

National Hospital Inpatient Quality Reporting Measures Specifications Manual

Release Notes Version: 4.3

Release Notes Completed: June 24, 2013

Guidelines for Using Release Notes

Release Notes 4.3 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 01-01-2014**, unless otherwise specified. The headings are described below:

- **Impacts** - used to identify which portion(s) of the Manual Section is impacted by the change listed. Examples are Alphabetical Data Dictionary, (Measure Set) Data Element List, Measure Information Form (MIF) and Flowchart (Algorithm). The measures that the data element is collected for are identified.
- **Description of Changes** - used to identify the section within the document where the change occurs, e.g., Definition, Data Collection Question, Allowable Values, and Denominator Statement - Data Elements.
- **Rationale** - provided for the change being made.

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

Table of Contents

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

Table of Contents	1
Acknowledgement	1
Introduction.....	1
Using the Manual.....	1
SECTION 1 – Data Dictionary	2
Introduction to Data Dictionary	2
Alphabetical Data Dictionary	3
SECTION 2 – Measurement Information.....	50
Subsection 2.1 – Acute Myocardial Infarction (AMI)	50
Subsection 2.2 – Heart Failure (HF)	53
Subsection 2.3 – Pneumonia (PN).....	55
Subsection 2.4 – Surgical Care Improvement Project (SCIP).....	57
Subsection 2.6 – Children’s Asthma Care (CAC).....	69
Subsection 2.7 – Venous Thromboembolism (VTE)	70
Subsection 2.8 – Stroke (STK).....	72
Subsection 2.9 – Global Initial Patient Population (ED, IMM, TOB, SUB).....	90
Emergency Department (ED)	90
Immunization (IMM).....	92
Substance Use (SUB)	94
Tobacco Use (TOB).....	100
SECTION 3 – Missing and Invalid Data.....	107
SECTION 4 – Population and Sampling Specifications.....	107
SECTION 9 – Data Transmission.....	107
Hospital Clinical XML File Layout.....	108
SECTION 10 – CMS Outcome Measures (Claims Based)	114
Subsection 10.1 – Introduction Risk Standardized Mortality Measures	114
Subsection 10.2 – Introduction Risk Standardized Readmission Measures	116
Subsection 10.3 – Agency for Healthcare Research and Quality (AHRQ).....	121
Subsection 10.4 – Healthcare Associated Infections (HAI) Measures	121
Subsection 10.5 – Hospital-Acquired Conditions (HAC) Measures.....	122
Subsection 10.6 – Structural Measures	123
APPENDICES	124
Appendix A – ICD-9-CM Diagnoses Code Tables	124
Appendix C – Medication Tables	125
Appendix D – Glossary of Terms	134
Appendix E – Overview of Measure Information Form and Flowchart Formats	134
Appendix F – Measure Name Crosswalk.....	134
Appendix G – Resources	135
Appendix H – Miscellaneous Tables	135

Release Notes version 4.3 - The notes in the tables below are organized to follow the Table of Contents in the specifications manual. The **implementation date is 01/01/2014** unless otherwise specified.

Table of Contents

Impacts:

N/A

Rationale: Adding preview section to display future manual updates. This section is for preview only and is not to be used for programming.

Description of Changes:

Add to Table of Contents under Appendices:
P. Preview Section.

Acknowledgement

No updates in the Acknowledgement section.

Introduction

Impacts:

N/A

Rationale: The content needed to be updated to reflect current initiatives and language for Meaningful Use (MU) and Value-based Purchasing (VBP).

Description of Changes:

Change section.

Refer to 'Introduction' page for changes. Section contains extensive revisions.

Using the Manual

Impacts:

N/A

Rationale: Adding preview section to display future manual updates. This section is for preview only and is not to be used for programming or submitting.

Description of Changes:

Add language for new Appendix P section after Appendix H – Miscellaneous Tables paragraph:

Appendix P – Preview Section

The preview section is intended to provide an overview of future updates. The information provided in this section **is not** to be programmed or submitted. Placement in this appendix does not assume that the information listed will be implemented in a future manual.

SECTION 1 – Data Dictionary

Introduction to Data Dictionary

Impacts:

N/A

Rationale: To provide recommendations for episodes of care with multiple ED visits.

Description of Changes:

Episode of Care

Add to end of first paragraph:

In the event that there are multiple ED visits within the inpatient medical record, for the same episode of care, it is recommended that the ED visit resulting in the admission to observation or inpatient status be utilized for the purposes of abstraction.

Impacts:

N/A

Rationale: To align with Medicare regulations and provide guidance and clarification regarding documentation requirements for addendums, corrections and late entries.

Description of Changes:

General Abstraction Guidelines – *Medical Record Documentation*

Change 1st paragraph to:

The intent of abstraction is to use only documentation that was part of the medical record during the hospitalization (is present upon discharge) and that is present at the time of abstraction. There are instances where an addendum or late entry is added after discharge. This late entry or addendum can be used, for abstraction purposes, as long as it has been added within 30 days of discharge, [Refer to the Medicare Conditions of Participation for Medical Records, 42CFR482.24(c)(2)(viii)], unless otherwise specified in the data element. Documents containing amendments, corrections, or delayed entries must employ the following widely accepted recordkeeping principles (CMS “Medicare Program Integrity Manual” Chapter 3, Section 3.3.2.4):

- Clearly and permanently identify any amendments, corrections or addenda;
- Clearly indicate the date and author of any amendments, corrections, or addenda; and
- Clearly identify all original content.

It is not the intent to have documentation added at the time of abstraction to ensure the passing of a measure.

Impacts:

N/A

Rationale: Per the Medicare Conditions of Participation, CMS allows hospitals to have an optional program for patient(s)/support person(s) on self-administration of appropriate medications.

Description of Changes:

General Abstraction Guidelines – *Medications*

Add new bullet:

Hospitals may allow a patient (or his or her caregiver/support person where appropriate) to self-administer both hospital-issued medications and the patient's own medications brought into the hospital. Hospitals must document the administration of each medication, as reported by the patient (or the patient's caregiver/support person where appropriate), in the patient's medical record [42CFR482.23(c)(6)].

Impacts:

N/A

Rationale: CMS has allowed hospitals the options of having a stand-alone nursing care plan or a single interdisciplinary care plan. In addition, CMS has allowed hospitals the flexibility to use standing orders, electronic standing orders, order sets and protocols.

Description of Changes:General Abstraction Guidelines

Add new section under *Medications*:

Nursing Care Plans, Standing Orders and Protocols

- Per Medicare Conditions of Participation [42CFR482.23(b)(4)] hospitals have the option of having a stand-alone nursing care plan or a single interdisciplinary care plan that addresses nursing and other disciplines.
- Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders if such orders and protocols are dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner responsible for the care of the patient [42CFR482.24(c)(3)].

Alphabetical Data Dictionary**Impacts:**

Alphabetical Data Dictionary Index

Rationale: Footnotes are being removed because the "collected for" designation is already referenced in each data element.

Description of Changes:

Remove all footnotes in "Collected For" column.

- ¹ CMS Voluntary ONLY
- ² The Joint Commission ONLY
- ³ CMS Informational ONLY
- ⁴ CMS ONLY
- ⁵ Transmission Data Element

Impacts:

Alphabetical Data Dictionary Index
SCIP Data Element List

Data Elements*Glucose*

Glucose POD 1
Glucose POD 2
Perioperative Death

Rationale: The measure is being updated based on NQF and TEP recommendations.

Description of Changes:

Remove data elements *Glucose POD 1* and *Glucose POD 2* from left column and SCIP-Inf-4 from right column.

Add data element *Glucose* to left column and SCIP-Inf-4 to right column.

Remove SCIP-Inf-4 from the Collected for column for *Perioperative Death*.

Impacts:

Alphabetical Data Dictionary Index

Rationale: The current data element requires a review of the entire hospitalization for evidence of an alcohol use screen to determine alcohol use status. Restricting the timeframe to within 3 days of admission for performing the screen to determine alcohol use status will substantially reduce the burden of abstraction for hospitals. Additionally, examples of single validated questions to determine alcohol use status were requested by the field. The only patients who require outpatient treatment are those with an abuse or addiction problem. Restricting the population for SUB-4 to these patients will simplify the measure as desired by NQF and also substantially reduce the burden for follow up by hospitals.

Description of Changes:

Alcohol Use Status

Remove under 'Collected For' column:
 SUB-4

Impacts:

Alphabetical Data Element Index and Data Elements

Rationale: The Observation Services data element is being removed from the manual based on ED TEP recommendation.

Description of Changes:

Remove:

Observation Services

Impacts:

Alphabetical Data Element Index and Data Elements

Rationale: This change is being made to differentiate if there was a documented reason why overlap therapy did not occur.

Description of Changes:

Add new Data Element:

Reason for No Overlap Therapy

Collected for column:

Add:

VTE-3

Impacts:*Admission Date*

Rationale: Reorder of the notes for abstraction with the addition of a note in the suggested data sources for clarification.

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

- The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.

Example:

- Preoperative Orders are dated as 04-06-20xx with an order to admit to Inpatient. Postoperative Orders, dated 05-01-20xx, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 05-01-20xx. The admission date would be abstracted as 05-01-20xx.

Change 3rd bullet to:

- If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.

Suggested Data Sources

Add Note: The physician order is the priority data source for this data element. If there is not a physician order in the medical record, use the other only allowable sources to determine the *Admission Date*.

Comparison between pathogen directed antibiotic treatment and empirical broad spectrum antibiotic treatment in patients with community acquired pneumonia: a prospective randomised study

Impacts:*Alcohol Use Status*

Rationale: The current data element requires a review of the entire hospitalization for evidence of an alcohol use screen to determine alcohol use status. Restricting the timeframe to within 3 days of admission for performing the screen to determine alcohol use status will substantially reduce the burden of abstraction for hospitals. Additionally, examples of single validated questions to determine alcohol use status were requested by the field. The only patients who require outpatient treatment are those with an abuse or addiction problem. Restricting the population for SUB-4 to these patients will simplify the measure as desired by NQF and also substantially reduce the burden for follow up by hospitals.

Description of Changes:**Remove:**

SUB 4 from Collected For: The Joint Commission Only, and from CMS Informational Only

Definition

Change the first sentence to:

Documentation of the adult patient's alcohol use status using a validated screening questionnaire for unhealthy alcohol use within the first three days of admission.

Allowable Values**Change** from:

- 1 The patient is screened with a validated tool and the score on the alcohol screen indicates no or low risk of alcohol related problems.
- 2 The patient was screened with a validated tool and the score on the alcohol screen indicates unhealthy alcohol use (moderate risk) benefiting from brief intervention.
- 3 The patient was screened with a non-validated tool and the score on the alcohol screen indicates no or low risk of alcohol related problems.
- 4 The patient was screened with a non-validated tool and the score on the alcohol screen indicates unhealthy alcohol use (moderate risk) benefiting from brief intervention.
- 5 The patient refused the screen for alcohol use.
- 6 The patient was not screened for alcohol use during this hospital stay or unable to determine from medical record documentation.

To:

- 1 The patient is screened with a validated tool within the first three days of admission and the score on the alcohol screen indicates no or low risk of alcohol related problems.
- 2 The patient was screened with a validated tool within the first three days of admission and the score on the alcohol screen indicates unhealthy alcohol use (moderate risk) benefiting from brief intervention.
- 3 The patient was screened with a non-validated tool within the first three days of admission and the score on the alcohol screen indicates no or low risk of alcohol related problems.
- 4 The patient was screened with a non-validated tool within the first three days of admission and the score on the alcohol screen indicates unhealthy alcohol use (moderate risk) benefiting from brief intervention.
- 5 The patient refused the screen for alcohol use within the first three days of admission.
- 6 The patient was not screened for alcohol use during the first three days of admission or unable to determine from medical record documentation.

Notes for Abstraction**Add** under the second bullet:

Examples of single validated questions include:

- Do you drink alcohol? If yes, a follow-up question applies:
 - How many times in the last month have you had 5 or more drinks on an occasion (for males) or four or more drinks on an occasion (for females)?

Add new bullet:

- The alcohol use status screening timeframe must have occurred within the first three days of admission. The day after admission is defined as the first day.

Impacts:

Anesthesia End Date

Rationale: The measure is being updated based on NQF and TEP recommendations.

Description of Changes:Alphabetical Data Dictionary- Data Elements List

Remove SCIP-Inf-4 from the Collected for column for *Anesthesia End Date*.

Alphabetical Data Dictionary

Remove SCIP-Inf-4 from the Collected for section in the data element *Anesthesia End Date*.

Impacts:

Anesthesia Type

Rationale: The measure specifications are being revised to maintain consistency with the updated American College of Chest Physicians' guidelines on prevention of VTE in surgical patients.

Description of Changes:Alphabetical Data Dictionary Data Element List

Remove: SCIP-VTE-2 in the row for *Anesthesia Type* in the Collected For column.

Alphabetical Data Dictionary:

Remove: SCIP-VTE-2 in the Collected for section of *Anesthesia Type*.

Impacts:

Arrival Date

Rationale: Abstraction guidelines are being revised to not allow reference to non-Only Acceptable Sources and to disregard a date when unable to identify if it was documented in an Only Acceptable Source, in order to simplify abstraction. Additionally, changes are being made to abstraction guidelines to encourage an abstractor to carefully examine Only Acceptable Source documentation and to not use a date when it is obviously an error. Additional examples are being provided for clarification. Lastly, the abstraction guideline directing the abstractor to not use pre-printed dates on a vital signs graphic sheet is being deleted due to its difficulty in applying to EHRs.

Description of Changes:Notes for Abstraction

Change ONLY ACCEPTABLE SOURCES everywhere it appears to:

Only Acceptable Sources

Change 3rd bullet to:

- Review the Only Acceptable Sources to determine the earliest date the patient arrived at the ED, nursing floor, or observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab for a direct admit.

Change 4th bullet to:

- The source "Emergency department record" includes any documentation from the time period that the patient was an ED patient – e.g., ED face sheet, ED consent/Authorization for treatment forms, ED/Outpatient Registration/sign-in forms, ED vital sign record, ED triage record, ED physician orders, ED ECG reports, ED telemetry/rhythm strips, ED laboratory reports, ED x-ray reports.

Remove 5th bullet:

- Do not use preprinted dates on a vital sign graphic record.

Add bullets:

- Documentation outside of the Only Acceptable Sources list should NOT be referenced (e.g., ambulance record, physician office record, H&P).
Examples:
 - ED Triage Date/Time 03-22-20xx 2355. ED rhythm strip dated/timed 03-23-20xx 0030. EMS report indicates patient was receiving EMS care from 0005 through 0025 on 03-23-20xx. The EMS report is disregarded. Enter 03-22-20xx for *Arrival Date*.
 - ED noted arrival time of 0100 on 04-14-20xx. Lab report shows blood culture collected at 2345 on 04-13-20xx. It is not clear that the blood culture was collected in the ED because the lab report does not specify it was collected in the ED (unable to confirm lab report as an Only Acceptable Source). Enter 04-14-20xx for *Arrival Date*.
- Arrival date should NOT be abstracted simply as the earliest date in one of the Only Acceptable Sources, without regard to other substantiating documentation. When looking at the Only Acceptable Sources, if the earliest date documented appears to be an obvious error, this date should not be abstracted.
Examples:
 - ED arrival time noted as 0030 on 10-29-20xx. ED MAR shows an antibiotic administration time of 0100 on 10-28-20xx. Surrounding documentation on the ED MAR makes clear that the 10-28-20xx date is an obvious error - Date was not changed to 10-29-20xx. The antibiotic administration date/time would be converted to 0100 on 10-29-20xx. Enter 10-29-20xx for *Arrival Date*.
 - ED MAR shows an antibiotic administration time of 1430 on 11-03-20xx. All other dates in the ED record note 12-03-20xx. The antibiotic administration date of 11-03-20xx would not be used for *Arrival Date* because it is an obvious error.
 - ED ECG dated/timed as 05-07-20xx 2142. ED Greet Date/Time 05-08-20xx 0125. ED Triage Date/Time 05-08-20xx 0130. There is no documentation in the Only Acceptable Sources which suggests the 05-07-20xx is an obvious error. Enter 05-07-20xx for *Arrival Date*.
 - ED RN documents on a nursing triage note dated 04-24-20xx, "Blood culture collected at 2230." ED arrival time is documented as 0130 on 04-25-20xx. There is no documentation in the Only Acceptable Sources which suggests the 04-24-20xx is an obvious error. Enter 04-24-20xx for *Arrival Date*.

Impacts:*Arrival Time*

Rationale: Abstraction guidelines are being revised to not allow reference to non-Only Acceptable Sources and to disregard a time when unable to identify if it was documented in an Only Acceptable Source, in order to simplify abstraction. Additionally, changes are being made to abstraction guidelines to encourage an abstractor to carefully examine Only Acceptable Source documentation and to not use a time when it is obviously an error. Additional examples are being provided for clarification. Lastly, the abstraction guideline directing the abstractor to

not use pre-printed times on a vital signs graphic sheet is being deleted due to its difficulty in applying to EHRs.

Description of Changes:Notes for Abstraction

Change ONLY ACCEPTABLE SOURCES everywhere it appears to:

Only Acceptable Sources

Change 4th bullet to:

- Review the Only Acceptable Sources to determine the earliest time the patient arrived at the ED, nursing floor, or observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab for a direct admit.

Change 5th bullet to:

- The source “Emergency department record” includes any documentation from the time period that the patient was an ED patient – e.g., ED face sheet, ED consent/Authorization for treatment forms, ED/Outpatient Registration/sign-in forms, ED vital sign record, ED triage record, ED physician orders, ED ECG reports, ED telemetry/rhythm strips, ED laboratory reports, ED x-ray reports.

Remove 6th bullet:

- Do not use preprinted times on a vital sign graphic record.

Add bullets:

- Documentation outside of the Only Acceptable Sources list should NOT be referenced (e.g., ambulance record, physician office record, H&P).
Examples:
 - ED Triage Time 0800. ED rhythm strip 0830. EMS report indicates patient was receiving EMS care from 0805 through 0825. The EMS report is disregarded. Enter 0800 for *Arrival Time*.
 - ED noted arrival time of 0945. Lab report shows blood culture collected at 0830. It is not clear that the blood culture was collected in the ED because the lab report does not specify it was collected in the ED (unable to confirm lab report as an Only Acceptable Source). Enter 0945 for *Arrival Time*.
- Arrival time should NOT be abstracted simply as the earliest time in one of the Only Acceptable Sources, without regard to other substantiating documentation. When looking at the Only Acceptable Sources, if the earliest time documented appears to be an obvious error, this time should not be abstracted.
Examples:
 - ED arrival time noted as 2300 on 10-28-20xx. ED MAR shows an antibiotic administration time of 0100 on 10-28-20xx. Surrounding documentation on the ED MAR makes clear that the 10-28-20xx date is an obvious error - Date was not changed to 10-29-20xx. The antibiotic administration date/time would be converted to 0100 on 10-29-20xx. Enter 2300 for *Arrival Time*.
 - ED face sheet lists arrival time of 13:20. ED Registration Time 13:25. ED Triage Time 13:30. ED consent to treat form has 1:17 time but “AM” is circled. ED record documentation suggests the 1:17 AM is an obvious error. Enter 13:20 for *Arrival Time*.

- ED ECG timed as 1742. ED Greet Time 2125. ED Triage Time 2130. There is no documentation in the Only Acceptable Sources which suggests the 1742 is an obvious error. Enter 1742 for *Arrival Time*.
- ED RN documents on the nursing triage note, “Blood culture collected at 0730.” ED arrival time is documented as 1030. There is no documentation in the Only Acceptable Sources which suggests the 0730 is an obvious error. Enter 0730 for *Arrival Time*.

Impacts:*Aspirin Prescribed at Discharge**Aspirin Received Within 24 Hours Before or After Hospital Arrival*

Rationale: Aggrenox contains only a sub-therapeutic amount of aspirin (25 mg). ACC/AHA class I, Level A clinical guidelines for STEMI/NSTEMI state that the recommended maintenance dose of aspirin is 75 mg - 325 mg/day. An abstraction guideline is needed to clarify that Aggrenox does not count for aspirin, for the purposes of the aspirin measures.

Description of Changes:Guidelines for Abstraction - Exclusions**Add:**

Aggrenox (aspirin/dipyridamole)

Impacts:*Brief Intervention*

Rationale: A typo is being corrected in the definition.

Description of Changes:Definition

Change the last sentence to:

Brief intervention corresponds directly with the 5 A's (Ask, Advise, Assess, Assist, Arrange) recommended for alcohol dependence.

Impacts:*Catheter Removed*

Rationale: Instructions are being added to address how to abstract the data element if the patient expires prior to the end of the second postoperative day. Clarification is being added regarding the reinsertion of catheters after they are removed on POD 0, 1 or 2.

Description of Changes:Notes for Abstraction:

Change the 2nd bullet to be the 1st bullet.

- Postoperative Day 2 (POD 2) ends at midnight of the second postoperative day with *Anesthesia End Date* being POD 0.

Remove the 3rd and 4th bullets.

Add as the 3rd bullet:

- If the patient expires before the end of POD 2 prior to catheter removal select Value 1.

Add as the 4th, 5th, and 6th bullets:

- If the catheter was discontinued or was unintentionally removed on POD 0 through POD 2 and was not reinserted, select value "1." This includes catheter removal by a patient.
- If the catheter was removed and was reinserted prior to the end of POD 2 due to an inability to void or to urinary retention, select value "1." This includes catheter removal by a patient.
- If the catheter was removed and was replaced or exchanged with a catheter that remained in place beyond POD 2, select value "2." This includes catheter removal by a patient.

Impacts:

Chest X-Ray

Rationale: The inclusion terms list chest x-ray or CT scan findings. A bronchogram is a radiograph of the bronchial tree. Bronchogram will be replaced with air bronchogram, an abnormality usually caused by an infiltrate/consolidation that surrounds the bronchi.

Description of Changes:

Inclusion Guidelines for Abstraction

Change 3rd bullet to:

Air bronchogram

Impacts:

Cognitive Impairment

Rationale: The current specifications do not state the period of time for cognitive impairment to be documented in the medical record. Clarification has been added to include the entire hospitalization.

Description of Changes:

Definition

Change last sentence to:

Cognitive impairment for the purposes of this measure set related to documentation that the patient cannot be screened for tobacco and alcohol use due to the impairment (e.g., comatose, obtunded, confused, memory loss) during the entire hospitalization.

Suggested Data Collection Question

Change to:

Is there documentation in the medical record that indicates the patient was cognitively impaired during the entire hospitalization?

Allowable Values

Change from:

Y (Yes)

There is documentation in the medical record that the patient is cognitively impaired.

	N (No)	There is no documentation in the medical record that indicates the patient is cognitively impaired or Unable to Determine (UTD) from medical record documentation.
To:	Y (Yes)	There is documentation in the medical record that the patient was cognitively impaired during the entire hospitalization.
	N (No)	There is no documentation in the medical record that indicates the patient was cognitively impaired during the entire hospitalization or Unable to Determine (UTD) from medical record documentation.

Notes for Abstraction**Remove:** None**Add:**

Cognitive impairment must be documented at all times during the hospitalization in order to answer “yes”. If there is documentation in the medical record that a patient is cognitively impaired, and there is no additional documentation that the patient’s mental status was normal at any other time during the hospitalization, i.e., alert and oriented, the abstractor can select value “Yes”.

Inclusion Guidelines for Abstraction**Add:**

- Altered Mental Status
- Altered Level of Consciousness (LOC)

Impacts:*Comfort Measures Only*

Rationale: Terminally ill patients are currently included in the measure population, even if they are receiving comfort measures only. Excluding these patients for the SUB and TOB measures will simplify the measure as desired by the Technical Advisory Panel (TAP) and also substantially reduce the burden of abstraction for hospitals.

Description of Changes:**Add** under ‘Collected For’ for The Joint Commission Only:

All SUB Measures, All TOB Measures

Add under ‘Collected For’ after CMS Voluntary Only:

CMS Informational Only: All SUB Measures, All TOB Measures

Impacts:*Compromised**Healthcare Associated PN*

Rationale: The data elements *Compromised* and *Healthcare Associated Pneumonia* have been retired and combined into *Reason for Alternative Empiric Antibiotic Therapy* to allow for additions of other exclusions as the need arises and to keep the PN-6 antibiotic regimens evidence based according to the guidelines.

Description of Changes:Data Element List**Remove:***Compromised**Healthcare Associated PN*Collected For**Remove:** PN-6⁵, PN-6a², PN-6b²Data Element**Remove:***Compromised**Healthcare Associated PN***Impacts:***Decision to Admit Date*

Rationale: Currently, there appears to be confusion regarding how to determine if a patient was admitted to “inpatient” status or placed in “observation”. The focus should be centered on when the physician/APN/PA decides to keep the patient in the hospital instead of the particular status into which the patient is admitted. Additionally, there appears to be confusion regarding how to abstract structured data fields in electronic health records; therefore, a Note for Abstraction was added to address this. Suggested data sources are now limited to physician/APN/PA.

Description of Changes:Definition**Change to:**

The documented date the decision to admit to observation or inpatient status occurred. Decision to admit to observation or inpatient status date is the date the physician/APN/PA makes the decision to admit the patient from the emergency department to the hospital for continued care in the facility.

Notes for Abstraction**Change 1st bullet to:**

- If the date of the decision to admit to observation or inpatient status is unable to be determined from medical record documentation, select “UTD”.

Change second sentence of 3rd bullet to:

The intent is to utilize any documentation that reflects processes that occurred in the ED or hospital.

Add new 4th bullet:

- For purposes of this data element, the source “Emergency department record” includes any documentation from the time of ED arrival to the time the patient physically departed from the ED.

Example:

ED departure is at 11:00 on 3/12/20XX. The attending physician’s admit orders written in the inpatient record at 10:00 on 3/12/20XX are considered part of the ED record.

Delete 5th bullet:

- If there are multiple dates documented for the decision to admit abstract the earliest date.

Add new 5th bullet:

- Disregard physician/APN/PA narrative documentation of a consult or orders for consult, transfer to another physician's service, or discussion with another physician since this does not reflect a decision was made.

Add new 6th bullet:

- Use the date from the first documentation of decision to admit for either observation or inpatient. If there are multiple dates documented for the decision to admit to observation or inpatient status, abstract the earliest date.

Example:

The physician ordered "Admit Observation Services." Four hours later the physician wrote an order to admit the patient to inpatient status. These orders were written while the patient was still receiving care in the ED. Use the earlier order for Observation Services to abstract as date and time.

Change 7th bullet to:

If it can be determined that the patient arrived on the same date and departed on the same date, the arrival date can be used as the decision to admit to observation or inpatient status date.

Change 8th bullet to:

Data fields representing 'decision to admit' in electronic documentation for this specific episode of care are acceptable to use as long as they are the earliest physician/APN/PA documentation and clearly defined to capture the date an observation status or inpatient admit decision was documented. Information found in an electronically interfaced event log or Admit/Decision/Transfer (ADT) is acceptable provided this information is part of the submitted medical record covering the arrival to discharge date being abstracted.

Examples:

- Decision to Admit
- Dispo
- Disposition set to admit

Change first sentence of 9th bullet to:

For purposes of this data element *Decision to Admit Date* is the date on which the physician/APN/PA makes the decision to admit the patient from the emergency department to the hospital.

Change 10th bullet to:

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

Change 11th bullet to:

If the decision to admit to observation or inpatient status date is dated prior to the date of patient arrival or after the date of departure, select "UTD".

Add new 12th bullet:

Decision to Admit Date includes physician/APN/PA documentation of a decision to send the patient to cath lab or surgery.

Example:

The ED physician documents that he/she is sending the patient to the OR for surgery. The decision to admit to observation or inpatient status date will abstract as the date this was documented.

Suggested Data Sources:

Remove ONLY ACCEPTABLE SOURCES:

Add:

ONLY ACCEPTABLE SOURCES

PHYSICIAN/APN/PA DOCUMENTATION ONLY

Impacts:

Decision to Admit Time

Rationale: Currently, there appears to be confusion regarding how to determine if a patient was admitted to “inpatient” status or placed in “observation”. The focus should be centered on when the physician/APN/PA decides to keep the patient in the hospital instead of the particular status into which the patient is admitted. Additionally, there appears to be confusion regarding how to abstract structured data fields in electronic health records; therefore, a Note for Abstraction was added to address this. Suggested data sources are now limited to physician/APN/PA.

Description of Changes:Definition**Change to:**

The documented time (military time) the decision to admit to observation or inpatient status occurred. Decision to admit to observation or inpatient status time is the time the physician/APN/PA makes the decision to admit the patient from the emergency department to the hospital for continued care in the facility.

Notes for Abstraction**Change** 2nd bullet to:

If the time of the decision to admit to observation or inpatient status is unable to be determined from medical record documentation, select “UTD”.

Delete 5th bullet:

If there are multiple times documented for the *Decision to Admit Time* abstract the earliest time.

Add new 5th bullet:

- For purposes of this data element, the source “Emergency Department record” includes any documentation from the time of ED arrival to the time the patient physically departed from the ED.

Example:

ED departure is at 11:00 on 3/12/20XX. The attending physician’s admit orders written in the inpatient record at 10:00 on 3/12/20XX are considered part of the ED record.

Add new 6th bullet:

- Disregard physician/APN/PA narrative documentation of a consult or orders for consult, transfer to another physician's service, or discussion with another physician since this does not reflect a decision was made.

Add new 7th bullet:

- For narrative documentation that clearly refers to the decision to admit to observation /inpatient status or that the patient will be going to cath lab or surgery, take the initial note time unless there is a later time specified within that note.

Add new 8th bullet:

- Use the time from the first documentation for either observation or inpatient. If there are multiple times documented for the *Decision to Admit Time* abstract the earliest time.

Example: The physician ordered "Admit Observation Services." Four hours later the physician wrote an order to admit the patient to inpatient status. These orders were written while the patient was still receiving care in the ED. Use the earlier order for Observation Services to abstract decision to admit time.

Change 9th bullet to:

- Data fields representing 'decision to admit' in electronic documentation for this specific episode of care are acceptable to use as long as they are the earliest physician/APN/PA documentation and clearly defined to capture the time an observation status or inpatient admit decision was documented. Information found in an electronically interfaced event log or Admit/Decision/Transfer (ADT) is acceptable provided this information is part of the submitted medical record covering the arrival to discharge time being abstracted.

Examples:

- Decision to Admit
- Dispo
- Disposition set to admit

Change first sentence of 10th bullet to:

For purposes of this data element, "*Decision to Admit Time*" is the time the physician/APN/PA communicates the decision to admit the patient to observation or inpatient status from the emergency department to the hospital.

Change 11th bullet to:

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

Change 12th bullet to:

- If documentation of the decision to admit to observation or inpatient status time is prior to arrival or after departure from the ED, select, "UTD".

Example:

The APN saw the patient in the clinic and sent him/her to the ED for admission. Select UTD.

Add new 13th bullet:

- *Decision to Admit Time* includes physician/APN/PA documentation of a decision to send the patient to cath lab or surgery.

Example:

The ED physician documents that he/she is sending the patient to the OR for surgery. The decision to admit to observation or inpatient status time will abstract as the time this was documented.

Suggested Data Sources:

Remove ONLY ACCEPTABLE SOURCES:

Add:

ONLY ACCEPTABLE SOURCES

PHYSICIAN/APN/PA DOCUMENTATION ONLY

Impacts:

Discharge Disposition

Rationale: Clarifications to assist abstractors in handling discharges to a Veterans Home and use of post-discharge dated documentation are being added.

Description of Changes:

Notes for Abstraction

Change 1st bullet to:

- **Only use documentation written on the day prior to discharge through 30 days after discharge** when abstracting this data element.

Remove 2nd bullet:

- 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.

Inclusion Guidelines for Abstraction - Other Health Care Facility (Value 5)

Add:

- Veterans Home
-

Impacts:

ED Departure Date

Rationale: Notes for Abstraction were clarified to capture the date and time of ED departure more consistently. Disposition was removed as an exclusion. Q and A questions reflect abstractor confusion over how to abstract data fields from an electronic health record. Clarification was added that it is allowable to use an Event Log, ADT etc. from an electronic medical record if ED departure date and time are noted.

Description of Changes:

Notes for Abstraction

Change 3rd bullet to:

- If the date of departure is not documented, but the date can be determined from other documentation in the ED record this is acceptable to use (the patient arrived and was transferred on the same day).

Add new 5th bullet:

- Data fields representing *ED Departure Date* in electronic documentation for this specific episode of care are acceptable to use as long as the fields are easily understood to mean departure. Information found in an electronically interfaced event log or Admit/Decision/Transfer (ADT) is acceptable provided this information is part of the submitted medical record covering the arrival to discharge date being abstracted.

Examples:

- Patient departed
- Patient transferred off the floor (OTF)
- Check out time
- Transported to

Add new 8th bullet:

- If there is a departure date listed within a disposition heading from the ED, this may be used for *ED Departure Date*

Change 9th bullet to:

- The inclusion list is not to be considered a comprehensive list of inclusions.

Inclusion Guidelines for Abstraction**Add:**

- ED Transport Date
- ED Checkout Date

Exclusion Guidelines for Abstraction**Remove:** Disposition Date**Add:** None**Impacts:***ED Departure Time*

Rationale: Notes for Abstraction were clarified to capture the date and time of ED departure more consistently. Disposition was removed as an exclusion. Q and A questions reflect abstractor confusion over how to abstract data fields from an electronic health record. Clarification was added that it is allowable to use an Event Log, ADT etc. from an electronic medical record if ED departure date and time are noted.

Description of Changes:Notes for Abstraction**Remove** in 2nd bullet: or awaiting transport to services/care.**Remove** 7th bullet:

- If patient expired in the ED, use the time of death as the departure time.

Add new 8th bullet:

- Data fields representing *ED Departure Time* in electronic documentation for this specific

episode of care are acceptable to use as long as the fields are easily understood to mean departure. Information found in an electronically interfaced event log or Admit/Decision/Transfer (ADT) is acceptable provided this information is part of the submitted medical record covering the arrival to discharge time being abstracted.

Examples:

- Patient departed
- Patient transferred off the floor (OTF)
- Check out time
- Transported to

Add new 9th bullet:

- If there is a departure time listed within a disposition heading from the ED, this may be used for *ED Departure Time*.

Inclusion Guidelines for Abstraction

Add:

- ED Transport Time

Exclusion Guidelines for Abstraction

Remove:

Disposition Time

Impacts:

Education Addresses Warning Signs and Symptoms of Stroke

Rationale: Correct typo.

Description of Changes:

Allowable Values:

Change “symtoms” to “symptoms”

Impacts:

First PCI Time

Rationale: Brand names are being removed from the specifications.

Description of Changes:

Notes for Abstraction

Change 4th bullet to:

- Use the **earliest time** from the following allowable times:
 1. Time of the first balloon inflation (Inflate #1, Balloon inflated, # ATM for # minutes/seconds, Time balloon deployed). If, however, there is documentation of a time associated with a balloon but not of a specific time that the balloon was inflated or deployed (e.g., “11:35 XYZ balloon” only), infer this to be the time of use, unless documentation suggests otherwise.
 2. Time of the first stent deployment (Time stent deployed, Time stent placed, Time stent inserted, Time stent expanded). If, however, there is documentation of a time associated with a stent but not of a specific time that the stent was deployed, placed, etc. (e.g., “11:35 XYZ stent” only), infer this to be the time deployed, placed, etc., unless documentation suggests otherwise.

3. Time of the first treatment of lesion with another device (Time thrombectomy device used, Time of aspiration, Time of suction, Time of device pass, Excimer time, Laser time, Time Rotablator used). If, however, there is documentation of a time associated with a device but not of a specific time that the device was used (e.g., "11:35 XYZ export cath" only), infer this to be the time of use, unless documentation suggests otherwise.

Impacts:*Follow-Up Contact**Follow-Up Contact Date*

Rationale: The current requirement to make at least 6 attempts to contact the patient after discharge for follow-up is very labor intensive. Reducing the number of attempts to three will lessen the burden. The inpatient medical record does not always allow for additional documentation of the follow up attempts and calls which may be done by outpatient or clinic staff after discharge. Additional data sources will allow hospitals to use these for evidence of follow up. Finally, some patients' conditions may change after discharge making them unable to answer the follow up questions which could be answered by others on their behalf.

Description of Changes:*Follow Up Contact Date*Notes for Abstraction**Add** new bullet:

- The follow up contact date must be documented in the inpatient medical record regardless of whom performs the follow up.

*Follow Up Contact*Allowable Values**Change** Allowable Value 3 from:

- 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

To:

- 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, at least 3 unsuccessful attempts to contact the patient were made or the patient refused permission for a third party to contact them on behalf of the hospital.

Notes for Abstraction**Change** the third and seventh bullets to:

- If follow-up contact was made and contact was made with a family member or other person who answered the questions on behalf of the patient only, select value "1".
- If trying to contact the patient and at least 3 attempts were made but were unsuccessful, select value "3". If less than 3 unsuccessful attempts were made select value "2".

Add two new bullets:

- An example of a third party contacting the patient on behalf of the hospital includes, but is not limited to a Tobacco Quitline.
- The follow up contact information must be documented in the inpatient medical record regardless of whom performs the follow up.

Impacts:*Glucose**Glucose POD 1**Glucose POD 2**Perioperative Death***Rationale:** The measure is being updated based on NQF and TEP recommendations.**Description of Changes:****Remove** data elements *Glucose POD 1* and *Glucose POD 2***Add** data element: *Glucose***Remove** SCIP-Inf-4 from the Collected for section in the data element *Perioperative Death***Impacts:***ICU Admission or Transfer***Rationale:** Explicit criteria and data sources are needed to support data element question.**Description of Changes:**Notes for Abstraction:**Change** First bullet under **PN** to:

- In order to select value "1" (yes) for this data element there must be a physician order for admission or transfer to an ICU AND documentation that the patient was transferred or admitted to the ICU within 24 hours following hospital arrival.

Change

Bullet under VTE to:

- **The patient was admitted or transferred to the ICU anytime during this hospitalization regardless of the patient location select value "1" (yes).**

Suggested Data Sources:**Change**

- Physician/APN/PA orders

Add:**PN ONLY****Impacts:***ICU Admission or Transfer Date***Rationale:** Abstraction guidance for records where patients have more than one admission to the ICU.

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

Fourth bullet to:

- If a patient has more than one admission to the ICU for more than one day, subsequent transfers back to an ICU during the same hospitalization will NOT be abstracted.

Suggested Data Sources:**Change**

- Physician/APN/PA orders

Impacts:

Infection Prior to Anesthesia

Rationale: Changes were made to the lists of Inclusions and Exclusions as infection.

Description of Changes:Notes for Abstraction

Change 5th bullet to:

- If there are two or more history and physicals (H&Ps), use the most current. To select, “Yes,” an H&P, consult, pre-op clearance, pre-op Chest X-ray or other form that is dated prior to admission that includes documentation of an infection, must be updated after admission and prior to surgery. It must be noted that there have been no changes since the form was filled out previously.

Add 6th and 7th bullet:

- Preoperative information such as an Active Problem List or other assessment form listing infections must be supported with documentation to reflect that the infection is current. The following example is not sufficient to abstract as a current infection:

Example:

Patient admitted on 04-10-20XX with the following Active Problem List (Diagnosis):
Diverticulitis Date Noted: 1-4-20XX

- If an infection is documented as chronic or recent there must be additional documentation that the infection is current or still present preoperatively.

Suggested Data Sources

In the Note under Excluded Data Sources

Change second sentence to:

This data element has an inclusion list to use as a guideline that provides the types of infection that are acceptable.

Inclusion Guidelines for Abstraction**Add:**

- Chronic Obstructive Pulmonary Disease (COPD) acute exacerbation
- Systemic Inflammatory Response Syndrome (SIRS)

Exclusion Guidelines for Abstraction**Add:**

- Fistulas without documentation of abscess or fecal contamination

- Orders for preoperative tests or screens without documentation of an infection or suspected infection
-

Impacts:

IV OR IA Thrombolytic (t-PA) Therapy Administered at This Hospital or Within 24 Hours Prior to Arrival

Rationale: Provide clarification for abstractor.

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

Documentation in the medical record must reflect that the patient received IV or IA thrombolytic (t-PA) therapy at this hospital or within 24 hours prior to arrival (i.e., drip and ship).

Inclusion Guidelines for Abstraction:

Change “Altepaste” to “Alteplase”

Exclusion Guidelines for Abstraction:**Change** “None” to:

- Heparin Flush
 - Heparin Lock
 - Thrombolytic administration to flush, open, or maintain patency of a central line, e.g., PICC line.
-

Impacts:

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

Rationale: Provide clarification for abstractor.

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

- For this measurement, look for the highest level from testing done within the first 48 hours after hospital arrival or within 30 days prior to hospital arrival.
 - Direct and calculated (indirect) LDL-c values are both acceptable.
 - Fasting and non-fasting LDL-c values are both acceptable.
 - 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”.
 - If all LDL-c value(s) from testing done within the first 48 hours after hospital arrival or within 30 days prior to hospital arrival are reported as not calculated (e.g., high triglycerides render the LDL-c calculation inaccurate), select “No”.
 - If an LDL-c value on the laboratory report conflicts with that from another source of documentation for the same specimen, use the value from the laboratory report.
 - If a laboratory report documents discrepant LDL-c values for the same specimen, use the highest value.
-

- If sources other than a laboratory report document discrepant LDL-c values for the same specimen, use the highest value.
- Disregard LDL-c values reported in units of mmol/L or any other unit of measurement other than mg/dL or mg/100 ml. If the unit of measurement is not documented, assume the unit of measurement is mg/dL.

Impacts:

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

Rationale: Provide clarification for abstractor.

Description of Changes:

Notes for Abstraction

Add:

“after hospital arrival”

Impacts:

LVF Assessment

Rationale: A duplicative Note for Abstraction bullet needs to be removed. The remaining bullet is being revised to provide a more realistic example of a "definitive plan" to assess LVSF after discharge.

Description of Changes:

Notes for Abstraction

Remove third bullet:

- Consider LVSF assessment as planned for after discharge only if a definitive plan is documented (e.g., “Will do echo as outpatient”). Documentation which indicates only that an LVSF assessment after discharge will be considered is not sufficient.

Change last bullet to:

- In determining whether there is a plan to assess LVSF after discharge, the plan must be documented as definitive (e.g., “Will measure EF next week”). Documentation which indicates only that an LVSF assessment after discharge will be considered (e.g., “May do echo in 1 month”) is not sufficient.

Impacts:

Monitoring Documentation

Rationale: The VTE Technical Advisory Panel recommended that abstraction guidelines be revised to clarify duration of IV Unfractionated Heparin and specify the exclusion of the route IV push.

Description of Changes:

Notes for Abstraction

Change fourth bullet to:

- If IV UFH was managed by a nomogram for less than 24 hours, but was discontinued prior to monitoring the platelet counts, select “Yes”.

Exclusion Guidelines for Abstraction**Change** header to:

Route

- Intravenous push
- IV push
- IVP
- One time dose

Impacts:*Overlap Therapy*

Rationale: This change is being made to remove the word “initiated” from the suggested data collection question and to specify the appropriate documentation needed to inquire if overlap therapy did occur. It will also separate the data element concepts of overlap therapy occurrence from a documented reason why the overlap therapy did not occur.

Description of Changes:Definition:**Change** to:

Documentation that parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation therapy and warfarin were both administered on the same day.

Suggested Data Collection Question**Change** to:

Were parenteral anticoagulation therapy and warfarin both administered on the same day anytime during the hospitalization?

Allowable Values:**Change** allowable value 1 to:

Y (YES) There is documentation that parenteral anticoagulation therapy and warfarin were both administered on the same day.

Change allowable value 2 to:

N (No) There is no documentation that parenteral anticoagulation therapy and warfarin were administered on the same day, or, unable to determine from medical record documentation.

Remove allowable value number 3:

Parenteral anticoagulation therapy and warfarin were **not** administered on the same day and there is no documentation of a reason for no overlap therapy or unable to determine from medical record documentation.

Notes for Abstraction**Remove** first bullet:

- If a patient refuses overlap therapy, select “2”.

Remove second bullet:

- The list of reasons for not administering overlap therapy is not all inclusive.

Add new first bullet:

- To select “Yes”, both parenteral anticoagulation therapy and warfarin must be administered and documented on the same calendar day at least one time.

Add new second bullet

- Substitution of one parenteral anticoagulation drug for another parenteral anticoagulation drug is still considered sufficient therapy.

Add new third bullet

- If conflicting documentation is present whether or not both warfarin and parenteral anticoagulation therapy were administered on the same day, select “No”.

Add new fourth bullet

- If there is documentation that the warfarin therapy is on a schedule other than daily or it is not clear that one dose was given along with parenteral therapy, select “No”.

Suggested Data Sources:**Change** to:

- Ambulance record
- Consultation notes
- Discharge summary
- Emergency department record
- History and physical
- Medication administration record
- Medication reconciliation form
- Nursing admission assessment
- Nursing notes
- Progress notes
- Transfer sheet

Inclusion Guidelines for Abstraction:**Remove** Header:

Reasons for not administering overlap therapy:

Remove first bullet:

- Surgical procedure

Remove second bullet:

- Bleeding complications

Remove third bullet:

Use of oral anticoagulants other than warfarin (such as Xarelto or rivaroxaban for treatment of VTE)

Impacts:

Pneumonia Diagnosis: ED/Direct Admit

Rationale: Various changes are being made to make the data element more readable, less repetitious by removing a duplicate bullet regarding pneumonia pathway, and more clear with respect to appropriate documentation.

Description of Changes:Notes for Abstraction**Change** the 6th bullet to:

- If there is any documentation of a diagnosis of “aspiration pneumonia” on an ONLY ACCEPTABLE SOURCE, select value “2.”

Example:

ED final diagnosis “Pneumonia vs. aspiration pneumonia.”

Direct Admits

Remove the last sentence in 6th bullet: A History & Physical can be used ONLY if the physician/APN/PA documents on one of the ONLY ACCEPTABLE SOURCES to “see H&P”, or the H&P is an Admit H&P written or dictated within 24 hours of arrival.

Add to the end of the 5th bullet: A History & Physical can be used ONLY if the physician/APN/PA documents on one of the ONLY ACCEPTABLE SOURCES to “see H&P”, or the H&P is an Admit H&P written or dictated within 24 hours of arrival.

Remove the 10th bullet: If the admit orders refer to a Pneumonia Pathway or equivalent, or the Pneumonia Pathway contains orders to admit, select value “1”.

Inclusion Guidelines for Abstraction

Add Lower respiratory tract infection

Impacts:

Prescription for Tobacco Cessation Medication

Referral for Outpatient Tobacco Cessation Counseling

Rationale: The current measure requires post discharge follow up for all patients whether they refused outpatient tobacco cessation counseling and/or tobacco cessation medication or not. Follow-up currently addresses compliance with outpatient treatment (counseling and/or medication) and quit status. Restricting the population for TOB-4 to patients who accepted counseling and/or medication will simplify the measure as desired by NQF and also substantially reduces the burden for follow up by hospitals.

Description of Changes:

Alphabetical Data Dictionary List

Add:

TOB-4 in column Collected For

Alphabetical Data Dictionary

Add:

TOB-4 to Collected For: The Joint Commission Only, and for CMS Informational Only

Impacts:

Reason for Alternative Empiric Antibiotic Therapy

Rationale: Rather than continuing to add antibiotic regimens to address rare conditions, a new data element has been created to exclude such patients from the measure population. The data elements *Compromised* and *Healthcare Associated Pneumonia* have been retired and combined into *Reason for Alternative Empiric Antibiotic Therapy* to allow for additions of other exclusions as the need arises and to keep the PN-6 antibiotic regimens evidence-based according to the guidelines.

Description of Changes:

Data Element List

Add: *Reason for Alternative Empiric Antibiotic Therapy*

Collected For**Add:** PN-6, PN-6a, PN-6bData Element**Add:** *Reason for Alternative Empiric Antibiotic Therapy***Impacts:***Reason for Delay in PCI***Rationale:** Brand names are being removed from the specifications.**Description of Changes:**Notes for Abstraction**Change** 3rd example under 2nd bullet to:

- “Thrombectomy catheter did not cross lesion. Balloon catheter successfully crossed the stenosis. Flow reestablished after 30 min. delay.”

Impacts:*Reason for Discontinuation of Parenteral Therapy***Rationale:** This change will define the timeframe for patients who have a hospital stay greater than five days and define requirements for explicit documentation.**Description of Changes:**Notes for Abstraction**Add** new first and second bullet:

- Reasons for discontinuation of parenteral therapy must be explicitly documented (e.g., “GI Bleed – Discontinue Lovenox”) or clearly implied (e.g., “Severe anemia, discontinue Heparin,” or “Actively Bleeding- Anticoagulation Contraindicated”).
- If reasons are not mentioned in the context of the discontinuation of the parenteral therapy, do not make inferences (e.g., Do not assume that Lovenox is not prescribed at discharge because of the patient’s history of anemia).

Change fourth 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. Select “Yes”.

Add fifth bullet:

- For patients with five or more days of overlap therapy and INR <2.0, explicit documentation of a reason for discontinuation of the parenteral therapy is needed to select “Yes”.

Add sixth bullet:

- For patients with less than five days of overlap therapy and discharged without parenteral anticoagulation therapy, explicit reason for discontinuation of the parenteral therapy is needed to select “Yes”.

Add seventh bullet:

- Overlap therapy days are calculated by taking the *Parenteral Anticoagulant End Date* minus the *Overlap Therapy Start Date*.

Add eighth bullet:

- Reasons for discontinuation of overlap therapy must be documented by a Physician/APN/PA or pharmacist within the same day that the parenteral therapy was discontinued.

Examples of Physician/APN/PA documentation include:

- Discontinue Lovenox therapy, INR 1.75, patient is actively bleeding. Select “Yes”.
- Discontinue Lovenox therapy, INR 1.75, home on warfarin. Select “No”.
- Discontinue Lovenox therapy, INR 6.0. Select “Yes”.

Add ninth bullet:

- Abstractors are not to infer reasons based on laboratory values alone, ONLY Physician/APN/PA or Pharmacist documentation of the specified reason is acceptable.

Add as last bullet:

- If rivaroxaban (Xarelto) is ordered or administered during hospitalization or prescribed at discharge, select “Yes.”

Inclusion Guidelines for Abstraction**Add header:****ONLY PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION OF A REASON FOR DISCONTINUING OF PARENTERAL THERAPY:****Add Sub-header:**

Acceptable terms synonymous with:

Change second bullet to:

- “High” INR value, supratherapeutic, INR >3.0

Change seventh bullet to:

- Patient received blood during overlap therapy

Add eleventh bullet:

- Use of oral anticoagulants other than warfarin (such as Xarelto or rivaroxaban for treatment of VTE)

Impacts:

Reason for No Aspirin at Discharge

Rationale: Apixaban/Eliquis and rivaroxiban/Xarelto are new FDA-approved direct Xa inhibitors for prevention of blood clots in patients with atrial fibrillation. These medications should be treated like warfarin in AMI-2: Use of either drug should count as an automatic reason for not prescribing ASA at discharge.

Description of Changes:**Definition****Change 2nd bullet to:**

- One or more of the medications listed in the Inclusion list were prescribed at discharge

Notes for Abstraction**Change** 3rd bullet and 1st sub-bullet to:

- When determining whether a medication listed in the Inclusion list was prescribed at discharge (i.e., a reason for not prescribing aspirin at discharge):
 - Include a medication on hold at discharge but there is documentation of a plan to restart it after discharge. E.g., “Resume Coumadin after INR normalizes.”

Inclusion Guidelines for Abstraction**Add** Inclusion list:**Discharge medications that count as an automatic reason for no aspirin:**

- Apixaban
- Coumadin
- Dabigatran
- Eliquis
- Jantoven
- Pradaxa
- Rivaroxiban
- Warfarin
- Warfarin Sodium
- Xarelto

Remove:

Refer to Appendix C, Table 1.4 for a comprehensive list of Warfarin medications.

Impacts:*Reason for No Aspirin on Arrival*

Rationale: Apixaban/Eliquis and rivaroxiban/Xarelto are new FDA-approved direct Xa inhibitors for prevention of blood clots in patients with atrial fibrillation. These medications should be treated like warfarin in AMI-1: Use of either drug should count as an automatic reason for not giving ASA on arrival.

Description of Changes:Definition**Change** 2nd bullet to:

- One or more of the medications listed in the Inclusion list as pre-arrival medication

Notes for Abstraction**Change** 4th bullet to:

- Consider a medication listed in the Inclusion list to be a pre-arrival medication (a reason for not prescribing aspirin on arrival) if there is documentation the patient was on it prior to arrival, regardless of setting. Include cases where there is indication the medication was on temporary hold or the patient has been non-compliant/self-discontinued their medication (e.g., refusal, side effects, cost).

Inclusion Guidelines for Abstraction**Add** Inclusion list:**Pre-arrival medications that count as an automatic reason for no aspirin:**

- Apixaban

- Coumadin
- Dabigatran
- Eliquis
- Jantoven
- Pradaxa
- Rivaroxiban
- Warfarin
- Warfarin Sodium
- Xarelto

Remove:

Refer to Appendix C, Table 1.4 for a comprehensive list of Warfarin medications.

Impacts:

Reason for No Tobacco Cessation Medication During the Hospital Stay

Rationale: The current measure requires a review of the entire hospitalization for evidence of the reason that the patient did not receive cessation medication. Restricting the timeframe to within 3 days of admission for TOB-2 will simplify the measure as desired by the Technical Advisory Panel (TAP) and also substantially reduces the burden of abstraction for hospitals.

Description of Changes:Definition**Change to:**

Reasons for not administering an FDA-approved tobacco cessation medication documented during the first three days of admission include:

- Allergy to all of the FDA-approved tobacco cessation medications.
- Drug interaction (for all of the FDA-approved medications) with other drugs the patient is currently taking.
- Other reasons documented by physician, advanced practice nurse (APN), physician assistant (PA), or pharmacist

Suggested Data Collection Question**Change to:**

Is there documentation of a reason for not administering one of the FDA-approved tobacco cessation medications during the first three days of admission?

Allowable Values**Change from:**

- | | |
|---------|---|
| Y (Yes) | There is documentation of a reason for not administering an FDA-approved cessation medication during the hospital stay. |
| N (No) | There is no documentation of a reason for not administering an FDA-approved cessation medication during the hospital stay or unable to determine from medical record documentation. |

To:

Y (Yes) There is documentation of a reason for not administering an FDA-approved cessation medication during the first three days of admission.

N (No) There is no documentation of a reason for not administering an FDA-approved cessation medication during the first three days of admission or unable to determine from medical record documentation.

Notes for Abstraction**Add** new bullet:

The timeframe for documenting a reason for not administering FDA-approved tobacco cessation medications must have occurred within the first three days of admission. The day after admission is defined as the first day.

Impacts:*Reason for No Tobacco Cessation Medication During the Hospital Stay*

Rationale: The current measure requires a review of the entire hospitalization for evidence of the reason that the patient did not receive cessation medication. Restricting the timeframe to within 3 days of admission for TOB-2 will simplify the measure as desired by the Technical Advisory Panel (TAP) and also substantially reduces the burden of abstraction for hospitals.

Description of Changes:Definition**Change** to:

- Reasons for not administering an FDA-approved tobacco cessation medication documented during the first three days of admission include:
- Allergy to all of the FDA-approved tobacco cessation medications.
- Drug interaction (for all of the FDA-approved medications) with other drugs the patient is currently taking.
- Other reasons documented by physician, advanced practice nurse (APN), physician assistant (PA), or pharmacist

Suggested Data Collection Question**Change** to:

Is there documentation of a reason for not administering one of the FDA-approved tobacco cessation medications during the first three days of admission?

Allowable Values**Change** from:

Y (Yes) There is documentation of a reason for not administering an FDA-approved cessation medication during the hospital stay.

N (No) There is no documentation of a reason for not administering an FDA-approved cessation medication during the hospital stay or unable to determine from medical record documentation.

To:

Y (Yes) There is documentation of a reason for not administering an FDA-approved cessation medication during the first three days of admission.

- N (No) There is no documentation of a reason for not administering an FDA-approved cessation medication during the first three days of admission or unable to determine from medical record documentation.

Notes for Abstraction

Add new bullet:

The timeframe for documenting a reason for not administering FDA-approved tobacco cessation medications must have occurred within the first three days of admission. The day after admission is defined as the first day.

Impacts:

Reason for No VTE Prophylaxis – Hospital Admission

Rationale: Clarifications of time frame and reasons acceptable for documentation based on questions submitted, and Technical Advisory Panel suggestions.

Description of Changes:

Definition

Change to:

Documentation why mechanical AND pharmacologic VTE prophylaxis was not administered at hospital admission.

Notes for Abstraction

Change 1st bullet to:

- To select “Yes” for this data element, documentation of a reason for not administering mechanical AND pharmacological VTE prophylaxis must be dated from arrival, to the day after hospital admission or surgery end date.

Remove sub-bullet under 1st 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.

Change 2nd bullet to:

- Documentation written after arrival but prior to admission is acceptable.

Change 4th bullet to:

- For patients documented to be **AT RISK FOR VTE** (All patients NOT documented to be “low risk”) documentation of a contraindication of mechanical and pharmacological prophylaxis must be addressed.

Change sub-bullets under 4th bullet to:

Examples

- If there is physician documentation of “bleeding, no pharmacologic prophylaxis”, review the chart for documentation about mechanical prophylaxis such as “no mechanical prophylaxis needed” to select “Yes.”
- Reasons must be explicitly documented (e.g., “Active GI bleed –low molecular weight heparin (LMWH) contraindicated, No mechanical prophylaxis needed” select “Yes”
- “No enoxaparin, no mechanical prophylaxis needed”, select “Yes.”

Add example with sub-bullet under 5th bullet:

Example:

“Bleeding risk” , review the chart for documentation about reasons for no mechanical AND pharmacological VTE Prophylaxis.

Add new 6th and 7th bullet:

- Documentation that the patient is ambulating without mention of VTE prophylaxis is insufficient. Do not infer that VTE prophylaxis is not needed unless explicitly documented.
- For patients with a reason for no pharmacologic or no mechanical prophylaxis and an order for ANY prophylaxis that was **not** administered without a reason_(e.g. patient refusal), select “No.”

Add new 8th bullet with sub-bullets:

- Reasons for not administering VTE prophylaxis must be documented by a physician/APN/PA or pharmacist.

EXCEPTIONS:

- Risk Assessment form may be completed by a nurse.
- Patient/family refusal may be documented by a nurse, but should be documented within the same timeframe as the reason for no VTE prophylaxis. Patient/family refusal of any form of prophylaxis is acceptable to select “Yes.” For example, “patient refused heparin,” select “Yes.”

Change 9th bullet

For patients determined to be **AT LOW RISK** for VTE:

Change 3rd sub-bullet under 9th bullet to:

- If it is documented that the patient is at low risk for VTE and does not need VTE prophylaxis, select “Yes.”

Example:

“Low Risk, No VTE Prophylaxis”

Change 10th bullet to:

If there are multiple completed risk assessments with conflicting outcomes within this timeframe, select “No”.

Add header after 10th bullet

Exceptions

Change 14th bullet to:

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

Add after last bullet:

STK

- 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.

Exclusion Guidelines for Abstraction**Remove:**

None

Add:

Aspirin

Impacts:*Reason for No VTE Prophylaxis – ICU Admission*

Rationale: Clarifications of time frame and reasons acceptable for documentation based on questions submitted, and Technical Advisory Panel suggestions.

Description of Changes:Definition**Change to:**

Documentation why mechanical AND pharmacologic VTE prophylaxis was not administered at ICU admission/transfer.

Notes for Abstraction**Change to:**

- To select “Yes” for this data element, documentation of a reason for not administering mechanical AND pharmacological VTE prophylaxis must be dated from arrival to the day after ICU admission/transfer or surgery end date for those surgeries that start the day of or the day after ICU admission/transfer.
- Documentation written after arrival to the ICU, but prior to the decision to admit is acceptable.
- If a patient did not receive VTE prophylaxis on the medical unit due to physician documentation and is transferred to the ICU, another reason (even if it is the same reason) must be documented if no VTE prophylaxis was administered upon admission/transfer to ICU.
- If there is conflicting information about the need for prophylaxis, select “No”.
- For patients documented to be **AT RISK FOR VTE** (All patients NOT documented to be “low risk”) documentation of a contraindication of mechanical and pharmacological prophylaxis must be addressed.

Example

- If there is physician documentation of “bleeding, no pharmacological prophylaxis”, review the chart for documentation about mechanical prophylaxis such as “no mechanical prophylaxis needed” to select “Yes.”
- Reasons must be explicitly documented (e.g., “Active GI bleed –low molecular weight heparin (LMWH) contraindicated, No mechanical prophylaxis needed” select “YES”.
- “No enoxaparin, no mechanical prophylaxis needed”, select “Yes”.

- **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).

Example:

“Bleeding risk” , review the chart for documentation about reasons for no mechanical AND pharmacological VTE Prophylaxis.

- Documentation that the patient is ambulating without mention of VTE prophylaxis is insufficient. Do not infer that VTE prophylaxis is not needed unless explicitly documented.
- Reasons for not administering VTE prophylaxis must be documented by a physician/APN/PA or pharmacist.

EXCEPTIONS:

- Risk Assessment form may be completed by a nurse.
- Patient/family refusal may be documented by a nurse, but should be documented within the same timeframe as the reason for no VTE prophylaxis. Patient/family refusal of any form of prophylaxis is acceptable to select “Yes.” For example, “patient refused heparin,” select “Yes.”
- For patients documented 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.”
 - A completed nursing risk assessment within this timeframe is an acceptable source for this data element.
 - If it is documented that the patient is at low risk for VTE and does not need VTE prophylaxis, select “Yes.”

Example:

“Low Risk, No VTE Prophylaxis”, select “Yes”.

- If there are multiple completed risk assessments with conflicting outcomes within this timeframe, select “No.”

EXCEPTIONS:

- For patients on continuous IV heparin therapy the day of or day after ICU admission, select “Yes”.
- For patients on warfarin therapy prior to ICU admission, but placed on hold due to “high INR”, select “Yes”.
- For patients receiving anticoagulant therapy other than warfarin for atrial fibrillation or other conditions the day of or the day after ICU admission/transfer, select “Yes”.
- 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”.

Examples:

- Patient arrives in the ED on 06/01/20xx but is in observation until admission to the ICU on 06/03/20xx. If CMO is documented by 06/04/20xx, select “Yes”.
- The patient was admitted on 05/31/20xx and the surgery end date was 06/01/20xx, select “Yes” if CMO was documented by 06/02/20xx

Inclusion Guidelines for Abstraction**Change** header to:**Reasons for not administering any mechanical AND pharmacologic prophylaxis:**Exclusion Guidelines for Abstraction**Remove:**

None

Add:

Aspirin

Impacts:*Reason for Not Administering **Antithrombotic** Therapy by End of Hospital Day 2***Rationale:** Provide clarification for abstractor. Align with “*Reason for Not Prescribing **Antithrombotic** Therapy at Discharge.*”**Description of Changes:**Notes for Abstraction**Change** the first bullet to the second bullet:

- To compute end of hospital day 2, count the arrival date as hospital day 1. If a reason for not administering antithrombotic therapy was documented by 11:59 P.M. of hospital day 2, select “Yes” for this data element.

Change the fifth bullet to the first bullet:

- Documentation for allowable value “Yes” 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.

Change the second bullet to the third bullet:

- Reasons for not administering antithrombotic therapy must be documented by a physician/APN/PA or pharmacist with one exception: Patient/family refusal of any form of antithrombotic therapy (e.g., “ASA refused”, “Patient refusing antithrombotic therapy”) may be documented by a nurse. However, it must be documented in the timeframe of arrival to the end of hospital day 2.

Example: Patient arrived on 03/01/XX. Nursing notes on 03/02/20XX indicates that patient refused antithrombotic therapy, select “YES”.

Change the third bullet to the fourth bullet:

- **If reasons are not mentioned in the context of antithrombotics, do not make inferences** (e.g., do not assume that antithrombotic therapy was not administered because of a bleeding disorder unless documentation explicitly states so).
 - Reasons must be explicitly documented (e.g., “Hemorrhagic transformation – do not give aspirin”, “Active GI bleed – antithrombotic therapy contraindicated”, “H/O bleeding disorder – anticoagulation therapy contraindicated”, “Low platelet count - do not give antiplatelet medications”, “No ASA” [no reason given]).
 - Physician/APN/PA or pharmacist documentation of a hold on an antithrombotic medication or discontinuation of an antithrombotic medication that occurs the day of or day after hospital arrival constitutes a “clearly implied” reason for not administering antithrombotic therapy by end of hospital day 2. A hold/discontinuation of all p.o. medications counts if an antithrombotic was on order at the time of the notation.

Change the sixth bullet to the fifth bullet:

- An allergy or adverse reaction to one type of antithrombotic would NOT be a reason for not administering all antithrombotics. Another medication can be ordered.

Change the eighth bullet to the sixth bullet:

- For patients on warfarin therapy prior to hospital arrival, but placed on hold the day of or after arrival due to “high INR”, select “Yes”.

Notes for Abstraction

Remove the fourth bullet:

- See the inclusion list for acceptable reasons for not administering antithrombotic therapy. The list is not all-inclusive.

Remove the seventh bullet:

- Physician/APN/PA or pharmacist documentation of a hold on an antithrombotic medication or discontinuation of an antithrombotic medication that occurs the day of or day after hospital arrival constitutes a “clearly implied” reason for not administering antithrombotic therapy by end of hospital day 2. A hold/discontinuation of all p.o. medications counts if an antithrombotic was on order at the time of the notation.

Inclusion Guidelines for Abstraction

Change “Reason for not administering antithrombotic therapy by end of hospital day 2:” to “Examples:”

Inclusion Guidelines for Abstraction

Change “Allergy to or complication related to antithrombotic” to “Allergy to all antithrombotic medications”

Inclusion Guidelines for Abstraction

Remove

- Other documented by physician/APN/PA or pharmacist

Add

Refer to Appendix C, Table 8.2 for a comprehensive list of Antithrombotic Medications

Exclusion Guidelines for Abstraction

Change

“Orders to hold antithrombotic therapy without a documented reason” to “None”

Impacts:

Reason for Not Administering VTE Prophylaxis

Rationale: The data element is being updated to provide clarification to the abstractors.

Description of Changes:

Definition:

Change to:

Reason for not administering both mechanical and pharmacological venous thromboembolism (VTE) prophylaxis.

Suggested Data Collection Question:**Change to:**

Is there documentation by a physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist in the medical record of a reason for not administering both mechanical and pharmacological VTE prophylaxis?

Allowable Values:**Change to:**

- Y (Yes) There is physician/APN/PA or pharmacist documentation of a reason for not administering both mechanical and pharmacological VTE prophylaxis.
- N (No) There is no physician/APN/PA or pharmacist documentation of a reason for not administering either mechanical or pharmacological VTE prophylaxis or unable to determine from medical record documentation.

Notes for Abstraction:**Change to:**

- To select “Yes,” there must be physician/APN/PA or pharmacist documentation of reasons for not administering BOTH mechanical and pharmacological prophylaxis.
- Physician documentation of the VTE risk level alone is not sufficient as a reason. The physician/APN/PA or pharmacist must document an inclusion or a specific reason for not administering pharmacological and mechanical VTE prophylaxis.

EXCEPTION:

For General Surgeries only: If there is documentation of a Roger’s VTE risk factor score < 7 or a Caprini VTE risk factor score of 0 (zero), select value “Yes”. Refer to Appendix A, Table 5.19, General Surgery.

- Reasons for not administering VTE prophylaxis must be documented within the timeframe of arrival to 24 hours after *Anesthesia End Time*. It is not necessary to review documentation outside of this timeframe to answer this data element.
- To select “Yes” based on patient refusal, there must be documentation that the patient refused both pharmacological and mechanical prophylaxis. Patient refusal does not have to be documented by a physician/APN/PA or pharmacist, but it must be documented in the timeframe from arrival to 24 hours after *Anesthesia End Time*.
- See the inclusion list for examples of acceptable reasons for not administering prophylaxis. See the exclusion list for examples of unacceptable reasons for not administering prophylaxis. These lists are not all-inclusive.
- An allergy or adverse reaction to one type of pharmacological prophylaxis is NOT sufficient as a reason for not administering all pharmacological prophylaxis. Another medication can be ordered. Example: Physician documentation of, “No coumadin due to allergy.” This is not sufficient as a reason for not administering all pharmacological VTE prophylaxis.
- If the physician orders a transfusion and the blood products are administered in the timeframe of arrival to 24 hours after *Anesthesia End Time*, it is sufficient as a reason for not administering pharmacological VTE prophylaxis.
- Re-infusion of blood products collected with blood recovery systems, plasma or volume expanders and platelet gels are not considered sufficient as a reason for not administering pharmacological VTE prophylaxis.

- Blood or blood products documented on the anesthesia record or in the operative report as administered intraoperatively (during surgery), do not require a physician order to be sufficient as a reason for not administering pharmacological VTE prophylaxis.
- For patients on continuous IV heparin therapy within 24 hours before or after surgery, select “Yes.”
- Physician documentation of a bleeding risk or active bleeding in reference to the normal risk of bleeding or to the normal bleeding associated with surgery, is not sufficient as a reason for not administering pharmacological VTE prophylaxis.
- A timeframe for starting or holding VTE prophylaxis is not sufficient as a reason for not administering VTE prophylaxis in the allowable timeframe. Example: “Hold heparin 48 hours postop.” This is an order to hold but does not include a reason.
- There must be documentation indicating which type, pharmacological or mechanical prophylaxis, the reason applies to. Whether or not the reason applies to either or to both mechanical and pharmacological prophylaxis must be indicated in the documentation. Example: “No heparin due to bleeding risk.” It is clear that this reason applies only to pharmacological prophylaxis.
- If pharmacological VTE prophylaxis is not administered based on physician parameters, there must be substantiating documentation. Example: Hold heparin for INR > 2.5. To be sufficient as a reason, there must be documentation that the heparin was held due to an INR value > 2.5 during that same timeframe.

Inclusion Guidelines for Abstraction:

Add: to Reasons for not administering mechanical prophylaxis:

- Arterial insufficiency of lower extremities

Impacts:

*Reason for Not Prescribing **Anticoagulation** Therapy at Discharge*

Rationale: Provide clarification for abstractor.

Description of Changes:

Inclusion Guidelines for Abstraction

Change “Reasons for not prescribing anticoagulation therapy at of hospital discharge:” to “Examples:”

Inclusion Guidelines for Abstraction

Remove:

- Other documented by physician/APN/PA or pharmacist

Inclusion Guidelines for Abstraction

Add:

Refer to Appendix C, Table 8.3 for a comprehensive list of Anticoagulant Medications

Impacts:

*Reason for Not Prescribing **Antithrombotic** Therapy at Discharge*

Rationale: Provide clarification for abstractor.

Description of Changes:Notes for Abstraction**Change** second bullet to:

- **If reasons are not mentioned in the context of antithrombotics, do not make inferences** (e.g., do not assume that antithrombotic therapy was not prescribed because of a bleeding disorder unless documentation explicitly states so).
 - Reasons must be explicitly documented (e.g., “Active GI bleed – antithrombotic therapy contraindicated”, “H/O bleeding disorder – anticoagulation therapy contraindicated”, “Low platelet count - do not give antiplatelet medications”, “No ASA” [no reason given]).

Inclusion Guidelines for Abstraction**Change** “Reasons for not prescribing antithrombotic therapy at of hospital discharge:” to “Examples:”Inclusion Guidelines for Abstraction**Remove:**

- Other documented by physician/APN/PA or pharmacist

Inclusion Guidelines for Abstraction**Add:**

Refer to Appendix C, Table 8.2 for a comprehensive list of Antithrombotic Medications

Impacts:*Reasons to Extend Antibiotics*

Rationale: Additional reasons for the extended use of postoperative antibiotics are being added to the Allowable Values along with correction in the verbiage used in the Notes for Abstraction. Changes were made to the lists of Inclusion and Exclusions as documentation of infection.

Description of Changes:Allowable Values:**Change** Value 3 to:

- 3 There is physician/APN/PA documentation of any of (and only) the following reasons to extend antibiotics:
 - Erythromycin was administered postoperatively for the purpose of increasing gastric motility.
 - An antibiotic was administered postoperatively for the treatment of hepatic encephalopathy.
 - An antibiotic was administered postoperatively for the treatment of pulmonary fibrosis.
 - An antibiotic was administered postoperatively as prophylaxis of *Pneumocystis pneumonia (PCP)*.
 - Demeclocycline was administered postoperatively for the treatment of syndrome of inappropriate antidiuretic hormone hypersecretion (SIADH) or hyponatremia.
 - An antibiotic was administered postoperatively for the treatment of acne or rosacea.

Notes for Abstraction:**Change** in the first bullet under the section, **For Value 1:**

The word *Time* to the word *Date*

Delete in the 2nd bullet under the section, **For Value 3:**

The first “3”

Inclusion Guidelines for Abstraction:**Add:**

- Chronic Obstructive Pulmonary Disease (COPD),
- Systemic Inflammatory Response Syndrome (SIRS)

Exclusion Guidelines for Abstraction:**Add:**

- Fistulas without documentation of abscess or fecal contamination
- Orders for tests or screens without documentation of an infection or suspected infection

Impacts:

Surgical Incision Date

Rationale: Clarification is being added to ensure the abstraction of the correct date for the surgical incision.

Description of Changes:Notes for Abstraction:**Change** the EXCEPTIONS to:

- A. **Cystoscopy:** If a patient has a cystoscopy after 00:00 (midnight) prior to the principal procedure during the same surgical episode, AND antibiotics were given prior to this procedure, use the start date for the cystoscopy. If no antibiotics were given prior to the start of the cystoscopy, use the date that the principal procedure began as the *Surgical Incision Date*.
Example:
Anesthesia start date and time is 01-01-20xx at 2300. Antibiotics are given at 2345. Cysto is started at 0015. Abstract the *Surgical Incision Date* as 01-02-20xx as it is clear that the date would change if the cysto was started after 00:00.
- B. **Laparoscopy to Open:** If the first procedure is a laparoscopic procedure or a procedure performed with a scope (ex: colonoscopy) **AND** antibiotics were given prior to the first procedure and it is followed by an open procedure, abstract the start/begin date (or other synonym) that is documented for the first procedure.

If the procedure starts as a laparoscopic procedure or a procedure performed with a scope (ex: colonoscopy) **AND** antibiotics were NOT given prior to this procedure and it is followed by an open procedure, abstract the *Surgical Incision Date* that is documented for the open procedure.
- C. **Multiple Procedures:** If multiple procedures occur during the **same surgical episode** and the incision for the principal procedure is not the first incision made, the *Surgical Incision Date* captured will be the date that the first incision occurs.

Impacts:*Surgical Incision Time*

Rationale: Clarification is being added to ensure the abstraction of the correct time for the surgical incision.

Description of Changes:Notes for Abstraction:

Add as the last bullet:

- If the incision time is obviously an erroneous time and there is additional documentation of the correct time associated with the same priority term, the correct time should be abstracted.

Example:

The time to OR is documented correctly as 1400. There are two documents with incision times of 1115 and 1415. Both are associated with the term incision. Abstract the incision time as 1415.

Change the EXCEPTIONS to:

- Cystoscopy:** If a patient has a cystoscopy prior to the principal procedure, during the same surgical episode, AND antibiotics were given prior to this procedure, use the start/begin time (or other synonym) for the cystoscopy.
If no antibiotics were given prior to the start of the cystoscopy, use the time that the principal procedure began as the *Surgical Incision Time*.
- Laparoscopy to Open:** If the first procedure is a laparoscopic procedure or a procedure performed with a scope (ex: colonoscopy) **AND** antibiotics were given prior to the first procedure and it is followed by an open procedure, abstract the start/begin time (or other synonym) that is documented for the first procedure.
If the procedure starts as a laparoscopic procedure or as a procedure performed with a scope (ex: colonoscopy) **AND** antibiotics were NOT given prior to this procedure and it is followed by an open procedure, abstract the *Surgical Incision Time* that is documented for the open procedure.
- Multiple Procedures:** If multiple procedures occur during the **same surgical episode** and the incision for the principal procedure is not the first incision made, the *Surgical Incision Time* captured will be for the incision that occurs first and the *Anesthesia End Time* will be the end time that occurs last.

Impacts:*Tobacco Use Status*

Rationale: The current specifications have 14 different allowable values which have been difficult to abstract from the medical record. Combining allowable values will reduce the burden of data abstraction.

Description of Changes:Definition

Change to:

Documentation of the adult patient's tobacco use status within the past 30 days prior to the day of hospital admission. Tobacco use includes all forms of tobacco including cigarettes,

smokeless tobacco products, pipe, and cigars. A tobacco use screen should identify the type of tobacco product used, the volume used, and the timeframe of use.

Allowable Values

Change from:

- 1 The patient has smoked cigarettes on average in a volume of more than five cigarettes per day during the past 30 days.
- 2 The patient has smoked cigarettes on average in a volume of five or less cigarettes per day during the past 30 days.
- 3 The patient smokes cigarettes but does not smoke daily.
- 4 The patient has used smokeless tobacco products in the past 30 days.
- 5 The patient has smoked a pipe or cigar daily in the past 30 days.
- 6 The patient has not used any forms of tobacco in the past 30 days.
- 7 The patient refused the tobacco use screen.
- 8 The patient was not screened for tobacco use during this hospitalization or unable to determine the patient's tobacco use status from medical record documentation.
- 9 The patient has smoked cigarettes on average in a volume of more than five cigarettes per day during the past 30 days and has used smokeless tobacco products in the past 30 days.
- 10 The patient has smoked cigarettes on average in a volume of more than five cigarettes per day during the past 30 days, has used smokeless tobacco products in the past 30 days, and has smoked a pipe or cigars daily in the past 30 days.
- 11 The patient has smoked cigarettes on average in a volume of five or less cigarettes per day during the past 30 days and has used smokeless tobacco products in the past 30 days.
- 12 The patient has smoked cigarettes on average in a volume of five or less cigarettes per day during the past 30 days and has smoked a pipe or cigars daily in the past 30 days, and has used smokeless tobacco products in the past 30 days.
- 13 The patient has smoked cigarettes on average in a volume of five or less cigarettes per day during the past 30 days and has smoked a pipe or cigars daily in the past 30 days.
- 14 The patient has smoked cigarettes on average in a volume of more than five cigarettes per day during the past 30 days and has smoked a pipe or cigars daily in the past 30 days.

To:

- 1 The patient has smoked cigarettes daily on average in a volume of five or more cigarettes (=>1/4 pack) per day and/or cigars daily and/or pipes daily during the past 30 days.
- 2 The patient has smoked cigarettes daily on average in a volume of four or less cigarettes (< 1/4 pack) per day and/or used smokeless tobacco and/or smoked cigarettes but not daily and/or cigars but not daily and/or pipes but not daily during the past 30 days.
- 3 The patient has not used any forms of tobacco in the past 30 days.
- 4 The patient refused the tobacco use screen.
- 5 The patient was not screened for tobacco use during this hospitalization or unable to determine the patient's tobacco use status from medical record documentation.

Notes for Abstraction

Remove second and seventh bullets:

- If the patient is non-daily smoker (occasional smoker) information should be collected on the number of days they smoked during the past 30 days and the number of cigarettes smoked on those days.
- If the patient is only using chew plus pipe or cigars, select allowable value "5" if the volume of cigar/pipe use is daily, otherwise select allowable value "4".

Change the sixth and seventh bullets to:

- When there is conflicting information in the record with regard to volume, for instance, one document indicates patient is a light smoker and another indicates patient is a volume greater than light smoking; select the allowable value "1" indicating the heaviest usage.
- If the medical record indicates the patient smokes cigarettes and the volume is not documented or is unknown, assume smoking at the heaviest level and select allowable value "1".

Add new bullet:

- The tobacco use status screening timeframe must have occurred within the first three days of admission. The day after admission is defined as the first day.

Impacts:

Tobacco Use Treatment FDA-Approved Cessation Medication

Rationale: The current measure requires a review of the entire hospitalization for evidence of the patient receiving cessation medication. Restricting the timeframe to within 3 days of admission for TOB-2 will simplify the measure as desired by the Technical Advisory Panel (TAP) and also substantially reduces the burden of abstraction for hospitals.

Description of Changes:

Suggested Data Collection Question

Change to:

Did the patient receive one of the FDA-approved tobacco cessation medications during the first three days after admission?

Allowable Values**Change** from:

- 1 The patient received one of the FDA-approved tobacco cessation medications during the hospital stay.
- 2 The patient refused the FDA-approved tobacco cessation medications during the hospital stay.
- 3 FDA-approved tobacco cessation medications were not offered to the patient during the hospital stay or unable to determine from medical record documentation.

To:

- 1 The patient received one of the FDA-approved tobacco cessation medications during the first three days after admission.
- 2 The patient refused the FDA-approved tobacco cessation medications during the first three days after admission.
- 3 FDA-approved tobacco cessation medications were not offered to the patient during the first three days after admission or unable to determine from medical record documentation.

Notes for Abstraction**Add** new bullet:

- The timeframe for receiving FDA-approved tobacco cessation medications must have occurred within the first three days of admission. The day after admission is defined as the first day.

Impacts:

Tobacco Use Treatment Practical Counseling

Rationale: The current measure requires a review of the entire hospitalization for evidence of practical counseling received. Restricting the timeframe to within 3 days of admission for TOB-2 will simplify the measure as desired by the Technical Advisory Panel (TAP) and also substantially reduces the burden of abstraction for hospitals.

Description of Changes:Suggested Data Collection Question**Change** to:

Did the patient receive all of the components of practical counseling during the first three days after admission?

Allowable Values**Change** from:

- 1 The patient received all components of practical counseling prior to discharge.
- 2 The patient refused/declined practical counseling.

- 3 Practical counseling was not offered to the patient during the hospital stay or unable to determine if tobacco use treatment was provided from medical record documentation.

To:

- 1 The patient received all components of practical counseling during the first three days after admission.
- 2 The patient refused/declined practical counseling during the first three days after admission.
- 3 Practical counseling was not offered to the patient during the first three days after admission or unable to determine if tobacco use treatment was provided from medical record documentation.

Notes for Abstraction

Add new bullet:

- The timeframe for receiving practical counseling must have occurred within the first three days of admission. The day after admission is defined as the first day.

Impacts:

UFH Therapy Administration

Rationale: The VTE Technical Advisory Panel recommended that abstraction guidelines be revised to specify the exclusion of the route IV push.

Description of Changes:

Exclusion Guidelines for Abstraction:

Change header to:

Route

- IV push
- IVP
- Intravenous push
- One time dose

Impacts:

Vancomycin

Rationale: An MRSA positive test result (screen or culture) should not require physician/APN/PA or pharmacist documentation to suffice as a reason for the use of vancomycin.

Description of Changes:

Allowable Values:

Change Value 2

From:

Physician/APN/PA or pharmacist documentation of MRSA colonization or infection.

To:

Documentation of colonization with MRSA, a positive MRSA screen, an MRSA infection, or a history of MRSA.

Notes for Abstraction:

Remove in the 1st bullet:
the Examples.

Remove in the 2nd bullet:
“2”

Suggested Data Sources:

Add: Laboratory reports

Impacts:

VTE Prophylaxis

Rationale: The measure specifications are being revised to maintain consistency with the updated American College of Chest Physicians’ guidelines on prevention of VTE in surgical patients.

Description of Changes:

Format

Change Occurs to: 1-9

Allowable Values

Add Value 9 Aspirin.

Notes for Abstraction, ALL section:

Add 2nd bullet:

Application of mechanical prophylaxis may be documented by any personnel.

Example:

Nursing assistant documentation of IPC application during the allowable timeframe is acceptable.

Notes for Abstraction, SCIP section:

Add 3rd bullet:

To select value “9,” there must be an order for aspirin for VTE prophylaxis. For hip and knee arthroplasties, aspirin must be received in the timeframe specified for *VTE Timely*.

Notes for Abstraction, VTE or STK section:

Change 8 to 9 in the first bullet.

Add 4th bullet:

Aspirin is not an approved medication for prophylaxis in the VTE and STK population. If aspirin is the only source of prophylaxis found in the record, select “A”, and check for a *Reason for No VTE Prophylaxis*.

Impacts:*VTE Prophylaxis Status*

Rationale: To specify acceptable inclusion criteria for “reason for no prophylaxis” for those records that have a documented acquired VTE during the hospital stay.

Description of Changes:Notes for Abstraction

Add last bullet

- For patients receiving anticoagulant therapy other than warfarin for atrial fibrillation or other conditions, select “3”.

Inclusion Guidelines for Abstraction:

Add header

THIS LIST IS ALL INCLUSIVEReason for not administering mechanical prophylaxis:

Add sub-header

Acceptable terms synonymous with:

Reasons for not administering pharmacological prophylaxis:

Add sub-header

Acceptable terms synonymous with:

Add 8th bullet

- Anticoagulant therapy other than warfarin for atrial fibrillation or other conditions

Impacts:*VTE Timely*

Rationale: Allowable value 9 has been added to the data element VTE Prophylaxis.

Description of Changes:Format

Occurs to:

Change to: 1-9

SECTION 2 – Measurement Information

Subsection 2.1 – Acute Myocardial Infarction (AMI)

Impacts:

Measure(s)

AMI-1
 AMI-2
 AMI-3
 AMI-5
 AMI-7
 AMI-7a
 AMI-8
 AMI-8a
 AMI-10

Rationale: Clarification is needed for collection of retrospective and concurrent data. This change will provide consistency in the measure information forms (MIFs) for each measure topic.

Description of Changes:

Data Collection Approach

Change to:

Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-9-CM diagnosis and procedure codes, which require retrospective data entry.

Impacts:

AMI Data Element List

Rationale: Footnotes are being removed because the “collected for” designation is already referenced in each data element.

Description of Changes:

ACUTE MYOCARDIAL INFARCTION NATIONAL HOSPITAL INPATIENT QUALITY MEASURES

Remove all footnotes in “Set Measure ID#” column.

- ¹ CMS Voluntary ONLY
- ² The Joint Commission ONLY

AMI DATA ELEMENT LIST

Remove all footnotes in “Collected For” columns.

- ¹ CMS Voluntary ONLY
- ² The Joint Commission ONLY
- ³ CMS ONLY
- ⁴ Transmission Data Element

Impacts:Measure(s)

AMI-1

Rationale: Selected References and Rationale need to be updated with the latest ACCF/AHA STEMI and unstable angina/non-STEMI clinical guideline releases.

Description of Changes:Rationale:

Change the references in the last sentence to:

O’Gara, 2013 and Jneid, 2012

Impacts:Measure(s)

AMI-1

AMI-2

Rationale: Selected References and Rationale need to be updated with the latest ACCF/AHA STEMI and unstable angina/non-STEMI clinical guideline releases.

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

- Jneid H, Anderson JL, Wright RS, Adams CD, Bridges CR, Casey DE Jr, et al. 2012 ACCF/AHA focused update of the guideline for the management of patients with unstable angina/non–ST-elevation myocardial infarction (updating the 2007 guideline and replacing the 2011 focused update): a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol* 2012;60:645–81.
- O’Gara PT, Kushner FG, Ascheim DD, Casey DE, Jr, Chung MK, de Lemos JA, et al. 2013 ACCF/AHA guideline for the management of ST-elevation myocardial infarction: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol* 2013;61:485–510.

Remove:

- Antman EM, Anbe DT, Armstrong PW, Bates ER, Green LA, Hand M, et al. ACC/AHA guidelines for the management of patients with ST-elevation myocardial infarction: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Revise the 1999 Guidelines for the Management of Patients With Acute Myocardial Infarction). 2004.
- Antman EM, Hand M, Armstrong PW, Bates ER, Green LA, Halasyamani LK, et al. 2007 focused update of the ACC/AHA 2004 Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Writing Group to Review New Evidence and Update the ACC/AHA 2004 Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction). *J Am Coll Cardiol*. 2008;51:210–47.
- Wright RS, Anderson JL, Adams CD, Bridges CR, Casey DE Jr, Ettinger SM, et al. 2011 ACCF/AHA focused update of the guidelines for the management of patients with unstable angina/non–ST-elevation myocardial infarction (updating the 2007 guideline): a

report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol* 2011;57:1920–59.

Impacts:Measure(s)

AMI-2

Rationale: Selected References and Rationale need to be updated with the latest ACCF/AHA STEMI and unstable angina/non-STEMI clinical guideline releases.

Description of Changes:Rationale:

Change the references in the last sentence to:
O’Gara, 2013; Jneid, 2012; and Smith, 2011

Impacts:Measure(s)

AMI-3

AMI-5

AMI-8

AMI-8a

AMI-10

Rationale: Selected References and Rationale need to be updated with the latest ACCF/AHA STEMI clinical guideline release.

Description of Changes:Rationale:

Change the Antman, 2004 and Antman, 2008 references to:
O’Gara, 2013

Selected References:**Add:**

- O’Gara PT, Kushner FG, Ascheim DD, Casey DE, Jr, Chung MK, de Lemos JA, et al. 2013 ACCF/AHA guideline for the management of ST-elevation myocardial infarction: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol* 2013;61:485–510.

Remove:

- Antman EM, Anbe DT, Armstrong PW, Bates ER, Green LA, Hand M, et al. ACC/AHA guidelines for the management of patients with ST-elevation myocardial infarction: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Revise the 1999 Guidelines for the Management of Patients With Acute Myocardial Infarction). 2004.
- Antman EM, Hand M, Armstrong PW, Bates ER, Green LA, Halasyamani LK, et al. 2007 focused update of the ACC/AHA 2004 Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Writing

Group to Review New Evidence and Update the ACC/AHA 2004 Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction). *J Am Coll Cardiol*. 2008;51:210–47.

Impacts:Measure(s)

AMI-7

AMI-7a

Rationale: Selected References and Rationale need to be updated with the latest ACCF/AHA STEMI clinical guideline release.

Description of Changes:

Change the reference in the last sentence to:

O’Gara, 2013

Selected References:**Add:**

- O’Gara PT, Kushner FG, Ascheim DD, Casey DE, Jr, Chung MK, de Lemos JA, et al. 2013 ACCF/AHA guideline for the management of ST-elevation myocardial infarction: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol* 2013;61:485–510.

Remove:

- Antman EM, Anbe DT, Armstrong PW, Bates ER, Green LA, Hand M, et al. ACC/AHA guidelines for the management of patients with ST-elevation myocardial infarction: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Revise the 1999 Guidelines for the Management of Patients With Acute Myocardial Infarction). 2004.

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

HF Data Element List

Rationale: Footnotes are being removed because the “collected for” designation is already referenced in each measure and data element.

Description of Changes:

Remove all footnotes in “Collected For” columns.

¹ CMS ONLY² Transmission Data Element³ The Joint Commission ONLY**Impacts:**Measure(s)

HF-1

Rationale: NQF Measure Maintenance process removed endorsement for five measures in 2012.

Description of Changes:**Remove:**

NQF ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE

Impacts:Measure(s)

HF-1

Rationale: URL listings in Selected References are being removed.

Description of Changes:Selected References:

Remove last sentence from 1st bullet:

Available at <http://www.acc.org> and <http://www.americanheart.org>.

Change 2nd bullet to:

- Bonow RO, Ganiats TG, Beam CT, Blake K, Casey DE Jr, Goodlin SJ, et al. ACCF/AHA/AMA-PCPI 2011 performance measures for adults with heart failure: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Performance Measures and the American Medical Association-Physician Consortium for Performance Improvement. *J Am Coll Cardiol* 2012;59:1812–32.
-

Impacts:Measure(s)

HF-1

HF-2

HF-3

Rationale: Clarification is needed for collection of retrospective and concurrent data. This change will provide consistency in the measure information forms (MIFs) for each measure topic.

Description of Changes:Data Collection Approach**Change to:**

Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-9-CM diagnosis and procedure codes, which require retrospective data entry.

Impacts:Measure(s)

HF-2

HF-3

Rationale: URL listings in Selected References are being removed.

Description of Changes:**Change 1st** bullet to:

- Bonow RO, Ganiats TG, Beam CT, Blake K, Casey DE Jr, Goodlin SJ, et al. ACCF/AHA/AMA-PCPI 2011 performance measures for adults with heart failure: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Performance Measures and the American Medical Association-Physician Consortium for Performance Improvement. *J Am Coll Cardiol* 2012;59:1812–32.

Subsection 2.3 – Pneumonia (PN)**Impacts:**

PN Data Element List

Rationale: The footnotes are being removed because the “collected for” designation is already referenced in each measure and data element.

Description of Changes:PNEUMONIA NATIONAL HOSPITAL INPATIENT QUALITY MEASURES

Remove all footnotes in “Set Measure ID#” column.

- ¹ CMS Voluntary ONLY
- ² The Joint Commission ONLY

PN DATA ELEMENT LIST

Remove all footnotes in “Collected For” columns.

- ¹ CMS ONLY
- ² Joint Commission ONLY
- ³ Transmission Data Element

Impacts:Measure(s)

PN-3a
PN-3b

Rationale: NQF Measure Maintenance process removed endorsement for five measures in 2012.

Description of Changes:**Remove:**

NQF ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE

Impacts:Measure(s)

PN-6
PN-6a
PN-6b

Rationale: The data elements *Compromised* and *Healthcare Associated Pneumonia* have been retired and combined into '*Reason for Alternative Empiric Antibiotic Therapy*' to allow for additions of other exclusions as the need arises and to keep the PN-6 antibiotic regimens evidence based according to the guidelines.

Description of Changes:

PN DATA ELEMENT LIST

Remove:

Compromised

Healthcare Associated PN

Collected For

Remove: PN-6¹, PN-6a², PN-6b²

PN DATA ELEMENT LIST

Add: *Reason for Alternative Empiric Antibiotic Therapy*

Collected For

Add: PN-6, PN-6a, PN-6b

Impacts:

Measure(s)

PN-6

PN-6a

PN-6b

Rationale: The data elements *Compromised* and *Healthcare Associated Pneumonia* have been retired and combined into '*Reason for Alternative Empiric Antibiotic Therapy*' to allow for additions of other exclusions as the need arises and to keep the PN-6 antibiotic regimens evidence based according to the guidelines.

Description of Changes:

Denominator Excluded Populations

Add: Patients with a *Reason for Alternative Empiric Antibiotic Therapy* as defined in the Data Dictionary

Remove: Patients with *Healthcare Associated PN* as defined in the Data Dictionary

Remove: Patients who are *Compromised* as defined in the Data Dictionary

Denominator Data Elements

Add: *Reason for Alternative Empiric Antibiotic Therapy*

Remove: *Compromised*

Remove: *Healthcare Associated PN*

Impacts:

Algorithm

Measure(s)

PN-6

PN-6a

PN-6b

Rationale: The data elements *Compromised* and *Healthcare Associated Pneumonia* have been retired and combined into '*Reason for Alternative Empiric Antibiotic Therapy*' to allow for additions of other exclusions as the need arises and to keep the PN-6 antibiotic regimens evidence based according to the guidelines.

Description of Changes:

PN-6, PN-6a, PN-6b algorithms

Remove: the decision box for *Compromised* and all associated logic

Remove: the decision box for *Healthcare Associated Pneumonia* and all associated logic.

Add: a decision box for *Reason for Alternative Empiric Antibiotic Therapy* and associated logic below the decision box for *Antibiotic Received* (replacing the decision boxes and logic for *Compromised* and *Healthcare Associated Pneumonia*, but moving the decision box below *Antibiotic Received*).

Change: Note box near *Antibiotic Name* to “Note: Cases containing invalid data and/or an incomplete Antibiotic Grid will be rejected. A complete Antibiotic Grid requires all data elements in the row to contain either a valid value and/or ‘UTD’.”

Impacts:

Algorithm

Measure(s)

PN-6a

Rationale: The CMS abstraction tool (CART) will align with the current algorithm.

Description of Changes:

PN-6a algorithm

Remove: The note box above the branch going from Antibiotic Days to above *Antibiotic Allergy* that outlined the algorithm programming related to CART only.

Subsection 2.4 – Surgical Care Improvement Project (SCIP)

Impacts:

SCIP Data Element List

Rationale: The footnotes are being removed because the “collected for” designation is already referenced in each measure and data element.

Description of Changes:

SURGICAL CARE IMPROVEMENT PROJECT NATIONAL HOSPITAL INPATIENT QUALITY MEASURES

Remove all footnotes in “Set Measure ID#” column.

¹ CMS Voluntary ONLY

⁴ The Joint Commission ONLY

SCIP DATA ELEMENT LIST

Remove all footnotes in “Collected For” columns.

- ¹ CMS Voluntary ONLY
- ² CMS ONLY
- ³ Transmission Data Element
- ⁴ The Joint Commission ONLY

Impacts:

SCIP Data Element List

Rationale: The measure is being updated based on NQF and TEP recommendations.

Description of Changes:

Remove SCIP-Inf-4 from the Collected for column for *Anesthesia End Date*.

Impacts:

SCIP Data Element List

Glucose
 Glucose POD 1
 Glucose POD 2
 Perioperative Death

Measure(s)

SCIP-Inf-4

Rationale: The measure is being updated based on NQF and TEP recommendations.

Description of Changes:

Remove data elements *Glucose POD 1* and *Glucose POD 2* from left column and SCIP-Inf-4 from right column.

Add data element *Glucose* to left column and SCIP-Inf-4 to right column.

Remove SCIP-Inf-4 from the Collected for column for *Perioperative Death*.

Impacts:

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-2

Rationale: Clarification is needed for collection of retrospective and concurrent data. This change will provide consistency in the measure information forms (MIFs) for each measure topic.

Description of Changes:Data Collection Approach**Change to:**

Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-9-CM diagnosis and procedure codes, which require retrospective data entry.

Impacts:Measure(s)

SCIP-Inf-1

SCIP-Inf-2

SCIP-Inf-3

Rationale: The exclusion statements were updated to match changes in the algorithms and to maintain the data in the warehouse necessary for Value-Based Purchasing (VBP) calculations.

Description of Changes:SCIP-Inf-1 Denominator Excluded Populations:**Add:**

- Patients whose Principal Procedure was on Table 5.25

Remove:

- Patients who were receiving antibiotics more than 24 hours prior to surgery
- Patients who were receiving antibiotics within 24 hours prior to arrival (except colon surgery patients taking oral prophylactic antibiotics)

SCIP-Inf-2 Denominator Excluded Populations:**Add:**

- Patients whose Principal Procedure was on Table 5.25
- Patients who received ONLY oral or intramuscular (IM) antibiotics or the route was unable to be determined
- Patients who received ALL antibiotics greater than 1440 minutes prior to *Surgical Incision Date and Time*

Change 10th bullet to:

- Patients who did not receive any antibiotics within the timeframe 24 hours before *Surgical Incision Date and Time* (i.e., patient did not receive prophylactic antibiotics) through discharge

Change 11th bullet to:

- Patients who received antibiotics prior to arrival and did not receive any antibiotics during this hospitalization

Remove:

- Patients who were receiving antibiotics more than 24 hours prior to surgery (except colon surgery patients taking oral prophylactic antibiotics)
- Patients who were receiving antibiotics within 24 hours prior to arrival (except colon surgery patients taking oral prophylactic antibiotics)

SCIP-Inf-3 Denominator Excluded Populations:**Add:**

- Patients whose Principal Procedure was on Table 5.25
- Patients who received antibiotics prior to arrival and did not receive any antibiotics during this hospitalization
- Patients who received ONLY antibiotics with the route unable to be determined (UTD)
- Patients who did not receive any antibiotics within the timeframe 24 hours before *Surgical Incision Date and Time* (i.e., patient did not receive prophylactic antibiotics) through discharge
- Patients who received ALL antibiotics greater than 1440 minutes prior to *Surgical Incision Date and Time*
- Patients who received ALL antibiotics greater than 3 days after *Anesthesia End Date* OR greater than 2 days after *Anesthesia End Date* for Principal Procedures on Tables 5.03-5.08
- Patients who received ALL antibiotics greater than 4320 minutes after *Anesthesia End Time* OR greater than 2880 minutes after *Anesthesia End Time* for Principal Procedures on Tables 5.03-5.08

Remove:

- Patients who were receiving antibiotics more than 24 hours prior to surgery (except colon surgery patients taking oral prophylactic antibiotics)
- Patients who were receiving antibiotics within 24 hours prior to arrival (except colon surgery patients taking oral prophylactic antibiotics)
- Patients who did not receive any antibiotics during this hospitalization

Impacts:

Algorithm

Data Elements*Antibiotic Received**Oral Antibiotics*Measure(s)

SCIP-Inf-1

SCIP-Inf-2

SCIP-Inf-3

Rationale: Cases with documented infection will be excluded with the data element *Infection Prior to Anesthesia* instead of using antibiotic administration information.

Description of Changes:SCIP-INF-1 Algorithm**Remove** – Antibiotic Days I from the Variable Key

Change – Antibiotic Received, Oral Antibiotic and Principal Procedure Code logic at bottom of page to:

First *Antibiotic Received* decision box – when ‘4’ arrow to right goes to Measure Category “D”, when ‘1’, ‘2’ or ‘3’ continue down algorithm to *Principal Procedure Code* – when on Table 5.03 arrow to right goes to *Oral Antibiotics*, when not on Table 5.03 continue down algorithm to re-

check *Antibiotic Received*. When *Oral Antibiotics* is missing it goes to Measure Category “X” and when it is ‘Y’ or ‘N’ it flows down algorithm to the re-check of *Antibiotic Received*. When *Antibiotics Received* is ‘1’ it goes to Measure Category of “D” and when ‘2’ or ‘3’ it continues down algorithm.

Change – *Antibiotic Administration Route* – allowable value “1” goes to “D” also now along with “3” and “10”.

Remove – *Oral Antibiotics*, Table 5.03 logic and the all the Antibiotic Days variable logic.

Change – two note boxes about antibiotic doses are moved into an arrow description. The Note Box at the top of page removes language “front end edits reject”.

Remove – first decision box for Antibiotic Timing I, *Oral Antibiotics* and the Table 5.03 logic.

SCIP-INF-2 Algorithm

Remove – Antibiotic Days I and Antibiotic Days II from the Variable Key

Change – Antibiotic Received, Oral Antibiotic and Principal Procedure Code logic at bottom of page to:

First *Antibiotic Received* decision box – when ‘4’ arrow to right goes to Measure Category “B”, when ‘1’, ‘2’ or ‘3’ continue down algorithm to *Principal Procedure Code* – when on Table 5.03 arrow to right goes to *Oral Antibiotics*, when not on Table 5.03 continue down algorithm to re-check *Antibiotic Received*. When *Oral Antibiotics* is missing it goes to Measure Category “X” and when it is ‘Y’ or ‘N’ it flows down algorithm to the re-check of *Antibiotic Received*. When *Antibiotics Received* is ‘1’ it goes to Measure Category of “B” and when ‘2’ or ‘3’ it continues down algorithm.

Change – *Antibiotic Administration Route* – allowable value “1” excludes to “B” also now along with “3” and “10”.

Remove – *Oral Antibiotics*, Table 5.03 logic and the all the Antibiotic Days variable logic.

Change – two note boxes about antibiotic doses are moved into an arrow description. The Note Box at the top of page removes language “front end edits reject”.

Remove – 2nd decision box and logic for *Antibiotic Administration Time*.

Remove – Antibiotic Days language from Antibiotic Timing I calculation box.

Change – Antibiotic Timing I decision box arrow to right to “>1440 minutes for ALL antibiotic doses” and arrow down to “<= 1440 minutes for at least one dose with non-UTD date and time. Proceed with antibiotic doses that have Antibiotic Timing I calculated.”

Add – Antibiotic Timing I run box directly below Antibiotic Timing I decision box.

Remove – *Antibiotic Administration Route* decision box and all associated logic.

SCIP-INF-3 Algorithm

Remove – Antibiotic Days I from the Variable Key

Change – Antibiotic Received, Oral Antibiotic and Principal Procedure Code logic at bottom of page to:

First *Antibiotic Received* decision box – when ‘4’ arrow to right goes to Measure Category “B”, when ‘1’, ‘2’ or ‘3’ continue down algorithm to *Principal Procedure Code* – when on Table 5.03 arrow to right goes to *Oral Antibiotics*, when not on Table 5.03 continue down algorithm to re-check *Antibiotic Received*. When *Oral Antibiotics* is missing it goes to Measure Category “X” and when it is ‘Y’ or ‘N’ it flows down algorithm to the re-check of *Antibiotic Received*. When *Antibiotics Received* is ‘1’ it goes to Measure Category of “B” and when ‘2’ or ‘3’ it continues down algorithm.

Change – *Antibiotic Administration Route* – allowable value “3” continues down algorithm along with “1” and “2”.

Remove – *Oral Antibiotics*, Table 5.03 logic and the all the Antibiotic Days variable logic.

Change – Note Box about antibiotic doses are moved into an arrow description. The Note Box at the top of page removes language “front end edits reject”.

Remove – 2nd decision box and logic for *Antibiotic Administration Time*.

Change – Antibiotic Timing I decision box arrow to right to “>1440 minutes for ALL antibiotic doses” and arrow down to “<= 1440 minutes for at least one dose with non-UTD date and time. Proceed with antibiotic doses that have Antibiotic Timing I calculated.”

Add – Antibiotic Timing I run box directly below Antibiotic Timing I decision box.

Remove – *Antibiotic Administration Time* decision box, run box and all associated logic.

Impacts:

Measure(s)

SCIP-Inf-2

Rationale: The references were updated.

Description of Changes:

References

Add:

Bratzler DW, Dellinger EP, Olsen KM, Perl TM, Auwaerter PG, Bolon MK, Fish DN, Napolitano LM, Sawyer RG, Slain D, Steinberg JP, Weinstein RA. Clinical practice guidelines for antimicrobial prophylaxis in surgery. *Am J Health-Syst Pharm.* 2013; 70:195-283.

Impacts:

Prophylactic Antibiotic Regimen Selection for Surgery

Measure(s)

SCIP-Inf-2

Rationale: Changes were made to allow the recommended antibiotic or antibiotic combinations to be given for colon surgeries and for hysterectomies based on guideline changes.

An omission typo was corrected in the chart.

Description of Changes:

Change column and row headers in table.

Colon Surgeries Approved Antibiotics:

Change the number after Ceftriaxone Table to 3.6

Add the word “or” between

Cefazolin or Cefuroxime Table 3.2 + Metronidazole Table 3.6a

and

Ceftriaxone Table 3.5 + Metronidazole Table 3.6a4

For the rows:

Abdominal Hysterectomy Table 5.06 or Vaginal Hysterectomy Table 5.07

and

Principal Procedure Code of Abdominal Hysterectomy Table 5.06 with an Other Procedure Code of Colon Surgery Table 5.03

Or

Vaginal Hysterectomy Table 5.07 with an Other Procedure Code of Colon Surgery Table 5.03:

Add after Metronidazole Table 3.6a + Quinolone Table 3.12:

OR Vancomycin Table 3.8 + Aminoglycoside Table 2.11

OR Vancomycin Table 3.8 + Aztreonam Table 2.7

OR Vancomycin Table 3.8 + Quinolone Table 3.12

Impacts:

Algorithm

Measure(s)

SCIP-Inf-2

Rationale: These changes are to allow the recommended antibiotic combination to be given for colon surgeries and to correct an omission typo in the chart.

Description of Changes:

SCIP-INF-2 Algorithm

Remove – all logic associated with the variable Antibiotic Days II. This is after decision box for *Anesthesia End Date*.

Remove – all logic associated with Antibioticday Flag. This is after decision box for *Anesthesia End Date* and includes removing a run box and 3 decision boxes.

Remove – the 2nd decision box for *Antibiotic Administration Time* – this one is directly below the decision box for *Anesthesia End Time*.

Change – the arrow to the right from decision box for *Anesthesia End Time* which is = UTD now goes to measure category “D”.

Change – Antibiotic Timing II arrow to right to “> 0 minutes for all doses of all Antibiotics with non-UTD date and time.” which now proceeds to measure category of “D” and change down arrow to “≤ 0 minutes for at least one dose of **ANY** Antibiotic. Proceed with antibiotic doses that have Antibiotic Timing II calculated”.

Change – run box below decision box for Antibiotic Timing II to only proceed when “Antibiotic Timing II \leq 0”.

Change - After decision box for *Antibiotic Name* checking for On Table 3.5 change the next decision box for *Antibiotic Name* to check for On Table 3.6a instead of Table 3.2. If on Table 3.6a check *Antibiotic Name* to check for On Table 3.2 – if on then go to measure category “E”, if not on then check *Antibiotic Name* to check for On Table 3.6 - if on then go to measure category “E”, if not go to off page connector “M”.

Add – after *Antibiotic Allergy* if on Tables 5.03, 5.06 5.07 – add a decision box for *ICD-9-CM Principal Procedure Code* – if on Table 5.06 or 5.07 check *Antibiotic Name*, if on Table 5.03 continue down algorithm.

Add – after new *ICD-9-CM Principal Procedure Code* – add a decision box for *Antibiotic Name* – if at least one on Table 3.8 check *Antibiotic Name*, if none on Table 3.8 continue down algorithm.

Add – after new *Antibiotic Name* – add a decision box for *Antibiotic Name* – if at least one on Tables 2.11 or 3.12 or 2.7 go to measure category “E”, if none on Tables 2.11 or 3.12 or 2.7 continue down algorithm.

Impacts:

Glucose

Glucose POD 1

Glucose POD 2

Perioperative Death

Measure(s)

SCIP-Inf-4

Rationale: The measure is being updated based on NQF and TEP recommendations.

Description of Changes:

Data Element List- Measure Short Name

Remove 6 A.M. from Measure Short Name for SCIP-Inf-4.

Measure Information Form- Performance Measure Name

Remove 6 A.M.

Description

Change to:

Cardiac surgery patients with controlled postoperative blood glucose (less than or equal to 180 mg/dL) in the timeframe of 18 to 24 hours after *Anesthesia End Time*.

Rationale

Change to:

Hyperglycemia has been associated with increased in-hospital morbidity and mortality for multiple medical and surgical conditions. In a study by Zerr, et al (1997), the risk of infection was significantly higher for patients undergoing coronary artery bypass graft (CABG) if blood glucose levels were elevated. Studies have shown there is an independent rise in the risk of surgical infection with blood glucose levels > 180 mg/dL (Van den Berghe, 2001). Latham, et al (2001), found that hyperglycemia in the immediate postoperative phase increases the risk of

infection in both diabetic and nondiabetic patients and the higher the level of hyperglycemia, the higher the potential for infection in both patient populations. A study conducted in Leuven, Belgium (Van den Berghe, 2001), demonstrated that intensive insulin therapy not only reduced overall in-hospital mortality but also decreased blood stream infections, acute renal failure, red cell transfusions, ventilator support and intensive care. Hyperglycemia is a risk factor that, once identified, could minimize adverse outcomes for cardiac surgical patients. Guidelines highlight the need for perioperative (particularly intraoperative and postoperative) glucose control in cardiac surgery patients. The Society of Thoracic Surgeons Workforce guidelines (Lazar, 2009) recommended cardiac surgery patients, with and without diabetes, maintain serum glucose of < 180 mg/dL. It is acknowledged that controlling the blood glucose in the immediate time period after surgery may be challenging (due to changing medications, use of inotropes, etc.), however, cardiac care teams should be able to reasonably control the blood sugar to levels of 180 mg/dL or less within the 18 – 24 hour post-operative time frame.

Numerator Statement

Change to:

Cardiac surgery patients with controlled postoperative blood glucose (less than or equal to 180 mg/dL) in the timeframe of 18 to 24 hours after *Anesthesia End Time*.

Numerator Statement- Included Populations

Change populations to Populations.

Numerator Statement- Data Elements

Change to:

Glucose

Denominator Statement- Excluded Populations

Change 2nd bullet to:

Patients who have a length of stay greater than 120 days

Change 3rd bullet to:

Patients who had a principal diagnosis suggestive of preoperative infectious disease (as defined in Appendix A, Table 5.09 for ICD-9-CM codes)

Remove 8th bullet:

Patients who expired perioperatively.

Change last bullet to:

Patients who undergo CPR or surgery, discharge, expire, or leave Against Medical Advice (AMA) prior to 24 hours after *Anesthesia End Time*.

Denominator Statement- Data Elements

Remove:

Perioperative Death

Measure Analysis Suggestions

Change 2nd sentence to:

In the course of quality improvement efforts, hospitals may find it useful to drill down to the response for the data element *Glucose*.

Selected References**Add:**

Lazar H, McDonnell M, Chipkin S, Furnary A, Engelman R, Sadhu A, Bridges C, Haan C, Svedjeholm R, Taegtmeier H, Shemin R. The Society of Thoracic Surgeons practice guideline series: Blood glucose management during adult cardiac surgery. *Ann Thorac Surg.* 2009;87:663-669.

Impacts:Measure(s)

SCIP-Inf-4

Rationale: The measure is being updated based on NQF and TEP recommendations.

Description of Changes:

Denominator Statement - Data Elements

Remove: *Anesthesia End Date*

Impacts:

Algorithm

Measure(s)

SCIP-Inf-4

Rationale: The measure is being updated based on NQF and TEP recommendations.

Description of Changes:

Remove previous algorithm and narrative.

Add new algorithm and narrative.

Impacts:Measure(s)

SCIP-VTE-2

Rationale: The measure specifications are being revised to maintain consistency with the updated American College of Chest Physicians' guidelines on prevention of VTE in surgical patients.

Description of Changes:

SCIP Data Element List

Remove: SCIP-VTE-2 in the row for *Anesthesia Type* in the Collected For column.

Impacts:Measure(s)

SCIP-VTE-2

Rationale: The selection of Value A should no longer exclude surgeries from SCIP-VTE-2 due to the removal of SCIP-VTE-1.

Description of Changes:Denominator Statement:**Remove** the last bullet under the Excluded Populations:

- Patients who did not receive *VTE Prophylaxis* (as defined in the Data Dictionary)

Impacts:Measure(s)

SCIP-VTE-2

Rationale: The measure specifications are being revised to maintain consistency with the updated American College of Chest Physicians' guidelines on prevention of VTE in surgical patients.

Description of Changes:Selected References:**Delete:** the 3rd reference.

Add: Guyatt G, Akl E, Crowther M, Gutterman D, Schuünemann H. Executive summary: antithrombotic therapy and prevention of thrombosis. The Ninth ACCP edition: ACCP evidence-based clinical practice guidelines. *Chest* 2012; 141;7S-47S. PMID: 22315257

VTE Prophylaxis Options for Surgery

Add "Intermittent pneumatic compression devices (IPC)" to the Options column for the General Surgery row.

Remove: LDUH or LMWH or Factor Xa Inhibitor combined with IPC or GCS from the General Surgery row.

Remove the row for General Surgery with a reason for not administering pharmacological prophylaxis.

Remove "Graduated compression stockings (GCS)" from the Options column for the Urologic Surgery row.

Remove: the rows for Elective Hip Replacement Surgery.

Change the Total Knee Replacement Surgery Type column to:

Elective Total Knee or Total Hip Replacement Appendix A, Tables 5.22 and 5.23

Add to the Options column in the row for Elective Total Knee or Total Hip Replacement Appendix A, Tables 5.23 and 5.22:

- Low-dose unfractionated heparin (LDUH)
- Aspirin

Add to the Options column for the Hip Fracture Surgery row:

- Intermittent pneumatic compression devices (IPC)
- Aspirin

Remove the rows: Elective Total Hip Replacement with a reason for not administering pharmacological prophylaxis and Hip Fracture Surgery with a reason for not administering pharmacological prophylaxis Appendix A, Table 5.24 and Table 5.22

Remove: Footnotes 1 and 2 from table and below table

Change: footnote 3 to footnote 1 in the row Elective Total Knee or Total Hip Replacement Appendix A, Tables 5.22 and 5.23 next to Oral Factor Xa Inhibitor.

Impacts:

Algorithm

Measure(s)

SCIP-VTE-2

Rationale: The selection of Value A should no longer exclude surgeries from SCIP-VTE-2 due to the removal of SCIP-VTE-1.

Description of Changes:

SCIP-VTE-2 Algorithm

Change note box at top of page to include “9” as an allowable value for VTE Prophylaxis.

Change allowable values for *Reason for Not Administering VTE Prophylaxis* to “Y” and “N” from 1-4, “Y” goes to measure category “B” and “N” continues down algorithm.

Change arrow to right from *VTE Prophylaxis* for allowable value “A” to flow to measure category “D” instead of “B” and add “9” as an allowable value to the down arrow to continue in the algorithm.

Add “9” as an allowable value to the Note Boxes on top of algorithm pages 3, 4, 5.

Add for Table 5.19 - add “3” as an allowable value to *VTE Prophylaxis* and *VTE Timely*. Deleted all *Reason for Not Administering VTE Prophylaxis* logic.

Remove for Table 5.21 - remove “4” as an allowable value to *VTE Prophylaxis* and *VTE Timely*.

Change the 4th *ICD-9-CM Principal Procedure Code* decision box on page 4 to have arrow to right say “On Tables 5.22, 5.23” and have the down arrow only have “On Table 5.24”.

Add for combined Table 5.22 and 5.23 sections - add “1”, “3”, “7” and “9” as allowable values to first *VTE Prophylaxis* and *VTE Timely* and down arrows from each now go to measure category “D”.

Remove from combined Table 5.22 and 5.23 section all logic after the down arrow from the 1st *VTE Prophylaxis* decision box.

Remove all Table 5.23 logic on page 5.

Add for Table 5.24 section - add “3” and “9” as allowable values to first *VTE Prophylaxis* and *VTE Timely* and down arrows from each now go to measure category “D”.

Remove from Table 5.24 section all logic after the down arrow from the 1st *VTE Prophylaxis* decision box.

Subsection 2.6 – Children’s Asthma Care (CAC)

Impacts:

CAC Data Element List

Rationale: The footnotes are being removed because the “collected for” designation is already referenced in each measure and data element.

Description of Changes:

Remove all footnotes in “Collected For” columns.

¹ Transmission Data Element

Impacts:

Measure(s)

CAC-1

CAC-2

CAC-3

Rationale: Clarification is needed for collection of retrospective and concurrent data. This change will provide consistency in the measure information forms (MIFs) for each measure topic.

Description of Changes:

Data Collection Approach

Change to:

Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-9-CM diagnosis and procedure codes, which require retrospective data entry.

Impacts:

Measure(s)

CAC-3

Rationale: NQF Measure Maintenance process removed endorsement for five measures in 2012.

Description of Changes:**Remove:**

NQF ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE

Impacts:

Measure(s)

CAC-3

Rationale: The Leferve reference and citation are being removed from the Rationale section to correct an inaccurate statement.

Description of Changes:Rationale

Remove 4th sentence from 3rd paragraph:

Furthermore, evidence of this transaction in a written action plan improves patient outcomes in asthma (Lefevre, et al., 2002).

Impacts:Measure(s)

CAC-3

Rationale: The Lefevre reference is being removed from the Selected References to correct an inaccuracy.

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

Lefevre, F., Piper, M., Weiss, K., Mark, D., Clark, N., Aronson, N. (2002). Do Written action plans improve patient outcomes in asthma? An evidence based analysis. Family Practice; Vol 51, No. 10. Retrieved December 21, 2011 from <http://www.jfponline.com/pages.asp?AID=1308>

Subsection 2.7 – Venous Thromboembolism (VTE)**Impacts:**

VTE Data Element List

Rationale: The footnotes are being removed because the “collected for” designation is already referenced in each measure and data element.

Description of Changes:

Remove all footnotes in “Collected For” columns.

- ¹ CMS ONLY
- ² Transmission Data Element
- ³ Joint Commission ONLY

Impacts:Measure(s)

VTE-1

VTE-2

VTE-3

VTE-4

VTE-5

VTE-6

Rationale: Clarification is needed for collection of retrospective and concurrent data. This change will provide consistency in the measure information forms (MIFs) for each measure topic.

Description of Changes:Data Collection Approach**Change to:**

Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-9-CM diagnosis and procedure codes, which require retrospective data entry.

Impacts:

Algorithm

Measure(s)

VTE-1

Rationale: The measure specifications are being revised to maintain consistency with the updated American College of Chest Physicians' guidelines on prevention of VTE in surgical patients.

Description of Changes:VTE-1 Algorithm

Add a new allowable value 9 to *VTE Prophylaxis Only = A* as 'Only = A or Only = 9'

Add a new allowable value 9 to *VTE Prophylaxis Only = 8* as 'Only = 8 or = 8 and 9'

Impacts:Measure(s)

VTE-3

Rationale: This change is being made to differentiate if there was a documented reason why overlap therapy did not occur.

Description of Changes:VTE Data Element:

Add new data element:

Reason for No Overlap Therapy

Collected for:**Add:**

VTE-3

Data Elements:

Add new seventh bullet to numerator data elements:

Reason for No Overlap Therapy

Impacts:

Algorithm

Measure(s)

VTE-3

Rationale: This change is being made to differentiate if there was a documented reason why overlap therapy did not occur.

Description of Changes:

VTE-3 Algorithm:

Change allowable values of *Overlap Therapy* to 'Y' or 'N':

- If *Overlap Therapy* equals 'Y', it goes to check *Overlap Therapy Start Date*
- If *Overlap Therapy* equals 'N', it goes to check *Reason for No Overlap*

Add a new branch of *Reason for No Overlap Therapy* when *Overlap Therapy* equals 'N'

- If *Reason for No Overlap Therapy* is missing, it goes to Category Assignment 'X'.
- If *Reason for No Overlap Therapy* equals 'Y', it goes to Category Assignment 'E'
- If *Reason for No Overlap Therapy* equals 'N', it goes to Category Assignment 'D'

Impacts:

Measure(s)

VTE-4

VTE-5

VTE-6

Rationale: NQF Measure Maintenance process removed endorsement for five measures in 2012.

Description of Changes:

Remove:

NQF ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE

Subsection 2.8 – Stroke (STK)

Impacts:

Stroke Data Element List

Rationale: The footnotes are being removed because the “collected for” designation is already referenced in each measure and data element.

Description of Changes:

Remove all footnotes in “Collected For” columns.

¹ CMS ONLY

² Transmission Data Element

³ Joint Commission ONLY

Impacts:

Measure(s)

STK-1

Rationale: Update references to reflect current evidence as submitted for NQF re-endorsement.

Description of Changes:Selected References**Change to:**

- Adams, H.P., G. del Zoppo, M. J. Alberts, D. L. Bhatt, L. Brass, A. Furlan, R. L. Grubb, *et al.* "Guidelines for the Early Management of Adults with Ischemic Stroke: A Guideline from the American Heart Association/American Stroke Association Stroke Council, Clinical Cardiology Council, Cardiovascular Radiology and Intervention Council, and the Atherosclerotic Peripheral Vascular Disease and Quality of Care Outcomes in Research Interdisciplinary Working Groups." *Stroke* 38 (2007): 1655-711.
- Albers, G. W., P Amarenco, J. D. Easton, R. L. Sacco, and P. Teal. "Antithrombotic and Thrombolytic Therapy for Ischemic Stroke." *Chest* 119 (2001): 300-20.
- Caprini, J. A., and J. I. Arcelus. "State-of the Art Venous Thromboembolism Prophylaxis." *SCOPE on Phlebology & Lymphology* 1 (2005): 228-40.
- Centers for Disease Control and Prevention. "Prevalence and Most Common Causes of Disability among Adults--United States, 2005." [In eng]. *MMWR Morb Mortal Wkly Rep* 58, no. 16 (May 1 2009): 421-6.
- Coull, B. M., L. S. Williams, L. B. Goldstein, J. F. Meschia, D. Heitzman, S. Chaturvedi, K. C. Johnston, *et al.* "Anticoagulants and Antiplatelet Agents in Acute Ischemic Stroke: Report of the Joint Stroke Guideline Development Committee of the American Academy of Neurology and the American Stroke Association (a Division of the American Heart Association)." [In eng]. *Stroke* 33, no. 7 (Jul 2002): 1934-42.
- Desmukh, M., M. Bisignami, P. Landau, and T. J. Orchard. "Deep Vein Thrombosis in Rehabilitating Stroke Patients: Incidence, Risk Factors and Prophylaxis." *American Journal Physical Medicine Rehabilitation* 70 (1991): 313-16.
- Duncan, P. W., R. Zorowitz, B. Bates, J. Y. Choi, J. J. Glasberg, G. D. Graham, R. C. Katz, K. Lamberty, and D. Reker. "Management of Adult Stroke Rehabilitation Care: A Clinical Practice Guideline." [In eng]. *Stroke* 36, no. 9 (Sep 2005): e100-43.
- Geerts, W. H., D. Bergqvist, G. F. Pineo, J. A. Heit, C. M. Samama, M. R. Lassen, C. W. Colwell, and Physicians American College of Chest. "Prevention of Venous Thromboembolism: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition)." [In eng]. *Chest* 133, no. 6 Suppl (Jun 2008): 381S-453S.
- Geerts, W. H., J. A. Heit, G. P. Clagett, G. F. Pineo, C. W. Colwell, F. A. Anderson, Jr., and H. B. Wheeler. "Prevention of Venous Thromboembolism." [In eng]. *Chest* 119, no. 1 Suppl (Jan 2001): 132S-75S.
- Geerts, W. H., G. F. Pineo, J. A. Heit, D. Bergqvist, M. R. Lassen, C. W. Colwell, and J. G. Ray. "Prevention of Venous Thromboembolism: The Seventh Accp Conference on Antithrombotic and Thrombolytic Therapy." [In eng]. *Chest* 126, no. 3 Suppl (Sep 2004): 338S-400S.
- Gresham, G. E., P. W. Duncan, W. B. Stason, H. P. Adams, A. M. Adelman, D. N. Alexander, D. S. Bishop *et al.* "Post-stroke rehabilitation. Clinical practice guideline, no. 16. Rockville, MD: US Department of Health and Human Services." *Public Health Service, Agency for Health Care Policy and Research* (1995): 95-0062.
- Guyatt, G. H., E. A. Akl, M. Crowther, D. D. Gutterman, H. J. Schuunemann, Therapy American College of Chest Physicians Antithrombotic, and Panel Prevention of Thrombosis. "Executive Summary: Antithrombotic Therapy and Prevention of Thrombosis, 9th Ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines." [In eng]. *Chest* 141, no. 2 Suppl (Feb 2012): 7S-47S.

- Heit, J. A. "The Epidemiology of Venous Thromboembolism in the Community." [In eng]. *Arterioscler Thromb Vasc Biol* 28, no. 3 (Mar 2008): 370-2.
- Jauch, E. C., J. L. Saver, H. P. Adams, Jr., A. Bruno, J. J. Connors, B. M. Demaerschalk, P. Khatri, *et al.* "Guidelines for the Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association." [In Eng]. *Stroke* (Jan 31 2013).
- Kase, C. S., G. W. Albers, C. Bladin, C. Fieschi, A. A. Gabbai, W. O'Riordan, G. F. Pineo, and Prevail Investigators. "Neurological Outcomes in Patients with Ischemic Stroke Receiving Enoxaparin or Heparin for Venous Thromboembolism Prophylaxis: Subanalysis of the Prevention of Vte after Acute Ischemic Stroke with Lmwh (Prevail) Study." [In eng]. *Stroke* 40, no. 11 (Nov 2009): 3532-40.
- Kase, C. S., and G. F. Pineo. "Prevention of Venous Thromboembolism after Ischemic Stroke." [In eng]. *Curr Opin Pulm Med* 14, no. 5 (Sep 2008): 389-96.
- Kelly, J., A. Rudd, R. Lewis, and B. J. Hunt. "Venous Thromboembolism after Acute Stroke." [In eng]. *Stroke* 32, no. 1 (Jan 2001): 262-7.
- Kelly, J., A. Rudd, R. R. Lewis, C. Coshall, A. Moody, and B. J. Hunt. "Venous Thromboembolism after Acute Ischemic Stroke: A Prospective Study Using Magnetic Resonance Direct Thrombus Imaging." [In eng]. *Stroke* 35, no. 10 (Oct 2004): 2320-5.
- Kucher, N., S. Koo, R. Quiroz, J. M. Cooper, M. D. Paterno, B. Soukonnikov, and S. Z. Goldhaber. "Electronic Alerts to Prevent Venous Thromboembolism among Hospitalized Patients." [In eng]. *N Engl J Med* 352, no. 10 (Mar 10 2005): 969-77.
- "Making Healthcare Safer: A Critical Analysis of Patient Safety Practices.". In *Evidence Report/Technology Assessment # 43*. Rockville, MD: Agency for Healthcare Research and Quality, July 2001.
- Michota, F. A. "Venous Thromboembolism Prophylaxis in Medical Patients." [In eng]. *Curr Opin Cardiol* 19, no. 6 (Nov 2004): 570-4.
- Naccarato, M., F. Chiodo Grandi, M. Dennis, and P. A. Sandercock. "Physical Methods for Preventing Deep Vein Thrombosis in Stroke." [In eng]. *Cochrane Database Syst Rev*, no. 8 (2010): CD001922.
- National Heart, Lung, and Blood Institute, and National Institutes of Health. "Stroke Belt Initiative: Project Accomplishments and Lessons Learned." (1996).
- Pineo, G., J. Lin, L. Stern, T. Subrahmanian, and L. Annemans. "Economic Impact of Enoxaparin Versus Unfractionated Heparin for Venous Thromboembolism Prophylaxis in Patients with Acute Ischemic Stroke: A Hospital Perspective of the Prevail Trial." [In eng]. *J Hosp Med* 7, no. 3 (Mar 2012): 176-82.
- Raskob, G. E., R. Silverstein, D. W. Bratzler, J. A. Heit, and R. H. White. "Surveillance for Deep Vein Thrombosis and Pulmonary Embolism: Recommendations from a National Workshop." [In eng]. *Am J Prev Med* 38, no. 4 Suppl (Apr 2010): S502-9.
- Roger, V. L., A. S. Go, D. M. Lloyd-Jones, E. J. Benjamin, J. D. Berry, W. B. Borden, D. M. Bravata, *et al.* "Heart Disease and Stroke Statistics--2012 Update: A Report from the American Heart Association." [In eng]. *Circulation* 125, no. 1 (Jan 3 2012): e2-e220.
- Sacco, R. L., R. Adams, G. Albers, M. J. Alberts, O. Benavente, K. Furie, L. B. Goldstein, *et al.* "Guidelines for Prevention of Stroke in Patients with Ischemic Stroke or Transient Ischemic Attack: A Statement for Healthcare Professionals from the American Heart Association/American Stroke Association Council on Stroke: Co-Sponsored by the Council on Cardiovascular Radiology and Intervention: The American Academy of Neurology Affirms the Value of This Guideline." [In eng]. *Stroke* 37, no. 2 (Feb 2006): 577-617.

- Sandercock, P. A., C. Counsell, and M. C. Tseng. "Low-Molecular-Weight Heparins or Heparinoids Versus Standard Unfractionated Heparin for Acute Ischaemic Stroke ". *Cochrane Database Syst Rev*, no. 3 (2011): CD000119.
- Stein, P. D., and F. Matta. "Epidemiology and Incidence: The Scope of the Problem and Risk Factors for Development of Venous Thromboembolism." [In eng]. *Clin Chest Med* 31, no. 4 (Dec 2010): 611-28.
- Vergouwen, M. D., Y. B. Roos, and P. W. Kamphuisen. "Venous Thromboembolism Prophylaxis and Treatment in Patients with Acute Stroke and Traumatic Brain Injury." [In eng]. *Curr Opin Crit Care* 14, no. 2 (Apr 2008): 149-55.
- Warlow, C., D. Ogston, and A. S. Douglas. "Deep Venous Thrombosis of the Legs after Strokes. Part I--Incidence and Predisposing Factors." [In eng]. *Br Med J* 1, no. 6019 (May 15 1976): 1178-81.
- Wijdicks, E. F., and J. P. Scott. "Pulmonary Embolism Associated with Acute Stroke." [In eng]. *Mayo Clin Proc* 72, no. 4 (Apr 1997): 297-300.

Impacts:Measure(s)

STK-1
STK-2
STK-3
STK-4
STK-5
STK-6
STK-8
STK-10

Rationale: Clarification is needed for collection of retrospective and concurrent data. This change will provide consistency in the measure information forms (MIFs) for each measure topic.

Description of Changes:Data Collection Approach**Change to:**

Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-9-CM diagnosis and procedure codes, which require retrospective data entry.

Impacts:

Algorithm

Measure(s)

STK-1

Rationale: The measure specifications are being revised to maintain consistency with the updated American College of Chest Physicians' guidelines on prevention of VTE in STK patients.

Description of Changes:

Add a new allowable value 9 to *VTE Prophylaxis Any*=1, 2, 3, 4, 5, 6, 7 or 8 as 'Any = 1, 2, 3, 4, 5, 6, 7, 8, or 9'

Change allowable value of 2nd *VTE Prophylaxis All* = 4 or/and 8 as 'None = 1, 2, 3, 5, 6 or 7'

Change allowable value of 3rd *VTE Prophylaxis Only* = 4 as 'Not = 8'

Impacts:Measure(s)

STK-2

Rationale: Update references to reflect current evidence as submitted for NQF re-endorsement.

Description of Changes:Selected References**Change to:**

- Adams, H., R. Adams, G. Del Zoppo, L. B. Goldstein, Association Stroke Council of the American Heart, and Association American Stroke. "Guidelines for the Early Management of Patients with Ischemic Stroke: 2005 Guidelines Update a Scientific Statement from the Stroke Council of the American Heart Association/American Stroke Association." [In eng]. *Stroke* 36, no. 4 (Apr 2005): 916-23.
- Adams, H. P., Jr., G. del Zoppo, M. J. Alberts, D. L. Bhatt, L. Brass, A. Furlan, R. L. Grubb, *et al.* "Guidelines for the Early Management of Adults with Ischemic Stroke: A Guideline from the American Heart Association/American Stroke Association Stroke Council, Clinical Cardiology Council, Cardiovascular Radiology and Intervention Council, and the Atherosclerotic Peripheral Vascular Disease and Quality of Care Outcomes in Research Interdisciplinary Working Groups: The American Academy of Neurology Affirms the Value of This Guideline as an Educational Tool for Neurologists." [In eng]. *Stroke* 38, no. 5 (May 2007): 1655-711.
- Albers, G. W, P Amarenco, J. D. Easton, R. L. Sacco, and P. Teal. "Antithrombotic and Thrombolytic Therapy for Ischemic Stroke." *Chest* 119 (2001): 300-20.
- Albers, G. W., P. Amarenco, J. D. Easton, R. L. Sacco, and P. Teal. "Antithrombotic and Thrombolytic Therapy for Ischemic Stroke: The Seventh Accp Conference on Antithrombotic and Thrombolytic Therapy." [In eng]. *Chest* 126, no. 3 Suppl (Sep 2004): 483S-512S.
- Antithrombotic Trialists, Collaboration. "Collaborative Meta-Analysis of Randomised Trials of Antiplatelet Therapy for Prevention of Death, Myocardial Infarction, and Stroke in High Risk Patients." [In eng]. *BMJ* 324, no. 7329 (Jan 12 2002): 71-86.
- Bhatt, D. L., K. A. Fox, W. Hacke, P. B. Berger, H. R. Black, W. E. Boden, P. Cacoub, *et al.* "Clopidogrel and Aspirin Versus Aspirin Alone for the Prevention of Atherothrombotic Events." [In eng]. *N Engl J Med* 354, no. 16 (Apr 20 2006): 1706-17.
- Brott, T. G., W. M. Clark, S. C. Fagan, J. C. Grotta, L. N. Hopkins, E. C. Jauch, R. E. Latchaw, and S. Starkman. "Stroke: The First Hours. Guidelines for Acute Treatment." *National Stroke Association (NSA)* (2000).
- Centers for Disease Control and Prevention. "Prevalence and Most Common Causes of Disability among Adults--United States, 2005." [In eng]. *MMWR Morb Mortal Wkly Rep* 58, no. 16 (May 1 2009): 421-6.

- Chen, Z. M., P. Sandercock, H. C. Pan, C. Counsell, R. Collins, L. S. Liu, J. X. Xie, C. Warlow, and R. Peto. "Indications for Early Aspirin Use in Acute Ischemic Stroke : A Combined Analysis of 40 000 Randomized Patients from the Chinese Acute Stroke Trial and the International Stroke Trial. On Behalf of the Cast and Ist Collaborative Groups." [In eng]. *Stroke* 31, no. 6 (Jun 2000): 1240-9.
- "Collaborative Overview of Randomised Trials of Antiplatelet Therapy--I: Prevention of Death, Myocardial Infarction, and Stroke by Prolonged Antiplatelet Therapy in Various Categories of Patients. Antiplatelet Trialists' Collaboration." [In eng]. *BMJ* 308, no. 6921 (Jan 8 1994): 81-106.
- Committee, Caprie Steering. "A Randomised, Blinded, Trial of Clopidogrel Versus Aspirin in Patients at Risk of Ischaemic Events (Caprie). Caprie Steering Committee." [In eng]. *Lancet* 348, no. 9038 (Nov 16 1996): 1329-39.
- "A Comparison of Two Doses of Aspirin (30 Mg Vs. 283 Mg a Day) in Patients after a Transient Ischemic Attack or Minor Ischemic Stroke. The Dutch Tia Trial Study Group." [In eng]. *N Engl J Med* 325, no. 18 (Oct 31 1991): 1261-6.
- Coull, B. M., L. S. Williams, L. B. Goldstein, J. F. Meschia, D. Heitzman, S. Chaturvedi, K. C. Johnston, *et al.* "Anticoagulants and Antiplatelet Agents in Acute Ischemic Stroke: Report of the Joint Stroke Guideline Development Committee of the American Academy of Neurology and the American Stroke Association (a Division of the American Heart Association)." [In eng]. *Stroke* 33, no. 7 (Jul 2002): 1934-42.
- Diener, H. C., J. Bogousslavsky, L. M. Brass, C. Cimminiello, L. Csiba, M. Kaste, D. Leys, *et al.* "Aspirin and Clopidogrel Compared with Clopidogrel Alone after Recent Ischaemic Stroke or Transient Ischaemic Attack in High-Risk Patients (Match): Randomised, Double-Blind, Placebo-Controlled Trial." [In eng]. *Lancet* 364, no. 9431 (Jul 24-30 2004): 331-7.
- Eccles, M., N. Freemantle, and J. Mason. "North of England Evidence Based Guideline Development Project: Guideline on the Use of Aspirin as Secondary Prophylaxis for Vascular Disease in Primary Care. North of England Aspirin Guideline Development Group." [In eng]. *BMJ* 316, no. 7140 (Apr 25 1998): 1303-9.
- "The European Stroke Prevention Study (EspS). Principal End-Points. The EspS Group." [In eng]. *Lancet* 2, no. 8572 (Dec 12 1987): 1351-4.
- Farrell, B., J. Godwin, S. Richards, and C. Warlow. "The United Kingdom Transient Ischaemic Attack (Uk-Tia) Aspirin Trial: Final Results." [In eng]. *J Neurol Neurosurg Psychiatry* 54, no. 12 (Dec 1991): 1044-54.
- Furie, K. L., S. E. Kasner, R. J. Adams, G. W. Albers, R. L. Bush, S. C. Fagan, J. L. Halperin, *et al.* "Guidelines for the Prevention of Stroke in Patients with Stroke or Transient Ischemic Attack: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association." [In eng]. *Stroke* 42, no. 1 (Jan 2011): 227-76.
- Gaspoz, J. M., P. G. Coxson, P. A. Goldman, L. W. Williams, K. M. Kuntz, M. G. Hunink, and L. Goldman. "Cost Effectiveness of Aspirin, Clopidogrel, or Both for Secondary Prevention of Coronary Heart Disease." [In eng]. *N Engl J Med* 346, no. 23 (Jun 6 2002): 1800-6.
- Gent, M., J. A. Blakely, J. D. Easton, D. J. Ellis, V. C. Hachinski, J. W. Harbison, E. Panak, *et al.* "The Canadian American Ticlopidine Study (Cats) in Thromboembolic Stroke." [In eng]. *Lancet* 1, no. 8649 (Jun 3 1989): 1215-20.
- Gorelick, P. B., D. Richardson, M. Kelly, S. Ruland, E. Hung, Y. Harris, S. Kittner, S. Leurgans, and Investigators African American Antiplatelet Stroke Prevention Study. "Aspirin and Ticlopidine for Prevention of Recurrent Stroke in Black Patients: A Randomized Trial." [In eng]. *JAMA* 289, no. 22 (Jun 11 2003): 2947-57.

- Group, Esprit Study, P. H. Halkes, J. van Gijn, L. J. Kappelle, P. J. Koudstaal, and A. Algra. "Aspirin Plus Dipyridamole Versus Aspirin Alone after Cerebral Ischaemia of Arterial Origin (Esprit): Randomised Controlled Trial." [In eng]. *Lancet* 367, no. 9523 (May 20 2006): 1665-73.
- Guyatt, G. H., E. A. Akl, M. Crowther, D. D. Gutterman, H. J. Schunemann, Therapy American College of Chest Physicians Antithrombotic, and Panel Prevention of Thrombosis. "Executive Summary: Antithrombotic Therapy and Prevention of Thrombosis, 9th Ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines." [In eng]. *Chest* 141, no. 2 Suppl (Feb 2012): 7S-47S.
- Guyatt, G., H. Schunemann, D. Cook, R. Jaeschke, S. Pauker, H. Bucher, and Physicians American College of Chest. "Grades of Recommendation for Antithrombotic Agents." [In eng]. *Chest* 119, no. 1 Suppl (Jan 2001): 3S-7S.
- Hass, W. K., J. D. Easton, H. P. Adams, Jr., W. Pryse-Phillips, B. A. Molony, S. Anderson, and B. Kamm. "A Randomized Trial Comparing Ticlopidine Hydrochloride with Aspirin for the Prevention of Stroke in High-Risk Patients. Ticlopidine Aspirin Stroke Study Group." [In eng]. *N Engl J Med* 321, no. 8 (Aug 24 1989): 501-7.
- "The International Stroke Trial (Ist): A Randomised Trial of Aspirin, Subcutaneous Heparin, Both, or Neither among 19435 Patients with Acute Ischaemic Stroke. International Stroke Trial Collaborative Group." [In eng]. *Lancet* 349, no. 9065 (May 31 1997): 1569-81.
- Jauch, E. C., J. L. Saver, H. P. Adams, Jr., A. Bruno, J. J. Connors, B. M. Demaerschalk, P. Khatri, *et al.* "Guidelines for the Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association." [In Eng]. *Stroke* (Jan 31 2013).
- Johnson, E. S., S. F. Lanes, C. E. Wentworth, 3rd, M. H. Satterfield, B. L. Abebe, and L. W. Dicker. "A Metaregression Analysis of the Dose-Response Effect of Aspirin on Stroke." [In eng]. *Arch Intern Med* 159, no. 11 (Jun 14 1999): 1248-53.
- Kennedy, J., M. D. Hill, K. J. Ryckborst, M. Eliasziw, A. M. Demchuk, A. M. Buchan, and Faster Investigators. "Fast Assessment of Stroke and Transient Ischaemic Attack to Prevent Early Recurrence (Faster): A Randomised Controlled Pilot Trial." [In eng]. *Lancet Neurol* 6, no. 11 (Nov 2007): 961-9.
- "A Randomized Trial of Aspirin and Sulfinpyrazone in Threatened Stroke. The Canadian Cooperative Study Group." [In eng]. *N Engl J Med* 299, no. 2 (Jul 13 1978): 53-9.
- Roger, V. L., A. S. Go, D. M. Lloyd-Jones, E. J. Benjamin, J. D. Berry, W. B. Borden, D. M. Bravata, *et al.* "Heart Disease and Stroke Statistics--2012 Update: A Report from the American Heart Association." [In eng]. *Circulation* 125, no. 1 (Jan 3 2012): e2-e220.
- Sacco, R. L., R. Adams, G. Albers, M. J. Alberts, O. Benavente, K. Furie, L. B. Goldstein, *et al.* "Guidelines for Prevention of Stroke in Patients with Ischemic Stroke or Transient Ischemic Attack: A Statement for Healthcare Professionals from the American Heart Association/American Stroke Association Council on Stroke: Co-Sponsored by the Council on Cardiovascular Radiology and Intervention: The American Academy of Neurology Affirms the Value of This Guideline." [In eng]. *Stroke* 37, no. 2 (Feb 2006): 577-617.
- Sacco, R. L., H. C. Diener, S. Yusuf, D. Cotton, S. Ounpuu, W. A. Lawton, Y. Palesch, *et al.* "Aspirin and Extended-Release Dipyridamole Versus Clopidogrel for Recurrent Stroke." [In eng]. *N Engl J Med* 359, no. 12 (Sep 18 2008): 1238-51.
- "Swedish Aspirin Low-Dose Trial (Salt) of 75 Mg Aspirin as Secondary Prophylaxis after Cerebrovascular Ischaemic Events. The Salt Collaborative Group." [In eng]. *Lancet* 338, no. 8779 (Nov 30 1991): 1345-9.

- "United Kingdom Transient Ischaemic Attack (Uk-Tia) Aspirin Trial: Interim Results. Uk-Tia Study Group." [In eng]. *Br Med J (Clin Res Ed)* 296, no. 6618 (Jan 30 1988): 316-20.

Impacts:Measure(s)

STK-3

Rationale: Update references to reflect current evidence as submitted for NQF re-endorsement.

Description of Changes:Selected References**Change to:**

- Berge, E., M. Abdelnoor, P. H. Nakstad, and P. M. Sandset. "Low Molecular-Weight Heparin Versus Aspirin in Patients with Acute Ischaemic Stroke and Atrial Fibrillation: A Double-Blind Randomised Study. Haest Study Group. Heparin in Acute Embolic Stroke Trial." [In eng]. *Lancet* 355, no. 9211 (Apr 8 2000): 1205-10.
- Centers for Disease Control and Prevention. "Prevalence and Most Common Causes of Disability among Adults--United States, 2005." [In eng]. *MMWR Morb Mortal Wkly Rep* 58, no. 16 (May 1 2009): 421-6.
- Connolly, S. J., M. D. Ezekowitz, S. Yusuf, J. Eikelboom, J. Oldgren, A. Parekh, J. Pogue, *et al.* "Dabigatran Versus Warfarin in Patients with Atrial Fibrillation." [In eng]. *N Engl J Med* 361, no. 12 (Sep 17 2009): 1139-51.
- Furie, K. L., S. E. Kasner, R. J. Adams, G. W. Albers, R. L. Bush, S. C. Fagan, J. L. Halperin, *et al.* "Guidelines for the Prevention of Stroke in Patients with Stroke or Transient Ischemic Attack: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association." [In eng]. *Stroke* 42, no. 1 (Jan 2011): 227-76.
- Fuster, V., L. E. Ryden, R. W. Asinger, D. S. Cannom, H. J. Crijns, R. L. Frye, J. L. Halperin, *et al.* "Acc/Aha/Esc Guidelines for the Management of Patients with Atrial Fibrillation: Executive Summary. A Report of the American College of Cardiology/ American Heart Association Task Force on Practice Guidelines and the European Society of Cardiology Committee for Practice Guidelines and Policy Conferences (Committee to Develop Guidelines for the Management of Patients with Atrial Fibrillation): Developed in Collaboration with the North American Society of Pacing and Electrophysiology." [In eng]. *J Am Coll Cardiol* 38, no. 4 (Oct 2001): 1231-66.
- Fuster, V., L. E. Ryden, D. S. Cannom, H. J. Crijns, A. B. Curtis, K. A. Ellenbogen, J. L. Halperin, *et al.* "Acc/Aha/Esc 2006 Guidelines for the Management of Patients with Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the European Society of Cardiology Committee for Practice Guidelines (Writing Committee to Revise the 2001 Guidelines for the Management of Patients with Atrial Fibrillation): Developed in Collaboration with the European Heart Rhythm Association and the Heart Rhythm Society." [In eng]. *Circulation* 114, no. 7 (Aug 15 2006): e257-354.
- Goldstein, L. B., R. Adams, M. J. Alberts, L. J. Appel, L. M. Brass, C. D. Bushnell, A. Culebras, *et al.* "Primary Prevention of Ischemic Stroke: A Guideline from the American Heart Association/American Stroke Association Stroke Council: Cosponsored by the Atherosclerotic Peripheral Vascular Disease Interdisciplinary Working Group; Cardiovascular Nursing Council; Clinical Cardiology Council; Nutrition, Physical Activity, and Metabolism

Council; and the Quality of Care and Outcomes Research Interdisciplinary Working Group: The American Academy of Neurology Affirms the Value of This Guideline." [In eng]. *Stroke* 37, no. 6 (Jun 2006): 1583-633.

- Gorelick, P. B., R. L. Sacco, D. B. Smith, M. Alberts, L. Mustone-Alexander, D. Rader, J. L. Ross, *et al.* "Prevention of a First Stroke: A Review of Guidelines and a Multidisciplinary Consensus Statement from the National Stroke Association." [In eng]. *JAMA* 281, no. 12 (Mar 24-31 1999): 1112-20.
- Hart, R. G., O. Benavente, R. McBride, and L. A. Pearce. "Antithrombotic Therapy to Prevent Stroke in Patients with Atrial Fibrillation: A Meta-Analysis." [In eng]. *Ann Intern Med* 131, no. 7 (Oct 5 1999): 492-501.
- Jauch, E. C., J. L. Saver, H. P. Adams, Jr., A. Bruno, J. J. Connors, B. M. Demaerschalk, P. Khatri, *et al.* "Guidelines for the Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association." [In Eng]. *Stroke* (Jan 31 2013).
- Lin, H. J., P. A. Wolf, M. Kelly-Hayes, A. S. Beiser, C. S. Kase, E. J. Benjamin, and R. B. D'Agostino. "Stroke Severity in Atrial Fibrillation. The Framingham Study." [In eng]. *Stroke* 27, no. 10 (Oct 1996): 1760-4.
- Penado, S., M. Cano, O. Acha, J. L. Hernandez, and J. A. Riancho. "Atrial Fibrillation as a Risk Factor for Stroke Recurrence." [In eng]. *Am J Med* 114, no. 3 (Feb 15 2003): 206-10.
- Roger, V. L., A. S. Go, D. M. Lloyd-Jones, E. J. Benjamin, J. D. Berry, W. B. Borden, D. M. Bravata, *et al.* "Heart Disease and Stroke Statistics--2012 Update: A Report from the American Heart Association." [In eng]. *Circulation* 125, no. 1 (Jan 3 2012): e2-e220.
- Sacco, R. L., R. Adams, G. Albers, M. J. Alberts, O. Benavente, K. Furie, L. B. Goldstein, *et al.* "Guidelines for Prevention of Stroke in Patients with Ischemic Stroke or Transient Ischemic Attack: A Statement for Healthcare Professionals from the American Heart Association/American Stroke Association Council on Stroke: Co-Sponsored by the Council on Cardiovascular Radiology and Intervention: The American Academy of Neurology Affirms the Value of This Guideline." [In eng]. *Stroke* 37, no. 2 (Feb 2006): 577-617.
- Saxena, R., and P. J. Koudstaal. "Anticoagulants for Preventing Stroke in Patients with Nonrheumatic Atrial Fibrillation and a History of Stroke or Transient Ischemic Attack (Review). ." *Cochrane Database Syst Rev*, no. 4 (2011): CD000185.
- Saxena, R., S. Lewis, E. Berge, P. A. Sandercock, and P. J. Koudstaal. "Risk of Early Death and Recurrent Stroke and Effect of Heparin in 3169 Patients with Acute Ischemic Stroke and Atrial Fibrillation in the International Stroke Trial." [In eng]. *Stroke* 32, no. 10 (Oct 2001): 2333-7.
- van Walraven, C., R. G. Hart, D. E. Singer, A. Laupacis, S. Connolly, P. Petersen, P. J. Koudstaal, Y. Chang, and B. Hellemons. "Oral Anticoagulants Vs Aspirin in Nonvalvular Atrial Fibrillation: An Individual Patient Meta-Analysis." [In eng]. *JAMA* 288, no. 19 (Nov 20 2002): 2441-8.
- Wann, L. S., A. B. Curtis, K. A. Ellenbogen, N. A. Estes, 3rd, M. D. Ezekowitz, W. M. Jackman, C. T. January, *et al.* "2011 Accf/Aha/Hrs Focused Update on the Management of Patients with Atrial Fibrillation (Update on Dabigatran): A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines." [In eng]. *J Am Coll Cardiol* 57, no. 11 (Mar 15 2011): 1330-7.

Impacts:Measure(s)

STK-4

Rationale: Update references to reflect current evidence as submitted for NQF re-endorsement.

Description of Changes:Selected References**Change to:**

- Adams, H., R. Adams, G. Del Zoppo, L. B. Goldstein, Association Stroke Council of the American Heart, and Association American Stroke. "Guidelines for the Early Management of Patients with Ischemic Stroke: 2005 Guidelines Update a Scientific Statement from the Stroke Council of the American Heart Association/American Stroke Association." [In eng]. *Stroke* 36, no. 4 (Apr 2005): 916-23.
- Adams, H. P., Jr., G. del Zoppo, M. J. Alberts, D. L. Bhatt, L. Brass, A. Furlan, R. L. Grubb, *et al.* "Guidelines for the Early Management of Adults with Ischemic Stroke: A Guideline from the American Heart Association/American Stroke Association Stroke Council, Clinical Cardiology Council, Cardiovascular Radiology and Intervention Council, and the Atherosclerotic Peripheral Vascular Disease and Quality of Care Outcomes in Research Interdisciplinary Working Groups: The American Academy of Neurology Affirms the Value of This Guideline as an Educational Tool for Neurologists." [In eng]. *Stroke* 38, no. 5 (May 2007): 1655-711.
- Albers, G. W., P. Amarenco, J. D. Easton, R. L. Sacco, and P. Teal. "Antithrombotic and Thrombolytic Therapy for Ischemic Stroke: The Seventh Accp Conference on Antithrombotic and Thrombolytic Therapy." [In eng]. *Chest* 126, no. 3 Suppl (Sep 2004): 483S-512S.
- Brott, T. G., W. M. Clark, S. C. Fagan, J. C. Grotta, L. N. Hopkins, E. C. Jauch, R. E. Latchaw, and S. Starkman. "Stroke: The First Hours. Guidelines for Acute Treatment." *National Stroke Association (NSA)* (2000).
- Centers for Disease Control and Prevention. "Prevalence and Most Common Causes of Disability among Adults--United States, 2005." [In eng]. *MMWR Morb Mortal Wkly Rep* 58, no. 16 (May 1 2009): 421-6.
- Del Zoppo, G. J., J. L. Saver, E. C. Jauch, H. P. Adams, Jr., and Council American Heart Association Stroke. "Expansion of the Time Window for Treatment of Acute Ischemic Stroke with Intravenous Tissue Plasminogen Activator: A Science Advisory from the American Heart Association/American Stroke Association." [In eng]. *Stroke* 40, no. 8 (Aug 2009): 2945-8.
- "Diagnosis and Initial Treatment of Ischemic Stroke." *Institute for Clinical Systems Improvement* (2001).
- Fagan, S. C., L. B. Morgenstern, A. Petitta, R. E. Ward, B. C. Tilley, J. R. Marler, S. R. Levine, *et al.* "Cost-Effectiveness of Tissue Plasminogen Activator for Acute Ischemic Stroke. Ninds Rt-Pa Stroke Study Group." [In eng]. *Neurology* 50, no. 4 (Apr 1998): 883-90.
- Guyatt, G. H., E. A. Akl, M. Crowther, D. D. Gutterman, H. J. Schunemann, Therapy American College of Chest Physicians Antithrombotic, and Panel Prevention of Thrombosis. "Executive Summary: Antithrombotic Therapy and Prevention of Thrombosis, 9th Ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines." [In eng]. *Chest* 141, no. 2 Suppl (Feb 2012): 7S-47S.

- Hacke, W., G. Donnan, C. Fieschi, M. Kaste, R. von Kummer, J. P. Broderick, T. Brott, *et al.* "Association of Outcome with Early Stroke Treatment: Pooled Analysis of Atlantis, Ecass, and Ninds Rt-Pa Stroke Trials." [In eng]. *Lancet* 363, no. 9411 (Mar 6 2004): 768-74.
- Hacke, W., M. Kaste, E. Bluhmki, M. Brozman, A. Davalos, D. Guidetti, V. Larrue, *et al.* "Thrombolysis with Alteplase 3 to 4.5 Hours after Acute Ischemic Stroke." [In eng]. *N Engl J Med* 359, no. 13 (Sep 25 2008): 1317-29.
- Hacke, W., M. Kaste, C. Fieschi, D. Toni, E. Lesaffre, R. von Kummer, G. Boysen, *et al.* "Intravenous Thrombolysis with Recombinant Tissue Plasminogen Activator for Acute Hemispheric Stroke. The European Cooperative Acute Stroke Study (Ecass)." [In eng]. *JAMA* 274, no. 13 (Oct 4 1995): 1017-25.
- Jauch, E. C., J. L. Saver, H. P. Adams, Jr., A. Bruno, J. J. Connors, B. M. Demaerschalk, P. Khatri, *et al.* "Guidelines for the Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association." [In Eng]. *Stroke* (Jan 31 2013).
- Kwiatkowski, T. G., R. B. Libman, M. Frankel, B. C. Tilley, L. B. Morgenstern, M. Lu, J. P. Broderick, *et al.* "Effects of Tissue Plasminogen Activator for Acute Ischemic Stroke at One Year. National Institute of Neurological Disorders and Stroke Recombinant Tissue Plasminogen Activator Stroke Study Group." [In eng]. *N Engl J Med* 340, no. 23 (Jun 10 1999): 1781-7.
- "Management of Patients with Stroke: Rehabilitation, Prevention and Management of Complications, and Discharge Planning. A National Clinical Guideline." <http://www.sign.ac.uk/pdf/sign118.pdf>.
- Marler, J. R., B. C. Tilley, M. Lu, T. G. Brott, P. C. Lyden, J. C. Grotta, J. P. Broderick, *et al.* "Early Stroke Treatment Associated with Better Outcome: The Ninds Rt-Pa Stroke Study." [In eng]. *Neurology* 55, no. 11 (Dec 12 2000): 1649-55.
- Roger, V. L., A. S. Go, D. M. Lloyd-Jones, E. J. Benjamin, J. D. Berry, W. B. Borden, D. M. Bravata, *et al.* "Heart Disease and Stroke Statistics--2012 Update: A Report from the American Heart Association." [In eng]. *Circulation* 125, no. 1 (Jan 3 2012): e2-e220.
- Sacco, R. L., R. Adams, G. Albers, M. J. Alberts, O. Benavente, K. Furie, L. B. Goldstein, *et al.* "Guidelines for Prevention of Stroke in Patients with Ischemic Stroke or Transient Ischemic Attack: A Statement for Healthcare Professionals from the American Heart Association/American Stroke Association Council on Stroke: Co-Sponsored by the Council on Cardiovascular Radiology and Intervention: The American Academy of Neurology Affirms the Value of This Guideline." [In eng]. *Stroke* 37, no. 2 (Feb 2006): 577-617.
- Saposnik, G., J. Fang, M. K. Kapral, J. V. Tu, M. Mamdani, P. Austin, S. C. Johnston, Network Investigators of the Registry of the Canadian Stroke, and Group Stroke Outcomes Research Canada Working. "The Iscore Predicts Effectiveness of Thrombolytic Therapy for Acute Ischemic Stroke." [In eng]. *Stroke* 43, no. 5 (May 2012): 1315-22.
- "Tissue Plasminogen Activator for Acute Ischemic Stroke. The National Institute of Neurological Disorders and Stroke Rt-Pa Stroke Study Group." [In eng]. *N Engl J Med* 333, no. 24 (Dec 14 1995): 1581-7.
- Wardlaw, J. M., V. Murray, E. Berge, and G. J. Del Zoppo. "Thrombolysis for Acute Ischaemic Stroke." [In eng]. *Cochrane Database Syst Rev*, no. 4 (2009): CD000213.

Impacts:Measure(s)

STK-5

Rationale: Update references to reflect current evidence as submitted for NQF re-endorsement.

Description of Changes:Selected References**Change to:**

- Adams, H., R. Adams, G. Del Zoppo, L. B. Goldstein, Association Stroke Council of the American Heart, and Association American Stroke. "Guidelines for the Early Management of Patients with Ischemic Stroke: 2005 Guidelines Update a Scientific Statement from the Stroke Council of the American Heart Association/American Stroke Association." [In eng]. *Stroke* 36, no. 4 (Apr 2005): 916-23.
- Adams, H. P., Jr., G. del Zoppo, M. J. Alberts, D. L. Bhatt, L. Brass, A. Furlan, R. L. Grubb, *et al.* "Guidelines for the Early Management of Adults with Ischemic Stroke: A Guideline from the American Heart Association/American Stroke Association Stroke Council, Clinical Cardiology Council, Cardiovascular Radiology and Intervention Council, and the Atherosclerotic Peripheral Vascular Disease and Quality of Care Outcomes in Research Interdisciplinary Working Groups: The American Academy of Neurology Affirms the Value of This Guideline as an Educational Tool for Neurologists." [In eng]. *Stroke* 38, no. 5 (May 2007): 1655-711.
- Albers, G. W., P. Amarenco, J. D. Easton, R. L. Sacco, and P. Teal. "Antithrombotic and Thrombolytic Therapy for Ischemic Stroke." *Chest* 119 (2001): 300-20.
- Antithrombotic Trialists, Collaboration. "Collaborative Meta-Analysis of Randomised Trials of Antiplatelet Therapy for Prevention of Death, Myocardial Infarction, and Stroke in High Risk Patients." [In eng]. *BMJ* 324, no. 7329 (Jan 12 2002): 71-86.
- Brott, T. G., W. M. Clark, S. C. Fagan, J. C. Grotta, L. N. Hopkins, E. C. Jauch, R. E. Latchaw, and S. Starkman. "Stroke: The First Hours. Guidelines for Acute Treatment." *National Stroke Association (NSA)* (2000).
- Centers for Disease Control and Prevention. "Prevalence and Most Common Causes of Disability among Adults--United States, 2005." [In eng]. *MMWR Morb Mortal Wkly Rep* 58, no. 16 (May 1 2009): 421-6.
- Chen, Z. M., P. Sandercock, H. C. Pan, C. Counsell, R. Collins, L. S. Liu, J. X. Xie, C. Warlow, and R. Peto. "Indications for Early Aspirin Use in Acute Ischemic Stroke : A Combined Analysis of 40 000 Randomized Patients from the Chinese Acute Stroke Trial and the International Stroke Trial. On Behalf of the Cast and Ist Collaborative Groups." [In eng]. *Stroke* 31, no. 6 (Jun 2000): 1240-9.
- Coull, B. M., L. S. Williams, L. B. Goldstein, J. F. Meschia, D. Heitzman, S. Chaturvedi, K. C. Johnston, *et al.* "Anticoagulants and Antiplatelet Agents in Acute Ischemic Stroke: Report of the Joint Stroke Guideline Development Committee of the American Academy of Neurology and the American Stroke Association (a Division of the American Heart Association)." [In eng]. *Stroke* 33, no. 7 (Jul 2002): 1934-42.
- Eccles, M., N. Freemantle, and J. Mason. "North of England Evidence Based Guideline Development Project: Guideline on the Use of Aspirin as Secondary Prophylaxis for Vascular Disease in Primary Care. North of England Aspirin Guideline Development Group." [In eng]. *BMJ* 316, no. 7140 (Apr 25 1998): 1303-9.

- "The European Stroke Prevention Study (EspS). Principal End-Points. The EspS Group." [In eng]. *Lancet* 2, no. 8572 (Dec 12 1987): 1351-4.
- Furie, K. L., S. E. Kasner, R. J. Adams, G. W. Albers, R. L. Bush, S. C. Fagan, J. L. Halperin, *et al.* "Guidelines for the Prevention of Stroke in Patients with Stroke or Transient Ischemic Attack: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association." [In eng]. *Stroke* 42, no. 1 (Jan 2011): 227-76.
- Gaspoz, J. M., P. G. Coxson, P. A. Goldman, L. W. Williams, K. M. Kuntz, M. G. Hunink, and L. Goldman. "Cost Effectiveness of Aspirin, Clopidogrel, or Both for Secondary Prevention of Coronary Heart Disease." [In eng]. *N Engl J Med* 346, no. 23 (Jun 6 2002): 1800-6.
- Guyatt, G. H., E. A. Akl, M. Crowther, D. D. Gutterman, H. J. Schunemann, Therapy American College of Chest Physicians Antithrombotic, and Panel Prevention of Thrombosis. "Executive Summary: Antithrombotic Therapy and Prevention of Thrombosis, 9th Ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines." [In eng]. *Chest* 141, no. 2 Suppl (Feb 2012): 7S-47S.
- "The International Stroke Trial (Ist): A Randomised Trial of Aspirin, Subcutaneous Heparin, Both, or Neither among 19435 Patients with Acute Ischaemic Stroke. International Stroke Trial Collaborative Group." [In eng]. *Lancet* 349, no. 9065 (May 31 1997): 1569-81.
- Jauch, E. C., J. L. Saver, H. P. Adams, Jr., A. Bruno, J. J. Connors, B. M. Demaerschalk, P. Khatri, *et al.* "Guidelines for the Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association." [In Eng]. *Stroke* (Jan 31 2013).
- Johnson, E. S., S. F. Lanes, C. E. Wentworth, 3rd, M. H. Satterfield, B. L. Abebe, and L. W. Dicker. "A Metaregression Analysis of the Dose-Response Effect of Aspirin on Stroke." [In eng]. *Arch Intern Med* 159, no. 11 (Jun 14 1999): 1248-53.
- Roger, V. L., A. S. Go, D. M. Lloyd-Jones, E. J. Benjamin, J. D. Berry, W. B. Borden, D. M. Bravata, *et al.* "Heart Disease and Stroke Statistics--2012 Update: A Report from the American Heart Association." [In eng]. *Circulation* 125, no. 1 (Jan 3 2012): e2-e220.
- Sacco, R. L., R. Adams, G. Albers, M. J. Alberts, O. Benavente, K. Furie, L. B. Goldstein, *et al.* "Guidelines for Prevention of Stroke in Patients with Ischemic Stroke or Transient Ischemic Attack: A Statement for Healthcare Professionals from the American Heart Association/American Stroke Association Council on Stroke: Co-Sponsored by the Council on Cardiovascular Radiology and Intervention: The American Academy of Neurology Affirms the Value of This Guideline." [In eng]. *Stroke* 37, no. 2 (Feb 2006): 577-617.

Impacts:Measure(s)

STK-6

Rationale: Provide clarification for abstractor.**Description of Changes:**Rationale**Change** "admission" to "hospital arrival"

Impacts:Measure(s)

STK-6

Rationale: Update references to reflect current evidence as submitted for NQF re-endorsement.

Description of Changes:Selected References**Change to:**

- Adams, R. J., G. Albers, M. J. Alberts, O. Benavente, K. Furie, L. B. Goldstein, P. Gorelick, *et al.* "Update to the Aha/Asa Recommendations for the Prevention of Stroke in Patients with Stroke and Transient Ischemic Attack." [In eng]. *Stroke* 39, no. 5 (May 2008): 1647-52.
- Amarenco, P., J. Bogousslavsky, A. Callahan, 3rd, L. B. Goldstein, M. Hennerici, A. E. Rudolph, H. Sillesen, *et al.* "High-Dose Atorvastatin after Stroke or Transient Ischemic Attack." [In eng]. *N Engl J Med* 355, no. 6 (Aug 10 2006): 549-59.
- Biffi, A., W. J. Devan, C. D. Anderson, L. Cortellini, K. L. Furie, J. Rosand, and N. S. Rost. "Statin Treatment and Functional Outcome after Ischemic Stroke: Case-Control and Meta-Analysis." [In eng]. *Stroke* 42, no. 5 (May 2011): 1314-9.
- Centers for Disease Control and Prevention. "Prevalence and Most Common Causes of Disability among Adults--United States, 2005." [In eng]. *MMWR Morb Mortal Wkly Rep* 58, no. 16 (May 1 2009): 421-6.
- Chan, P. S., B. K. Nallamothu, H. S. Gurm, R. A. Hayward, and S. Vijan. "Incremental Benefit and Cost-Effectiveness of High-Dose Statin Therapy in High-Risk Patients with Coronary Artery Disease." [In eng]. *Circulation* 115, no. 18 (May 8 2007): 2398-409.
- Craig, S. R., R. V. Amin, D. W. Russell, and N. F. Paradise. "Blood Cholesterol Screening Influence of Fasting State on Cholesterol Results and Management Decisions." [In eng]. *J Gen Intern Med* 15, no. 6 (Jun 2000): 395-9.
- Culver, A. L., I. S. Ockene, R. Balasubramanian, B. C. Olendzki, D. M. Sepavich, J. Wactawski-Wende, J. E. Manson, *et al.* "Statin Use and Risk of Diabetes Mellitus in Postmenopausal Women in the Women's Health Initiative." [In eng]. *Arch Intern Med* 172, no. 2 (Jan 23 2012): 144-52.
- Feher, A., G. Pusch, K. Koltai, A. Tibold, B. Gasztonyi, L. Szapary, and G. Feher. "Statintherapy in the Primary and the Secondary Prevention of Ischaemic Cerebrovascular Diseases." [In eng]. *Int J Cardiol* 148, no. 2 (Apr 14 2011): 131-8.
- Feinberg, W. M., G. W. Albers, H. J. Barnett, J. Biller, L. R. Caplan, L. P. Carter, R. G. Hart, *et al.* "Guidelines for the Management of Transient Ischemic Attacks. From the Ad Hoc Committee on Guidelines for the Management of Transient Ischemic Attacks of the Stroke Council of the American Heart Association." [In eng]. *Circulation* 89, no. 6 (Jun 1994): 2950-65.
- Furie, K. L., S. E. Kasner, R. J. Adams, G. W. Albers, R. L. Bush, S. C. Fagan, J. L. Halperin, *et al.* "Guidelines for the Prevention of Stroke in Patients with Stroke or Transient Ischemic Attack: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association." [In eng]. *Stroke* 42, no. 1 (Jan 2011): 227-76.
- Gore, J. M., R. J. Goldberg, A. S. Matsumoto, W. P. Castelli, P. M. McNamara, and J. E. Dalen. "Validity of Serum Total Cholesterol Level Obtained within 24 Hours of Acute Myocardial Infarction." [In eng]. *Am J Cardiol* 54, no. 7 (Oct 1 1984): 722-5.
- Grundy, S. M., J. I. Cleeman, C. N. Merz, H. B. Brewer, Jr., L. T. Clark, D. B. Hunninghake, R. C. Pasternak, *et al.* "Implications of Recent Clinical Trials for the National Cholesterol

Education Program Adult Treatment Panel III Guidelines." [In eng]. *Circulation* 110, no. 2 (Jul 13 2004): 227-39.

- Kostis, W. J., J. Q. Cheng, J. M. Dobrzynski, J. Cabrera, and J. B. Kostis. "Meta-Analysis of Statin Effects in Women Versus Men." [In eng]. *J Am Coll Cardiol* 59, no. 6 (Feb 7 2012): 572-82.
- Lazar, L. D., M. J. Pletcher, P. G. Coxson, K. Bibbins-Domingo, and L. Goldman. "Cost-Effectiveness of Statin Therapy for Primary Prevention in a Low-Cost Statin Era." [In eng]. *Circulation* 124, no. 2 (Jul 12 2011): 146-53.
- Mitka, M. "Some Question Use of Statins to Reduce Cardiovascular Risks in Healthy Women." [In eng]. *JAMA* 307, no. 9 (Mar 7 2012): 893-4.
- National Cholesterol Education Program Expert Panel on Detection, Evaluation, and Adults Treatment of High Blood Cholesterol in. "Third Report of the National Cholesterol Education Program (Ncep) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report." [In eng]. *Circulation* 106, no. 25 (Dec 17 2002): 3143-421.
- Pitt, B., J. Loscalzo, J. Ycas, and J. S. Raichlen. "Lipid Levels after Acute Coronary Syndromes." [In eng]. *J Am Coll Cardiol* 51, no. 15 (Apr 15 2008): 1440-5.
- Rodriguez-Yanez, M., J. Agulla, R. Rodriguez-Gonzalez, T. Sobrino, and J. Castillo. "Statins and Stroke." [In eng]. *Ther Adv Cardiovasc Dis* 2, no. 3 (Jun 2008): 157-66.
- Roger, V. L., A. S. Go, D. M. Lloyd-Jones, E. J. Benjamin, J. D. Berry, W. B. Borden, D. M. Bravata, *et al.* "Heart Disease and Stroke Statistics--2012 Update: A Report from the American Heart Association." [In eng]. *Circulation* 125, no. 1 (Jan 3 2012): e2-e220.
- Sacco, R. L., R. Adams, G. Albers, M. J. Alberts, O. Benavente, K. Furie, L. B. Goldstein, *et al.* "Guidelines for Prevention of Stroke in Patients with Ischemic Stroke or Transient Ischemic Attack: A Statement for Healthcare Professionals from the American Heart Association/American Stroke Association Council on Stroke: Co-Sponsored by the Council on Cardiovascular Radiology and Intervention: The American Academy of Neurology Affirms the Value of This Guideline." [In eng]. *Stroke* 37, no. 2 (Feb 2006): 577-617.
- Schellinger, P. D., R. N. Bryan, L. R. Caplan, J. A. Detre, R. R. Edelman, C. Jaigobin, C. S. Kidwell, *et al.* "Evidence-Based Guideline: The Role of Diffusion and Perfusion MRI for the Diagnosis of Acute Ischemic Stroke: Report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology." [In eng]. *Neurology* 75, no. 2 (Jul 13 2010): 177-85.
- Squizzato, A., E. Romualdi, F. Dentali, and W. Ageno. "Statins for Acute Ischemic Stroke." [In eng]. *Cochrane Database Syst Rev*, no. 8 (2011): CD007551.
- Van Dis, F. J., L. M. Keilson, C. A. Rundell, and M. W. Rawstron. "Direct Measurement of Serum Low-Density Lipoprotein Cholesterol in Patients with Acute Myocardial Infarction on Admission to the Emergency Room." [In eng]. *Am J Cardiol* 77, no. 14 (Jun 1 1996): 1232-4.
- Weiss, R., M. Harder, and J. Rowe. "The Relationship between Nonfasting and Fasting Lipid Measurements in Patients with or without Type 2 Diabetes Mellitus Receiving Treatment with 3-Hydroxy-3-Methylglutaryl-Coenzyme a Reductase Inhibitors." [In eng]. *Clin Ther* 25, no. 5 (May 2003): 1490-7.

Impacts:Measure(s)

STK-8

Rationale: NQF Measure Maintenance process removed endorsement for five measures in 2012.

Description of Changes:**Remove:**

NQF ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE

Impacts:Measure(s)

STK-8

Rationale: Update references to reflect current evidence as submitted for NQF re-endorsement.

Description of Changes:Selected References**Change to:**

- Anderson, R. T., F. Camacho, A. I. Iaconi, C. H. Tegeler, and R. Balkrishnan. "Enhancing the Effectiveness of Community Stroke Risk Screening: A Randomized Controlled Trial." [In eng]. *J Stroke Cerebrovasc Dis* 20, no. 4 (Jul-Aug 2011): 330-5.
- Boysen, G., L. H. Krarup, X. Zeng, A. Oskedra, J. Korv, G. Andersen, C. Gluud, *et al.* "Exstroke Pilot Trial of the Effect of Repeated Instructions to Improve Physical Activity after Ischaemic Stroke: A Multinational Randomised Controlled Clinical Trial." [In eng]. *BMJ* 339 (2009): b2810.
- Byers, A. M., L. Lamanna, and A. Rosenberg. "The Effect of Motivational Interviewing after Ischemic Stroke on Patient Knowledge and Patient Satisfaction with Care: A Pilot Study." [In eng]. *J Neurosci Nurs* 42, no. 6 (Dec 2010): 312-22.
- Centers for Disease Control and Prevention. "Prevalence and Most Common Causes of Disability among Adults--United States, 2005." [In eng]. *MMWR Morb Mortal Wkly Rep* 58, no. 16 (May 1 2009): 421-6.
- Chan, Y. F., R. Lavery, N. Fox, R. Kwon, S. Zinzuwadia, R. Massone, and D. Livingston. "Effect of an Educational Video on Emergency Department Patient Stroke Knowledge." [In eng]. *J Emerg Med* 34, no. 2 (Feb 2008): 215-20.
- Davis, S. M., D. Martinelli, B. Braxton, K. Kutrovac, and T. Crocco. "The Impact of the Extended Parallel Process Model on Stroke Awareness: Pilot Results from a Novel Study." [In eng]. *Stroke* 40, no. 12 (Dec 2009): 3857-63.
- Dromerick, A. W., M. C. Gibbons, D. F. Edwards, D. E. Farr, M. L. Giannetti, B. Sanchez, N. M. Shara, *et al.* "Preventing Recurrence of Thromboembolic Events through Coordinated Treatment in the District of Columbia." [In eng]. *Int J Stroke* 6, no. 5 (Oct 2011): 454-60.
- Duncan, P. W., R. Zorowitz, B. Bates, J. Y. Choi, J. J. Glasberg, G. D. Graham, R. C. Katz, K. Lamberty, and D. Reker. "Management of Adult Stroke Rehabilitation Care: A Clinical Practice Guideline." [In eng]. *Stroke* 36, no. 9 (Sep 2005): e100-43.
- Eames, S., T. Hoffmann, L. Worrall, and S. Read. "Delivery Styles and Formats for Different Stroke Information Topics: Patient and Carer Preferences." [In eng]. *Patient Educ Couns* 84, no. 2 (Aug 2011): e18-23.

- Eames, S., T. Hoffmann, L. Worrall, and S. Read. "Stroke Patients' and Carers' Perception of Barriers to Accessing Stroke Information." [In eng]. *Top Stroke Rehabil* 17, no. 2 (Mar-Apr 2010): 69-78.
- Evans, R. L., A. L. Matlock, D. S. Bishop, S. Stranahan, and C. Pederson. "Family Intervention after Stroke: Does Counseling or Education Help?" [In eng]. *Stroke* 19, no. 10 (Oct 1988): 1243-9.
- Furie, K. L., S. E. Kasner, R. J. Adams, G. W. Albers, R. L. Bush, S. C. Fagan, J. L. Halperin, *et al.* "Guidelines for the Prevention of Stroke in Patients with Stroke or Transient Ischemic Attack: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association." [In eng]. *Stroke* 42, no. 1 (Jan 2011): 227-76.
- Goldstein, L. B., C. D. Bushnell, R. J. Adams, L. J. Appel, L. T. Braun, S. Chaturvedi, M. A. Creager, *et al.* "Guidelines for the Primary Prevention of Stroke: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association." [In eng]. *Stroke* 42, no. 2 (Feb 2011): 517-84.
- Gresham, G. E., P. W. Duncan, W. B. Stason, H. P. Adams, A. M. Adelman, D. N. Alexander, D. S. Bishop *et al.* "Post-stroke rehabilitation. Clinical practice guideline, no. 16. Rockville, MD: US Department of Health and Human Services." *Public Health Service, Agency for Health Care Policy and Research* (1995): 95-0062.
- Hafsteinsdottir, T. B., M. Vergunst, E. Lindeman, and M. Schuurmans. "Educational Needs of Patients with a Stroke and Their Caregivers: A Systematic Review of the Literature." [In eng]. *Patient Educ Couns* 85, no. 1 (Oct 2011): 14-25.
- Harrington, R., G. Taylor, S. Hollinghurst, M. Reed, H. Kay, and V. A. Wood. "A Community-Based Exercise and Education Scheme for Stroke Survivors: A Randomized Controlled Trial and Economic Evaluation." [In eng]. *Clin Rehabil* 24, no. 1 (Jan 2010): 3-15.
- "Kaiser Permanente Clinical Practice Guidelines for Acute Stroke Quartet III Inpatient Management." The Permanente Medical Group, <http://www.kaiserpapers.org/cajud/acutestroke/inpaman.html>.
- Jauch, E. C., J. L. Saver, H. P. Adams, Jr., A. Bruno, J. J. Connors, B. M. Demaerschalk, P. Khatri, *et al.* "Guidelines for the Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association." [In Eng]. *Stroke* (Jan 31 2013).
- Lindsay, M. P., G. Gubitz, M. Bayley, M. D. Hill, C. Davies-Schinkel, S. Singh, and S. Phillips. "Canadian Best Practice Recommendations for Stroke Care (Update 2010)." In, *The Canadian Stroke Strategy* (2010): 17-20, 129-50. http://www.strokebestpractices.ca/wp-content/uploads/2011/04/2010BPR_ENG.pdf.
- Lorig, K. R., D. S. Sobel, A. L. Stewart, B. W. Brown, Jr., A. Bandura, P. Ritter, V. M. Gonzalez, D. D. Laurent, and H. R. Holman. "Evidence Suggesting That a Chronic Disease Self-Management Program Can Improve Health Status While Reducing Hospitalization: A Randomized Trial." [In eng]. *Med Care* 37, no. 1 (Jan 1999): 5-14.
- Maasland, L., D. Brouwer-Goossensen, H. M. den Hertog, P. J. Koudstaal, and D. W. Dippel. "Health Education in Patients with a Recent Stroke or Transient Ischaemic Attack: A Comprehensive Review." [In eng]. *Int J Stroke* 6, no. 1 (Feb 2011): 67-74.
- Ostwald, S. K., S. Davis, G. Hersch, C. Kelley, and K. M. Godwin. "Evidence-Based Educational Guidelines for Stroke Survivors after Discharge Home." [In eng]. *J Neurosci Nurs* 40, no. 3 (Jun 2008): 173-9, 91.
- Roger, V. L., A. S. Go, D. M. Lloyd-Jones, E. J. Benjamin, J. D. Berry, W. B. Borden, D. M. Bravata, *et al.* "Heart Disease and Stroke Statistics--2012 Update: A Report from the American Heart Association." [In eng]. *Circulation* 125, no. 1 (Jan 3 2012): e2-e220.

- Smith, J., A. Forster, A. House, P. Knapp, J. Wright, and J. Young. "Information Provision for Stroke Patients and Their Caregivers." [In eng]. *Cochrane Database Syst Rev*, no. 2 (2008): CD001919.
- Yvonne Chan, Y. F., R. Nagurka, L. D. Richardson, S. B. Zaets, M. B. Brimacombe, and S. R. Levine. "Effectiveness of Stroke Education in the Emergency Department Waiting Room." [In eng]. *J Stroke Cerebrovasc Dis* 19, no. 3 (May 2010): 209-15.

Impacts:Measure(s)

STK-10

Rationale: Update references to reflect current evidence as submitted for NQF re-endorsement.

Description of Changes:Selected References**Change to:**

- Affairs, Department of Veterans, and Department of Defense. "Va/Dod Clinical Practice Guideline for the Management of Stroke Rehabilitation in the Primary Care Setting," In, (2003).
- Bates, B., J. Y. Choi, P. W. Duncan, J. J. Glasberg, G. D. Graham, R. C. Katz, K. Lamberty, *et al.* "Veterans Affairs/Department of Defense Clinical Practice Guideline for the Management of Adult Stroke Rehabilitation Care: Executive Summary." [In eng]. *Stroke* 36, no. 9 (Sep 2005): 2049-56.
- Centers for Disease Control and Prevention. "Prevalence and Most Common Causes of Disability among Adults--United States, 2005." [In eng]. *MMWR Morb Mortal Wkly Rep* 58, no. 16 (May 1 2009): 421-6.
- Duncan, P. W., R. Zorowitz, B. Bates, J. Y. Choi, J. J. Glasberg, G. D. Graham, R. C. Katz, K. Lamberty, and D. Reker. "Management of Adult Stroke Rehabilitation Care: A Clinical Practice Guideline." [In eng]. *Stroke* 36, no. 9 (Sep 2005): e100-43.
- Foley, N., R. Teasell, S. Bhogal, and M. Speechley. "The Efficacy of Stroke Rehabilitation." In, (2011): 1-50. http://www.ebrsr.com/uploads/Module-5_efficacy.pdf.
- Gresham, G. E., P. W. Duncan, W. B. Stason, H. P. Adams, A. M. Adelman, D. N. Alexander, D. S. Bishop *et al.* "Post-stroke rehabilitation. Clinical practice guideline, no. 16. Rockville, MD: US Department of Health and Human Services." *Public Health Service, Agency for Health Care Policy and Research* (1995): 95-0062.
- Kalra, L., A. Evans, I. Perez, M. Knapp, C. Swift, and N. Donaldson. "A Randomised Controlled Comparison of Alternative Strategies in Stroke Care." [In eng]. *Health Technol Assess* 9, no. 18 (May 2005): iii-iv, 1-79.
- Keith, R. A. "Rehabilitation after Stroke: Cost-Effectiveness Analyses." [In eng]. *J R Soc Med* 89, no. 11 (Nov 1996): 631-3.
- Langhorne, P., B. O. Williams, W. Gilchrist, and K. Howie. "Do Stroke Units Save Lives?" [In eng]. *Lancet* 342, no. 8868 (Aug 14 1993): 395-8.
- "Management of Patients with Stroke: Rehabilitation, Prevention and Management of Complications, and Discharge Planning. A National Clinical Guideline." In, (2002). <http://www.nhsggc.org.uk/content/mediaassets/pdf/HSD/sign64.pdf>.
- Moodie, M., D. Cadilhac, D. Pearce, C. Mihalopoulos, R. Carter, S. Davis, G. Donnan, and Scopes Study Group. "Economic Evaluation of Australian Stroke Services: A Prospective,

Multicenter Study Comparing Dedicated Stroke Units with Other Care Modalities." [In eng]. *Stroke* 37, no. 11 (Nov 2006): 2790-5.

- Noorani, H. Z., B. Brady, L. McGahan, R. Teasell, B. Skidmore, and T. J. Doherty. "Stroke Rehabilitation Services: Systematic Reviews of the Clinical and Economic Evidence." In *Ottawa: Canadian Coordinating, Office for Health Technology Assessment*, 2003.
- Ottenbacher, K. J., and S. Jannell. "The Results of Clinical Trials in Stroke Rehabilitation Research." [In eng]. *Arch Neurol* 50, no. 1 (Jan 1993): 37-44.
- "Outcomes in Stroke Rehabilitation." *Topics in Stroke Rehabilitation* 12, no. 4 (Fall 2005): 1-10, 11-19, 20-27, 28-36, 37-49.
- "Rehabilitation Helps Stroke Patients Recover Skills ". American Academy of Physical Medicine and Rehabilitation, <http://www.aapmr.org/patients/conditions/neurologic/Pages/recover.aspx>.
- Saka, O., V. Serra, Y. Samyshkin, A. McGuire, and C. C. Wolfe. "Cost-Effectiveness of Stroke Unit Care Followed by Early Supported Discharge." [In eng]. *Stroke* 40, no. 1 (Jan 2009): 24-9.
- Stroke, National Institute of Neurological Disorders and. "Post-Stroke Rehabilitation Fact Sheet." <http://www.ninds.nih.gov/disorders/stroke/poststrokerehab.htm>.
- "Urgency Key but Perseverance Pays Off." American Academy of Physical Medicine and Rehabilitation, http://www.zoominfo.com/CachedPage/?archive_id=0&page_id=389260562&page_url=//www.aapmr.org/condtreat/rehab/strokeusa.htm&page_last_updated=2010-07-28T02:27:25&firstName=Charles&lastName=Levy.

Subsection 2.9 – Global Initial Patient Population (ED, IMM, TOB, SUB)

Emergency Department (ED)

Impacts:

ED Data Element List

Rationale: The footnotes are being removed because the “collected for” designation is already referenced in each measure and data element.

Description of Changes:

Remove all footnotes in “Collected For” columns.

¹ CMS ONLY

² Transmission Data Element

³ The Joint Commission ONLY

Impacts:

Measure(s)

ED-1

Rationale: The Observation Services data element is being removed from the manual based on ED TEP recommendation.

Description of Changes:

EMERGENCY DEPARTMENT NATIONAL HOSPITAL INPATIENT QUALITY MEASURES

Remove from Set Measure ID # and Measure short name:

ED 1c Median Time from ED Arrival to ED Departure for Admitted ED Patients – Observation Patients

Change ED-1d to ED-1c

ED Data Element List

Remove: Observation Services

Impacts:

Measure(s)

ED-1

ED-2

Rationale: Clarification is needed for collection of retrospective and concurrent data. This change will provide consistency in the measure information forms (MIFs) for each measure topic.

Description of Changes:

Data Collection Approach

Change to:

Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-9-CM diagnosis and procedure codes, which require retrospective data entry.

Impacts:

Measure(s)

ED-2

Rationale: The Observation Services data element is being removed from the manual based on ED TEP recommendation.

Description of Changes:

ED Data Element List

Remove: Observation Services

Description

Change to:

Median time from admit decision time to time of departure from the emergency department for admitted patients.

Continuous Variable Statement

Change to:

Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients.

Continuous Variable Statement - Data Elements

Remove:

Observation Services

Impacts:

Algorithms

Measure(s)

ED-1

ED-2

Rationale: The Observation Services data element is being removed from the manual based on ED TEP recommendation.

Description of Changes:ED-1 Algorithm

Remove: Observation Services and all related logic from the ED-1 algorithm flow.

Change: ED-1d to ED-1c and all the notes that related to ED-1d.

Change: All the strata logic by eliminating ED-1c and changing ED-1d to ED-1c.

Remove: ED-1d

ED-2 Algorithm

Remove: Observation Services and all related logic from the ED-2 algorithm flow

Immunization (IMM)**Impacts:**

Immunization Data Element List

Rationale: The footnotes are being removed because the “collected for” designation is already referenced in each measure and data element.

Description of Changes:

Remove all footnotes in “Collected For” columns.

¹ CMS ONLY

² Transmission Data Element

³ The Joint Commission ONLY

Impacts:Measure(s)

IMM-1

IMM-2

Rationale: NQF endorsement header added to the IMM measure sets.

Description of Changes:**Add:**

NQF ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE

Impacts:Measure(s)

IMM-1

IMM-2

Rationale: Clarification is needed for collection of retrospective and concurrent data. This change will provide consistency in the measure information forms (MIFs) for each measure topic.

Description of Changes:

Data Collection Approach

Change to:

Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-9-CM diagnosis and procedure codes, which require retrospective data entry.

Impacts:

Measure(s)

IMM-2

Rationale: Remove the acronym “CDC” and replace with “Centers for Disease Control and Prevention” to provide consistency in the Selected References section.

Description of Changes:

Selected References

Change 2nd bullet to:

- Centers for Disease Control and Prevention. Prevention and control of seasonal Influenza with vaccines. Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2009 :55 (RR 08); 1-52.

Change 6th bullet to:

- Centers for Disease Control and Prevention. Key facts about influenza and the influenza vaccine, August 2006. Available at: <http://www.cdc.gov/flu/keyfacts.htm>. Accessed August 11, 2007.

Change 7th bullet to:

- Centers for Disease Control and Prevention. Newsroom press release February 24, 2010. CDC’s Advisory Committee on Immunization Practices (ACIP) Recommends Universal Annual Influenza Vaccination [Internet Cited 2010 March 3]. Available from <http://www.cdc.gov/media/pressrel/2010/r100224.htm>.

Impacts:

Measure(s)

IMM-2

Rationale: The wording of a bullet under the Denominator Statement that addresses vaccine unavailability is being revised to be consistent with Allowable Value 6 in *Influenza Vaccination Status* data element.

Description of Changes:

Denominator Statement-Excluded Populations

Change 4th bullet to:

- Patients for whom vaccination was indicated, but supply had not been received by the hospital due to problems with vaccine production or distribution

Impacts:Measure(s)

IMM-2

Rationale: The wording of the Numerator population that addresses vaccine allergy/sensitivity is being revised to be accurate and consistent with Allowable Value “4” in *Influenza Vaccination Status* data element.

Description of Changes:Numerator Statement- Included Populations

Change 5th bullet to:

- Patients who have an allergy/sensitivity to the influenza vaccine, anaphylactic latex allergy or anaphylactic allergy to eggs, or for whom the vaccine is not likely to be effective because of bone marrow transplant within the past 6 months, or history of Guillian-Barre Syndrome within 6 weeks after a previous influenza vaccination.

Substance Use (SUB)**Impacts:**

SUB Data Element List

Rationale: The footnotes are being removed because the “collected for” designation is already referenced in each measure and data element.

Description of Changes:

Remove all footnotes in “Collected For” columns.

¹ Transmission Data Element

² The Joint Commission ONLY

Impacts:

SUB Data Element List

Rationale: The only patients who require outpatient treatment are those with an abuse or addiction problem. Restricting the population for SUB-4 to these patients will simplify the measure as desired by NQF and also substantially reduce the burden for follow up by hospitals. Additionally, terminally ill patients are included in the measure population, even if they are receiving comfort measure only.

Description of Changes:Alcohol Use Status

Remove under ‘Collected For’ column:

SUB-4

Add data element under ‘SUB Data Element Name’ column:

Comfort Measures Only

Add under 'Collected For' column for *Comfort Measures Only* data element:
SUB-1, SUB-2, SUB-3, SUB-4

Impacts:Measure(s)

All SUB

Rationale: Clarification is needed for collection of retrospective and concurrent data. This change will provide consistency in the measure information forms (MIFs) for each measure topic.

Description of Changes:Data Collection Approach**Change to:**

Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-9-CM diagnosis and procedure codes, which require retrospective data entry.

Impacts:Measure(s)

SUB-1

Rationale: The current measure requires a review of the entire hospitalization for evidence of an alcohol use screen. Additionally, terminally ill patients are included in the measure population, even if they are receiving comfort measures only. Restricting the timeframe to within 3 days of admission for performing the screen and excluding these patients for SUB-1 will simplify the measure as desired by the Technical Advisory Panel (TAP) and also substantially reduces the burden of abstraction for hospitals. Patients are now excluded with a length of stay \leq 3 days in order to allow the hospital sufficient time to perform the screen.

Description of Changes:Description**Change to:**

Hospitalized patients who are screened within the first three days of admission using a validated screening questionnaire for unhealthy alcohol use.

Numerator Statement**Change to:**

The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking within the first three days of admission.

Denominator - Excluded Populations**Change** the third bullet to:

Patients who have a duration of stay less than or equal to three days or greater than 120 days

Add new fourth bullet:

Patients with *Comfort Measures Only* documented

Denominator Data Elements

Add:

Comfort Measures Only

Impacts:

Algorithm

Measure(s)

SUB-1

Rationale: Change algorithm logic to reflect MIF changes.

Description of Changes:

Algorithm Change

Add data element – *Comfort Measures Only*

Add Comfort Measures Only decision point below Length of Stay decision point

- When allowable value equals 1,2,3 flow to category 'B'
- When allowable value equals 4 flow down
- When allowable value is missing flow to category 'X'

Change variable - Length of Stay allowable value lower end to: 3

Change Numerator Statement to:

The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking within the first three days of admission.

Impacts:

Measure(s)

SUB-2

Rationale: Terminally ill patients are included in the measure population, even if they are receiving comfort measures only. Excluding these patients for SUB-2 will simplify the measure as desired by the Technical Advisory Panel (TAP) and also substantially reduces the burden of abstraction for hospitals. Patients are now excluded from SUB-2 if the length of stay is equal to or less than 3 days in order to remain consistent with SUB-1.

Description of Changes:

Denominator Statement - Excluded Populations

Change fourth bullet to:

- Patients who have a duration of stay less than or equal to three days or greater than 120 days

Add new bullet:

- Patients receiving *Comfort Measures Only* documented

Denominator Statement - Data Elements

Add:

Comfort Measures Only

Impacts:

Algorithm

Measure(s)

SUB-2

Rationale: The algorithm was modified to reflect the MIF change.**Description of Changes:****Add** *Comfort Measures Only* data element decision point below Length of Stay decision point

- When allowable value equals 1,2,3 flow to category 'B'
- When allowable value equals 4 flow down
- When allowable value is missing flow to category 'X'

Change variable - Length of Stay allowable value lower end**Change** to: 3**Impacts:**Measure(s)

SUB-3

Rationale: Terminally ill patients are now excluded from the measure, if they are receiving comfort measures only. Excluding these patients for TOB-3 will simplify the measure as desired by the TAP and also substantially reduces the burden of abstraction for hospitals. Clarification of how pregnant patients are identified was also added. Patients are now excluded from TOB-3 if the length of stay is equal to or less than 3 days in order to remain consistent with TOB-1.

Description of Changes:Numerator Statement-Excluded Populations: (for FDA approved medications only)**Change** second bullet in TOB-3 and TOB-3a columns to:

- Pregnant smokers with an *ICD-9-CM Principal Diagnosis Code* or *ICD-9-CM Other Diagnosis Codes* for pregnancy as defined in Appendix A, Table 12.3

Denominator Statement- Excluded Populations**Change** fifth bullet to:

- Patients who have a duration of stay less than or equal to three days or greater than 120 days

Add new bullet:

- Patients with *Comfort Measures Only* documented

Denominator Statement-Data Elements**Add:***Comfort Measures Only*

Impacts:

Algorithm

Measure(s)

SUB-3

Rationale: Change algorithm logic to reflect MIF changes.**Description of Changes:****Add** data element – *Comfort Measures Only*Add *Comfort Measures Only* decision point below Length of Stay decision point

- When allowable value equals 1, 2, 3 flow to category 'B'
- When allowable value equals 4 flow down
- When allowable value is missing flow to category 'X'

Change Label for ICD-9-CM Principal Diagnosis Code decision Change to: ICD-9-CM Principal or Other Diagnosis Codes**Remove** ICD-9-CM Other Diagnosis Code decision point and related logical braches**Change** variable - Length of Stay allowable value lower end
Change to: 3**Change** allowable value for data element Tobacco Use Status

- When allowable value equals 3, 4, 5 flow to category 'B'
- When allowable value equals 1,2 flow down
- When allowable value is missing flow to category 'X'

Rechecking if none of ICD-9-CM Principal or other diagnosis code on table 12.3

- When allowable value equals 2, flow to category 'E'
- When allowable value equals 1 flow down

Change allowable value lower end for variable - Length of Stay
Change to: 3**Change** Label for ICD-9-CM Principal Diagnosis Code decision point in TOB-3 and TOB-3a
Change to: ICD-9-CM Principal or Other Diagnosis Codes**Remove** ICD-9-CM Other Diagnosis Code decision point and related logical braches from TOB-3 and TOB-3a**Impacts:**Measure(s)

SUB-4

Rationale: The current measure requires post discharge follow up for all patients with unhealthy alcohol use identified through screening and those who received a diagnosis of alcohol or drug abuse or dependence. Follow up currently addresses compliance with outpatient treatment (counseling and/or medication) and quit status. The only patients who

require outpatient treatment are those with an abuse or addiction problem. Restricting the population for SUB-4 to these patients will simplify the measure as desired by NQF and also substantially reduce the burden for follow up by hospitals. Additionally, terminally ill patients are included in the measure population, even if they are receiving comfort measures only. Excluding these patients for SUB-4 will simplify the measure as desired by the Technical Advisory Panel (TAP) and also substantially reduces the burden of abstraction for hospitals. Patients are now excluded from SUB-4 if the length of stay is equal to or less than 3 days in order to remain consistent with SUB-1.

Description of Changes:

Description

Change to:

Discharged patients 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.

Denominator Statement

Change to:

The number of discharged patients 18 years of age and older who received a diagnosis of alcohol or drug use disorder during their hospital stay.

Denominator - Included Populations

Change last bullet to:

Patients who were identified with an alcohol or drug disorder

Denominator - Excluded Populations

Remove third and sixth bullets:

- Patients who were not screened or refused to be screened for alcohol use
- Patients who do not screen positive for unhealthy alcohol use

Change the fifth bullet (now fourth bullet) to:

- Patients who have a duration of stay less than or equal to three days or greater than 120 days

Add new bullet:

- Patients with *Comfort Measures Only* documented

Denominator Data Elements

Remove:

Alcohol Use Status

Add:

Comfort Measures Only

Impacts:

Algorithm

Measure(s)

SUB-4

Rationale: Change algorithm logic to reflect MIF changes.

Description of Changes:

Add data element – *Comfort Measures Only*

Add Comfort Measures Only decision point below Length of Stay decision point

- When allowable value equals 1,2,3 flow to category 'B'
- When allowable value equals 4 flow down
- When allowable value is missing flow to category 'X'

Change variable - Length of Stay allowable value lower end

Change to: 3

Change Label for ICD-9-CM Principal Diagnosis Code decision point Change to: ICD-9-CM Principal or Other Diagnosis Codes

Remove ICD-9-CM Other Diagnosis Code decision point and related logical branches

Remove Alcohol Use Status decision point and logic branches

Change Denominator Statement

Change to:

The number of discharged patients 18 years of age and older who received a diagnosis of alcohol or drug use disorder during their hospital stay.

Tobacco Use (TOB)

Impacts:

TOB Data Element List

Rationale: The footnotes are being removed because the “collected for” designation is already referenced in each measure and data element.

Description of Changes:

Remove all footnotes in “Collected For” columns.

¹ Transmission Data Element

² The Joint Commission ONLY

Impacts:

TOB Data Element List

Rationale: The current measure requires a review of the entire hospitalization for evidence of a tobacco use screen. Additionally, terminally ill patients are now excluded from the measure, if they are receiving comfort measures only.

Description of Changes:

Add data element under ‘TOB Data Element Name’ column:

Comfort Measures Only

Add under ‘Collected For’ column for *Comfort Measures Only* data element:

TOB-1, TOB-2, TOB-3, TOB-4

Impacts:Measure(s)

TOB-1

Rationale: The current measure requires a review of the entire hospitalization for evidence of a tobacco use screen. Additionally, terminally ill patients are now excluded from the measure, if they are receiving comfort measures only. Restricting the timeframe to within 3 days of admission for performing the screen and excluding these patients for TOB-1 will simplify the measure as desired by the Technical Advisory Panel (TAP) and also substantially reduces the burden of abstraction for hospitals. Patients are now excluded with a length of stay \leq 3 days in order to allow the hospital sufficient time to perform the screen.

Description of Changes:Description**Change to:**

Hospitalized patients who are screened within the first three days of admission for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days.

Numerator Statement**Change to:**

The number of patients who were screened for tobacco use status within the first three days of admission.

Denominator Statement- Excluded Populations**Change** the third bullet to:

- Patients who have a duration of stay less than or equal to three days or greater than 120 days

Add new bullet:

Patients with *Comfort Measures Only* documented

Denominator Statement- Data Elements**Add:**

Comfort Measures Only

Impacts:Measure(s)

TOB-1

Rationale: The algorithm was modified to reflect the MIF change.

Description of Changes:**Add** data element – Comfort Measures Only

Add Comfort Measures Only decision point below Length of Stay decision point

- When allowable value equals 1,2,3 flow to category 'B'
- When allowable value equals 4 flow down
- When allowable value is missing flow to category 'X'

Change allowable value for data element Tobacco Use Status

- When allowable value equals 5 flow to category 'D'

- When allowable value equals 1,2,3,4 flow to category 'E'
- When allowable value is missing flow to category 'X'

Change allowable value lower end for variable - Length of Stay

Change to: 3

Numerator Statement

Change to:

The number of patients who were screened for tobacco use status within the first three days of admission.

Impacts:

Measure(s)

TOB-1
TOB-2
TOB-3
TOB-4

Rationale: Clarification is needed for collection of retrospective and concurrent data. This change will provide consistency in the measure information forms (MIFs) for each measure topic.

Description of Changes:

Data Collection Approach

Change to:

Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-9-CM diagnosis and procedure codes, which require retrospective data entry.

Impacts:

Measure(s)

TOB-2

Rationale: The current measure requires a review of the entire hospitalization for evidence of practical counseling and/or cessation medication. Restricting the timeframe to within 3 days of admission for TOB-2 will simplify the measure as desired by the Technical Advisory Panel (TAP) and also substantially reduces the burden of abstraction for hospitals. Patients are now excluded from TOB-2 if the length of stay is equal to or less than 3 days in order to remain consistent with TOB-1. Clarification of how pregnant patients are identified was also added. Terminally ill patients are now excluded from the measure, if they are receiving comfort measures only. Excluding these patients for TOB-2 will simplify the measure as desired by the Technical Advisory Panel (TAP) and also substantially reduces the burden of abstraction for hospitals.

Description of Changes:Description**Change to:**

- TOB-2 Patients identified as tobacco product users within the past 30 days who receive or refuse practical counseling to quit AND receive or refuse FDA-approved cessation medications during the first three days after admission.
- TOB-2a Patients who received counseling AND medication as well as those who received counseling and had reason for not receiving the medication during the first three days after admission.

Numerator Statement**Change to:**

TOB-2: The number of patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications during the first three days after admission.

TOB-2a: The number of patients who received practical counseling to quit AND received FDA-approved cessation medications during the first three days after admission.

Numerator Statement- Excluded Populations: (for FDA approved medications only)**Change** third bullet in TOB-2 and TOB-2a columns to:

- Pregnant smokers with an *ICD-9-CM Principal Diagnosis Code* or *ICD-9-CM Other Diagnosis Codes* for pregnancy as defined in Appendix A, Table 12.3

Denominator Statement-Excluded Populations**Change** fifth bullet to:

- Patients who have a duration of stay less than or equal to three days or greater than 120 days

Add new bullet:

- Patients with *Comfort Measures Only* documented

Denominator Statement-Data Elements**Add:**

Comfort Measures Only

Impacts:

Algorithm

Measure(s)

TOB-2

Rationale: The algorithm was modified to reflect the MIF change.

Description of Changes:

Add data element – Comfort Measures Only

Add Comfort Measures Only decision point below Length of Stay decision point

- When allowable value equals 1,2,3 flow to category 'B'
- When allowable value equals 4 flow down
- When allowable value is missing flow to category 'X'

Change allowable value for data element Tobacco Use Status

- When allowable value equals 3,4,5 flow to category 'B'
- When allowable value equals 1,2 flow down
- When allowable value is missing flow to category 'X'

Rechecking if none of ICD-9-CM Principal or other diagnosis code on table 12.3

- When allowable value equals 2, flow to category 'E'
- When allowable value equals 1 flow down

Change allowable value lower end for variable - Length of Stay

Change to: 3

Change Label for ICD-9-CM Principal Diagnosis Code decision point in TOB-2 and TOB-2a
To: ICD-9-CM Principal or Other Diagnosis Codes

Remove ICD-9-CM Other Diagnosis Code decision point and related logical branches from TOB-2 and TOB-2a

Numerator Statement**Change** to:

TOB-2: The number of patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications during the first three days after admission.

TOB-2a: The number of patients who received practical counseling to quit AND received FDA-approved cessation medications during the first three days after admission.

Impacts:Measure(s)

TOB-3

Rationale: Terminally ill patients are now excluded from the measure, if they are receiving comfort measures only. Excluding these patients for TOB-3 will simplify the measure as desired by the Technical Advisory Panel (TAP) and also substantially reduces the burden of abstraction for hospitals. Clarification of how pregnant patients are identified was also added. Patients are now excluded from TOB-3 if the length of stay is equal to or less than 3 days in order to remain consistent with TOB-1.

Description of Changes:

Numerator Statement-Excluded Populations: (for FDA approved medications only)

Change second bullet in TOB-3 and TOB-3a columns to:

- Pregnant smokers with an *ICD-9-CM Principal Diagnosis Code* or *ICD-9-CM Other Diagnosis Codes* for pregnancy as defined in Appendix A, Table 12.3

Denominator Statement- Excluded Populations

Change fifth bullet to:

- Patients who have a duration of stay less than or equal to three days or greater than 120 days

Add new bullet:

- Patients with *Comfort Measures Only* documented

Denominator Statement-Data Elements**Add:***Comfort Measures Only***Impacts:**

Algorithm

Measure(s)

TOB-3

Rationale: The algorithm was modified to reflect the MIF change.**Description of Changes:****Add** data element – *Comfort Measures Only*Add *Comfort Measures Only* decision point below Length of Stay decision point

- When allowable value equals 1,2,3 flow to category 'B'
- When allowable value equals 4 flow down
- When allowable value is missing flow to category 'X'

Change allowable value for data element Tobacco Use Status

- When allowable value equals 3,4,5 flow to category 'B'
- When allowable value equals 1,2 flow down
- When allowable value is missing flow to category 'X'

Rechecking if none of ICD-9-CM Principal or other diagnosis code on table 12.3

- When allowable value equals 2, flow to category 'E'
- When allowable value equals 1 flow down

Change allowable value lower end for variable - Length of Stay

Change to: 3

Change Label for ICD-9-CM Principal Diagnosis Code decision point in TOB-3 and TOB-3a

Change to: ICD-9-CM Principal or Other Diagnosis Codes

Remove ICD-9-CM Other Diagnosis Code decision point and related logical branches from TOB-3 and TOB-3a**Impacts:**Measure(s)

TOB-4

Rationale: The current measure requires post discharge follow up for all patients whether they refused outpatient tobacco cessation counseling and/or tobacco cessation medication or not. Follow-up currently addresses compliance with outpatient treatment (counseling and/or medication) and quit status. Restricting the population for TOB-4 to patients who accepted

counseling and/or medication will simplify the measure as desired by NQF and also substantially reduces the burden for follow up by hospitals. Additionally, terminally ill patients are now excluded from the measure, if they are receiving comfort measures only. Excluding these patients for TOB-4 will simplify the measure as desired by the Technical Advisory Panel (TAP) and also substantially reduces the burden of abstraction for hospitals. Patients are now excluded from TOB-4 if the length of stay is equal to or less than 3 days in order to remain consistent with TOB-1.

Description of Changes:

Denominator Statement-Excluded Populations

Change the sixth bullet to:

- Patients who have a duration of stay less than or equal to three days

Add two new bullets:

- Patients who refused a *Referral for Outpatient Tobacco Cessation Counseling* AND with NO ICD-9-CM *Principal Diagnosis Code* or ICD-9-CM *Other Diagnosis Codes* for pregnancy as defined in Appendix A, Table 12.3 AND refused a *Prescription for Tobacco Cessation Medication*
- Patients with *Comfort Measures Only* documented

Denominator Statement-Data Elements

Add:

- *Comfort Measures Only*
- *Prescription for Tobacco Cessation Medication*
- *Referral for Outpatient Tobacco Cessation Counseling*

Impacts:

Algorithm

Measure(s)

TOB-4

Rationale: The algorithm was modified to reflect the MIF change.

Description of Changes:

Add data element – Comfort Measures Only, Referral for Outpatient Tobacco Cessation Counseling, and Prescription for Tobacco Cessation Medication

Add Comfort Measures Only decision point below Length of Stay decision point

- When allowable value equals 1,2,3 flow to category ‘B’
- When allowable value equals 4 flow down
- When allowable value is missing flow to category ‘X’

Add Referral for Outpatient Tobacco Cessation Counseling decision point below Tobacco Use Status decision point

- When allowable value equals 1, 2, 4, 5 flow to K connector
- When allowable value equals 3 flow to the ICD-9-CM Principal or Other Diagnosis Codes decision point
- When allowable value is missing flow to category ‘X’

Add Prescription for Tobacco Cessation Medication decision point below ICD-9-CM Principal or Other Diagnosis Codes decision point

- When allowable value equals 1, 3, 4 flow to K connector
- When allowable value equals 2 flow to category 'B'
- When allowable value is missing flow to category 'X'

Change allowable value for data element Tobacco Use Status

- When allowable value equals 3,4,5 flow to category 'B'
- When allowable value equals 1,2 flow down
- When allowable value is missing flow to category 'X'

Change allowable value lower end for variable - Length of Stay to 3

Change Label for ICD-9-CM Principal Diagnosis Code decision point

Change to: ICD-9-CM Principal or Other Diagnosis Codes

Remove ICD-9-CM Other Diagnosis Code decision point and related logical braches

SECTION 3 – Missing and Invalid Data

Impacts:

N/A

Rationale: Allowable value 9 has been added to the data element VTE Prophylaxis.

Description of Changes:

Missing and Invalid Episode of Care (EOC) Data

Change the allowable values from 1-8 to 1-9 in the first sentence and third sentence of the 5th sub-bullet under the 4th bullet.

SECTION 4 – Population and Sampling Specifications

No updates in Section 4.

SECTION 9 – Data Transmission

Impacts:

Data Transmission – Alphabetical Data Dictionary

Rationale: The footnotes are being removed because the “collected for” designation is already referenced in each measure and data element.

Description of Changes:

Remove all footnotes in “Collected For” column.

¹ Collected for CMS for all patients, optional for The Joint Commission

² The Joint Commission ONLY

³ Collected for The Joint Commission for all patients, optional for CMS

Impacts:

Data Transmission – CMS & TJC Guidelines for Submission of Hospital Clinical Data

Rationale: Allowable value 9 has been added to the data element VTE Prophylaxis.

Description of Changes:

Missing Data Policy

Change the allowable values from 1-8 to 1-9 in the first sentence and second sentence of the 5th bullet.

Hospital Clinical XML File Layout

Impacts:

Alcohol Use Status

Rationale: To reflect changes made to the data element allowable values.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Change Answer Value 1, 2, 3, 4 and 6 to:

1 The patient is screened with a validated tool within the first three days of admission and the score on the alcohol screen indicates no or low risk of alcohol related problems.

2 The patient was screened with a validated tool within the first three days of admission and the score on the alcohol screen indicates unhealthy alcohol use (moderate risk) benefitting from brief intervention.

3 The patient was screened with a non-validated tool within the first three days of admission and the score on the alcohol screen indicates no or low risk of alcohol related problems.

4 The patient was screened with a non-validated tool within the first three days of admission and the score on the alcohol screen indicates unhealthy alcohol use (moderate risk) benefitting from brief intervention.

6 The patient was not screened for alcohol use during the first three days of admission or unable to determine from medical record documentation.

Remove under Applicable Measure(s):

SUB-4

Impacts:

Anesthesia End Date

Rationale: To reflect changes made to the data element allowable values.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Remove under Applicable Measure(s):

SCIP-Inf-4

Impacts:

Anesthesia Type

Rationale: To reflect changes made to the data element allowable values.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Remove under Applicable Measure(s):

SCIP-VTE-2

Impacts:

Cognitive Impairment

Rationale: To reflect changes made to the Suggested Data Question in the data element.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Change Suggested Data Collection Question to:

Is there documentation in the medical record that indicates the patient was cognitively impaired during the entire hospitalization?

Impacts:

Comfort Measures Only

Rationale: To reflect changes to the data element.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Add to the Applicable Measure(s) All SUB and All TOB

Add to the Programming Notes under The Joint Commission Only All SUB and All TOB

Impacts:

Compromised

Glucose POD1

Glucose POD 2

Healthcare Associated PN

Observation Services

Rationale: To reflect changes made to the Alphabetical Data Dictionary.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Remove the following Question and associated fields:

Compromised

Glucose POD 1

Glucose POD 2

Healthcare Associated Pneumonia

Observation Services

Impacts:

Follow-Up Contact

Rationale: To reflect changes made to the Alphabetical Data Dictionary.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Change Answer Value 3 to:

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, at least 3 unsuccessful attempts to contact the patient were made, or the patient refused permission for a third party to contact them on behalf of the hospital.

Impacts:

Glucose

Reason for Alternative Empiric Antibiotic Therapy

Reason for No Overlap Therapy

Rationale: To reflect changes made to the Alphabetical Data Dictionary.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Add Question and associated fields:

Glucose

Reason for Alternative Empiric Antibiotic Therapy

Reason for No Overlap Therapy

Impacts:

Overlap Therapy

Rationale: To reflect changes made to the data element.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Change Suggested Data Question to:

Were parenteral anticoagulation therapy and warfarin both administered on the same day anytime during the hospitalization?

Change Answer Code to N and Y and Answer Value to No and Yes.

Impacts:

Perioperative Death

Rationale: To reflect changes made to the data element.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Remove under Applicable Measure(s):
SCIP-Inf-4

Impacts:

Prescription for Tobacco Cessation Medication

Rationale: To reflect changes made to the data element.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Add to the Applicable Measure(s) TOB-4

Impacts:

Reasons to Extend Antibiotics

Rationale: To reflect changes made to the data element allowable values.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Change Answer Value 3 to:

There is physician/APN/PA documentation of any of (and only) the following reasons to extend antibiotics: Erythromycin was administered postoperatively for the purpose of increasing gastric motility OR an antibiotic was administered postoperatively for the treatment of hepatic encephalopathy OR an antibiotic was administered postoperatively for the treatment of pulmonary fibrosis OR an antibiotic was administered postoperatively as prophylaxis of *Pneumocystis pneumonia (PCP)* OR Demeclocycline was administered postoperatively for the treatment of syndrome of inappropriate antidiuretic hormone hypersecretion (SIADH) or hyponatremia OR an antibiotic was administered postoperatively for the treatment of acne or rosacea.

Impacts:

Reason for No Tobacco Cessation Medication During the Hospital Stay

Rationale: To reflect changes made to the Suggested Data Collection Question in the data element.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Change Suggested Data Collection Question to:

Is there documentation of a reason for not prescribing one of the FDA-approved tobacco cessation medications during the first three days of admission?

Impacts:

Reason for Not Administering VTE Prophylaxis

Rationale: To reflect changes made to the Suggested Data Collection Question in the data element.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Change Suggested Data Collection Question to:

Is there documentation by a physician/advanced nurse practitioner/physician assistant (physician/APN/PA) or pharmacist in the medical record of a reason for not administering both mechanical and pharmacological VTE prophylaxis?

Change Answer Code to N and Y and Answer Value to No and Yes.

Impacts:

Referral for Outpatient Tobacco Cessation Counseling

Rationale: To reflect changes made to the data element.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Add under Applicable Measure(s):

TOB-4

Impacts:

Sample

Rationale: To reflect changes made to the data element.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Add to the Programming Notes:

CMS: Required data element for all records.

Impacts:

Tobacco Use Status

Rationale: To reflect changes made to the allowable values in the data element.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Change Answer Values to:

1 The patient has smoked cigarettes daily on average in a volume of five or more cigarettes (=>1/4 pack) per day and/or cigars daily and/or pipes daily during the past 30 days.

2 The patient has smoked cigarettes daily on average in a volume of four or less cigarettes (<1/4 pack) per day and/or used smokeless tobacco and/or smoked cigarettes but not daily and/or cigars but not daily and/or pipes but not daily during the past 30 days.

3 The patient has not used any forms of tobacco in the past 30 days.

4 The patient refused the tobacco use screen.

5 The patient was not screened for tobacco use during this hospitalization or unable to determine the patient's tobacco use status from medical record documentation.

Impacts:

Tobacco Use Treatment Practical Counseling

Rationale: To reflect changes made to the data element.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Change Suggested Data Collection Question to:

Did the patient receive all of the components of practical counseling during the first three days after admission?

Change Answer Values to:

- 1 The patient received all components of practical counseling during the first three days after admission.
- 2 The patient refused/declined practical counseling during the first three days after admission.
- 3 Practical counseling was not offered to the patient during the first three days after admission or unable to determine if tobacco use treatment was provided from medical record documentation.

Impacts:

Tobacco Use Treatment

Rationale: To reflect changes made to the data element.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Change Suggested Data Collection Question to:

Did the patient receive one of the FDA-approved tobacco cessation medications during the first three days after admission?

Change Answer Values to:

- 1 The patient received one of the FDA-approved tobacco cessation medications during the first three days after admission.
- 2 The patient refused the FDA-approved tobacco cessation medications during the first three days after admission.
- 3 FDA-approved tobacco cessation medications were not offered to the patient during the first three days after admission or unable to determine (UTD) from medical record documentation.

Impacts:

Vancomycin

Rationale: To reflect changes made to allowable value 2 in the data element.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Change Answer Value 2 to:

Documentation of colonization with MRSA, a positive MRSA screen, an MRSA infection, or a history of MRSA.

Impacts:

VTE Prophylaxis

Rationale: To reflect changes made to the data element.

Description of Changes:

Hospital Clinical Data – Detail Elements Information

Add Answer Code 9 and Answer Value Aspirin

SECTION 10 – CMS Outcome Measures (Claims Based)**Subsection 10.1 – Introduction Risk Standardized Mortality Measures****Impacts:**

Introduction

Rationale: Updated dates to be consistent with currently reported data.

Description of Changes:

Change last sentence in 2nd paragraph to:

The 2013 reporting will be based on hospital admissions from three years of data (July 2009 [3Q 2009] through June 2012 [2Q 2012]).

Impacts:

MORT-30-AMI

Rationale: Updated language and dates to be consistent with currently reported data.

Description of Changes:

Numerator Statement

Change to:

This outcome measure does not have a traditional numerator and denominator like a core process measure (e.g., percentage of adult patients with diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year); thus, we are using this field to define our outcome. The calculation of the rate is defined below under Measure Calculation.

Excluded Populations

Change dates in 6th bullet to:

This measure excludes admissions for patients:

- 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, 2010 and readmitted on January 2nd, 2011; the patient dies on January 15th, 2011. If both of these admissions are randomly selected for inclusion (one for the 2010 calendar year time period and the other for the 2011 calendar year time period), the January 2, 2011 admission will be excluded to avoid assigning the death to two admissions (one in 2010 and one in 2011)

Impacts:

MORT-30-HF

Rationale: Updated language and dates to be consistent with currently reported data.**Description of Changes:**Numerator Statement**Change to:**

This outcome measure does not have a traditional numerator and denominator like a core process measure (e.g., percentage of adult patients with diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year); thus, we are using this field to define our outcome. The calculation of the rate is defined below under Measure Calculation.

Excluded Populations**Change** dates in 6th bullet to:

This measure excludes admissions for patients:

- 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, 2010 and readmitted on January 2nd, 2011; the patient dies on January 15th, 2011. If both of these admissions are randomly selected for inclusion (one for the 2010 calendar year time period and the other for the 2011 calendar year time period), the January 2, 2011 admission will be excluded to avoid assigning the death to two admissions (one in 2010 and one in 2011)

Impacts:

MORT-30-PN

Rationale: Updated language and dates to be consistent with currently reported data.**Description of Changes:**Numerator Statement**Change to:**

This outcome measure does not have a traditional numerator and denominator like a core process measure (e.g., percentage of adult patients with diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year); thus, we are using this field to define our outcome. The calculation of the rate is defined below under Measure Calculation.

Excluded Populations**Change** dates in 6th bullet to:

This measure excludes admissions for patients:

- 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, 2010 and readmitted on January 2nd, 2011; the patient dies on January 15th, 2011. If both of these admissions are randomly selected for inclusion (one for the 2010 calendar year time period and the other for the 2011 calendar year time period), the January 2, 2011 admission will be excluded to avoid assigning the death to two admissions (one in 2010 and one in 2011)

Subsection 10.2 – Introduction Risk Standardized Readmission Measures

Impacts:

Introduction

Rationale: Updated contact information is needed for readmission and complication measures.

Description of Changes:

Change 3rd sentence in 4th paragraph to:

Questions and comments about the readmission measures should be directed to cmsreadmissionmeasures@yale.edu.

Change 4th sentence in 4th paragraph to:

Questions and comments about the THA/TKA complication measure should be directed to cmscomplicationmeasures@yale.edu.

Impacts:

READM-30-AMI

Rationale: Adding planned readmission algorithm language to reflect Centers for Medicare & Medicaid Services (CMS) measure updates.

Description of Changes:Description

Change to:

The measure estimates a hospital-level, risk-standardized, all-cause unplanned 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of AMI.

Numerator Statement

Change to:

This outcome measure does not have a traditional numerator and denominator like a core process measure (e.g., percentage of adult patients with diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year); thus, we are using this field to define our outcome. The calculation of the rate is defined below under Measure Calculation.

The outcome for this measure is 30-day all-cause unplanned readmission. We define this as readmission for any unplanned cause within 30 days from the date of discharge of the index AMI admission.

Admissions not counted as readmissions (“Planned readmissions”)

Change to:

Admissions identified as planned by the planned readmissions algorithm are not counted as readmissions. The “algorithm” is a set of criteria for classifying readmissions as planned using Medicare claims. The algorithm identifies admissions that are typically planned and may occur within 30 days of discharge from the hospital. CMS based the planned readmission algorithm on three principles:

1. A few specific, limited types of care are always considered planned (obstetrical delivery, transplant surgery, maintenance chemotherapy, rehabilitation);
2. Otherwise, a planned readmission is defined as a non-acute readmission for a scheduled procedure; and
3. Admissions for acute illness or for complications of care are never planned.

The planned readmission algorithm uses a flow chart and four tables of procedures and conditions to operationalize these principles and to classify readmissions as planned. The flow chart and tables are available in a report, CMS Planned Readmission Algorithm Version 2.1 – General Population at [Centers for Medicare & Medicaid Services Planned Readmission Algorithm Version 2.1: General Population report](#)

Impacts:

READM-30-HF

Rationale: Adding planned readmission algorithm language to reflect Centers for Medicare & Medicaid Services (CMS) measure updates.

Description of Changes:

Description

Change to:

The measure estimates a hospital-level, risk-standardized, all-cause unplanned 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of HF.

Numerator Statement

Change to:

This outcome measure does not have a traditional numerator and denominator like a core process measure (e.g., percentage of adult patients with diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year); thus, we are using this field to define our outcome. The calculation of the rate is defined below under Measure Calculation.

The outcome for this measure is 30-day all-cause unplanned readmission. We define this as readmission for any unplanned cause within 30 days from the date of discharge of the index HF admission.

Add new topic after ‘Cohort exclusions (excluded admissions)’ topic:

Admissions not counted as readmissions (“Planned readmissions”)

Admissions identified as planned by the planned readmissions algorithm are not counted as readmissions. The “algorithm” is a set of criteria for classifying readmissions as planned using Medicare claims. The algorithm identifies admissions that are typically planned and may occur within 30 days of discharge from the hospital. CMS based the planned readmission algorithm on three principles:

1. A few specific, limited types of care are always considered planned (obstetrical delivery, transplant surgery, maintenance chemotherapy, rehabilitation);
2. Otherwise, a planned readmission is defined as a non-acute readmission for a scheduled procedure; and
3. Admissions for acute illness or for complications of care are never planned.

The planned readmission algorithm uses a flow chart and four tables of procedures and conditions to operationalize these principles and to classify readmissions as planned. The flow chart and tables are available in a report, CMS Planned Readmission Algorithm Version 2.1 – General Population at [Centers for Medicare & Medicaid Services Planned Readmission Algorithm Version 2.1: General Population report](#)

Impacts:

READM-30-PN

Rationale: Adding planned readmission algorithm language to reflect Centers for Medicare & Medicaid Services (CMS) measure updates.

Description of Changes:Description**Change to:**

The measure estimates a hospital-level, risk-standardized, all-cause unplanned 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of pneumonia (PN).

Numerator Statement**Change to:**

This outcome measure does not have a traditional numerator and denominator like a core process measure (e.g., percentage of adult patients with diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year); thus, we are using this field to define our outcome. The calculation of the rate is defined below under Measure Calculation.

The outcome for this measure is 30-day all-cause unplanned readmission. We define this as readmission for any unplanned cause within 30 days from the date of discharge of the index pneumonia admission.

Add new topic after ‘Cohort exclusions (excluded admissions)’ topic:

Admissions not counted as readmissions (“Planned readmissions”)

Admissions identified as planned by the planned readmissions algorithm are not counted as readmissions. The “algorithm” is a set of criteria for classifying readmissions as planned using Medicare claims. The algorithm identifies admissions that are typically planned and may occur within 30 days of discharge from the hospital. CMS based the planned readmission algorithm on three principles:

1. A few specific, limited types of care are always considered planned (obstetrical delivery, transplant surgery, maintenance chemotherapy, rehabilitation);
2. Otherwise, a planned readmission is defined as a non-acute readmission for a scheduled procedure; and
3. Admissions for acute illness or for complications of care are never planned.

The planned readmission algorithm uses a flow chart and four tables of procedures and conditions to operationalize these principles and to classify readmissions as planned. The flow chart and tables are available in a report, CMS Planned Readmission Algorithm Version 2.1 – General Population at [Centers for Medicare & Medicaid Services Planned Readmission Algorithm Version 2.1: General Population report](#).

Impacts:

READM-30-THA/TKA

Rationale: Adding planned readmission algorithm language to reflect Centers for Medicare & Medicaid Services (CMS) measure updates.

Description of Changes:Performance Measure Name

Add after risk-standardized readmission rate:
(RSRR)

Rationale

Add new 1st sentence and 2nd sentence in 2nd paragraph:

Hospitals vary in their readmission rates. Analyses in Medicare fee-for-service (FFS) patients (2008-2010) demonstrate a median hospital-level RSRR of 5.7% (range 3.2% to 9.9%) after elective primary THA and/or TKA, suggesting room for improvement in clinical care.

Add new 1st sentence in 3rd paragraph:

The variation in readmission rates across hospitals suggests there are considerable differences in the quality of care at the hospital level.

Numerator Statement

Change 2nd paragraph to:

The outcome for this measure is unplanned readmission within 30 days. The measure defines a readmission as an unplanned subsequent acute care hospital inpatient admission within 30 days of the discharge date of index admission. The intent is to include all readmissions except for those associated with another elective primary THA/TKA procedure or other planned procedure, which are considered planned readmissions (see below) and are excluded from the measure outcome as they are likely not adequate measures of care quality. An index admission is any eligible hospitalization to an acute care hospital assessed in the measure for the readmission outcome.

Admissions not counted as readmissions (“Planned readmissions”)

Change 1st sentence in 1st paragraph to:

Some patients are readmitted within 30 days of the index hospitalization to undergo another elective primary THA/TKA procedure.

Add new paragraph:

Additionally, admissions identified as planned by the planned readmissions algorithm are not counted as readmissions. The “algorithm” is a set of criteria for classifying readmissions as planned using Medicare claims. The algorithm identifies admissions that are typically planned and may occur within 30 days of discharge from the hospital. CMS based the planned readmission algorithm on three principles:

1. A few specific, limited types of care are always considered planned (obstetrical delivery, transplant surgery, maintenance chemotherapy, rehabilitation);
2. Otherwise, a planned readmission is defined as a non-acute readmission for a scheduled procedure; and
3. Admissions for acute illness or for complications of care are never planned.

The planned readmission algorithm uses a flow chart and four tables of procedures and conditions to operationalize these principles and to classify readmissions as planned. The flow chart and tables are available in a report, CMS Planned Readmission Algorithm Version 2.1 – General Population at [Centers for Medicare & Medicaid Services Planned Readmission Algorithm Version 2.1: General Population report](#).

Impacts:

READM-30-HWR

Rationale: Adding planned readmission algorithm language to reflect Centers for Medicare & Medicaid Services (CMS) measure updates.

Description of Changes:

Admissions not counted as readmissions (“Planned readmissions”)

Change to:

Admissions identified as planned by the planned readmissions algorithm are not counted as readmissions. The “algorithm” is a set of criteria for classifying readmissions as planned using Medicare claims. The algorithm identifies admissions that are typically planned and may occur within 30 days of discharge from the hospital. CMS based the planned readmission algorithm on three principles:

1. A few specific, limited types of care are always considered planned (obstetrical delivery, transplant surgery, maintenance chemotherapy, rehabilitation);
2. Otherwise, a planned readmission is defined as a non-acute readmission for a scheduled procedure; and
3. Admissions for acute illness or for complications of care are never planned.

The planned readmission algorithm uses a flow chart and four tables of procedures and conditions to operationalize these principles and to classify readmissions as planned. The flow chart and tables are available in a report, CMS Planned Readmission Algorithm Version 2.1 - General Population at [Centers for Medicare & Medicaid Services Planned Readmission Algorithm Version 2.1: General Population report](#)

Remove:

List of planned procedures (Table 1)

ICD-9-CM codes for procedures are aggregated into procedure categories using the AHRQ Clinical Classification System (CCS). Table 1 contains the list of procedure categories that are considered potentially planned. Readmissions in which any of these procedures are performed are considered planned if the discharge condition category is not acute or a complication of care (i.e., not listed in Table 2).

Remove in its entirety:

Table 1

Remove:

List of discharge condition categories that are acute or complications of care (Table 2)

ICD-9-CM codes for the principal discharge diagnosis are aggregated into discharge condition categories using the AHRQ CCS. Table 2 contains the list of discharge condition categories considered either acute or complications of care. Admissions in which a planned procedure

was performed are only considered “planned” if the patient was not admitted for an acute illness or complication of care (i.e., if the discharge condition category is not listed in Table 2).

Remove in its entirety:
Table 2

Impacts:

COMP-THA/TKA

Rationale: Adding planned readmission algorithm language to reflect Centers for Medicare & Medicaid Services (CMS) measure updates.

Description of Changes:

Performance Measure Name

Add after risk-standardized complication rate:
(RSCR)

Description

Remove in 1st sentence:
's' in the word “complications”

Data Accuracy

Change 3rd sentence to:

A validation study to determine whether administrative data can reliably identify complications showed a final overall agreement of 99% between claims and medical records in identifying complications after minor changes to the complication definition.

Subsection 10.3 – Agency for Healthcare Research and Quality (AHRQ)

No updates in Section 10.3.

Subsection 10.4 – Healthcare Associated Infections (HAI) Measures

Impacts:

N/A

Rationale: Update the language used by the IQR Program for the HAI Measures and the links to HAI resources.

Description of Changes:

Healthcare Associated Infection

Remove: 2nd and 3rd paragraph

Hospitals with no ICU beds need to request a waiver annually to fulfill the CLABSI and CAUTI reporting requirement for the CMS Hospital IQR Program. A hospital must have no ICU beds to be eligible for this waiver.

Hospitals that have a change in their bed designation and incorporate ICU beds need to enroll with NHSN and complete the Annual Survey Form on NHSN designating the location of those beds.

Measure:

1. Central Line-Associated Bloodstream Infection (CLABSI)

Add:

Hospitals with NO Intensive Care Unit (ICU) locations can request a HAI exception for submission of CLABSI measure to fulfill the CMS Hospital IQR Program NHSN reporting requirement.

2. Catheter-Associated Urinary Tract Infection (CAUTI)

Add:

Hospitals with NO ICU locations can request a HAI exception for submission of CAUTI measure to fulfill the CMS Hospital IQR Program NHSN reporting requirement.

3. Surgical Site Infection (SSI)

Change to:

Hospitals that performed 9 or fewer of any of the specified colon and abdominal hysterectomy procedures in the calendar year prior to the reporting year can request a HAI exception for submission of SSI measures to fulfill the CMS Hospital IQR Program NHSN reporting requirement.

Healthcare Associated Infection- Resources**Change** resource to:

For more information about the NHSN measures, see the resources located at <http://www.cdc.gov/nhsn/acute-care-hospital/index.html>

Change submission of questions to:

If you have questions regarding the HAI Measures that are collected for the Hospital IQR Program, please go to the QualityNet web site <http://www.qualitynet.org> and select “Hospitals-Inpatient” under “Questions & Answers” to submit your questions.

Impacts:

N/A

Rationale: Update the language used by the IQR Program for the HAI Measures and the links to HAI resources.

Description of Changes:**Healthcare Associated Infection**

Change 1st paragraph: CMS to Centers for Medicare & Medicaid (CMS) and CDC to Centers for Disease Control and Prevention (CDC)

Subsection 10.5 – Hospital-Acquired Conditions (HAC) Measures

No updates in this Section 10.5.

Subsection 10.6 – Structural Measures

Impacts:

Web-based Measure

Measure(s)

PC-01

Rationale: Revise the web-link to reference versions of The Joint Commission's (TJC) specifications manual applicable to discharges.

Description of Changes:Measure Information Form

Change to: Using the Joint Commission's specifications* for this measure found at <https://manual.jointcommission.org/bin/view/Manual/WebHome>, enter the following information:

CMS Specifications overview*:

Change last paragraph web link to:

<https://manual.jointcommission.org/bin/view/Manual/WebHome>

Impacts:

Web-Based Measure

Measure(s)

PC-01

Rationale: Changes due to The Joint Commission's (TJC) Technical Expert Panel recommendation.

Description of Changes:Measure Information Form- Exclusions

Remove: Prior uterine surgery

CMS Specifications overview- Excluded Populations

Remove: Prior uterine surgery

Impacts:Measure(s)

PC-01

Rationale: Revise the web-link to reference versions of The Joint Commission's (TJC) specifications manual for applicable to Discharges.

Description of Changes:Inpatient Web-Based Measure

Change to: For more information about the requirements and specifications of this measure, refer to <https://manual.jointcommission.org/bin/view/Manual/WebHome>

APPENDICES

Impacts:

N/A

Rationale: Adding preview section to display future manual updates. This section is for preview only and **is not** to be used for programming.

Description of Changes:

Add new Appendix:

Appendix P - Preview section.

Appendix A – ICD-9-CM Diagnoses Code Tables

Impacts:

N/A

Rationale: These codes do not represent a major surgical procedure.

Description of Changes:

Tables 5.10, 5.19 and 5.25

Remove code and shortened description:

45.34 from code column and “DESTR SM BOWEL LES NEC” from the description column

Tables 5.02, 5.10 and 5.11

Remove code and shortened description:

35.98 from code column and “OTHER HEART SEPTA OPS” from the description column

Impacts:

N/A

Rationale: Several urological procedure codes are being added to the exclusion table for SCIP-Inf-9.

Description of Changes:

Table 5.16

Add codes and short descriptions:

56.51 to code column and “FORM CUTAN ILEOURETEROST” to description column

56.52 to code column and “REVIS CUTAN ILEOURETEROS” to description column

56.71 to code column and “URIN DIVERSION TO BOWEL” to description column

56.72 to code column and “REVIS URETEROENTEROSTOMY” to description column

Impacts:

N/A

Rationale: This table is no longer required based on updated ACCP guidelines.

Description of Changes:

Index

Remove name “Hip Fractures” and page number from row for Table 5.13.

Add “Reserved for Future Use” to name column and “N/A” to Page column.

ICD-9-CM Code Tables

Remove Table 5.13.

Add text “Table 5.13 -Reserved for Future Use.”

Impacts:

N/A

Rationale: Several codes have been removed which reflect post-partum conditions.

Description of Changes:

Table 12.3

Add codes and short descriptions:

640.80 to code column and HEM EARLY PREG NEC-UNSP to description column

640.83 to code column and HEM EARLY PG NEC-ANTEPAR to description column

Remove codes and short descriptions:

644.20 from code column and EARLY ONSET DELIV-UNSPEC from description column

664.00 from code column and DEL W 1 DEG LACERAT-UNSP from description column

664.10 from code column and DEL W 2 DEG LACERAT-UNSP from description column

664.20 from code column and DEL W 3 DEG LACERAT-UNSP from description column

664.30 from code column and DEL W 4 DEG LACERAT-UNSP from description column

664.40 from code column and OB PERINEAL LAC NOS-UNSP from description column

664.50 from code column and OB PERINEAL HEMATOM-UNSP from description column

664.60 from code column and ANAL SPHINCTER TEAR NOS from description column

664.80 from code column and OB PERIN TRAUM NEC-UNSP from description column

664.90 from code column and OB PERIN TRAUM NOS-UNSP from description column

665.10 from code column and RUPTURE UTERUS NOS-UNSP from description column

666.00 from code column and THIRD-STAGE HEM-UNSPEC from description column

669.30 from code column and AC KIDNEY FAIL W DEL-UNSP from description column

671.40 from code column and DEEP THROMB POSTPAR-UNSP from description column

674.80 from code column and PUERP COMPL NEC-UNSPEC from description column

674.90 from code column and PUERP COMPL NOS-UNSPEC from description column

677 from code column and LATE EFFCT CMPLCATN PREG from description column

Appendix C – Medication Tables

Impacts:

N/A

Rationale: FDA approved apixaban (Eliquis) for reducing the risk of stroke and dangerous blood clots in patients with atrial fibrillation on December 28, 2012.

Description of Changes:

Table 8.2 Antithrombotic Medications-Stroke

Add:

Apixaban

Eliquis

Remove:

Innohep
Tinzaparin

Impacts:

N/A

Rationale: FDA approved apixaban (Eliquis) for reducing the risk of stroke and dangerous blood clots in patients with atrial fibrillation on December 28, 2012.

Description of Changes:

Table 8.3 Anticoagulant Medications-Stroke

Add:

Apixaban
Eliquis

Remove:

Innohep
Tinzaparin

Impacts:

N/A

Rationale: The decision point for Oral Antibiotics is being removed from the algorithms for SCIP-Inf-1-3. Tables of oral antibiotics are no longer necessary.

Description of Changes:

Medication Tables

Remove: Table 3.3. Colon-Oral Antibiotics - I

Remove: Table 3.4 Colon- Oral Antibiotics-II

Add comments: Table 3.3 Reserved for Future Use, Table 3.4 Reserved for Future Use

Impacts:

N/A

Rationale: A new table is being created to allow combination therapy for colon procedures.

Description of Changes:

Table 3.5 Colon-Parenteral-Antibiotics-I

Remove medication trade name and generic name:

Ceftriaxone from left column and Ceftriaxone from right column

Ceftriaxone Sodium from left column and Ceftriaxone from right column

Rocephin from left column and Ceftriaxone from right column

Remove statement "Table 3.6 Reserved for Future Use"

Add new Table 3.6 Colon-Parenteral-Antibiotics-II

Ceftriaxone to left column and Ceftriaxone to right column

Ceftriaxone Sodium to left column and Ceftriaxone to right column

Rocephin to left column and Ceftriaxone to right column

Impacts:

N/A

Rationale: The decision point for Oral Antibiotics is being removed from the algorithms for SCIP-Inf-1-3. Tables of oral antibiotics are no longer necessary.

Description of Changes:Index

Remove name: “Colon-Oral Antibiotics-I” from row for Table 3.3.

Remove name: “Colon-Oral Antibiotics-II” from row for Table 3.4.

Add: “Reserved for Future Use” to name column for Tables 3.3 and 3.4.

Add: “N/A” to page column for rows for Tables 3.3 and 3.4.

Remove statement: “Reserved for Future Use” from row for Table 3.6.

Add name: “Colon- Parenteral-Antibiotics-II” to row for Table 3.6.

Add: page number to page column.

Change misspelling in name for Table 3.10 from “fluroquinolone” to “fluoroquinolone.”

Impacts:

N/A

Rationale: Two medications for alcohol and drug dependence are no longer available and have been discontinued.

Description of Changes:Table 9.1 FDA-Approved Tobacco Cessation Medications**Remove**

Buproban

Table 9.2 FDA-Approved Medications for Alcohol and Drug Dependence**Remove**

Depade

Subutex

Impacts:

N/A

Rationale: The medication tables were updated to add or remove medications discontinued and/or not on the FDA website in order to maintain consistency with guidelines.

Description of Changes:Table 1.6 – Lipid-Lowering Medications

Remove the following medications:

Abitrate

Choloxin

Locholest

Locholest Light

Questran

Questran Light

Tricor

Table 2.1-Antimicrobial Medications:

Remove the following medications and their corresponding generic name crosswalks:

Adoxa from left column and Doxycycline from right column
 Alatrofloxacin from left column and Alatrofloxacin from right column
 Alatrofloxacin Mesylate from left column and Alatrofloxacin from right column
 Amikin from left column and Amikacin from right column
 Ampicin from left column and Ampicillin from right column
 Anspor from left column and Cephadrine from right column
 Bacampicillin from left column and Bacampicillin from right column
 Bacampicillin Hydrochloride from left column and Bacampicillin from right column
 Bactocill from left column and Oxacillin from right column
 Biocef from left column and Cephalexin from right column
 Biomox from left column and Amoxicillin from right column
 Carbenicillin Indanyl Sodium from left column and Carbenicillin from right column
 Cefonicid from left column and Cefonicid from right column
 Cefonicid Sodium from left column and Cefonicid from right column
 Cefoperazone Sodium from left column and Cefoperazone from right column
 Cephalexin Hydrochloride from left column and Cephalexin from right column
 Cinobac from the left column and Cinoxacin from right column
 Cinoxacin from left column and Cinoxacin from right column
 Cloxacillin from the left column and Cloxacillin from right column
 Cloxacillin Sodium from left column and Cloxacillin from right column
 Cloxapen from the left column and Cloxacillin from the right column
 Dirithromycin from left column and Dirithromycin from right column
 DoxyCaps from left column and Doxycycline from right column
 Doxycycline Hydrochloride from left column and Doxycycline from right column
 Doxycycline Monohydrate from left column and Doxycycline from right column
 Dynabac from left column and Dirithromycin from right column
 E-Mycin from left column and Erythromycin from right column
 Erythromycin Estolate from left column and Erythromycin from right column
 Erythromycin Gluceptate from left column and Erythromycin Gluceptate from right column
 Fatroximin from left column and Rifaximin from right column
 Furalan from left column and Nitrofurantoin from right column
 Gantanol from left column and Sulfamethoxazole from right column
 Garamycin from left column and Gentamicin from right column
 Genticin from left column and Gentamicin from right column
 Geocillin from left column and Carbenicillin Indanyl Sodium from right column
 Ilosone from left column and Erythromycin from right column
 Ilotycin from left column and Erythromycin Gluceptate from right column
 Keftab from left column and Cephalexin Hydrochloride from right column
 Lomefloxacin from left column and Lomefloxacin from right column
 Lomefloxacin Hydrochloride from left column and Lomefloxacin from right column
 Lyphocin from left column and Vancomycin from right column
 Maxaquin from left column and Lomefloxacin from right column
 Metizol from left column and Metronidazole from right column
 Mezlin from left column and Mezlocillin from right column
 Mezlocillin from left column and Mezlocillin from right column
 Mezlocillin Sodium from left column and Mezlocillin from right column
 Monocid from left column and Cefonicid from right column

Nalidixic Acid from left column and Nalidixic Acid from right column
 Nebcin from left column and Tobramycin from right column
 Neggram from left column and Nalidixic Acid from right column
 Novodoxylin from left column and Doxycycline from right column
 Pediazole from left column and Erythromycin from right column
 Pefloxacin from left column and Pefloxacin from right column
 Proquin XR from left column and Ciprofloxacin Hydrochloride from right column
 Protostat from left column and Metronidazole from right column
 Raxar from left column and Grepafloxacin from right column
 Robimycin from left column and Erythromycin from right column
 Spectrobid from left column and Bacampicillin from right column
 Streptograminis from left column and Streptograminis from right column
 TAO from left column and Troleandomycin from right column
 Tegopen from left column and Cloxacillin from right column
 Ticar from left column and Ticarcillin from right column
 Tobra from left column and Tobramycin from right column
 Troleandomycin from left column and Troleandomycin from right column
 Velosef from left column and Cephadrine from right column
 Zagam from left column and Sparfloxacin from right column

Add the following medication and corresponding generic name crosswalk:
 Oracea to left column and Doxycycline to right column

Table 2.2-Immunosuppressive Medications:

Remove the following medications:

Acetocot
 Adbeon
 Adrenocot
 Adrenocot LA
 Amcort
 Amprenavir
 Meticorten
 Predcor
 Sterapred

Table 2.5-Macrolides (Non-ICU):

Remove the following medication and its corresponding generic name crosswalk:

E-mycin from left column and Erythromycin from right column
 Erythromycin Estolate from left column and Erythromycin from right
 Erythromycin Gluceptate from left column and Erythromycin Gluceptate from right column
 Ilosone from left column and Erythromycin from right
 Ilotycin from left column and Erythromycin Gluceptate from right
 Pediazole from left column and Erythromycin from right
 Robimycin from left column and Erythromycin from right

Table 2.6-Macrolides (ICU)

Remove the following medication and its corresponding generic name and crosswalk:

Erythromycin Gluceptate from left column and Erythromycin Gluceptate from right column
 Ilotycin from left column and Erythromycin Gluceptate from right

Table 2.8- Antipseudomonal Quinolones

Remove the following medication and its corresponding generic name crosswalk:
Proquin XR from the left column and Ciprofloxacin Hydrochloride from the right column

Table 2.10- Tetracyclines:

Remove the following medication and its corresponding generic name crosswalk:
Adoxa from the left column and Doxycycline from the right column
DoxyCaps from the left column and Doxycycline from the right column
Doxycycline Hydrochloride from the left column and Doxycycline from the right column
Doxycycline Monohydrate from the left column and Doxycycline from the right column
Novodoxylin from left column and Doxycycline from right column

Add the following medications and their corresponding generic name crosswalks:
Oracea to the left column and Doxycycline to the right column

Table 2.11 Aminoglycosides (PN-Pseudomonal Risk/SCIP-Colon or Hysterectomy Beta-lactam Allergy):

Remove the following medication and its corresponding generic name crosswalk:
Amikin from the left column and Amikacin from the right column
Garamycin from the left column and Gentamicin from the right column
Genticin from the left column and Gentamicin from the right column
Nebcin from the left column and Tobramycin from the right column
Tobra from the left column and Tobramycin from the right column

Table 2.15-Systemic Corticosteroid Medications:

Remove the following medications and their corresponding generic name crosswalks:
Amcort from the left column and Triamcinolone Diacetate from the right column
Meticorten from left column and Prednisone from right column
Panasol-S from left column and Prednisone from right column
Predcor from left column and Prednisone Acetate from right column
Predcor TBA from left column and Prednisone Terbutate from right column

Table 3.6a-Colon,Hysterectomy-Parenteral-Antibiotics-III:

Remove the following medications and their corresponding generic name crosswalks:
Metizol from left column and Metronidazole from right column
Protostat from left column and Metronidazole from right column

Table 3.8- CABG, Cardiac or Vascular, Hip/Knee Arthroplasty- Antibiotics:

Remove the following medication and its corresponding generic name crosswalk:
Lyphocin from left column and Vancomycin from right column

Table 3.10- All Surgeries- Antibiotics/Fluoroquinolones:

Remove the following medication and its corresponding generic name crosswalk:
Alatrofloxacin from left column and Alatrofloxacin from right column
Alatrofloxacin Mesylate from the left column and Alatrofloxacin from the right column

Table 3.11 All Surgeries – Urinary Antiseptics

Remove the following medication and its corresponding generic name and crosswalk:
Furalan from the left column and Nitrofurantoin from the right column

Table 3.13- Diuretics:

Remove the following medications and their corresponding generic name crosswalks:

Aquatensen from left column and Methyclothiazide from right column
 Benzthiazide from left column and Benzthiazide from right column
 Diucardin from left column and Hydroflumethiazide from right column
 Diurese from left column and Trichlormethiazide from right column
 Enduron from left column and Methyclothiazide from right column
 Esidrix from left column and Hydrochlorothiazide from right column
 Exna from left column and Benzthiazide from right column
 Hydroflumethiazide from left column and Hydroflumethiazide from right column
 Hydromox from left column and Quinethazone from right column
 Hydro-Par from left column and Hydrochlorothiazide from right column
 Methyclothiazide from left column and Methyclothiazide from right column
 Naqua from left column and Trichlormethiazide from right column
 Naturetin from left column and Bendroflumethiazide from right column
 Quinethazone from left column and Quinethazone from right column
 Renese from left column and Polythiazide from right column

Add the following medications and corresponding generic name crosswalk:

Chlorothiazide to the left column and Chlorothiazide to the right column.
 Chlorothiazide Sodium to the left column and Chlorothiazide Sodium to the right column.
 Diuril to the left column and Chlorothiazide to the right column.
 Diuril to the left column and Chlorothiazide Sodium to the right column.

Table 3.14-Positive Inotropic and Vasopressor Agents (IV only)-SCIP:

Remove the following medications and their corresponding generic name crosswalks:

Crystodigin from left column and Digitoxin from right column
 Digitoxin from left column and Digitoxin from right column

Table 3.15- Paralytic Agents:

Remove the following medications:

Arduan
 Flaxedil
 Jexin
 Metocurine
 Mivacron
 Norcuron
 Nuromax
 Pavulon
 Raplon
 Tracrium
 Tubocurarine

Table 4.0- Antibiotic Allergy:

Remove the following medications:

Ampicin
 Bacampicillin
 Bacampicillin Hydrochloride
 Bactocill
 Biocef

Biomox
Carbenicillin Indanyl Sodium
Cefonicid
Cefonicid Sodium
Cefoperazone Sodium
Cephalexin Hydrochloride
Cloxacillin
Cloxacillin Sodium
Cloxapen
Geocillin
Keftab
Mezlin
Mezlocillin
Mezlocillin Sodium
Monocid
Spectrobid
Ticar
Velosef

Impacts:

N/A

Rationale: Medication table 2.3 needs to be updated to maintain consistency with Infectious Diseases Society of America/American Thoracic Society Consensus Guidelines on the Management of Community-Acquired Pneumonia.

Description of Changes:Table 2.3-Beta-Lactams:

Remove the following medication and its corresponding generic name crosswalk:
Ampicillin/Sulbactam from left column and Ampicillin/Sulbactam from right column

Add the following medication and its corresponding generic name crosswalk:
Ampicillin to left column and Ampicillin to right column

Impacts:

N/A

Rationale: AMI/HF/SCIP medications that have been discontinued/withdrawn need to be removed from listings.

Description of Changes:Table 1.1 – Aspirin and Aspirin-Containing Medications**Remove:**

Invagesic
Invagesic Forte
Robaxisal

Table 1.2 – ACEIs**Remove:**

Prinzide

Table 1.3 – Beta-Blockers**Remove:**

Visken

Table 1.5 – Fibrinolytic Agents**Remove:**

Abbokinase

Anisoylated Plasminogen-Streptokinase Activator Complex

Anistreplase

APSAC

Eminase

Kabikinase

Table 1.7 – ARBs**Remove:**

Verdia

Impacts:

N/A

Rationale: Two ARB combination drugs need to be added to the ARB medication listing.**Description of Changes:**Table 1.7 – ARBs**Add:**

Exforge HCT

Valsartan/amlodipine/hydrochlorothiazide

Impacts:

N/A

Rationale: Correct typos in drug names.**Description of Changes:**Table 8.2 - Antithrombotic Medications-Stroke**Change**

Lepirudin

Litecoat Aspirin

Table 8.3 - Anticoagulant Medications-Stroke**Change**

Lepirudin

Table 1.1 - Aspirin and Aspirin-Containing Medications**Change**

Litecoat Aspirin

Impacts:

N/A

Rationale: The medication tables need to be updated to:
Remove medications discontinued and/or not on the FDA website; change a drug to correct spelling; add new drugs, in order to maintain consistency with guidelines.

Description of Changes:Table 6.1 Controller Medications – CAC

Remove the following medications and their corresponding generic name crosswalks:

Azmacort from left column and Triamcinolone Acetonide from right column

Intal from left column and Cromolyn Sodium from right column

Triamcinolone Acetonide from left column and Triamcinolone Acetonide from right column

Table 6.2 Reliever Medications – CAC

Change Adrenaline in left column to Adrenalin

Add the following medications and their generic name crosswalks:

Isoproterenol to the left column and Isoproterenol to the right column

Isuprel to the left column and Isoproterenol to the right column

Table 6.3 Systemic Corticosteroid Medications – CAC

Remove the following medications and their corresponding generic name crosswalks:

Sterapred from the left column and Prednisone from the right column

Baycadron from the left column and Dexamethasone from the right column

Appendix D – Glossary of Terms

No updates in Appendix D.

Appendix E – Overview of Measure Information Form and Flowchart Formats

No updates in Appendix E.

Appendix F – Measure Name Crosswalk**Impacts:**

N/A

Rationale: Update the measures names to match the changes made to the measures names in this version of the specifications manual.

Description of Changes:Measure Name In Hospital Inpatient Specifications Manual

SCIP-Inf-4

Change 2nd column year from 2013 to 2014

Change to: Cardiac Surgery Patients With Controlled Postoperative Blood Glucose

READM-30-THA/TKA

Change to: Hospital-level 30-day all-cause risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)

COMP-THA/TKA

Change to: Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)

Appendix G – Resources

No updates in Appendix G.

Appendix H – Miscellaneous Tables**Impacts:**

N/A

Rationale: Brand names are being removed from the specifications.

Description of Changes:

Table 2.1 VTE Prophylaxis Inclusion Table- Inclusions/Synonyms

Remove:

Jobst stockings
 TED hose (TEDs)
 Alternating Leg Pressure (ALP)
 Athrombic pumps-calf/thigh
 Continuous Enhanced Circulation Therapy (CECT)
 Flotron/Flotron DVT system-thigh
 Impulse pump-thigh
 KCI stockings
 PAS (Pulsatile anti-embolic stockings)
 Plexipulse-calf/thigh
 Thromboguard
 Vascultherm
 VasoPress DVT System
 Venodyne boots- calf/thigh
 A-V impulse system
 Kendall AV impulse (foot)
 Kendall boots
 Plexiboots-foot only
 Pneumoboots- foot only

Impacts:

N/A

Rationale: The US Food and Drug Administration (FDA) has approved apixaban for the prevention of stroke and systemic embolism in patients with nonvalvular atrial fibrillation. Rivaroxaban has been approved to reduce the risk of stroke in patients with non-valvular atrial

fibrillation; for treatment of DVT or PE; to reduce the risk of recurrent DVT and PE following initial treatment.

Description of Changes:

Table 2.1- VTE Prophylaxis Inclusion Table

Remove footnote in left column next to Oral Factor Xa Inhibitor.

Add footnote “2” in right column next to Rivaroxaban and Xarelto.

Add to right column:

Apixaban¹

Eliquis¹

Change footnote “1” to:

The U.S. Food and Drug Administration has approved Eliquis (apixaban) to reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation.

Add footnote “2”:

The U.S. Food and Drug Administration has approved Xarelto (rivaroxaban) to reduce the risk of blood clots, deep vein thrombosis (DVT) and pulmonary embolism (PE) following knee or hip replacement surgery only. It is additionally approved: to reduce the risk of stroke in patients with non-valvular atrial fibrillation; for treatment of DVT or PE; to reduce the risk of recurrent DVT and PE following initial treatment.

Impacts:

N/A

Rationale: The ACCP Guidelines recommend aspirin for total knee and hip arthroplasties.

Description of Changes:

Table 2.1- VTE Prophylaxis Inclusion Table

VTE Prophylaxis and Inclusion/Synonyms:

Add Aspirin to left column.

Add to right column:

Acetylsalicylic Acid (ASA) ³

Aspirin/caffeine ³

Buffered aspirin ³

Coated aspirin ³

Enteric coated aspirin (EC ASA) ³

Tri-buffered aspirin ³

Add footnote “3” to end of table:

The American College of Chest Physicians (ACCP) Evidence-Based Clinical Practice Guidelines recommend aspirin (Grade 1b) to reduce the risk of venous thromboembolism in patients undergoing total hip or knee arthroplasty.