility.
- The Statement Covers Period (“From” and “Through” dates in Form Locator 6) identifies the span of service dates included in a particular claim. The “From” Date is the earliest date of service on the claim.

---

**Impacts:** Alphabetical Data Dictionary

**Data Element(s)**

- Admission Date

**Measure(s)**

- N/A

**Rationale:** To provide clarification regarding the admission date for newborns born within the hospital.

**Description of Changes:**

**Notes for Abstraction**
**Add** bullet:
- For newborns that are born within this hospital, the admission date would be the date the baby was born.

**Impacts:**
- Alphabetical Data Dictionary
  - Data Element(s)
  - Admission Date
  - Measure(s)
  - All

**Rationale:**
To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

**Description of Changes:**
- Allowable Values
- Change Year
  - From: (2001 – Current Year)
  - To: (20xx)

**Add:**
- Note: For CMS, only dates that are equal to or less than 120 days from the Discharge Date will be accepted into the QIO Clinical Warehouse.
  - Refer to the Data Transmission section of this manual for further guidance related to data transmission.

**Impacts:**
- Alphabetical Data Dictionary
  - Data Element(s)
  - Alcohol or Drug Use Status Post Discharge
  - Alcohol or Drug Use Status Post Discharge – Counseling
  - Alcohol or Drug Use Status Post Discharge – Medication
  - Alcohol Use Status Post Discharge – Quit Status
  - Drug Use Status Post Discharge – Quit Status
  - Measure(s)
  - SUB-4

**Rationale:**
Measure currently does not utilize the post discharge status information. The original desire of the TAP was that the measure eventually be revised to capture the discharge status information.

**Description of Changes:**
- Alphabetical Data Dictionary List
- Alphabetical Data Dictionary
- Add:
  - Alcohol or Drug Use Status Post Discharge – Counseling
  - Alcohol or Drug Use Status Post Discharge – Medication
  - Alcohol Use Status Post Discharge – Quit Status
  - Drug Use Status Post Discharge – Quit Status
Remove:
Alcohol or Drug Use Status Post Discharge

Impacts: Alphabetical Data Dictionary
Data Element(s)
Alcohol Use Status
Measure(s)
SUB-1
SUB-2
SUB-4

Rationale: A reference list of validated screening instruments for unhealthy alcohol use will provide users with a list of tools that can be used to meet the intent of the measure.

Description of Changes:
Notes for abstraction
Add:
Refer to the Inclusion Guidelines for examples of commonly used validated screening tools; note that the CAGE, although a validated tool, is not recommended for this measure set.

Inclusion Guidelines for Abstraction
Add:
Validated Screening Tools for Alcohol Use: This list is not ALL Inclusive
- AUDIT
- AUDIT-C
- ASSIST
- TWEAK
- CRAFFT
- MAST
- G-MAST

Exclusion Guidelines for Abstraction:
Add:
CAGE

Impacts: Alphabetical Data Dictionary
Data Element(s)
Anesthesia End Date
Measure(s)
SCIP-Inf-2
SCIP-Inf-3
SCIP-Inf-4
SCIP-Inf-9
SCIP-Inf-10
SCIP-Card-2
SCIP-VTE-1
SCIP-VTE-2
**Rationale:** To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

**Description of Changes:**

**Allowable Values**

**Change Year**

From: 
(2001 – Current Year)

To: 
(20xx)

**Impacts:** Alphabetical Data Dictionary

<table>
<thead>
<tr>
<th>Data Element(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia Start Date</td>
</tr>
<tr>
<td>Anticoagulation Therapy Prescribed at Discharge</td>
</tr>
<tr>
<td>Antithrombotic Therapy Administered by End of Hospital Day 2</td>
</tr>
<tr>
<td>Antithrombotic Therapy Prescribed at Discharge</td>
</tr>
<tr>
<td>Arrival Date</td>
</tr>
<tr>
<td>Arrival Time</td>
</tr>
<tr>
<td>Assessed for Rehabilitation Services</td>
</tr>
<tr>
<td>Atrial Fibrillation/Flutter</td>
</tr>
<tr>
<td>Clinical Trial</td>
</tr>
<tr>
<td>Comfort Measures Only</td>
</tr>
<tr>
<td>Date Last Known Well</td>
</tr>
<tr>
<td>Discharge Disposition</td>
</tr>
<tr>
<td>Discharge Instructions Address Compliance Issues</td>
</tr>
<tr>
<td>Discharge Instructions Address Dietary Advice</td>
</tr>
<tr>
<td>Discharge Instructions Address Follow-up Monitoring</td>
</tr>
<tr>
<td>Discharge Instructions Address Potential for Adverse Drug Reactions and Interactions</td>
</tr>
<tr>
<td>ED Patient</td>
</tr>
<tr>
<td>Education Addresses Activation of Emergency Medical System (EMS)</td>
</tr>
<tr>
<td>Education Addresses Follow-up After Discharge</td>
</tr>
<tr>
<td>Education Addresses Medications Prescribed at Discharge</td>
</tr>
<tr>
<td>Education Addresses Risk Factors for Stroke</td>
</tr>
<tr>
<td>Education Addresses Warning Signs and Symptoms of Stroke</td>
</tr>
<tr>
<td>Elective Carotid Intervention</td>
</tr>
<tr>
<td>ICU Admission Date</td>
</tr>
<tr>
<td>ICU Admission or Transfer</td>
</tr>
<tr>
<td>ICU Discharge Date</td>
</tr>
<tr>
<td>ICU VTE Prophylaxis</td>
</tr>
<tr>
<td>ICU VTE Prophylaxis Date</td>
</tr>
<tr>
<td>INR Value</td>
</tr>
<tr>
<td>IV OR IA Thrombolytic (t-PA) Therapy Administered at This Hospital or Within 24 Hours Prior to Arrival</td>
</tr>
<tr>
<td>IV Thrombolytic Initiation</td>
</tr>
<tr>
<td>IV Thrombolytic Initiation Date</td>
</tr>
<tr>
<td>IV Thrombolytic Initiation Time</td>
</tr>
</tbody>
</table>
Last Known Well
LDL-c Greater Than or Equal to 100 mg/dL
LDL-c Measured Within the First 48 Hours or 30 Days Prior to Hospital Arrival
Monitoring Documentation
Overlap Therapy
Overlap Therapy Start Date
Parenteral Anticoagulant End Date
Parenteral Anticoagulant Prescribed at Discharge
Pre-Arrival Lipid-Lowering Agent
Reason for Discontinuation of Overlap Therapy
Reason for No VTE Prophylaxis – Hospital Admission
Reason for No VTE Prophylaxis – ICU Admission
Reason for Not Administering Antithrombotic Therapy by End of Hospital Day 2
Reason for Not Initiating IV Thrombolytic
Reason for Not Prescribing Anticoagulation Therapy at Discharge
Reason for Not Prescribing Antithrombotic Therapy at Discharge
Reason for Not Prescribing Statin Medication at Discharge
Statin Medication Prescribed at Discharge
Surgery End Date
Surgery End Date – ICU Admission
Surgical Procedure
Surgical Procedure – ICU Admission
Time Last Known Well
UFH Therapy Administration
VTE Confirmed
VTE Diagnostic Test
VTE Present at Admission
VTE Prophylaxis
VTE Prophylaxis Date
VTE Prophylaxis Status
Warfarin Administration
Warfarin Prescribed at Discharge

Measure(s)
All STK
All VTE

Rationale: Change based on August 1, 2011 published IPPS Final Rule.

Description of Changes:
Alphabetical Data Dictionary List and Data Elements – Collected For
Remove footnotes from the STK and VTE measure listings
Change all STK and VTE measure listings:
From: Collected For: The Joint Commission Only and CMS Informational Only
To: Collected For: CMS/The Joint Commission

Impacts:
Alphabetical Data Dictionary
Data Element(s)
Anesthesia Start Date
Measure(s)
SCIP-Inf-1
SCIP-Inf-2
SCIP-Inf-3
SCIP-Inf-4
SCIP-Inf-6
SCIP-Inf-9
SCIP-Inf-10
SCIP-Card-2
SCIP-VTE-1
SCIP-VTE-2
VTE-2

**Rationale:**
To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

### Description of Changes:

**Allowable Values**

**Change Year**
From:
(2001 – Current Year)
To:
(20xx)

**Impacts:**
Alphabetical Data Dictionary
- Data Element(s)
  - Anesthesia Type
Measure(s)
- SCIP-Inf-10
- SCIP-VTE-1
- SCIP-VTE-2

**Rationale:**
Adding TIVA as an inclusion for general anesthesia for clarification.

### Description of Changes:

**Inclusion Guidelines for Abstraction:**

**Add** under General Anesthesia:
- Total Intravenous Anesthesia (TIVA)

**Impacts:**
Alphabetical Data Dictionary
- Data Element(s)
  - Antibiotic Administration Date
  - Antibiotic Administration Time
  - Antibiotic Administration Route
  - Antibiotic Name
Measure(s)
- SCIP-Inf-1
- SCIP-Inf-2
- SCIP-Inf-3
Rationale: Instructions were added regarding the collection of test doses of antibiotics. A correction was made in the Example in the last bullet in the Notes for Abstraction.

Description of Changes:

Notes for Abstraction

Change first bullet in the section titled For SCIP-Inf to:

- Do not abstract test doses of antibiotics.

Change last bullet to:

Example: Arrival time and date were 07:00 on 04-02-20xx

_Surgical Incision Time_ was 12:00. _Anesthesia End Time_ was 14:00.
Cefazolin was administered at 08:00, 10:00, 15:30, 17:00 and 19:00 on 04-02-20xx.

Abstract:

**First dose:** cefazolin 08:00 4-02-20xx IV

**Second dose:** cefazolin 10:00 4-02-20xx IV

**Last dose:** cefazolin 19:00 4-02-20xx IV

Impacts: Alphabetical Data Dictionary

_Data Element(s)_

*Antibiotic Administration Date*

_Measure(s)_

PN-3b
PN-6
PN-6a
PN-6b
SCIP-Inf-1
SCIP-Inf-2
SCIP-Inf-3

Rationale: To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

Description of Changes:

Allowable Values

Change Year

From: (2001 – Current Year)

To: (20xx)

Impacts: Alphabetical Data Dictionary

_Data Element(s)_

*Antibiotic Allergy*

_Measure(s)_

PN-6
PN-6a
PN-6b
SCIP-Inf-2
Rationale: Instructions were clarified regarding documentation of other intolerances to and reasons for not administering a beta-lactam, penicillin, or cephalosporin.

Description of Changes:

Notes for Abstraction:

Change the 2nd bullet

To:

If one source in the record documents “Allergies: penicillin” and another source in the record documents “penicillin causes upset stomach,” or other intolerance to one of these medications, select “Yes”.

Remove the last bullet:

- If a physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist documents a specific reason not to give penicillin, beta-lactams, or cephalosporins, select “Yes”.

Impacts: Alphabetical Data Dictionary

Data Element(s)

Anticoagulation Therapy Prescribed at Discharge

Measure(s)

STK-3

Rationale: Provide clarification for abstractor; consistency with inclusion guidelines in similar data elements across other measure sets.

Description of Changes:

Definition

Change:

Documentation that anticoagulation therapy was prescribed at hospital discharge.

Anticoagulant medications prevent the clotting of blood.

Impacts: Alphabetical Data Dictionary

Data Element(s)

Antithrombotic Therapy Administered by End of Hospital Day 2

Measure(s)

STK-5

Rationale: Provide clarification for abstractor; consistency with inclusion guidelines in similar data elements across other measure sets.

Description of Changes:

Definition

Change:

Documentation that antithrombotic therapy was administered by the end of hospital day 2. Antithrombotics include both anticoagulant and antiplatelet drugs.

Notes for Abstraction

Change first bullet:

- To compute end of hospital day 2, count the arrival date as hospital day 1. If
antithrombotic therapy was administered by 11:59 P.M. of hospital day two, select “Yes” for this data element. Documentation of antithrombotic administration must be found within the timeframe of arrival to the end of hospital day 2. It is not necessary to review documentation outside of this timeframe to answer this data element.

Remove fifth bullet:
Documentation of antithrombotic administration must be found within the timeframe of arrival to the end of hospital day 2. It is not necessary to review documentation outside of this timeframe to answer this data element.

### Impacts:
- Alphabetical Data Dictionary

#### Data Element(s)
- Antithrombotic Therapy Prescribed at Discharge

#### Measure(s)
- STK-2

### Rationale:
Provide clarification for abstractor; consistency with inclusion guidelines in similar data elements across other measure sets.

### Description of Changes:

#### Definition

#### Change:
Documentation that antithrombotic therapy was prescribed at hospital discharge. Antithrombotics include both anticoagulant and antiplatelet drugs.

### Impacts:
- Alphabetical Data Dictionary

#### Data Element(s)
- Arrival Date

#### Measure(s)
- AMI-1
- AMI-7
- AMI-7a
- AMI-8
- AMI-8a
- ED-1
- PN-3a
- PN-3b
- PN-6
- PN-6a
- PN-6b
- STK-4
- STK-5

### Rationale:
To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

### Description of Changes:

#### Allowable Values
**Change** Year
From: (2001 – Current Year)
To: (20xx)

**Impacts:** Alphabetical Data Dictionary
  *Data Element(s)*
  *Assessed for Rehabilitation Services*

  *Measure(s)*
  STK-10

**Rationale:** Provide clarification for abstractor; consistency with inclusion guidelines in similar data elements across other measure sets.

**Description of Changes:**

**Notes for Abstraction**

**Change** fourth bullet:
- When an assessment is not found in the medical record but documentation indicates that rehabilitation services were initiated (i.e., Physical Therapy (PT), Occupational Therapy (OT), Speech Language Therapy (SLT), Neuropsychology) during the hospital stay, select “Yes”.
  Examples:
  - “PT x2 for range of motion (ROM) exercises at bedside.”
  - Patient aphasic – evaluated by speech pathology”

**Suggested Data Sources:**

**Add:**
PHYSICIAN/PT/OT/SLT OR NEUROPSYCHOLOGIST DOCUMENTATION ONLY FOR REHABILITATION ASSESSMENT:

**Excluded Data Sources:**

**Change:**
**Excluded Data Sources:**
- Nursing notes
- Nursing assessments for activities of daily living (ADLs).

**Inclusion Guidelines for Abstraction:**

**Change** third bullet:
- Rehabilitation team members include:
  - Physician
  - Psychiatrist
  - Neuro-psychologist
  - Physical therapist
  - Occupational therapist
  - Speech and language pathologist

**Impacts:** Alphabetical Data Dictionary
  *Data Element(s)*
**Beta-Blocker Current Medication**

Measure(s)  
SCIP-Card-2

**Rationale:** Clarification is being added to the Notes for Abstraction, based on the significant number of emails/questions regarding the previous changes made in the data elements related to SCIP-Card-2.

**Description of Changes:**

**Notes for Abstraction:**

**Change** the 1st Bullet:
- If there is documentation that the beta-blocker was taken daily at home or as a current medication prior to arrival, select “Yes”. If the patient was transferred from a facility where they were started on a beta-blocker as a daily medication, select “Yes”.

**Change** bullets 3-12
- If a beta-blocker was a daily “home” or “current” medication, and the physician documents to discontinue or hold the beta-blocker before surgery along WITH a documented reason for not administering the beta-blocker, select “No”.
- If a beta-blocker was a daily “home” or “current” medication, and the physician documents to hold or discontinue the beta-blocker before surgery WITHOUT a documented reason for not administering the beta-blocker, select “Yes”.
- The use of hypotension as a reason must be substantiated by documentation that the blood pressure was < 100 mm/Hg. The use of bradycardia as a reason must be substantiated with documentation that the heart rate was less than 50 bpm.
- If the patient stopped or was not taking a beta-blocker prior to arrival but was started on one in the hospital prior to surgery, select “No”.
- A checklist does not take priority over specific documentation that a beta-blocker was or was not a home medication. Example: The home medication list shows a beta-blocker as a daily home medication and a checklist on the anesthesia form indicates: No. This is not sufficient to select “No”.
- When conflicting documentation exists concerning whether or not the beta-blocker was being taken on a daily basis or if the patient stopped taking it at home, there must be clear documentation that they actually stopped or had not been taking the medication to select “No”. Do not select “No” based on documentation that the patient did not take the beta-blocker “the day before” or “misses it sometimes”.
- The lack of the beta-blocker on one form is not sufficient to select “No” if the beta-blocker is listed as a daily home medication on another form. Without specific documentation that a beta-blocker was not a daily home medication or that the patient was not taking it, select “Yes”.
- If a list of medications is labeled as current medications but is clearly a list of current medications that were started during the hospital stay and not a list of current home medications, select “No”.
- If there is documentation that the beta-blocker is on a schedule other than daily or was given on a “prn basis” for cardiac or non-cardiac reasons, select “No”.
- A beta-blocker can be given more than once daily, the number of doses in a day does not affect abstraction.
**Impacts:** Alphabetical Data Dictionary

Data Element(s)

*Beta-Blocker Perioperative*

Measure(s)

SCIP-Card-2

**Rationale:** Clarification is being added to the Notes for Abstraction, based on the significant number of emails/questions regarding the previous changes made in the data elements related to SCIP-Card-2.

**Description of Changes:**

**Notes for Abstraction**

**Change the 1st bullet:**

To select Value “1”, there must be a date or other documentation that the last dose of the beta-blocker was taken on the day prior to the day of surgery. This can include a date for the last dose or specific documentation on the day of surgery that the patient took the beta-blocker on the day before surgery, such as “patient states they took beta-blocker last night before going to bed” or “states took beta-blocker yesterday”.

---

**Impacts:** Alphabetical Data Dictionary

Data Element(s)

*Comfort Measures Only*

Measure(s)

All HF Measures
All PN Measures
AMI-1
AMI-2
AMI-3
AMI-5
AMI-10
STK-1
STK-2
STK-3
STK-5
STK-6
STK-8
STK-10
VTE-1
VTE-2
VTE-3
VTE-4
VTE-6

**Rationale:** These changes will provide clarification for the abstractor, reduce abstraction burden, improve consistency, and reduce false measure exclusions.

**Description of Changes:**

**Definition**

**Change:**
Comfort Measures Only refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient’s family. Comfort Measures Only is commonly referred to as “comfort care” by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

**Change** Third bullet:
- Determine the earliest day the physician/APN/PA DOCUMENTED comfort measures only in the ONLY ACCEPTABLE SOURCES. Do not factor in when comfort measures only was actually instituted.
  
  **Examples:**
  - “Discussed comfort care with family on arrival” noted in day 2 progress note – Select “2”.
  - POLST order for comfort care dated prior to arrival – Select “1”.

**Remove** Fifth bullet:
- Consider comfort measures only documentation in the discharge summary as documentation on the last day of the hospitalization, regardless of when the summary is dictated.

**Change** Sixth bullet:
- Documentation of an Inclusion term in the following situations should be disregarded. Continue to review the remainder of the ONLY ACCEPTABLE SOURCES for acceptable Inclusion terms. If the ONLY documentation found is an Inclusion term in the following situations, select value “4”:
  
  **Examples:**
  - Documentation that is dated prior to arrival or documentation which refers to the pre-arrival time period (e.g., comfort measures only order in previous hospitalization record, “Pt. on hospice at home” in MD ED note).
  - If there is a specific option for “Comfort Measures Only” (or other Inclusion term) that is unchecked, then disregard documentation on that form, regardless of whether that Inclusion term might be used in a different option that is checked.

**EXCEPTION:**
State-authorized portable orders (SAPOs). SAPOs are specialized forms, Out-of-Hospital DNR (OOH DNR) or Do Not Attempt Resuscitation (DNAR) orders, or identifiers authorized by state law, that translate a patient’s preferences about specific-end-of-life treatment decisions into portable medical orders.

**Examples:**
- DNR-Comfort Care form
- MOLST (Medical Orders for Life-Sustaining Treatment)
- POLST (Physician Orders for Life-Sustaining Treatment)
- Pre-printed order forms signed by the physician/APN/PA:
  - Disregard an Inclusion term in a statement that is not part of the order or that is not clearly selected (on a form that offers options to select from).
    
    **Examples:**
    - Inclusion term used only in the title of the form (e.g., “DNR-Comfort Care” form, option “Comfort Care” is not checked)
    - Inclusion term used only in the pre-printed instruction for completing the form (e.g., “Copy of form to hospice”, “Instructions” section of the form further defines the option “Comfort care”)
    - If there is a specific option for “Comfort Measures Only” (or other Inclusion term) that is unchecked, then disregard documentation on that form, regardless of whether that Inclusion term might be used in a different option that is checked.
Example:
- POLST form - The “Limited Additional Interventions” option checked is described as “In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, …”.

- Inclusion term clearly described as negative.
  Examples:
  - “No comfort care”
  - “Not a hospice candidate”
  - “Not appropriate for hospice care”
  - “I offered hospice care consult to discuss end of life issues. Family did not show any interest.”
  - “Patient declines hospice care at this time but I feel this will be an important plan of care when his condition deteriorates further”
  - “Comfort care would also be reasonable - defer decision for now”

- Comfort measures made conditional upon whether or not the patient arrests.
  Examples:
  - “DNRCCA” (Do Not Resuscitate – Comfort Care Arrest)
  - “Comfort Care Protocol will be implemented in the event of a cardiac arrest or a respiratory arrest”
  - “Family requests comfort measures only should the patient arrest.”

Add bullet:
- Documentation of “CMO” should be disregarded if documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., “hx dilated CMO” – Cardiomyopathy context).

Suggested Data Sources:
Add bullet:
- Emergency department record

Exclusion Guidelines for Abstraction
Remove:
DNR-Comfort Care Arrest Inclusion list
Add:
None

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>Alphabetical Data Dictionary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Element(s)</td>
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<td></td>
<td>PN-6a</td>
</tr>
<tr>
<td></td>
<td>PN-6b</td>
</tr>
</tbody>
</table>

Rationale: Patients with a prolonged QT interval have a clinical condition requiring alternative antibiotic treatment.

Description of Changes:
Definition
Change to:
1. The patient has a clinical condition that could justify alternative antibiotic treatment or is on a therapy that puts them at a higher risk for infection.

**Notes for Abstraction:**

**Add** bullet:
- If there is physician/APN/PA documentation within 24 hours after hospital arrival that the patient has a “prolonged” QT interval (QTc), select value “1”.

**Inclusion Guidelines for Abstraction:**

**Add:**

**Compromising Conditions Within the first 24 Hours After Hospital Arrival:**
- Prolonged QT interval (QTc)

**Impacts:**

<table>
<thead>
<tr>
<th>Alphabetical Data Dictionary</th>
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<tbody>
<tr>
<td>Data Element(s)</td>
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<tr>
<td>Date Last Known Well</td>
</tr>
<tr>
<td>Measure(s)</td>
</tr>
<tr>
<td>STK-4</td>
</tr>
</tbody>
</table>

**Rationale:**
Provide clarification for abstractor; consistency with inclusion guidelines in similar data elements across other measure sets.

**Description of Changes:**

**Notes for Abstraction**

**Change** second bullet:
- The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid date/format) and no other documentation is found that provides this information, the abstractor should select “UTD”. Example:
  Documentation indicates the date last known well was 03-**42**-20xx. No other documentation in the medical record provides a valid date. Since the Date Last Known Well is outside of the range listed in the Allowable Values for “Day,” it is not a valid date 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 and the Joint Commission’s Data Warehouse. Use of “UTD” for Date Last Known Well allows the case to be accepted into the warehouse.

**Add:**
- If there are multiple dates of last known well documented, use the date recorded according to the following hierarchy:
  1. Neurology
  2. Admitting physician
  3. Emergency department physician
  4. ED nursing notes
  5. EMS
- If multiple dates last known well are documented by the same provider, use the earliest date recorded by that provider.

**Impacts:**

| Alphabetical Data Dictionary |
### Data Element(s)

**Date Last Known Well**

### Measure(s)

STK-4

**Rationale:** To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

### Description of Changes:

**Allowable Values**

**Change Year**

From: (2001 – Current Year)

To: (20xx)

**Impacts:** Alphabetical Data Dictionary

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</table>

**Rationale:** To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

### Description of Changes:

**Allowable Values**

**Change Year**

From: (2001 – Current Year)

To: (20xx)

**Impacts:** Alphabetical Data Dictionary

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<th>Data Element(s)</th>
<th>Discharge Date</th>
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<tbody>
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</table>

**Rationale:** To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

### Description of Changes:

**Allowable Values**

**Change Year**

From: (2001 – Current Year)

To: (20xx)
Add:
Note: The QIO Clinical Warehouse only allows data containing dates applicable to a specified quarter of data transmission. Data submitted for discharge quarters outside of the current submission deadline will be rejected. Refer to the Data Transmission section of this manual for further guidance related to data transmission.

Impacts: Alphabetical Data Dictionary
Data Element(s)
Discharge Disposition
Measure(s)
AMI-1
AMI-2
AMI-3
AMI-5
AMI-10
HF-1
HF-2
HF-3
IMM-1
IMM-2
PN-3b
CAC-3
STK-2
STK-3
STK-6
STK-8
STK-10
SUB-3
SUB-4
TOB-3
TOB-4
VTE-3
VTE-4
VTE-5

Rationale: These changes will provide clarification for the abstractor, improve consistency, and reduce false measure inclusions.

Description of Changes:
Notes for Abstraction
Change last sentence in First bullet to:
The documentation from 04-06-20xx would be used to select value “5” (“Other Health Care Facility”).

Change Second bullet to:
• Consider discharge disposition documentation in the discharge summary, a post-discharge addendum, or a late entry as day of discharge documentation, regardless of when it was
dictated/written.

Change Third bullet to:
- If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract. If documentation is contradictory, use the latest documentation.
  Examples:
  - Discharge summary dictated 2 days after discharge states patient went “home”. Physician note on day of discharge further clarifies that the patient will be going “home with hospice”. Select value “2” (“Hospice - Home”).
  - Discharge planner note from day before discharge states “XYZ Nursing Home”. Discharge order from day of discharge states “Discharge home”. Contradictory documentation, use latest. Select value “1” (“Home”).
  - Physician order on discharge states “Discharge to ALF”. Discharge instruction sheet completed after the physician order states patient discharged to “SNF”. Contradictory documentation, use latest. Select value “5” (“Other Health Care Facility”).

Change Fourth bullet to:
- If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select value “4” (“Acute Care Facility”).

Change Fifth bullet to:
- When determining whether to select value “7” (“Left Against Medical Advice/AMA”):
  - Explicit “left against medical advice” documentation is not required. E.g., “Patient is refusing to stay for continued care” – Select value “7”.
  - Documentation suggesting that the patient left before discharge instructions could be given does not count.
  - A signed AMA form is not required, for the purposes of this data element.
  - Do not consider AMA documentation and other disposition documentation as “contradictory”. If any source states the patient left against medical advice, select value “7”, regardless of whether the AMA documentation was written last. E.g., AMA form signed and discharge instruction sheet states “Discharged home with belongings” – Select “7”.

Add bullets:
- The medical record must be abstracted as documented (taken at “face value”). Inferences should not be made based on internal knowledge.
- If documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. See Inclusion lists for examples.
  - Acute Care Facility
  - Hospice – Health Care Facility
  - Hospice – Home
  - Other Health Care Facility
  - Home
- Hospice (values “2” and “3”) includes discharges with hospice referrals and evaluations.
- If the medical record identifies the facility the patient is being discharged to by name only (e.g., “Park Meadows”), and does not reflect the type of facility or level of care, select value
“5” (“Other Health Care Facility”).

- If the medical record states only that the patient is being “discharged” and does not address the place or setting to which the patient was discharged, select value “1” (“Home”).

**Excluded Data Sources:**

**Change** First bullet to:

- Any documentation prior to the last two days of hospitalization

Add bullet:

- Coding documents

**Inclusion Guidelines for Abstraction Value 1**

**Change** heading to:

**Home (Value 1):**

**Change** First bullet to:

- Assisted Living Facilities (ALFs) - Includes ALFs and assisted living care at nursing home, intermediate care, and skilled nursing facilities

**Change** Third bullet to:

- Home – includes board and care, foster or residential care, group or personal care homes, retirement communities, and homeless shelters

**Inclusion Guidelines for Abstraction Value 2 Inclusion list:**

Add Value 2 Inclusion list:

**Hospice – Home (Value 2):**

- Hospice in the home (or other “Home” setting as above in Value 1)

**Inclusion Guidelines for Abstraction Value 3**

**Change** heading to:

**Hospice – Health Care Facility (Value 3):**

**Inclusion Guidelines for Abstraction Value 4**

**Change** heading to:

**Acute Care Facility (Value 4):**

**Inclusion Guidelines for Abstraction Value 5**

**Change** heading to:

**Other Health Care Facility (Value 5):**

**Impacts:** Alphabetical Data Dictionary

- Data Element(s)
- ED Departure Date

- Measure(s)
- ED-1
- ED-2

**Rationale:** To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

**Description of Changes:**
Allowable Values

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**Impacts:**

- Alphabetical Data Dictionary
- Data Element(s)
  - *Fibrinolytic Administration Date*
- Measure(s)
  - AMI-7
  - AMI-7a

**Rationale:** To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

**Description of Changes:**

Allowable Values

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**Impacts:**

- Alphabetical Data Dictionary
- Data Element(s)
  - *First PCI Date*
- Measure(s)
  - AMI-8
  - AMI-8a

**Rationale:** To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

**Description of Changes:**

Allowable Values

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<tbody>
<tr>
<td></td>
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<td>(20xx)</td>
</tr>
</tbody>
</table>

**Impacts:**

- Alphabetical Data Dictionary
- Data Element(s)
  - *Follow-Up Contact*
- Measure(s)
  - TOB-4
SUB-4

Rationale: The measures currently do not utilize the post discharge status information. The original desire of the TAP was that the measure eventually be revised to capture the discharge status information. The data element Follow-up Contact is modified to accommodate this change.

Description of Changes:

Change:

Definition

From:
Contact is made for the discharged patient within a specified time frame post discharge and information about the patient's post discharge status relative to alcohol, tobacco, or other drug use is collected and catalogued. Contact with the patient may be made using a variety of methods including phone calls, discussion at follow-up clinic visits; or by mailings (either electronic or hard copy mail) as long as information about alcohol, tobacco, or other drug use post discharge is received and cataloged by the hospital. Post discharge alcohol, tobacco, and other drug use information must be obtained/received in a HIPAA compliant manner.

To:
Contact is made with the discharged patient within a specified time frame post discharge for the purpose of gaining information about the patient's post discharge status relative to alcohol, tobacco, or other drug use. Contact with the patient may be made using a variety of methods including phone calls, discussion at follow-up clinic visits; or by mailings (either electronic or hard copy mail).

Allowable Values

From:
1. A follow up contact was made within the specified time frame post discharge and information regarding substance use was collected.
2. A follow-up contact was made within the specified time frame post discharge; no information regarding substance use was collected.
3. A follow-up contact was not made within the specified time frame post discharge because the patient's residence is not in the USA, the patient was incarcerated, contact number was no longer valid, the patient had no phone, the patient was re-admitted to the hospital within 30 to 45 days post discharge, or at least 6 unsuccessful attempts to contact the patient were made.
4. A follow up contact was not made within the specified time frame post discharge or unable to determine from medical record documentation.

To:
1. A follow-up contact was made within the specified time frame post discharge.
2. A follow-up contact was made but not within the specified time frame post discharge.
3. A follow-up contact was not made within the specified time frame post discharge because the patient's residence is not in the USA, the patient was incarcerated, contact number was no longer valid, the patient had no phone, the patient was re-admitted to the hospital within 30 days post discharge, or at least 6 unsuccessful attempts to contact the patient were made.
4. A follow-up contact was not made within the specified time frame post discharge or unable to determine from medical record documentation.

Notes for Abstraction
**Change:**
1st bullet
From: Select value “4”
To: Select value “2”

**Add**
First Bullet:
The specified time frame for post discharge contact for SUB and TOB are defined as follows:
- **TOB:** A follow-up contact should be made between 15 and 30 days post-discharge
- **SUB:** A follow-up contact should be made between 7 and 30 days post discharge

**Suggested Data Collection Question**

**Change**

From:

**Suggested Data Collection Question:** What is the status of the follow-up contact with the discharged patient relative to their alcohol, tobacco, or other drug use status within 30 days post discharge?

To:

**Suggested Data Collection Question:** Was contact made with the patient within the specified time frame post discharge?

**Suggested Data Sources**

**Change**

From:
Phone call logs or other logs that record follow up information

To:
- Medical record documentation dated within the follow-up time frame
  - Patient specific follow-up forms
  - Other documentation as specified by the hospital.

**Impacts:**

Alphabetical Data Dictionary

**Data Element(s)**

*Follow-Up Contact*

**Measure(s)**

TOB-4

SUB-4

**Rationale:**
Data shows that relapse is most common in the first 2 weeks post discharge so changing the time frame for follow-up to 15-30 days for TOB 4 would move past the relapse period and yield better information. Limiting the number of contact attempts to 6 will reduce burden associated with meeting the measure intent.

**Description of Changes:**

**Notes for Abstraction**

**Add:**
- If trying to contact the patient and at least 6 attempts were made but were unsuccessful, select value 3. If less than 6 unsuccessful attempts were made select value 2.
- If trying to contact the patient by mail or e-mail or phone and a return is received indicating the contact information is no longer valid, select value 3
If the patient is readmitted following the initial hospitalization, select value 3 if the hospitalization continued into the specified time frame for follow-up.

**Change**

Third bullet to:

- If information was obtained in person at the time of a clinic visit that occurred within the specified time frame post discharge, select value “1”.

Fifth bullet to:

- If follow-up contact is made by letter or e-mail and no response is received from patient within the specified timeframe post discharge, select value “4”.

---

**Impacts:** Alphabetical Data Dictionary

Data Element(s)

*Follow-Up Contact Date*

Measure(s)

SUB-4

TOB-4

**Rationale:** To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

**Description of Changes:**

**Allowable Values**

**Change** Year

From:

(2001 – Current Year)

To:

(20xx)

---

**Impacts:** Alphabetical Data Dictionary

Data Element(s)

*Follow-Up Contact Date*

Measure(s)

SUB-4

TOB-4

**Rationale:** Measure currently does not utilize the post discharge status information. The original desire of the TAP was that the measure eventually be revised to capture the discharge status information.

**Description of Changes:**

**Notes for abstraction**

**Change** First bullet

From:

- If multiple contacts are made with the discharged patient post discharge, select the date of the contact where progress with tobacco or substance use was addressed even if this contact occurred outside of the 30 day window.

To:
• If multiple contacts are made with the discharged patient post discharge, select the date of the latest contact where information is received relative to treatment and quit status.

Remove second bullet (third bullet becomes second bullet):
• If multiple contacts address tobacco or substance use post discharge, select the date of the earliest contact.

Add Third bullet:
• If follow-up contact is not made, select UTD do not leave the date field blank.

Suggested Data Sources
Change
From:
• Phone call logs or other logs that record follow-up information
To:
• Medical Record Documentation within the follow-up time frame
  o Patient specific follow-up forms
  o Other documentation as specified by the hospital

Impacts: Alphabetical Data Dictionary
  Data Element(s)
    Hispanic Ethnicity
    Race

Rationale: The Joint Commission now requires Race and Hispanic Ethnicity.

Description of Changes:
Alphabetical Data Dictionary List - Collected For
Remove footnote for
  Hispanic Ethnicity
  Race

Collected For:
For elements:
  Hispanic Ethnicity
  Race

Change from “CMS Only” to “CMS/The Joint Commission” under the ‘Collected For’

Impacts: Alphabetical Data Dictionary
  Data Element(s)
    ICD-9-CM Other Diagnosis Codes
  Measure(s)
    All VTE

Rationale: Change based on August 1, 2011 published IPPS Final Rule

Description of Changes:
Collected For
**Change to:**
**Collected For: CMS/The Joint Commission:** All Records; **Used in Algorithms for:** CMS/The Joint Commission: IMM-1, PN-3a, PN-3b, All VTE Measures; **CMS Only:** PN-6; **The Joint Commission Only:** PN-6a, PN-6b, SUB-3, SUB-4, TOB-2, TOB-3; **CMS Informational Only:** SUB-3, SUB-4, TOB-2, TOB-3

**Impacts:** Alphabetical Data Dictionary

*Data Element(s)*
*ICD-9-CM Other Procedure Dates*

*Measure(s)*
All

**Rationale:**
To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

**Description of Changes:**

*Allowable Values*

**Change Year**
From: (2001 – Current Year)
To: (20xx)

**Impacts:** Alphabetical Data Dictionary

*Data Element(s)*
*ICD-9-CM Principal Diagnosis Code*

*Measure(s)*
STK-2
STK-3
STK-4
STK-5
STK-6
All VTE

**Rationale:** Change based on August 1, 2011 published IPPS Final Rule

**Description of Changes:**

*Collected For:*
*Change to:*

**Collected For: CMS/The Joint Commission:** All Records; **Used in Algorithms for:** CMS/The Joint Commission: ED-1, ED-2, IMM-1, STK-2, STK-3, STK-4, STK-5, STK-6, All VTE Measures; **The Joint Commission Only:** SUB-3, SUB-4, TOB-2, TOB-3; **CMS Informational Only:** SUB-3, SUB-4, TOB-2, TOB-3

**Impacts:** Alphabetical Data Dictionary
**Data Element(s)**
*ICD-9-CM Principal Procedure Code*

**Measure(s)**
VTE-1
VTE-2

**Rationale:** Change based on August 1, 2011 published IPPS Final Rule

**Description of Changes:**

**Collected For**

**Change to:**

**Collected For: CMS/The Joint Commission:** All Records; **Used in Algorithm For: CMS/The Joint Commission:** AMI-8, AMI-8a, All HF Measures, All IMM Measures, SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-4, SCIP-Inf-9, SCIP-Inf-10, SCIP-Card-2, SCIP-VTE-1, SCIP-VTE-2 VTE-1, VTE-2; **The Joint Commission Only:** SCIP-Inf-6, SUB-3, SUB-4; **CMS Informational Only:** SUB-3, SUB-4; **CMS Voluntary Only:** SCIP-Inf-6

**Impacts:**
Alphabetical Data Dictionary

**Data Element(s)**
*ICD-9-CM Principal Procedure Date*

**Measure(s)**
All

**Rationale:** To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

**Description of Changes:**

**Allowable Values**

**Change Year**

**From:**
(2001 – Current Year)

**To:**
(20xx)

**Impacts:**
Alphabetical Data Dictionary

**Data Element(s)**
*ICU Admission Date*

**Measure(s)**
VTE-1
VTE-2

**Rationale:** Clarification for the benefit of the public user.

**Description of Changes:**

**Data Element Name:**

**Change**
*ICU Admission or Transfer Date*
Notes for Abstraction:

**Change**
First Bullet:
- The intent of this data element is to determine the date that the patient was actually admitted to ICU.

**Change**
Second bullet Example to:
Medical record documentation reflects that the patient was admitted to observation on 04-05-20xx. On 04-06-20xx the physician writes an order to admit to ICU. The *ICU Admission or Transfer Date* would be abstracted as 04-06-20xx; the date the determination was made to admit to acute inpatient care and the order was written.

**Change**
Third bullet:
- If there are discrepancies in the physicians order date refer to the ICU admission or transfer vital signs, nurse’s notes or progress notes to determine the date.

**Change**
Fourth bullet:
- If a patient was a direct admit to the ICU for more than one day, subsequent transfers back to an ICU during the same hospitalization will NOT be abstracted.

**Remove**
Fifth Bullet:
- If the patient had more than one ICU admission/transfer greater than one day during hospitalization, select the ICU admission date that was closest to the hospital admission date.

**Change**
Eighth Bullet:
- Documentation indicates the *ICU Admission or Transfer Date* was 03-42-20xx. No other physician order in the medical record provides a valid date. Since the *ICU Admission or Transfer 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.”

**Note:** Transmission of a case with an invalid date as described above will be rejected from the QIO Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” allows the case to be accepted into the warehouses.

**Suggested Data Sources:**
- Remove:
  - Face Sheet
  - UB-04, Field Location: 12

**Impacts:**
Alphabetical Data Dictionary
- *Data Element(s)*
  - *ICU Admission Date*
- *Measure(s)*
  - VTE-1
VTE-2

Rationale: To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

Description of Changes:
Allowable Values

Change Year
From:
(2001 – Current Year)
To:
(20xx)

Impacts: Alphabetical Data Dictionary
Data Element(s)
ICU Discharge Date
Measure(s)
VTE-1
VTE-2

Rationale: Clarification for the benefit of the public user.

Description of Changes:
Notes for Abstraction

Change
First bullet:
- The intent of this data element is to determine the date that the patient was actually discharged from the ICU.

Change
Third bullet:
- A patient may have multiple ICU discharges within the same hospitalization. Select the discharge date that corresponds with the ICU Admission or Transfer Date.

Change Note under 5th bullet to:
Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” allows the case to be accepted into the warehouses.

Suggested Data Sources
Remove:
- Face Sheet
- UB-04, Field Location:6

Impacts: Alphabetical Data Dictionary
Data Element(s)
ICU Discharge Date
Measure(s)
VTE-1
VTE-2

Rationale: To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

Description of Changes:
Allowable Values
Change Year
From:
(2001 – Current Year)
To:
(20xx)

Impacts: Alphabetical Data Dictionary
Data Element(s)
ICU VTE Prophylaxis
Measure(s)
VTE-2

Rationale: Change based on Nov. 4, 2011 FDA approval of rivaroxaban for stroke prevention in patients with atrial fibrillation.

Description of Changes:
Format:
Change: Occurs: 1-8

Allowable Values
Add:
8 Oral Factor Xa Inhibitor

Notes for Abstraction
Change
First Bullet:
• Abstract the initial ICU VTE prophylaxis(s) that was administered the day of or the day after ICU admission or the day of or the day after Surgery End Date for surgeries that start the day of or the day after ICU admission. If no ICU VTE prophylaxis was administered during this timeframe, select value "A" and check for a Reason for No VTE Prophylaxis – ICU Admission.

Second Bullet:
• Selection of allowable values 1-8 includes any prophylaxis that were initially administered on the same date.

Impacts: Alphabetical Data Dictionary
Data Element(s)
**ICU VTE Prophylaxis Date**

**Measure(s)**
VTE-2

**Rationale:** To clarify data element for the general public user.

**Description of Changes:**

**Notes for Abstraction**

**Change:**
Second Bullet note under the Example to:

**Note:** Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” allows the case to be accepted into both warehouses.

**Impacts:**
- Alphabetical Data Dictionary
- Data Element(s)
  - **ICU VTE Prophylaxis Date**
- Measure(s)
  - VTE-2

**Rationale:** To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

**Description of Changes:**

**Allowable Values**

**Change** Year
From: (2001 – Current Year)
To: (20xx)

**Impacts:**
- Alphabetical Data Dictionary
- Data Element(s)
  - **Initial Blood Culture Collection Date**
- Measure(s)
  - PN-3a
  - PN-3b

**Rationale:** To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

**Description of Changes:**

**Allowable Values**

**Change** Year
From: (2001 – Current Year)
To:
(20xx)

**Impacts:**  
Alphabetical Data Dictionary  
**Data Element(s)**  
*Initial ECG Interpretation*

**Measure(s)**  
AMI-7  
AMI-7a  
AMI-8  
AMI-8a

**Rationale:**  
These changes will provide clarification for the abstractor and reduce false measure inclusions/exclusions.

**Description of Changes:**

**Notes for Abstraction**

**Add** Third sentence to step #1 in Methodology section:
Exception: If the pre-arrival ECG and the first ECG performed after arrival at the hospital are exactly the same amount of time away from hospital arrival (e.g., both ECGs are 10 minutes away from *Arrival Time*), use the first ECG performed after hospital arrival.

**Change** step #2 in Methodology section to:
2. Start with review of the SIGNED tracing. Determine if the terms or phrases are Inclusions or Exclusions. Evaluate findings line by line. Do not cross reference between lines except for those Exclusions with “with mention of” phrasing (e.g., LVH and ST-elevation noted on separate lines on the same ECG meets the Exclusion "ST-elevation with any mention of early repolarization, left ventricular hypertrophy (LVH), normal variant, pericarditis, or Printzmetal/Printzmetal's variant in one interpretation"). If you have an Exclusion, select “No,” regardless of other documentation, and there is no need to review further.

**Change** First sentence under step #3 in Methodology section to:
If there is no signed tracing, or in the absence of an Exclusion on the signed tracing, proceed to other interpretations that clearly refer to the ECG done closest to arrival.

**Change** Third bullet to:
Consider a tracing 12-lead if it has the appropriate markings (the presence of at least 12 leads: I, II, III, AVR, AVL, AVF, V1-V6).

**Change** Sixth bullet to:
• If documentation is contradictory within the same interpretation or between different interpretations, select “No”.
  Examples:
  o “ST-elevation” and “No ST-elevation”
  o "STEMI" and "not consistent with STEMI"
  o "Acute anterior MI" and "no acute MI"
    – Documentation such as "ST-elevation in anterior leads" and "not a STEMI" should not be considered contradictory, for the purposes of this data element.
Change Second sentence under 8th bullet to:
- Other documentation of ST-elevation within the same interpretation or a different interpretation may still count as an Inclusion or Exclusion.

Change Ninth bullet to:
- Notations which describe ST-elevation as a range where it cannot be determined if elevation is less than 1 mm/.10mV (e.g., "0.5-1 mm ST-elevation", ST >0.06 mV V2-V6), should be disregarded. Other documentation of ST-elevation within the same interpretation or a different interpretation may still count as an Inclusion or Exclusion.

Inclusion Guidelines for Abstraction  ST-segment elevation
Add:
- "STEMI or equivalent"

Exclusion Guidelines for Abstraction  ST-segment elevation
Change Fourth bullet to:
- ST-elevation (ST ↑) with any mention of early repolarization, left ventricular hypertrophy (LVH), normal variant, pericarditis, or Printzmetal/Printzmetal’s variant in one interpretation

Change Sixth bullet to:
- ST-segment elevation, or any of the other ST-segment elevation Inclusion terms, with any mention of pacemaker/pacing (unless atrial only or nonfunctioning pacemaker) in one interpretation

Change last bullet to:
- ALL ST-elevation (ST ↑, STE) in one interpretation is described in one or more of the following ways:
  o Minimal
  o Non-diagnostic
  o Non-specific
  o ST-elevation (or ST-segment noted as greater than or equal to .10mV/1 mm) described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table (except “possible”)
  o ST-elevation or ST-segment noted as less than .10mV in elevation
  o ST-elevation or ST-segment noted as less than 1 mm in elevation

Exclusion Guidelines for Abstraction  Left bundle branch block (LBBB)
Change last bullet to:
- Left bundle branch block (LBBB), or any of the other left bundle branch block inclusion terms, with any mention of pacemaker/pacing (unless atrial only or nonfunctioning pacemaker) in one interpretation

Impacts:

Alphabetical Data Dictionary
Data Element(s)
IV Thrombolytic Initiation
Measure(s)
STK-4
Rationale: Provide clarification for abstractor; consistency with inclusion guidelines in similar data elements across other measure sets.

Description of Changes:
Notes for Abstraction

Remove first bullet:
• If IV thrombolytic was initiated at this hospital, select “Yes”.

Change fifth bullet:
• When IV thrombolytic therapy is initiated beyond 3 hours (180 min.) because a reason for not initiating IV thrombolytic therapy existed during the 3 hour timeframe, select “No”. Examples:
  • Patient arrives in the emergency department within 2 hours of time last known well. Blood pressure 195/110 mmHg on arrival. Physician documents that patient is within the t-PA window, but blood pressure is an issue. Elevated blood pressure treated prior to t-PA administration. IV thrombolytic therapy administered at 3 hours and 30 minutes from time last known well.
  • Patient arrives in the emergency department within 2 hours of time last known well and refuses t-PA. Family arrives and after further discussion with them, patient consents to t-PA. IV thrombolytic therapy administered 4 hours later.

Impacts: Alphabetical Data Dictionary
Data Element(s)
IV Thrombolytic Initiation Date
Measure(s)
STK-4

Rationale: 1. Provide clarification for abstractor; consistency with inclusion guidelines in similar data elements across other measure sets. 2. Provide consistency with GWTG.

Description of Changes:
Notes for Abstraction:

Change first bullet:
• Use the date at which initiation of the IV thrombolytic was first documented. If a discrepancy exists in date documentation from different sources, choose nursing documentation first before other sources. If multiple dates are documented by the same individual, use the earliest date recorded by that person.

Change third bullet:
• The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid date/format) and no other documentation is found that provides this information, the abstractor should select “UTD”. Example: Documentation indicates the IV thrombolytic initiation date was 03-42-20xx. No other documentation in the medical record provides a valid date. Since the IV thrombolytic initiation 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”.

**Note:** Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for *IV Thrombolytic Initiation Date* allows the case to be accepted into the warehouse.

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<thead>
<tr>
<th>Impacts:</th>
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<tr>
<td></td>
<td>Data Element(s)</td>
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<td><em>IV Thrombolytic Initiation Date</em></td>
</tr>
<tr>
<td>Measure(s)</td>
<td>STK-4</td>
</tr>
</tbody>
</table>

**Rationale:** To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

**Description of Changes:**

**Allowable Values**

**Change Year**

**From:**

(2001 – Current Year)

**To:**

(20xx)

<table>
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<th>Impacts:</th>
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<tr>
<td></td>
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<tr>
<td></td>
<td><em>IV Thrombolytic Initiation Time</em></td>
</tr>
<tr>
<td>Measure(s)</td>
<td>STK-4</td>
</tr>
</tbody>
</table>

**Rationale:**

1. Provide clarification for abstractor; consistency with inclusion guidelines in similar data elements across other measure sets.

2. Provide consistency with GWTG.

**Description of Changes:**

**Definition**

**Change** to:

The time for which IV thrombolytic therapy was initiated at this hospital.

**Notes for Abstraction**

**Change** first bullet:

- Use the time at which initiation of the IV thrombolytic was first documented. If a discrepancy exists in time documentation from different sources, choose nursing documentation first before other sources. If multiple times are documented by the same individual, use the earliest time recorded by that person.

**Change** fifth bullet:

Do not use physician orders unless there is documentation with the order that it was administered.
**Change** seventh bullet:

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

  **Example:**
  Documentation indicates the IV thrombolytic initiation time was 3300. No other documentation in the medical record provides a valid time. Since the IV thrombolytic initiation time is outside of the range listed 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 and the Joint Commission’s Data Warehouse. Use of “UTD” for IV Thrombolytic Initiation Time allows the case to be accepted into the warehouse.

---

**Impacts:**  
Alphabetical Data Dictionary

**Data Element(s)**

Last Known Well

**Measure(s)**

STK-4

**Rationale:**  
Provide clarification for abstractor; consistency with inclusion guidelines in similar data elements across other measure sets.

**Description of Changes:**

**Allowable Values:**

**Change**

**From:**

N (No)  
There is no documentation that the date and time of last known well was witnessed or reported, OR date, time, or both date and time are unknown.

**To:**

N (No)  
There is no documentation that the date and time of last known well was witnessed or reported, OR unable to determine from medical record documentation.

**Suggested Data Sources**

**Add:**

**Excluded Data Sources:**

Discharge summary

---

**Impacts:**  
Alphabetical Data Dictionary

**Data Element(s)**

LDL-c Greater Than or Equal to 100 mg/dL

**Measure(s)**

STK-6

**Rationale:**  
Provide clarification for abstractor; consistency with inclusion guidelines in similar data elements across other measure sets.

**Description of Changes:**
Notes for Abstraction

Change second bullet:
The medical record must be abstracted as documented (taken at “face value”). When the LDL-c value documented is obviously in error (not a valid number) and no other documentation is found that provides this information, the abstractor should select “No”.

**Impacts:**
Alphabetical Data Dictionary

Data Element(s)

LDL-c Measured Within the First 48 Hours or 30 Days Prior to Hospital Arrival

Measure(s)

STK-6

**Rationale:**
Provide clarification for abstractor; consistency with inclusion guidelines in similar data elements across other measure sets.

**Description of Changes:**

**Allowable Values**

<table>
<thead>
<tr>
<th>Change</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL-c not measured within the first 48 hours or 30 days prior to hospital arrival, OR unable to determine from medical record documentation (e.g., LDL-c testing was done within 48 hours but no values are available).</td>
<td>N (No)</td>
<td>N (No)</td>
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</table>

**Impacts:**
Alphabetical Data Dictionary

Data Element(s)

Monitoring Documentation

Measure(s)

VTE-4

**Rationale:**
To clarify understanding for the public user.

**Description of Changes:**

**Suggested Data Collection Question:**

**Change to:**

Suggested Data Collection Question: Was there Physician/Advanced Practice Nurse/Physician Assistant (Physician/APN/PA) or Pharmacist documentation that the IV UFH AND platelet counts were managed by defined parameters using a nomogram or protocol?

**Allowable Values**

<table>
<thead>
<tr>
<th>Change</th>
<th>Y (Yes)</th>
<th>N (No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is Physician/APN/PA or Pharmacist documentation that defined parameters such as a protocol or nomogram were used to manage dosages of the IV UFH AND the platelet counts.</td>
<td></td>
<td>There is no Physician/APN/PA or Pharmacist documentation that defined parameters such as a protocol or nomogram were used to manage dosages of the IV UFH AND the platelet counts.</td>
</tr>
</tbody>
</table>
parameters such as a protocol or nomogram were used to manage dosages of the IV UFH AND/OR the platelet counts or unable to determine from medical record documentation.

Suggested Data Sources

Change to:

Exception:
Nursing documentation on pathways

Inclusion Guidelines for Abstraction:

Remove:
Refer to Appendix H, Table 2.3 VTE Parenteral Therapy Table

Add:
Intravenous (IV) Unfractionated Heparin (UFH)
- HEP
- Heparin
- Heparin Na
- Heparin Sod
- Heparin Sodium

Impacts:  
Alphabetical Data Dictionary
Data Element(s)
Observation Services
Measure(s)
ED-1
ED-2

Rationale: Abstractors requested clarification and change will decrease abstraction burden and align with CMS policy for observation services.

Description of Changes:

Definition
Change to:
Documentation of an order for observation services written by the physician/APN/PA.
Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient.

Suggested Data Collection Question
Change to:

Suggested Data Collection Question: Was there documentation of an order for observation services written by the physician/APN/PA?

Allowable Values
Change:
Y (Yes)  There was documentation of an order for observation services written by the physician/APN/PA.
N (No) There was no documentation of an order for observation services written by the physician/APN/PA or unable to determine from medical record documentation.

Notes for Abstraction

Change First bullet:
- If there is documentation of an order for observation services and the patient received care in observation, select “Yes”.

Remove Second bullet

Change Third bullet to:
- If there is no documentation of an order for observation either in the emergency department or another department, select “No”.

Change Fourth bullet to:
The intent is to capture emergency department patients with an order for observation services prior to admission to the facility as an inpatient.

Suggested Data Sources

ONLY ALLOWABLE SOURCES: Remove:
Emergency Department record

Add:
Physician orders

Inclusion Guidelines for Abstraction

Remove:
“None”

Add:
Orders for:
- Observation
- Observation status
- Observation services
- Admit to observation
- Admit to observation status
- Admit to observation services

Impacts: Alphabatical Data Dictionary
- Data Element(s)
- Overlap Therapy Start Date
- Measure(s)
- VTE-3

Rationale: To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.
Description of Changes:
Allowable Values
Change Year
From:
(2001 – Current Year)
To:
(20xx)

Notes for Abstraction
Change Fourth bullet note under Example to:
Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for Overlap Therapy Start Date allows the case to be accepted into the warehouses.

Impacts:  
Alphabetical Data Dictionary
Data Element(s)
Parenteral Anticoagulant End Date
Measure(s)
VTE-3

Rationale:  
To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

Description of Changes:
Allowable Values
Change Year
From:
(2001 – Current Year)
To:
(20xx)

Notes for Abstraction
Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for Parenteral Anticoagulant End Date allows the case to be accepted into the warehouses.

Impacts:  
Alphabetical Data Dictionary
Data Element(s)
Pneumococcal Vaccination (PPV23) Status
Data Measures(s)
IMM-1

Rationale:  
1) The measure no longer just looks at PPV23 so PPV23 needs to be removed
2) Need to change the lower end of the population age range from 6 years to 5 years of age to match the guidelines

Description of Changes:
Alphabetical Data Dictionary
Data Element List
Pneumococcal Vaccination (PPV23) Status

**REMOVE** (PPV23)

**Data Element Name**
Pneumococcal Vaccination (PPV23) Status

**Allowable Values**
**REMOVE** "(PPV23)" from value “1"

**Change:**
Value 4, Fifth bullet
From:
- “for patients 6 years of age or older who received a conjugate vaccine within the previous 8 weeks”
To:
- “for patients 5 – 18 years of age who received a conjugate vaccine within the previous 8 weeks”

**Notes for Abstraction**
**Change** Sixth bullet
From:
- “In children 6 – 18 years of age”
To:
- “In children 5 – 18 years of age”

**Impacts:**
Alphabetical Data Dictionary

**Data Element(s)**
Pre-Arrival Lipid-Lowering Agent

**Measure(s)**
STK-6

**Rationale:**
Provide clarification for abstractor; consistency with inclusion guidelines in similar data elements across other measure sets.

**Description of Changes:**

**Notes for Abstraction**
**Change** first bullet
If there is documentation that the patient was on a lipid-lowering medication at home but there is indication it was on temporary hold or the patient has been non-compliant/self-discontinued their medication (e.g., refusal, side effects, cost), select “Yes”.

**Impacts:**
Alphabetical Data Dictionary

**Data Element(s)**
Reason for Delay in Fibrinolytic Therapy

**Measure(s)**
AMI-7
AMI-7a
Rationale: These changes will allow physician/APN/PA documentation of an LVAD placement within 30 minutes after hospital arrival to automatically exclude a case when the fibrinolysis was delayed more than 30 minutes. Removing “code” as Inclusion for Arrest will reduce false measure exclusions.

Description of Changes:

Notes for Abstraction

Change EXCEPTIONS section in the 2nd bullet to:

Physician/APN/PA documentation that a cardiopulmonary arrest, mechanical circulatory assist device placement, or intubation occurred within 30 minutes after hospital arrival OR initial patient/family refusal of fibrinolysis/reperfusion (documented by a physician/APN/PA) are acceptable reasons for delay that do NOT require documentation that a “hold,” “delay,” “deferral,” or “wait” in initiating fibrinolysis actually occurred. In order for cardiopulmonary arrest, mechanical circulatory assist device placement, or intubation within 30 minutes after hospital arrival to be considered an automatic acceptable reason for delay, physician/APN/PA documentation that it occurred within 30 minutes after hospital arrival must be CLEAR.

Inclusion Guidelines for Abstraction

Balloon pump

Remove list:
- Aortic balloon pump
- Intra-aortic balloon (IAB)
- Intra-aortic balloon counterpulsation (IABC)
- Intra-aortic balloon pump (IABP)
- Intra-aortic counterpulsation (IAC)
- Intra-aortic counterpulsation balloon pump (IACBP)

Cardiopulmonary arrest

Remove Code bullet

Add Mechanical circulatory assist devices list:

Mechanical circulatory assist devices
- Aortic balloon pump
- Biventricular assist device (BiVAD)
- Intra-aortic balloon (IAB)
- Intra-aortic balloon counterpulsation (IABC)
- Intra-aortic balloon pump (IABP)
- Intra-aortic counterpulsation (IAC)
- Intra-aortic counterpulsation balloon pump (IACBP)
- Left ventricular assistive device (LVAD)
- Percutaneous ventricular assist device (PVAD)
- Ventricular assist device (VAD)

Impacts: Alphabetical Data Dictionary

Data Element(s)
Reason for Delay in PCI
Measure(s)
AMI-8
AMI-8a

**Rationale:** These changes will allow physician/APN/PA documentation of an LVAD placement within 90 minutes after hospital arrival to automatically exclude a case when the PCI was delayed more than 90 minutes. Removing “code” as Inclusion for Arrest will reduce false measure exclusions.

**Description of Changes:**

**Notes for Abstraction**

**Change** EXCEPTIONS section in the 2nd bullet to:

- Physician/APN/PA documentation that a cardiopulmonary arrest, **mechanical circulatory assist device placement**, or intubation occurred within 90 minutes after hospital arrival OR initial patient/family refusal of PCI/reperfusion/cath/transfer to cath lab (documented by a physician/APN/PA) are acceptable reasons for delay that do NOT require documentation that a “hold,” “delay,” “deferral”, or “wait” in doing the PCI actually occurred. In order for cardiopulmonary arrest, mechanical circulatory assist device placement, or intubation within 90 minutes after hospital arrival to be considered an automatic acceptable reason for delay, physician/APN/PA documentation that it occurred within 90 minutes after hospital arrival must be CLEAR.

**Inclusion Guidelines for Abstraction**

- **Balloon pump**
  - Remove list:
    - Aortic balloon pump
    - Intra-aortic balloon (IAB)
    - Intra-aortic balloon counterpulsation (IABC)
    - Intra-aortic balloon pump (IABP)
    - Intra-aortic counterpulsation (IAC)
    - Intra-aortic counterpulsation balloon pump (IACBP)

- **Cardiopulmonary arrest**
  - Remove Code bullet

**Inclusion Guidelines for Abstraction**

- **Mechanical circulatory assist devices**
  - Aortic balloon pump
  - Biventricular assist device (BiVAD)
  - Intra-aortic balloon (IAB)
  - Intra-aortic balloon counterpulsation (IABC)
  - Intra-aortic balloon pump (IABP)
  - Intra-aortic counterpulsation (IAC)
  - Intra-aortic counterpulsation balloon pump (IACBP)
  - Left ventricular assistive device (LVAD)
  - Percutaneous ventricular assist device (PVAD)
  - Ventricular assist device (VAD)

**Impacts:**

- Alphabetical Data Dictionary
- Data Element(s)
- **Reason for Discontinuation of Overlap Therapy**

**Encounter dates** 01-01-13 (1Q13) through 06-30-13 (2Q13) v.4.2
Measure(s)
VTE-3

Rationale: To clarify understanding for the public user.

Description of Changes:
Data Element Name:
Change: Reason for Discontinuation of Parenteral Therapy

Definition: Change to:
Definition: Documentation of a reason for discontinuation of the parenteral therapy by a physician/advanced practice nurse/physician assistant or pharmacist (physician/APN/PA or pharmacist).

Suggested Data Collection Question
Change to:
Suggested Data Collection Question: Is there a reason documented by a physician/APN/PA or pharmacist for discontinuation of the parenteral therapy?

Allowable Values
Change:
Y (Yes) There is a reason documented by a physician/APN/PA or pharmacist for discontinuation of the parenteral therapy.
N (No) There is no reason documented by a physician/APN/PA or pharmacist for discontinuation of the parenteral therapy or unable to determine from medical record documentation.

Notes for Abstraction
Change
Second Bullet:
• Substitution of one parenteral drug for another parenteral drug is not considered discontinuation of parenteral therapy.
  Example, if patient was on Heparin subcutaneous and was changed to Arixtra subcutaneous on day 3, the patient is still on a parenteral anticoagulant.

Suggested Data Sources
Change First bulleted list header to:
ONLY PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION OF A REASON FOR DISCONTINUING PARENTERAL THERAPY

Change Second bulleted list header to:
SUGGESTED DATA SOURCES FOR PATIENT REFUSAL other than physician/APN/PA or pharmacist documentation of a reason for discontinuing parenteral therapy:

Exclusion Guidelines for Abstraction:
Change First Bullet:
A therapeutic INR equal to 2.0-3.0 (target range of 2.5) without additional documentation that notes a decision was made to discontinue parenteral therapy.

**Impacts:** Alphabetical Data Dictionary

Data Element(s)
*Reason for No ACEI and No ARB at Discharge*

Measure(s)
AMI-3
HF-3

**Rationale:** This change will provide clarification for the abstracter.

**Description of Changes:**

Guidelines for Abstraction – Inclusion - Worsening renal function/renal disease/dysfunction

**Change 8th bullet:**
- References to renal/renal function not specified or described as renal dysfunction (e.g., “Hold on ACEI pending kidney function panel in a.m.”)

**Impacts:** Alphabetical Data Dictionary

Data Element(s)
*Reason for No VTE Prophylaxis- Hospital Admission*

Measure(s)
STK-1
VTE-1

**Rationale:** Change based on Nov. 4, 2011 FDA approval of rivaroxaban for stroke prevention in patients with atrial fibrillation.

**Description of Changes:**

**Notes for Abstraction:**

**Remove:**
- (exception: see STK note below)

**Add**
Under First bullet:

**EXCEPTION:**
- Stroke patients require a documented reason for not administering another form of prophylaxis when graduated compression stockings (GCS) are the ONLY form of VTE prophylaxis administered.

**Add** new Third bullet:
- Reasons for not administering VTE prophylaxis must be documented by a physician/APN/PA or pharmacist.

**EXCEPTIONS:**
- Patient refusal may be documented by a nurse.
Risk assessment form may be completed by a nurse.

Add new Fourth bullet:
- **If reasons are not mentioned in the context of VTE prophylaxis, do not make inferences** (e.g., do not assume that VTE Prophylaxis was not administered because of a bleeding disorder unless documentation explicitly states so).
  - Reasons must be explicitly documented (e.g., “Active GI bleed – low molecular weight heparin (LMWH) contraindicated”, “No enoxaparin” [no reason given]).

Add new Fifth bullet:
- To select “Yes” for this data element, documentation of a reason for not administering both mechanical and pharmacological VTE prophylaxis must be present in the medical record.
  - Documentation of a reason for not administering pharmacological forms of prophylaxis in the absence of documentation why no mechanical prophylaxis was administered is not sufficient reason documentation when no VTE prophylaxis is administered the day of or day after hospital admission.
  - If “No VTE Prophylaxis” is documented in the medical record, then it will be inferred that both mechanical and pharmacological options were considered and not indicated for the patient.

Change First sub-bullet under Sixth bullet to:
- For patients determined to be at low risk for VTE:
  - If documentation of “No VTE Prophylaxis needed” is written, then it will be inferred that both mechanical and pharmacological options were not indicated for the patient, select “Yes”.

Remove STK:
If graduated compression stockings (GCS) are the only form of VTE prophylaxis administered, a reason for not administering another form of prophylaxis must be documented in the medical record.

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<tr>
<td>Data Element(s)</td>
<td>Reason for No VTE Prophylaxis – ICU Admission</td>
</tr>
<tr>
<td>Measure(s)</td>
<td>VTE-2</td>
</tr>
</tbody>
</table>

Rationale: To clarify data element for the general public user.

Description of Changes:
Notes for Abstraction

Remove First Bullet:
- If any form of VTE prophylaxis was administered the day of or the day after ICU
admission/transfer, this data element is not required.

**Change**

First sub bullet under Third Bullet:

- If documentation of “No VTE Prophylaxis needed” is written, then it will be inferred that both mechanical and pharmacological options were not indicated for the patient, select “Yes”.

Eighth Bullet:

- If Comfort Measures Only (CMO) was documented after the day after arrival (Day 1) but by the day after ICU admission or surgery end date for surgeries that start the day of or the day after ICU admission, select “Yes”.

**Impacts:** Alphabetical Data Dictionary

Data Element(s)
Reason for Not Administering Beta-Blocker - Perioperative

Measure(s)
SCIP-Card-2

**Rationale:** Clarification is being added to the Notes for Abstraction, based on the significant number of emails/questions regarding the previous changes made in the data elements related to SCIP-Card-2.

**Description of Changes:**

**Notes for Abstraction:**

Remove the 1st sentence from the First bullet:

**Change** the Fourth through Tenth bullets:

To:

- If the beta-blocker was held on the day prior to hospital arrival and prior to the day of surgery the reason it was held or not taken can be documented on the day of surgery. There must be a reason documented for each day the beta-blocker is held or not administered to select the corresponding value.

- Preoperative documentation that the patient is NPO or due to NPO status alone is not acceptable to select values 1-4.

- If the physician writes an order to hold the beta-blocker when the patient’s vital signs are outside certain parameters and there is documentation that the beta blocker was held because the vital signs were outside the parameters during one of the periods specified in the allowable values, select the appropriate value. The vital signs to support this documentation are required and must be documented as present during the timeframe for the value being selected. Example: The physician writes the order, “Hold atenolol for SBP less than 120” and the nurse documents that the atenolol was held for a SBP of 110/50 on POD 2, select value “4”. If it is apparent on the MAR that the medication was held based on physician parameters during the specified timeframe a notation on the MAR or in the nursing narrative is acceptable to select the appropriate value.

- Documentation of hypotension as a reason must be substantiated by documentation of a blood pressure < 100 mm/ Hg during the timeframe for the value. Documentation of
bradycardia as a reason must be substantiated by a heart rate of less than 50 bpm
during the timeframe for the value.

- If intravenous use of inotropic medication (Appendix C, Table 3.14) is administered at
  any time during the time period represented in an allowable value, select the value that
  represents that timeframe in the perioperative period.
- Vital signs obtained while patient is on cardiopulmonary bypass machine or while being
  removed from bypass cannot be used to determine bradycardia.
- A documented systolic blood pressure of less than 100 mm/Hg and/or of a heart rate
  less than 50 bpm during the time period represented in the value being abstracted, is
  sufficient to select that value.

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<tbody>
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<td><em>Reason for Not Administering Beta-Blocker - Perioperative</em></td>
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<tr>
<td></td>
<td>Measure(s)</td>
</tr>
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<td>SCIP-Card-2</td>
</tr>
</tbody>
</table>

| Rationale: | Documentation is being added stating that patient refusal does not have to be physician/APN/PA documentation. |

Description of Changes:
Add as the last bullet:

- Patient refusal does not have to be documented by a physician/APN/PA, but it must be
documented in the timeframe corresponding to the timeframe for the value being
abstracted.

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<td>Data Element(s)</td>
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<td></td>
<td><em>Reason for Not Initiating IV Thrombolytic</em></td>
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<td>Measure(s)</td>
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<td>STK-4</td>
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</tbody>
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| Rationale: | Provide clarification for abstractor; consistency with inclusion guidelines in similar
data elements across other measure sets. |

Description of Changes:
Definition
Remove
IV thrombolytics convert plasminogen to plasmin, which in turn breaks down fibrin and
fibrinogen, thereby dissolving thrombus.

Notes for Abstraction
Change fifth bullet
- Reason documentation which refers to intravenous medications only (e.g., “Hold IV
medications”, “No IVs”), is not acceptable.

Suggested Data Sources
Add
Excluded Data Sources:
Discharge summary

Impacts:  Alphabetical Data Dictionary  
Data Element(s)  
*Reason for Not Prescribing Anticoagulation Therapy at Discharge*

Measure(s)  
STK-3

Rationale:  Provide clarification for abstractor; consistency with inclusion guidelines in similar data elements across other measure sets.

Description of Changes:  
Notes for Abstraction  
**Change** third sub-bullet  
- Deferral of anticoagulation therapy from one physician/APN/PA or pharmacist to another does NOT count as a reason for not prescribing anticoagulation therapy at discharge unless the problem underlying the deferral is also noted.  
Examples:  
- “Consulting neurologist to evaluate pt. for warfarin therapy.” - select “No”.  
- “Rule out GI bleed. Start Coumadin if OK with gastroenterology.” - select “Yes”.

Impacts:  Alphabetical Data Dictionary  
Data Element(s)  
*Reason for Not Prescribing Anticoagulation Therapy at Discharge*

Measure(s)  
STK-3

Rationale:  Provide clarification for abstractor.

Description of Changes:  
Notes for Abstraction:  
**Change** 2nd sub-bullet of the 2nd bullet to:  
**EXCEPTIONS:**  
- Documentation of a conditional hold or discontinuation of an anticoagulant medication does not count as a reason for not prescribing an anticoagulant medication at discharge (e.g., “Hold Coumadin if guaiac positive”, “Stop warfarin if rash persists”, “No warfarin for 24 hours following thrombolytic therapy”).

Impacts:  Alphabetical Data Dictionary  
Data Element(s)  
*Reason for Not Prescribing Antithrombotic Therapy at Discharge*

Measure(s)  
STK-2

Rationale:  Provide clarification for abstractor.
Description of Changes:

Notes for Abstraction:
Change second sub-bullet of the second bullet to:

EXCEPTIONS:
- Documentation of a conditional hold or discontinuation of an antithrombotic medication does not count as a reason for not prescribing an antithrombotic medication at discharge (e.g., “Hold ASA if guaiac positive”, “Stop Plavix if rash persists”, “No ASA for 24 hours following thrombolytic therapy”).

Impacts:

Alphabetical Data Dictionary
Data Element(s)
Reason for Not Prescribing Antithrombotic Therapy at Discharge

Measure(s)
STK-2

Rationale:
Provide clarification for abstractor; consistency with inclusion guidelines in similar data elements across other measure sets.

Description of Changes:

Notes for Abstraction
Change second sub-bullet, third exception to:

- Discontinuation of an antithrombotic medication at a particular dose documented in combination with the start of a different dose of that antithrombotic (i.e., change in dosage) does not count as a reason for not prescribing an antithrombotic medication at discharge.
  Examples:
  - “Stop Ecotrin 300 mg po daily” and “Start Ecotrin 325 mg po daily” in same physician order
  - “Increase Ecotrin 81 mg to 325 mg daily” in progress note
  - “Do not continue after discharge” checked for Ecotrin 300 mg and “Continue after discharge” checked for Ecotrin 325 mg on a physician-signed discharge medication reconciliation form

Change third sub-bullet to:

- Deferral of antithrombotic therapy from one physician/APN/PA or pharmacist to another does NOT count as a reason for not prescribing antithrombotic therapy at discharge unless the problem underlying the deferral is also noted.
  Examples:
  - “Consulting neurologist to evaluate pt. for warfarin therapy.” - select “No”.
  - “Rule out GI bleed. Start ASA if OK with gastroenterology.” - select “Yes”.

Impacts:

Alphabetical Data Dictionary
Data Element(s)
Reason for Not Prescribing Statin Medication at Discharge

Measure(s)
AMI-10
STK-6
Rationale: Provide clarification for abstractor; consistency with inclusion guidelines in similar data elements across other measure sets.

Description of Changes:

Inclusion Guidelines for Abstraction:
Add:
Refer to Appendix C, Table 8.1 for a comprehensive list of Statin Medications.

Impacts: Alphabetical Data Dictionary
Data Element(s)
Reason for Oral Factor Xa Inhibitor
ICU Admission Date

Measure(s)
VTE-1

Rationale: To clarify understanding for the public user.

Description of Changes:

Data Element List
Add new element:
Reason for Oral Factor Xa Inhibitor
Change
From: ICU Admission Date
To: ICU Admission or Transfer Date

Data Element
Add new element:
Reason for Oral Factor Xa Inhibitor
Change
From: ICU Admission Date
To: ICU Admission or Transfer Date

Impacts: Alphabetical Data Dictionary
Data Element List

Data Element(s)
Reason for Oral Factor Xa Inhibitor- ICU Admission

Measure(s)
VTE-2

Rationale: 1. To clarify understanding for the public user
2. Change based on Nov. 4, 2011 FDA approval of rivaroxaban for stroke prevention in patients with atrial fibrillation.

Description of Changes:
Add new data element:
Reason for Oral Factor Xa Inhibitor- ICU Admission
Impacts: Alphabetical Data Dictionary

Data Element(s)
Reasons for Continuing Urinary Catheterization

Measure(s)
SCIP-Inf-9

Rationale: Expert panel recommended adding paralytics and vasopressors/inotropics to value “1” as a reason to continue urinary catheterization.

Description of Changes:

Definition:

Change to:
Reasons for not removing the urinary catheter postoperatively are documented in the medical record. Reasons may include ICU placement with diuretic OR vasopressor/inotropic OR paralytic therapy or other reasons documented by physician/advanced practice nurse/physician assistant (physician/APN/PA).

Allowable Values:

Change Value 1 to:
There is documentation that the patient was in the intensive care unit (ICU) AND receiving one or more of the listed medications.

Notes for Abstraction:

Change First bullet to:
- Value “1” does not require physician/APN/PA documentation. If the patient is in the intensive care unit (ICU) on POD 1 or POD 2 AND it is documented that the patient received even one dose of diuretics OR vasopressors/inotropics OR paralytics, select value “1”.

Change Second bullet to:
- If no diuretic OR vasopressor/inotropic OR paralytic is being administered for a patient in the ICU, but there is physician/APN/PA documentation on POD 1 or POD 2 of a reason for not removing the urinary catheter, select value “2”.

Change Third bullet to:
The Medication Administration Record (MAR) can be used to determine whether the patient in the ICU is receiving a diuretic OR vasopressor/inotropic OR paralytic. There must be documentation of administration not just a physician order for diuretics OR vasopressors/inotropics OR paralytics.

Inclusion Guidelines for Abstraction:

Add statements
Refer to Appendix C, Table 3.13 for a list of common diuretics
Refer to Appendix C, Table 3.14 for a list of inotropic and vasopressor agents
Refer to Appendix C, Table 3.15 for a list of paralytic agents

Exclusion Guidelines for Abstraction:

Remove statement
See Appendix C, Table 3.13 for a list of common diuretics

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<td>VTE-1</td>
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| Rationale: | To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse. |

<table>
<thead>
<tr>
<th>Description of Changes:</th>
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<tbody>
<tr>
<td>Allowable Values</td>
</tr>
<tr>
<td>Change Year</td>
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<tr>
<td>From:</td>
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<tr>
<td>(2001 – Current Year)</td>
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<td>To:</td>
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<td>Measure(s)</td>
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<td>VTE-1</td>
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| Rationale: | To clarify data element for the general public user. |

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<th>Description of Changes:</th>
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<tr>
<td>Notes for Abstraction</td>
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<tr>
<td>Change Fourth bullet note under Example to:</td>
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<tr>
<td>Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” allows the case to be accepted into the warehouses.</td>
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| Rationale: | To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse. |

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<th>Description of Changes:</th>
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<tr>
<td>Allowable Values</td>
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<tr>
<td>Change Year</td>
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</table>
### Impacts:

- **Alphabetical Data Dictionary**
- **Data Element(s)**: *Surgery End Date – ICU Admission*
- **Measure(s)**: VTE-2

### Rationale:
To clarify data element for the general public user.

### Description of Changes:

#### Notes for Abstraction

**Change:**

**Note:** Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” allows the case to be accepted into the warehouses.

### Impacts:

- **Alphabetical Data Dictionary**
- **Data Element(s)**: *Surgical Incision Date*
- **Measure(s)**: SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3

### Rationale:
To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

### Description of Changes:

#### Allowable Values

**Change:**

**Year**

- **From:** (2001 – Current Year)
- **To:** (20xx)

### Impacts:

- **Alphabetical Data Dictionary**
- **Data Element(s)**: *Surgical Procedure*
- **Measure(s)**: VTE-1

### Rationale:
Adding TIVA as an inclusion for general anesthesia for clarification.

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

Add under General Anesthesia:
- Total Intravenous Anesthesia (TIVA)

Impacts:
- Alphabetical Data Dictionary
- Data Element(s)
  - Surgical Procedure – ICU Admission
- Measure(s)
  - VTE-2

Rationale:
Adding TIVA as an inclusion for general anesthesia for clarification.

Description of Changes:

Inclusion Guidelines for Abstraction:
Add to General Anesthesia:
- Total Intravenous Anesthesia (TIVA)

Impacts:
- Alphabetical Data Dictionary
- Data Element(s)
  - Time Last Known Well
- Measure(s)
  - STK-4

Rationale:
Provide clarification for abstractor; consistency with inclusion guidelines in similar data elements across other measure sets.

Description of Changes:

Definition
Change to:
The time prior to hospital arrival at which the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.

Notes for Abstraction

Change Third bullet:
- The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid time) and no other documentation is found that provides this information, the abstractor should select “UTD”.
  
  Example:
  
  Documentation indicates the time last known well was 3300. No other documentation in the medical record provides a valid time. Since the time last known well is outside of the range listed 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 and the Joint Commission’s Data Warehouse. Use of “UTD” for Time Last Known Well allows the case to be accepted into the warehouse.

Change Sixth bullet:
- If there are multiple times of last known well documented, use the time recorded according to the following hierarchy:
Change  Seventh bullet:
- If multiple times last known well are documented by the same provider, use the earliest
time recorded by that provider.

**Impacts:**
- Alphabetical Data Dictionary
  - Data Element(s)
  - Tobacco Use Status Post-Discharge
  - Measure(s)
  - TOB-4

**Rationale:**
Measure currently does not utilize the post discharge status information. The
original desire of the TAP was that the measure eventually be revised to capture
the discharge status information.

**Description of Changes:**

**Alphabetical Data Dictionary List**

**Alphabetical Data Dictionary**

**Data Element**

**Remove:**
- Tobacco Use Status Post-Discharge – TOB-4

**Data Element**

**Add** new:
- Tobacco Use Status Post Discharge – Counseling – TOB-4
- Tobacco Use Status Post Discharge – Medication – TOB-4
- Tobacco Use Status Post Discharge – Quit Status – TOB-4

**Impacts:**
- Alphabetical Data Dictionary
  - Data Element(s)
  - UFH Therapy Administration
  - Measure(s)
  - VTE-4

**Rationale:**
To clarify understanding for the public user.

**Description of Changes:**

**Notes for Abstraction**

**Change**

Third Bullet:
- Review heparin administration in proximity to this VTE event.

**Suggested Data Sources**
Add:
- Ambulance Record

Inclusion Guidelines for Abstraction

Add:
Intravenous (IV) Unfractionated Heparin (UFH)
- HEP
- Heparin
- Heparin Na
- Heparin Sod
- Heparin Sodium

Remove:
Refer to Appendix H, Table 2.3 VTE Parenteral Therapy Table.

Impacts: Alphabetical Data Dictionary

Data Element(s)
VTE Confirmed

Measure(s)
VTE-3
VTE-4
VTE-5
VTE-6

Rationale: To clarify understanding for the public user.

Description of Changes:

Notes for Abstraction

Add:
- Any documentation used other than radiology reports must reflect the time frame related
to this hospitalization to select “Yes”.
- Any documentation used other than radiology reports must have documentation that
  supports the clinician’s confirmation of VTE.
  o Example: Physician Notes: “Venous Doppler positive for DVT left popliteal” select
    “Yes”.

Inclusion Guidelines for Abstraction:

Add:
THIS LIST IS ALL INCLUSIVE
Rationale: To clarify understanding for the public user.

Description of Changes:
Suggested Data Collection Question:
Change to:
Suggested Data Collection Question: Is there documentation that a diagnostic test for VTE was performed relating to this hospitalization?

Notes for Abstraction
Add:
First Bullet:
- This data element includes patients who are diagnosed with VTE on arrival or during hospitalization. For example: A patient may have documentation that VTE was confirmed on arrival or the patient may have been admitted without VTE, but there is documentation that the patient developed VTE after admission.

Third Bullet:
- Any documentation other than radiology reports must reflect the time frame related to this hospitalization to select “Yes”.

Fourth Bullet:
- Any documentation used other than radiology reports must have documentation that supports the clinician’s confirmation of VTE.
  - Example: Physician Notes: “Venous Doppler positive for DVT left popliteal” select “Yes”.

Change:
Fifth Bullet
- If a diagnostic test for VTE was performed that is not on the inclusion list, select “No”.
  For example: If an echo was done that confirmed a PE, select “No”.

Inclusion Guidelines for Abstraction:
Add:
THIS LIST IS ALL INCLUSIVE

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<td>VTE-6</td>
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Rationale: To clarify data element for the general public use.

Description of Changes:
Notes for Abstraction
Remove
First Bullet:
- If a record has been designated as “Y” for Present on Admission (POA) for VTE based on the coding rules, select “Yes”.

Change
Second Bullet:

- The term “on admission” includes any documentation of a test to be performed to rule out VTE (pulmonary embolism or deep vein thrombosis) or diagnosis or suspicion of VTE written from arrival to admission date.
  - Example: If a patient arrived on 10/1/20xx with documentation that a Pulmonary Emboli (PE) was suspected and a test was ordered to rule out PE, select “Yes”.

Third Bullet:

- If documentation is insufficient or there is conflicting information regarding whether VTE was present or suspected at admission, select “No”. Please refer to above bullet for sufficient documentation.

Remove

Sixth Bullet:

Documentation of suspected or possible VTE (DVT or PE) is acceptable, but must be written the day of or the day after hospital admission date for non-surgical patients. For example: If a patient was admitted on 10/1/20xx with documentation that a PE was suspected and a test was ordered to rule out PE, select “Yes”.

Change

Seventh Bullet:

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

Remove

Eighth bullet:

- If there is documentation that VTE was suspected or diagnosed in one of the defined locations on admission, select “Yes”. The defined locations include: DVT located in the proximal leg veins, including the inferior vena cava (IVC), iliac, femoral or popliteal veins, or to pulmonary emboli (PE).

Inclusion Guidelines for Abstraction Possible VTE Diagnoses

Remove:

Possible VTE Diagnoses

Add

First Bullet:

- DVT located in the proximal leg veins, including the inferior vena cava (IVC), iliac, femoral or popliteal veins.

Impacts:

Alphabetical Data Dictionary
- Data Element(s)
- VTE Prophylaxis

Measure(s)
- SCIP-VTE-1
- SCIP-VTE-2
Rationale: Change based on Nov. 4, 2011 FDA approval of rivaroxaban for stroke prevention in patients with atrial fibrillation

Description of Changes:

Notes for Abstraction:

Add above the first bullet: ALL

Change
Third bullet to first bullet:
- No value should be selected more than once. If a value of "A" is selected, no other selection should be recorded. Example: Lovenox is ordered and substituted with Fragmin. Only abstract value "2" once, as both are LMWH.

Change
First bullet under VTE:
- Abstract the initial VTE prophylaxis(s) that was administered the day of or the day after hospital admission or the day of or the day after Surgery End Date for surgeries that start the day of or the day after hospital admission. If no VTE prophylaxis was administered during this timeframe, select A and check for a Reason for No VTE Prophylaxis.

Remove
Second bullet under VTE:
- Selection of allowable values 1-7 includes any prophylaxis that was initially administered on the same date. Allowable value ‘8’ is not used for VTE. Example:
  - If a patient was admitted on 12/8/20xx and had bilateral GCS applied at 13:00 on 12/08/20xx and LMWH was administered at 22:00 on 12/8/20xx, select values “2” and “4”.

Remove
Bullets 2-4 under STK:
- Selection of allowable values 1-7 includes any prophylaxis that was initially administered on the same date. Allowable value ‘8’ is not used for STK. Examples:
  - If a patient was admitted on 12/8/20xx and had bilateral GCS applied at 13:00 on 12/08/20xx and LMWH was administered at 22:00 on 12/8/20xx, select only value “2”.
  - If a patient was admitted on 12/8/20xx and had bilateral IPC applied at 13:00 on 12/08/20xx and LMWH was administered at 22:00 on 12/8/20xx, select values “2” and “3”.
- If GCS was the only prophylaxis administered the day of and/or the day after hospital admission, select value “4”. If a value of “4” is selected, no other selections should be recorded.
- Select value “3”. If bilateral GCS are administered on the day of admission and another form of prophylaxis was administered the day after admission, select the value of the
prophylaxis other than GCS.
Examples:
- If bilateral GCS are administered at 1300 on 12/08/20xx and LMWH at 0200 on 12/09/20xx, select value “2”.
- If bilateral GCS are administered on the day of admission and IPC is administered the day after admission,

VTE or STK
Remove:
- If the patient received an anticoagulation medication for other reasons, select the allowable value that was administered during the specified timeframe. For example: if the patient received warfarin for atrial fibrillation on the day of admission, select value “6”.

Add:
- Selection of allowable values 1-8 includes any prophylaxis that was initially administered on the same date.
  Example:
  If a patient was admitted on 12/8/20xx and had bilateral GCS applied at 13:00 on 12/08/20xx and LMWH was administered at 22:00 on 12/8/20xx, select values “2” and “4”.

Remove:
- If a value of “A” is selected, no other selections should be recorded.

Impacts: Alphabetical Data Dictionary
  Data Element(s)
  VTE Prophylaxis Date
  Measure(s)
  STK-1
  VTE-1

Rationale: Change based on Nov. 4, 2011 FDA approval of rivaroxaban for stroke prevention in patients with atrial fibrillation

Description of Changes:
Notes for Abstraction:
Remove:
VTE
- If VTE prophylaxis was administered the day of and the day after hospital admission in a non-ICU setting, select the date that the initial VTE prophylaxis was administered.
  Example:
  If the patient was admitted on 12/8/20xx and bilateral GCS was applied at 13:00 on 12/8/20xx and LMWH was administered at 02:00 on 12/9/20xx, use the 12/8/20xx date.

STK
- If VTE prophylaxis was administered the day of and the day after hospital admission, select the date that the initial VTE prophylaxis was administered. Example:
  If the patient was admitted on 12/8/20xx and bilateral IPC was applied at 13:00 on
12/8/20xx and LMWH was administered at 02:00 on 12/9/20xx, use the 12/8/20xx date with one exception.

**Note:** For STK cases, use the date of the other form of prophylaxis as the initial date of VTE prophylaxis when GCS was applied the day of hospital admission and another form the day after hospital admission.

**STK or VTE Change:**

**Note:** Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” allows the case to be accepted into both warehouses.

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**Rationale:** To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

**Description of Changes:**

**Allowable Values**

**Change Year**

- **From:** (2001 – Current Year)
- **To:** (20xx)

**Impacts:** Alphabetical Data Dictionary

- Data Element(s)
- Warfarin Administration

- Measure(s)
- VTE-3

**Rationale:** To clarify understanding for the public user.

**Description of Changes:**

**Notes for Abstraction:**

**Change**

**2nd Bullet:**

- If VTE was diagnosed prior to the hospitalization and warfarin was administered, select “Yes”.

---

**SECTION 2 – Measurement Information**

**Impacts:** AMI, ED, HF, PN, SCIP, IMM
Data Element List

Data Element(s)
Hispanic Ethnicity
Race

**Rationale:** The Joint Commission now requires Race and Hispanic Ethnicity.

**Description of Changes:**

General Data Element list – Hispanic Ethnicity, Race

Collected For

Remove appropriate footnote that marks ‘CMS Only’

**Impacts:**

CAC, STK, VTE, SUB, TOB

Data Element List

Data Element(s)
Hispanic Ethnicity
Race

**Rationale:** The Joint Commission now requires Race and Hispanic Ethnicity.

**Description of Changes:**

General Data Element Name and Collected For:

Add:

Hispanic Ethnicity and Race to the General Data Elements Name and “All Records” to the Collected For.

**Impacts:**

STK, VTE

General Data Element List

Measure(s)

All STK

All VTE

**Rationale:** Change based on August 1, 2011 published IPPS Final Rule

**Description of Changes:**

VTE Data Element List

STK Data Element List

Add data elements to the General Data Element Name Column: First Name, Last Name, Patient HIC#, Patient Identifier, Physician 1, Physician 2, and Postal Code.

Add “All Records” to Collected For column for data elements First Name, Last Name, Patient Identifier, and Postal Code.

Add “Collected by CMS for patients with a standards HIC #” to Collected For column for data element Patient HIC#

Add “Optional for All Records” to Collected For column for data elements Physician 1 and Physician 2.

Add corresponding footnote # and footnote: CMS ONLY to data elements First Name, Last Name, Patient Identifier, Physician 1, Physician 2, and Postal Code.

---

**Subsection 2.1 – Acute Myocardial Infarction (AMI)**
Impacts: AMI-7a

Rationale: Language in Reason for Delay exclusion bullet is being changed to be consistent with other AMI measures.

Description of Changes:
Denominator Statement – Excluded Populations:
Change last bullet:
To:
Patients who did not receive fibrinolytic therapy within 30 minutes and had a documented Reason for Delay in Fibrinolytic Therapy

Impacts: AMI-8a

Rationale: Language in Reason for Delay exclusion bullet is being changed to be consistent with other AMI measures.

Description of Changes:
Denominator Statement – Excluded Populations:
Change last bullet:
To:
Patients who did not receive PCI within 90 minutes and had a documented Reason for Delay in PCI

Impacts: AMI-7

Rationale: Language in Reason for Delay exclusion bullet is being changed to be consistent with other AMI measures.

Description of Changes:
Continuous Variable Statement – Excluded Populations:
Change last bullet:
To:
 Patients who did not receive fibrinolytic therapy within 30 minutes and had a documented Reason for Delay in Fibrinolytic Therapy

Impacts: AMI-8

Rationale: Language in Reason for Delay exclusion bullet is being changed to be consistent with other AMI measures.

Description of Changes:
Continuous Variable Statement – Excluded Populations:
Change last bullet:
To:
Patients who did not receive PCI within 90 minutes and had a documented Reason for Delay in PCI

Impacts: AMI-3, AMI-5, AMI-10

Rationale: Updates to the Selected References and Rationale sections were warranted.
**Description of Changes:**

**Rationale:**

**Change** reference from:
Anderson, 2007
To:
Wright, 2011

**Selected References:**

**Add:**

**Remove:**

**Impacts:**
AMI-3, AMI-5, AMI-10

**Rationale:**
Updates to the Selected References and Rationale sections were warranted.

**Description of Changes:**

**Rationale:**

**Change** reference to:
Smith, 2011

**Selected References:**

**Add:**

**Remove:**

**Impacts:**
AMI-1

**Rationale:**
Updates to the Selected References and Rationale sections were warranted.
Description of Changes:

**Rationale:**

**Change** reference from:
Anderson, 2007

To:
Wright, 2011

**Change** reference to:
Smith, 2011

**Selected References:**

**Add:**

**Remove:**

**Subsection 2.2 – Heart Failure (HF)**

**Impacts:**
- HF-1
  - Flowchart (Algorithm)

**Rationale:**
Note box is inaccurate and is not needed.

**Description of Changes:**

**HF-1**

**Remove** Note box that states “Discharge counter and missing flags must be stored to identify the specific discharge instructions that are missing.” on 2nd page of algorithm.

**Subsection 2.3 – Pneumonia (PN)**

Specifications Manual for Hospital Inpatient Quality Measures

Encounter dates **01-01-13 (1Q13) through 06-30-13 (2Q13)** v.4.2
Impacts: PN-6, PN-6a, PN-6b

Rationale: Clarification for the abstractor.

Description of Changes:
Pneumonia Antibiotic Consensus Recommendations Table
Add to the bottom of the table
Note:
The regimen numbers following each antibiotic regimen on the Antibiotic Consensus Recommendation Table above correspond directly to the regimen numbers in the algorithm.

Impacts: PN-6a
Flowchart (Algorithm)

Rationale: When “Antibiotic Days” is =0 for ALL antibiotic doses it currently goes to the “K” connector taking it to the next page (which allows it to miss the check for Antibiotic Allergy). It should attach directly above Antibiotic Allergy. CART will not be programming this change at this time due to infrastructure.

Description of Changes:
PN6a algorithm

Change: In the PN-6a algorithm, the second decision box for Antibiotic Days - the branch that goes to the off-page “K” connector now connects directly above the Antibiotic Allergy decision box.

Add: Note: The algorithm branch from Antibiotic Days to above the Antibiotic Allergy decision box will not be programmed in the CMS Abstraction and Reporting Tool (CART). CART will continue to use version 4.1 of the PN-6a algorithm where Antibiotic Days goes directly to the “K” page connector at the top of next algorithm page.

Impacts: PN-3b

Rationale: Clarification of phrasing of exclusion so that it ties back to a value covered in a data element.

Description of Changes:
Denominator Statement
Excluded Populations
CHANGE TO
“Patients not admitted through the ED”

Subsection 2.4 – Surgical Care Improvement Project (SCIP)

Impacts: SCIP-Inf-2

Rationale: The SCIP Technical Expert Panel agreed to the addition of Ceftriaxone plus Metronidazole to the list of approved antibiotics for colon surgeries along with stating that this combination is only to be used in hospitals where surgical site infection surveillance demonstrates gram negative surgical infections that are resistant to first- and second-generation cephalosporins. It is not recommended
Description of Changes:

Change the table
Prophylactic Antibiotic Regimen Selection for Surgery in the column titled, Approved Antibiotics in the row titled, Surgical Procedure, Colon:

To:
Cefotetan, Cefoxitin, Ampicillin/Sulbactam Table 3.5, or Ertapenem Table 3.6b OR Cefazolin or Cefuroxime Table 3.2 + Metronidazole Table 3.6a Ceftriaxone Table 3.5 + Metronidazole Table 3.6a

If β-lactam allergy:
Clindamycin Table 3.9 + Aminoglycoside Table 2.11 or
Clindamycin Table 3.9 + Quinolone Table 3.12, or
Clindamycin Table 3.9 + Aztreonam Table 2.7 OR Metronidazole Table 3.6a with Aminoglycoside Table 2.11, or
Metronidazole Table 3.6a + Quinolone Table 3.12

Add at end of Table Prophylactic Antibiotic Regimen Selection for Surgery, as the 4th end note:

4This combination should only be used in hospitals where surgical site infection surveillance demonstrates gram negative surgical infections resistant to first and second generation cephalosporins. It is recommended not to be used routinely.

Impacts: SCIP-Card-2, SCIP-Inf-9, SCIP-VTE-1, SCIP-VTE-2

Rationale: There are typos in the pictures of the flowcharts for the algorithms.

Description of Changes:

SCIP-Card-2
Add the on-page “E” connector to the final “E” box.

Change the portion of the allowable value from “Any=5” to “Only=5” in six locations on the 2nd page of the algorithm – 3 of them after the “Beta-Blocker Perioperative” decision boxes and 3 of them after “Reason for Not Administering Beta-Blocker Perioperative”.

SCIP-Inf-9
Change the “Inf-4” to “Inf-9” in the off-page “B” connector to final “B” box.

SCIP-VTE1
Remove the “On Tables 5.23, 5.24” after “K” connector at top of last page of algorithm.

SCIP-VTE2
Remove the “On Tables 5.23, 5.24” after “K” connector at top of last page of algorithm.

Remove the 3 Note boxes for “evaluating VTE Timely” – one on the 3rd page, one on the 4th page and one on the 5th page of the algorithm.
### Impacts:
- SCIP-Inf-10
- Flowchart (Algorithm)

### Rationale:
There is a typo in the picture of the flowchart for the algorithm.

### Description of Changes:
**SCIP-Inf-10**

**Change** the “Inf-9” to “Inf-10” in the off-page “D” connector to final “D” box.

<table>
<thead>
<tr>
<th>Impacts</th>
<th>SCIP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Element(s)</strong></td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Rationale:**
Clarification to the example for submission of Five or Fewer discharges for CMS to align with the IPPS Final Rule.

### Description of Changes:
**Sample Size Examples – Quarterly Sampling**

**Change** the last sub-bullet from:
- The SCIP Initial Patient Population sizes for a hospital are 1, 1, 0, 0, 1, 0, 1, and 1 patients respectively per stratum for the quarter. Since the total Initial Patient Population for SCIP is 5, the hospital may choose to not submit patient level data. If the hospital chooses to submit patient level data, the required quarterly sample sizes for each stratum would be 1, 1, 0, 1, 0, 1, and 1.
  - The 1st, 2nd, 5th, 7th and 8th strata are less than the minimum required quarterly sample size, so 100% of each of these strata are sampled.
  - There is no data to sample for the 3rd, 4th, and 6th strata.

**To:**
- The SCIP Initial Patient Population sizes for a hospital are 1, 1, 0, 0, 1, 0, 1, and 1 patients respectively per stratum for the quarter. Since the total Initial Patient Population for SCIP is 5, the hospital may choose to not submit patient level data. If the hospital chooses to submit patient level data:
  - The Joint Commission: the required quarterly sizes for each stratum would be 1, 1, 0, 1, 0, 1, and 1.
    - The 1st, 2nd, 5th, 7th and 8th strata are less than the minimum required quarterly sample size, so 100% of each of these strata are sampled.
    - There is no data to sample for the 3rd, 4th, and 6th strata.
  - CMS: the quarterly sample size would be 0 – 5 of the total SCIP cases.

### Subsection 2.6 – Children’s Asthma Care (CAC)

<table>
<thead>
<tr>
<th>Impacts</th>
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<tbody>
<tr>
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<tr>
<td><strong>Measure(s)</strong></td>
<td>CAC-1</td>
</tr>
</tbody>
</table>

**Rationale:**
This is to modify and update the measure rationale to more closely match current scientific findings.
Description of Changes:

Rationale

Change to:

Asthma is the most common chronic disease in children and a major cause of morbidity and increased health care expenditures nationally (Adams, et al., 2001). According to the 2006-2008 data from the Centers for Disease Control and Prevention (CDC), 9.3% of the United States population is composed of children suffering from asthma (CDC Health Disparities and Inequalities Report, 2011). In 2005, 5.2% of children with asthma had at least one asthma attack in the previous year (3.8 million children). Nearly two of every three children who currently have asthma had at least one attack in the past 12 months. Asthma admissions account for 3% of all childhood hospitalizations (Akinbami, L, 2006)

Although there are means to prevent attacks or exacerbations among children with asthma, unfortunately, the majority of children with asthma do not have the disease under control and still suffer from acute asthma attacks, or exacerbations of asthma (www.cdc.gov/nchs/products/pub/pubd, 2006). Less effective treatment modalities such as under treatment, or over treatment of chronic asthmatic children contributes to morbidity and mortality, and has affected the already overwhelmed healthcare system in the United States.

The National Heart Lung and Blood Institute (NHLBI) recommend the use of relievers for acute asthma exacerbation. The NHLBI provides these updated, scientific recommendations in an Expert Panel Report (EPR), and that report states that “SABAs are the drug of choice for treating acute asthma symptoms and exacerbations and for preventing EIB (Evidence A).” (Expert Panel Report 3, Guidelines for the Diagnoses and Management of Asthma, 2007). Additionally the Panel recommends the use of LABAs for reliever therapy in patients’ who are not well controlled.

Impact:

Impact Data Element(s) CAC
Impact Measure(s) N/A
CAC-1

Rationale:

This is to modify and update the references to more closely match current scientific findings.

Description of Changes:

Selected References

Change to:

- Barnes, Peter, (2006). Treatment with ® - Albuterol Has No Advantage over Racemic
Asthma is the most common chronic disease in children and a major cause of morbidity and increased health care expenditures nationally (Adams, et al., 2001). According to the 2006-2008 data from the Centers for Disease Control and Prevention (CDC), 9.3% of the United States population is composed of children suffering from asthma (CDC Health Disparities and Inequalities Report, 2011). In 2005, 5.2% of children with asthma had at least one asthma attack in the previous year (3.8 million children). Nearly two of every three children who currently have asthma had at least one attack in the past 12 months. Asthma admissions account for 3% of all childhood hospitalizations (Akinbami, L, 2006).

Chronic asthma in children can account for an annual loss of more than 14 million school days per year, according to the Asthma and Allergy Foundation, and has also been known to create more childhood hospitalizations than any other childhood disease in this decade (Asthma Facts and Figures). Less effective treatment modalities such as under treatment, or over treatment of chronic asthmatic children contributes to morbidity and mortality, and has affected the already overwhelmed healthcare system in the United States.

Use of systematic corticosteroids has been common practice since the early 1900’s when the first discussion of oral steroid use was published in the JAMA (Solis-Cohen, 1900). Schuh , S., et al (2000) reviewed data that showed superior efficacy with systemic corticosteroids in their research study when compared to inhaled steroid therapy.  Guidelines for the diagnosis and management of asthma in children developed by the National Asthma Education and Prevention Program (NAEPP) of the National Heart, Lung and Blood Institute (NHLBI), as well as by the American Academy of Pediatrics, recommend the use of systemic corticosteroids to gain control of acute asthma exacerbation and reduce severity as quickly as possible in children with mild, moderate and severe persistent asthma. Guideline recommendations for
therapies such as systematic corticosteroid use in inpatient asthma maintenance programs will relieve the bronchoconstriction that children suffer during acute asthmatic exacerbation during hospitalization.

**Impacts:**

<table>
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</table>

**Measure(s)**

| CAC-2 |

**Rationale:**

This is to modify and update the measure rationale to more closely match current scientific findings.

**Description of Changes:**

**Selected References**

**Change to:**


• Stanley J. Szefler MD, Advances in pediatric asthma in 2009: Gaining control of childhood asthma. Journal of Allergy and Clinical Immunology Volume 125, Issue 1, January 2010, Pages 69-78


<table>
<thead>
<tr>
<th>Impacts:</th>
<th>CAC</th>
</tr>
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<tr>
<td>Data Element(s)</td>
<td>N/A</td>
</tr>
<tr>
<td>Measure(s)</td>
<td>CAC-3</td>
</tr>
</tbody>
</table>

**Rationale:** This is to modify and update the measure rationale to more closely match current scientific findings.

**Description of Changes:**

**Rationale**

**Change** to:

Asthma is the most common chronic disease in children and a major cause of morbidity and increased health care expenditures nationally (Adams, et al., 2001). In 2005, 5.2% of children with asthma had at least one asthma attack in the previous year (3.8 million children). Nearly two of every three children who currently have asthma had at least one attack in the past 12 months. Chronic asthma in children can account for an annual loss of more than 14 million school days per year, according to the Asthma and Allergy Foundation (Asthma Facts and Figures).

It is clear from multiple sources of evidence including the National Heart Lung and Blood Institute (NHLBI) Guidelines that actual self-management of asthma by the patient or caregiver leads to more positive outcomes. Appropriate self-management is completely reliant upon patient education. Patient education is more effective when it aims at training self-management skills that will alter behavior (Norris, et al., 2001).
NHLBI notes that review of asthma management by expert clinicians is necessary but not sufficient to improve outcomes. Active learning, participating and verbalization of understanding are all strategies that a healthcare organization must incorporate with parents or caregivers of asthmatic children in order for them to understand and make the appropriate changes that can impact the disease in the child in question. Education programs have been effective in improving lung function, feelings of self-esteem, and consequently decreased missed days of school in children and adolescents (Phipatanakul, 2004). Furthermore, evidence of this transaction in a written action plan improves patient outcomes in asthma (Lefervre, et al., 2002). Acute hospitalization follow up is imperative to a successful discharge from the hospital, providing the caretaker with the resource information needed to contact the follow up facility, medical office or clinic setting (Schatz, et al, 2009).

Environmental control consists of removal of asthma triggers from the environment. Multiple studies support the positive correlation of household maintenance factors such as control of cockroach dust, and the number of acute asthma attacks in asthmatic children (McConnell, et al, 2005 and Eggleston, et al., 2005). Evidence from Carter et al, (2001) supported by the National Institute of Health (NIH) grant found specifically that reduction in triggers such as household conditions i.e. dust mites, cockroach, cats and presence of molds and fungus, resulted in a decrease in acute care visits and an overall positive outcome of children.

Rescue action education related to early recognition of symptoms and proper action to control incidence of asthma attacks is noted to have positive outcomes for asthmatic children (Ducharme and Bhogal, 2008).

### Impacts:

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</tr>
</thead>
<tbody>
<tr>
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</table>

### Rationale:

This is to modify and update the measure rationale to more closely match current scientific findings.

### Description of Changes:

#### Selected References

**Change to:**

- Bhogal,S.K., Zemek, R.L., and Ducharme, F. (2009). Written action plans for asthma in


<table>
<thead>
<tr>
<th>Subsection 2.7 – Venous Thromboembolism (VTE)</th>
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<tr>
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<td>Clinical Trial</td>
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<td>Comfort Measures Only</td>
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<td>Discharge Disposition</td>
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<td>Discharge Instructions Address Compliance Issues</td>
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<td>Discharge Instructions Address Dietary Advice</td>
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<tr>
<td>Discharge Instructions Address Follow-up Monitoring</td>
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<tr>
<td>Discharge Instructions Address Potential for Adverse Drug Reactions and Interactions</td>
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<tr>
<td>ICU Admission Date</td>
</tr>
<tr>
<td>ICU Admission or Transfer</td>
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<tr>
<td>ICU Discharge Date</td>
</tr>
<tr>
<td>ICU VTE Prophylaxis</td>
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<tr>
<td>ICU VTE Prophylaxis Date</td>
</tr>
<tr>
<td>INR Value</td>
</tr>
<tr>
<td>Monitoring Documentation</td>
</tr>
<tr>
<td>Overlap Therapy</td>
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<td>Overlap Therapy Start Date</td>
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<tr>
<td>Parenteral Anticoagulant End Date</td>
</tr>
<tr>
<td>Parenteral Anticoagulant Prescribed at Discharge</td>
</tr>
<tr>
<td>Reason for Discontinuation of Overlap Therapy</td>
</tr>
<tr>
<td>Reason for No VTE Prophylaxis – Hospital Admission</td>
</tr>
<tr>
<td>Reason for No VTE Prophylaxis – ICU Admission</td>
</tr>
</tbody>
</table>

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Encounter dates 01-01-13 (1Q13) through 06-30-13 (2Q13) v.4.2
Surgery End Date
Surgery End Date – ICU Admission
Surgical Procedure
Surgical Procedure – ICU Admission
UFH Therapy Administration
VTE Confirmed
VTE Diagnostic Test
VTE Present At Admission
VTE Prophylaxis
VTE Prophylaxis Date
VTE Prophylaxis Status
Warfarin Administration
Warfarin Prescribed at Discharge

Measure(s)
VTE-1
VTE-2
VTE-3
VTE-4
VTE-5
VTE-6

Rationale: Change based on August 1, 2011 published IPPS Final Rule

Description of Changes:

Collected For
Remove footnotes for The Joint Commission Only; CMS Informational Only

Impacts:
VTE
Data Element(s)
N/A

Rationale: To align the submission of 5 or Fewer cases for VTE, for CMS, with the IPPS rule and current CMS specifications.

Description of Changes:

Sample Size Requirements – Quarterly Sampling
Add to the beginning of the footnote under the Quarterly Sample Size table “The Joint Commission Only”.

Sample Size Requirements – Monthly Sampling
Add to the beginning of the footnote under the Monthly Sample Size table “The Joint Commission Only”.

Sample Size Requirements – Sample Size Examples
Change the 2nd sub-bullet under the 4th bullet
From:
  o The VTE Initial Patient Population sizes for a hospital are 1, 0, and 3 patients respectively per the sub-populations for the quarter. Since the total Initial Patient Population for VTE is 4, the hospital may choose to not submit patient level data. If the hospital chooses to submit patient level data, the required quarterly sample sizes for each sub-population
would be 1, 0, and 3.

- The 1st sub-population is less than the minimum required quarterly sample size, so 100% of this sub-population is sampled.
- There is no data to sample for the 2nd sub-population.
- The 3rd sub-population is not eligible for sampling, so 100% of this sub-population is sampled.

To:
- The VTE Initial Patient Population sizes for a hospital are 1, 0, and 3 patients respectively per the sub-populations for the quarter. Since the total Initial Patient Population for VTE is 4, the hospital may choose to not submit patient level data. If the hospital chooses to submit patient level data:
  - The Joint Commission: the required quarterly sample sizes for each sub-population would be 1, 0, and 3.
    - The 1st sub-population is less than the minimum required quarterly sample size, so 100% of this sub-population is sampled.
    - There is no data to sample for the 2nd sub-population.
    - The 3rd sub-population is not eligible for sampling, so 100% of this sub-population is sampled.
  - CMS: the quarterly sample size would be 1 – 4 of the total VTE cases.

**Impacts:** VTE-1

**Rationale:** To update the measure rationale and to include current references.

**Description of Changes:**

**Change**

**To:**

Hospitalized patients at high-risk for VTE may develop an asymptomatic deep vein thrombosis (DVT), and die from pulmonary embolism (PE) even before the diagnosis is suspected. The majority of fatal events occur as sudden or abrupt death, underscoring the importance of prevention as the most critical action step for reducing death from PE (Heit, 2008).

The estimated annual incidence of deep-vein thrombosis (DVT) and pulmonary embolism (PE), known collectively as venous thromboembolism (VTE), is approximately 900,000 (Heit, 2008). Approximately two-thirds of cases of DVT or PE are associated with recent hospitalization. This is consistent with the 2001 report by The Agency for Healthcare Research and Quality (AHRQ). AHRQ indicates that “the appropriate application of effective preventive measures in hospitals has major potential for improving patient safety by reducing the incidence of venous thromboembolism” (Shojania, 2001).

Despite its proven effectiveness, rates of appropriate thromboprophylaxis remain low in both medical and surgical patients. A recent analysis from the ENDORSE survey, which evaluated prophylaxis rates in 17,084 major surgery patients, found that more than one third of patients at risk for VTE (38%) did not receive prophylaxis and that rates varied by surgery type (Cohen, et al., 2008).

In a review of evidence-based patient safety practices, the Agency for Healthcare Research and Quality defined thromboprophylaxis against VTE as the "number one patient safety practice" for hospitalized patients (Shojania, 2001). Updated “safe practices” published by the

As noted by the ACCP, a vast number of randomized clinical trials provide irrefutable evidence that thromboprophylaxis reduces VTE events, and there are studies that have also shown that fatal PE is prevented by thromboprophylaxis (Geerts, et al. 2008).

Numerator
Data Elements
Add:
Reason for Oral Factor Xa Inhibitor

Denominator
Data Elements
Change:
ICU Admission or Transfer Date

Impacts: VTE-1

Rationale: To update the measure to include current references.

Description of Changes:
Selected References:
Remove:

Add:

**Impacts:** VTE-1
Flowchart (Algorithm)

**Rationale:** The data element name was changed to match the parent element ICU Admission or Transfer.

**Description of Changes:**

**Change** the data element name listed in the VTE-1
From: ICU Admission Date
To: ICU Admission or Transfer Date

**Impacts:** VTE-1
Flowchart (Algorithm)

**Reason for Oral Factor Xa Inhibitor**

**VTE Prophylaxis**

**Rationale:** To clarify understanding for the public user

**Description of Changes:**

**Change** the branch going down from VTE Prophylaxis
From:
Any = 1, 2, 3, 4, 5, 6, 7 and NOT = A
To:
Any = 1, 2, 3, 4, 5, 6, 7 or 8

**Change** the branch going to the right of *VTE Prophylaxis*

From
= A
To:
Only = A

**Add** one decision branch of “*VTE Prophylaxis*”,
- When allowable value is “Only = 8”, the case will continue processing and proceed to “Reason for Oral Factor Xa Inhibitor”.
- When allowable value is “Any = 1, 2, 3, 4, 5, 6 or 7”, the case will flow down to “*VTE Prophylaxis Date*”.

**Add** one decision branch of “Reason for Oral Factor Xa Inhibitor”,
- When allowable value is missing, the case will proceed to a Category Assignment ‘X’.
- When allowable value “= N”, the case will proceed to a Category Assignment ‘D’.
- When allowable value “= Y”, the case will flow down to “*VTE Prophylaxis Date*”.

**Impacts:**
VTE-1
Flowchart (Algorithm)

Data Element(s)
*VTE Prophylaxis Date*
*Surgery End Date*

**Rationale:** To clarify understanding for the public user.

**Description of Changes:**

**Add** one branch to “Initial Surgical Prophylaxis Day”,
- When Initial Surgical Prophylaxis Day < 0 days, the case will proceed to a Category Assignment ‘X’.

**Impacts:**
VTE-2

**Rationale:** To update the measure rationale and to include current references.

**Description of Changes:**

**Rationale**

**Change**

From:
The vast majority of patients admitted to a critical care unit (CCU) have a major risk factor for VTE, and many have multiple risk factors: advanced age, serious medical illness, and recent surgical procedures or trauma that are common in critically ill patients. The use of thromboprophylaxis has been demonstrated to be efficacious in preventing deep venous thrombosis in these patients. Accordingly, The Eighth American College of Chest Physicians Conference on Antithrombotic and Thrombolytic Therapy: Evidence-Based Guidelines

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recommends that all patients on admission to a critical care unit be assessed for their risk of VTE, with the expectation that appropriate thromboprophylaxis will be instituted.

To: Approximately two-thirds of cases of Deep Vein Thrombosis (DVT) or Pulmonary Emboli (PE) are associated with recent hospitalization. This is consistent with the 2001 report by Agency for Healthcare Research and Quality (Shojania, et al., 2001). AHRQ reports that “the appropriate application of effective preventive measures in hospitals has major potential for improving patient safety, by reducing the incidence of VTE.”

Almost all hospitalized patients have at least one risk factor for Venous Thromboembolism (VTE), and approximately 40% have three or more risk factors. Without thromboprophylaxis, the incidence of objectively confirmed, hospital-acquired DVT is approximately 10% to 40% among medical or general surgical patients and 40% to 60% following major orthopedic surgery (Geerts et al., 2008).

Commonly, criteria for admission to the Intensive Care Unit (ICU) itself, puts patient’s at an increased risk for developing VTE, and subsequent increased risk of morbidity from PE. Some risk factors are related to the acute illness present that allowed for the admission to the ICU unit, and some risk factors may be acquired during the ICU admission due to subsequent medical treatments, for example limitations of mobility, presence of central venous lines or mechanical ventilation and subsequent pharmacological paralysis. Reports of DVT in the population of ICU patients vary in relation to the acuity of the illness in this population. DVT in ICU patients diagnosed with routine venography or Doppler ultrasound found ranges between 10% to 100%. Five studies prospectively screened patients who were not receiving thromboprophylaxis during their ICU stays. The rates of DVT using Fibrinogen Uptake Test, Doppler Ultrasound or venography ranged from 13 to 31% (Geerts et al., 2008). It is essential for all ICUs to assess each patient upon admission to the ICU unit, a change in level of status, for the need for VTE prophylaxis due to the above increased development of risk factors (Geerts, et al., 2004).

Numerator
Data Elements
Add:

Reason for Oral Factor Xa Inhibitor-ICU Admission

Denominator
Change:
ICU Admission or Transfer Date

Impacts: VTE-2

Rationale: To update the measure to include current references.

Description of Changes:
Selected References
Add:

Impacts: VTE-2
Flowchart (Algorithm)
Data Element(s)
ICU Admission or Transfer Date
Rationale: To clarify understanding for the public user.

Description of Changes:

VTE-2 Flowcharts:

Change  the data element name listed in the VTE-2:

ICU Admission Date
To:
ICU Admission or Transfer Date

Impacts: VTE-2 Flowchart (Algorithm)

Data Element(s)
Reason for Oral Factor Xa Inhibitor-ICU Admission

Rationale: 1. To clarify understanding for the public user
2. Change based on Nov. 4, 2011 FDA approval of rivaroxaban for stroke prevention in patients with atrial fibrillation.

Description of Changes:

VTE-2 Flowchart:

Change  branch going down from ICU VTE Prophylaxis
From:
Any = 1, 2, 3, 4, 5, 6, 7 and NOT = A
To:
Any = 1, 2, 3, 4, 5, 6, 7 or 8

Change the branch going to the right of ICU VTE Prophylaxis
From:
= A
To:
Only = A

Add one decision branch of “ICU VTE Prophylaxis”,
  • When allowable value is “Only = 8”, the case will continue processing and proceed to
    “Reason for Oral Factor Xa Inhibitor – ICU Admission”.
  • When allowable value is “Any = 1, 2, 3, 4, 5, 6 or 7”, the case will flow down to “ICU
    VTE Prophylaxis Date”.

Add one decision branch of “Reason for Oral Factor Xa Inhibitor – ICU Admission”,
  • When allowable value is missing, the case will proceed to a Category Assignment ‘X’.
  • When allowable value “= N”, the case will proceed to a Category Assignment ‘D’.
  • When allowable value “= Y”, the case will flow down to “ICU VTE Prophylaxis Date”.

Impacts: VTE-2 Flowchart (Algorithm)
Data Element(s)
N/A

**Rationale:** To clarify understanding for the public user.

**Description of Changes:**

**Add** one branch to “ICU Initial Surgical Prophylaxis Day” calculation:
- When ICU Initial Surgical Prophylaxis Day < 0 days, the case will proceed to a Category Assignment ‘X’.

**Impacts:** VTE-3

**Rationale:** To update the measure rationale to include current references.

**Description of Changes:**

**Description:** This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they should be discharged on both medications or have a Reason for Discontinuation of Parenteral Therapy. Overlap therapy should be administered for at least five days with an international normalized ratio (INR) greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation therapy, discharged on both medications or have a Reason for Discontinuation of Parenteral Therapy.

**Rationale**

**Change**

From:
For patients who present with a confirmed acute VTE, parenteral anticoagulation is the first line of therapy because of its rapid onset of action. Because the oral anticoagulant warfarin has a very slow onset of action, it cannot be used as mono-therapy for acute VTE. Pretreatment with parenteral anticoagulants prior to initiation of warfarin also avoids an early period of hypercoagulability that can result from the selective inhibition of proteins S and C (which have very short half-lives). Warfarin can be initiated on the first day of treatment after the first dose of a parenteral anticoagulant has been given.

Warfarin interferes with the synthesis of vitamin K dependent pro-coagulant factors (factors II, VII, IX, and X) as well as some anticoagulant factors (proteins S and C). It takes several days for warfarin to achieve its effect because time is required for normal coagulation factors to be cleared from plasma. The adequacy of warfarin therapy is monitored by measurement of the international normalized ratio (INR). The INR can sometimes appear prolonged (or “therapeutic”) as soon as 24 hours after the institution of warfarin due to a reduction in factor VII levels, even while factor II levels are still high and the patient is not in fact therapeutically anticoagulated. Because factor II has a half-life of 60-72 hours, a minimum of five days of parenteral anticoagulation is recommended as “overlap therapy” while warfarin is being initiated. Parenteral therapy should also be continued until the INR is greater than or equal to 2.0, even if this takes longer than five days, so that patients are fully anticoagulated during the period before warfarin takes its full effect.
To:
For patients who present with a confirmed acute VTE, parenteral anticoagulation is the first line of therapy because of its rapid onset of action (Buller et al., 2004). Warfarin can be initiated on the first day of treatment after the first dose of a parenteral anticoagulant has been given. Because the warfarin has a very slow onset of action, it cannot be used as mono-therapy for acute VTE (Ansell et al., 2008).

The strong (Level I) recommendations to overlap parenteral anticoagulation with oral warfarin therapy in the initial treatment of VTE events is based in part on the known effect of warfarin on the coagulation cascade (Brandjes, et al., 1992). The early increase in the Pro thrombin time (PT) and INR often reflects the laboratory finding of initial reduction in clotting factors of the extrinsic pathway of coagulation resulting in prolongation of the PT/INR, while the patient is still at risk of thromboembolic events due to persistent levels of coagulation factors of the intrinsic pathway and common pathways of coagulation.

The recommendation that heparins and warfarin overlap for a five-day period is based on pharmacokinetic, pharmacologic, pathophysiologic, and clinical evidence as noted by Wittkowsky A.K. (2005). All studies support the pharmacokinetic characteristics of warfarin and the time delay in achieving an antithrombotic effect suggesting the need for overlap of heparin during initial warfarin dosing in order to prevent thrombus extension, embolization to the lungs, death due to Pulmonary Emboli (PE), and the development of complications such as recurrent thromboembolic events and the post thrombotic syndrome. Kearon et al, 2008 also denotes current recommendation for treatment of confirmed VTE to begin with oral warfarin therapy, with combination of initial anticoagulation therapy for a minimum of 5 days and until the INR is >2.0 for at least 24 hours, and then a recommended target rate.

**Included Populations**

**Change**

With documentation of reason for discontinuation of parenteral therapy Or

**Numerator Data Elements:**

**Change**

Reason for Discontinuation of Parenteral Therapy

**Impacts:**

VTE-3

**Rationale:**

To update the measure to include current references.

**Description of Changes:**

**Selected References**

**Add:**


---

**Impacts:** VTE-3

Flowchart (Algorithm)

**Data Element(s)**

**Reason for Discontinuation of Overlap Therapy**

**Rationale:** To clarify understanding for the public user.

**Description of Changes:**

VTE-3 Flowchart:

**Change** the data element name

To:

*Reason for Discontinuation of Parenteral Therapy*

**Impacts:** VTE-4
Rationale: To update the measure rationale and include current references.

Description of Changes:
Rationale
Change
To:
Heparin is commonly involved in adverse drug events (Geerts et al., 2008). Sub-therapeutic and supratherapeutic levels can lead to thromboembolic or bleeding complications that may increase the patient’s length of stay. The use of weight-based nomograms has increased the likelihood that a therapeutic partial prothromboplastin time (aPTT) will be achieved within the first 24 to 48 hours of therapy. The risk of recurrent thromboembolism is reduced when a therapeutic level of heparin is reached quickly.

Unfractionated heparin (UFH) management by weight-based aPTT adjusted protocols have demonstrated their ability through clinical trials to achieve a therapeutic aPTT more rapidly than with standard UFH dosing without increasing major bleeding (Rashke et al. 1993).

Heparin nomograms are superior compared to routine care in the timely achievement of therapeutic anticoagulation despite the trend toward patients having aPTTs above the target range (ahrq.gov/clinic/ptsafety/chap9.htm, retrieved October 6, 2011).

Heparin-induced thrombocytopenia (HIT) occurs more commonly in patients who receive UFH than in those who receive low molecular weight heparin (Martin et. al., 2005). HIT is defined as an unexplained fall in platelet count (specifically, a 50% fall in platelet count from baseline, even if the platelet count remains above 150 x 10^9/L) (Warkentin et. al., 2008). Platelet counts generally begin to fall 5-10 days after the initiation of heparin therapy. Prompt recognition of HIT is important so that heparin can be discontinued and the risk of venous and arterial thrombosis minimized.

To detect HIT, platelet count monitoring is recommended for all patients treated with UFH (Warkentin et. al., 2008).

Impacts: VTE-4

Rationale: To update the measure references.

Description of Changes:
Selected References
Remove:

Add:
• Geerts WH, Pineo GF, Heit JA, et al. Prevention of venous thromboembolism: the
### Impacts:

**VTE-4**
Data Element List

### Rationale:
To clarify understanding for the public user.

### Description of Changes:

**Measure Short Name**

**Change**

**VTE-4 Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosage/Platelet Count Monitoring by Protocol or Nomogram**

---

Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy. Chest. 2004 Sep; 126(3 Suppl):338S-400S.

- Warkentin TE, Sigouin CS. Gender and risk of immune heparin-induced thrombocytopenia. Blood 2002; 100(suppl 1):17a [abstract].
### Impacts:
- VTE-5

### Rationale:
This is to clarify that the measure is specific to Warfarin therapy, and does not apply to any other discharge medications.

### Description of Changes:
#### Performance Measure Name
- **Change**
- **To:** Venous Thromboembolism Warfarin Therapy Discharge Instructions

### Impacts:
- VTE-5
- Flowchart (Algorithm)

### Rationale:
This is to clarify that the measure is specific to Warfarin therapy, and does not apply to any other discharge medications.

### Description of Changes:
#### Measure Name (Flowchart (algorithm))
- **Change**
- **To:** Venous Thromboembolism Warfarin Therapy Discharge Instructions

### Impacts:
- VTE-5
- Data Element List

### Rationale:
This is to clarify that the measure is specific to Warfarin therapy, and does not apply to any other discharge medications.

### Description of Changes:
#### VENOUS THROMBOEMBOLISM NATIONAL HOSPITAL INPATIENT QUALITY MEASURES
- **Measure Short Name**
- **Change**
- **To:** Venous Thromboembolism Warfarin Therapy Discharge Instructions

### Impacts:
- VTE-5

### Rationale:
To update the measure rationale to include current references

### Description of Changes:
#### Rationale
- **Remove:**
- In the hospital, effective patient and family education is emerging as an important issue of health care in spite of inconsistent results related to patient outcomes. However, there is evidence that clear and understandable instructions given when the patients are ready to learn, can increase their satisfaction. Due to decreased length of stay, patients are discharged sooner with more complex medical conditions and need to be knowledgeable about their treatment and health care needs.

Anticoagulation therapy poses risks to patients and often leads to adverse drug events due to
complex dosing, requisite follow-up monitoring and inconsistent patient compliance. The use of standardized practices for anticoagulation therapy that includes patient/caregiver involvement may reduce the risk of adverse drug events. The 2009 National Patient Safety Goal 3E, Implementation Expectation (M) C.10 states that the organization provides education regarding anticoagulation therapy to patients/family that includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse drug reactions and interactions.

**Add:**
In anticoagulation therapy programs, patient education is a vital component to achieve successful outcomes, and reducing hospital readmission rate. Patients benefit from education about the potential consequences of both their disease and its treatment (Institute for Clinical Systems Improvement 2006). Warfarin is commonly involved in adverse drug events (Ansell, J. 2008). Adverse drug events can include subtherapeutic clot formation, and supertherapeutic hemorrhage. Anticoagulation therapy poses risks to patients due to complex dosing, requisite follow-up monitoring and inconsistent patient compliance. The use of standardized practices for anticoagulation therapy that includes patient/caregiver involvement may reduce the risk of adverse drug events (van Walraven, et. al. 2006).

The Joint Commission National Patient Safety Goal “Reduce the likelihood of patient harm associated with the use of anticoagulant therapy” states that the organization provides education regarding anticoagulation therapy to patients/family that includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse drug reactions and interactions.

**Impacts:**  VTE-5

**Rationale:** To update the measure rationale to include current references

**Description of Changes:**
**Selected References**

Add:
- Beyth RJ, Quinn L, Landefeld CS. A multicomponent intervention to prevent major bleeding complications in older patients receiving warfarin: a randomized, controlled trial. Annals of Internal Medicine, 2000 Nov 7;133(9):687-95
- Institute for Clinical Systems Improvement (ICSI). Anticoagulation therapy supplement. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2006 Apr.49p. [91 references]

**Impacts:** VTE-6

**Rationale:** To update the measure rationale to include current references

**Description of Changes:**

**Performance Measure Name:**

**Change:**

Hospital Acquired Potentially–Preventable Venous Thromboembolism

---

Specifications Manual for Hospital Inpatient Quality Measures

Encounter dates 01-01-13 (1Q13) through 06-30-13 (2Q13) v.4.2
Change
From:
The concept of “failure to prevent” has generated interest in national health policy organizations to identify evidence-based practice that will improve patient safety in the hospital setting. In spite of formal guidelines, pulmonary embolism is the most common preventable cause of death among hospitalized patients, causing or contributing to 5% to 10% of all in-hospital deaths. A study at a large teaching hospital found that potentially preventable cases of VTE represented two-thirds of all VTE cases where prophylaxis was indicated, with 47.7% due to failure to give any prophylaxis, 22.7% because of inadequate duration or 20% due to incorrect type of prophylaxis. Almost one-half of all VTEs occurring in the community are related to recent hospitalization, either for major surgery or for acute medical illness.

Gillies and colleagues identified three groups of surgical patients less likely to receive prophylaxis: moderate-risk patients, emergency admission, and conservatively treated patients. Failure to prevent VTE can result in delayed hospital discharge or readmission, increased risk for long-term morbidity from post-thrombotic syndrome, and recurrent thrombosis in the future.

To:
The concept of “failure to prevent” has generated interest in national health policy organizations to identify evidence-based practice that will improve patient safety in the hospital setting (Wachter et al 2008). The incidence of preventable venous thromboembolism (VTE) among hospitalized patients is overwhelming, and contributes to extended hospital stays, and the rising cost of health care. Zhan 2003, states that “VTE was the second most common medical complication of postoperative patients, the second most common cause of excess length of stay, and the third most common cause of excess mortality and excess charges”. According to Arnold, D.M. (2001), preventable VTE is defined as “objectively diagnosed Deep Vein Thrombosis (DVT) or Pulmonary Emboli (PE) that occurred in a setting in which thromboprophylaxis was indicated but was either administered inadequately or not administered at all.” In spite of formal guidelines, and recommendations for preventative care, pulmonary embolism is still the most common preventable cause of death among hospitalized patients (Wachter et al, 2008).

Impacts: VTE-6

Rationale: To update the measure to include current references.

Description of Changes:
Selected References
Add:
- Goldhaber SZ, Dunn K, Mac Dougall RC. New onset of venous thromboembolism among hospitalized patients at Brigham and Women’s Hospital is caused more often by prophylaxis failure than by withholding treatment. Chest 2000;118:1680
- Heit JA, Cohen AT, Anderson FA Jr, et al., Estimated annual number of incident and


Impacts: VTE-6
Flowchart (Algorithm)

Rationale: To clarify measure purpose to general public.

Description of Changes:
Name Change

Change:
VTE-6 Hospital Acquired Potentially-Preventable Venous Thromboembolism

Impacts: VTE-6
Data Element List

Rationale: To clarify measure purpose to general public.

Description of Changes:

Measure Short Name

Change:
VTE-6 Hospital Acquired Potentially-Preventable Venous Thromboembolism

**Subsection 2.8 – Stroke (STK)**

Impacts: STK

Data Element(s)
Anticoagulation Therapy Prescribed At Discharge
Antithrombotic Therapy Administered by End of Hospital Day 2
Antithrombotic Therapy Prescribed At Discharge
Arrival Date
Arrival Time
Assessed for Rehabilitation Services
Atrial Fibrillation/Flutter
Clinical Trial
Comfort Measures Only
Date Last Known Well
Discharge Disposition
ED Patient
Education Addresses Activation of Emergency Medical System
Education Addresses Follow-up After Discharge
Education Addresses Medications Prescribed at Discharge
Education Addresses Risk Factors For Stroke
Education Addresses Warning Signs and Symptoms of Stroke
Elective Carotid Intervention
IV OR IA Thrombolytic (t-PA) Therapy Administered at This Hospital or Within 24 Hours Prior to Arrival
IV Thrombolytic Initiation
IV Thrombolytic Initiation Date
IV Thrombolytic Initiation Time
Last Known Well
LDL-c Greater Than or Equal to 100 mg/dL
LDL-c Measured Within the First 48 Hours or 30 Days Prior to Hospital Arrival
Pre-Arrival Lipid-Lowering Agent
Reason for No VTE Prophylaxis – Hospital Admission
Reason For Not Administering Antithrombotic Therapy By End of Hospital Day 2
Reason For Not Initiating IV Thrombolytic
Reason For Not Prescribing Anticoagulation Therapy at Discharge
Reason For Not Prescribing Antithrombotic Therapy at Discharge
Reason For Not Prescribing Statin Medication At Discharge
Statin Medication Prescribed At Discharge
Time Last Known Well
VTE Prophylaxis
VTE Prophylaxis Date

Measure(s)
STK-1
STK-2
STK-3
STK-4
STK-5
STK-6
STK-8
STK-10

Rationale: Change based on August 1, 2011 published IPPS Final Rule

Description of Changes:
Collected For
Remove footnotes for The Joint Commission Only and CMS Informational Only

Impacts: STK-1
Data Element(s)
Reason for Oral Factor Xa Inhibitor
Measure(s)
STK-1

Rationale: Change based on Nov. 4, 2011 FDA approval of rivaroxaban for stroke prevention in patients with atrial fibrillation.

Description of Changes:
Numerator Data Elements:
Add:
  • Reason for Oral Factor Xa Inhibitor
Impacts:       STK-1
Flowchart (Algorithm)
Data Element(s)
N/A
Measure(s)
STK-1

Rationale:       Change based on Nov. 4, 2011 FDA approval of rivaroxaban for stroke prevention in patients with atrial fibrillation.

Description of Changes:
Change the branch going down from VTE Prophylaxis:
    Any = 1, 2, 3, 4, 5, 6, 7 and NOT = A
    To: Any = 1, 2, 3, 4, 5, 6, 7 or 8

Change the branch going to the right of VTE Prophylaxis:
    From:
    Any = 4 or A
    To:
    Only = A

Add another "VTE Prophylaxis" decision box
    • When allowable values is "All = 4 or/and 8", the case will flow to the right to another decision branch of "VTE Prophylaxis",
    • When allowable values is "Any = 1, 2, 3, 5, 6 or 7", the case will flow down to "VTE Prophylaxis Date"

Add another "VTE Prophylaxis" decision box
    • When allowable value is “ Only = 4 ”, the case will flow to the right to "Reason for No VTE Prophylaxis - Hospital Admission"
    • When allowable value is “Any = 8”, the case will flow down to “Reason for Oral Factor Xa Inhibitor”.

Add one decision branch of “Reason for No VTE Prophylaxis - Hospital Admission”
    • When allowable value “= Y”, case proceed to a Category Assignment ‘E’.
    • When allowable value “= N”, case proceed to a Category Assignment ‘D’.
    • When allowable value is missing, case proceed to a Category Assignment ‘X’.

Add one decision branch of “Reason for Oral Factor Xa Inhibitor”
    • When allowable value “= Y”, the case will flow down to "VTE Prophylaxis Date”
    • When allowable value “= N”, case proceed to a Category Assignment ‘D’.
    • When allowable value is missing, case proceed to a Category Assignment ‘X’

Impacts:       STK-1
Data Element List

Data Element(s)
Reason for Oral Factor Xa Inhibitor
Measure(s)
STK-1

Rationale: Change based on Nov. 4, 2011 FDA approval of rivaroxaban for stroke prevention in patients with atrial fibrillation.

Description of Changes:
Add
Reason for Oral Factor Xa Inhibitor

Impacts: STK-1
Data Element(s)
N/A
Measure(s)
STK-1

Rationale: Update reference

Description of Changes:
Selected References:
Add:

Impacts: STK
Data Element(s)
N/A

Rationale: To align the submission of 5 or Fewer cases for STK, for CMS, with the IPPS rule and current CMS specifications.

Description of Changes:
Sample Size Requirements – Quarterly Sampling
Change the Quarterly Sample Size table. Please refer to the Sampling Requirements in the Measure Information section for specific changes.

Sample Size Requirements – Sample Size Examples
Change the Third bullet under the Quarterly sampling
From:
- A hospital’s STK Initial Patient Population is 4 patients during the first quarter. Submission of patient level data is not required. If the hospital chooses to submit patient level data, the required quarterly sample size would be 100% of the patient population or 4 cases for the quarter.
To:
- A hospital’s STK Initial Patient Population is 4 patients during the first quarter. Submission of patient level data is not required. If the hospital chooses to submit patient level data:
  - CMS: the quarterly sample size would be 1 – 4 cases for the quarter
  - The Joint Commission: the required quarterly sample size would be 100% of the patient population or 4 cases for the quarter.

### Subsection 2.9 – Global Initial Patient Population (ED, IMM, TOB, SUB)
No updates in this section

### Subsection 2.10 – Emergency Department (ED)
No updates in this section

### Subsection 2.11 – Prevention

#### 2.11.1 Prevention – Immunization (IMM)

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<tbody>
<tr>
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<td>Flowchart (Algorithm)</td>
</tr>
</tbody>
</table>

**Rationale:** Consistency in terminology. Edits are now referred to as Feedback Messages.

**Description of Changes:**

**IMM-1**

**Change** 2<sup>nd</sup> sentence in Patient Age note box on 1<sup>st</sup> page of algorithm

To:
Only cases with valid Admission Date and Birthdate will pass the critical feedback messages into the measure specific algorithm.

**IMM-2**

**Change** 2<sup>nd</sup> sentence in Patient Age note box on 1<sup>st</sup> page of algorithm

To:
Only cases with valid Admission Date and Birthdate will pass the critical feedback messages into the measure specific algorithm.

| Impacts: | IMM-1, IMM-2 |

**Rationale:**
1) The CDC’s full title is Centers for Disease Control and Prevention. This is a simple correction of terminology that needs to be addressed.

**Description of Changes:**

**IMM-1**

**Selected References**

**Change**

- Bullets 1, 3-6:
  - FROM “Centers for Disease Control” TO “Centers for Disease Control and Prevention”

**IMM-2**
**Selected References**

**Change**

- Bullet 4:
  - FROM “Centers for Disease Control” TO “Centers for Disease Control and Prevention”

**Impacts:** IMM-1, IMM-2

**Rationale:**

1) Add exclusion for patients with length of stay greater than 120 days as this exclusion applies to all hospital measures since it is an issue with overlap of quarters.
2) Add new reference showing safety of use of influenza vaccine in cancer patients
3) Add supportive documentation for use of influenza vaccine in patients with egg allergy
4) Add back in exclusions for patients who transfer to another hospital, and those who leave Against Medical Advice. These were removed as a result of NQF harmonization; however, CMS and TJC believe it is clinically appropriate to add them back.
5) Add exclusion for patients discharged to another hospital since we do not want to hold hospitals accountable for giving vaccines to critically ill patients that they are transferring to another hospital.

**Description of Changes:**

**IMM-1**

**Excluded Populations (Denominator):**

**Add**

- Patients who are transferred or discharged to another acute care hospital
- Patients who leave Against Medical Advice (AMA)

**IMM-2**

**Excluded Populations (Denominator):**

**Add**

- Patients who have a Length of Stay greater than 120 days
- Patients who are transferred or discharged to another acute care hospital
- Patients who leave Against Medical Advice (AMA)

**Selected References**

**Add**


**Impacts:** IMM-1

- Flowchart (Algorithm)
- Measure Short Name
- Immunization List
Rationale: 1) The measure no longer just looks at PPV23 so PPV23 needs to be removed from the manual where it presents as “(PPV23).” If it stands alone as “PPV23”, it needs to be replaced with “pneumococcal vaccine.”
2) Need to change the lower end of the population age range from 6 years to 5 years of age to match the guidelines.

Description of Changes:

Immunization National Hospital Inpatient Quality Measures

Measure Short Name
Remove (PPV23)

Immunization Data Element List
Pneumococcal Vaccination (PPV23) Status
Remove (PPV23)

Measure Information Form
Performance Measure Name
Stratified Measure Name
Description
Numerator Statement
Data Elements
Remove (PPV23)

Description
Remove 23-valent

Description
Change - FROM
  o “contraindications to PPV23” TO “contraindications to pneumococcal vaccine”
  o “offered and declined PPV23” TO “offered and declined pneumococcal vaccine”
  o “patients who received PPV23” TO “patients who received pneumococcal vaccine”

Rationale
Change - FROM
  o “evidence that PPV23 can prevent” TO “evidence that pneumococcal vaccine can prevent”
  o “PPV23 coverage is suboptimal” TO “pneumococcal vaccine is suboptimal”

Numerator Statement
Change - FROM
  o “screened for PPV23” TO “screened for pneumococcal vaccine”
  o “received PPV23” TO “received pneumococcal vaccine”

Included Populations
Change - FROM
  o “received PPV23 during” TO “received pneumococcal vaccine during”
  o “received PPV23 anytime” TO “received pneumococcal vaccine anytime”
  o “declined PPV23” TO “declined pneumococcal vaccine”
Change – FROM
  o  (Age 6 through 64 years) TO (Age 5 through 64 years)

Description
Change – FROM
  o  “AND inpatients aged between 6 and 64 years” TO “AND inpatients aged between 5 and 64 years”

Numerator Statement
Included Populations
Change – FROM
  o  “Patients 6 years of age who received a conjugate vaccine within the previous 8 weeks” TO “Patients 5 - 18 years of age who received a conjugate vaccine within the previous 8 weeks”

Denominator Statement
Change – FROM
  o  “Inpatient discharges 65 years of age and older, and 6 through 64 years of age who have a high risk condition” TO “Inpatient discharges 65 years of age and older, and 5 through 64 years of age who have a high risk condition”

Included Populations
Change – FROM
  o  “Inpatient discharges 6 – 64 years of age” TO “Inpatient discharges 5 – 64 years of age”

Excluded Populations
Change – FROM “Patients less than 6 years of age” TO “Patients less than 5 years of age”

Impacts: IMM-1

Rationale: Add PIDS flow diagram to be used as a physician reference regarding pneumococcal vaccine assessment/administration for high risk pediatric patients.

Description of Changes:
IMM-1
After Selected References Section
Add:
PIDS flow diagram

Impacts: IMM-1
Flowchart (Algorithm)
Data Element(s)
Pneumococcal Vaccination Status

Rationale: Correct algorithm logic.

Description of Changes:
Algorithm
Change:
- 1st diamond allowable value of patient age from 6 to 5
- 5th and 10th diamond of lower end of patient age from 6 to 5

Change:
- data element name of Pneumococcal Vaccination Status
  From: Pneumococcal Vaccination (PPV23) Status
  To: Pneumococcal Vaccination Status

Remove:
- “(Age Range)” from stratification table box.
- “(PPV23)” from the measure name, the numerator statement and the stratified table measure name.

Impacts: IMM-2
  Flowchart (Algorithm)
  Data Element(s)
  Discharge Disposition

Rationale: Correct label missing.

Description of Changes:
Algorithm
Add “Missing” to Discharge Disposition branch flowing to the “X” category assignment

Impacts: IMM-1, IMM-2
  Flowchart (Algorithm)
  Data Element(s)
  Discharge Disposition

Rationale: Change algorithm logic to reflect MIF change

Description of Changes:
Algorithm
Change Discharge Disposition decision point, allowable value 4,7:
  From: branch of continuing down
  To: branch of category assignment ‘B’

2.11.2 Prevention – Tobacco Treatment (TOB)

Impacts: TOB-3a
  Flowchart (Algorithm)
  Data Element(s)
  Reason for No Tobacco Cessation Medication at Discharge

Rationale: Correct label error.

Description of Changes:
Algorithm
Change
Label for Reason for No Tobacco Cessation Medication at Discharge, from “During Hospital Stay” to “at Discharge”

Impacts:
- TOB
  - Data Element(s)
  - N/A
  - Measure(s)
  - TOB-4

Rationale: Data shows that relapse is most common in the first 2 weeks post discharge so changing the time frame for follow-up to 15-45 days would move past the relapse period and yield better information.

Description of Changes:
Description
Change: Discharged patients who are identified through the screening process as having used tobacco products (cigarettes, smokeless tobacco, pipe, and cigars) within the past 30 days who are contacted between 15 and 30 days after hospital discharge and follow-up information regarding tobacco use status is collected.

Numerator Statement
Change: The number of discharged patients who are contacted between 15 and 30 days after hospital discharge and follow-up information regarding tobacco use status is collected.

Impacts:
- TOB-4
  - Flowchart (Algorithm)

Data Element(s)
Follow Up Days

Rationale: Correct algorithm logic

Description of Changes:
Algorithm
Change: Algorithm logic for Follow-up Days, allowable value is greater than or equal to 15 days and less than or equal to 30 days, now flows to Measure Category Assignment ‘E’; allowable value is greater than or equal to zero days and less than 15 days, or Follow up Days is greater than 30 days, now flows to Measure Category Assignment ‘D’.

Impacts:
- TOB-4
  - Data Element List

- Tobacco Use Status Post Discharge – Counseling – TOB-4
- Tobacco Use Status Post Discharge – Medication – TOB-4
- Tobacco Use Status Post Discharge – Quit Status – TOB-4
- Tobacco Use Status Post-Discharge – TOB-4
Rationale: Measure currently does not utilize the post discharge status information. The original desire of the TAP was that the measure eventually be revised to capture the discharge status information.

Description of Changes:
Data Element List
Add:
- Tobacco Use Status Post Discharge – Counseling – TOB-4
- Tobacco Use Status Post Discharge – Medication – TOB-4
- Tobacco Use Status Post Discharge – Quit Status – TOB-4

Remove:
- Tobacco Use Status Post-Discharge – TOB-4

Measure Information Form – Numerator Data Elements
Add:
- Tobacco Use Status Post Discharge – Counseling
- Tobacco Use Status Post Discharge – Medication
- Tobacco Use Status Post Discharge – Quit Status

Remove:
- Tobacco Use Status Post-Discharge

Denominator Excluded Populations
Add:
- Patients who are cognitively impaired
- Patients who were not screened for tobacco use
- Patients readmitted within the follow-up time frame

Type of Measure
Change to: Process

Data Collection Approach
Change
From:
The informational data element for Tobacco Use Status Post Discharge should be referenced and pertinent allowable values recorded on follow-up log sheets or other documentation as determined appropriate by the hospital.
To:
The 3 data elements regarding Tobacco Use Status Post Discharge should be referenced and pertinent allowable values recorded on follow-up documentation as determined appropriate by the hospital and recorded in the medical record.

Remove:
Second paragraph of Data Collection Approach

Data Accuracy
Add:
Paragraph removed from Data Collection Approach
Measure Analysis Suggestions

Change
From:
Hospitals may wish to analyze the measure data using the informational data element Tobacco Use Status Post Discharge to determine the difference in use status related to interventions made during the hospital stay or referrals at discharge.

To:
Hospitals may wish to analyze the measure data using the data elements Tobacco Use Status Post Discharge – Counseling, Tobacco Use Status Post Discharge – Medication, and Tobacco Use Status Post Discharge – Quit Status to determine the difference in use status related to interventions made during the hospital stay or referrals at discharge.

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>TOB-4</th>
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<tr>
<td></td>
<td>Flowchart (Algorithm)</td>
</tr>
</tbody>
</table>

Data Element(s)
Tobacco Use Status Post Discharge – Counseling
Tobacco Use Status Post Discharge – Medication
Tobacco Use Status Post Discharge – Quit Status

Rationale: Add algorithm logic to reflect MIF changes.

Description of Changes:
Flowchart (Algorithm)
Add:
Data elements to algorithm with associated logic.

2.11.3 Prevention – Substance Use (SUB)

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>SUB-3a</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Flowchart (Algorithm)</td>
</tr>
</tbody>
</table>

Data Element(s)
Prescription for Alcohol or Drug Disorder Medication

Rationale: Correct label error.

Description of Changes:
Algorithm change
Change:
Label Prescription for Alcohol or Drug Disorder Medication, from “Prescription for Alcohol or Drug Dependency Medication” to “Prescription for Alcohol or Drug Disorder Medication”

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>SUB-3, SUB-3a</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Flowchart (Algorithm)</td>
</tr>
</tbody>
</table>

Data Element(s)
Prescription for Alcohol or Drug Disorder Medication
Referral for Addictions Treatment

Rationale: Correct typographical errors

Description of Changes:
Measure Information Form
### Numerator Data Elements for SUB-3 & SUB-3a

**Change:**
Prescriptions for Alcohol or Drug Disorder Medication to Prescription for Alcohol or Drug Disorder Medication
Referral for Addiction Treatment to Referral for Addictions Treatment

**Denominator Excluded Populations**

**Add:**
To the 8th bullet: or another healthcare facility after the word home and before the word for.

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>SUB-4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Element(s):</strong></td>
<td>Prescription for Alcohol or Drug Disorder Medication</td>
</tr>
</tbody>
</table>

**Rationale:**
Only patients identified through screening who have risky behavior will need to have follow-up contact. Value 3 represents patients screened with an invalidated tool who do not have such behavior. The value currently flows through the algorithm and requires follow up which is not necessary. Flowing the value to category B will correct this problem and make the measure consistent with SUB 2.

**Description of Changes:**

**Algorithm change**

**Change:**
Algorithm logic for Alcohol Use Status, allowable value ‘3’ now flows to Measure Category Assignment ‘B’

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>SUB</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Element List</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Data Element(s):</strong></td>
<td></td>
</tr>
<tr>
<td>Alcohol or Drug Use Status Post Discharge</td>
<td></td>
</tr>
<tr>
<td>Alcohol or Drug Use Status Post Discharge – Counseling</td>
<td></td>
</tr>
<tr>
<td>Alcohol or Drug Use Status Post Discharge – Medication</td>
<td></td>
</tr>
<tr>
<td>Alcohol Use Status Post Discharge – Quit Status</td>
<td></td>
</tr>
<tr>
<td>Drug Use Status Post Discharge – Quit Status</td>
<td></td>
</tr>
</tbody>
</table>

**Rationale:**
Measure currently does not utilize the post discharge status information. The original desire of the TAP was that the measure eventually be revised to capture the discharge status information.

**Description of Changes:**

**Data Element List**

**Add:**
Alcohol or Drug Use Status Post Discharge – Counseling
Alcohol or Drug Use Status Post Discharge – Medication
Alcohol Use Status Post Discharge – Quit Status
Drug Use Status Post Discharge – Quit Status

**Remove**
Alcohol or Drug Use Status Post Discharge

Measure Information Form – Numerator Data Elements
Add:
Alcohol or Drug Use Status Post Discharge – Counseling
Alcohol or Drug Use Status Post Discharge – Medication
Alcohol Use Status Post Discharge – Quit Status
Drug Use Status Post Discharge – Quit Status
Remove:
Alcohol or Drug Use Status Post Discharge

Description
Change
To:
Discharged patients who screened positive for unhealthy alcohol use or who received a diagnosis of alcohol or drug disorder during their inpatient stay, who are contacted between 7 and 30 days after hospital discharge and follow up information regarding their alcohol or drug use status post discharge is collected.

Numerator Statement
Change
To:
The number of discharged patients that are contacted between 7 and 30 days after hospital discharge and follow up information regarding alcohol or drug use status is collected.

Denominator Included Populations
Change
From:
Patients who screened positive for unhealthy alcohol use
To:
Patients who screened positive for unhealthy alcohol use or who were identified with an alcohol or drug disorder

Denominator Excluded Populations
Add:
Patients who are cognitively impaired
Patients who were not screened or refused to be screened for alcohol use
Or other health care facility, following Patients discharged to home and prior to, for hospice care
Patients who are readmitted within the follow-up time frame

Type of Measure
Change to:
Process

Data Collection Approach
Change:
The measure intent as described in the measure description and numerator statement is that information gathered during the follow-up contact regarding the patient’s compliance with prescribed outpatient treatment and post discharge status relevant to substance use will be
cataloged at the hospital. The 3 data elements for Alcohol or Drug Use Status Post Discharge should be referenced and pertinent allowable values recorded on follow up documentation as determined appropriate by the hospital and recorded in the medical record.

**Remove:**
Second paragraph of Data Collection Approach

**Data Accuracy**

**Add:**
Paragraph removed from Data Collection Approach

**Measure Analysis Suggestions**

**Change**
To: Hospitals may wish to analyze the measure data using the data elements Alcohol or Drug Use Status Post Discharge – Counseling, Alcohol or Drug Use Status Post Discharge – Medication, and Alcohol or Drug Use Status Post Discharge - Quit Status to determine the difference in use status related to interventions made during the hospital stay or referrals at discharge.

**Impacts:**

<table>
<thead>
<tr>
<th>SUB</th>
<th>Data Element(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Alcohol or Drug Use Status Post Discharge – Counseling</td>
</tr>
<tr>
<td></td>
<td>Alcohol or Drug Use Status Post Discharge – Medication</td>
</tr>
<tr>
<td></td>
<td>Alcohol Use Status Post Discharge – Quit Status</td>
</tr>
<tr>
<td></td>
<td>Drug Use Status Post Discharge – Quit Status</td>
</tr>
<tr>
<td></td>
<td>Follow-up Days</td>
</tr>
<tr>
<td></td>
<td>Complete Plan Counter I</td>
</tr>
<tr>
<td></td>
<td>Complete Plan Counter II</td>
</tr>
</tbody>
</table>

**Measure(s)**

| SUB-4 |

**Rationale:** Change algorithm logic to reflect MIF changes

**Description of Changes:**

**Algorithm**

**Add** variable - Complete Plan Counter I

**Add** variable - Complete Plan Counter II

**Add** initialization process below Follow-up Days decision point
- Initialize Complete Plan Counter I to 0
- Initialize Complete Plan Counter II to 0

**Add** Alcohol or Drug Use Status Post Discharge – Counseling decision point below initialization process
- When allowable value equals 1, 2, 3, 4 add 1 to Complete Plan Counter I and flow down
- When allowable value equals 5 flow down
- When allowable value is missing flow to category ‘X’
Add Alcohol or Drug Use Status Post Discharge – Medication decision point below Alcohol or Drug Use Status Post Discharge – Counseling decision point
- When allowable value equals 1, 2, 3, 4 add 1 to Complete Plan Counter I and flow down
- When allowable value equals 5 flow down
- When allowable value is missing flow to category ‘X’

Add 1st Alcohol Use Status Post Discharge – Quit Status decision point below Alcohol or Drug Use Status Post Discharge – Medication decision point
- When allowable value equals 3 flow right to 1st Drug Use Status Post Discharge – Quit Status
- When allowable value is missing flow to category ‘X’
- When allowable value equals 1, 2, 4, 5 flow down to 2nd Alcohol Use Status Post Discharge – Quit Status decision point

Add 1st Drug Use Status Post Discharge – Quit Status decision point right to Alcohol Use Status Post Discharge – Quit Status decision point
- When allowable value equals 3 or Missing flow to category ‘X’
- When allowable value equals 1, 2, 4, 5 flow down to 2nd Drug Use Status Post Discharge – Quit Status decision point

Add 2nd Alcohol Use Status Post Discharge – Quit Status decision point below 1st Alcohol Use Status Post Discharge – Quit decision point
- When allowable value equals 1, 2, 4 add 1 to Complete Plan Counter II and flow down to 2nd Drug Use Status Post Discharge – Quit Status
- When allowable value equals 5 flow down to 2nd Drug Use Status Post Discharge – Quit decision point

Add 2nd Drug Use Status Post Discharge – Quit Status decision point below 2nd Alcohol Use Status Post Discharge – Quit decision point
- When allowable value equals 1, 2, 4 add 1 to Complete Plan Counter II and flow down
- When allowable value equals 3, 5 flow down

Add Complete Plan Counter I decision point below 2nd Drug Use Status Post Discharge – Quit Status decision point
- When Complete Plan Counter I equals 2 flow down
- When Complete Plan Counter I is less than 2 flow to Category ‘D’

Add Complete Plan Counter II decision point below Complete Plan Counter I decision point
- When Complete Plan Counter II is greater or equals 1 flow to Category ‘E’
- When Complete Plan Counter II is less than 1 flow to Category ‘D’

Change Follow-up Days allowable value lower end
From: 0
To: 7

SECTION 3 – Missing and Invalid Data
**SECTION 4 – Population and Sampling Specifications**

**Impacts:** Population and Sampling

**Rationale:** Required submission of VTE and STK measures by CMS.

**Description of Changes:**

**Sample Size Requirements**

**Change** last paragraph

From:

A hospital may choose to use a larger sample size than is required. Hospitals whose Initial Patient Population size is less than the minimum number of cases per quarter/month for the measure set, stratum, or sub-population, cannot sample. Hospitals that have five or fewer AMI, GLB (ED, IMM, SUB, TOB), HF, PN and/or SCIP discharges (both Medicare and non-Medicare combined) are not required to submit patient level data to the QIO Clinical Warehouse and Joint Commission’s Data Warehouse. Hospitals that have five or fewer CAC, STK, and/or VTE discharges (both Medicare and non-Medicare combined) are not required to submit patient level data to the Joint Commission’s Data Warehouse. Refer to the Sample Size Requirement tables provided in each measure set’s Measure Information section to determine the minimum number of cases that need to be sampled for each population.

To

A hospital may choose to use a larger sample size than is required. Hospitals whose Initial Patient Population size is less than the minimum number of cases per quarter/month for the measure set, stratum, or sub-population, cannot sample. Hospitals that have five or fewer AMI, GLB (ED, IMM, SUB, TOB), HF, PN, SCIP, STK and/or VTE discharges (both Medicare and non-Medicare combined) are not required to submit patient level data to the QIO Clinical Warehouse and Joint Commission’s Data Warehouse. Hospitals that have five or fewer CAC discharges (both Medicare and non-Medicare combined) are not required to submit patient level data to the Joint Commission’s Data Warehouse. Refer to the Sample Size Requirement tables provided in each measure set’s Measure Information section to determine the minimum number of cases that need to be sampled for each population.

**SECTION 9 – Data Transmission**

**Impacts:** N/A

**Rationale:** To provide clarification regarding the types of feedback messages that are received during data submission and processing.
Description of Changes:
CMS and Joint Commission Guidelines for Submission of Data – Overview

**Change** from:
The below guidelines are for the submission of Hospital Clinical Data and Hospital Initial Patient Population Data to both CMS and The Joint Commission. Additionally, for the current QIO Clinical Warehouse Edits Documents (Error Messages and Measure Messages) please refer to the QualityNet website. For the Joint Commission’s Hospital Clinical Data Edit and Algorithm Error Messages, please refer to the Joint Commission’s extranet for ORYX Vendors (PET).

To:
The below guidelines are for the submission of Hospital Clinical Data and Hospital Initial Patient Population Data to both CMS and The Joint Commission. Additionally, for the current Feedback Messages document (Error Messages, Missing Messages and Measure Messages) for the QIO Clinical Warehouse please refer to the QualityNet website. For the Joint Commission’s Hospital Clinical Data Feedback Messages, please refer to the Joint Commission’s extranet for ORYX Vendors (PET).

- Error Messages provide feedback regarding submitted data, file structure and data integrity that either cause the case to be rejected from the warehouses (Critical) or ask for further verification (Informational). Cases with any critical error messages will not be processed or stored in the warehouse. For cases to be accepted into the warehouses all critical errors must be corrected and the case resubmitted. Informational errors are feedback that warn of potential issues and ask for verification. Cases that receive no error messages or that receive informational messages only will be processed as per the measure algorithm.

- Missing Messages are critical edits that will cause the case to be rejected from the warehouses due to missing data, as per the measure algorithms, resulting in a measure outcome of “X” (Data are Missing).

- Measure Messages provide feedback related to the outcome of the case, as per the measure algorithm, resulting in any other measure outcome, i.e., “B” (Not in Measure Population/Excluded), “D” (In Measure Population/Failed), “E” (In Numerator Population/Passed), or “Y” (Unable to Determine Allowable Value Does Not Allow Calculation of the Measure/UTD).

CMS and Joint Commission Guidelines for Submission of Hospital Clinical Data – Minimum Data Requirements

**Change** the word “edits” to “Feedback Messages” in the first sentence.

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale:</td>
<td>Required collection of the VTE and STK measure sets by CMS.</td>
</tr>
</tbody>
</table>

**Description of Changes:**
CMS and Joint Commission Guidelines for Submission of Hospital Clinical Data – Allowable Measure Set Combination per Patient Episode of Care

**Change** “1.” From:
1. QIO Clinical Warehouse and Joint Commission’s Data Warehouse
   a. HF, ED, IMM and SCIP for patients age 18 and older
   b. AMI, ED, IMM and SCIP for patients age 18 and older
   c. PN, ED, IMM and SCIP for patients age 18 and older
   d. ED, IMM and SCIP
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To:

1. QIO Clinical Warehouse and Joint Commission’s Data Warehouse
   a. HF, ED, IMM, SCIP, VTE – No VTE sub-population and VTE – Other VTE Only sub-population for patients age 18 and older
   b. AMI, ED, IMM, SCIP, VTE – No VTE sub-population and VTE – Other VTE Only sub-population for patients age 18 and older
   c. PN, ED, IMM, SCIP, VTE – No VTE sub-population and VTE – Other VTE Only sub-population for patients age 18 and older
   d. STK, ED, IMM, SCIP, VTE-No VTE sub-population and VTE-Other VTE Only sub-population for patients age 18 and older
   e. ED, IMM and SCIP
   f. ED and IMM

Remove “STK” and “VTE” from 2. Joint Commission’s Data Warehouse only.

Add to 3. Submission of multiple files for the same episode of care will not be accepted into either the QIO Clinical Warehouse or Joint Commission’s Data Warehouse for the following Measure Set combinations:
   d. STK and HF
   e. STK and AMI
   f. STK and PN
   g. VTE – Principal VTE sub-population and HF
   h. VTE – Principal VTE sub-population and AMI
   i. VTE – Principal VTE sub-population and PN
   j. VTE – Principal VTE sub-population and STK

Remove from 4. Submission of multiple files for the same episode of care will not be accepted into the Joint Commission’s Data Warehouse for the following Measure Set combinations:
   f. STK and HF
   g. STK and AMI
   h. STK and PN

Impacts: N/A

Rationale: To provide further clarification regarding the elements within the Provider section of the XML File Layout.

Description of Changes:
CMS and Joint Commission Guidelines for Submission of Hospital Clinical Data – Patient-Level Clinical Data XML File Layout

Change “Provider” section from:
Data elements in this section of the XML file relate to Provider identification. These data elements include:
1. CMS Certification Number (CMS Certification Number - Required)
2. NPI
3. HCOID
To:
Data elements in this section of the XML file relate to Provider identification. These data elements include:
1. **CMS Certification Number** - Hospital’s six digit acute CMS Certification Number (CCN), which is required by CMS and optional for The Joint Commission.
2. **NPI** – National Provider Identifier as assigned by CMS, optional for both CMS and The Joint Commission.
3. **HCOID** - Identifies the healthcare organization that is accredited by The Joint Commission and is required as a key element of the patient file for The Joint Commission. Is optional for CMS.

CMS and Joint Commission Guidelines for Submission of Hospital Initial Patient Population Data – Hospital Initial Patient Population Data XML File Layout

**Change** “Provider” section from:

Data elements in this section of the XML file relate to Provider identification. These data elements include:

1. **CMS Certification Number** (CMS Certification Number - Required)
2. **NPI**
3. **HCOID**

To:

Data elements in this section of the XML file relate to Provider identification. These data elements include:

1. **CMS Certification Number** - Hospital’s six digit acute CMS Certification Number (CCN), which is required by CMS and optional for The Joint Commission.
2. **NPI** – National Provider Identifier as assigned by CMS, optional for both CMS and The Joint Commission.
3. **HCOID** - Identifies the healthcare organization that is accredited by The Joint Commission and is required as a key element of the patient file for The Joint Commission. Is optional for CMS.

**Impacts:** N/A

**Rationale:** Required submission of VTE sub-population population and sample counts by CMS.

**Description of Changes:**

**CMS Data Transmission – Overview**

**Change** the first sentence from:

Hospitals currently submit patient-level clinical data to the QIO Clinical Warehouse, and hospitals submit the Medicare and non-Medicare Initial Patient Population Size (by measure set or stratum for SCIP) and designation of sampling for the Medicare and non-Medicare sample size.

To:

Hospitals currently submit patient-level clinical data to the QIO Clinical Warehouse, and hospitals submit the Medicare and non-Medicare Initial Patient Population Size (by measure set, sub-populations for VTE, or stratum for SCIP) and designation of sampling for the Medicare and non-Medicare sample size.

**Impacts:** Data Transmission

**Rationale:** The Joint Commission now allows the optional submission of the CMS NPI.

**Description of Changes:**

**Joint Commission Data Transmission – Hospital Clinical Data**
Remove from the Data Elements Not Accepted by The Joint Commission:
  o National Provider Identifier (NPI)

CMS and Joint Commission Guidelines for Submission of Hospital Clinical Data
Remove from the Data Elements Not Accepted by The Joint Commission:
  National Provider Identifier (NPI)

Impacts: Data Transmission

Rationale: The Joint Commission now requires Race and Hispanic Ethnicity.

Description of Changes:
Joint Commission Data Transmission – Hospital Clinical Data
Remove from the Data Elements Not Accepted by The Joint Commission:
  o Race
  o Hispanic Ethnicity

CMS and Joint Commission Guidelines for Submission of Hospital Clinical Data
Remove from the Data Elements Not Accepted by The Joint Commission:
  o Race
  o Hispanic Ethnicity

Impacts: Data Transmission

Rationale: To add clarification that the QIO Clinical Warehouse will only accept data for the specified quarter of data transmission.

Description of Changes:
CMS Data Transmission – Submission of Hospital Clinical Data
Add after 1st sentence in the 1st paragraph:
Only data containing dates applicable to a specified quarter of data transmission will be allowed into the QIO Clinical Warehouse. Data submitted for discharge quarters outside of the current submission deadline will be rejected.

Impacts: Transmission Alphabetical Data Dictionary

Data Element(s)
NPI

Rationale: The Joint Commission now allows the optional submission of the CMS NPI.

Description of Changes:
Transmission Alphabetical Data Dictionary
Remove footnote from National Provider Identifier (NPI) from the ‘Collected For’ column in the list of elements.

Collected For Change from “CMS Only” to “CMS/The Joint Commission” under the ‘Collected For’ in the data element.

XML File Layout

Impacts: Hospital Initial Patient Population Data XML File
Data Elements
<measure-set>

**Rationale:** STK and VTE measure sets will be required by CMS.

**Description of Changes:**
*Hospital Initial Patient Population Data XML File Layout*

**Remove** “(The Joint Commission only)” from VTE and STK under the Valid Values.

**Impacts:** Hospital Initial Patient Population Data XML File

Data Elements
<stratum>

**Rationale:** STK and VTE measure sets will be required by CMS.

**Description of Changes:**
*Hospital Initial Patient Population Data XML File Layout*

**Change** “No” to “VTE only” under the Data Required (CMS) for the VTE stratum id.

**Impacts:** Hospital Initial Patient Population Data XML File

Data Element(s)
<create-date>

**Rationale:** To align with the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse.

**Description of Changes:**
*Hospital Initial Patient Population Data XML File Layout*

**Change** the Year under the Valid Values from “YYYY (2001 – Current Year)” to “YYYY (20xx)”

**Impacts:** Hospital Clinical Data XML File Layout

Data Element(s)
<create-date>

**Rationale:** To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

**Description of Changes:**
*Elements*

**Change** the Year under the Valid Values from “YYYY (2001 – Current Year)” to “(20xx)”

**Impacts:** Hospital Clinical Data XML File Layout

Data Element(s)
<abstraction-date>

**Rationale:** To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

**Description of Changes:**
**Elements**

**Change** the Year under the Valid Values from “YYYY (2001 – Current Year)” to “(20xx)”

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>Hospital Clinical Data XML File Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data Element(s)</td>
</tr>
<tr>
<td></td>
<td>&lt;npi&gt;</td>
</tr>
</tbody>
</table>

**Rationale:** The Joint Commission allows the optional submission of NPI.

**Description of Changes:**

**Elements**

**Change** “Not allowed” to “No” under the Data Required (The Joint Commission)

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>Hospital Clinical Data XML File Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data Element(s)</td>
</tr>
<tr>
<td></td>
<td>&lt;race&gt;</td>
</tr>
</tbody>
</table>

**Rationale:** The Joint Commission will now require Race to be submitted.

**Description of Changes:**

**Elements**

**Change** “Not allowed” to “Yes” under the Data Required (The Joint Commission)

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>Hospital Clinical Data XML File Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data Element(s)</td>
</tr>
<tr>
<td></td>
<td>&lt;ethnic&gt;</td>
</tr>
</tbody>
</table>

**Rationale:** The Joint Commission will now require Hispanic Ethnicity to be submitted.

**Description of Changes:**

**Elements**

**Change** “Not allowed” to “Yes” under the Data Required (The Joint Commission)

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>Hospital Clinical Data XML File Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data Element(s)</td>
</tr>
<tr>
<td></td>
<td>&lt;episode of care&gt;</td>
</tr>
</tbody>
</table>

**Rationale:** STK and VTE will be required by CMS.

**Description of Changes:**

**Elements**

**Remove** “(The Joint Commission Only)” from STK and VTE under the Valid Values.

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>Hospital Clinical Data XML File Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data Element(s)</td>
</tr>
<tr>
<td></td>
<td>&lt;admit-date&gt;</td>
</tr>
</tbody>
</table>

**Rationale:** To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.
Description of Changes:
Elements
Change the Year under the Valid Values from “YYYY (2001 – Current Year)” to “(20xx)”

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>Hospital Clinical Data XML File Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Element(s)</td>
<td>&lt;discharge-date&gt;</td>
</tr>
</tbody>
</table>

Rationale: To align with the QIO Clinical Warehouse and Joint Commission’s Data Warehouse.

Description of Changes:
Elements
Change the Year under the Valid Values from “YYYY (2001 – Current Year)” to “(20xx)”

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>Hospital Clinical Data XML File Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Element(s)</td>
<td>Alcohol or Drug Use Status Post Discharge – Counseling</td>
</tr>
<tr>
<td></td>
<td>Alcohol or Drug Use Status Post Discharge – Medication</td>
</tr>
<tr>
<td></td>
<td>Alcohol Use Status Post Discharge – Quit Status</td>
</tr>
<tr>
<td></td>
<td>Drug Use Status Post Discharge – Quit Status</td>
</tr>
<tr>
<td></td>
<td>Reason for Oral Factor Xa Inhibitor</td>
</tr>
<tr>
<td></td>
<td>Reason for Oral Factor Xa Inhibitor – ICU Admission</td>
</tr>
<tr>
<td></td>
<td>Tobacco Use Status Post Discharge – Counseling</td>
</tr>
<tr>
<td></td>
<td>Tobacco Use Status Post Discharge – Medication</td>
</tr>
<tr>
<td></td>
<td>Tobacco Use Status Post Discharge – Quit Status</td>
</tr>
</tbody>
</table>

Rationale: To align with changes to the Alphabetical Data Dictionary

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Add
Alcohol or Drug Use Status Post Discharge – Counseling
Alcohol or Drug Use Status Post Discharge – Medication
Alcohol Use Status Post Discharge – Quit Status
Drug Use Status Post Discharge – Quit Status
Reason for Oral Factor Xa Inhibitor
Reason for Oral Factor Xa Inhibitor – ICU Admission
Tobacco Use Status Post Discharge – Counseling
Tobacco Use Status Post Discharge – Medication
Tobacco Use Status Post Discharge – Quit Status

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>Hospital Clinical Data XML File Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Element(s)</td>
<td>Anesthesia End Date</td>
</tr>
<tr>
<td></td>
<td>Antibiotic Administration Date</td>
</tr>
<tr>
<td></td>
<td>Decision to Admit Date</td>
</tr>
<tr>
<td></td>
<td>ED Departure Date</td>
</tr>
<tr>
<td></td>
<td>First PCI Date</td>
</tr>
</tbody>
</table>
Fibrinolytic Administration Date
Follow-up Contact Date
ICD-9-CM Other Procedure Dates
ICD-9-CM Principal Procedure Date
Initial Blood Culture Collection Date
Surgical Incision Date

Rationale: To align with changes to the Alphabetical Data Dictionary

Description of Changes:
Hospital Clinical Data – Detail Elements Information

Change Year under Answer Code from “(2001 – Current Year)” to “(20xx)” in the following elements:
Anesthesia End Date
Antibiotic Administration Date
Decision to Admit Date
ED Departure Date
First PCI Date
Fibrinolytic Administration Date
Follow-up Contact Date
ICD-9-CM Other Procedure Dates
ICD-9-CM Principal Procedure Date
Initial Blood Culture Collection Date
Surgical Incision Date

Impacts: Hospital Clinical Data XML File Layout

Data Element(s)
Anesthesia Start Date

Rationale: To align with changes to the Alphabetical Data Dictionary

Description of Changes:
Hospital Clinical Data – Detail Elements Information

Change Year under Answer Code from “(2001 – Current Year)” to “(20xx)”.

Remove VTE-2 from The Joint Commission Only under the Programming Notes.

Impacts: Hospital Clinical Data XML File Layout

Data Element(s)
Anticoagulation Therapy Prescribed at Discharge
Antithrombotic Therapy Administered by End of Hospital Day 2
Antithrombotic Therapy Prescribed at Discharge
Assessed for Rehabilitation Services
Atrial Fibrillation/Flutter
Discharge Instructions Address Compliance Issues
Discharge Instructions Address Dietary Advice
Discharge Instructions Address Follow-up Monitoring
Discharge Instructions Address Potential for Adverse Drug Reactions and Interactions
Education Addresses Activation of Emergency Medical System (EMS)
Education Addresses Follow-up After Discharge
Education Addresses Medications Prescribed At Discharge
Education Addresses Risk Factors for Stroke
Education Addresses Warning Signs and Symptoms of Stroke
Elective Carotid Intervention
INR Value
IV OR IA Thrombolytic (t-PA) Therapy Administered at This Hospital or Within 24 Hours Prior to Arrival
IV Thrombolytic Initiation
IV Thrombolytic Initiation Time
Last Known Well
LDL-c Greater Than or Equal to 100 mg/dL
LDL-c Measured Within the First 48 Hours or 30 Days Prior to Hospital Arrival
Overlap Therapy
Parenteral Anticoagulant Prescribed at Discharge
Pre-Arrival Lipid-Lowering Agent
Reason for No VTE Prophylaxis – Hospital Admission
Reason for No VTE Prophylaxis – ICU Admission
Reason For Not Administering Antithrombotic Therapy by End Of Hospital Day 2
Reason for Not Initiating IV Thrombolytic
Reason for Not Prescribing Anticoagulation Therapy at Discharge
Reason for Not Prescribing Antithrombotic Therapy at Discharge
Surgical Procedure
Surgical Procedure – ICU Admission
Time Last Known Well
UFH Therapy Administration
VTE Confirmed
VTE Present at Admission
VTE Prophylaxis Status
Warfarin Administration
Warfarin Prescribed at Discharge

**Rationale:** STK and VTE will be required by CMS.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information
**Remove** “Collected by The Joint Commission Only” under the Programming Notes from the following elements:
Anticoagulation Therapy Prescribed at Discharge
Antithrombotic Therapy Administered by End of Hospital Day 2
Antithrombotic Therapy Prescribed at Discharge
Assessed for Rehabilitation Services
Atrial Fibrillation/Flutter
Discharge Instructions Address Compliance Issues
Discharge Instructions Address Dietary Advice
Discharge Instructions Address Follow-up Monitoring
Discharge Instructions Address Potential for Adverse Drug Reactions and Interactions
Education Addresses Activation of Emergency Medical System (EMS)
Education Addresses Follow-Up After Discharge
Education Addresses Medications Prescribed At Discharge
Education Addresses Risk Factors for Stroke
Education Addresses Warning Signs and Symptoms of Stroke
Elective Carotid Intervention
INR Value
IV OR IA Thrombolytic (t-PA) Therapy Administered at This Hospital or
  Within 24 Hours Prior to Arrival
IV Thrombolytic Initiation
IV Thrombolytic Initiation Time
Last Known Well
LDL-c Greater Than or Equal to 100 mg/dL
LDL-c Measured Within the First 48 Hours or 30 Days Prior to Hospital
  Arrival
Overlap Therapy
Parenteral Anticoagulant Prescribed at Discharge
Pre-Arrival Lipid-Lowering Agent
Reason for No VTE Prophylaxis – Hospital Admission
Reason for No VTE Prophylaxis – ICU Admission
Reason For Not Administering Antithrombotic Therapy by End Of
  Hospital Day 2
Reason for Not Initiating IV Thrombolytic
Reason for Not Prescribing Anticoagulation Therapy at Discharge
Reason for Not Prescribing Antithrombotic Therapy at Discharge
Surgical Procedure
Surgical Procedure – ICU Admission
Time Last Known Well
UFH Therapy Administration
VTE Confirmed
VTE Present at Admission
VTE Prophylaxis Status
Warfarin Administration
Warfarin Prescribed at Discharge

**Impacts:** Hospital Clinical Data XML File Layout

**Data Element(s)**
Arrival Date

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information
**Change** Year under Answer Code from “(2001 – Current Year)” to “(20xx)”.

**Remove** STK-4 and STK-5 from The Joint Commission Only under the Programming Notes.

**Impacts:** Hospital Clinical Data XML File Layout

**Data Element(s)**
Arrival Time

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Remove** STK-4 from The Joint Commission Only under the Programming Notes.

**Impacts:** Hospital Clinical Data XML File Layout
- Data Element(s)
- Clinical Trial

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Remove** STK and VTE from The Joint Commission Only under the Programming Notes.

**Impacts:** Hospital Clinical Data XML File Layout
- Data Element(s)
- Comfort Measures Only

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Remove** STK-1, STK-2, STK-3, STK-5, STK-6, STK-8, STK-10, VTE-1, VTE-2, VTE-3, VTE-4, and VTE-6 from The Joint Commission Only under the Programming Notes.

**Impacts:** Hospital Clinical Data XML File Layout
- Data Element(s)
- Date Last Known Well

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Change** Year under Answer Code from "(2001 – Current Year)" to "(20xx)".
**Remove** Collected by The Joint Commission Only under the Programming Notes.

**Impacts:** Hospital Clinical Data XML File Layout
- Data Element(s)
- Discharge Disposition

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Remove** STK-2, STK-3, STK-6, STK-8, STK-10, VTE-3, VTE-4, VTE-6 from the Collected by The Joint Commission Only under the Programming Notes.
**Impacts:** Hospital Clinical Data XML File Layout

**Data Element(s)**

**ED Patient**

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**

Hospital Clinical Data – Detail Elements Information

**Remove** STK-4 from The Joint Commission Only under the Programming Notes.

---

**Impacts:** Hospital Clinical Data XML File Layout

**Data Element(s)**

**Follow-up Contact**

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**

Hospital Clinical Data – Detail Elements Information

**Change** the Suggested Data Collection Question to:

Was contact made with the patient within the specified time frame post discharge?

**Change** the Answer Value to

1. A follow-up contact was made within the specified time frame post discharge.
2. A follow-up contact was made but not within the specified time frame post discharge.
3. A follow-up contact was not made within the specified time frame post discharge because the patient’s residence is not in the USA, the patient was incarcerated, contact number was no longer valid, the patient had no phone, or the patient was re-admitted to the hospital within 30 days post discharge, or at least 6 unsuccessful attempts to contact the patient were made.
4. A follow-up contact was not made within the specified time frame post discharge or unable to determine from medical record documentation.

---

**Impacts:** Hospital Clinical Data XML File Layout

**Data Element(s)**

**ICD-9-CM Other Diagnosis Codes**

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**

Hospital Clinical Data – Detail Elements Information

**Remove** All VTE Measures from The Joint Commission Only under the Programming Notes.

---

**Impacts:** Hospital Clinical Data XML File Layout

**Data Element(s)**

**ICD-9-CM Principal Diagnosis Code**

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
### Hospital Clinical Data – Detail Elements Information

**Remove** STK-2, STK-3, STK-4, STK-5, STK-6 and All VTE Measures from The Joint Commission Only under the Programming Notes.

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>Hospital Clinical Data XML File Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data Element(s)</td>
</tr>
<tr>
<td></td>
<td>ICD-9-CM Principal Procedure Code</td>
</tr>
</tbody>
</table>

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**

Hospital Clinical Data – Detail Elements Information

**Remove** VTE-1 and VTE-2 from The Joint Commission Only under the Programming Notes.

<table>
<thead>
<tr>
<th>Impacts:</th>
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</tr>
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<tr>
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<td>Data Element(s)</td>
</tr>
<tr>
<td></td>
<td>ICU Admission or Transfer</td>
</tr>
</tbody>
</table>

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**

Hospital Clinical Data – Detail Elements Information

**Remove** VTE-1 and VTE-2 from The Joint Commission Only under the Programming Notes.

<table>
<thead>
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<th>Impacts:</th>
<th>Hospital Clinical Data XML File Layout</th>
</tr>
</thead>
<tbody>
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<td>Data Element(s)</td>
</tr>
<tr>
<td></td>
<td>ICU Admission Date</td>
</tr>
</tbody>
</table>

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**

Hospital Clinical Data – Detail Elements Information

**Remove** Collected by The Joint Commission Only under the Programming Notes.

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>Hospital Clinical Data XML File Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data Element(s)</td>
</tr>
<tr>
<td></td>
<td>ICU Discharge Date</td>
</tr>
</tbody>
</table>

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**

Hospital Clinical Data – Detail Elements Information

**Change** Question from ICU Admission Date to ICU Admission or Transfer Date

**Change** Year under Answer Code from “(2001 – Current Year)” to “(20xx)”.

**Remove** Collected by The Joint Commission Only under the Programming Notes.

<table>
<thead>
<tr>
<th>Impacts:</th>
<th>Hospital Clinical Data XML File Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data Element(s)</td>
</tr>
<tr>
<td></td>
<td>ICU Discharge Date</td>
</tr>
</tbody>
</table>

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**

Hospital Clinical Data – Detail Elements Information

**Change** Year under Answer Code from “(2001 – Current Year)” to “(20xx)”.

**Remove** Collected by The Joint Commission Only under the Programming Notes.
Impacts: Hospital Clinical Data XML File Layout

Data Element(s)
ICU VTE Prophylaxis

Rationale: To align with changes to the alphabetical data dictionary.

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change Occurs from “1 – 7” to “1 – 8"

Add to Answer Code and Answer Value
8 Oral Factor Xa Inhibitor

Remove Collected by The Joint Commission Only under the Programming Notes.

Impacts: Hospital Clinical Data XML File Layout

Data Element(s)
ICU VTE Prophylaxis Date

Rationale: To align with changes to the alphabetical data dictionary.

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change Year under Answer Code from “(2001 – Current Year)” to “(20xx)”.

Remove Collected by The Joint Commission Only under the Programming Notes.

Impacts: Hospital Clinical Data XML File Layout

Data Element(s)
IV Thrombolytic Initiation Date

Rationale: To align with changes to the alphabetical data dictionary.

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change Year under Answer Code from “(2001 – Current Year)” to “(20xx)”.

Remove Collected by The Joint Commission Only under the Programming Notes.

Impacts: Hospital Clinical Data XML File Layout

Data Element(s)
Monitoring Documentation

Rationale: To align with changes to the alphabetical data dictionary.

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change Suggested Data Collection Question to:
Was there Physician/Advanced Practice Nurse/Physician Assistant (Physician/APN/PA) or...
Pharmacist documentation that the IV UFH AND platelet counts were managed by defined parameters using a nomogram or protocol?

**Remove** Collected by The Joint Commission Only under the Programming Notes.

**Impacts:** Hospital Clinical Data XML File Layout
- Data Element(s)
- Observation Services

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Change** Suggested Data Collection Question to
Was there documentation of an order for observation services written by the physician/APN/PA?

**Impacts:** Hospital Clinical Data XML File Layout
- Data Element(s)
- Overlap Therapy Start Date

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Change** Year under Answer Code from “(2001 – Current Year)” to “(20xx)”.

**Remove** Collected by The Joint Commission Only under the Programming Notes.

**Impacts:** Hospital Clinical Data XML File Layout
- Data Element(s)
- Parenteral Anticoagulant End Date

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Change** Year under Answer Code from “(2001 – Current Year)” to “(20xx)”.

**Remove** Collected by The Joint Commission Only under the Programming Notes.

**Impacts:** Hospital Clinical Data XML File Layout
- Data Element(s)
- Pneumococcal Vaccination (PPV23) Status

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Change** Question to Pneumococcal Vaccination Status
Change Answer Value 1 to:
Pneumococcal vaccine was given during this hospitalization.

Change Answer Value 4 to:
There is documentation of an allergy/sensitivity to pneumococcal vaccine OR is not likely to be
effective because of a bone marrow transplant within the past 12 months OR currently
receiving a scheduled course of chemotherapy or radiation therapy, or received chemotherapy
or radiation during this hospitalization or less than 2 weeks prior OR received the shingles
vaccine (Zostavax) within the last 4 weeks OR for patients 5 - 18 years of age who received a
conjugate vaccine within the previous 8 weeks.

**Impacts:** Hospital Clinical Data XML File Layout
- Data Element(s)
  - Reason for Discontinuation of Overlap Therapy

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

Change Question to Reason for Discontinuation of Parenteral Therapy

Change Suggested Data Collection Question to: Is there a reason documented by a
physician/APN/PA or pharmacist for discontinuation of the parenteral therapy?

Remove Collected by The Joint Commission Only under the Programming Notes.

**Impacts:** Hospital Clinical Data XML File Layout
- Data Element(s)
  - Reason for Not Prescribing Statin Medication at Discharge

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

Remove The Joint Commission Only: STK-6 under the Programming Notes.

**Impacts:** Hospital Clinical Data XML File Layout
- Data Element(s)
  - Reasons for Continuing Urinary Catheterization

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

Change Answer Value 1 to
There is documentation that the patient was in the intensive care unit (ICU) AND receiving one
or more of the listed medications.

**Impacts:** Hospital Clinical Data XML File Layout
**Data Element(s)**
Statin Medication Prescribed at Discharge

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Remove** The Joint Commission Only: STK-6 under the Programming Notes.

**Impacts:**
Hospital Clinical Data XML File Layout

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Remove** Collected by The Joint Commission Only under the Programming Notes.

**Impacts:**
Hospital Clinical Data XML File Layout

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Remove** Collected by The Joint Commission Only under the Programming Notes.

**Impacts:**
Hospital Clinical Data XML File Layout

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Remove** Collected by The Joint Commission Only under the Programming Notes.

**Impacts:**
Hospital Clinical Data XML File Layout

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Remove** Collected by The Joint Commission Only under the Programming Notes.

**Impacts:**
Hospital Clinical Data XML File Layout

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Remove** Collected by The Joint Commission Only under the Programming Notes.
**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**

**Hospital Clinical Data – Detail Elements Information**

**Remove** the following under the Programming Notes:
- The Joint Commission Only: STK-1, VTE-1
- For STK Only: If a value of “4” is selected, no other selections should be recorded.
- For STK and VTE: Allowable value “8” is not used.

**Impacts:** Hospital Clinical Data XML File Layout

- **Data Element(s):** VTE Prophylaxis Date

**Rationale:** To align with changes to the alphabetical data dictionary.

**Description of Changes:**

**Hospital Clinical Data – Detail Elements Information**

**Change** Year under Answer Code from “(2001 – Current Year)” to “(20xx)”.

**Remove** Collected by The Joint Commission Only under the Programming Notes.

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**SECTION 10 – CMS Outcome Measures (Claims Based)**

**Subsection 10.1 – Introduction Risk Standardized Mortality Measures**

**Impacts:** Introduction to Mortality

**Rationale:** Adjusted language for clarity, Updated the years of data (2008-2010)

**Description of Changes:**

**Introduction**

**Change** to: This section of the manual includes the Measure Information Forms (MIFs) for the CMS 30-day risk-standardized mortality measures. These are administrative claims data-based measures, so there is no abstraction responsibility on the part of the hospital. The mortality measures include admissions for Medicare FFS and Veterans Health Administration (VA) beneficiaries aged ≥65 years discharged from non-federal acute care hospitals or VA hospitals, respectively, having a principal discharge diagnosis of Acute Myocardial Infarction (AMI), Heart Failure (HF), or Pneumonia (PN).

**Change** to:

In June 2007, CMS began publicly reporting 30-day RSMRs for AMI and HF for the nation’s acute care and critical access hospitals. CMS added a 30-day mortality measure for pneumonia in August 2008. These measures are posted on Hospital Compare (http://www.hospitalcompare.hhs.gov) and updated annually. The 2012 reporting will be based on hospital admissions from three years of data (July 2008 [3Q 2008] through June 2011 [2Q 2011]).

The information in the following MIFs is being provided in the interest of transparency and to promote understanding of the methodology on the part of the hospital and vendor communities. Additional background information about the measures’ methodology, including Frequently Asked Questions (FAQ) documents, fact sheets, and relevant journal articles can
be found on QualityNet (http://www.qualitynet.org). Questions and comments about the mortality measures should be directed to cmsmortalitymeasures@yale.edu.

CMS calculates the risk-standardized mortality rates (RSMRs). Hospitals and their ORYX® Vendors do not have sufficient data to produce the hospitals’ RSMRs. CMS extracts and utilizes physician office, inpatient and institutional outpatient claims data from the year prior to the index hospitalizations as well as claims data from the index hospitalizations to risk adjust the rates. Finally, the CMS Enrollment Database is used to determine if a beneficiary has died within 30 days of admission.

**Impacts:** MORT-30-AMI

**Rationale:** Added a cohort exclusion for VA hospice patients in the mortality measures. Updated the years of data (2008-2010)

**Description of Changes:**

**Rationale:**

**Change to:**

CMS developed the AMI 30-day mortality measure to complement the existing AMI process of care measures. Risk-standardized mortality rates (RSMRs) can provide important additional information about quality of care that is not currently captured by the process measures and is currently unavailable to hospitals. Variation in mortality, after adjusting for case-mix, may reflect differences in hospitals’ general environments (such as coordination of care, patient safety policies, and staffing) or variation in care processes not measured in the current core measure set. Outcome measures can focus attention on a broader set of healthcare activities that affect patients’ well-being. Moreover, improving outcomes is the ultimate goal of quality improvement, and so the inclusion of outcomes measures assists in attaining improvement goals.

**Denominator Statement**

**Change:**

The target population for this measure includes admissions for Medicare Fee-for-Service (FFS) and Veteran Health Administration (VA) beneficiaries aged ≥65 years discharged from acute care non-federal hospitals or VA hospitals, having a principal discharge diagnosis of AMI.

**Included Populations:**

**Change to** 1st paragraph

Admissions for Medicare FFS and VA beneficiaries aged ≥65 years discharged from non-federal acute care hospitals or VA hospitals, having a principal discharge diagnosis of AMI.

2nd paragraph

CMS FFS beneficiaries with an index hospitalization within an acute care non-federal hospital are included if they have been enrolled in Part A and Part B Medicare for the 12 months prior to the date of admission to ensure a full year of administrative data for risk-adjustment. (This requirement is dropped for patients with an index admission within a VA hospital.)

3rd paragraph

For patients with more than one admission in a given year for a given condition, only one admission is randomly selected to include in the cohort (others are excluded). An index
admission is the hospitalization considered for mortality outcome determination. The measure includes patients who are admitted to an acute care hospital with a diagnosis of AMI and then transferred to another acute facility if the primary discharge diagnosis is AMI at the second hospital. The measure considers admission to the first hospital as the start of an acute episode of care and assigns the patient’s outcome to the hospital that initially admitted them.

Excluded Populations:

Change 4th and 6th bullet
- enrolled in the VA or Medicare Hospice programs any time in the 12 months prior to the index hospitalization including the first day of the index admission (since it is likely these patients are continuing to seek comfort measures only)
- that were not the first hospitalization in the 30 days prior to a patient’s death. This exclusion criterion is applied after one admission per patient per year is randomly selected. It only applies when two randomly selected admissions occur during the transition months (December and January for calendar-year data) and the patient subsequently dies. For example: a patient is admitted on December 18th, 2008 and readmitted on January 2nd, 2009; the patient dies on January 15th, 2009. If both of these admissions are randomly selected for inclusion (one for the 2008 calendar year time period and the other for the 2009 calendar year time period), the January 2, 2009 admission will be excluded to avoid assigning the death to two admissions (one in 2008 and one in 2009)

Risk Adjustment:

Change 1st and 2nd paragraphs to
For each patient, covariates are obtained from administrative data extending 12 months prior to, and including, the index admission. For all patients, information from Medicare inpatient claims, physician Part B claims and hospital outpatient claims are used for risk adjustment. For patients with an index admission in a VA hospital, VA administrative data is also obtained. Inpatient claim records have data on hospitalization for and include demographic information, principal and secondary diagnosis codes, and procedure codes. Diagnosis codes for comorbidities are also collected from physician and hospital outpatient files. These data are captured from the claim(s) for the index admission and from all inpatient and outpatient claims for the entire year before the patient’s index AMI hospitalization to be utilized in the risk-adjustment model.

The VA administrative data includes 41 diagnosis and 46 procedure codes (as opposed to 25 and 25, respectively, in CMS administrative data). For the index hospitalization, all diagnosis and procedure codes were retained. For risk adjustment, all diagnosis and procedure codes were retained for visits prior to the index hospitalization.

Cardiovascular

Remove:
Unstable angina

Add:
Other acute/subacute forms of ischemic heart disease

Data Accuracy

Change 1st paragraph to:
The administrative claims data used to calculate the measure are maintained by CMS’ Office
of Information Services. These data undergo additional quality assurance checks during measure development and maintenance.

**Impacts:** MORT-30-AMI

**Rationale:** Adjusted language for clarity.

**Description of Changes:**

Measure Calculation

**Change 2**nd paragraph
“adjusted actual deaths to “predicted” deaths case mix to case-mix wherever occurs

**Remove** (also known as “predicted”)

**Change 3**nd paragraph
“adjusted actual deaths to predicted number of deaths

**Impacts:** MORT-30-HF

**Rationale:** Adjusted language for clarity. Updated the years of data (2008-2010).

**Description of Changes:**

**Rationale**

**Change** case mix to case-mix

**Improvement Noted As:**

**Change** to:
A decrease in the RSMR.

**Denominator Statement**

**Change:**
The target population for this measure includes admissions for Medicare Fee-for-Service (FFS) and Veteran Health Administration (VA) beneficiaries aged ≥65 years discharged from acute care non-federal hospitals or VA hospitals, having a principal discharge diagnosis of HF.

**Included Populations:**

**Change** to:
Admissions for Medicare FFS and VA beneficiaries aged ≥65 years discharged from non-federal acute care hospitals or VA hospitals having a principal discharge diagnosis of HF.

CMS FFS beneficiaries with an index hospitalization within a non-federal hospital are included if they have been enrolled in Part A and Part B Medicare for the 12 months prior to the date of admission to ensure a full year of administrative data for risk-adjustment. (This requirement is dropped for patients with an index admission within a VA hospital.)

For patients with more than one admission in a given year for a given condition, only one admission is randomly selected to include in the cohort (others are excluded). An index admission is the hospitalization considered for mortality outcome determination. The measure includes patients who are admitted to an acute care hospital with a diagnosis of HF and then
transferred to another acute facility if the primary discharge diagnosis is HF at the second hospital. The measure considers admission to the first hospital as the start of an acute episode of care and assigns the patient’s outcome to the hospital that initially admitted them.

**Excluded Populations:**

**Change** 4th and 6th bullets

- enrolled in the VA or Medicare Hospice programs any time in the 12 months prior to the index hospitalization including the first day of the index admission (since it is likely these patients are continuing to seek comfort measures only)
- that were not the first hospitalization in the 30 days prior to a patient’s death. This exclusion criterion is applied after one admission per patient per year is randomly selected. It only applies when two randomly selected admissions occur during the transition months (December and January for calendar-year data) and the patient subsequently dies. For example: a patient is admitted on December 18th, 2008 and readmitted on January 2nd, 2009; the patient dies on January 15th, 2009. If both of these admissions are randomly selected for inclusion (one for the 2008 calendar year time period and the other for the 2009 calendar year time period), the January 2, 2009 admission will be excluded to avoid assigning the death to two admissions (one in 2008 and one in 2009)

**Risk Adjustment:**

**Change** 2nd paragraph:

The VA administrative data includes 41 diagnosis and 46 procedure codes (as opposed to 25 and 25’, respectively, in CMS administrative data). For the index hospitalization, all diagnosis and procedure codes were retained. For risk adjustment, all diagnosis and procedure codes were retained for visits prior to the index hospitalization.

**Cardiovascular**

**Remove:**

Unstable angina

**Add:**

Other acute/subacute forms of ischemic heart disease

**Model Validation:**

**Change** Cooperative Cardiovascular Project to Cooperative Cardiovascular Project Initiative

**Data Accuracy:**

**Change:**

Information System to Information Services

**Measure Calculation**

**Change** 2nd paragraph

‘adjusted actual’ deaths to “predicted” deaths

*case mix to case-mix wherever occurs*

**Remove** (also known as “predicted”)

**Change** 3rd paragraph

‘adjusted actual’ deaths to predicted number of deaths

**Selected References:**

**Change** to

Impacts: MORT-30-PN

Rationale: Adjusted language for clarity, Updated the years of data (2008-2010)

Description of Changes:
Rationale
Change
PN to Pneumonia
case mix to case-mix

Denominator Statement
Change
The target population for this measure includes admissions for Medicare Fee-for-Service (FFS) and Veteran Health Administration (VA) beneficiaries aged ≥65 years discharged from acute care non-federal hospitals or VA hospitals, having a principal discharge diagnosis of pneumonia.

Included Populations:
Change 1st paragraph to
Admissions for Medicare FFS and VA beneficiaries aged ≥65 years discharged from non-federal acute care hospitals or VA hospitals, having a principal discharge diagnosis of pneumonia.

Change 2nd paragraph to
CMS FFS beneficiaries with an index hospitalization within an acute care non-federal hospital are included if they have been enrolled in Part A and Part B Medicare for the 12 months prior to the date of admission to ensure a full year of administrative data for risk-adjustment. (This requirement is dropped for patients with an index admission within a VA hospital.)

Change 3rd paragraph to
For patients with more than one admission in a given year for a given condition, only one admission is randomly selected to include in the cohort (others are excluded). An index admission is the hospitalization considered for mortality outcome determination. The measure includes patients who are admitted to an acute care hospital with a diagnosis of pneumonia and then transferred to another acute facility if the primary discharge diagnosis is pneumonia at the second hospital. The measures consider admission to the first hospital as the start of an acute episode of care and assigns the patient’s outcome to the hospital that initially admitted them.

Excluded Populations
Change 4th bullet
enrolled in the VA or Medicare Hospice programs any time in the 12 months prior to the index hospitalization including the first day of the index admission (since it is likely these patients are continuing to seek comfort measures only)
Change 6th bullet

- that were not the first hospitalization in the 30 days prior to a patient’s death. This exclusion criterion is applied after one admission per patient per year is randomly selected. It only applies when two randomly selected admissions occur during the transition months (December and January for calendar-year data) and the patient subsequently dies. For example: a patient is admitted on December 18th, 2008 and readmitted on January 2nd, 2009; the patient dies on January 15th, 2009. If both of these admissions are randomly selected for inclusion (one for the 2008 calendar year time period and the other for the 2009 calendar year time period), the January 2, 2009 admission will be excluded to avoid assigning the death to two admissions (one in 2008 and one in 2009).

Risk Adjustment:

Change
PN to Pneumonia

Remove: The word Medicare from the first sentence.

Change 2nd paragraph
The VA administrative data includes 41 diagnosis and 46 procedure code fields (as opposed to 25 and 25, respectively, in CMS administrative data). For the index hospitalization, all diagnosis and procedure codes were retained. For risk adjustment, all diagnosis and procedure codes were retained for visits prior to the index hospitalization.

Cardiovascular
Remove
Unstable angina

Add
Other acute/subacute forms of ischemic heart disease

Model Validation:

Change
Hospital-specific risk-standardized mortality estimates derived from this claims-based model were compared to hospital-specific RSMRs based on a model developed using medical record data from the Medicare National Pneumonia Project Initiative. The correlation coefficient of the RSMRs from the claims-based and medical record models was 0.86. Similarly, a medical record validation was conducted for use of the measures for VA hospitals.

Data Accuracy

Change
Information System to Information Services

Measure Calculation

Change 1st paragraph
PN to pneumonia

Change 2nd paragraph
"adjusted actual' deaths to “predicted” deaths
case mix to case-mix where occurs
**Remove** (also known as ‘predicted’)

**Change** 3\textsuperscript{rd} paragraph
“adjusted actual’ deaths to predicted number of deaths

Selected References:

**Change** 1\textsuperscript{st} and 2\textsuperscript{nd} bullet to


### Subsection 10.2 – Introduction Risk Standardized Readmission Measures

**Impacts:** Introduction to Readmission

**Rationale:** Adjusted language for clarity, Updated the years of data (2008-2010).

**Description of Changes:**

**Introduction**

**Change** 1\textsuperscript{st} and 2\textsuperscript{nd} paragraphs

This section of the manual includes the Measure Information Forms (MIFs) for the CMS 30-day risk-standardized readmission measures. These are administrative claims data based measures, so there is no abstraction responsibility on the part of the hospital. The readmission measures include admissions for Medicare FFS and Veterans Health Administration (VA) beneficiaries aged ≥65 years discharged from non-federal acute care hospitals or VA hospitals, respectively, having a principal diagnosis of Acute Myocardial Infarction (AMI), Heart Failure (HF), or Pneumonia.

In June 2009, CMS began publicly reporting annually the AMI, HF, and Pneumonia readmission measures on Hospital Compare (http://www.hospitalcompare.hhs.gov). The 2012 reporting will be based on hospital admissions from three years of data (July 2008 [3Q 2008] through June 2011 [2Q 2011]).

**Change** 4\textsuperscript{th} paragraph to

The information in the following MIFs is being provided in the interest of transparency and to promote understanding of the methodology on the part of the hospital and vendor communities. Additional background information about the measures’ methodology, including Frequently Asked Questions (FAQ) documents, fact sheets, and relevant journal articles can be found on QualityNet (http://www.qualitynet.org). Questions and comments about the readmission measures should be directed to cmsreadmissionmeasures@yale.edu.

**Change** Last sentence in last paragraph to

Finally, the CMS inpatient data is used to determine if a beneficiary has been readmitted within 30 days of discharge.

**Impacts:** READM-30-AMI
Rationale: Adjusted language for clarity, Updated the years of data (2008-2010).

Description of Changes:

Performance Measure Name:

Change
Hospital, 30-day all-cause, risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization.

Numerator Statement:
Remove 1st paragraph the word Note:

Denominator Statement:
Change to
The target population for this measure includes admissions for Medicare Fee-for-Service (FFS) and Veteran Health Administration (VA) beneficiaries aged greater than or equal to 65 years discharged from acute care non-federal hospitals or VA hospitals with a principal discharge diagnosis of AMI.

Included Populations:
Change 1st paragraph
Admissions for Medicare FFS and VA beneficiaries greater than or equal to 65 years of age discharged from non-federal acute care hospitals or VA hospitals, having a principal discharge diagnosis of AMI.

Change 2nd paragraph
CMS FFS beneficiaries with an index hospitalization within an acute care non-federal hospital are included if they have been enrolled in Part A and Part B Medicare for the 12 months prior to the date of admission to ensure a full year of administrative data for risk-adjustment. (This requirement is dropped for patients with an index admission within a VA hospital.)

Cohort exclusions (excluded admissions):
Change 4th bullet
- Admissions are excluded for patients who are discharged alive on the same day that they are admitted because these patients are unlikely to have had a clinically significant AMI.

Change:
In addition, if a patient has one or more AMI admissions within 30 days of discharge from the index AMI admission, only one is counted as a readmission. No admissions within 30 days of discharge from an index admission are considered as additional index admissions for AMI. The next eligible admission after the 30-day time period following an index admission will be considered another index admission.

Admissions not counted as readmissions:
Change 1st paragraph
unstable angina to acute/subacute forms of ischemic heart disease.

Change 3rd paragraph to:
ICD-9-CM codes associated with HF, AMI, other acute/subacute forms of ischemic heart disease, arrhythmia, and cardiac arrest:
HF: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.xx
AMI: 410.xx except 410.x2 (AMI, subsequent episode of care)
Other acute/subacute forms of ischemic heart disease: 411.xx
Arrhythmia: 427.xx, except 427.5
Cardiac arrest: 427.5

Risk Adjustment

Change 2nd paragraph to
The measure adjusts for key variables that are clinically relevant and have strong relationships with the outcome (e.g., age, sex, comorbid diseases, and indicators of frailty). For each patient, covariates are obtained from administrative data extending 12 months prior to, and including, the index admission. For all patients, information from Medicare inpatient claims, physician Part B claims and hospital outpatient claims are used for risk adjustment. For patients with an index admission in a VA hospital, VA administrative data is also obtained.

Remove 3rd paragraph
CMS FFS beneficiaries with an index hospitalization within a non-federal hospital are included if they have been enrolled in Part A and Part B Medicare for the 12 months prior to the date of admission to ensure a full year of administrative data for risk adjustment. (This requirement is dropped for patients with an index admission within a VA hospital.)

Change 4th paragraph
The VA administrative data includes 41 diagnosis and 46 procedure code fields (as opposed to 25 and 25, respectively, in CMS administrative data). For the index hospitalization, all diagnosis and procedure codes were retained. For risk adjustment, all diagnosis and procedure codes were retained for visits prior to the index hospitalization.

Remove last paragraph
Candidate and Final Variables: Candidate variables were patient-level risk-adjustors that are expected to be predictive of readmission, based on empirical analysis, prior literature, and clinical judgment, including demographic factors (age, sex) and indicators of comorbidity and disease severity.

Data Accuracy:

Change
Information System to Information Services

Measure Calculation

Change 2nd paragraph
“adjusted actual’ readmissions to “predicted” readmissions

Change case mix to case-mix wherever occurs

Remove (also known as “predicted”)

Change 3rd paragraph
“adjusted actual’ readmissions to predicted number of readmissions

Impacts: READM-30-HF

Rationale: Adjusted language for clarity, Updated the years of data (2008-2010)

Description of Changes:
Performance Measure Name:

Change

Hospital 30-day all-cause, risk-standardized readmission rate (RSRR) following heart failure (HF) hospitalization.

Numerator Statement:

Remove

1st paragraph the word Note:

Change 2nd paragraph to

The outcome for this measure is 30 day all-cause readmission. We define this as readmission for any cause within 30 days from the date of discharge of the index HF admission.

Denominator Statement:

Change to

The target population for this measure includes admissions for Medicare Fee-for-Service (FFS) and Veteran Health Administration (VA) beneficiaries aged greater than or equal to 65 years discharged from acute care non-federal hospitals or VA hospitals with a principal discharge diagnosis of HF.

Included Populations:

Change 1st paragraph to

Admissions for Medicare FFS and VA beneficiaries greater than or equal to 65 years of age discharged from non-federal acute care hospitals or VA hospitals, having a principal discharge diagnosis of HF.

Change 2nd paragraph to

CMS FFS beneficiaries with an index hospitalization within an acute care non-federal hospital are included if they have been enrolled in Part A and Part B Medicare for the 12 months prior to the date of admission to ensure a full year of administrative data for risk adjustment. (This requirement is dropped for patients with an index admission within a VA hospital.)

Cohort exclusions (excluded admissions):

Change 1st paragraph

In addition, if a patient has one or more HF admissions within 30 days of discharge from the index HF admission, only one is counted as a readmission. No admissions within 30 days of discharge from an index admission are considered as additional index admissions for heart failure. The next eligible admission after the 30-day time period following an index admission will be considered another index admission.

Risk Adjustment:

Change 2nd paragraph

The measures adjust for key variables that are clinically relevant and have strong relationships with the outcome (e.g., age, sex, comorbid diseases, and indicators of frailty). For each patient, covariates are obtained from administrative data extending 12 months prior to, and including, the index admission. For all patients, information from Medicare inpatient claims, physician Part B claims and hospital outpatient claims are used for risk adjustment. For patients with an index admission in a VA hospital, VA administrative data is also obtained.

Remove 3rd paragraph

CMS FFS beneficiaries with an index hospitalization within a non-federal hospital are included
if they have been enrolled in Part A and Part B Medicare for the 12 months prior to the date of admission to ensure a full year of administrative data for risk adjustment. (This requirement is dropped for patients with an index admission within a VA hospital.)

**Change 4th paragraph**
The VA administrative data includes 41 diagnosis and 46 procedure codes (as opposed to 25 and 25, respectively, in CMS administrative data). For the index hospitalization, all diagnosis and procedure codes were retained. For risk adjustment, all diagnosis and procedure codes were retained for visits prior to the index hospitalization.

**Remove last paragraph**
Candidate and Final Variables: Candidate variables were patient-level risk-adjustors that are expected to be predictive of readmission, based on empirical analysis, prior literature, and clinical judgment, including demographic factors (age, sex) and indicators of comorbidity and disease severity.

**Data Accuracy:**
**Change**
Information System to Information Services

**Measure Calculation**
**Change 2nd paragraph**
"adjusted actual' readmissions to "predicted" readmissions case mix to case-mix wherever occurs

**Remove (also known as “predicted”)**

**Change 3rd paragraph**
"adjusted actual' readmissions to "predicted" number of readmissions

**Impacts:** READM-30-PN

**Rationale:** Adjusted language for clarity, Updated the years of data (2008-2010)

**Description of Changes:**
**Performance Measure Name:**
**Change**
Hospital 30-day all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization.

**Description:**
**Change** to The measure estimates a hospital-level, risk-standardized, all-cause 30 day readmission for patients discharged from the hospital with a principal discharge diagnosis of pneumonia (PN).

**Numerator Statement:**
**Remove 1st paragraph the word Note:**
**Change 2nd paragraph to** The outcome for this measure is 30 day all-cause readmission. We define this as readmission for any cause within 30 days from the date of discharge of the index pneumonia admission.
Denominator Statement:
Change 1st paragraph to
The target population for this measure includes admissions for Medicare Fee-for-Service (FFS) and Veteran Health Administration (VA) beneficiaries aged greater than or equal to 65 years discharged from acute care non-federal hospitals or VA hospitals with a principal discharge diagnosis of pneumonia.

Included Populations:
Change 1st paragraph to
Admissions for Medicare FFS and VA beneficiaries greater than or equal to 65 years of age discharged from non-federal acute care hospitals or VA hospitals, having a with a principal discharge diagnosis of pneumonia.

Change 2nd paragraph to
CMS FFS beneficiaries with an index hospitalization within an acute care non-federal hospital are included if they have been enrolled in Part A and Part B Medicare for the 12 months prior to the date of admission to ensure a full year of administrative data for risk-adjustment. (This requirement is dropped for patients with an index admission within a VA hospital.)

Cohort exclusions (excluded admissions)
Change 1st paragraph
In addition, if a patient has one or more pneumonia admissions within 30 days of discharge from the index pneumonia admission, only one is counted as a readmission. No admissions within 30 days of discharge from an index admission are considered as additional index admissions for pneumonia. The next eligible admission after the 30-day time period following an index admission will be considered another index admission.

Risk Adjustment:
Change 2nd paragraph
The measure adjusts for key variables that are clinically relevant and have strong relationships with the outcome (e.g., age, sex, comorbid diseases, and indicators of frailty). For each patient, covariates are obtained from administrative data extending 12 months prior to, and including, the index admission. For all patients, information from Medicare inpatient claims, physician Part B claims and hospital outpatient claims are used for risk adjustment. For patients with an index admission in a VA hospital, VA administrative data is also obtained.

Remove 3rd paragraph
CMS FFS beneficiaries with an index hospitalization within a non-federal hospital are included if they have been enrolled in Part A and Part B Medicare for the 12 months prior to the date of admission to ensure a full year of administrative data for risk adjustment. (This requirement is dropped for patients with an index admission within a VA hospital.)

Change 4th paragraph
The VA administrative data includes 41 diagnosis and 46 procedure code fields (as opposed to 25 and 25, respectively, in CMS administrative data). For the index hospitalization, all diagnosis and procedure codes were retained. For risk adjustment, all diagnosis and procedure codes were retained for visits prior to the index hospitalization.

Remove last paragraph
Candidate and Final Variables: Candidate variables were patient-level risk-adjustors that are expected to be predictive of readmission, based on empirical analysis, prior literature, and clinical judgment, including demographic factors (age, sex) and indicators of comorbidity and disease severity.

Data Accuracy:

Change
Information System to Information Services

Measure Calculation:

Change 1st paragraph, last sentence
If there were no differences among hospitals, then after adjusting for patient risk the hospital intercepts should be identical across all hospitals.

Change 2nd paragraph
“adjusted actual’ readmissions to “predicted” readmissions case mix to case-mix wherever occurs
Remove (also known as “predicted”)

Change 3rd paragraph
“adjusted actual’ readmissions to “predicted” number of readmissions

Subsection 10.3 – Agency for Healthcare Research and Quality (AHRQ)
No updated in this section.

Subsection 10.4 – Healthcare Associated Infections (HAI) Measures
No updated in this section.

Subsection 10.5 – Hospital-Acquired Conditions (HAC) Measures

Impacts: HAC

Rationale: [rationale was not provided on SCR, will email SCR submitter]

Description of Changes:
Centers for Medicare & Medicaid Services (CMS) Hospital-Acquired Condition Measures
Remove: “formerly known as the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program.”

Subsection 10.6 – Structural Measures

Impacts: Inpatient Structural

Rationale: Remove reference to hospital reporting program name RHQDAPU.

Description of Changes:
Inpatient Structural Measures
Remove: “formerly RHQDAPU”
APPENDICES

Appendix A – ICD-9-CM Diagnoses Code Tables
No updates in this section.

Appendix C – Medication Tables

Impacts: Pneumonia (PN)

Rationale: Previously only used for treatment of Leprosy. Now being used to prevent PCP.

Description of Changes:
Table 2.1 Antimicrobial Medications
Add: Dapsone / Dapsone

Impacts: N/A
Measure(s)
STK-2
STK-5

Rationale: Change based on November 4, 2011 FDA approval of rivaroxaban for stroke prevention in patients with atrial fibrillation.

Description of Changes:
Table 8.2 Antithrombotic Medications-Stroke
Add: Rivaroxaban
Xarelto

Impacts: N/A
Measure(s)
STK-3

Rationale: Change based on November 4, 2011 FDA approval of rivaroxaban for stroke prevention in patients with atrial fibrillation.

Description of Changes:
Table 8.3 Anticoagulant Medications-Stroke
Add: Rivaroxaban
Xarelto

Impacts: N/A
Measure(s)
N/A

Rationale: Table 2.8 and 2.9 names in Appendix C do not currently coincide with the Antibiotic Recommendation table names in the MIF.

Description of Changes:
Table 2.8 Quinolones (PN-Pseudomonal Risk)
Change
To
“Antipseudomonal Quinolones”

Table 2.9 Quinolones
Change
To
“Antipneumococcal Quinolones”

<table>
<thead>
<tr>
<th>Impacts:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Measure(s)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Rationale: New FDA-approved ARB medication.

Description of Changes:
Table 1.7 ARBs
Add:
Azilsartan/chlorthalidone
Edarbyclor

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Measure(s)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Rationale: Medication was incorrectly represented in the crosswalk.

Description of Changes:
Table 2.8 Quinolones (PN-Pseudomonas Risk)
Table 3.10 All Surgeries – Antibiotics/Fluroquinolone
Table 3.12 Hysterectomy and Colon Quinolones
Add “Hydrochloride” to the generic column for the trade name entry Ciprofloxacin Hydrochloride.

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<th>Impacts:</th>
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</thead>
<tbody>
<tr>
<td>Measure(s)</td>
<td>CAC-3</td>
</tr>
</tbody>
</table>

Rationale: Update CAC medication tables by removing discontinued drugs in order to provide the most current list of medications available at the time of publication.

Description of Changes:
Table 6.1 Controller Medications – CAC
Remove:
AeroBid M/Flunisolide
Aerospan/Flunisolide

<table>
<thead>
<tr>
<th>Impacts:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Measure(s)</td>
<td>CAC-2</td>
</tr>
</tbody>
</table>
**Rationale:** Update CAC medication tables by removing discontinued drugs in order to provide the most current list of medications available at the time of publication.

**Description of Changes:**
**Table 6.3 Systemic Corticosteroid Medications – CAC**
**Add:** Kenalog/Triamcinolone acetonide Triamcinolone acetonide/Triamcinolone acetonide

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Measure(s)</td>
<td>SCIP-Inf-9</td>
</tr>
</tbody>
</table>

**Rationale:** Adding paralytics and vasopressors/inotropics as a reason to continue urinary catheterization per TEP member recommendation.

**Description of Changes:**
**Index**
**Add:** Table 3.15 Paralytic Agents

<table>
<thead>
<tr>
<th>Impacts</th>
<th>N/A</th>
</tr>
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<tbody>
<tr>
<td>Measure(s)</td>
<td>SCIP-Inf-2</td>
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</table>

**Rationale:** The SCIP Technical Expert Panel agreed to the addition of Ceftriaxone plus Metronidazole to the list of approved antibiotics for colon surgeries along with stating that this combination should only be used in hospitals where surgical site infection surveillance demonstrates gram negative surgical infections resistant to first- and second-generation cephalosporins.

**Description of Changes:**
**Table 3.5 Colon - Parenteral – Antibiotics – I**
**Add:**
Ceftriaxone/ Ceftriaxone Ceftriaxone Sodium/ Ceftriaxone Rocephin/ Ceftriaxone

**Appendix D – Glossary of Terms**

<table>
<thead>
<tr>
<th>Impacts</th>
<th>N/A</th>
</tr>
</thead>
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<tr>
<td>Measure(s)</td>
<td>PN-6 IMM-1</td>
</tr>
<tr>
<td>Data Element(s)</td>
<td>Compromised Pneumococcal Vaccination (PPV23) Status</td>
</tr>
</tbody>
</table>
Rationale: The data dictionary lacks a definition of this term, used in the PN and IMM measure sets.

Description of Changes:
Add:
Chemotherapy – For purposes of the PN and IMM measure sets, chemotherapy is defined as antineoplastic agents used to treat cancer. Types include targeted agents, alkylating agents, antimetabolites, plant alkaloids and terpenoids, topoisomerase inhibitors, antitumor antibiotics, monoclonal antibodies, and biologics and related agents. Hormonal therapies are not included.

Impacts: N/A
Measure(s) All ED IMM-1 IMM-2
Data Element(s) N/A

Rationale: The ED and IMM, SUB and TOB measure sets lack definitions in Appendix D.

Description of Changes:
Add:
Emergency Department (ED) A portion of the hospital where emergency diagnosis and treatment of illness or injury is provided.

Immunization (IMM) The process by which a person becomes protected against a disease through vaccination or inoculation. For the purposes of this measure set, the population is defined as hospitalized inpatients screened for pneumococcal and seasonal influenza immunization status.

Tobacco Use (TOB) For the purposes of the Tobacco Treatment measure set (TOB), tobacco use includes cigarettes, pipe, cigars and smokeless tobacco products.

Substance Use (SUB) For the purposes of the Substance Use measure set (SUB) substance use includes unhealthy alcohol use and drug abuse or dependence including opioids, sedative/hypnotics, cocaine, cannabis, amphetamines, and hallucinogens.

Impacts: N/A
Measure(s) N/A
Data Element(s) N/A

Rationale: Update of SCIP definition.

Description of Changes:
Change
To:
Surgical Care Improvement Project (SCIP) The Surgical Care Improvement Project (SCIP)
is a national quality partnership of organizations focused on improving surgical care by significantly reducing surgical complications through performance measurement. Utilizing ten process measures in three separate modules (infection, cardiac, and VTE), the goal is to reduce the incidence of surgical complications nationally.

**Impacts:** N/A

**Data Element Name**
N/A

**Rationale:** Remove reference to hospital reporting program name RHQDAPU.

**Description of Changes:**

**Appendix D**
Hospital Inpatient Quality Reporting Program

**Remove:**
“formerly known as the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program.”

**Appendix E – Overview of Measure Information Form and Flowchart Formats**

**Impacts:** N/A

**Measure(s)**
N/A

**Rationale:** To provide clarification that cases that have a measure outcome of ‘Y’ are included in the measure’s population.

**Description of Changes:**

**Measure Outcomes (CMS Only)**

**Change** the ‘Y’ definition for the continuous variable measures

To:
For continuous variable measures: EOC record is a member of the measure’s population however contains a Date, Time or Numeric data element with a value of ‘UTD.’

**Appendix F – Measure Name Crosswalk**

**Impacts:** N/A

**Measure(s)**
N/A

**Rationale:** Update to time frames, measure names, and addition of Stroke and VTE measure sets.

**Description of Changes:**

**Change:**
Review this document as it has significantly changed.

**Appendix G – Resources**

**Impacts:** N/A

**Measure(s)**
N/A
**Rationale:** Provide resource on measures required for CMS Hospital IQR Program.

**Description of Changes:**

**Add:**

**CMS Hospital Inpatient Quality Reporting Program**

For information on measures that are required for CMS Hospital IQR Program and/or used for Public Reporting on Hospital Compare, refer to the Measure Comparison Document at http://www.qualitynet.org/. Please go to the QualityNet web site and select “Measure Comparison” under “Hospital Quality Alliance (HQA)” located under Hospitals-Inpatient; or refer to the Final IPPS Rule at http://www.cms.gov/AcuteInpatientPPS/.

| Impacts: | N/A Measure(s) N/A |

**Rationale:** Resources updated for submission of questions and answers.

**Description of Changes:**

**Change:**

Medication Questions

If you have questions regarding medications, please go to the QualityNet web site http://www.qualitynet.org and select “Hospitals-Inpatient” under “Questions & Answers” to submit your questions. Questions & Answers is an online questions and answers database that allows for the submission and retrieval of questions and answers based on the measure set and keyword criterion.

**Abstraction or Measure Questions**

For questions you may go to one of the following websites and select “Hospitals-Inpatient” under “Questions & Answers” to submit your questions. Questions & Answers is an online questions and answers database that allows for the submission and retrieval of questions and answers based on the measure set and keyword criterion.

Children’s Asthma, Substance Use, and Tobacco Treatment Measure Sets

If you have questions regarding the Children’s Asthma, Substance Use, and Tobacco Treatment Measure Sets that are collected for The Joint Commission only, please submit them to http://manual.jointcommission.org/.

**Appendix H – Miscellaneous Tables**

| Impacts: | N/A Measure(s) AMI HF SUB STK |

**Rationale:** Updates to the negative qualifier/modifier lists were warranted.

**Description of Changes:**

Table 2.6 Qualifiers and Modifiers Table
Qualifiers

Change 2nd bullet to:
The following qualifiers should be abstracted as negative findings, unless otherwise specified in a data element’s guidelines – Consider this list all-inclusive:

Qualifiers - Negative findings list

Change:
- Could/may/might be
- Could/may/might have been
- Could/may/might have had
- Could/may/might indicate

Add:
- Could/may/might have

Remove:
- May be
- May have

Modifiers

Change 2nd bullet to:
The following quantitative modifiers should be abstracted as negative findings, unless otherwise specified in a data element’s guidelines - Consider this list all-inclusive:

Modifiers - Negative findings list

Change:
- Insignificant/not significant/no significant

Add:
- Minor

Impacts:
- N/A
- Measure(s)
- N/A

Rationale: Required submission of VTE and STK by CMS.

Description of Changes:
Table 2.7 Allowable Measure Set Combinations

Remove Footnote 1 from STK and VTE.
Remove column and row for VTE.
Add columns and rows for VTE-No VTE, VTE – O Dx VTE, and VTE – P Dx VTE