Guidelines for Using Release Notes

The Release Notes Version 5.1 provides modifications to the Specifications Manual for National Hospital Inpatient Quality Measures. The information in this document is to be used as a reference and is not intended to be used to program abstraction tools. Please refer to the Specifications Manual for National Hospital Inpatient Quality Measures for the complete and current technical specifications and abstraction information.

The notes are organized to follow the order of the Table of Contents. The implementation date is 07/01/2016, unless otherwise specified. The headings are described below:

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

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

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

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

**NOTE**: In addition to being called out specifically in the Release Notes document, additions are yellow highlighted in the corresponding documents. The changes in the Hospital Initial Patient Population and Clinical Data XML File Layouts have yellow highlighted cells with actual changes noted in bold font.
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Specifications Manual for Hospital Inpatient Quality Measures
Discharges 07-01-2016 (3Q16) through 12-31-16 (4Q16)
The content below is organized to follow the Table of Contents in the specifications manual.

**Table of Contents**

**Impacts:**
Section 2: Measurement Information

**Rationale:** Measures and measure sets are being removed from CMS’ Hospital Inpatient Quality Reporting Program and The Joint Commission’s Flexible ORYX® Performance reporting requirements beginning with 1/1/2016 discharges.

**Description of Changes:**

**Remove:**
- 2.1 – Acute Myocardial Infarction (AMI)
- 2.3 – Surgical Care Improvement Project (SCIP)
- 2.4 - Reserved for Future Use
- 2.5 – Children’s Asthma Care (CAC)
- 2.6 – Venous Thromboembolism (VTE)
- 2.7 – Stroke (STK)
- 2.10 – Prevention

**Remove** under Measure Information form (MIF) and Flowchart (Algorithm):
- VTE-1, VTE-2, VTE-3
- STK-1, STK-2, STK-3, STK-5, STK-6, STK-8, STK-10
- IMM-1

**Change** section numbers for the following from:
- 2.2 - Severe Sepsis and Septic Shock (SEP)
- 2.6 - Venous Thromboembolism (VTE)
- 2.7 - Stroke (STK)
- 2.8 - Global Initial Patient Population (ED, IMM, TOB, SUB)
- 2.9 - Emergency Department (ED)
- 2.10 - Prevention
  - 2.10.1 ………..Immunization (IMM)
  - 2.10.2 ………..Tobacco Treatment (TOB)
  - 2.10.3 ………..Substance Use (SUB)

**To:**
- 2.1 - Severe Sepsis and Septic Shock (SEP)
- 2.2 - Venous Thromboembolism (VTE)
- 2.3 - Stroke (STK)
- 2.4 - Global Initial Patient Population (ED, IMM, TOB, SUB)
- 2.5 - Emergency Department (ED)
- 2.6 - Prevention
  - 2.6.1 - Immunization (IMM)
  - 2.6.2 - Substance Use (SUB)
  - 2.6.3 - Tobacco Treatment (TOB)
Impacts:
Appendices

Rationale: Measures and measure sets are being removed from CMS’ Hospital Inpatient Quality Reporting Program and The Joint Commission’s Flexible ORYX® Performance reporting requirements beginning with 1/1/2016 discharges.

Description of Changes:
Remove under ‘A’:
AMI, CAC, SCIP

Acknowledgement

No updates in the Acknowledgement section.

Introduction

No updates in the Introduction section.

Using the Specifications Manual for National Hospital Inpatient Quality Measures

No updates in the Using the Specifications Manual for National Hospital Inpatient Quality Measures section.

SECTION 1 – Data Dictionary

Introduction to Data Dictionary

No updates in the Introduction to Data Dictionary section.

Alphabetical Data Dictionary

Impacts:
Index

Rationale: Measures and measure sets are being removed from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

Description of Changes:
Arrival Date
Remove under ‘Collected For’:
AMI-7a, STK-5

Arrival Time
Transfer From Another Hospital or ASC
Remove under ‘Collected For’:
AMI-7a
Clinical Trial
Change ‘Collected For’ to:
STK-4, VTE-5, VTE-6

Comfort Measures Only
Remove under ‘Collected For’:
STK-1, STK-2, STK-3, STK-5, STK-6, STK-8, STK-10, VTE-1, VTE-2, VTE-3

Discharge Disposition
Remove under ‘Collected For’:
IMM-1, CAC-3, STK-2, STK-3, STK-6, STK-8, STK-10, VTE-3

Elective Carotid Intervention
Change ‘Collected For’ to:
STK-4

VTE Confirmed
VTE Diagnostic Test
Remove under ‘Collected For’:
VTE-3

Impacts:
Index and Data Element Pages

Rationale: Measures and measure sets are being removed from CMS' Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

Description of Changes:
Remove the following data elements in their entirety:
Anesthesia Start Date
Anticoagulation Therapy Prescribed at Discharge
Antithrombotic Therapy Administered by End of Hospital Day 2
Antithrombotic Therapy Prescribed at Discharge
Assessed for Rehabilitation Services
Atrial Fibrillation/Flutter
Education Addresses Activation of Emergency Medical System (EMS)
Education Addresses Follow-up After Discharge
Education Addresses Medications Prescribed at Discharge
Education Addresses Risk Factors for Stroke
Education Addresses Warning Signs and Symptoms of Stroke
Fibrinolytic Administration
Fibrinolytic Administration Date
Fibrinolytic Administration Time
Glucose
Home Management Plan of Care Document Addresses Arrangements for Follow-up Care
Home Management Plan of Care Document Addresses Environmental Control and Control of Other Triggers
Home Management Plan of Care Document Addresses Methods and Timing of Rescue Actions
Home Management Plan of Care Document Addresses Use of Controllers
Home Management Plan of Care Document Addresses Use of Relievers
Home Management Plan of Care Document Given to Patient/Caregiver
Home Management Plan of Care Document Present
ICU Admission or Transfer
ICU Admission or Transfer Date
ICU Discharge Date
ICU VTE Prophylaxis
ICU VTE Prophylaxis Date
Infection Prior to Anesthesia
Initial ECG Interpretation
INR Value
IV OR IA Thrombolytic (t-PA) Therapy Administered at This Hospital or Within 24 Hours Prior to Arrival
Overlap Therapy
Overlap Therapy Start Date
Parenteral Anticoagulant End Date
Parenteral Anticoagulant Prescribed at Discharge
Pneumococcal Vaccination Status
Reason for Delay in Fibrinolytic Therapy
Reason for Discontinuation of Parenteral Anticoagulation Therapy
Reason for No Overlap Therapy
Reason for No VTE Prophylaxis – Hospital Admission
Reason for No VTE Prophylaxis – ICU Admission
Reason for Not Administering Antithrombotic Therapy by End of Hospital Day 2
Reason for Not Prescribing Anticoagulation Therapy at Discharge
Reason for Not Prescribing Antithrombotic Therapy at Discharge
Reason for Not Prescribing Statin Medication at Discharge
Reason for Oral Factor Xa Inhibitor
Reason for Oral Factor Xa Inhibitor – ICU Admission
Statin Medication Prescribed at Discharge
Surgery End Date
Surgery End Date – ICU Admission
Surgical Procedure
Surgical Procedure – ICU Admission
VTE Prophylaxis
VTE Prophylaxis Date
Warfarin Administration

Impacts:
New Data Element

Rationale: New data element for Septic Shock is being added.

Description of Changes:
Index
Add new data element:
Administrative Contraindication to Care, Septic Shock

Data Element
Add new data element page:
Administrative Contraindication to Care, Septic Shock
Impacts:
New Data Element

Rationale: New data elements for Septic Shock are being added.

Description of Changes:
Index
Add new data elements:
Initial Hypotension
Documentation of Septic Shock

Data Element
Add new data element page:
Initial Hypotension
Documentation of Septic Shock

Impacts:
Administrative Contraindication to Care

Rationale: Specific wording related to Severe Sepsis is being added to the data element.

Description of Changes:
Index
Change data element name from:
Administrative Contraindication to Care
To:
Administrative Contraindication to Care, Severe Sepsis

Data Element
Change data element name to:
Administrative Contraindication to Care, Severe Sepsis

Definition
Change to:
Documentation of refusal of blood draw, fluid administration, or antibiotic administration prior to or within 6 hours following presentation of severe sepsis.

Suggested Data Collection Question
Change to:
Did the patient or surrogate decision-maker decline consent for blood draw, fluid administration, or antibiotic administration prior to or within 6 hours following presentation of severe sepsis?

Allowable Values
Change from:
1 Yes. There is documentation by a physician/APN/PA that the patient or decision-maker has refused either blood draw, fluid administration, or antibiotic administration.
2 Yes. There is a witnessed consent form for either blood draw, fluid administration, or antibiotic administration that is marked “refused.”
3 No. There is no physician/APN/PA documentation or witnessed consent form that the patient or decision-maker has refused either blood draw, fluid administration, or antibiotic administration.

To:
1 (Yes) There is documentation by a physician/APN/PA that the patient or decision-maker has refused either blood draw, fluid administration, or antibiotic administration prior to or within 6 hours following presentation of severe sepsis.
2 (Yes) There is a witnessed consent form for either blood draw, fluid administration, or antibiotic administration that is marked "refused" prior to or within 6 hours following presentation of severe sepsis.
3 (No) There is no physician/APN/PA documentation or witnessed consent form that the patient or decision-maker has refused either blood draw, fluid administration, or antibiotic administration prior to or within 6 hours following presentation of severe sepsis.

Notes for Abstraction
Change second bullet to:
- Consent forms either signed or unsigned by the patient or decision maker that are marked "refused" and witnessed by a physician, APN, PA or other hospital personnel, are acceptable.

Add new bullet:
- Documentation of refusal of blood draw, fluid administration, or antibiotic administration that is present prior to or within 6 hours following presentation of severe sepsis can be used.

Impacts:
Alcohol Use Status

Rationale: The revision provides guidance on screening tools completed prior to admission to a psychiatric unit and clarifies how to identify cognitive impairment.

Description of Changes:
Notes for Abstraction
Change to:
• If patient has a blood alcohol test with a result of .08 or greater or the clinician documents the patient was acutely intoxicated per blood alcohol test results select Value “2.”
• Screening may be done with a “validated” Single Alcohol Screening Question (SASQ) in order to identify those patients with no risk or low risk or who do not drink. Further screening should be done with a validated tool for those patients with a positive result to determine if there is need for a brief intervention.
Examples of SASQs include:
  o “On any single occasion during the past 3 months, have you had more than 5 drinks containing alcohol?” (Yes response is considered positive.)
  o "When was the last time you had more than X drinks in 1 day?” (X = 4 for women and 5 for men) (Within the last 3 months is considered positive.)
  o “How many times in the past year have you had X or more drinks in a day?” (X = 5 men and 4 women) (Response of >1 is considered positive.)
• How often have you had 6 or more drinks on one occasion in the past year? (Ever in the past year considered positive.)
• How often do you have X or more drinks on one occasion? (X = 4 for women and 5 for men) (Ever in the past year considered positive.)

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

**EXCEPTION:**
If the screening was performed prior to admission to the psychiatric unit, i.e., at the transferring facility, in another inpatient hospital unit, emergency department or observation unit, the screening documentation must be present in the psychiatric unit medical record.

• Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set is related to documentation that the patient cannot be screened for alcohol use due to the impairment (e.g., comatose, obtunded, confused, memory loss) within the first three days of admission.

• If there is documentation that the patient has temporary cognitive impairment due to acute substance use (e.g., overdose or acute intoxication), Value “7” cannot be selected.

• If there is documentation within the first 3 days of admission that the patient was psychotic with documented symptoms, e.g., hallucinating, non-communicative, catatonic, etc., which prevented them from answering questions reliably, they would be considered cognitively impaired.

• If there is documentation that the patient was intubated the entire first three days of admission, select allowable value “7” as the patient is unable to answer.

• If there is documentation within the first 3 days of admission of any of the examples below, select Value “7” regardless of conflicting documentation.

Examples of cognitive impairment include:
 o Altered Level of Consciousness (LOC)
 o Altered Mental Status
 o Cognitive impairment
 o Cognitively impaired
 o Dementia
 o Confused
 o Memory loss
 o Mentally retarded
 o Obtunded
 o Psychotic/psychosis

**Impacts:**
**Arrival Date**

**Rationale:** These changes provide clarification in response to questions received from abstractors and clinicians.
Description of Changes:
Notes for Abstraction
Add third sub-bullet to fourth bullet:
  o ED Triage Date/Time 06-18-20xx 0025. EMS report indicates patient arrived by ambulance on 06-17-20xx 2355. Patient routed directly to CT. The EMS report is disregarded. Enter 06-18-20xx for Arrival Date.

Change sixth 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, ED head CT scan, CTA, MRI, MRA reports).

Impacts:
Arrival Date
Arrival Time

Rationale: Measures and measure sets are being removed from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

Description of Changes:
Change ‘Collected For’ to:
CMS/The Joint Commission: ED-1, STK-4

Impacts:
Arrival Time

Rationale: These changes provide clarification in response to questions received from abstractors and clinicians.

Description of Changes:
Notes for Abstraction
Add third sub-bullet to fifth bullet:
  o ED Triage Time 1525. EMS report indicates patient was receiving care 1435 through 1455. ED report documents time of head CT 1505. The EMS report is disregarded. Enter 1505 for Arrival Time.

Change seventh 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, ED head CT scan, CTA, MRI, MRA reports).
Impacts:

Brief Intervention

Rationale: The Definition and Notes for Abstraction were updated to provide additional information on the key components of a brief intervention.

Description of Changes:
Definition
Change to:
A brief intervention is a single session or multiple sessions conducted by a qualified healthcare professional or trained peer support person, following a positive screen for unhealthy alcohol use. The intervention includes motivational discussion focused on increasing insight and awareness regarding alcohol use and motivation toward behavioral change. Brief interventions can be tailored for variance in population or setting and can be used as a stand-alone treatment for those at risk as well as a vehicle for engaging those in need of more extensive levels of care.

A brief intervention focuses on increasing the patient’s understanding of the impact of substance use on his or her health and motivating the patient to change risky behaviors. The components of the intervention include feedback concerning the quantity and frequency of alcohol consumed by the patient in comparison with national norms; a discussion of negative physical, emotional, and occupational consequences; and a discussion of the overall severity of the problem. The qualified health care professional engages the patient in a joint decision-making process regarding alcohol use and plans for follow-up are discussed and agreed to.

Notes for Abstraction
Add new fifth bullet:
- A brief intervention includes at a minimum the following three components:
  a. Concern that the patient is drinking at unhealthy levels known to increase his/her risk of alcohol-related health problems
  b. Feedback linking alcohol use and health, including:
     - Personalized feedback (i.e., explaining how alcohol use an interact with patient’s medical concerns [hypertension, depression/anxiety, insomnia, injury, congestive heart failure (CHF), diabetes mellitus (DM), breast cancer risk, interactions with medications]) OR
     - General feedback on health risks associated with drinking.
  c. Advice:
     - To abstain (if there are contraindications to drinking) OR
     - To drink below recommended limits (specified for patient).

Impacts:

Broad Spectrum or Other Antibiotic Administration Selection

Rationale: This change is to include antibiotics given for a known causative organism and susceptibility.
Description of Changes:

Notes for Abstraction

Change second bullet to:

- If the administered IV antibiotics were NOT on Table 5.0, determine if the IV antibiotics are on Table 5.1 in Appendix C. Determine the class the administered IV antibiotics belong to, based on the class name in the shaded row above the antibiotic names. Next, refer to the following Combination Antibiotic Therapy Table to determine if an antibiotic from a class in both Column A and Column B were given. There must be at least one from a class in column A and at least one from a class in column B administered to select Value “1.” Review the chart to see that both drugs were started or given within 3 hours of severe sepsis presentation and if so, choose Value “1.” If both drugs were not started or given, choose Value “2.”

Add in third bullet:
‘IV’ before ‘antibiotics’

Add new fourth bullet:

- If an IV antibiotic from Table 5.0 or an appropriate combination of IV antibiotics from Table 5.1 is not started or given within the 3 hours following presentation of severe sepsis, but there is a lab report or physician/APN/PA documentation indicating the causative organism and susceptibility is known and an IV antibiotic identified as appropriate to treat the causative organism is given within 3 hours following presentation of severe sepsis, choose Value "1."

Impacts:

Broad Spectrum or Other Antibiotic Administration Time

Rationale: This change clarifies abstraction guidance for Broad Spectrum or Other Antibiotic Administration Time.

Description of Changes:

Notes for Abstraction

Change first bullet to:

- If antibiotics were administered intravenously (IV) within 24 hours prior to Severe Sepsis Presentation Time, abstract the earliest time that a dose of IV antibiotic was given. This may be the same time as the time of presentation, within 24 hours prior to presentation, or a time greater than 24 hours before presentation.

Change second bullet to:

- If the patient was started on IV antibiotics within the 3 hours following the date and time of presentation of severe sepsis, and not on antibiotics in the 24 hours prior to the date and time of presentation of severe sepsis, abstract the earliest time at which the first dose of antibiotic was given. This may be the same time as the time of presentation or may be a time after presentation.

Change example under second bullet to:

The date and time of presentation of severe sepsis was 11-02-20xx at 10:00. Patient was placed on a broad spectrum IV antibiotic every 6 hours. The first dose of IV antibiotic was given immediately after the severe sepsis presentation date and time on 11-02-20xx at 13:00. The time of presentation would be 11-02-20xx at 10:00, the Broad Spectrum or Other Antibiotic Administration Time is 11-02-20xx at 13:00.
**Change** third bullet to:
- If more than one IV antibiotic was given within the 3 hours after the presentation of severe sepsis, and the patient did not receive an IV antibiotic in the 24 hours before severe sepsis presentation, abstract the dose given closest to the time of presentation of severe sepsis.

**Change** fourth bullet to:
- If IV antibiotics were administered both 24 hours prior to and within 3 hours after the time of presentation of severe sepsis, abstract the earliest time that an IV dose of antibiotic was given.

**Impacts:**
*Risk of Inappropriate IV Antibiotic Dosing*

**Rationale:** This change clarifies the requirements for the capillary refill examination.

**Description of Changes:**

**Definition**

**Change** to:

Documentation of the date indicating a capillary refill examination was performed.

**Suggested Data Collection Question**

**Change**:

‘performed’ to ‘documented’

**Notes for Abstraction**

**Change** in second bullet:

‘done’ to ‘documented’

**Impacts:**
*Risk of Inappropriate IV Antibiotic Dosing*

**Rationale:** This change clarifies the requirements for the capillary refill examination.

**Description of Changes:**

**Suggested Data Collection Question**

**Change**

‘performed’ to ‘documented’

**Allowable Values**

**Change** from:
- 1 (Yes) Capillary refill examination was performed by a physician/APN/PA.
- 2 (No) Capillary refill examination was not performed by a physician/APN/PA, or unable to determine.

**To:**
- 1 (Yes) Capillary refill examination was documented by a physician/APN/PA.
- 2 (No) Capillary refill examination was not documented by a physician/APN/PA, or unable to determine.
Notes for Abstraction
Add to third bullet:
, or make reference to peripheral perfusion.

Change in sixth bullet:
‘done’ to ‘documented’

Change in seventh bullet:
‘performed’ to ‘documented’

Inclusion Guidelines for Abstraction
Add new bullet:
• Peripheral perfusion

Impacts:
Capillary Refill Examination Time

Rationale: This change clarifies the requirements for the capillary refill examination.

Description of Changes:
Definition
Change to:
Documentation of the time indicating a capillary refill examination was performed.

Suggested Data Collection Question
Change:
‘performed’ to ‘documented’

Notes for Abstraction
Change second bullet to:
• If multiple capillary refill examinations were documented in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, abstract the date and time of the examination that was documented latest within the time window.

Impacts:
Cardiopulmonary Evaluation Date

Rationale: This change clarifies the requirements for the cardiopulmonary evaluation.

Description of Changes:
Definition
Change to:
Documentation of the date indicating a cardiopulmonary evaluation was performed by a physician/APN/PA.

Suggested Data Collection Question
Add:
and documented
Notes for Abstraction

Change in second bullet:
‘done’ to ‘documented’

Impacts:
Cardiopulmonary Evaluation Performed

Rationale: This change clarifies the requirements for the cardiopulmonary evaluation.

Description of Changes:
Suggested Data Collection Question
Add: and documented

Allowable Values

Change from:
1 (Yes) Cardiopulmonary evaluation was performed by a physician/APN/PA.
2 (No) Cardiopulmonary evaluation was not performed by a physician/APN/PA, or unable to determine.

To:
1 (Yes) Cardiopulmonary evaluation was performed and documented by a physician/APN/PA.
2 (No) Cardiopulmonary evaluation was not performed and documented by a physician/APN/PA, or unable to determine.

Notes for Abstraction

Change in fourth bullet:
‘done’ to ‘documented’

Change in fifth bullet:
‘performed’ to ‘documented’

Impacts:
Cardiopulmonary Evaluation Time

Rationale: This change clarifies the requirements for the cardiopulmonary evaluation.

Description of Changes:
Definition
Change to: Documentation of the time indicating a cardiopulmonary evaluation was performed by a physician/APN/PA.

Suggested Data Collection Question
Add: and documented
Notes for Abstraction

Change second bullet to:

- If there are multiple cardiopulmonary evaluations documented in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, abstract the time of the evaluation that was documented latest within the time window.

Impacts:

Central Venous Oxygen Measurement

Rationale: Changes are being made to provide clarification and maintain consistency with other similar data elements.

Description of Changes:

Definition

Change to:

Documentation of measurement of central venous oxygen within 6 hours after presentation of septic shock.

Suggested Data Collection Question

Add after the word “obtained”:

within 6 hours

Allowable Values

Change from:

<table>
<thead>
<tr>
<th>Allowable Values:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Yes) Central Venous Oxygen Measurement was obtained after the presentation of septic shock.</td>
</tr>
<tr>
<td>2 (No) Central Venous Oxygen Measurement was not obtained after the presentation of septic shock, or unable to determine.</td>
</tr>
</tbody>
</table>

To:

<table>
<thead>
<tr>
<th>Allowable Values:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Yes) Central Venous Oxygen Measurement was obtained within 6 hours after the presentation of septic shock.</td>
</tr>
<tr>
<td>2 (No) Central Venous Oxygen Measurement was not obtained within 6 hours after the presentation of septic shock, or unable to determine.</td>
</tr>
</tbody>
</table>

Notes for Abstraction

Add new first bullet:

- If there are multiple central venous oxygen measurements, abstract the first one that occurs after the time and date of septic shock presentation.

Change third bullet to:

- There must be documentation reflecting the oxygen reading was obtained via central venous catheter. A notation such as via “central catheter” or “CVP catheter” or “central venous oximetry catheter” with an oxygen reading or the oxygen reading recorded on a flow sheet in an area designated for central venous catheter readings is acceptable.
Impacts:
Central Venous Oxygen Measurement Date

Rationale: Changes are being made to provide clarification and maintain consistency with other similar data elements.

Description of Changes:
Definition
Add after the word “obtained”:
within 6 hours

Suggested Data Collection Question
Add after the word “obtained”:
within 6 hours

Notes for Abstraction
Add in first bullet after the word “occurs”:
within 6 hours

Change third bullet to:
- There must be documentation reflecting the oxygen reading was obtained via central venous catheter. A notation such as via “central catheter” or “CVP catheter” or “central venous oximetry catheter” with an oxygen reading or the oxygen reading recorded on a flow sheet in an area designated for central venous catheter readings is acceptable.

Impacts:
Central Venous Oxygen Measurement Time

Rationale: Changes are being made to provide clarification and maintain consistency with other similar data elements.

Description of Changes:
Definition
Add after the word “obtained”:
within 6 hours

Suggested Data Collection Question
Add after the word “obtained”:
within 6 hours

Notes for Abstraction
Add in first bullet after the word “occurs”:
within 6 hours

Change third bullet to:
- There must be documentation reflecting the oxygen reading was obtained via central venous catheter. A notation such as via “central catheter” or “CVP catheter” or “central venous oximetry catheter” with an oxygen reading or the oxygen reading recorded on a flow sheet in an area designated for central venous catheter readings is acceptable.

Suggested Data Sources
Add new bullet:
- Vital signs flow sheet
Impacts:
Clinical Trial

Rationale: Measures and measure sets are being removed from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

Description of Changes:
Change ‘Collected For’ to:
CMS/The Joint Commission: STK-4, VTE-5, VTE-6

Definition
Remove:
AMI, CAC, SCIP

Suggested Data Collection Question
Remove:
AMI, CAC, SCIP

Allowable Values
Change from:
Y (Yes) There is documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AMI, CAC, SCIP, STK, VTE).
N (No) There is no documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AMI, CAC, SCIP, STK, VTE), or unable to determine from medical record documentation.

To:
Y (Yes) There is documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. STK, VTE).
N (No) There is no documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. STK, VTE), or unable to determine from medical record documentation.

Notes for Abstraction:
Remove in first bullet number ‘2’:
AMI, CAC, SCIP

Remove:
AMI:
Only capture patients enrolled in clinical trials studying patients with acute myocardial infarction (AMI), ST-elevation myocardial infarction (STEMI), Non ST-elevation MI (NSTEMI), heart attack, or acute coronary syndrome (ACS).

CAC:
Only capture patients enrolled in clinical trials studying children with asthma.
**SCIP:**
The clinical trial should be relevant to one or more of the SCIP measures.
Some examples may include but are not limited to:
- The clinical trial involved the use of antibiotics.
- The clinical trial involved testing a new beta-blocker.
- The clinical trial involved the use of VTE prophylaxis.

**Impacts:**
*Comfort Measures Only*

**Rationale:** Measures and measure sets are being removed from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

**Description of Changes:**
**Change** ‘Collected For’ to:
CMS/The Joint Commission: VTE-6; The Joint Commission Only: All SUB Measures, All TOB Measures

**Impacts:**
*Crystalloid Fluid Administration*

**Rationale:** This change is to provide clarification regarding infusion rates and clarifies the acceptable fluids for resuscitation in the *Crystalloid Fluid Administration* data element.

**Description of Changes:**
**Definition**
**Change** to:
Documentation of administration of crystalloid fluids prior to, at the time of, or after the presentation of initial hypotension, initial lactate >= 4, or documentation of septic shock.

**Suggested Data Collection Question**
**Change** to:
Were crystalloid fluids administered prior to, at the time of, or after the presentation of initial hypotension, initial lactate >= 4, or documentation of septic shock?

**Allowable Values**
**Change** from:
1 (Yes) Crystalloid fluids were administered prior to, at the time of, or after the presentation of septic shock, AND the volume ordered was 30 mL/kg.
2 (No) Crystalloid fluids were administered prior to, at the time of, or after the presentation of septic shock, AND the volume ordered was less than 30 mL/kg., or unable to determine volume ordered.
3 (No) Crystalloid fluids were not administered prior to, at the time of, or after the presentation of septic shock, or unable to determine whether or not they were administered.
To:

1 (Yes) 30 mL/kg of crystalloid fluids were ordered and administered prior to, at the time of, or after the presentation of initial hypotension, initial lactate >= 4, or documentation of septic shock.

2 (No) Less than 30 mL/kg of crystalloid fluids were ordered and administered prior to, at the time of, or after the presentation of initial hypotension, initial lactate >= 4, or documentation of septic shock, or unable to determine volume ordered.

3 (No) Crystalloid fluids were not administered prior to, at the time of, or after the presentation of initial hypotension, initial lactate >= 4, or documentation of septic shock, or unable to determine whether or not they were administered.

Notes for Abstraction

Change to:

• The ONLY acceptable fluids are crystalloid or balanced crystalloid solutions (such as 0.9% sodium chloride solution, normal saline, Lactated Ringers Solution, PlasmaLyte, or Normosol).

• Only abstract crystalloid fluids given for the presence of severe sepsis with hypotension, OR for the presence of severe sepsis with a lactate >= 4 mmol/L, OR physician/APN/PA documentation of septic shock.

• Do not abstract crystalloid solutions that are used to flush IV lines or give medications, such as antibiotics.

• To determine the volume, first calculate the patient weight in kilograms. To do this, divide the weight in pounds by 2.2; that yields the weight in kilograms. Next, multiply the weight in kilograms by 30; the result is the number of mLs of IV fluid that should be specified in the physician/APN/PA order.

Example:

Patient weight is 160 pounds. 160/2.2 = 72.72. 72.72 x 30 = 2182 (mLs). Physician order is “Infuse 2400 mLs 0.9% Normal Saline over the next two hours.” Choose Value “1” (2400 mL is greater than 2182).

Example:

Patient weight is 160 pounds. 160/2.2 = 72.72. 72.72 x 30 = 2182 (mLs). Physician order is “Give 1000 mL Lactated Ringers over the next 4 hours.” Choose Value “2” (1000 mL is less than 2182).

• Medical record documentation must be clear that crystalloid fluids were actually administered (i.e., date and time of administration is noted). Do not use physician/APN/PA orders as equivalent to actual administration of fluids as they are not specific to administration.

• Physician/APN/PA orders are required for the fluids. The order must include the type of fluid, the volume of fluid, and a rate or time over which the fluids are to be given. If the type of fluid, IV route, rate or duration over which to give the fluids is missing, choose Value “2.”

• If the crystalloid fluid order is equivalent to 30 mL/kg, the IV route is indicated, and a specific time over which the IV fluids are to be given or a rate is not in the order, but the terms "bolus" or “wide open” are included in the order this is acceptable. The terms "bolus" and “wide open” imply the fluids will be administered rapidly and are acceptable in place of a specific rate or infusion duration.
• If crystalloid fluids are given at a usual rate, maintenance rate or at a “Keep Vein Open” (KVO) rate, which for purposes of the measure is 1000 mL over 8 hours (125 mL/hour) or less, choose Value “2.”
• The volume of crystalloid fluids ordered may be in a single order or a series of multiple orders. If the total volume of crystalloid fluids ordered is less than 30 mL/kg, choose Value “2.”
• Use the weight documented closest to and prior to the order for crystalloid fluids. If a weight is not documented prior to the crystalloid fluid order, use the weight recorded closest to and after the crystalloid fluid order.
• Use the patient’s actual weight. Use estimated weight only if actual weight is not available to determine the volume of crystalloid fluids the patient should receive. Do not use ideal weight.
• If there is documentation the infusion was stopped prior to 30 mL/kg being completely infused, select Value “2.”

Suggested Data Sources
Add two new bullets:
• Ambulance or transport vehicle records
• Entire ED record

Inclusion Guidelines for Abstraction
Change to:
• 0.9% saline solution
• Lactated Ringers Solution
• normal saline
• Normosol
• PlasmaLyte

Impacts:
Crystalloid Fluid Administration Date

Rationale: This change is to provide clarification regarding infusion rates.

Description of Changes:
Definition
Change to:
The date on which crystalloid fluids were initiated for initial hypotension, initial lactate >=4, or documentation of septic shock.

Suggested Data Collection Question
Change to:
What was the date on which crystalloid fluids were initiated for initial hypotension, initial lactate >=4, or documentation of septic shock?

Notes for Abstraction
Change to:
• If a single order is written for the entire 30 mL/kg volume, use the date the crystalloid solution was started as an IV infusion.
• If a single order for the equivalent of 30 mL/kg is written and the infusion is given over multiple infusions, use the start date of the first crystalloid fluid infusion.
• If multiple orders are written that total 30 mL/kg or more, use the start date of the crystalloid fluid infusion that completes the 30 mL/kg volume.
• If a crystalloid infusion is running at a maintenance rate (125 mL/hour or less) and the rate is increased to administer the 30 mL/kg, use the date the infusion rate is increased.
• In some cases, the crystalloid fluid will be infusing prior to the time of presentation of septic shock; if so, use the date the unit of fluid was started or hung.
  a. Example: Septic Shock presentation date and time was 07-12-20xx at 14:00. At the time of presentation of septic shock, one liter of Lactated Ringers had been hung at 13:00 on 07-12-20xx. The Crystalloid Fluid Administration Date was 07-12-20xx.
  b. Example: Septic Shock presentation date and time was 07-12-20xx at 14:00. Lactated Ringers solution was started on 07-12-20xx at 14:15 – there was no fluid infusing at the date and time of presentation of septic shock. The Crystalloid Fluid Administration Date was 07-12-20xx.
  c. Example: Septic Shock presentation date and time was 08-15-20xx at 01:00. The patient needs to receive 3000 mL (30 mL/kg). An order for 3000 mL of 0.9% Normal Saline over 2 hours is written. The total volume is given as 3 separate infusions of 1000 mL each. The first of the three infusions is started on 08-14-20xx at 22:00. The Crystalloid Fluid Administration Date was 08-14-20xx.
  d. Example: Septic Shock presentation date and time was 08-15-20xx at 01:00. The patient needs to receive 3000 mL (30 mL/kg). An order for 1000 mL of 0.9% Normal Saline over 60 minutes is written and started on 08-14-20xx at 22:00. An order for another 1000 mL of Normal Saline is written and started on 08-14-20xx at 23:15. A third order for 1000 mL of Normal Saline is written and started on 08-15-20xx at 00:30. The Crystalloid Fluid Administration Date was 08-15-20xx.
• Do not abstract the date that fluids were ordered.
• Do not abstract the date that IV access was started; abstract the date that the crystalloid fluid infusion began.
• Do not abstract crystalloid solutions that are used to flush IV lines or give medications such as antibiotics.
• Do not use physician orders as equivalent to actual administration of fluids as they are not specific to administration; use the date and time that the fluid infusion was initiated.

Impacts:
Crystalloid Fluid Administration Time

Rationale: This change is to provide clarification regarding infusion rates.

Description of Changes:
Definition
Change to:
The earliest time at which crystalloid fluids were initiated for initial hypotension, initial lactate >=4, or documentation of septic shock.

Suggested Data Collection Question
Change to:
What was the earliest time at which crystalloid fluids were initiated for initial hypotension, initial lactate >=4, or documentation of septic shock?
Notes for Abstraction

Change to:

- If a single order is written for the entire 30 mL/kg volume, use the time the crystalloid solution was started as an IV infusion.
- If a single order for the equivalent of 30 mL/kg is written and the infusion is given over multiple infusions, use the start time of the first crystalloid infusion.
- If multiple orders are written that total 30 mL/kg or more, use the start time of the crystalloid fluid infusion that completes the 30 mL/kg volume.
- If a crystalloid infusion is running at a maintenance rate (125 mL/hour or less) and the rate is increased to administer the 30 mL/kg, use the time the infusion rate is increased.
- In some cases, the crystalloid fluid will be infusing prior to the time of presentation of septic shock; if so, use the time the unit of fluid was started or hung.
  a. Example: Septic Shock presentation date and time was 07-12-20xx at 14:00. At the time of presentation of septic shock, one liter of Lactated Ringers had been hung at 13:00 on 07-12-20xx. The Crystalloid Fluid Administration Time was 13:00.
  b. Example: Septic Shock presentation date and time was 07-12-20xx at 14:00. Lactated Ringers solution was started on 07-12-20xx at 14:15 – there was no fluid infusing at the date and time of presentation of septic shock. The Crystalloid Fluid Administration Time was 14:15.
  c. Example: Septic Shock presentation date and time was 08-15-20xx at 01:00. The patient needs to receive 3000 mL (30 mL/kg). An order for 3000 mL of 0.9% Normal Saline over 2 hours is written. The total volume is given as 3 separate infusions of 1000 mL each. The first of the three infusions was started on 08-14-20xx at 22:00. The Crystalloid Fluid Administration Time was 22:00.
  d. Example: Septic Shock presentation date and time was 08-15-20xx at 01:00. The patient needs to receive 3000 mL (30 mL/kg). An order for 1000 mL of Normal Saline over 60 minutes is written and started on 08-14-20xx at 22:00. An order for another 1000 mL of Normal Saline is written and started on 08-14-20xx at 23:15. A third order for 1000 mL of Normal Saline is written and started on 08-15-20xx at 00:30. The Crystalloid Fluid Administration Time was 00:30.

- Do not abstract the time that fluids were ordered.
- Do not abstract the time that IV access was started; abstract the time that the crystalloid fluid infusion began.
- Do not abstract crystalloid solutions that are used to flush IV lines or give medications such as antibiotics. For purposes of this measure, crystalloids are given in large volumes (> 1000 mL) over a period of a few hours.
- Do not use physician orders as equivalent to actual administration of fluids as they are not specific to administration; use the date and time that the fluid infusion was initiated.
Impacts:

Date Last Known Well

Rationale: These changes provide clarification in response to questions received from abstractors and clinicians.

Description of Changes:

Inclusion Guidelines for Abstraction

Add:

**Code Stroke Form**
- Stroke Activation Form
- Stroke Alert Form
- Stroke Assessment Form
- Stroke Intervention Form
- Stroke Rapid Response Form
- Thrombolysis Checklist
- tPA Eligibility Form

Exclusion Guidelines for Abstraction

Change to:

**Code Stroke Form**
- Stroke Education Form
- Core Measure Form

Impacts:

**Directive for Comfort Care, Septic Shock**

Rationale: Name change and addition of palliative care to the Directive for Comfort Care Severe Sepsis and Septic Shock data elements.

Description of Changes:

Index

Change data element name from:

**Directive for Comfort Care, Septic Shock**

To:

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

Data Element

Change data element name from:

**Directive for Comfort Care, Septic Shock**

To:

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

Definition

Add new paragraph:

Palliative Care is the identification, prevention, and treatment of suffering by means of assessment of the physical, psychosocial, intellectual, and spiritual needs of the patient with a goal of supporting and optimizing the patient’s quality of life. Palliative care ensures a partnership between practitioner, patient, and family to provide support in decision making at any stage in the patient’s care.
Suggested Data Collection Question
Add: or palliative care

Allowable Values
Change from:
1 (Yes)  Physician/APN/PA documentation of comfort measures only was prior to or within 6 hours of the presentation of septic shock.
2 (No)   Physician/APN/PA documentation of comfort measures only was not prior to or within 6 hours of presentation of septic shock, or not documented or time is unclear.

To:
1 (Yes)  Physician/APN/PA documentation of comfort measures only or palliative care was prior to or within 6 hours of the presentation of septic shock.
2 (No)   Physician/APN/PA documentation of comfort measures only or palliative care was not prior to or within 6 hours of presentation of septic shock, or not documented or time is unclear.

Note for Abstraction
Add in third bullet, 1st sentence: or palliative care
Add in first example under fifth bullet, 1st sub-bullet: or palliative care
Add in sixth bullet: or Palliative Care

Inclusion Guidelines for Abstraction
Add new bullet:
• Palliative care

Impacts:
Directive for Comfort Care, Severe Sepsis

Rationale: Name change and addition of palliative care to the Directive for Comfort Care Severe Sepsis and Septic Shock data elements.

Description of Changes:
Index
Change data element name from:
Directive for Comfort Care, Severe Sepsis
To:
Directive for Comfort Care or Palliative Care, Severe Sepsis

Data Element
Change data element name from:
Directive for Comfort Care, Severe Sepsis
To:
Directive for Comfort Care or Palliative Care, Severe Sepsis
Definition
Add new paragraph:
Palliative Care is the identification, prevention, and treatment of suffering by means of assessment of the physical, psychosocial, intellectual, and spiritual needs of the patient with a goal of supporting and optimizing the patient’s quality of life. Palliative care ensures a partnership between practitioner, patient, and family to provide support in decision making at any stage in the patient’s care.

Suggested Data Collection Question
Add:
or palliative care

Allowable Values
Change from:
1 (Yes) Physician/APN/PA documentation of comfort measures only was prior to or within 3 hours of the presentation of severe sepsis.
2 (No) Physician/APN/PA documentation of comfort measures only was not prior to or within 3 hours of presentation of severe sepsis, or not documented or time is unclear.

To:
1 (Yes) Physician/APN/PA documentation of comfort measures only or palliative care was prior to or within 3 hours of the presentation of severe sepsis.
2 (No) Physician/APN/PA documentation of comfort measures only or palliative care was not prior to or within 3 hours of presentation of severe sepsis, or not documented or time is unclear.

Note for Abstraction
Add in third bullet, 1st sentence:
or palliative care
Add in first example under fifth bullet, 1st sub-bullet:
or palliative care
Add in sixth bullet:
or Palliative Care

Inclusion Guidelines for Abstraction
Add new bullet:
• Palliative care

Impacts:
Discharge Disposition

Rationale: Measures and measure sets are being removed from CMS' Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

Description of Changes:
Change ‘Collected For’ to:
CMS/The Joint Commission: IMM-2, VTE-5; The Joint Commission Only: SUB-3, SUB-4 data collection suspended, TOB-3, TOB-4 data collection suspended; CMS Only: SEP-1
Impacts:  
*Elective Carotid Intervention*

**Rationale:** Measures and measure sets are being removed from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

**Description of Changes:**  
**Change** ‘Collected For’ to:  
CMS/The Joint Commission: STK-4

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Impacts:  
*Elective Carotid Intervention*

**Rationale:** The change provides clarification in response to Right Now questions.

**Description of Changes:**  
**Notes for Abstraction**  
**Change** to:  
- When documentation clearly indicates that the carotid intervention is elective (e.g., admitting orders to obtain informed consent for a carotid procedure; pre-operative testing completed prior to admission; surgical orders for carotid endarterectomy dated prior to arrival; physician office visit documentation prior to arrival stating, “CEA with Dr. X planned in the near future”), select “Yes.”  
- Patients, who are sent to the hospital by their physician and admitted for performance of a carotid intervention, select “Yes.”  
- Patients admitted to the hospital for purposes of performance of a carotid intervention and the intervention cancelled/postponed during the hospital stay, select “Yes.”  
- Patients who request admission to the hospital for performance of a carotid intervention, select “Yes.”  
- Patients transferred to the hospital for purposes of surgical evaluation for performance of a carotid intervention, select “Yes.”  
- When the patient is directly admitted to the hospital post-procedure following an elective carotid intervention performed as an outpatient, select “Yes.”  

**Example:**  
Patient scheduled for elective carotid endarterectomy right side on 05/17/20xx at 08:30. Patient checks into outpatient surgery at 06:13 and proceeds to the O.R., then to PACU. Patient status is changed to inpatient at 11:35 on 05/17/20xx. Patient discharged home on 05/18/20xx.

**EXCEPTION:**  
Patients with documentation of an elective carotid intervention performed and discharged from the outpatient setting prior to hospital admission for stroke.  

**Example:**  
Pt. scheduled for outpatient placement of an elective right carotid stent on 05/17/20xx. Patient discharged home on 05/17/20xx following the procedure. Patient arrives in the ED two days later with complaints of syncope and left-sided numbness, and is admitted to the hospital on 05/19/20xx.
• Patients who are symptomatic and come to the ED for treatment of stroke signs and symptoms and then admitted to the hospital are not considered elective admissions, even if a carotid intervention was performed after admission, select “No.”
• When documentation of the procedure is not linked with “elective,” select “No.”

Impacts:
Influenza Vaccination Status

Rationale: The Notes for Abstraction section has been updated to provide clarification for abstractors based on consultation with the Immunization Expert Work Group.

Description of Changes:
Notes for Abstraction

Change fifth bullet to:
• If there is no documentation to support any of the Allowable Values 1-4, and there is physician/APN/PA documentation that they will administer the vaccine after discharge or physician/APN/PA documentation not to administer the vaccine for a reason other than those noted as acceptable in this data element, select value “5.”

Change eighth bullet to:
• If it is documented in the chart that the patient’s influenza vaccination status is “up to date” or “current,” select Allowable Value “2.” Documentation of “up to date” or “current” in the vaccination record that does not reference the influenza vaccine is not sufficient to select Allowable Value “2.”

Add new bullet:
• Documentation of the acronym “UTD,” even with specific reference to the influenza vaccine, is not sufficient to select Allowable Value “2.”

Exclusion Guidelines for Abstraction:
Remove:
• Patients with anaphylactic allergy to eggs, anaphylactic latex allergy or other specific allergy/sensitivity to the vaccine. The allergy/sensitivity should be accompanied by the exact complication. Must be a specific allergy/sensitivity not just physician/advanced practice nurse/physician assistant (physician/APN/PA) preference.

Impacts:
Initial Lactate Level Collection

Rationale: The Inclusion Guidelines have been updated to provide clarification of acceptable tests.

Description of Changes:
Inclusion Guidelines for Abstraction

Add new bullet:
• Lactic acid drawn
Impacts:

*Initial Lactate Level Date*

**Rationale:** Clarification regarding the initial lactate level is being provided.

**Description of Changes:**

Notes for Abstraction

**Change** in first bullet, the word “reported” to:

drawn

Inclusion Guidelines for Abstraction

**Add** new bullet:

- Lactic acid drawn

---

Impacts:

*Initial Lactate Level Result*

**Rationale:** This revision clarifies when a repeat lactate collection is indicated.

**Description of Changes:**

Notes for Abstraction

**Add** new bullet:

- Continue reviewing for a repeat lactate level if the initial lactate level is elevated (> 2), refer to *Repeat Lactate Level Collection*.

Inclusion Guidelines for Abstraction

**Change** to:

- Lactate results
- Lactic acid results

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Impacts:

*Initial Lactate Level Time*

**Rationale:** Clarification regarding the initial lactate level is being provided.

**Description of Changes:**

Notes for Abstraction

**Change** in first bullet, the word “reported” to:

drawn

Inclusion Guidelines for Abstraction

**Add** new bullet:

- Lactic acid drawn

---

Impacts:

*Last Known Well*

**Rationale:** These changes provide clarification in response to questions received from abstractors and clinicians.
Description of Changes:

Notes for Abstraction

Change to:

- Select “Yes” if BOTH a date and time Last Known Well are documented.
- Select “No” if there is ANY physician/APN/PA documentation that Last Known Well is “UNKNOWN.” Documentation must explicitly state that the Last Known Well is unknown/uncertain/unclear. Documentation that time of symptom onset is unknown/uncertain/unclear is also acceptable when Time Last Known Well is not documented. If Last Known Well is not explicitly documented as unknown, do not make inferences (e.g. do not assume that patient woke with stroke so Last Known Well unknown unless explicitly documented).
  - If one physician documents a Time Last Known Well and another documents time of symptom onset unknown, select “Yes.”
  - If physician documents a Time Last Known Well and nurse / EMS documents Last Known Well unknown, select “Yes.”
  - If one physician documents Last Known Well unknown and another documents a Time Last Known Well, select “No.”

EXCEPTION:
  - If the physician documents Last Known Well as unknown and the same physician crosses out unknown or mentions in a later note that Last Known Well is now known with a time documented, select “Yes.”

- If the Time Last Known Well is clearly greater than 2 hours prior to hospital arrival AND no time is documented, select “No.”
  Example
  “Patient OK last night.” Select “No” because no other documentation of a specific time/time range/time reference was present in the medical record and the time is required for the Time Last Known Well.

- If the only Time Last Known Well is documented as a time immediately before hospital arrival without a specific time range in minutes, e.g., “symptoms started just prior to ED arrival,” select “Yes.”

- If there is no documentation that Last Known Well or stroke signs/symptoms occurred prior to hospital arrival but there is documentation that Last Known Well first occurred after Arrival Time (e.g., in-house stroke), select “No.”

Exclusion Guidelines for Abstraction

Change to:

Delay in stroke diagnosis

Impacts:

Passive Leg Raise Exam Date

Rationale: This change clarifies the requirements for the passive leg raise exam.

Description of Changes:

Definition

Change to:

Documentation of the date indicating a passive leg raise examination was performed.
**Suggested Data Collection Question**

**Change:**
‘performed’ to ‘documented’

**Notes for Abstraction**

**Change** third bullet to:
- Only abstract physician/APN/PA documentation indicating actual performance of a passive leg raise exam.

**Change** in fourth bullet:
‘done’ to ‘documented’

**Impacts:**

*Passive Leg Raise Exam Performed*

**Rationale:** This change clarifies the requirements for the passive leg raise exam.

**Description of Changes:**

**Suggested Data Collection Question**

**Change** to:
Was there physician/APN/PA documentation that a passive leg raise examination was performed in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time?

**Allowable Values**

**Change** from:

1 (Yes) Passive leg raise examination was performed by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time.

2 (No) Passive leg raise examination was not performed by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, or unable to determine.

**To:**

1 (Yes) Passive leg raise examination was documented by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time.

2 (No) Passive leg raise examination was not documented by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, or unable to determine.

**Notes for Abstraction**

**Change** third bullet to:
- Only abstract physician/APN/PA documentation indicating a passive leg raise was performed.

**Change** in fourth bullet:
‘performed’ to ‘documented’
‘done’ to ‘documented’
Change in fifth bullet:
‘performed’ to ‘documented’

Impacts:
Passive Leg Raise Exam Time

Rationale: This change clarifies the requirements for the passive leg raise exam.

Description of Changes:
Definition
Change to:
Documentation of the time indicating a passive leg raise examination was performed.

Suggested Data Collection Question
Change:
‘performed’ to ‘documented’

Notes for Abstraction
Change third bullet to:
- Only abstract physician/APN/PA documentation indicating actual performance of a passive leg raise exam.

Change in fourth bullet:
‘done’ to ‘documented’

Impacts:
Peripheral Pulse Evaluation Date

Rationale: This change clarifies the requirements for the peripheral pulse evaluation.

Description of Changes:
Definition
Change to:
Documentation of the date indicating a peripheral pulse evaluation was performed.

Suggested Data Collection Question
Change:
‘performed’ to ‘documented’

Notes for Abstraction
Change in second bullet:
‘must’ to ‘may’

Change in third bullet:
‘done’ to ‘documented’

Impacts:
Peripheral Pulse Evaluation Performed

Rationale: This change clarifies the requirements for the peripheral pulse evaluation.
Description of Changes:

Definition

Remove:
performance of

Suggested Data Collection Question

Change:
'performed' to 'documented'

Allowable Values

Change from:
1 (Yes) Peripheral pulse evaluation was performed by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time.

2 (No) Peripheral pulse evaluation was not performed by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, or unable to determine.

To:
1 (Yes) Peripheral pulse evaluation was documented by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time.

2 (No) Peripheral pulse evaluation was not documented by a physician/APN/PA in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time, or unable to determine.

Notes for Abstraction

Change in third bullet:
'performed' to 'documented'
'done' to 'documented'

Change in fourth bullet:
'performed' to 'documented'

Impacts:

Peripheral Pulse Evaluation Time

Rationale: This change clarifies the requirements for the peripheral pulse evaluation.

Description of Changes:

Definition

Change to:
Documentation of the time indicating a peripheral pulse evaluation was performed.

Suggested Data Collection Question

Change:
'performed' to 'documented'
Notes for Abstraction

Change in second bullet:
‘must’ to ‘may’

Change in third bullet:
‘done’ to ‘documented’

Impacts:

Persistent Hypotension

Rationale: This revision clarifies what qualifies as a decrease in systolic blood pressure by >40 mmHG.

Description of Changes:

Definition

Change first sentence to:
Documentation of the presence of persistent hypotension or new hypotension following the administration of 30 mL/kg of crystalloid fluids in septic shock.

Change third bullet to:
• a decrease in systolic blood pressure by >40 mmHg. Physician/APN/PA documentation must be present in the medical record indicating a >40 mmHg decrease in SBP has occurred and is related to infection, severe sepsis or septic shock and not other causes.

Suggested Data Collection Question

Add:
or new hypotension

Allowable Values

Change from:
1 (Yes) Crystalloid fluids were administered at a volume of 30 mL/kg and persistent hypotension was present within one hour of conclusion of fluid administration.

2 (No) Persistent hypotension was not present within one hour of the conclusion of crystalloid fluid administration at a volume of 30 mL/kg.

3 (No) or UTD The patient was not assessed for persistent hypotension within the one hour after the conclusion of crystalloid fluid administration at a volume of 30 mL/kg, or Unable to Determine.

4 (Not applicable) Crystalloid fluids were not administered, or crystalloid fluids were administered but at a volume less than 30 mL/kg.

To:
1 (Yes) Crystalloid fluids were administered at a volume of 30 mL/kg and persistent hypotension or new hypotension was present within one hour of conclusion of fluid administration.

2 (No) Persistent hypotension or new hypotension was not present within one hour of the conclusion of crystalloid fluid administration at a volume of 30 mL/kg.
3 (No) or UTD  The patient was not assessed for persistent hypotension or new hypotension within the one hour after the conclusion of crystalloid fluid administration at a volume of 30 mL/kg, or Unable to Determine.

4 (Not applicable)  Crystalloid fluids were not administered, or crystalloid fluids were administered but at a volume less than 30 mL/kg.

**Notes for Abstraction**

**Change** second sentence in first bullet to:
Choose Value “1” if persistent hypotension or new hypotension was present, choose Value “2” if persistent hypotension or new hypotension was not present.

Add to second bullet:

or new hypotension

Add to ninth bullet:

or new hypotension

Add to tenth bullet:

or new

**Impacts:**

*Prescription for Tobacco Cessation Medication*

**Rationale:** Notes for Abstraction were clarified to provide guidance regarding patient refusal during hospitalization, requirements when no prescription is written at discharge, and to provide examples of key components of counseling.

**Description of Changes:**

**Notes for Abstraction**

**Change** to:

- All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor. In determining whether a tobacco cessation medication was prescribed at discharge, it is not uncommon to see conflicting documentation among different medical record sources. For example, the discharge summary may list Varenicline and this is not included in any of the other discharge medication sources (e.g., discharge orders). Select Value “1” unless documentation elsewhere in the medical record suggests that it (tobacco cessation medication) was not prescribed at discharge.
- If documentation is contradictory (physician noted “d/c Varenicline” or “hold Varenicline” in the discharge orders, but Varenicline is listed in the discharge summary’s discharge medication list) or after careful examination of circumstance, context, timing, etc., the documentation remains unclear, the case should be deemed unable to determine. Select Value “4.”
- If the physician wishes the patient to continue on medication that does not require a prescription (for example, over-the-counter nicotine replacement therapy (NRT) or medication that will be provided by the outpatient counseling or quit line), select Value “1” if the medication is listed on the discharge medication list.
- If the patient does not have a residence in the USA, Value “3” must be selected.
• If the patient refused tobacco cessation medication during the hospitalization, a prescription must be offered again at the time of discharge. Select Value “4” if documentation reflects that a prescription for cessation medication was not offered at the time of discharge.

**Impacts:**
*Reason for Extending the Initiation of IV Thrombolytic*

**Rationale:** These changes provide clarification in response to questions received from abstractors and clinicians.

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

**Add** under fourth bullet:

**Examples:**
- Documentation to initiate IV thrombolytic for worsening symptoms following documentation to not give tPA because symptoms resolved after hospital arrival, select “Yes.”
- NIHSS score of 1 on arrival. IV thrombolytic ordered 4 hours after hospital arrival, select “No.”

**Exclusion Guidelines for Abstraction**

**Change** to:
- Delay in hospital arrival greater than 2 hours
- Delay in stroke diagnosis
- Hold IV thrombolytic without a documented reason
- No IV access

**Impacts:**
*Reason for No Administration of VTE Prophylaxis*

**Rationale:** This change is to decrease abstractor burden regarding patients transferred from the emergency room.

**Description of Changes:**
*Definition*

**Add:**

or pharmacist

**Suggested Data Collection Question:**

**Add:**

or pharmacist

**Allowable Values**

**Change** from:

**Allowable Values:**

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y (Yes)</td>
<td>There is physician/APN/PA documentation why VTE prophylaxis was not administered any time between arrival and the performance of a VTE Diagnostic Test.</td>
</tr>
<tr>
<td>N (No)</td>
<td>There is no physician/APN/PA of documentation why VTE prophylaxis was not administered any time between arrival and the performance of a VTE Diagnostic Test, or unable to determine from medical record documentation.</td>
</tr>
</tbody>
</table>
To: Allowable Values:
Y (Yes) There is physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered any time between arrival and the performance of a VTE Diagnostic Test.
N (No) There is no physician/APN/PA or pharmacist of documentation why VTE prophylaxis was not administered any time between arrival and the performance of a VTE Diagnostic Test, or unable to determine from medical record documentation.

Notes for Abstraction
Change to:
• If a patient received prophylaxis as per the data element VTE Prophylaxis Status, select “No.”
• To select “Yes” for this data element, documentation of a reason for not administering mechanical AND pharmacological VTE prophylaxis must be dated between arrival and the VTE Diagnostic Test performed. Refer to the data element VTE Diagnostic Test for a list of acceptable tests.
• Reasons for not prescribing VTE prophylaxis must be documented by a physician/APN/PA or pharmacist.

EXCEPTIONS:
  o 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.”
  o For patients receiving anticoagulant therapy other than warfarin for atrial fibrillation or other conditions the day of or the day after hospital admission, 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: Physician/APN/PA documentation of bleeding risk, review the chart for documentation about reasons for no mechanical AND pharmacological VTE prophylaxis.
• If the VTE Diagnostic Test was performed the day of or the day after arrival or admission, select “Yes.”
• 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.
  Example: There is documentation of “No VTE Prophylaxis, patient ambulating,” select “Yes.”
• For patients with an order for ANY prophylaxis that was not administered without a reason, select “No.”
  Example: Patient has documentation of low risk for VTE and there is an order for SCDs that were not applied. Select “No.”
• If two physicians/APN/PA or pharmacist document conflicting or questionable needs for prophylaxis, select “No.”
• If Comfort Measures Only (CMO) was documented prior to the VTE Diagnostic Test, select “Yes.”
Remove:

**EXCEPTIONS:**

- 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.”
- If Comfort Measures Only (CMO) was documented prior to the VTE Diagnostic Test, select “Yes.”
- For patients receiving anticoagulant therapy other than warfarin for atrial fibrillation or other conditions the day of or the day after hospital admission, select “Yes.”

**Suggested Data Sources**

Remove:

- Risk assessment form

**Inclusion Guidelines for Abstraction**

**Change** to:

None

**Exclusion Guidelines for Abstraction**

**Change** to:

- Continuous IV Heparin infusion prior to the diagnostic test
- Low Risk Assessment

**Impacts:**

*Reason for No Tobacco Cessation Medication at Discharge*

**Rationale:** Notes for Abstraction were clarified to provide guidance regarding patient refusal during hospitalization, requirements when no prescription is written at discharge, and to provide examples of key components of counseling.

**Description of Changes:**

*Notes for Abstraction*

**Change** to:

- Reasons for not prescribing FDA-approved tobacco cessation medications must be documented by a physician/APN/PA or pharmacist.
- An allergy or adverse reaction to one of the FDA-approved cessation medications would not be a reason for not prescribing another of the cessation medications.
- In determining whether there is a reason documented by physician/APN/PA or pharmacist for not prescribing tobacco cessation medications, the reason must be explicitly documented (e.g., “No tobacco cessation medication as patient is post-operative and nicotine may place them at risk for impaired wound healing”) or clearly implied (e.g., “Patient becomes anxious when they take tobacco cessation medication”). If reasons are not mentioned in the context of cessation medication, do not make inferences (e.g., Do not assume that a tobacco cessation medication is not being prescribed because of the patient’s history of recent surgery alone).
- When conflicting information is documented in the medical record, select Value “No” for the indicated reasons present for not prescribing the tobacco cessation medications.
If the reason for not prescribing FDA-approved cessation medication is documented at any time during the hospitalization, additional documentation of the reason at the time of discharge is not required.

Documentation by the physician, advanced practice nurse (APN), physician assistant (PA), or pharmacist that the patient refused tobacco cessation medication is not considered a valid reason for no tobacco cessation medication at discharge. If refusal is documented as the reason, select Value “No.”

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

**Rationale:** Language was clarified to provide better guidance to the abstractor in the Notes for Abstraction. Additional language was added for documentation requirements for the reason for no cessation medication during the hospital stay. The time frame to provide interventions was changed based on recommendations from the TOB Technical Advisory Panel.

**Description of Changes:**

**Definition**

**Remove:** within the first three days of admission

**Suggested Data Collection Question**

**Remove:** within 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 within 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 hospital stay within the first three days of admission 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 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. |

**Notes for Abstraction**

**Change to:**

- Reasons for not administering FDA-approved tobacco cessation medications must be documented by a physician/APN/PA or pharmacist.
- An allergy or adverse reaction to one of the FDA-approved cessation medications would not be a reason for not administering another of the cessation medications.
- In determining whether there is a reason documented by physician/APN/PA or pharmacist for not administering tobacco cessation medications, the reason must be explicitly
documented (e.g., “No tobacco cessation medication as patient is post-operative and nicotine may place them at risk for impaired wound healing”) or clearly implied (e.g., “Patient becomes anxious when they take tobacco cessation medication”). If reasons are not mentioned in the context of cessation medication, do not make inferences (e.g., Do not assume that a tobacco cessation medication is not being prescribed because of the patient’s history of recent surgery alone).

- When conflicting information is documented in the medical record, select Value “No” for the indicated reasons present for not administering the tobacco cessation medications.
- Documentation by the physician, advanced practice nurse (APN), physician assistant (PA), or pharmacist that the patient refused tobacco cessation medication is not considered a valid reason for no tobacco cessation medication during the hospitalization. If refusal is documented as the reason, select Value “No.”

**Impacts:**

**Reason for Not Initiating IV Thrombolytic**

**Rationale:** These changes provide clarification in response to questions received from abstractors and clinicians.

**Description of Changes:**

**Definition**

Add new fourth bullet:
- Documentation by a physician/APN/PA that the patient has “no neurological deficit” or “normal neurological exam” in the emergency department

**Notes for Abstraction**

Add new 4th sub-bullet, under third bullet:
- Documentation by a physician/APN/PA that the patient has “no neurological deficit” or “normal neuro exam” in the emergency department

Add under fourth bullet:

Unacceptable examples (select “No”):
- “Symptoms resolving”
- “No gait deficit”
- “Metastatic brain tumor”

**Remove** sixth bullet:
- Documentation by a physician/APN/PA that the patient has no neurological deficits, e.g., “normal neuro exam,” “neurological exam has returned to baseline” at the time of presentation to the emergency department, is acceptable as an “other” reason if it is documented on the day of or day after hospital arrival.

**Exclusion Guidelines for Abstraction**

Add new first bullet:
- Delay in hospital arrival greater than 2 hours
Impacts:

Referral for Outpatient Tobacco Cessation Counseling

Rationale: Notes for Abstraction were clarified to provide guidance regarding patient refusal during hospitalization, requirements when no prescription is written at discharge, and to provide examples of key components of counseling.

Description of Changes:
Definition

Change third sentence to:
A counseling referral is defined as an appointment made by the healthcare provider or hospital either through telephone contact, fax or e-mail.

Notes for Abstraction

Change to:
• If a referral is made to a Quitline, defined as a telephone counseling in which at least some of the contact is initiated by the Quitline counselor to deliver tobacco use interventions, select Value “1.” If the patient directly calls the Quitline during the hospitalization, documentation must reflect that staff was present during the call to verify that an appointment was set.
• If the patient is provided with contact information for e-health or internet smoking cessation programs which tailor program content to the tobacco user’s needs (by collecting information from the tobacco user and using algorithms to tailor feedback or recommendations, permitting the user to select from various features including extensive information on quitting, tobacco dependence, and related topics), select Value “2.”
• If the patient is provided with self-help materials that are not tailored to the patient’s needs and do not provide a structured program, select Value “5.”
• Select Value “5” if:
  o it cannot be determined that a referral for outpatient cessation counseling was made or;
  o it is unclear that the absence of the referral was due to a patient refusal or;
  o a referral was not offered.
• If the patient does not have a residence in the USA, Value “4” must be selected.
• If the patient refused practical counseling during the hospitalization, a referral must be offered again at the time of discharge. Select Value “5” if a referral was not offered at the time of discharge.

Impacts:
Repeat Lactate Level Collection
Repeat Lactate Level Date
Repeat Lactate Level Time

Rationale: The Inclusion Guidelines and Notes for Abstraction have been updated to provide clarification regarding lactate level collection.

Description of Changes:
Notes for Abstraction
Add in first bullet, 1st sentence:
if the initial lactate is elevated (>2.0)
Inclusion Guidelines for Abstraction

Add new bullet:
- Lactic acid drawn

Impacts:
- Septic Shock Present

Rationale: This revision clarifies what qualifies as a decrease in systolic blood pressure by >40 mmHG and the inclusion of “Severe Sepsis with Septic Shock.”

Description of Changes:

Notes for Abstraction
Change third bullet under 'b' to:
- a decrease in systolic blood pressure by >40 mmHg. Physician/APN/PA documentation must be present in the medical record indicating a >40 mmHg decrease in SBP has occurred and is related to infection, severe sepsis or septic shock and not other causes.

Remove fourth bullet under 'b':
- from the last previously recorded SBP considered normal for that specific patient

Change in ‘Example 3’:
- ‘148’ to ‘140’

Remove sixth bullet:
- If crystalloid fluids were not administered after the presentation date and time of severe sepsis, choose Value “2.”

Inclusion Guidelines for Abstraction:
Add new bullet:
- Severe Sepsis with Septic Shock

Impacts:
- Septic Shock Presentation Date

Rationale: This revision clarifies the documentation for a decrease in systolic blood pressure by >40 mmHG and the inclusion of “Severe Sepsis with Septic Shock.”

Description of Changes:

Notes for Abstraction
Change third bullet under 'b' to:
- a decrease in systolic blood pressure by >40 mmHg. Physician/APN/PA documentation must be present in the medical record indicating a >40 mmHg decrease in SBP has occurred and is related to infection, severe sepsis or septic shock and not other causes.

Impacts:
- Septic Shock Presentation Time

Rationale: This revision clarifies what qualifies as a decrease in systolic blood pressure by >40 mmHG.
Description of Changes:
Notes for Abstraction
Change third bullet under 'b' to:
• a decrease in systolic blood pressure by >40 mmHg. Physician/APN/PA documentation must be present in the medical record indicating a >40 mmHg decrease in SBP has occurred and is related to infection, severe sepsis or septic shock and not other causes.

Impacts:
Severe Sepsis Present

Rationale: This revision clarifies what qualifies as a decrease in systolic blood pressure by >40 mmHg.

Description of Changes:
Notes for Abstraction
Change 'i' under sub-bullet 'c' to:
i. Systolic blood pressure (SBP) <90, or mean arterial pressure <65, or a systolic blood pressure decrease of more than 40 mmHg. Physician/APN/PA documentation must be present in the medical record indicating a >40 mmHg decrease in SBP has occurred and is related to infection, severe sepsis or septic shock and not other causes.

Add to second paragraph under first bullet:
, decrease in SBP associated with administration of a blood pressure medication

Impacts:
Skin Examination Date

Rationale: This change clarifies the requirements for the skin examination.

Description of Changes:
Definition
Change to:
Documentation of the date indicating a skin examination was performed.

Suggested Data Collection Question
Change:
‘performed’ to ‘documented’

Notes for Abstraction
Add new second bullet:
• Skin examination is done to assess superficial circulatory status and must include reference to skin color.

Change third bullet to:
• The assessment of skin color may include such terms as “flushed,” “mottled,” “pale,” “pallor,” “pink,” or similar terminology.

Change in fourth bullet:
‘done’ to ‘documented’
Impacts:

Skin Examination Performed

Rationale: This change clarifies the requirements for the skin examination.

Description of Changes:

Definition

Remove:

performance of

Suggested Data Collection Question

Change:

'performed' to 'documented'

Allowable Values

Change from:

1 (Yes) Skin examination was performed by a physician/APN/PA
2 (No) Skin examination was not performed by a physician/APN/PA, or unable to determine

To:

1 (Yes) Skin examination was documented by a physician/APN/PA
2 (No) Skin examination was not documented by a physician/APN/PA, or unable to determine

Notes for Abstraction

Change in sixth bullet:

'done' to 'documented'

Change in seventh bullet:

'performed' to 'documented'

Inclusion Guidelines for Abstraction

Add:

• Mottled

Remove:

• Skin unremarkable
• Diaphoretic
• Turgor good
• Turgor absent

Impacts:

Skin Examination Time

Rationale: This change clarifies the requirements for the skin examination.

Description of Changes:

Definition

Change to:

Documentation of the time indicating a skin examination was performed.
Suggested Data Collection Question

Change:
‘performed’ to ‘documented’

Notes for Abstraction

Add new second bullet:
- Skin examination is done to assess superficial circulatory status and must include reference to skin color.

Change third bullet to:
- The assessment of skin color may include such terms as “flushed,” “mottled,” “pale,” “pallor,” “pink,” or similar terminology.

Change in fourth bullet:
‘done’ to ‘documented’

Impacts:

Time Last Known Well

Rationale: These changes provide clarification in response to questions received from abstractors and clinicians.

Description of Changes:

Notes for Abstraction

Add new first bullet:
- The Time Last Known Well must be a time prior to the patient’s Arrival Time. Do not use times after hospital arrival for Time Last Known Well.

Change in third and fourth bullets:
time last known well
To:
Time Last Known Well

Change fifth bullet to:
- If the Time Last Known Well is documented as one specific time and entered as Time Last Known Well on a “Code Stroke” form or stroke-specific electronic template, enter that time as the Time Last Known Well. Documentation of Time Last Known Well on a stroke-specific form or template should be selected regardless of other times last known well documented elsewhere in the medical record.

EXCEPTIONS:
- ANY physician/APN/PA documentation that Last Known Well/onset of signs/symptoms is unknown/uncertain/unclear takes precedence over specific time on “Code Stroke” form.
- Crossing out of a specific time on a Code Stroke Form and a specific time documented on the same or different Code Stroke Form, use the specific time that is not crossed out.
- A specific time on a Code Stroke Form and another time reference documented, e.g. < 8 hours, on the same or different Code Stroke Forms, use the specific time.
- Multiple specific times on the same or different Code Stroke Forms, use abstraction guidelines for multiple Times Last Known Well.
Unable to determine if a form is a Code Stroke Form, continue to review the medical record for *Time Last Known Well* documentation in other sources.

**Add** new sixth, seventh, and eighth bullets:

- A Code Stroke Form is used by the stroke team or ED staff to document the acute stroke process.
- See the inclusion list for acceptable terms used for a Code Stroke Form. The list is not all-inclusive.
- *Time Last Known Well* on a Code Stroke Form may be documented by a nurse.

**Add** new eleventh bullet:

- If the time is noted to be “less than” a period of time prior to ED arrival, assume the maximum range.
  
  **Example:**
  
  *Time Last Known Well* less than one hour ago. Subtract one hour from the time of arrival to compute *Time Last Known Well*.

**Inclusion Guidelines for Abstraction**

**Add:**

- **Code Stroke Form**
  - Stroke Activation Form
  - Stroke Alert Form
  - Stroke Assessment Form
  - Stroke Intervention Form
  - Stroke Rapid Response Form
  - Thrombolysis Checklist
  - tPA Eligibility Form

**Exclusion Guidelines for Abstraction**

**Change** to:

- **Code Stroke Form**
  - Stroke Education Form
  - Core Measure Form

**Impacts:**

*Tobacco Use Status*

**Rationale:** Language was clarified to provide better guidance to the abstractor in the Allowable Values and Notes for Abstraction. The timeframe to complete the tobacco use screen was changed based on recommendations from the TOB Technical Advisory Panel.

**Description of Changes:**

**Allowable Values**

**Change** from:

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 (< ¼ 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.
6  The patient was not screened for tobacco use during the first three days of admission
because of cognitive impairment.

To:
1  The patient has during the past 30 days:
   • smoked, on average, 5 or more cigarettes (≥ ¼ pack) daily, and/or
   • smoked cigars and/or pipes daily

2  The patient has during the past 30 days:
   • smoked, on average, 4 or less cigarettes (< ¼ pack) daily, and/or
   • smoked cigarettes, cigars and/or pipes, but not daily, and/or
   • used smokeless tobacco, regardless of frequency

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.
6  The patient was not screened for tobacco use during the first day of admission because
of cognitive impairment.

Notes for Abstraction

Change to:
• If there is any documentation that the patient either currently uses tobacco products or is an
ex-user that quit less than 30 days prior to admission, select the appropriate allowable
value for the type of product used. In other words, even if there is conflicting
documentation about tobacco use, the abstractor must select the Value reflecting
that the patient uses tobacco.
• Documentation of "nicotine" use is not acceptable to determine tobacco use status. The
documentation of "nicotine" use needs to be supported by language showing it was in the
form of cigarettes, cigars, pipes and/or smokeless tobacco.
• If there is documentation that the patient has not used any tobacco products during the
past 30 days prior to admission, continued assessment for the type, volume and frequency
does not need to be performed.
• If there is documentation that the patient has used smokeless tobacco AND has also
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, select Value “1.”
• There is no requirement to capture volume and frequency of use for patients using only
smokeless tobacco.
• For the History and Physical (H&P) source, use only the H&P report for the current
admission. The H&P may be a dictated report, a handwritten report on an H&P form, or a
separate entry labeled as the H&P in the progress notes.
• Classify a form as a nursing admission assessment if the content is typical of nursing admission assessment (e.g., med/surg/social history, current meds, allergies, physical assessment) AND the form is completed/reviewed by a nurse or labeled as a “nursing form.”
• Disregard documentation of tobacco use history if the current tobacco use status or timeframe that patient quit is not defined (e.g., “20 pk/yr smoking history,” “History of tobacco abuse”).
• Do not include documentation of smoking history referenced as a “risk factor” (e.g., “risk factor: tobacco,” “risk factor: smoking,” “risk factor: smoker”), where current tobacco use status is indeterminable.
• 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 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 Value “1.”
• The tobacco use status screening timeframe must have occurred within the first day of admission. This includes the day of admission which is defined as day zero, and the day after admission which is defined as the first day.

**EXCEPTION:**
- If the screening was performed prior to admission to the psychiatric unit, i.e., at the transferring facility, in another inpatient hospital unit, emergency department or observation unit, the screening documentation must be present in the psychiatric unit medical record.

• Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set is related to documentation that the patient cannot be screened for tobacco use due to the impairment (e.g., comatose, obtunded, confused, memory loss) the entire first day of admission.
• If there is documentation within the first day of admission that the patient was psychotic with documented symptoms, e.g., hallucinating, non-communicative, catatonic, etc., which prevented them from answering questions reliably, they would be considered cognitively impaired.
• If there is documentation that the patient has temporary cognitive impairment due to acute substance use (e.g., overdose or acute intoxication) Value “6” cannot be selected.
• If there is documentation that the patient was intubated the entire first day of admission, select Value “6” as the patient is unable to answer.
• If there is documentation of any of the examples of cognitive impairment below within the first day of admission, select Value “6” regardless of conflicting documentation.

Examples of cognitive impairment include:
- Altered Level of Consciousness (LOC)
- Altered Mental Status
- Cognitive impairment
- Cognitively impaired
- Confused
- Dementia
- Memory loss
- Mentally retarded
- Obtunded
- Psychotic/psychosis
Exclusion Guidelines for Abstraction
Add fourth and fifth bullets:
• Nicotine delivery system
• Vaping or nicotine vaporizer use

Impacts:
Tobacco Use Treatment FDA-Approved Cessation Medication

Rationale: Language was clarified to provide better guidance to the abstractor in the Notes for Abstraction. Additional language was added for documentation requirements for the reason for no cessation medication during the hospital stay. The time frame to provide interventions was changed based on recommendations from the TOB Technical Advisory Panel.

Description of Changes:
Suggested Data Collection Question
Remove:
within 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 within the first three days after admission.
2 The patient refused the FDA-approved tobacco cessation medications during the hospital stay within the first three days after admission.
3 FDA-approved tobacco cessation medications were not offered to the patient during the hospital stay within the first three days after admission or unable to determine from medical record documentation

To:
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.

Notes for Abstraction
Change to:
• If nicotine replacement therapy (NRT) is ordered PRN and the patient does not receive any doses during the hospital stay, select Value “2” (the patient refused the FDA-approved tobacco cessation medications during the hospital stay).

Exclusion Guidelines
Change to:
None
Impacts:
*Tobacco Use Treatment Practical Counseling*

*Rationale:* Language was clarified to provide better guidance to the abstractor in the Notes for Abstraction. Additional language was added for documentation requirements for the reason for no cessation medication during the hospital stay. The time frame to provide interventions was changed based on recommendations from the TOB Technical Advisory Panel.

**Description of Changes:**

**Definition**

**Change** to:

Practical counseling requires a one-on-one interaction with the patient to address at a minimum the following three components: recognizing danger situations, developing coping skills, and providing basic information about quitting.

**Suggested Data Collection Question**

**Remove:**

within the first three days after admission

**Allowable Values**

**Change** from:

1. The patient received all components of practical counseling during the hospital stay within the first three days after admission.
2. The patient refused/declined practical counseling during the hospital stay within the first three days after admission.
3. Practical counseling was not offered to the patient during the hospital stay within the first three days after admission 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 hospital stay.
2. The patient refused/declined practical counseling during the hospital stay.
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.

**Notes for Abstraction**

**Change** to:

- A referral to the Quitline may be considered a component of practical counseling (providing basic information about quitting), however, handing the patient a phone number to call for the quit line will not meet the intent of practical counseling. There must be interaction between the patient and the caregiver.
- A pamphlet with basic information about quitting, recognizing danger situations and how to develop coping skills may be given to the patient; however, the caregiver must still document what was discussed with the patient from the pamphlet. Giving the patient a pamphlet alone does not constitute practical counseling which requires a one-on-one interaction with the patient.
- Danger situations covered in practical counseling might include alcohol use during the first month after quitting, being around smoke and/or other smokers, or times/situations when the patient routinely smoked (in the car, on break at work, with coffee, after a meal, upon
waking up, social events, etc.). Triggers and/or roadblocks are the same as danger situations.

- Coping skills covered in practical counseling might include learning new ways to manage stress, exercising, relaxation breathing, changing routines and distraction techniques to prevent tobacco use.
- Basic information on quitting covered in practical counseling might include the benefits of quitting tobacco, how to quit techniques and available resources to support quitting.
- If there is no documentation that practical counseling was given to the patient, select Value “3.”
- Select Value “3” if the documentation provided is not explicit enough to determine if the counseling provided contained all components or if the counseling meets the intent of the measure.

Exclusion Guidelines for Abstraction
Change to:
None

Impacts:
Transfer From Another Hospital or ASC

Rationale: Measures and measure sets are being removed from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

Description of Changes:
Change ‘Collected For’ to:
CMS Only: SEP-1

Impacts:
Vasopressor Administration

Rationale: These revisions provide abstraction guidance regarding vasopressor administration.

Description of Changes:
Definition
Change to:
Documentation of administration of an intravenous vasopressor in the time window beginning at septic shock presentation and ending 6 hours after the presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration.

Suggested Data Collection Question
Change to:
Was an intravenous vasopressor administered in the time window beginning at septic shock presentation and ending 6 hours after the presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration?

Allowable Values
Change from:
1 (Yes) The patient was given an intravenous vasopressor after the presentation of septic shock, or the patient was receiving a vasopressor at the time of presentation of septic shock.
2 (No) The patient was not given an intravenous vasopressor after the time of presentation of septic shock and was not receiving a vasopressor at the time of septic shock.

To:
1 (Yes) The patient was given an intravenous vasopressor in the time window beginning at septic shock presentation and ending 6 hours after the presentation of septic shock.

2 (No) The patient was not given an intravenous vasopressor in the time window beginning at septic shock presentation and ending 6 hours after the time of presentation of septic shock.

Notes for Abstraction

Add new sub-bullet under third bullet:
  o Acceptable examples of administration include: “vasopressor running” and “vasopressor given.”

Add in fourth bullet, 1st sentence:
  demonstrated by persistent hypotension after crystalloid fluid administration

Add new fifth bullet:
  • If a vasopressor was not started within the acceptable time frame, select Value “2.”

Inclusion Guidelines for Abstraction

Change to:
None

Impacts:
Vasopressor Administration Date

Rationale: These revisions provide abstraction guidance regarding vasopressor administration.

Description of Changes:

Definition
Change to:
The date on which an intravenous vasopressor was administered within 6 hours following the presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration.

Suggested Data Collection Question

Change to:
What was the date on which an intravenous vasopressor was administered within 6 hours following the presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration?

Notes for Abstraction

Add new sub-bullet under third bullet:
  o Acceptable examples of administration include: “vasopressor running” and “vasopressor given.”

Change fourth bullet to:
  • If a vasopressor was infusing at the time of presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration, or the vasopressor was infusing
at the time of septic shock and multiple doses were subsequently given, abstract the date
the vasopressor that was infusing at the time of presentation of septic shock was initiated.
Example:
Septic shock patient was triaged in the ED at 08:00. At the time of triage, the patient
was receiving Levophed via an IV started prior to arrival, abstract the date the
Levophed was started prior to arrival.

Inclusion Guidelines for Abstraction
Change to:
None

Impacts:
Vasopressor Administration Time

Rationale: These revisions provide abstraction guidance regarding vasopressor administration.

Description of Changes:
Definition
Change to:
The time at which an intravenous vasopressor was administered within 6 hours following the
presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid
administration.

Suggested Data Collection Question
Change to:
What was the time at which an intravenous vasopressor was administered within 6 hours
following the presentation of septic shock, demonstrated by persistent hypotension after
crystalloid fluid administration?

Notes for Abstraction
Add new sub-bullet under third bullet:
- Acceptable examples of administration include: “vasopressor running” and “vasopressor
given.”

Change fourth bullet to:
• If a vasopressor was infusing at the time of presentation of septic shock, demonstrated by
persistent hypotension after crystalloid fluid administration, or the vasopressor was infusing
at the time of septic shock and multiple doses were subsequently given, abstract the time
the vasopressor that was infusing at the time of presentation of septic shock was initiated.
Example:
Septic shock patient was triaged in the ED at 08:00. At the time of triage, the patient
was receiving Levophed via an IV started prior to arrival at 07:45, abstract the time
the Levophed was started prior to arrival, 07:45.

Inclusion Guidelines for Abstraction
Change to:
None
Impacts: 
Vital Signs Review Performed

Rationale: This change clarifies the requirements for the vital signs review.

Description of Changes:
Notes for Abstraction
Change second bullet to:
• Vital signs review is done to assess overall status. The review must include temperature, pulse (also referred to as heart rate), respirations, and systolic and diastolic blood pressure reading.

Impacts: 
VTE Confirmed

Rationale: This change is to clarify the acceptable VTE locations.

Description of Changes:
Notes for Abstraction
Add new sixth bullet:
• If conflicting documentation between providers is present, select “Yes.”

Change seventh bullet to:
• For patients with radiology reports that state “low probability” or “inconclusive test results” on any of the acceptable VTE Diagnostic Tests, select “No.”

Add new tenth bullet:
• If there is physician/APN/PA documentation that the patient had a VTE, select “Yes.”

Suggested Data Sources
Remove “/” after “PA”

VTE Location
Add “Or” after “Pulmonary Emboli (PE)”

Impacts: 
VTE Confirmed
VTE Diagnostic Test

Rationale: Measures and measure sets are being removed from CMS' Hospital Inpatient Quality Reporting program and The Joint Commission's Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

Description of Changes:
Change ‘Collected For’ to:
CMS/The Joint Commission: VTE-5, VTE-6
Impacts:

VTE Diagnostic Test

Rationale: This change is to clarify IV contrast material.

Description of Changes:

Documentation in sources other than radiology reports

Remove extra “/” after “APN” in second bullet

Inclusion Guidelines for Abstraction

Add new fifth and sixth bullets:
- Computed tomography (CT) Angiogram of Chest
- Computed tomography (CT) Pulmonary Angiogram of Chest

Add “IV” before the word “contrast” in 7th, 8th, 9th, 10th, 17th, 18th and 19th bullets

Impacts:

VTE Prophylaxis Status

Rationale: The Notes for Abstraction were updated to ensure cases with VTE diagnosed prior to arrival are not included in the numerator.

Description of Changes:

Notes for Abstraction

Remove eighth bullet:
- Aspirin is not an approved medication for prophylaxis in the VTE population. If aspirin is the only form of prophylaxis documented in the record, select “No.”

Add new bullet:
- When the VTE is diagnosed within four days prior to arrival you may select “Yes.” Use calendar days to determine this timeframe.

Inclusion Guidelines for Abstraction:

Add:
Refer to Appendix H, Table 2.1 VTE Prophylaxis Inclusion Table.

SECTION 2 – Measurement Information

Deleted Measures

Impacts:

AMI Measure Set

Rationale: Measures and measure sets are being removed from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

Description of Changes:

Remove AMI Measure Set in its entirety.
Impacts:
CAC Measure Set

Rationale: Measures and measure sets are being removed from CMS' Hospital Inpatient Quality Reporting program and The Joint Commission's Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

Description of Changes:
Remove CAC Measure Set in its entirety.

Impacts:
SCIP Measure Set

Rationale: Measures and measure sets are being removed from CMS' Hospital Inpatient Quality Reporting program and The Joint Commission's Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

Description of Changes:
Remove SCIP Measure Set in its entirety.

Subsection 2.1 – Severe Sepsis and Septic Shock (SEP)

Impacts:
SEP Measure Set

Rationale: This change will update the MIF to include data element name change and new data element.

Description of Changes:
SEP Data Elements Table
Change data element name from:
Administrative Contraindication to Care
To:
Administrative Contraindication to Care, Septic Shock

Add new data element:
Administrative Contraindication to Care, Septic Shock

Impacts:
SEP Measure Set

Rationale: Directive for Comfort Care Severe Sepsis and Septic Shock data elements name change in SEP Data Element List.

Description of Changes:
SEP Data Elements Table
Change data element names from:
Directive for Comfort Care, Septic Shock
Directive for Comfort Care, Severe Sepsis
To:
Directive for Comfort Care or Palliative Care, Septic Shock
Directive for Comfort Care or Palliative Care, Severe Sepsis
Impacts:
SEP Measure Set

Rationale: New data elements for Septic Shock are being added.

Description of Changes:

SEP Data Elements Table

Add row, Name and Collected For respectively:
Left column: Documentation of Septic Shock
Right column: SEP-1

Add row, Name and Collected For respectively:
Left column: Initial Hypotension
Right column: SEP-1

Impacts:
Measure
SEP-1

Rationale: New data elements for Septic Shock are being added.

Description of Changes:

Numerator Statement

Add new Data Elements:
• Documentation of Septic Shock
• Initial Hypotension

Impacts:
Measure
SEP-1

Rationale: This change will update the MIF to include data element name change and new data element.

Description of Changes:

Denominator Statement - Excluded Populations

Change third bullet to:
• Administrative contraindication to care within 6 hours of presentation of severe sepsis

Add new fourth bullet:
• Administrative contraindication to care within 6 hours of presentation of septic shock

Denominator Statement - Data Elements

Add new first bullet:
• Administrative Contraindication to Care, Septic Shock

Change second bullet to:
• Administrative Contraindication to Care, Severe Sepsis
Impacts:
Measure SEP-1

Rationale: The data element names Directive for Comfort Care, Severe Sepsis and Directive for Comfort Care, Septic Shock are being changed in the SEP Measure Information Form.

Description of Changes:
Denominator Statement – Excluded Populations
Add in first two bullets:
or Palliative Care

Denominator Statement – Data Elements
Change data element names from:
Directive for Comfort Care, Septic Shock
Directive for Comfort Care, Severe Sepsis
To:
Directive for Comfort Care or Palliative Care, Septic Shock
Directive for Comfort Care or Palliative Care, Severe Sepsis

Impacts:
SEP-1 Algorithm

Rationale: The algorithm is being revised to incorporate changes to the measure.

Description of Changes:
Remove first decision box Administrative Contraindication to Care.

Remove Shock Vasopressor Six Hour Counter from Variable Key list on page 1 of algorithm.

Change decision box name from 'Directive for Comfort Care, Severe Sepsis' to 'Directive for Comfort Care or Palliative Care, Severe Sepsis'.

Add new decision box Administrative Contraindication to Care, Severe Sepsis and allowable values 1, 2, 3 after Severe Sepsis Presentation Time.
If Administrative Contraindication to Care, Severe Sepsis is equal to 1 or 2 then it goes to off-page connector B.
If allowable value of 3 goes to Directive for comfort Care or Palliative Care, Severe Sepsis.
If allowable value is missing goes to off page connector X.

Remove Initialize Shock Vasopressor Six Hour Counter from initialize counter box after off-page connector H.

Change decision box name from 'Directive for Comfort Care, Septic Shock' to 'Directive for Comfort Care or Palliative Care, Septic Shock'.

Add new decision box Administrative Contraindication to Care, Septic Shock and allowable values 1, 2, 3 after Shock Presentation Time.
If Administrative Contraindication to Care, Septic Shock is equal to 1 or 2 then it goes to off-page connector B.
If allowable value of 3 goes to Directive for comfort Care or Palliative Care, Septic Shock.
If allowable value is missing goes to off page connector X.
Remove process box Add 1 to Shock Vasopressor Six Hour Counter after Vasopressor Time.

Add new decision box Shock Presentation Time after Septic Shock Present equal to 1.
When Shock Presentation Time value is greater than 360 minutes, goes directly to the Measure Category of E.
When Shock Presentation Time value is greater than or equal to 0 and less than or equal to 360 minutes, goes to 'Shock Three Hour Counter'

Remove decision box Shock Vasopressor Six Hour Counter after Persistent Hypotension decision box on last page of algorithm.

Impacts:
SEP-1 Algorithm

Rationale: The algorithm is being revised to discontinue data collection for cases that fail and the addition of new data elements Initial Hypotension and Documentation of Septic Shock.

Description of Changes:
Change Initial Lactate Level Collection branch that equals 2 to go to Measure Category Assignment of D.

Change Initial Lactate Level Date branch that equals UTD to go to Measure Category Assignment of D.

Change Initial Lactate Level Time branch that equals UTD to go to Measure Category Assignment of D.

Change Initial Lactate Time branch that is <-360 minutes or >180 minutes to go to Measure Category Assignment of D.

Change Broad Spectrum or Other Antibiotic Administration branch that equals 2 to go to Measure Category Assignment of D.

Change Broad Spectrum or Other Antibiotic Administration Date branch that equals UTD to go to Measure Category Assignment of D.

Change Broad Spectrum or Other Antibiotic Administration Time branch that equals UTD to go to Measure Category Assignment of D.

Change Broad Spectrum Antibiotic Time branch that is >180 minutes to go to Measure Category Assignment of D.

Change Broad Spectrum or Other Antibiotic Administration Selection branch that equals 2 to go to Measure Category Assignment of D.

Change Blood Culture Collection branch that equals 2 to go to Measure Category Assignment of D.

Change Blood Culture Collection Date branch that equals UTD to go to Measure Category Assignment of D.

Change Blood Culture Collection Time branch that equals UTD to go to Measure Category Assignment of D.

Change Blood Culture Time branch that is <-2880 minutes or >180 minutes to go to Measure Category Assignment of D.
**Change** Blood Culture Antibiotic Time branch that is <0 minutes to go to Measure Category Assignment of D.

**Remove** Sepsis Three Hour Counter and Sepsis Six Hour Counter from the Variable Key on the first page and the initialize counter box after off-page connector H.

**Remove** the Add 1 to Sepsis Three Hour Counter box that was before the off-page connector I, the off-page connector J and the off-page connector K.

**Remove** the Add 1 to Sepsis Six Hour Counter box that was before the off-page connector L.

**Remove** Sepsis Three Hour Counter, Sepsis Six Hour Counter and the first Initial Lactate Level Result decision box and all associated logic from the last page of the algorithm.

**Add** Initial Hypotension data element after off-page connector L. If missing goes to Measure Category Assignment of X. If equals 1 continues to Crystalloid Fluid Administration. If equals 2 continues to Initial Lactate Level Result.

**Add** Initial Lactate Level Result data element after Initial Hypotension. If equals 3 continues to Crystalloid Fluid Administration. If equals 1 or 2 continues to Documentation of Septic Shock.

**Add** Documentation of Septic Shock data element after Initial Lactate Level Result. If equals 1, continues to Crystalloid Fluid Administration. If equals 2 it goes the Measure Category Assignment of E.

**Add** off-page connector on the last page going into the Measure Category Assignment of E.

**Change** order of data elements – Crystalloid Fluid Administration, Crystalloid Fluid Administration Date and Crystalloid Fluid Administration Time are now before Septic Shock Present data element.

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### Subsection 2.2 – Venous Thromboembolism (VTE)

**Impacts:**

VTE Measure Set

**Rationale:** Measures and measure sets are being removed from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

**Description of Changes:**

VTE Measure Set Table

**Remove** the following ‘Set Measure ID#' Rows entirely:

- VTE-1 Venous Thromboembolism Prophylaxis
- VTE-2 Intensive Care Unit Venous Thromboembolism Prophylaxis
- VTE-3 Venous Thromboembolism Patients with Anticoagulation Overlap Therapy

VTE Data Elements Table

**Comfort Measures Only**

**Remove** under ‘Collected For’:

VTE-1, VTE-2, VTE-3
**Discharge Disposition**
- **VTE Confirmed**
- **VTE Diagnostic Test**

**Remove** under ‘Collected For’:
- VTE-3

**Remove** the following rows in their entirety:
- **Anesthesia Start Date**
- **ICU Discharge Date**
- **ICU Admission or Transfer Date**
- **ICU Admission or Transfer**
- **ICU VTE Prophylaxis**
- **ICU VTE Prophylaxis Date**
- **INR Value**
- **Overlap Therapy**
- **Overlap Therapy Start Date**
- **Parenteral Anticoagulant End Date**
- **Parenteral Anticoagulant Prescribed at Discharge**
- **Reason for Discontinuation of Parenteral Anticoagulation Therapy**
- **Reason for No Overlap Therapy**
- **Reason for No VTE Prophylaxis – Hospital Admission**
- **Reason for No VTE Prophylaxis – ICU Admission**
- **Reason for Oral Factor Xa Inhibitor**
- **Reason for Oral Factor Xa Inhibitor – ICU Admission**
- **Surgery End Date**
- **Surgery End Date – ICU Admission**
- **Surgical Procedure**
- **Surgical Procedure – ICU Admission**
- **VTE Prophylaxis**
- **VTE Prophylaxis Date**
- **Warfarin Admission**

**Remove** the following Measure Information Forms in their entirety:
- VTE-1
- VTE-2
- VTE-3

---

**Impacts:**
VTE Measure Set – Initial Patient Population

**Rationale:** The change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements beginning with 1/1/2016 discharges.

**Description of Changes:**
**Remove:**
Initial Patient Population Definitions (4th quarter 2015 discharges only) Table

**Remove:**
(starting with 1/1/2016 discharges)
**Remove:**
Note: Sub-population 1 (No VTE) will be in use during 4th quarter 2015 only.

**Change** fifth paragraph to:
1 – No VTE sub-population – is retired

**Impacts:**
VTE Measure Set – Initial Patient Population Algorithm

**Rationale:** The change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements beginning with 1/1/2016 discharges.

**Description of Changes:**
**Remove** Algorithm branch evaluating ICD-10-CM Principal or Other Diagnosis codes on table 7.02.

**Remove** the No-VTE Sub-population, VTE sub-population 1, exit point

**Remove** the Note regarding Sub-population 1, No VTE Sub-population, is removed as of 1/1/2016, from the algorithm

**Impacts:**
VTE Measure Set – Sample Size Requirements

**Rationale:** The change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements beginning with 1/1/2016 discharges.

**Description of Changes:**
**Change** last sentence in first paragraph to:
Hospitals that have five or fewer discharges for the two combined VTE sub-populations (both Medicare and non-Medicare combined) are not required to submit VTE patient level data to the CMS Clinical Warehouse or the Joint Commission’s Data Warehouse.

**Quarterly Sampling**
**Remove** in first paragraph, second sentence:
No VTE patients (4th quarter 2015 discharges only),

**Remove** word in first paragraph, third sentence:
“three”

**Change** second paragraph to:
To determine if a hospital may choose to not submit VTE patient level data to the CMS Clinical Warehouse or the Joint Commission’s Data Warehouse, the combined count of discharges, for the quarter, for the two sub-populations must be five or less (i.e., the combined count of discharges equals the count of all patients in Principal Patient Sub-population [2] plus the count of all patients in Other VTE Only Initial Patient Sub-population [3]).

**Remove** third paragraph:
1 (4th quarter 2015 discharges only) – Hospitals selecting sample cases for the No VTE sub-population must ensure that the Initial Patient Population and sample size for the No VTE sub-population meets the following conditions:
Remove:
Quarterly Sample Size Based on Initial Patient Population Size for the No VTE Patient Sub-
Population (4th quarter 2015 discharges only)* Table

Remove:
*The Joint Commission Only. To receive the most value for the VTE-2 measure, it is desirable to
enhance the population. Within the no VTE sub-population, hospitals are strongly advised to
identify patients that have been admitted or transferred to the intensive care unit (ICU) using
revenue codes or an alternative process. We suggest the following if sampling quarterly: if there
are 45 or less ICU patients within a quarter, then abstract all the ICU patients. If there are more
than 45 patients within a quarter, then abstract from a randomly selected sample of 45 ICU
patients a quarter.

Add before ‘2’:
Sampling for VTE Sub-population

Add before ‘3’:
Sampling for VTE Sub-population

Monthly Sampling
Change second sentence in first paragraph to:
This measure set contains two independent sub-populations: Principal VTE patients, and Other
VTE Only patients.

Remove word in first paragraph, third sentence:
“three”

Remove:
1 (4th quarter 2015 discharges only) – Hospitals selecting sample cases for the No VTE sub-
population must ensure that the Initial Patient Population and sample size for the No VTE sub-
population meets the following conditions:

Remove:
Monthly Sample Size Based on Initial Patient Population Size for the
No VTE Patient Sub-Population (4th quarter 2015 discharges only)* Table

Remove:
*The Joint Commission Only. To receive the most value for the VTE-2 measure, it is desirable to
enhance the population. Within the no VTE sub-population, hospitals are strongly advised to
identify patients that have been admitted or transferred to the intensive care unit (ICU) using
revenue codes or an alternative process. We suggest the following if sampling monthly: if less
than 15 ICU patients within a month, then abstract all the ICU patients. If there are more than 15
ICU patients within a month, then abstract from a randomly selected sample of 15 ICU patients a
month.

Add before ‘2’:
Sampling for VTE Sub-population

Add before ‘3’:
Sampling for VTE Sub-population
Sample Size Examples

Quarterly Sampling

Remove:

- Quarterly sampling for the No VTE sub-population (4th quarter 2015 discharges only):
  - A hospital's No VTE sub-population is 752 during the second quarter. Using the quarterly sampling table for the No VTE sub-population, the sample size required is 20% of this sub-population, or 151 cases for the quarter (twenty percent of 752 equals 150.4 rounded up to the next whole number equals 151).
  - A hospital's No VTE sub-population is 5 during the first quarter. Using the quarterly sampling table for the No VTE sub-population, the sample size is less than the minimum required quarterly sample size, so 100% of this sub-population is sampled.
  - A hospital's No VTE sub-population is 99 during the third quarter. The required quarterly sample is 45 cases.

- Quarterly sampling for all three combined populations (4th quarter 2015 discharges only):
  - The VTE Initial Patient Population sizes for a hospital are 752, 3, and 50 patients respectively per the sub-populations for the quarter. Since the total Initial Patient Population for VTE is 805, the hospital must submit patient level data. The required quarterly sample sizes for each sub-population would be 151, 3, and 50.
    - The 1st sub-population has 752 patients per quarter, which requires a 20% sample size, or 151 cases (twenty percent of 752 equals 150.4 rounded to the next highest whole number equals 151).
    - The 2nd sub-population is less than the minimum required quarterly sample size, so 100% of this sub-population is sampled.
    - The 3rd sub-population is not eligible for sampling, so 100% of this sub-population is sampled.
  - The VTE Initial Patient Population sizes for a hospital are 1, 0, and 3 patients respectively per the sub-populations for the quarter. Since the total Initial Patient Population for VTE is 4, the hospital may choose to not submit patient level data. If the hospital chooses to submit patient level data:
    - The Joint Commission: the required quarterly sample sizes for each sub-population would be 1, 0, and 3.
      - The 1st sub-population is less than the minimum required quarterly sample size, so 100% of this sub-population is sampled.
      - There is no data to sample for the 2nd sub-population.
      - The 3rd sub-population is not eligible for sampling, so 100% of this sub-population is sampled.
    - CMS: the quarterly sample size would be 1 – 4 of the total VTE cases.

Remove in third bullet:
( starting with 01/01/2016 discharges)

Remove under third bullet, under first sub-bullet:
- The 1st sub population (NO VTE) is removed

Remove under third bullet, under second sub-bullet:
- Sub Population 1 (no VTE) is removed
Monthly Sampling
Remove first bullet and sub-bullets:

• Monthly sampling for the No VTE sub-population (4th quarter 2015 discharges only):
  o A hospital’s No VTE sub-population is 81 during March. Using the monthly sampling table for the No VTE sub-population, the sample size required is 20% of this sub-population, or 17 cases for the month (twenty percent of 81 equals 16.2 rounded up to the next whole number equals 17).
  o A hospital’s No VTE sub-population is 5 during the February. Using the monthly sampling table for the No VTE sub-population, the sample size is less than the minimum required monthly sample size, so 100% of this sub-population is sampled.
  o A hospital’s No VTE sub-population is 45 during January. The required monthly sample is 15 cases.

Impacts:
Measure
VTE-5

Rationale: New references are being added based on the environmental scan.

Description of Changes:
Selected References
Add:

Impacts:
Measure
VTE-6

Rationale: New references are being added based on the environmental scan.

Description of Changes:
Selected References
Add:


**Subsection 2.3 – Stroke (STK)**

**Impacts:**
STK Measure Set

**Rationale:** Measures and measure sets are being removed from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

**Description of Changes:**

**STK Measure Set Table**

**Remove** the following ‘Set Measure ID#’ Rows entirely:

- STK-1 Venous Thromboembolism (VTE) Prophylaxis
- STK-2 Discharged on Antithrombotic Therapy
- STK-3 Anticoagulation Therapy for Atrial Fibrillation/Flutter
- STK-5 Antithrombotic Therapy By End of Hospital Day 2
- STK-6 Discharged on Statin Medication
- STK-8 Stroke Education
- STK-10 Assessed for Rehabilitation

**STK Data Elements Table**

**Arrival Date**

**Remove** under ‘Collected For’:

- STK-5

**Clinical Trial**

**Elective Carotid Intervention**

**Change** ‘Collected For’ to:

- STK-4

**Remove** the following rows in their entirety:

- Anticoagulation Therapy Prescribed At Discharge
- Antithrombotic Therapy Administered by End of Hospital Day 2
- Antithrombotic Therapy Prescribed At Discharge
- Assessed for Rehabilitation Services
- Atrial Fibrillation/Flutter
- Comfort Measures Only
- Discharge Disposition
- Education Addresses Activation of Emergency Medical System
- Education Addresses Follow-up After Discharge
- Education Addresses Medications Prescribed at Discharge
- Education Addresses Risk Factors For Stroke
Release Notes Version 5.1

**Education Addresses Warning Signs and Symptoms of Stroke**

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

**Reason for No VTE Prophylaxis – Hospital Admission**

**Reason for Not Administering Antithrombotic Therapy By End of Hospital Day 2**

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

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

**Reason For Not Prescribing Statin Medication at Discharge**

**Reason for Oral Factor Xa Inhibitor**

**Statin Medication Prescribed At Discharge**

**VTE Prophylaxis**

**VTE Prophylaxis Date**

**Remove** the following Measure Information Forms in their entirety:

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

**Impacts:**

STK Measure Set - Initial Patient Population

**Rationale:** The change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements.

**Description of Changes:**

**Change** first sentence to:

The STK measure set is unique in that there are two distinct Initial Patient Populations (or sub-populations) within the measure set, each identified by a specific group of diagnosis codes, or lack thereof.

**Remove** third paragraph:

The following is the Initial Patient Population for 4th quarter 2015 discharges only:

Patients admitted to the hospital for inpatient acute care with an **ICD-10-CM Principal Diagnosis Code** for ischemic or hemorrhagic stroke as defined in Appendix A, Table 8.1 or Table 8.2, a **Patient Age (Admission Date minus Birthdate)** greater than or equal to 18 years and a **Length of Stay (Discharge Date minus Admission Date)** less than or equal to 120 days are included in the STK Initial Patient Population and are eligible to be sampled.

**Change** sentence before Initial Patient Population Definitions Table to:

The following is the STK Initial Patient Population’s measure breakdown:

**Add** new paragraph after Initial Patient Population Definitions Table:

STK-1, 2, 3, 4, 5, 6, 8 and 10 are used for TJC Certification program. Please refer to The Joint Commission manual page at [https://manual.jointcommission.org](https://manual.jointcommission.org) for their definitions and required elements.
Impacts:
STK Measure Set - Initial Patient Population Algorithm

Rationale: The change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements.

Description of Changes:
Remove:
STK Initial Patient Population Algorithm and Narrative for 4th quarter 2015 discharges only.

Stroke (STK) Initial Patient Population Algorithm and Narrative (starting with 1/1/2016 discharges)
Remove:
(starining with 1/1/2016 discharges)

Impacts:
STK Measure Set – Sampling Size Requirements

Rationale: The change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements.

Description of Changes:
Remove second paragraph:
For 4th quarter discharges only: Hospitals whose Initial Patient Population size is less than the minimum number of cases per quarter/month for the measure set cannot sample. Hospitals that have five or fewer STK discharges (both Medicare and non-Medicare combined) in a quarter are not required to submit STK patient level data to the CMS Clinical Warehouse or the Joint Commission’s Data Warehouse.

Remove from third paragraph:
Starting with 1/1/2016 discharges:

Remove:
Quarterly Sampling (4th quarter 2015 discharges only)
Hospitals performing quarterly sampling for STK must ensure that its Initial Patient Population and sample size meet the following conditions:

Remove table:
Quarterly Sample Size Based on Initial Patient Population Size for the STK Measure Set Hospital’s Measure

Remove:
Monthly Sampling (4th quarter 2015 discharges only)
Hospitals performing monthly sampling for STK must ensure that its Initial Patient Population and sample size meet the following conditions:

Remove table:
Monthly Sample Size Based on Initial Patient Population Size for the STK Measure Set Hospital’s Measure
Remove:
Sample Size Examples (4th quarter 2015 discharges only)

- Quarterly sampling:
  - A hospital's STK Initial Patient Population size is 100 patients during the fourth quarter. The required sample size is seen to be a minimum of 45 STK patients for this quarter.
  - A hospital's STK Initial Patient Population size is 392 patients during the third quarter. The required sample size is 20% of the patient population or 79 cases for the quarter (twenty percent of 392 equals 78.4 rounded to the next highest whole number equals 79).
  - A hospital's STK Initial Patient Population is 4 patients during the first quarter. Submission of patient level data is not required. If the hospital chooses to submit patient level data:
    - CMS: the quarterly sample size would be 1 – 4 cases for the quarter
    - The Joint Commission: the required quarterly sample size would be 100% of the patient population or 4 cases for the quarter.

- Monthly sampling:
  - A hospital's STK Initial Patient Population size is 316 patients during March. The required sample size is 60 cases from the patient population.
  - A hospital's STK Initial Patient Population size is 228 patients during July. The required sample size is 20% of the patient population or 46 cases for the month (twenty percent of 228 equals 45.6 rounded to the next highest whole number equals 46).

Remove:
(starting with 1/1/2016 discharges)

Impacts:

Measure
STK-4

Rationale: Prescribing information about the contraindications and warnings for the administration of tPA were revised by the manufacturer in February 2015. The change updates the selected reference for FDA labeling instructions.

Description of Changes:
Selected References
Change last bullet to:

Subsection 2.4 – Global Initial Patient Population (ED, IMM, TOB, SUB)

No updates in Subsection 2.4 – Global Initial Patient Population (ED, IMM, TOB, SUB).
Subsection 2.5 – Emergency Department (ED)

No updates in Subsection 2.5 – Emergency Department (ED).

Subsection 2.6 - Prevention

2.6.1- Immunization (IMM)

Impacts:
IMM Measure Set

Rationale: Measures and measure sets are being removed from CMS' Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

Description of Changes:
IMM Measure Set Table
Remove the following ‘Set Measure ID#’ Rows entirely:
IMM-1a Pneumococcal Immunization – Overall Rate
IMM-1b Pneumococcal Immunization – Age 65 and Older
IMM-1c Venous Thromboembolism Patients with Anticoagulation Overlap Therapy

IMM Data Elements Table
Discharge Disposition
Change ‘Collected For’ to:
IMM-2

Remove the following row in its entirety:
Pneumococcal Vaccination Status

Remove the following Measure Information Form in its entirety:
IMM-1

Impacts:
Measure
IMM-2

Rationale: This change will remove the use of ICD-10 codes that are non-specific to influenza vaccination.

Description of Changes:
Numerator Statement – Included Populations
Remove second bullet:
• Patients who have an ICD-10-PCS Principal Procedure Code or Other Procedure Codes from Table 12.9 for Prophylactic Vaccination against Influenza during this inpatient hospitalization
Impacts: Algorithm

Measure IMM-2

Rationale: This change will remove the use of ICD-10 codes that are non-specific to influenza vaccination.

Description of Changes: Remove from connector H, under Discharge Date decision point: ICD-10-PCS Principal or Other Procedure Codes decision point and associated logic branches.

### 2.6.2 - Substance Use (SUB)

Impacts: Measure SUB-2

Rationale: References have been added based on recommendations from the SUB Technical Advisory Panel.

Description of Changes: Selected References Add new references:

### 2.6.3 - Tobacco Treatment (TOB)

Impacts: Measure TOB-1

Rationale: The denominator exclusion was changed from =< 3 days length of stay to =< 1 day length of stay to increase the denominator population. The time frame to complete the tobacco use screen was changed based on recommendations from the TOB Technical Advisory Panel.

Description of Changes: Description Change to: Hospitalized patients who are screened within the first day 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 day of admission.
Excluded Populations

Change third bullet to:

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

Impacts:

Measure

TOB-1 Algorithm

Rationale: The denominator exclusion was changed from \( \leq 3 \) days length of stay to \( \leq 1 \) day length of stay to increase the denominator population. The time frame to complete the tobacco use screen was changed based on recommendations from the TOB Technical Advisory Panel.

Description of Changes:

Change Numerator Statement to:
The number of patients who were screened for tobacco use status within the first day of admission.

Change Length of Stay to:

- If Length of Stay is equal to or less than 1 day, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
- If Length of Stay is greater than 1 day, continue processing and proceed to check Comfort Measures Only.

Impacts:

Measure

TOB-2

Rationale: The denominator exclusion was changed from \( \leq 3 \) days length of stay to \( \leq 1 \) day length of stay to increase the denominator population. The time frame to provide interventions was changed based on recommendations from the TOB Technical Advisory Panel.

Description of Changes:

Description

Remove:
within the first three days after admission

Numerator Statement

Remove:
within the first three days after admission

Excluded Populations

Change fifth bullet to:

- Patients who have a duration of stay less than or equal to one day or greater than 120 days
Impacts:
Measure TOB-2 Algorithm

Rationale: The denominator exclusion was changed from <= 3 days length of stay to <= 1 day length of stay to increase the denominator population. The time frame to provide interventions was changed based on recommendations from the TOB Technical Advisory Panel.

Description of Changes:
Change TOB-2 Numerator Statement to:
The number of patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications during the hospital stay.

Change TOB-2a Numerator Statement to:
The number of patients who received practical counseling to quit AND received FDA-approved cessation medications during the hospital stay.

Change Length of Stay to:
• If Length of Stay is equal to or less than 1 day, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
• If Length of Stay is greater than 1 day, continue processing and proceed to check Comfort Measures Only.

Impacts:
Measure TOB-3

Rationale: The denominator exclusion was changed from <= 3 days length of stay to <= 1 day length of stay to increase the denominator population.

Description of Changes:
Excluded Populations
Change fifth bullet to:
• Patients who have a duration of stay less than or equal to one day or greater than 120 days

Impacts:
Measure TOB-3 Algorithm

Rationale: The denominator exclusion was changed from <= 3 days length of stay to <= 1 day length of stay to increase the denominator population. The time frame to provide interventions was changed based on recommendations from the TOB Technical Advisory Panel.

Description of Changes:
Change Length of Stay to:
• If Length of Stay is equal to or less than 1 day, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
• If Length of Stay is greater than 1 day, continue processing and proceed to check Comfort Measures Only.
Impacts:
Measure TOB-3 Algorithm

Rationale: The algorithm is being revised to reduce data collection burden

Description of Changes:
Change to:
From Connector J
1. Decision point: Referral for Outpatient Tobacco Cessation Counseling
   - If AV is missing, the case will proceed to a Measure Category Assignment of X and will stop processing.
   - If AV equal to 4, the case will proceed to a Measure Category Assignment of B and will not be in the measure population.
   - If AV equal to 2, 5, the case will proceed to a Measure Category Assignment of D and will not be in the numerator population.
   - If AV equal to 1, 3, continue processing and proceed to next decision point.

2. Decision point: ICD-10-CM Principal or Other Diagnosis Codes
   - If at least one code is on table 12.3, the case will proceed to a Measure Category Assignment of E and will be in the numerator population.
   - If none is on table 12.3, continue processing and proceed to next decision point.

3. Decision point: Tobacco Use Status
   - If AV equal to 2, the case will proceed to a Measure Category Assignment of E and will be in the numerator population.
   - If AV equal to 1, continue processing and proceed to next decision point.

4. Decision point: Prescription for Tobacco Cessation Medication
   - If AV is missing, the case will proceed to a Measure Category Assignment of X and will stop processing.
   - If AV equal to 3, the case will proceed to a Measure Category Assignment of B and will not be in the measure population.
   - If AV equal to 1, 2, the case will proceed to a Measure Category Assignment of E and will be in the numerator population.
   - If AV equal to 4, continue processing and proceed to next decision point.

SECTION 3 – Missing and Invalid Data
No updates in Section 3 – Missing and Invalid Data.

SECTION 4 – Population and Sampling Specifications

Impacts:
Introduction

Rationale: This change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting Program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements.
Description of Changes:

Population

Change in third sentence of second paragraph:
Acute Myocardial Infarction measure
To:
Sepsis measure

ICD-10-CM-Principal Diagnosis Code
To:
ICD-10-CM-Principal or Other Diagnosis Code

Appendix A, Table 1.1
To:
Appendix A, Table 4.01

Sampling
Remove from second sentence in fourth paragraph:
, starting with 1/1/2016 discharges,

Impacts:
Order of Data Flow

Rationale: This change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting Program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements.

Description of Changes:
1. Hospitals Submitting Measure Sets Under the Global Initial Patient Population to Both the CMS Clinical Warehouse and The Joint Commission’s Data Warehouse

Change sub-header from:
Identify Cases To Be Abstracted For The Remaining Measure Sets, Strata, and Sub-populations (AMI, CAC, SCIP, SEP, STK, VTE)
To:
Identify Cases To Be Abstracted For The Remaining Measure Sets, Strata, and Sub-populations (SEP, STK, VTE)

Change first sentence in first bullet to:
Identify the Initial Patient Population for the other measure sets (SEP), strata or sub-populations (VTE and STK).

Change first sentence in second bullet to:
Using the Global Initial Patient Population identified above, identify and count the number of cases that are also in the other Measure Sets (e.g., SEP), strata or sub-populations (e.g., VTE and STK) Initial Patient Population(s).

Change in the Example under second bullet:
AMI to SEP
78 to 30
72 to 20
6 to 10
2. Hospitals Not Submitting the Measure Sets Under the Global Initial Patient Population to The Joint Commission Only

Remove from first paragraph:
AMI, CAC, SCIP,

Impacts:
Sample Size Requirements

Rationale: This change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting Program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements.

Description of Changes:
Remove from third paragraph:
and STK for 4th quarter 2015 discharges only

Remove from fourth paragraph:
starting with 1/1/2016 discharges

Remove from second sentence in seventh paragraph:
AMI,
SCIP,

Remove fourth sentence in seventh paragraph:
Hospitals that have five or fewer CAC discharges (both Medicare and non-Medicare combined) are not required to submit patient level data to the Joint Commission’s Data Warehouse.

SECTION 9 – Data Transmission

Impacts:
Joint Commission Data Transmission

Rationale: This change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting Program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements.

Description of Changes:
Hospital Initial Patient Population Data
Remove in first sentence:
AMI, CAC, SCIP,

Hospital Clinical Data
Change in fourth paragraph:
AMI to STK

Impacts:
CMS Data Transmission

Rationale: This change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting Program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements.
Description of Changes:
Submission of Hospital Clinical Data

Change in second paragraph:
AMI to STK

Impacts:
CMS and Joint Commission Guidelines for Submission of Hospital Clinical Data

Rationale: This change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting Program and The Joint Commission’s Flexible ORYX performance measure reporting requirements.

Description of Changes:
Allowable Measure Set Combination per Patient Episode of Care

Change 1 to:
1. CMS Clinical Warehouse and Joint Commission’s Data Warehouse
   a. ED, IMM, and VTE-Other VTE Only sub-population for patients age 18 and older
   b. STK, ED, IMM, and VTE-Other VTE Only sub-population for patients age 18 and older.
   c. ED and IMM

Change 2 to:
2. CMS Clinical Warehouse only
   a. ED, IMM, VTE-Other VTE Only sub-population, and Other Diagnosis of SEP for patients age 18 and older
   b. STK, ED, IMM, VTE-Other VTE Only sub-population, and Other Diagnosis of SEP for patients age 18 and older

Change 3 to:
3. Joint Commission’s Data Warehouse only
   a. ED, IMM, TOB, and SUB for patients age 18 and older
   b. STK, IMM, TOB, and SUB for patients age 18 and older
   c. ED, IMM, TOB and SUB

Change 4 to:
4. Submission of multiple files for the same episode of care will not be accepted into either the CMS Clinical Warehouse or Joint Commission’s Data Warehouse for the following Measure Set combinations:
   a. VTE – Principal VTE sub-population and STK

Change 5 to:
5. Submission of multiple files for the same episode of care will not be accepted into the CMS Clinical Warehouse for the following Measure Set combinations:
   a. STK and Principal Diagnosis of SEP
   b. VTE – Principal VTE sub-population and Principal Diagnosis of SEP

Remove:
6. Submission of multiple files for the same episode of care will not be accepted into the Joint Commission’s Data Warehouse for the following Measure Set combinations:
   a. CAC (removed as of 1/1/2016 discharges) and STK
   b. CAC (removed as of 1/1/2016 discharges) and VTE
   c. CAC (removed as of 1/1/2016 discharges) and SCIP (removed as of 1/1/2016 discharges)
**Unique Record Key – CMS Clinical Warehouse**  
**Change** “AMI” to:  
STK

**Unique Record Key – Joint Commission’s Data Warehouse**  
**Change** “AMI” to:  
STK

**Impacts:**  
CMS and Joint Commission Guidelines for Submission of Hospital Initial Patient Population Data

**Rationale:** This change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting Program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements.

**Description of Changes:**  
**Population Details**  
**Remove** in 1:  
AMI (removed as of 1/1/2016 discharges), SCIP (removed as of 1/1/2016 discharges), CAC (removed as of 1/1/2016 discharges),

**Remove** in 2:  
(starting with 1/1/2016 discharges)

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**Transmission Alphabetical Data Dictionary**

**Impacts:**  
*Initial Patient Population Size – Medicare Only*

**Rationale:** This change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting Program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements.

**Description of Changes:**  
**Change** ‘Occurs’ under ‘Format’ to:  
**Occurs:**

- Non-stratified Measure Sets
  One *Initial Patient Population Size - Medicare Only* per hospital’s measure set (e.g. GLB and SEP).

- Stratified Measure Sets
  One *Initial Patient Population Size – Medicare Only* per measure set, stratum or sub-population the hospital is participating in:
  - The VTE measure set has two occurrences, one for each sub-population (Principal VTE and Other VTE Only).
  - The STK measure set has two occurrences, one for each sub-population (Ischemic and Hemorrhagic).
Impacts:
Initial Patient Population Size – Non-Medicare Only

Rationale: This change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting Program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements.

Description of Changes:
Change ‘Occurs’ under ‘Format’ to:
Occurs:
- Non-stratified Measure Sets
  One Initial Patient Population Size – Non-Medicare Only per hospital’s measure set (e.g. GLB and SEP).
- Stratified Measure Sets
  One Initial Patient Population Size – Non-Medicare Only per measure set, stratum or sub-population the hospital is participating in:
  - The VTE measure set has two occurrences, one for each sub-population (Principal VTE and Other VTE Only).
  - The STK measure set has two occurrences, one for each sub-population (Ischemic and Hemorrhagic).

Impacts:
Measure Set

Rationale: This change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting Program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements.

Description of Changes:
Change ‘Occurs’ under ‘Format’ to:
Hospital Clinical Data file: 1
Hospital Initial Patient Population Data file: 1 - 4

Impacts:
Sample Size – Medicare Only

Rationale: This change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting Program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements.

Description of Changes:
Change ‘Occurs’ under ‘Format’ to:
Occurs:
- Non-stratified Measure Sets
  One Sample Size - Medicare Only per hospital’s measure set (e.g. GLB and SEP).
- Stratified Measure Sets
  One Sample Size – Medicare Only per measure set, stratum or sub-population the hospital is participating in:
  - The VTE measure set has two occurrences, one for each sub-population (Principal VTE and Other VTE Only).
The STK measure set has two occurrences, one for each sub-population (Ischemic and Hemorrhagic).

**Impacts:**
**Sample Size – Non-Medicare Only**

**Rationale:** This change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting Program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements.

**Description of Changes:**
**Change** ‘Occurs’ under ‘Format’ to:

Occurs:
- Non-stratified Measure Sets
  One **Sample Size – Non-Medicare Only** per hospital’s measure set (e.g. GLB and SEP).

- Stratified Measure Sets
  One **Sample Size – Non-Medicare Only** per measure set, stratum or sub-population the hospital is participating in:
  - The VTE measure set has two occurrences, one for each sub-population (Principal VTE and Other VTE Only).
  - The STK measure set has two occurrences, one for each sub-population (Ischemic and Hemorrhagic).

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**Impacts:**
**Sampling Frequency**

**Rationale:** This change is to address the removal of measures and measure sets from CMS’ Hospital Inpatient Quality Reporting Program and The Joint Commission’s Flexible ORYX® performance measure reporting requirements.

**Description of Changes:**
**Change** ‘Occurs’ under ‘Format’ to:

Occurs:
- Non-stratified Measure Sets
  One **Sampling Frequency** per hospital’s measure set (e.g. GLB and SEP).

- Stratified Measure Sets
  One **Sampling Frequency** per measure set, stratum or sub-population the hospital is participating in:
  - The VTE measure set has two occurrences, one for each sub-population (Principal VTE and Other VTE Only).
  - The STK measure set has two occurrences, one for each sub-population (Ischemic and Hemorrhagic).
Hospital Clinical Data XML File Layout

Impacts:
Hospital Clinical Data – Detail Elements Information

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

Description of Changes:
Add the following data elements:
Administrative Contraindication to Care, Septic Shock
Documentation of Septic Shock
Initial Hypotension

Impacts:
Hospital Clinical Data – Detail Elements Information

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

Description of Changes:
Remove the following data elements:
Anesthesia Start Date
Anticoagulation Therapy Prescribed at Discharge
Antithrombotic Therapy Administered by End of Hospital Day 2
Antithrombotic Therapy Prescribed at Discharge
Assessed for Rehabilitation Services
Atrial Fibrillation/Flutter
Education Addresses Activation of Emergency Medical System (EMS)
Education Addresses Follow-up After Discharge
Education Addresses Medications Prescribed at Discharge
Education Addresses Risk Factors for Stroke
Education Addresses Warning Signs and Symptoms of Stroke
Fibrinolytic Administration
Fibrinolytic Administration Date
Fibrinolytic Administration Time
Glucose
Home Management Plan of Care Document Addresses Arrangements for Follow-up Care
Home Management Plan of Care Document Addresses Environmental Control and Control of Other Triggers
Home Management Plan of Care Document Addresses Methods and Timing of Rescue Actions
Home Management Plan of Care Document Addresses Use of Controllers
Home Management Plan of Care Document Addresses Use of Relievers
Home Management Plan of Care Document Given to Patient/Caregiver
Home Management Plan of Care Document Present
ICU Admission or Transfer
ICU Admission or Transfer Date
ICU Discharge Date
ICU VTE Prophylaxis
ICU VTE Prophylaxis Date
Infection Prior to Anesthesia
Initial ECG Interpretation
INR Value
IV or IA Thrombolytic (t-PA) Therapy Administered at This Hospital or Within 24 Hours Prior to Arrival
Overlap Therapy Start Date
Overlap Therapy
Parenteral Anticoagulant End Date
Parenteral Anticoagulant Prescribed at Discharge
Pneumococcal Vaccination Status
Reason for Delay in Fibrinolytic Therapy
Reason for Discontinuation of Parenteral Anticoagulation Therapy
Reason for No Overlap Therapy
Reason for No VTE Prophylaxis – Hospital Admission
Reason for No VTE Prophylaxis – ICU Admission
Reason for Not Administering Antithrombotic Therapy by End Of Hospital Day 2
Reason for Not Prescribing Anticoagulation Therapy at Discharge
Reason for Not Prescribing Antithrombotic Therapy at Discharge
Reason for Not Prescribing Statin Medication at Discharge
Reason for Oral Factor Xa Inhibitor
Reason for Oral Factor Xa Inhibitor – ICU Admission
Statin Medication Prescribed at Discharge
Surgery End Date
Surgery End Date – ICU Admission
Surgical Procedure
Surgical Procedure – ICU Admission
VTE Prophylaxis
VTE Prophylaxis Date
Warfarin Administration

**Impacts:**
Administrative Contraindication to Care

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Change Question to:**
Administrative Contraindication to Care, Severe Sepsis

**Add** to the end of the Suggested Data Question and each Answer Value:
prior to or within 6 hours following presentation of severe sepsis

**Impacts:**
Arrival Date

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.
Description of Changes:
Hospital Clinical Data – Detail Elements Information
Remove under Applicable Measure(s):
AMI-7a, STK-5

Remove under Programming Notes:
Collected by The Joint Commission Only: STK-5
AMI-7a and STK-5: Collected for 4Q2015 discharges only

Impacts:
Arrival Time
Transfer From Another Hospital or ASC

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Remove under Applicable Measure(s):
AMI-7a

Remove under Programming Notes:
AMI-7a: Collected for 4Q2015 discharges only

Impacts:
Capillary Refill Examination Date
Capillary Refill Examination Performed
Capillary Refill Examination Time
Passive Leg Raise Exam Date
Passive Leg Raise Exam Time
Peripheral Pulse Evaluation Date
Peripheral Pulse Evaluation Performed
Peripheral Pulse Evaluation Time
Skin Examination Date
Skin Examination Performed
Skin Examination Time

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change in the Suggested Data Collection Question the word “performed” to “documented.”

Impacts:
Cardiopulmonary Evaluation Date
Cardiopulmonary Evaluation Performed
Cardiopulmonary Evaluation Time

Rationale: The changes are being made to align with the specifications manual alphabetical data dictionary.
Description of Changes:
Hospital Clinical Data – Detail Elements Information
Add in the Suggested Data Question after the word performed:
and documented

Impacts:
Central Venous Oxygen Measurement
Central Venous Oxygen Measurement Date
Central Venous Oxygen Measurement Time

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Add in the Suggested Data Collection Question after the word obtained:
within 6 hours

Impacts:
Clinical Trial

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change Applicable Measure(s) to:
STK-4, VTE-5, VTE-6

Remove from Programming Notes:
Collected by The Joint Commission Only: CAC-3, STK-2, STK-3, STK-5, STK-10
Data Collection Suspended: SCIP-Inf-4
AMI-7a, CAC-3, SCIP-Inf-4, STK-1, STK-2, STK-3, STK-5, STK-6, STK-8, STK-10, VTE-1, VTE-2, VTE-3: Collected for 4Q15 discharges only

Impacts:
Comfort Measures Only

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change Applicable Measure(s) to:
All SUB, All TOB, VTE-6

Change Programming Notes to:
Collected by The Joint Commission Only: All SUB, All TOB
Impacts: Crystalloid Fluid Administration

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change Suggested Data Collection Question to:
Were crystalloid fluids administered prior to, at the time of, or after the presentation of initial hypotension, initial lactate >=4, or documentation of septic shock?

Impacts: Crystalloid Fluid Administration Date

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change Suggested Data Collection Question to:
What was the date on which crystalloid fluids were initiated for initial hypotension, initial lactate >=4, or documentation of septic shock?

Impacts: Crystalloid Fluid Administration Time

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change Suggested Data Collection Question to:
What was the earliest time at which crystalloid fluids were initiated for initial hypotension, initial lactate >=4, or documentation of septic shock?

Impacts: Directive for Comfort Care, Septic Shock
Directive for Comfort Care, Severe Sepsis

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change Question to:
Directive for Comfort Care or Palliative Care, Severe Sepsis
Directive for Comfort Care or Palliative Care, Septic Shock

Add to the Suggested Data Collection Question after the word only:
or palliative care
**Impacts:**
Elective Carotid Intervention

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Change** Applicable Measure(s) to:
STK-4

**Remove** under Programming Notes:
Collected by The Joint Commission Only: STK-2, STK-3, STK-5, STK-10
STK-1, STK-2, STK-3, STK-5, STK-6, STK-8, STK-10: Collected for 4Q2015 discharges only

**Impacts:**
ICD-10-CM Other Diagnosis Codes

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Remove** under Applicable Measure(s):
IMM-1

**Remove** under Programming Notes:
IMM-1 from Suspended by The Joint Commission
Collected by CMS as Voluntary Only: IMM-1
IMM-1, VTE-1, VTE-2, VTE-3: Collected for 4Q15 discharges only

**Impacts:**
ICD-10-CM Principal Diagnosis Code

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**
Hospital Clinical Data – Detail Elements Information

**Remove** under Applicable Measure(s):
SCIP-Inf-4, IMM-1

**Change** Programming Notes to:
Collected by The Joint Commission Only: TOB-2, TOB-3, SUB-3
Suspended by The Joint Commission: TOB-4, SUB-4

**Impacts:**
ICD-10-PCS Other Procedure Codes

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.
Description of Changes:
Hospital Clinical Data – Detail Elements Information
Remove under Applicable Measure(s):
IMM-1

Remove under Programming Notes:
IMM-1 from Suspended by The Joint Commission
Collected by CMS as Voluntary Only: IMM-1
IMM-1: Collected for 4Q2015 discharges only

Impacts:
ICD-10-PCS Principal Procedure Code

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Remove from Applicable Measure(s):
VTE-1, VTE-2, IMM-1

Change Programming Notes to:
Collected by The Joint Commission Only: SUB-3
Suspended by The Joint Commission: SUB-4

Impacts:
Passive Leg Raise Exam Performed

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change Suggested Data Collection Question to:
Was there physician/APN/PA documentation that a passive leg raise examination was performed in the time window beginning at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time?

Impacts:
Persistent Hypotension

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change Suggested Data Collection Question to:
Was persistent hypotension or new hypotension present within one hour of the conclusion of crystalloid fluid administration?
Impacts: Reason for No Administration of VTE Prophylaxis

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Add to Suggested Data Collection Question after physician/APN/PA: or pharmacist

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

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change Suggested Data Collection Question to:
Is there documentation of a reason for not administering one of the FDA-approved tobacco cessation medications during the hospital stay?

Impacts: Tobacco Use Status

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change Answer Value to:
1 The patient has during the past 30 days: smoked, on average, 5 or more cigarettes (>=1/4 pack) daily, and/or smoked cigars and/or pipes daily.
2 The patient has during the past 30 days: smoked, on average, 4 or less cigarettes (<1/4 pack) daily, and/or smoked cigarettes, cigars and/or pipes, but not daily, and/or used smokeless tobacco, regardless of frequency.

Impacts: Tobacco Use Treatment FDA-Approved Cessation Medication Tobacco use Treatment Practical Counseling

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Remove from Suggested Data Collection Question and Answer Value: within the first three days after admission
Impacts:
Vasopressor Administration

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change Suggested Data Collection Question to:
Was an intravenous vasopressor administered in the time window beginning at septic shock presentation and ending 6 hours after the presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration?

Impacts:
Vasopressor Administration Date

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change Suggested Data Collection Question to:
What was the date on which an intravenous vasopressor was administered within 6 hours following the presentation of septic shock demonstrated by persistent hypotension after crystalloid fluid administration?

Impacts:
Vasopressor Administration Time

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Change Suggested Data Collection Question to:
What was the time at which an intravenous vasopressor was administered within 6 hours following the presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration?

Impacts:
VTE Confirmed
VTE Diagnostic Test

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

Description of Changes:
Hospital Clinical Data – Detail Elements Information
Remove from Applicable Measure(s):
VTE-3

Remove from Programming Notes:
VTE-3: Collected for 4Q15 discharges only
Hospital Initial Patient Population Data XML File Layout

Impacts:
<measure-set>

Rationale: The changes are being made due to the removal of measures.

Description of Changes:
Remove under Valid Values:
AMI (Removed as of 1/1/2016 discharges)
SCIP (Removed as of 1/1/2016 discharges)
CAC (The Joint Commission only; Removed as of 1/1/2016 discharges)

Impacts:
<stratum>

Rationale: The changes are being made due to the removal of measures.

Description of Changes:
Remove under Description for VTE
1 = No VTE (4th quarter 2015 discharges only)

Remove under Description for STK:
Note: The use of <stratum> for STK starts with 1/1/2016 discharges. For 4th quarter 2015 discharges, STK does not have sub-populations and, therefore, will not use the <stratum> XML tag.

Change Valid Values under VTE to:
2-3

SECTION 10 – CMS Outcome/Structural Measures

Subsection 10.1 – CMS Outcome Measures

No updates in Subsection 10.1 – CMS Outcome Measures.

Subsection 10.2 – Structural Measures

No updates in Subsection 10.2 – Structural Measures.
Impacts:
Multiple Tables

Rationale: Measures and measure sets are being removed from CMS' Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

Description of Changes:
Table Index and Tables
Remove the following in their entirety:
Table 1.1 Acute Myocardial Infarction (AMI)
Table 2.1 Heart Failure (HF)
Table 5.09 Infection
Table 5.11 Cardiac Surgery
Table 5.14 Burns
Table 5.15 Transplant
Table 5.17 Intracranial Neurosurgery
Table 5.19 General Surgery
Table 5.20 Gynecological Surgery
Table 5.21 Urological Surgery
Table 5.22 Elective Hip Replacement
Table 5.23 Elective Total Knee Replacement
Table 5.24 Hip Fracture Surgery
Table 6.1 Asthma
Table 7.02 Obstetrics
Table 12.1 Diabetes
Table 12.2 End-Stage Renal Disease
Table 12.4 Asthma
Table 12.5 Chronic Obstructive Pulmonary Disease (COPD)
Table 12.6 Nephrotic Syndrome
Table 12.7 Asplenia
Table 12.8 Human Immunodeficiency Virus (HIV)

Table 8.2 - Hemorrhagic Stroke (Q4 2015 Only)
Remove "(Q4 2015 only)" from table title

Impacts:
Table Index

Rationale: The tables designated as “Reserved for Future Use” and “Retired” are being removed to simplify the index.

Description of Changes:
Remove rows in Index:
Table 1.2
Table 2.2
Impacts: Excel

Rationale: This change is to provide clarification to the end-user.

Description of Changes:
Change third column header to:
ICD-10 Code

Impacts: Table 8.3: Carotid Intervention Procedures

Rationale: This change adds ICD-10-PCS codes equivalent to ICD-9-CM procedure code 39.22 aortic-subclavian-carotid-bypass.

Description of Changes:
Add (Word and Excel):
021W09D  Bypass Thoracic Aorta to Carotid with Autologous Venous Tissue, Open Approach
021W0AD  Bypass Thoracic Aorta to Carotid with Autologous Arterial Tissue, Open Approach
021W0JD  Bypass Thoracic Aorta to Carotid with Synthetic Substitute, Open Approach
021W0KD  Bypass Thoracic Aorta to Carotid with Nonautologous Tissue Substitute, Open Approach
021W0ZD  Bypass Thoracic Aorta to Carotid, Open Approach
021W49D  Bypass Thoracic Aorta to Carotid with Autologous Venous Tissue, Percutaneous Endoscopic Approach
021W4AD  Bypass Thoracic Aorta to Carotid with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
021W4JD  Bypass Thoracic Aorta to Carotid with Synthetic Substitute, Percutaneous Endoscopic Approach
021W4KD  Bypass Thoracic Aorta to Carotid with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
021W4ZD  Bypass Thoracic Aorta to Carotid, Percutaneous Endoscopic Approach
Impacts:
Table 12.9: Influenza

Rationale: This change will remove the use of ICD-10 codes that are non-specific to influenza vaccination.

Description of Changes:
Table Index and Table
Remove in its entirety:
Table 12.9: Influenza

Impacts:
Table 13.1: Alcohol Dependence

Rationale: These codes are being removed as they do not reflect a current alcohol use or substance use disorder.

Description of Changes:
Remove rows in their entirety:
- G621 Alcoholic polyneuropathy
- I426 Alcoholic cardiomyopathy
- K2920 Alcoholic gastritis without bleeding
- K2921 Alcoholic gastritis with bleeding
- K700 Alcoholic fatty liver
- K7010 Alcoholic hepatitis without ascites
- K7011 Alcoholic hepatitis with ascites
- K702 Alcoholic fibrosis and sclerosis of liver
- K7030 Alcoholic cirrhosis of liver without ascites
- K7031 Alcoholic cirrhosis of liver with ascites
- K7040 Alcoholic hepatic failure without coma
- K7041 Alcoholic hepatic failure with coma
- K709 Alcoholic liver disease, unspecified
- F1021 Alcohol dependence, in remission

Impacts:
Table 13.2: Drug Dependence

Rationale: These codes are being removed as they do not reflect a current alcohol use or substance use disorder.

Description of Changes:
Remove row in its entirety:
- F1921 Other psychoactive substance dependence, in remission

Appendix C – Medication Tables (Word and Excel)

Impacts:
Table Index

Rationale: The tables designated as “Reserved for Future Use” and “Retired” are being removed to simplify the index.
Description of Changes:
Remove rows in Index:
Table 1.1 – 1.3
Table 1.6
Table 1.7
Table 2.1 – 4.0

Impacts:
Multiple Tables

Rationale: Measures and measure sets are being removed from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

Description of Changes:
Table Index and Tables
Remove the following in their entirety:
Table 1.5  Fibrinolytic Agents
Table 6.1  Controller Medications – CAC
Table 6.2  Reliever Medications – CAC
Table 8.1  Statin Medications
Table 8.2  Antithrombotic Medications – Stroke
Table 8.3  Anticoagulant Medications – Stroke

Impacts:
Table 5.0 - Antibiotic Monotherapy, Sepsis

Rationale: Table 5.0 is being revised to remove Amoxicillin/clavulanate and Augmentin as it is only available orally and the measure requires IV antibiotics.

Description of Changes:
Remove rows under Antibiotic Selection Options and Generic Name respectively:
Left column: Amoxicillin/clavulanate
Right column: Amoxicillin/clavulanate
Left column: Augmentin
Right column: Amoxicillin/clavulanate

Impacts:
Table 5.0 - Antibiotic Monotherapy, Sepsis

Rationale: Table 5.0 is being revised to remove Tequin and gatifloxacin since IV formulations have been removed from the market due to safety reasons.

Description of Changes:
Remove rows under Antibiotic Selection Options and Generic Name respectively:
Left column: Gatifloxacin
Right column: Gatifloxacin
Left column: Tequin
Right column: Gatifloxacin
Impacts:
Table 5.1 - Antibiotic Generic/Trade Name Crosswalk, Sepsis

Rationale: Table 5.1 is being revised to add Cefotan and Cefotetan at the request of the measure steward.

Description of Changes:
Cephalosporins
Add rows under Antibiotic Selection Options and Generic Name respectively:
Left column: Cefotan
Right column: Cefotetan
Left column: Cefotetan
Right column: Cefotetan

Impacts:
Table 9.1: FDA-Approved Tobacco Cessation Medications

Rationale: Tobacco cessation medications inadvertently left off the table have been added.

Description of Changes:
Add:
Nicorette lozenge
Wellbutrin

Appendix D – Glossary of Terms

Impacts:
Multiple Terms

Rationale: Measures and measure sets are being removed from CMS' Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

Description of Changes:
Remove the following glossary terms in their entirety:
Acute Myocardial Infarction (AMI)
Antithrombotic Therapy
Atrial Fibrillation
Atrial Flutter
Children’s Asthma Care (CAC)
Fibrinolytic Therapy
Intermittent Pneumatic Compression Device
Surgical Care Improvement Project (SCIP)

Appendix E – Overview of Measure Information Form and Flowchart Formats

No updates in Appendix E – Overview of Measure Information Form and Flowchart Formats.
Appendix F – Measure Name Crosswalk

Impacts:
Multiple Measures

Rationale: This change is to address discrepancies between measure names in the Specifications Manual and the IPPS Final Rule.

Description of Changes:
Change second column header to:
Measure Name In Hospital Inpatient Specifications Manual 07/01/2016 discharges

Change third column header to:
Measure Name in Federal Register published August 2015 for FY2018 payment determination

Remove rows:
SCIP-Inf-4
VTE-3
PSI 90

Add rows:
SEP-1
MORT-30-CABG
READM-30-AMI
READM-30-PN
READM-30-CABG
READ-30-THA/TKA
COMP-THA/TKA
HAI Healthcare Personnel Influenza Vaccination

VTE-5
Change under third column to:
Venous Thromboembolism Discharge Instructions

VTE-6
Change under third column to:
Incidence of Potentially Preventable Venous Thromboembolism

MORT-30-AMI
Change under second column to:
Acute Myocardial Infarction (AMI) 30-Day Mortality

Change under third column to:
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization for patients 18 and older

MORT-30-HF
Change under second column to:
Heart Failure (HF) 30-Day Mortality
Change under third column to:
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization for patients 18 and older

MORT-30-COPD
Change under second column to:
Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality

Change under third column to:
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization

MORT-30-STR
Change under second column to:
Acute Ischemic Stroke 30-Day Mortality

Change under third column to:
Stroke 30-day Mortality Rate

READM-30-HF
Change under second column to:
Heart Failure (HF) 30-Day Readmission

Change under third column to:
Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization

READM-30-HWR
Change under second column to:
Hospital-Wide 30-Day Readmission

Add under third column:
Measure

READM-30-COPD
Change under second column to:
Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission

Change under third column to:
Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization

READM-30-STR
Change under second column to:
Acute Ischemic Stroke 30-Day Readmission

Change under third column to:
30-Day Risk-Standardized Readmission Rate Following Stroke Hospitalization
HAI – Central Line-Associated Bloodstream Infection
Change under third column to:
National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure

HAI – Clostridium Difficile
Change under second column to:
Clostridium Difficile (C-difficile)

PAYM-30-AMI
Change under second column to:
Acute Myocardial Infarction (AMI) 30-Day Payment

Change under third column to:
Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI)

PAYM-30-HF
Change under second column to:
Heart Failure (HF) 30-Day Payment

Change under third column to:
Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care For Heart Failure (HF)

PAYM-30-PN
Change under second column to:
Pneumonia (PN) 30-Day Payment

Remove under third column:
Hospital-Level, Risk-Standardized Payment Associated with a 30-day Episode-of-Care For Pneumonia

MSPB
Add under first column:
-1

Appendix G – Resources

No updates in Appendix G – Resources section.

Appendix H – Miscellaneous Tables

Impacts:
Table Index

Rationale: The tables designated as “Reserved for Future Use” and “Retired” are being removed to simplify the index.
**Description of Changes:**

**Remove** rows in Index:
Tables 1.1 – 2.0
Table 2.2
Table 2.5

**Impacts:**
Table 2.1: VTE Prophylaxis Inclusion

**Rationale:** The change is to remove Aspirin from the VTE Prophylaxis Inclusion table as it is no longer an FDA-approved medication for VTE Prophylaxis.

**Description of Changes:**
**Remove** row in its entirety:
Aspirin

**Impacts:**
Table 2.3 VTE Parenteral Therapy Table

**Rationale:** Measures and measure sets are being removed from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.

**Description of Changes:**
**Remove** the following in its entirety:
Table 2.3 VTE Parenteral Therapy Table

**Impacts:**
Table 2.7: Anticoagulation Therapy Table

**Rationale:** This change is to clarify that the table is “all-inclusive” and to correct the spelling of Tirofiban.

**Description of Changes:**
**Change** left column header to:
Anticoagulation Therapy – All-Inclusive

**Change** under “Inclusion/Synonyms”:
Tirobiban
**To:**
Tirofiban

**Appendix P – Preview Section**

No updates in Appendix P – Preview Section.