Alphabetical Data Dictionary

The General Abstraction Guidelines explain the different sections of the data element definitions and provide direction for common questions and issues that arise in medical record abstraction. Instructions in the specific data elements in this Data Dictionary should **ALWAYS** supersede those found in the General Abstraction Guidelines.

Element Name	Page #	Collected For:
Antithrombotic Therapy Prescribed at Discharge	1-71	STK-2
ARB Prescribed at Discharge	1-73	AMI-3, HF-3
Arrival Date	1-75	AMI-1, AMI-7, AMI-7a, AMI-8, AMI-8a, ED-1, PN-3a, PN-3b, PN-6, PN-6a, PN-6b, STK-4, STK-5
Arrival Time	1-78	AMI-7, AMI-7a, AMI-8, AMI-8a, ED-1, PN-3a, PN-3b, PN-6, PN-6a, PN-6b, STK-4
Aspirin Prescribed at Discharge	1-81	AMI-2
Aspirin Received Within 24 Hours Before or After Hospital Arrival	1-83	AMI-1
Assessed for Rehabilitation Services	1-85	STK-10
Atrial Fibrillation/Flutter	1-87	STK-3
Beta-Blocker Current Medication	1-89	SCIP-Card-2
Beta-Blocker During Pregnancy	1-91	SCIP-Card-2
Beta-Blocker Perioperative	1-92	SCIP-Card-2
Beta-Blocker Prescribed at Discharge	1-94	AMI-5
Birthdate	1-96	All Records
Blood Culture Collected	1-97	PN-3a, PN-3b
Brief Intervention	1-99	SUB-2
Catheter Removed	1-101	SCIP-Inf-9
Chest X-Ray	1-103	PN-3a, PN-3b, PN-6, PN-6a, PN-6b
Clinical Trial	1-106	AMI-1, AMI-2, AMI-3, AMI-5, AMI-7, AMI-7a, AMI-8, AMI-8a, AMI-10, All CAC Measures, All HF Measures, PN-3a, PN-3b, PN-6, PN-6a, PN-6b, SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-4, SCIP-Inf-6, SCIP-Inf-9, SCIP-Card-2, SCIP-VTE-2, All STK Measures, All VTE Measures
Cognitive Impairment	1-109	SUB-1, SUB-2, SUB-3, SUB-4, TOB-1, TOB-2, TOB-3, TOB-4
Comfort Measures Only	1-111	AMI-1, AMI-2, AMI-3, AMI-5, AMI-10, All HF Measures, PN-3a, PN-3b, PN-6, PN-6a, PN-6b, STK-1, STK-2, STK-3, STK-5, STK-6, STK-8, STK-10, All SUB Measures, All TOB Measures, VTE-1, VTE-2, VTE-3, VTE-4, VTE-6
Date Last Known Well	1-115	STK-4
Decision to Admit Date	1-117	ED-2
Decision to Admit Time	1-120	ED-2

Element Name	Page #	Collected For:
Discharge Date	1-123	All Records
Discharge Disposition	1-125	AMI-1, AMI-2, AMI-3, AMI-5, AMI-10, HF-1, HF-2, HF-3, IMM-1, IMM-2, PN-3b, CAC-3, STK-2, STK-3, STK-6, STK-8, STK-10, SUB-3, SUB-4, TOB-3, TOB-4, VTE-3, VTE-4, VTE-5
Discharge Instructions Address Activity	1-128	HF-1
Discharge Instructions Address Compliance Issues	1-130	VTE-5
Discharge Instructions Address Diet	1-132	HF-1
Discharge Instructions Address Dietary Advice	1-134	VTE-5
Discharge Instructions Address Follow-up	1-136	HF-1
Discharge Instructions Address Follow-up Monitoring	1-138	VTE-5
Discharge Instructions Address Medications	1-140	HF-1
Discharge Instructions Address Potential for Adverse Drug Reactions and Interactions	1-144	VTE-5
Discharge Instructions Address Symptoms Worsening	1-146	HF-1
Discharge Instructions Address Weight Monitoring	1-148	HF-1
Drug Use Status Post Discharge – Quit Status	1-150	SUB-4
ED Departure Date	1-152	ED-1, ED-2
ED Departure Time	1-154	ED-1, ED-2
ED Patient	1-157	ED-1, ED-2, STK-4
Education Addresses Activation of Emergency Medical System (EMS)	1-159	STK-8
Education Addresses Follow-up After Discharge	1-161	STK-8
Education Addresses Medications Prescribed at Discharge	1-163	STK-8
Education Addresses Risk Factors for Stroke	1-167	STK-8
Education Addresses Warning Signs and Symptoms of Stroke	1-170	STK-8
Elective Carotid Intervention	1-172	All STK Measures
Fibrinolytic Administration	1-174	AMI-7, AMI-7a, AMI-8, AMI-8a
Fibrinolytic Administration Date	1-175	AMI-7, AMI-7a
Fibrinolytic Administration Time	1-177	AMI-7, AMI-7a
First Name	1-179	All Records

Element Name	Page #	Collected For:
First PCI Date	1-180	AMI-8, AMI-8a
First PCI Time	1-182	AMI-8, AMI-8a
Follow-Up Contact	1-185	SUB-4, TOB-4
Follow-Up Contact Date	1-187	SUB-4, TOB-4
Glucose	1-188	SCIP-Inf-4
Hispanic Ethnicity	1-191	All Records
Home Management Plan of Care Document Addresses Arrangements for Follow-up Care	1-192	CAC-3
Home Management Plan of Care Document Addresses Environmental Control and Control of Other Triggers	1-194	CAC-3
Home Management Plan of Care Document Addresses Methods and Timing of Rescue Actions	1-196	CAC-3
Home Management Plan of Care Document Addresses Use of Controllers	1-198	CAC-3
Home Management Plan of Care Document Addresses Use of Relievers	1-200	CAC-3
Home Management Plan of Care Document Given to Patient/Caregiver	1-202	CAC-3
Home Management Plan of Care Document Present	1-204	CAC-3
ICD-9-CM Other Diagnosis Codes	1-205	All Records
ICD-9-CM Other Procedure Codes	1-206	All Records
ICD-9-CM Other Procedure Dates	1-207	All Records
ICD-9-CM Principal Diagnosis Code	1-209	All Records
ICD-9-CM Principal Procedure Code	1-210	All Records
ICD-9-CM Principal Procedure Date	1-211	All Records
ICU Admission or Transfer	1-213	PN-3a, PN-6, PN-6a, PN-6b, VTE-1, VTE-2
ICU Admission or Transfer Date	1-216	VTE-1, VTE-2
ICU Discharge Date	1-218	VTE-1, VTE-2
ICU VTE Prophylaxis	1-220	VTE-2
ICU VTE Prophylaxis Date	1-222	VTE-2
Infection Prior to Anesthesia	1-224	SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-4
Influenza Vaccination Status	1-227	IMM-2
Initial Blood Culture Collection Date	1-230	PN-3a, PN-3b
Initial Blood Culture Collection Time	1-232	PN-3a, PN-3b
Initial ECG Interpretation	1-234	AMI-7, AMI-7a, AMI-8, AMI-8a
INR Value	1-238	VTE-3
Intentional Hypothermia	1-239	SCIP-Inf-10

Element Name	Page #	Collected For:
*IV **OR** IA Thrombolytic (t-PA) Therapy Administered at This Hospital or Within 24 Hours Prior to Arrival*	1-241	STK-5
IV Thrombolytic Initiation	1-243	STK-4
IV Thrombolytic Initiation Date	1-245	STK-4
IV Thrombolytic Initiation Time	1-247	STK-4
Last Known Well	1-249	STK-4
Last Name	1-251	All Records
LDL-c Greater Than or Equal to 100 mg/dL	1-252	STK-6
LDL-c Less Than 100 mg/dL	1-254	AMI-10
LDL-c Measured Within the First 48 Hours or 30 Days Prior to Hospital Arrival	1-256	STK-6
LVF Assessment	1-258	HF-2
LVSD	1-261	AMI-3, HF-3
Measure Category Assignment	1-265	Used in the calculation of The Joint Commission's aggregate data and in the transmission of the Hospital Clinical Data file
Measurement Value	1-267	Used in the calculation of The Joint Commission's aggregate data Continuous Variable Measures (AMI-7, AMI-8, ED-1, ED-2), and in the transmission of the Hospital Clinical Data file
Monitoring Documentation	1-268	VTE-4
Non-Primary PCI	1-270	AMI-8, AMI-8a
Oral Antibiotics	1-272	SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3
Other Surgeries	1-274	SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3
Overlap Therapy	1-276	VTE-3
Overlap Therapy Start Date	1-278	VTE-3
Parenteral Anticoagulant End Date	1-280	VTE-3
Parenteral Anticoagulant Prescribed at Discharge	1-282	VTE-3
Patient HIC#	1-284	Collected by CMS for patients with a standard HIC#
Patient Identifier	1-286	All Records
Payment Source	1-287	All Records
Perioperative Death	1-288	SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-9, SCIP-Card-2, SCIP-VTE-2
Physician 1	1-290	Optional for All Records
Physician 2	1-291	Optional for All Records
Pneumococcal Vaccination Status	1-292	IMM-1

Element Name	Page #	Collected For:
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Postal Code	1-299	All Records
Preadmission Oral Anticoagulation Therapy	1-300	SCIP-VTE-2
Pre-Arrival Lipid-Lowering Agent	1-302	STK-6
Preoperative Hair Removal	1-303	SCIP-Inf-6
Prescription for Alcohol or Drug Disorder Medication	1-305	SUB-3
Prescription for Tobacco Cessation Medication	1-307	TOB-3, TOB-4
Pseudomonas Risk	1-309	PN-6, PN-6b
Race	1-311	All Records
Reason for Alternative Empiric Antibiotic Therapy	1-313	PN-6, PN-6a, PN-6b
Reason for Delay in Fibrinolytic Therapy	1-317	AMI-7, AMI-7a
Reason for Delay in PCI	1-320	AMI-8, AMI-8a
Reason for Discontinuation of Parenteral Therapy	1-323	VTE-3
Reason for No ACEI and No ARB at Discharge	1-326	AMI-3, HF-3
Reason for No Aspirin at Discharge	1-332	AMI-2
Reason for No Aspirin on Arrival	1-336	AMI-1
Reason for No Beta Blocker at Discharge	1-340	AMI-5
Reason for No Overlap Therapy	1-345	VTE-3
Reason for No Tobacco Cessation Medication at Discharge	1-347	TOB-3
Reason for No Tobacco Cessation Medication During the Hospital Stay	1-349	TOB-2
Reason for No VTE Prophylaxis – Hospital Admission	1-351	STK-1, VTE-1
Reason for No VTE Prophylaxis – ICU Admission	1-354	VTE-2
Reason for Not Administering Antithrombotic Therapy by End of Hospital Day 2	1-357	STK-5
Reason for Not Administering Beta-Blocker-Perioperative	1-360	SCIP-Card-2
Reason for Not Administering Relievers	1-363	CAC-1
Reason for Not Administering Systemic Corticosteroids	1-365	CAC-2
Reason for Not Administering VTE Prophylaxis	1-367	SCIP-VTE-2
Reason for Not Initiating IV Thrombolytic	1-370	STK-4
*Reason for Not Prescribing **Anticoagulation** Therapy at Discharge*	1-372	STK-3

Element Name	Page #	Collected For:
*Reason for Not Prescribing **Antithrombotic** Therapy at Discharge*	1-376	STK-2
Reason for Not Prescribing Statin Medication at Discharge	1-380	AMI-10, STK-6
Reason for Oral Factor Xa Inhibitor	1-384	STK-1, VTE-1
Reason for Oral Factor Xa Inhibitor- ICU Admission	1-386	VTE-2
Reasons for Continuing Urinary Catheterization	1-388	SCIP-Inf-9
Reasons to Extend Antibiotics	1-391	SCIP-Inf-3
Referral for Addictions Treatment	1-395	SUB-3
Referral for Outpatient Tobacco Cessation Counseling	1-397	TOB-3, TOB-4
Relievers Administered	1-399	CAC-1
Sample	1-401	Used in transmission of The Joint Commission's aggregate data file and the Hospital Clinical Data file
Sex	1-402	All Records
Statin Medication Prescribed at Discharge	1-403	AMI-10, STK-6
Surgery End Date	1-405	VTE-1
Surgery End Date – ICU Admission	1-407	VTE-2
Surgical Incision Date	1-409	SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3
Surgical Incision Time	1-411	SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3
Surgical Procedure	1-414	VTE-1
Surgical Procedure – ICU Admission	1-416	VTE-2
Systemic Corticosteroids Administered	1-418	CAC-2
Temperature	1-420	SCIP-Inf-10
Time Last Known Well	1-422	STK-4
Tobacco Use Status	1-424	TOB-1, TOB-2, TOB-3, TOB-4
Tobacco Use Status Post Discharge - Counseling	1-426	TOB-4
Tobacco Use Status Post Discharge - Medication	1-428	TOB-4
Tobacco Use Status Post Discharge – Quit Status	1-430	TOB-4
Tobacco Use Treatment FDA-Approved Cessation Medication	1-431	TOB-2
Tobacco Use Treatment Practical Counseling	1-432	TOB-2
Transfer From Another Hospital or ASC	1-434	AMI-7, AMI-7a, AMI-8, AMI-8a, PN-3a, PN-6, PN-6a, PN-6b
UFH Therapy Administration	1-436	VTE-4
Urinary Catheter	1-437	SCIP-Inf-9
Vancomycin	1-439	SCIP-Inf-2

Element Name	Page #	Collected For:
VTE Confirmed	1-442	VTE-3, VTE-4, VTE-5, VTE-6
VTE Diagnostic Test	1-444	VTE-3, VTE-4, VTE-5, VTE-6
VTE Present at Admission	1-446	VTE-6
VTE Prophylaxis	1-448	SCIP-VTE-2, STK-1, VTE-1
VTE Prophylaxis Date	1-451	STK-1, VTE-1
VTE Prophylaxis Status	1-453	VTE-6
VTE Timely	1-456	SCIP-VTE-2
Warfarin Administration	1-457	VTE-3
Warfarin Prescribed at Discharge	1-458	VTE-5

Data Element Name: *ACEI Prescribed at Discharge*

Collected For: The Joint Commission Only: AMI-3, HF-3; **CMS Voluntary Only:** AMI-3, HF-3

Definition: Documentation that an angiotensin converting enzyme inhibitor (ACEI) was prescribed at hospital discharge. ACEIs widen or dilate blood vessels, lowering blood pressure and making it easier for the heart to pump blood. They also inhibit the adverse effects of neurohormonal activation on the heart. These effects help reduce the risk of adverse outcomes such as death or hospitalization.

Suggested Data Collection Question: Was an angiotensin converting enzyme inhibitor (ACEI) prescribed at discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	ACEI prescribed at discharge.
N (No)	ACEI not prescribed at discharge, or unable to determine from medical record documentation.

Notes for Abstraction:

- In determining whether an ACEI was prescribed at discharge, it is not uncommon to see conflicting documentation amongst different medical record sources. For example, the discharge summary may list an ACEI that is not included in any of the other discharge medication sources (e.g., discharge orders). All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
  - In cases where there is an ACEI in one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select "Yes") unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge - **Consider it a discharge medication in the absence of contradictory documentation.**
  - If documentation is contradictory (e.g., physician noted “d/c Zestril” in the discharge orders, but Zestril is listed in the discharge summary’s discharge medication list), or after careful examination of circumstances, context, timing, etc., documentation raises enough questions, the case should be deemed “unable to determine” (select “No”).
  - Consider documentation of a hold on an ACEI after discharge in one location and a listing of that ACEI as a discharge medication in another location as contradictory ONLY if the timeframe on the hold is not **defined**

(e.g., “Hold Zestril”). Examples of a hold with a defined timeframe include “Hold captopril x2 days” and “Hold Quinaretic until after stress test.”

- If an ACEI is NOT listed as a discharge medication, and there is only documentation of a hold or plan to delay initiation/restarting of an ACEI after discharge (e.g., “Hold captopril x2 days,” “Start ACEI as outpatient,” “Hold Zestril”), select “No.”
- If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc.
  Examples:
  - Two discharge summaries, one dictated 5/22 (day of discharge) and one dictated 5/27 - Use the 5/27 discharge summary.
  - Two discharge medication reconciliation forms, one not dated and one dated 4/24 (day of discharge) - Use both.

- Disregard an ACEI medication documented only as a recommended medication for discharge (e.g., “Recommend sending patient home on Vasotec”). Documentation must be clearer that the ACEI was actually prescribed at discharge.
- Disregard documentation of ACEI prescribed at discharge when noted only by medication class (e.g., “ACEI Prescribed at Discharge: Yes” on a core measures form). The ACEI must be listed by name.

Suggested Data Sources:

- Discharge instruction sheet
- Discharge summary
- Medication reconciliation form
- Nursing discharge notes
- Physician orders sheet
- Transfer sheet

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 1.2 for a comprehensive list of ACEIs.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Admission Date*

Collected For: CMS/The Joint Commission: All Records

Definition: The month, day, and year of admission to acute inpatient care.

Suggested Data Collection Question: What is the date the patient was admitted to acute inpatient care?

Format:

Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)

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

Notes for Abstraction:

- The intent of this data element is to determine the date that the patient was actually admitted to acute inpatient care. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date from billing is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.
  If using claim information, the 'Statement Covers Period' is not synonymous with the 'Admission Date' and should not be used to abstract this data element. These are two distinctly different identifiers:
  - The Admission Date (Form Locator 12) is purely the date the patient was admitted as an inpatient to the facility.
  - The Statement Covers Period ("From" and "Through" dates in Form Locator 6) identifies the span of service dates included in a particular claim. The "From" Date is the earliest date of service on the claim.
- For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.
  Example:

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

- The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.
  Example:
  Preoperative Orders are dated as 04-06-20xx with an order to admit to Inpatient. Postoperative Orders, dated 05-01-20xx, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 05-01-20xx. The admission date would be abstracted as 05-01-20xx.
- If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.
- For newborns that are born within this hospital, the admission date would be the date the baby was born.

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

ONLY ALLOWABLE SOURCES
1. Physician orders
2. Face Sheet
3. UB-04, Field Location: 12

Excluded Data Sources
UB-04, Field Location: 06

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
- Admit to observation
- Arrival date

Data Element Name: *Alcohol or Drug Disorder*

Collected For: The Joint Commission Only: SUB-3, SUB-4; **CMS Informational Only:** SUB-3, SUB-4

Definition: Documentation in the medical record that the patient has an alcohol or drug use disorder. This documentation can be in the form of an ICD-9-CM code for alcohol or drug use disorder, or narrative documentation in which the physician or other qualified health professional explicitly documents alcohol or drug use disorder.

Suggested Data Collection Question: Is there documentation in the medical record that the patient has an alcohol or drug use disorder?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation in the medical record that the patient has an alcohol or drug use disorder.
N (No)	There is no documentation in the medical record that the patient has an alcohol or drug use disorder, or unable to determine from medical record documentation.

Notes for Abstraction:

- The abstractor should not try to determine if alcohol or drug abuse exists from documentation of symptoms. The health care provider must document explicitly that the patient has an alcohol or drug use disorder.
  For example, if documentation in the record indicates the patient has drink-seeking or drug seeking behavior or alcohol or drug tolerance, but does not specifically use the terminology “alcohol (or drug) disorder or dependent” or “suspect alcohol dependence,” select No.
- If the specific terms utilized in the inclusion notes below are used, select Yes.
- If an ICD-9-CM code for alcohol or drug disorder or dependence is documented, select Yes.

Suggested Data Sources:

- Coding records
- Consultation notes
- History and physical
- Physician progress notes
- Progress notes

Inclusion Guidelines for Abstraction:

- Alcohol or Drug dependent/dependence
  - Appears to have
  - Consider
  - Consistent with (C/W)
  - Diagnostic of
  - Evidence of
  - Indicative of
  - Likely
  - Most likely
  - Probable
  - Representative of
- Admission for Detoxification
- Delirium Tremens (DTs)
- Withdrawal syndrome
- See Appendix A code Table 13.1 for ICD-9-CM codes for Alcohol Disorders, and Table 13.2 for ICD-9-CM codes for Drug Use Disorders
- See Appendix A procedure code table 13.3 for procedures that would be administered to patients with alcohol or drug use disorders

Exclusion Guidelines for Abstraction:

- History of dependence
- Refer to Appendix H Table 2.6 for Qualifiers and Modifiers

Data Element Name: *Alcohol or Drug Use Status Post Discharge - Counseling*

Collected For: The Joint Commission: SUB-4; **CMS Informational Only:** SUB-4

Definition: This data element is used to determine if the patient with an alcohol or drug disorder or addiction is attending the referred addictions counseling. The referral may be to an addictions treatment program, to a mental health program or mental health specialist for follow-up for substance use or addiction treatment, or to a medical or health professional for follow-up for substance use or addiction. Follow-up contact to determine post-discharge status can be made with the patient anytime between the 7 and 30 day time frame specified by the measure.

Suggested Data Collection Question: Is the patient with an alcohol or drug disorder or addiction attending the referred addictions counseling post discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The patient was referred and is attending the referred addictions treatment.

2 The patient was referred and patient is not attending addictions treatment.

3 The patient was not referred to addictions treatment.

4 The patient refused to provide information relative to post discharge counseling attendance.

5 Not documented or unable to determine(UTD) from follow-up information collected.

Notes for Abstraction:

- If the first counseling session has not occurred at the time of the post discharge follow-up, and the patient intends to attend, select value 1.
- The counseling, medication, and use status information must relate to the follow-up contact date selected by the abstractor.
- If follow-up contact is made with the patient but no post discharge substance use status information is collected, select value 5 UTD.

Suggested Data Sources:

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

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Alcohol or Drug Use Status Post Discharge - Medication*

Collected For: The Joint Commission: SUB-4; **CMS Informational Only:** SUB-4

Definition: This data element is used to determine if the patient with an alcohol or drug disorder or addiction is taking the prescribed medication post discharge. Follow-up contact to determine post discharge substance use status can be made anytime between the 7and 30 day timeframe specified by the measure.

Suggested Data Collection Question: Is the patient with an alcohol or drug disorder or addiction taking the prescribed medication after discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The patient was given a prescription and is taking medication post discharge for an alcohol or drug use disorder as prescribed.

2 The patient was given a prescription and is not taking medication post discharge for an alcohol or drug use disorder as prescribed.

3 The patient was not given a prescription for medication to treat an alcohol or drug use disorder.

4 The patient refused to provide information relative to post discharge medication use.

5 Not documented or unable to determine(UTD) from follow-up information collected.

Notes for Abstraction:

- If the patient is contacted more than once during the 7 to 30 day time frame post discharge, select the value that corresponds to the compliance with medication use status obtained at the latest point in time.
- The counseling, medication, and use status information must relate to the follow-up contact date selected by the abstractor.
- If follow-up contact is made with the patient but no post discharge substance use status information is collected, select value 5 UTD.

Suggested Data Sources:

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

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Alcohol Use Status*

Collected For: The Joint Commission Only: SUB-1, SUB-2; **CMS Informational Only:** SUB-1, SUB-2

Definition: Documentation of the adult patient's alcohol use status using a validated screening questionnaire for unhealthy alcohol use within the first three days of admission. A validated screening questionnaire is an instrument that has been psychometrically tested for reliability (the ability of the instrument to produce consistent results), validity (the ability of the instrument to produce true results), and sensitivity (the probability of correctly identifying a patient with the condition). Validated screening questionnaires can be administered by pencil and paper, by computer or verbally. The screening questionnaire should be at a comprehension level or reading level appropriate for the patient population and in the appropriate language for non-English speaking patients.

An example of a validated questionnaire for alcohol screening is the 10 item Alcohol Use Disorder Identification Tests (AUDIT). The first three questions of the AUDIT, the AUDIT-C, ask about alcohol consumption, and can be used reliably and validly to identify unhealthy alcohol use. The four-item CAGE questionnaire is generally inappropriate for screening general populations, as it aims to identify only severely alcohol dependent patients.

Suggested Data Collection Question: What is the patient's alcohol use status?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

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

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

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

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

5 The patient refused the screen for alcohol use within the first three days of admission.

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

Notes for Abstraction:

- If patient has a blood alcohol test indicative of acute intoxication select value 2.
- Prescreening may be done for example with a single validated question in order to identify those patients with no risk or who do not drink. Further screening should be done on those patients who do drink to determine if there is need for intervention.
  Examples of single validated questions include:
  - Do you drink alcohol? If yes, a follow-up question applies:
    - How many times in the last month have you had 5 or more drinks on an occasion (for males) or four or more drinks on an occasion (for females)?
- 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.

Suggested Data Sources:

- Consultation notes
- Emergency Department record
- History and physical
- Nursing admission assessment
- Nursing admission notes
- Physician progress notes

Inclusion Guidelines for Abstraction:

Validated Screening Tools for Alcohol Use: This list is not ALL Inclusive

- AUDIT
- AUDIT-C
- ASSIST
- TWEAK
- CRAFFT
- MAST
- G-MAST

Exclusion Guidelines for Abstraction:

- CAGE

Data Element Name: *Alcohol Use Status Post Discharge – Quit Status*

Collected For: The Joint Commission: SUB-4; **CMS Informational Only:** SUB-4

Definition: This data element is used to determine the alcohol use status post discharge for patients with unhealthy alcohol use or an alcohol disorder or addiction. Follow-up contact with the patient to determine post discharge status can be made anytime between the 7 and 30 day time frame specified by the measure.

Suggested Data Collection Question: What is the status of the patient's alcohol use at the time of the post discharge follow-up contact?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The patient has quit or reduced their alcohol intake.

2 The patient has not quit or reduced their alcohol intake.

3 Not applicable, the patient does not use or does not have unhealthy alcohol use.

4 The patient refused to provide information relative to use status at the follow up contact.

5 Not documented or unable to determine(UTD) from follow-up information collected.

Notes for Abstraction:

- Quit is defined as not using drugs or alcohol in the previous 7 day timeframe.
- If the patient refuses to give information when contacted post discharge, select value 4.
- The counseling, medication, and use status information must relate to the follow-up contact date selected by the abstractor.
- If the patient did not screen positive for unhealthy alcohol use and alcohol use is not the substance of interest for follow up, select value 3.
- Select value 5 (UTD) if the patient was contacted post discharge and the patient was not questioned regarding their alcohol use post discharge.

Suggested Data Sources:

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

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Anesthesia End Date*

Collected For: CMS/The Joint Commission: SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-9, SCIP-Card-2, SCIP-VTE-2; **CMS Voluntary Only:** SCIP-Inf-10

Definition: The date the anesthesia for the principal procedure ended.

Suggested Data Collection Question: On what date did the anesthesia for the principal procedure end?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- If an anesthesia end date is not documented, use surrounding documentation to determine the date anesthesia ended.
  Example:
  The anesthesia start date is 10-01-20xx, the anesthesia start time is 2330 and the anesthesia end time is 0045. The *Anesthesia End Date* should be abstracted as 10-02-20xx because the date would change if the anesthesia ended after midnight.
- If the *Anesthesia End Date* cannot be determined from medical record documentation, enter UTD.
- The *Anesthesia End Date* occurs when the operative anesthesia provider signs-off the care of the patient to the person assuming the postoperative anesthesia care in the post-anesthesia care area, intensive care unit, or other non-PACU recovery area.
- If the *Anesthesia End Date* cannot be determined from medical record documentation, enter UTD. When the date documented is obviously invalid (not a valid format/range [12-39-20xx] or before the *Anesthesia Start Date*) **and** no other documentation can be found that provides the correct information, the abstractor should select “UTD.”
  Example:
  Patient expires on 02-12-20xx and documentation indicates the *Anesthesia End Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate, but no other documentation of the *Anesthesia*

End Date can be found. Since the *Anesthesia End Date* is outside of the parameter for care (after the *Discharge Date* [death]) and no other documentation is found, the abstractor should select "UTD."

- If the *Anesthesia End Date* is obviously incorrect (in error) but it is a valid date and the correct date can be supported with other documentation in the medical record, the correct date may be entered. If supporting documentation of the correct date cannot be found, the medical record must be abstracted as documented or at "face value."
  Examples:
  - The anesthesia form is dated 12-10-2007, but other documentation in the medical record supports that the correct date was 12-10-2009. Enter the correct date of 12-10-2009 as the *Anesthesia End Date.*
  - An *Anesthesia End Date* of 11-20-20xx is documented but the *Anesthesia Start Date* is documented as 11-10-20xx. Other documentation in the medical record supports the *Anesthesia Start Date* as being accurate. If no other documentation can be found to support another *Anesthesia End Date*, then it must be abstracted as 11-20-20xx because the date is not considered invalid or outside the parameter of care.

  Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *Anesthesia End Date* allows the case to be accepted into the warehouse.

Suggested Data Sources:
Note: The anesthesia record is the priority data source for this data element, if a valid *Anesthesia End Date* is found on the anesthesia record, use that date. If a valid date is not on the anesthesia record, other suggested data sources may be used in no particular order to determine the *Anesthesia End Date*.

Priority Source:
Anesthesia record

Other Suggested Sources:
- Circulator record
- Intraoperative record
- Operating room notes
- Post-anesthesia evaluation record

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Anesthesia End Time*

Collected For: CMS/The Joint Commission: SCIP-Inf-2, SCIP-Inf-3, SCIP-VTE-2;
CMS Voluntary Only: SCIP-Inf-10

Definition: The time the anesthesia ended for the principal procedure.

Suggested Data Collection Question: At what time did the anesthesia for the principal procedure end?

Format:

Length: 5 - HH:MM (with or without colon) or UTD
Type: Time
Occurs: 1

Allowable Values:

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight = 00:00	Noon = 12:00
5:31 am = 05:31	5:31 pm = 17:31
11:59 am = 11:59	11:59 pm = 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *Anesthesia End Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00, do not forget to change the *Anesthesia End Date.*
Example:
Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:

- For times that include “seconds,” remove the seconds and record the time as is.
  Example:
  15:00:35 would be recorded as 15:00
- The anesthesia end time is the time associated with the end of anesthesia for the principal procedure. If multiple procedures occur during the same surgical

episode as the principal procedure, the *Anesthesia End Time* will be the time associated with the end of anesthesia for the end of the surgical episode that included the principal procedure.

- The *Anesthesia End Time* occurs when the operative anesthesia provider signs-off the care of the patient to the person assuming the postoperative anesthesia care in the post-anesthesia care area, intensive care unit, or other non-PACU recovery area.
- If the *Anesthesia End Time* for the principal procedure cannot be determined from medical record documentation, enter "UTD." When the time documented is obviously invalid (not a valid format/range [26:33] or before *Anesthesia Start Time*), **and** no other documentation is found that provides the correct information, the abstractor should select "UTD."
  Example:
  Anesthesia End Time is documented as 11:00 and *Anesthesia Start Time* is documented as 11:10. Other documentation supports the *Anesthesia Start Time* as being accurate, but no other documentation of the *Anesthesia End Time* can be found. Since the *Anesthesia End Time* is outside of the parameter for care (before the *Anesthesia Start Time*) and no other documentation is found, the abstractor should select "UTD."
- If the *Anesthesia End Time* is obviously incorrect (in error) but it is a valid time and the correct time can be supported with other documentation in the medical record, the correct time may be entered. If supporting documentation of the correct time cannot be found, the medical record must be abstracted as documented or at "face value."
  Examples:
  - The *Anesthesia End Time* is documented as 12:00, but other documentation in the medical record supports the correct time as 22:00. Enter the correct time of 22:00 as the *Anesthesia End Time.*
  - An *Anesthesia End Time* of 11:58 is documented but the *Anesthesia Start Time* is documented as 11:57. If no other documentation can be found to support another *Anesthesia End Time*, then it must be abstracted as 11:58 because the time is not considered invalid or outside the parameter of care.

  Note: Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *Anesthesia End Time* allows the case to be accepted into the warehouse.
- If multiple procedures occur during the **same surgical episode**, the *Anesthesia End Time* captured will be the time associated with the anesthesia provider's sign-off after the surgical episode.
- If a patient leaves the operating room with an open incision (for closure at a later date/time), use the *Anesthesia End Time* of the principal procedure. Do NOT use the date/time the patient returns to the OR for closure.

Suggested Data Sources:
Note: The anesthesia record is the priority data source for this data element, if a valid *Anesthesia End Time* is found on the anesthesia record, use that time. If a valid time is

not on the anesthesia record, other suggested data sources may be used in no particular order to determine the *Anesthesia End Time*.

Priority Source:
Anesthesia record

Other Suggested Sources:
- Circulator record
- Intraoperative record
- Operating room notes
- Post-anesthesia evaluation record

Inclusion Guidelines for Abstraction:
Note: The anesthesia record is the priority data source.
1. Locate an inclusion term on the anesthesia record. If an inclusion term associated with a time is found on the anesthesia record, use that time. Use the latest time associated with an inclusion term that represents the *Anesthesia End Time*.
2. If an inclusion term associated with a time is not on the anesthesia record, other suggested data sources may be used in no particular order to locate an inclusion term. Use the latest time associated with an inclusion term that represents the *Anesthesia End Time*.
3. If no inclusion terms are found on any sources, beginning with the anesthesia record as the priority source, look for alternative terms associated with the anesthesia end time. If none are found, other forms can be used in no particular order. Abstract the latest time that represents the *Anesthesia End Time*.

- Anesthesia end
- Anesthesia finish
- Anesthesia stop

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Anesthesia Start Date*

Collected For: CMS/The Joint Commission: SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-4, SCIP-Inf-9, SCIP-Card-2, SCIP-VTE-2, VTE 2; **The Joint Commission Only:** SCIP-Inf-6; **CMS Voluntary Only:** SCIP-Inf-6, SCIP-Inf-10

Definition: The date the anesthesia for the procedure started.

Suggested Data Collection Question: On what date did the anesthesia for the procedure start?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- If an anesthesia start date is not documented use surrounding documentation to determine the date anesthesia started.
  Example:
  The anesthesia end date is 10-02-20xx, the anesthesia start time is 2330 and the anesthesia end time is 0045. The anesthesia start date should be abstracted as 10-01-20xx because it is obvious that the date would change if the anesthesia ended after midnight.
- If the date anesthesia started cannot be determined from medical record documentation, enter "UTD." When the date documented is obviously invalid (not a valid format/range [12-39-20xx] or before the anesthesia start date) and no other documentation can be found that provides the correct information, the abstractor should select "UTD."
  Example:
  Patient expires on 02-12-20xx and documentation indicates the anesthesia start date was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate, but no other documentation of the anesthesia start date can be found. Since the anesthesia start date is outside of the parameter for care (after the *Discharge Date* [death]) and no other documentation is found, the abstractor should select "UTD."
- If the anesthesia start date is an obvious error but it is a valid date and the correct date can be supported with other documentation in the medical record, the correct date may be entered. If supporting documentation of the correct date

cannot be found, the medical record must be abstracted as documented or at "face value."
Example:
The anesthesia form is dated 12-20-2008, but other documentation in the medical record supports that the correct date was 12-10-2009. Enter the correct date of 12-10-2009 as the *Anesthesia Start Date.*

- An *Anesthesia End Date* of 11-20-20xx is documented but the *Anesthesia Start Date* is documented as 11-10-20xx. Other documentation in the medical record supports the anesthesia start date as being accurate. If no other documentation can be found to support another *Anesthesia Start Date*, then it must be abstracted as 11-10-20xx because the date is not considered invalid or outside the parameter of care.
  Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for Anesthesia Start Date allows the case to be accepted into the warehouse.

SCIP: The *Anesthesia Start Date* is the date associated with the start of anesthesia for the surgical episode that includes the principal procedure. If a patient enters the operating room, but the surgery is canceled before incision and the principal procedure is performed on a later date, the *Anesthesia Start Date* is the date the principal procedure was actually performed.

Suggested Data Sources:
Note: The anesthesia record is the priority data source for this data element, if a valid *Anesthesia Start Date* is found on the anesthesia record, use that date. If a valid date is not on the anesthesia record, other suggested data sources may be used in no particular order to determine the *Anesthesia Start Date.*

Priority Source:
Anesthesia record

Other Suggested Sources:
- Circulator record
- Intraoperative record
- Operating room notes
- Post-anesthesia evaluation record

Inclusion Guidelines for Abstraction
None

Exclusion Guidelines for Abstraction
None

Data Element Name: *Anesthesia Start Time*

Collected For: CMS/The Joint Commission: SCIP-VTE-2; **CMS Voluntary Only:** SCIP-Inf-10

Definition: The time the anesthesia was initiated for the principal procedure.

Suggested Data Collection Question: At what time was the anesthesia initiated for the principal procedure?

Format:

Length: 5 - HH:MM (with or without colon) or UTD
Type: Time
Occurs: 1

Allowable Values:

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight - 00:00	Noon - 12:00
5:31 am - 05:31	5:31 pm - 17:31
11:59 am - 11:59	11:59 pm - 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *Anesthesia End Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00, do not forget to change the *Anesthesia End Date.*
Example:
Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx.

Notes for Abstraction:

- For times that include "seconds," remove the seconds and record the time as is.
  Example:
  15:00:35 would be recorded as 15:00.
- The *Anesthesia Start Time* is the time associated with the start of anesthesia for the principal procedure. If a patient enters the operating room, but the surgery is

canceled before incision and the principal procedure is performed at a later time, the *Anesthesia Start Time* is the time the principal procedure was actually performed.

- If the *Anesthesia Start Time* cannot be determined from medical record documentation, enter "UTD." When the time documented is obviously invalid (not a valid format/range [26:33] or after the *Anesthesia End Time)* **and** no other documentation is found that provides the correct information, the abstractor should select **"**UTD."
  Example:
  Anesthesia Start Time is documented as 14:00 and *Anesthesia End Time* is documented as 13:40. Other documentation in the medical record supports the *Anesthesia End Time* as being accurate, but no other documentation of the *Anesthesia Start Time* can be found. Since the *Anesthesia Start Time* is outside of the parameter for care (after the *Anesthesia End Time*) and no other documentation is found, the abstractor should select "UTD."
- If the *Anesthesia Start Time* is obviously incorrect (in error) but it is a valid time and the correct time can be supported with other documentation in the medical record, the correct time may be entered. If supporting documentation of the correct time cannot be found, the medical record must be abstracted as documented or at "face value."
  Examples:
  - The *Anesthesia Start Time* is documented as 12:00, but other documentation in the medical record supports the correct time as 22:00. Enter the correct time of 22:00 as the *Anesthesia Start Time.*
  - An *Anesthesia End Time* of 11:58 is documented but the *Anesthesia Start Time* is documented as 11:57. If no other documentation can be found to support another *Anesthesia Start Time*, then it must be abstracted as 11:57 because the time is not considered invalid or outside the parameter of care.

  Note: Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *Anesthesia Start Time* allows the case to be accepted into the warehouse.

Suggested Data Sources:
Note: The anesthesia record is the priority data source for this data element, if a valid *Anesthesia Start Time* is found on the anesthesia record, use that time. If a valid time is not on the anesthesia record, other suggested data sources may be used in no particular order to determine the *Anesthesia Start Time*.

Priority Source:
Anesthesia record

Other Suggested Sources:
- Circulator record
- Intraoperative record
- Operating room notes
- Post-anesthesia evaluation record

Inclusion Guidelines for Abstraction:
Note: The anesthesia record is the priority data source.

1. Locate an inclusion term on the anesthesia record. If an inclusion term associated with a time is found on the anesthesia record, use that time. Use the earliest time associated with an inclusion term that represents the *Anesthesia Start Time.*
2. If an inclusion term associated with a time is not on the anesthesia record, other suggested data sources may be used in no particular order to locate an inclusion term. Use the earliest time associated with an inclusion term that represents the *Anesthesia Start Time.*
3. If no inclusion terms are found on any sources, beginning with the anesthesia record as the priority source, look for alternative terms associated with the anesthesia start time. If none are found, other forms can be used in no particular order. Use the earliest time that represents the *Anesthesia Start Time.*

- Anesthesia start
- Anesthesia begin
- Anesthesia initiated

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Anesthesia Type*

Collected For: CMS Voluntary Only: SCIP-Inf-10

Definition: Documentation that the procedure was performed using general or neuraxial anesthesia. General anesthesia is used to achieve a state of drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. General anesthesia may be achieved using agents administered by any route. Neuraxial anesthesia is used to achieve the loss of pain sensation with the administration of medication into the epidural space or spinal canal.

Suggested Data Collection Question: Was there documentation that the procedure was performed using general or neuraxial anesthesia?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 There is documentation that the procedure was performed using general anesthesia.

2 There is documentation that the procedure was performed using neuraxial anesthesia.

3 There is documentation that the procedure was performed using **both** neuraxial and general anesthesia.

4 There is no documentation that the procedure was performed using either general or neuraxial anesthesia or unable to determine from the medical record documentation.

Notes for Abstraction:

- If there is documentation that the case was converted from a different type of anesthesia, such as a MAC, to a general or neuraxial anesthesia, select the appropriate value from the choices provided.
- If an attempt to use neuraxial anesthesia was unsuccessful and general anesthesia was used, select “3” because both methods were documented.
- If a general anesthesia is used **and** an epidural catheter is placed preoperatively or up to 24 hours after *Anesthesia End Time* for anesthesia or other reasons such as for postoperative pain control, select “3.”
- If an epidural catheter is placed preoperatively or up to 24 hours after *Anesthesia End Time* for anesthesia or other reasons such as for postoperative pain control, select “2.”

Suggested Data Sources:

- Anesthesia record
- Intraoperative Record
- Operative note
- PACU/recovery room record
- Procedure note

Inclusion Guidelines for Abstraction:

- General Anesthesia
  - Inhaled anesthetic gases
  - Endotracheal
  - Laryngeal mask airway or anesthesia (LMA)
  - Total Intravenous Anesthesia (TIVA)
- Neuraxial Anesthesia
  - Spinal block
  - Epidural block
  - Spinal anesthesia
  - Subarachnoid blocks

Exclusion Guidelines for Abstraction:

- Conscious sedation
- Deep sedation
- Local with sedation
- Local with stand-by
- Monitored anesthesia care (MAC)
- Paravertebral blocks
- Peripheral nerve blocks
- Saddle block

Data Element Name: *Another Source of Infection*

Collected For: CMS Only: PN-6; **The Joint Commission Only:** PN-6a, PN-6b

Definition: There was another suspected or identified bacterial infection in addition to pneumonia within 24 hours after arrival. For the purposes of this data element, an infection/suspected infection includes any of the following:

1) Physician/APN/PA documentation of a named bacterial infection outside of the respiratory tract OR of an identified pathogen that is documented as currently present.
2) Suspicion or known infection with *Francisella tularensis* (tularemia) or *Yersinia pestis* (pneumonic plague) documented by a Physician/APN/PA.
3) Lab results ONLY from the following positive diagnostic tests and pathogens:
   - Positive culture (blood, urine, sputum, wound, etc.) for bacteria
   - Positive urinary antigen test for *Streptococcus pneumoniae* or *Legionella pneumophilia*
   - Positive Polymerase Chain Reaction (PCR) test for *Legionella pneumophilia*

Suggested Data Collection Question: Was there another source of bacterial infection in addition to pneumonia within 24 hours after arrival?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 There was another source of bacterial infection in addition to pneumonia within 24 hours after arrival.

2 There was documentation of *Francisella tularensis* (tularemia) or *Yersinia pestis* (pneumonic plague) in addition to pneumonia within 24 hours after arrival.

3 There was no other source of bacterial infection within 24 hours after arrival or unable to determine from medical record documentation.

Notes for Abstraction:

- If both values 1 and 2 apply, select value "1."
- This data element will accept both "suspected" infections and "diagnosed" infections.
  Examples:
  - In the ED, after arrival, there is Physician Assistant documentation that she suspects the patient has a UTI, select value "1."

- Advanced Practice Nurse documents “suspect sepsis from decubitus ulcer,” select value “1.”

- There must be documentation of an infection/suspected infection, other than pneumonia, within 24 hours after arrival in order to select value “1” for this data element.
- Only consider infections/suspected infections that are being/will be treated by an ANTIBIOTIC listed in Appendix C, Table 2.1, that are administered via routes PO, IM or IV. There does not need to be documentation that ties the antibiotic to the infection/suspected infection, as one antibiotic may cover multiple infections.
- If the medical record contains documentation of a positive culture performed anytime within a week prior to arrival, select value “1.”
- If there is physician/APN/PA documentation of a known pathogen, select value “1.” The specific pathogen must be named and documented as currently present. Suspicion of or a history of a pathogen is not acceptable.
- Documentation of signs or symptoms (e.g., fever, elevated white blood cells, etc.) should not be considered infections unless documented as an infection or possible/suspected infection.
  Examples:
  - Do not assume a bacterial infection if a wound/surgical site is described as reddened, swollen, and hot, as other conditions can also cause these symptoms.
  - Do not assume a bacterial infection if there is only documentation with the suffix “itis.”
    Example:
    Physician documents patient has cystitis but there is no documentation of UTI, bladder infection or antibiotic treatment ordered for the cystitis, select value “3.”
  - If a condition can be either inflammation or an infection, there must be documentation that supports the condition is a bacterial infection.
    Example:
    Pericarditis without documentation of a bacterial infection, select value “3.”
- If a culture is drawn prior to arrival or within 24 hours after arrival but results (final or preliminary) documenting a pathogen are not available within 24 hours after arrival, select value “3.”
- Gram stain results alone are not acceptable.
  Example:
  Sputum reveals gram positive cocci, select value “3.”

Suggested Data Sources:
PHYSICIAN/ADVANCED PRACTICE NURSE/PHYSICIAN ASSISTANT DOCUMENTATION ONLY

- Admit notes
- Admitting physician orders
- Consult notes
- ED records
- History and physical
- Physician admitting note
- Physician’s notes

- Physician orders
- Progress notes

Other Suggested Data Sources:
- Lab results

Inclusion Guidelines for Abstraction:
- Abscess outside of the lung
- Bubonic plague
- Deerfly fever
- *Francisella tularensis*
- Infected skin ulcer
- Ohara disease
- Ohara fever
- Osteomyelitis or septic joint (infective arthritis)
- Pahvant Valley Plague
- Pneumonic plague
- Rabbit fever
- Septicemic plague
- Urinary Tract infection
- *Yersinia pestis*

Exclusion Guidelines for Abstraction:
- Any infection in the Respiratory Tract (sinusitis, laryngitis, bronchitis, pleurisy, other lung infections) with the exception of Tularemia and Pneumonic Plague
- Any yeast, viral or fungal infections
- Bacteremia or blood stream infections (unless there is another infection outside of the Respiratory Tract or at the time of arrival, patient has a central intravenous catheter [e.g., Hickman catheter, PICC line, Infusaport, etc.])
- Gram stain results. Examples: gram stain, positive cocci, gram negative rods, normal flora
- Sepsis (unless there is another infection outside of the Respiratory Tract) with the exception of Septicemic Plague
- Standing orders used to screen a population of patients or ALL patients
- Systemic Inflammatory Response Syndrome (SIRS)
- Tests performed with no mention of a pathogen within 24 hours after arrival

Data Element Name: *Antibiotic Administration Date*

Collected For: CMS/The Joint Commission: SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3; **CMS Only:** PN-6; **The Joint Commission Only:** PN-6a, PN-6b; **CMS Voluntary Only:** PN-3b

Definition: The date the antibiotic dose(s) was administered after hospital arrival and within the specified timeframe.

PN: Only abstract: from arrival through 24 hours after hospital arrival.

SCIP-Inf: Only abstract: from hospital arrival through the first 48 hours (72 hours for **CABG or Other Cardiac Surgery)** after *Anesthesia End Time*.

Suggested Data Collection Question: What was the date the antibiotic dose(s) were administered after hospital arrival and within the specified timeframe?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 75

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- For EACH specific antibiotic name collected, enter an antibiotic administration date. If the date is missing for a dose, the dose must be collected using “UTD” for the missing data.
- Do not abstract antibiotic administration information for a specific antibiotic dose from more than one data source.
  Example:
  The date on the MAR for an antibiotic cannot be used as the date for a dose of that same antibiotic on another form.
- If there are two or more entries representing the same antibiotic dose, do not abstract it more than once if the name, date and time are identical and only the route is missing.
- Antibiotic administration information should only be abstracted from documentation that demonstrates actual administration of the specific antibiotic.
  Examples:
  - Do not abstract doses from a physician order unless they are clearly designated as given on the physician order form.

- Do not collect antibiotics documented on the operative report unless the surgeon states that the surgeon actually administered the dose.

- If an ED form has a stamp or sticker on each page that contains the date, this may be abstracted for the date for ED documentation only. If this is not the case, utilize "UTD" for the missing date.
- The medical record must be abstracted as documented (taken at "face value"). When the documented date is an invalid date (not a valid format/range or outside of the parameter of care) **and** no other documentation is found on that same source that provides this information, the abstractor should select "UTD."
  Examples:
  - The date for a dose of antibiotic was documented as 02-42-20xx and no other documentation on that same source provides a valid date. The date for the dose is outside of the range of the allowable values and must be abstracted as "UTD."
  - The patient is discharged on 02-12-20xx and date for the dose of antibiotic was documented as 03-12-20xx. The date for antibiotic dose is outside of the parameter of care and must be abstracted as "UTD."
- If a valid date for an antibiotic dose is an obvious error (in error) and the correct date can be found on the same source, the correct date may be entered. If the correct date cannot be found on that same source, the date must be abstracted as UTD. If the date of the dose (at face value) is prior to arrival, it should be considered when abstracting the data element*, Antibiotic Received.*
  Example:
  The anesthesia form is dated 12-10-2009, but other documentation on that same source supports that the correct date was 12-10-2010. Enter the correct date of 12-10-2010.
- A dose can be abstracted that is given by one person and documented as being given by another person if that dose is not documented by the person that actually administered it.
  Example:
  OR nurse, S. Smith RN, documents, "Cefazolin 1 gm IV given at 0500 per J Doe RN." This dose can be abstracted as given if not documented by the person that gave the dose.
- Only abstract from an undated MAR if it has a patient sticker on it and it is titled first day or initial MAR. If an undated MAR is designated as the initial or first day MAR and it does not have a patient sticker on it, use UTD for the date.
- Authentication on one side/page of a multi-side or multi-page form applies to all pages of the form. The sides/pages of the form must be identifiable as being from the same form.
- The method of designation of administration on hand-written or pre-printed forms such as MARs or eMARs, with pre-printed scheduled times for administration, must be clearly designated as given. The methods may vary. Whatever method is used, it must be clear that the dose was administered.

For PN:

- Document the name of each antibiotic administered PO, IV, IM and UTD **during the first 24 hours** after hospital arrival.

- If an antibiotic is administered more than once by the same route **during the first 24 hours** after hospital arrival, only record the antibiotic name once. Enter the first administration date, time and route associated with each antibiotic name.
- In the ED any narrative documentation of an antibiotic being administered may be abstracted. This includes antibiotics that are hung, infusing, infused, etc. However, outside the ED, narrative documentation can ONLY be abstracted if it is the ONLY documentation of a specific antibiotic found in the medical record.
- Statements such as "Ancef given in ED" or "Antibiotic given per MAR" should not be abstracted as they do not demonstrate an antibiotic was given at this time.
- If the patient is on IV antibiotics when they arrive at the hospital collect the antibiotic name and route and use *Arrival Date* and *Arrival Time* as the date and time of antibiotic administration.

For SCIP-Inf:

- Do not abstract test doses of antibiotics.
- Do not abstract antibiotics from sources that do not represent actual administration.
  Examples that ***do not*** represent actual administration:
  Pre-Op Checklist states:
  X IV Started at 1730
  X Preop Antibiotic Given at 1800
  X Lab on Chart
  Operative report states:
  IV antibiotics were given prior to procedure.
- Do not abstract antibiotics from narrative charting unless there is no other documentation that reflects that the same antibiotic was given during the specified timeframe.
  Example:
  Narrative states: "Ancef 1 gram given IV prior to incision." No other doses of Ancef are documented. The dose in the narrative should be abstracted using UTD for missing data.
- **3-Dose Method:**
  Collect three doses (or less) of each antibiotic administered from hospital arrival through the first 48 hours (72 hours for CABG or Other Cardiac Surgery) after *Anesthesia End Time.*
  First: Abstract the first dose of each specific antibiotic administered.
  Second: Abstract the dose of each specific antibiotic administered prior to *and* closest to *Surgical Incision Time*.
  Third: Abstract the last dose of each specific antibiotic administered within 48 hours (72 hours for CABG or Other Cardiac Surgery) after *Anesthesia End Time*.
  Example:
  Arrival time and date were 07:00 on 04-02-20xx
  Surgical Incision Time was 12:00. *Anesthesia End Time* was 14:00.
  Cefazolin was administered at 08:00, 10:00, 15:30, 17:00, and 19:00 on 04-02-20xx.
  Abstract:
  First dose: Cefazolin 08:00 4-02-20xx IV

Second dose: Cefazolin 10:00 4-02-20xx IV
Last dose: Cefazolin 19:00 4-02-20xx IV

Suggested Data Sources:

- Anesthesia record
- Emergency Department record
- ICU flow sheet
- IV flow sheet
- Medication administration record (MAR)
- Operating room record
- PACU/recovery room record
- Perfusion record

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Antibiotic Administration Route*

Collected For: CMS/The Joint Commission: SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3; **CMS Only:** PN-6; **The Joint Commission Only:** PN-6a, PN-6b; CMS Voluntary Only: PN-3b

Definition: The route of the antibiotic dose(s) administered after hospital arrival and within the specified timeframe.

PN: Only abstract doses from arrival through 24 hours after hospital arrival.

SCIP-Inf: Only abstract doses from hospital arrival through the first 48 hours (72 hours for **CABG or Other Cardiac Surgery)** after *Anesthesia End Time*.

Suggested Data Collection Question: What is the route of the antibiotic dose(s) administered after hospital arrival and within the specified timeframe?

Format:

Length: 2
Type: Alphanumeric
Occurs: 75

Allowable Values:

1 PO/NG/PEG tube (Oral)

2 IV (Intravenous)

3 IM (Intramuscular)

10 UTD

Notes for Abstraction:

- For EACH specific antibiotic name collected, enter an antibiotic administration route, date, and time. If the route is missing for a dose, the dose must be collected using “UTD” for the missing data.
- If there are two or more entries representing the same antibiotic dose, do not abstract it more than once if the name, date and time are identical and only the route is missing.
- Do not abstract antibiotic administration information for a specific antibiotic dose from more than one data source. A specific antibiotic dose is defined as having a single trade or generic name and being administered via a single appropriate route.
  Example:
  The route on the MAR for an antibiotic cannot be used as the route for a dose of that same antibiotic on another form.
- If the administration route of an antibiotic dose changes during the hospital stay, abstract the antibiotic dose for each route by which it was administered.

Example:
Clindamycin doses given PO and clindamycin doses given IV should be abstracted individually.

- Antibiotic administration information should only be abstracted from documentation that demonstrates actual administration of the specific antibiotic.
  Examples:
  - Do not abstract doses from a physician order unless they are clearly designated as given on the physician order form.
  - Do not collect antibiotics documented on the operative report unless the surgeon states that the surgeon actually administered the dose.
- A dose can be abstracted that is given by one person and be documented as being given by another person if that dose is not documented by the person that actually administered it.
  Example:
  OR nurse, S. Smith RN, documents, "Cefazolin 1 gm IV given at 0500 per J Doe RN." This dose can be abstracted as given if not documented by the person that gave the dose.
- Only abstract from an undated MAR if it has a patient sticker on it and it is titled first day or initial MAR. If an undated MAR is designated as the initial or first day MAR and it does not have a patient sticker on it, use UTD for the date.
- Authentication on one side/page of a multi-side or multi-page form applies to all pages of the form. The sides/pages of the form must be identifiable as being from the same form.
- The method of designation of administration on hand-written or pre-printed forms such as MARs or eMARs, with pre-printed scheduled times for administration, must be clearly designated as given. The methods may vary. Whatever method is used, it must be clear that the dose was administered.

For PN:

- Document the name of each antibiotic administered PO, IV, IM and UTD **during the first 24 hours** after hospital arrival.
- If an antibiotic is administered more than once by the same route **during the first 24 hours** after hospital arrival, only record the antibiotic name once. Enter the first administration date, time and route associated with each antibiotic name.
- In the ED any narrative documentation of an antibiotic being administered may be abstracted. This includes antibiotics that are hung, infusing, infused, etc. However, outside the ED, narrative documentation can ONLY be abstracted if it is the ONLY documentation of a specific antibiotic found in the medical record.
- Statements such as "Ancef given in ED" or "Antibiotic given per MAR" should not be abstracted as they do not demonstrate an antibiotic was given at this time.

For SCIP-Inf:

- Do not abstract test doses of antibiotics.
- Do not abstract antibiotics from sources that do not represent actual administration.
  Examples that ***do not*** represent actual administration:

Pre-Op Checklist states:
X IV Started at 1730
X Preop Antibiotic Given at 1800
X Lab on Chart
Operative report states: IV antibiotics were given prior to procedure.

- Do not abstract antibiotics from narrative charting unless there is no other documentation that reflects that the same antibiotic was given during the specified timeframe.
  Example:
  Narrative states: "Ancef 1 gram given IV prior to incision." No other doses of Ancef are documented. The dose in the narrative should be abstracted using UTD for missing data.
- **3-Dose Method:**
  Collect three doses (or less) of each antibiotic administered from hospital arrival through the first 48 hours (72 hours for CABG or Other Cardiac Surgery) after *Anesthesia End Time.*
  First: Abstract the first dose of each specific antibiotic administered.
  Second: Abstract the dose of each specific antibiotic administered prior to *and* closest to *Surgical Incision Time*.
  Third: Abstract the last dose of each specific antibiotic administered within 48 hours (72 hours for CABG or Other Cardiac Surgery) after *Anesthesia End Time*.
  Example:
  Arrival time and date were 07:00 on 04-02-20xx
  Surgical Incision Time was 12:00. *Anesthesia End Time* was 14:00.
  Cefazolin was administered at 08:00, 10:00, 15:30, 17:00, and 19:00 on 04-02-20xx.
  Abstract:
  First dose: Cefazolin 08:00 4-02-20xx IV
  Second dose: Cefazolin 10:00 4-02-20xx IV
  Last dose: Cefazolin 19:00 4-02-20xx IV

Suggested Data Sources:

- Anesthesia record
- Emergency Department record
- ICU flow sheet
- IV flow sheet
- Medication administration record (MAR)
- Operating room record
- PACU/recovery room record
- Perfusion record

Inclusion Guidelines for Abstraction: This list is all inclusive
Include any antibiotics given:
Intravenous:

- Intravenous
- IV bolus
- IV infusion

- IV
- I.V.
- IVP
- IVPB
- IV piggyback
- IV push

PO/NG/PEG tube:
- Feeding tube (e.g., percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy, gastrostomy tube)
- By mouth
- Oral
- Gastric tube
- G-tube
- Jejunostomy
- J-tube
- Nasogastric tube
- PO
- P.O.

Intramuscular:
- Intramuscular
- IM
- I.M.
- IM per Z-track

Exclusion Guidelines for Abstraction:
All terms other than those on the Inclusion list

Data Element Name: *Antibiotic Administration Time*

Collected For: CMS/The Joint Commission: SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3; **CMS Only:** PN-6; **The Joint Commission Only:** PN-6a, PN-6b; **CMS Voluntary Only:** PN-3b

Definition: The time the antibiotic dose(s) was administered after hospital arrival and within the specified timeframe.

PN: Only abstract doses from arrival through 24 hours after hospital arrival.

SCIP-Inf: Only abstract doses from hospital arrival through the first 48 hours (72 hours for **CABG or Other Cardiac Surgery)** after *Anesthesia End Time*.

Suggested Data Collection Question: What time was the antibiotic dose(s) administered after hospital arrival and within the specified timeframe?

Format:

Length: 5 – HH:MM (with or without colon) or UTD
Type: Time
Occurs: 75

Allowable Values:

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.

With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required.
- If the time is in the p.m., add 12 to the clock time hour.

Examples:

Midnight - 00:00	Noon - 12:00
5:31 am - 05:31	5:31 pm - 17:31
11:59 am - 11:59	11:59 pm - 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *Antibiotic Administration Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00 do not forget to change the *Antibiotic Administration Date.*
Example:
Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:

- For EACH specific antibiotic name collected, enter an antibiotic administration time. If the time is missing for a dose, the dose must be collected using "UTD" for the missing data.
- Do not abstract antibiotic administration information for a specific antibiotic dose from more than one data source. A specific antibiotic dose is defined as having a single generic name and being administered during the specified timeframe.
  Example:
  The time on the MAR for an antibiotic cannot be used as the time for a dose of that same antibiotic on another form.
- For times that include "seconds," remove the seconds prior to recording the time.
  Example:
  15:00:35 would be recorded as 15:00
- The use of "hang time" or "infusion time" is acceptable as antibiotic administration time when other documentation cannot be found.
- The medical record must be abstracted as documented (taken at "face value"). When the time documented is an invalid time (not a valid format/range or outside of the parameter of care) **and** no other documentation is found on that same source that provides this information, the abstractor should select "UTD."
  Examples:
  - The time for a dose of antibiotic was documented as 2700 and no other documentation on that same source provides a valid time. The time for the dose is not a valid format/range and must be abstracted as "UTD."
  - The patient is discharged at 1200 and the time for the dose of antibiotic was documented as 1430 on the same date. The time for antibiotic dose is outside of the parameter of care and must be abstracted as "UTD."
- If a valid time for an antibiotic dose is an obvious error (in error) and the correct time can be found on the same source, the correct time may be entered. If the correct time cannot be found on that same source, the time must be abstracted as "UTD."
  Examples:
  - The time for an antibiotic dose is timed at 630, but other documentation on that same source supports that the correct time was 1830. Enter the correct time of 1830.
  - An arrival time of 0600 is documented but the administration time is documented as 0545 for the same date. That dose cannot be abstracted as given during the hospital stay but should be used to abstract *Antibiotic Received,* if applicable.
- If there are two or more entries representing the same antibiotic dose, do not abstract it more than once if the name, date and time are identical and only the route is missing.
- Antibiotic administration information should only be abstracted from documentation that demonstrates actual administration of the specific antibiotic.
  Examples:
  - Do not abstract doses from a physician order unless they are clearly designated as given on the physician order form.

- Do not collect antibiotics documented on the operative report unless the surgeon states that the surgeon actually administered the dose.

- A dose can be abstracted that is given by one person and documented as being given by another person if that dose is not documented by the person that actually administered it.
  Example:
  OR nurse, S. Smith RN, documents, “Cefazolin 1 gm IV given at 0500 per J Doe RN.” This dose can be abstracted as given if not documented by the person that gave the dose.
- Only abstract from an undated MAR if it has a patient sticker on it and it is titled first day or initial MAR. If an undated MAR is designated as the initial or first day MAR and it does not have a patient sticker on it, use UTD for the date.
- Authentication on one side/page of a multi-side or multi-page form applies to all pages of the form. The sides/pages of the form must be identifiable as being from the same form.
- The method of designation of administration on hand-written or pre-printed forms such as MARs or eMARs, with pre-printed scheduled times for administration, must be clearly designated as given. The methods may vary. Whatever method is used, it must be clear that the dose was administered.

For PN:

- Document the name of each antibiotic administered PO, IV, IM and UTD **during the first 24 hours** after hospital arrival.
- If an antibiotic is administered more than once by the same route **during the first 24 hours** after hospital arrival, only record the antibiotic name once. Enter the first administration date, time and route associated with each antibiotic name.
- In the ED any narrative documentation of an antibiotic being administered may be abstracted. This includes antibiotics that are hung, infusing, infused, etc. However, outside the ED, narrative documentation can ONLY be abstracted if it is the ONLY documentation of a specific antibiotic found in the medical record.
- Statements such as “Ancef given in ED” or “Antibiotic given per MAR” should not be abstracted as they do not demonstrate an antibiotic was given at this time.
- If the patient is on IV antibiotics when they arrive at the hospital collect the antibiotic name and route and use *Arrival Date* and *Arrival Time* as the date and time of antibiotic administration.

For SCIP-Inf:

- Do not abstract test doses of antibiotics.
- When collecting the time for an antibiotic administered via infusion (IV) the *Antibiotic Administration Time* refers to the time the antibiotic infusion was started.
- If there is documentation of an exact administration time in a non-grid area and it is apparent that a dose on a grid represents that same dose, abstract the non-grid time for the dose.
  Example:
  Ancef is entered on the grid between 0700 and 0715 and Ancef is entered in the medication given area at 0705, use 0705 for the *Antibiotic Administration Time*.

Note: If grid times are used, follow the instructions in the General Abstraction Guidelines for reading grids.

- Do not abstract antibiotics from narrative charting unless there is no other documentation that reflects that the same antibiotic was given during the specified timeframe.
  Example:
  Narrative states: “Ancef 1 gram given IV prior to incision.” No other doses of Ancef are documented. The dose in the narrative should be abstracted using UTD for missing data.
- **3-Dose Method:**
  Collect three doses (or less) of each antibiotic administered from hospital arrival through the first 48 hours (72 hours for CABG or Other Cardiac Surgery**)** after *Anesthesia End Time.*
  First: Abstract the first dose of each specific antibiotic administered.
  Second: Abstract the dose of each specific antibiotic administered prior to *and* closest to *Surgical Incision Time*.
  Third: Abstract the last dose of each specific antibiotic administered through the first 48 hours (72 hours for CABG or Other Cardiac Surgery.)
  Example:
  Arrival time and date were 07:00 on 04-02-20xx
  Surgical Incision Time was 12:00. *Anesthesia End Time* was 14:00.
  Cefazolin was administered at 08:00, 10:00, 15:30, 17:00, and 19:00 on 04-02-20xx.
  Abstract:
  First dose: Cefazolin 08:00 4-02-20xx IV
  Second dose: Cefazolin 10:00 4-02-20xx IV
  Last dose: Cefazolin 19:00 4-02-20xx IV

Suggested Data Sources:

- Anesthesia record
- Emergency Department record
- ICU flow sheet
- IV flow sheet
- Medication administration record (MAR)
- Operating room record
- PACU/recovery room record
- Perfusion record

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Antibiotic Allergy*

Collected For: CMS/The Joint Commission: SCIP-Inf-2; **CMS Only:** PN-6; **The Joint Commission Only:** PN-6a, PN-6b

Definition: Documentation that the patient has an allergy, sensitivity, or intolerance to penicillin, beta lactams, or cephalosporins. An allergy can be defined as an acquired, abnormal immune response to a substance (allergen) that does not normally cause a reaction.

Suggested Data Collection Question: Did the patient have any allergies, sensitivities or intolerance to beta-lactam/penicillin antibiotic or cephalosporin medications?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Documentation that the patient has an antibiotic allergy to beta-lactam, penicillin, or cephalosporins (e.g., either history or current finding).
N (No)	No documentation that the patient had an allergy to beta-lactam, penicillin, or cephalosporins or unable to determine from medical record documentation.

Notes for Abstraction:

- If the patient was noted to be allergic to “cillins,” “penicillin,” or “all cillins,” select “Yes.”
- If one source in the record documents “Allergies: penicillin” and another source in the record documents “penicillin causes upset stomach” or other intolerance to one of these medications, select “Yes.”

Suggested Data Sources:

- Consultation notes
- Emergency Department record
- History and physical
- ICU flowsheets
- Medication administration record
- Nursing admission assessment
- Nursing notes
- Physician orders
- Progress notes

For SCIP-Inf, in addition to the above suggested data sources, the following may also be utilized:

- Anesthesia record
- Operating room notes
- PACU/recovery room record
- Pre-anesthesia assessment

Inclusion Guidelines for Abstraction:
Symptoms include:

- Adverse drug event
- Adverse effect
- Adverse reaction
- Anaphylaxis
- Anaphylactic reaction
- Hives
- Rash

Refer to Appendix C, Table 4.0, Antibiotic Allergy Table.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Antibiotic Name*

Collected For: CMS/The Joint Commission: SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3; **CMS Only:** PN-6; **The Joint Commission Only:** PN-6a, PN-6b; **CMS Voluntary Only:** PN-3b

Definition: The name of the antibiotic dose(s) administered after hospital arrival and within the specified timeframe.

PN: Only abstract: doses from arrival through 24 hours after hospital arrival.

SCIP-Inf: Only abstract: doses from hospital arrival through the first 48 hours (72 hours for **CABG or Other Cardiac Surgery)** after *Anesthesia End Time*.

Suggested Data Collection Question: What is the name of the antibiotic dose(s) administered after hospital arrival and within the specified timeframe?

Format:

Length: 244
Type: Alphanumeric
Occurs: 75

Allowable Values: Name of any antibiotic - see Appendix C, Table 2.1 *Antimicrobial Medications* for a comprehensive list.

Notes for Abstraction:

- A crosswalk is provided in Appendix C, Table 2.1 with names of antibiotics including trade and generic names**.** Do not consider any medications other than antibiotics (e.g., antivirals, antifungals, antituberculins, antiprotozoans, etc.).
- For EACH specific antibiotic name collected, enter an antibiotic administration route, date and time. If all information for the antibiotic route, date and time is not contained in a single data source for that specific antibiotic, utilize “UTD” for the missing information.
- If there are two or more entries representing the same antibiotic dose, do not abstract it more than once if the name, date and time are identical and only the route is missing.
- Only use “Antibiotic NOS” in the following situations:
  - For new antibiotics that are not yet listed in Table 2.1.
  - When the *Antibiotic Name* is missing or if there is documentation that a medication was administered and it cannot be determined what the name of the medication is. It must be apparent that the medication is an antibiotic.
- Abbreviations or minor misspellings in an antibiotic name can be overlooked as long as the abbreviated name/spelling error is readily recognizable or if it can be determined using supporting documentation from the same source as that antibiotic dose.

Example:
Ansef would be abstracted as Ancef.

- If the administration route of an antibiotic dose changes during the hospital stay, record the antibiotic name for each route by which it was administered.
  Example:
  Clindamycin doses given PO and clindamycin doses given IV should be abstracted individually.
- Antibiotic administration information should only be abstracted from documentation that demonstrates actual administration of the specific antibiotic.
  Examples:
  - Do not abstract doses from a physician order unless they are clearly designated as given on the physician order form.
  - Do not collect antibiotics documented on the operative report unless the surgeon states that the surgeon actually administered the dose.
- A dose can be abstracted that is given by one person and documented as being given by another person if that dose is not documented by the person that actually administered it.
  Example:
  OR nurse, S. Smith RN, documents, “Cefazolin 1 gm IV given at 0500 per J Doe RN.” This dose can be abstracted as given if not documented by the person that gave the dose.
- Only abstract from an undated MAR if it has a patient sticker on it and it is titled first day or initial MAR. If an undated MAR designated as the initial or first day MAR and does not have a patient sticker on it, use UTD for the date.
- Authentication on one side/page of a multi-side or multi-page form applies to all pages of the form. The sides/pages of the form must be identifiable as being from the same form.
- The method of designation of administration on hand-written or pre-printed forms such as MARs or eMARs, with pre-printed scheduled times for administration, must be clearly designated as given. The methods may vary. Whatever method is used, it must be clear that the dose was administered.

For PN:

- Document the name of each antibiotic administered PO, IV, IM and UTD **during the first 24 hours** after hospital arrival.
- If an antibiotic is administered more than once by the same route **during the first 24 hours** after hospital arrival, only record the antibiotic name once. Enter the first administration date, time and route associated with each antibiotic name.
- In the ED any narrative documentation of an antibiotic being administered may be abstracted. This includes antibiotics that are hung, infusing, infused, etc. However, outside the ED, narrative documentation can ONLY be abstracted if it is the ONLY documentation of a specific antibiotic found in the medical record.
- Statements such as “Ancef given in ED” or “Antibiotic given per MAR” should not be abstracted as they do not demonstrate an antibiotic was given at this time.

For SCIP-Inf:

- Do not abstract test doses of antibiotics.

- If there is documentation of an exact administration time in a non-grid area and it is apparent that a dose on a grid represents that same dose, abstract the non-grid time for the dose.
  Example: Ancef is entered on the grid between 0700 and 0715 and Ancef is entered in the medication given area at 0705, use 0705 for the *Antibiotic Administration Time*. Note: If grid times are used, follow the instructions in the General Abstraction Guidelines for reading grids.
- Do not abstract antibiotics from sources that do not represent actual administration.
  Examples that ***do not*** represent actual administration:
  Pre-Op Checklist states:
  X IV Started at 1730
  X Preop Antibiotic Given at 1800
  X Lab on Chart
  Operative report states:
  IV antibiotics were given prior to procedure.
- Do not abstract antibiotics from narrative charting unless there is no other documentation that reflects that the same antibiotic was given during the specified timeframe for SCIP.
  Example:
  Narrative states: "Ancef 1 gram given IV prior to incision." No other doses of Ancef are documented. The dose in the narrative should be abstracted using UTD for missing data.
- **3-Dose Method:**
  Collect three doses (or less) of each antibiotic administered from hospital arrival through the first 48 hours (72 hours for CABG or Other Cardiac Surgery) after *Anesthesia End Time.*
  First: Abstract the first dose of each specific antibiotic administered.
  Second: Abstract the dose of each specific antibiotic administered prior to and closest to *Surgical Incision Time.*
  Third: Abstract the last dose of each specific antibiotic administered within 48 hours (72 hours for CABG or Other Cardiac Surgery) after *Anesthesia End Time*.
  Example:
  Arrival time and date were 07:00 on 04-02-20xx
  Surgical Incision Time was 12:00. *Anesthesia End Time* was 14:00.
  Cefazolin was administered at 08:00, 10:00, 15:30, 17:00, and 19:00 on 04-02-20xx.
  Abstract:
  First dose: Cefazolin 08:00 4-02-20xx IV
  Second dose: Cefazolin 10:00 4-02-20xx IV
  Last dose: Cefazolin 19:00 4-02-20xx IV

Suggested Data Sources:

- Anesthesia record
- Emergency Department record
- ICU flow sheet
- IV flow sheet

- Medication administration record (MAR)
- Operating room record
- PACU/recovery room record
- Perfusion record

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Antibiotic Received*

Collected For: CMS/The Joint Commission: SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3; **CMS Only:** PN-6; **The Joint Commission Only:** PN-6a, PN-6b; **CMS Voluntary Only:** PN-3b

Definition: Documentation that the patient received antibiotics within 24 hours of arrival or the day prior to arrival and/or during this hospital stay (arrival through 24 hours for PN and arrival through 48 hours postop [72 hours postop for CABG or Other Cardiac Surgery] for SCIP-Inf).

Suggested Data Collection Question: Did the patient receive antibiotics within 24 hours of arrival or the day prior to arrival and/or during this hospital stay?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 Antibiotic received only within 24 hours of arrival or the day prior to arrival and not during hospital stay.

2 Antibiotic received within 24 hours of arrival or the day prior to arrival and during hospital stay (arrival through 24 hours for PN and arrival through 48 hours postop [72 hours postop for CABG or Other Cardiac Surgery] for SCIP-Inf).

3 Antibiotic received only during hospital stay (arrival through 24 hours for PN and arrival through 48 hours postop [72 hours postop for CABG or Other Cardiac Surgery] for SCIP-Inf).

4 Antibiotic not received (within 24 hours of arrival or arrival through 24 hours for PN and arrival through 48 hours postop [72 hours postop for CABG or Other Cardiac Surgery] for SCIP-Inf), or unable to determine from medical record documentation.

Notes for Abstraction:

- Only consider antibiotics listed in Appendix C, Table 2.1. Do **not** consider any medications other than antibiotics (e.g., antivirals, antifungals, antituberculins, antiprotozoans, etc.).
- In order to ascertain whether antibiotics were administered during this hospitalization, please see the Notes for Abstraction for the data element, *Antibiotic Name.*
- Antibiotics listed as “current” or “home meds,” etc., should be inferred as taken within 24 hours of arrival or the day prior to arrival, unless there is documentation

they were **not** taken within the last 24 hours. Documentation that a prescription for antibiotics was given to the patient is not sufficient.

- If the medical record contains documentation of medication administration and the antibiotic is not listed as a current medication and there is NO specific documentation to suggest the medication was taken within 24 hours of arrival or the day prior to arrival, do not consider it given within this time frame.
  Example:
  "Patient started on antibiotics two days ago."

PN:

- The data elements *Arrival Date* and *Arrival Time* should be taken into consideration when determining if the antibiotic was given prior to arrival or during the stay.
- If a valid date/time for an antibiotic dose(s) found within the current record is an obvious error (in error) and the correct date/time can be found on the same source, the correct date/time may be used to determine if the antibiotic was given prior to arrival or during the stay.
  Note: The ED record is considered the same data source.
- If the correct date/time for the antibiotic dose(s) that was documented in error is not supported by other documentation in the same source, the chart must be abstracted at face value.
  Example:
  The earliest time the patient arrived at the hospital is found to be 1400. The antibiotic is documented as given at 1100 on the same date with no further documentation to support that this was given during the stay. The dose cannot be abstracted as given during the hospital stay and should be used to abstract *Antibiotic Received* as Value "1" or "2" as applicable.

SCIP:

- The medical record must be abstracted as documented (taken at "face value"). When the documented date is an invalid date or time (not a valid format/range or outside of the parameter of care) **and** no other documentation is found on that same source that provides this information, the abstractor should consider that date or time at face value.
  Example:
  An arrival time is documented as 1400 on 12-10-20xx and the antibiotic is documented as given at 1352 12-10-20xx on the same date. No other documentation is found on that same source that provides this information. The dose cannot be considered as given during the hospital stay and should be considered at face value to abstract Value "1" or "2" as applicable.
- If a valid date or time for an antibiotic dose is an obvious error (in error) and the correct date or time can be found on the same source, the correct date or time may be considered. If the correct date or time cannot be found on that same source, the date must be abstracted at face value. If the date or time of the dose (at face value) is prior to arrival, it should be used to abstract Value "1" or "2" as applicable.
  Example:

The anesthesia form is dated 12-10-2009, but other documentation on that same source supports that the correct date was 12-10-2010. Consider the correct date of 12-10-2010.

- If the *Antibiotic Administration Time* and/or *Antibiotic Administration Date* are corrected using the same source document, *Antibiotic Received* should be abstracted to correlate with the corrected date or time.

Suggested Data Sources:

- Anesthesia record
- Emergency Department record
- History and physical
- ICU flow sheet
- IV flow sheet
- Medication administration record
- Nursing notes
- Operating room record
- PACU/recovery room record
- Perfusion record

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Anticoagulation Therapy Prescribed at Discharge*

Collected For: CMS/The Joint Commission: STK-3

Definition: Documentation that anticoagulation therapy was prescribed at hospital discharge. Anticoagulant medications prevent the clotting of blood.

Suggested Data Collection Question: Was anticoagulation therapy prescribed at hospital discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Anticoagulation therapy was prescribed at hospital discharge.
N (No)	Anticoagulation therapy was not prescribed at hospital discharge, OR unable to determine from the medical record documentation.

Notes for Abstraction:

- In determining whether anticoagulation therapy was prescribed at discharge, it is not uncommon to see conflicting documentation amongst different medical record sources. For example, the discharge summary may list an anticoagulant that is not included in any of the other discharge medication sources (e.g., discharge orders). All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
  - In cases where there is an anticoagulant in one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select "Yes") unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge - **Consider it a discharge medication in the absence of contradictory documentation.**
  - If documentation is contradictory (e.g., physician noted “d/c Coumadin” in the discharge orders, but Coumadin is listed in the discharge summary’s discharge medication list), or after careful examination of circumstances, context, timing, etc., documentation raises enough questions, the case should be deemed "unable to determine" (select "No").
  - Consider documentation of a hold on an anticoagulant after discharge in one location and a listing of that anticoagulant as a discharge medication in another location as contradictory ONLY if the timeframe on the hold is not **defined** (e.g., “Hold Coumadin”). Examples of a hold with a defined timeframe include “Hold Coumadin x2 days” and “Hold warfarin until after stress test.”

- If an anticoagulant is NOT listed as a discharge medication, and there is only documentation of a hold or plan to delay initiation/restarting of anticoagulation therapy after discharge (e.g., “Hold Coumadin x2 days,” “Start Coumadin as outpatient,” “Hold Coumadin”), select “No.”
- If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc.
  Examples:
  - Two discharge summaries, one dictated 5/22 (day of discharge) and one dictated 5/27 - Use the 5/27 discharge summary.
  - Two discharge medication reconciliation forms, one not dated and one dated 4/24 (day of discharge) - Use both.

- Disregard an anticoagulant medication documented only as a recommended medication for discharge (e.g., “Recommend sending patient home on dabigatran”). Documentation must be clearer that an anticoagulant was actually prescribed at discharge.
- Disregard documentation of anticoagulant prescribed at discharge when noted only by medication class (e.g., “Anticoagulant Prescribed at Discharge: Yes” on a core measures form). The anticoagulant must be listed by name.

Suggested Data Sources:
- Consultation notes
- Discharge summary
- Medication reconciliation form
- Physician orders
- Progress notes

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 8.3 for a list of medications used for anticoagulation therapy.

Exclusion Guidelines for Abstraction:
- Heparin Flush
- Heparin SQ
- Hep-Lock

Data Element Name*: Antithrombotic Therapy Administered by End of Hospital Day 2*

Collected For: CMS/The Joint Commission: STK-5

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

Suggested Data Collection Question: Was antithrombotic therapy administered by the end of hospital day 2?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Antithrombotic therapy was administered by the end of hospital day 2.
N (No)	Antithrombotic therapy was not administered by the end of hospital day 2, OR unable to determine from medical record documentation.

Notes for Abstraction:

- To compute end of hospital day 2, count the arrival date as hospital day 1. If antithrombotic therapy was administered by 11:59 P.M. of hospital day two, select "Yes" for this data element. Documentation of antithrombotic administration must be found within the timeframe of arrival to the end of hospital day 2*. It is not necessary to review documentation outside of this timeframe to answer this data element.*
- For antithrombotic therapy administered in the Emergency Department/observation area prior to the end of hospital day 2, select "Yes."
- Antithrombotic therapy administration information must demonstrate actual administration of the medication.
  Example:
  Do not use physician orders as they do not demonstrate administration of the antithrombotic therapy (in the ED this may be used if signed/initialed by a nurse).
- When antithrombotic is noted as a "home" or "current" medication or documentation indicates that it was received prior to hospital arrival only, select "No."

Suggested Data Sources:

- Emergency Department record
- Medication administration record (MAR)
- Progress notes
- Nursing flow sheet
- Nursing notes

Excluded Data Sources:

- Emergency medical system (EMS) or ambulance documentation.
- Any documentation dated/timed prior to hospital arrival or after hospital day 2.

Inclusion Guidelines for Abstraction:

Refer to Appendix C, Table 8.2 for a list of medications used for antithrombotic therapy.

Exclusion Guidelines for Abstraction:

- Heparin Flush
- Heparin SQ
- Hep-Lock

Data Element Name*: Antithrombotic Therapy Prescribed at Discharge*

Collected For: CMS/The Joint Commission: STK-2

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

Suggested Data Collection Question: Was antithrombotic therapy prescribed at hospital discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Antithrombotic therapy was prescribed at hospital discharge.
N (No)	Antithrombotic therapy was not prescribed at hospital discharge, OR unable to determine from medical record documentation.

Notes for Abstraction:

- In determining whether antithrombotic therapy was prescribed at discharge, it is not uncommon to see conflicting documentation amongst different medical record sources. For example, the discharge summary may list an antithrombotic that is not included in any of the other discharge medication sources (e.g., discharge orders). All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
  - In cases where there is an antithrombotic in one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select "Yes") unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge - **Consider it a discharge medication in the absence of contradictory documentation.**
  - If documentation is contradictory (e.g., physician noted “d/c Plavix” in the discharge orders, but Plavix is listed in the discharge summary’s discharge medication list), or after careful examination of circumstances, context, timing, etc., documentation raises enough questions, the case should be deemed "unable to determine" (select "No").
  - Consider documentation of a hold on an antithrombotic after discharge in one location and a listing of that antithrombotic as a discharge medication in another location as contradictory ONLY if the timeframe on the hold is not **defined** (e.g., “Hold Plavix”). Examples of a hold with a defined timeframe include “Hold Plavix x2 days” and “Hold ASA until after stress test.”

- If an antithrombotic is NOT listed as a discharge medication, and there is only documentation of a hold or plan to delay initiation/restarting of antithrombotic therapy after discharge (e.g., “Hold Plavix x2 days,” “Start Plavix as outpatient,” “Hold Plavix”), select “No.”
- If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc.
  Examples:
  - Two discharge summaries, one dictated 5/22 (day of discharge) and one dictated 5/27 - Use the 5/27 discharge summary.
  - Two discharge medication reconciliation forms, one not dated and one dated 4/24 (day of discharge) - Use both.

- Disregard an antithrombotic medication documented only as a recommended medication for discharge (e.g., “Recommend sending patient home on aspirin”). Documentation must be clearer that an antithrombotic was actually prescribed at discharge.
- Disregard documentation of antithrombotic prescribed at discharge when noted only by medication class (e.g., “Antithrombotic Prescribed at Discharge: Yes” on a core measures form). The antithrombotic must be listed by name.

Suggested Data Sources:
- Consultation notes
- Discharge summary
- Medication reconciliation form
- Physician orders
- Progress notes

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 8.2 for a list of medications used for antithrombotic therapy.

Exclusion Guidelines for Abstraction:
- Heparin Flush
- Heparin SQ
- Hep-Lock

Data Element Name: *ARB Prescribed at Discharge*

Collected For: The Joint Commission Only: AMI-3, HF-3; **CMS Voluntary Only:** AMI-3, HF-3

Definition: Documentation that an angiotensin receptor blocker (ARB) was prescribed at hospital discharge. ARBs widen or dilate blood vessels, lowering blood pressure and making it easier for the heart to pump blood. They also inhibit the adverse effects of neurohormonal activation on the heart. These effects help reduce the risk of adverse outcomes such as death or hospitalization.

Suggested Data Collection Question: Was an angiotensin receptor blocker (ARB) prescribed at discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	ARB prescribed at discharge.
N (No)	ARB not prescribed at discharge, or unable to determine from medical record documentation.

Notes for Abstraction:

- In determining whether an ARB was prescribed at discharge, it is not uncommon to see conflicting documentation amongst different medical record sources. For example, the discharge summary may list an ARB that is not included in any of the other discharge medication sources (e.g., discharge orders). All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
  - In cases where there is an ARB in one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select "Yes") unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge - **Consider it a discharge medication in the absence of contradictory documentation.**
  - If documentation is contradictory (e.g., physician noted “d/c losartan” in the discharge orders, but losartan is listed in the discharge summary’s discharge medication list), or after careful examination of circumstances, context, timing, etc, documentation raises enough questions, the case should be deemed "unable to determine” (select "No").
  - Consider documentation of a hold on an ARB after discharge in one location and a listing of that ARB as a discharge medication in another location as contradictory ONLY if the timeframe on the hold is not **defined**

(e.g., “Hold losartan”). Examples of a hold with a defined timeframe include “Hold Diovan x2 days” and “Hold Verdia until after stress test.”

- If an ARB is NOT listed as a discharge medication, and there is only documentation of a hold or plan to delay initiation/restarting of an ARB after discharge (e.g., “Hold Diovan x2 days,” “Start ARB as outpatient,” “Hold losartan”), select “No.”
- If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc.
  Examples:
  - Two discharge summaries, one dictated 5/22 (day of discharge) and one dictated 5/27 - Use the 5/27 discharge summary.
  - Two discharge medication reconciliation forms, one not dated and one dated 4/24 (day of discharge) - Use both.

- Disregard an ARB medication documented only as a recommended medication for discharge (e.g., “Recommend sending patient home on candesartan”). Documentation must be clearer that the ARB was actually prescribed at discharge.
- Disregard documentation of ARB prescribed at discharge when noted only by medication class (e.g., "ARB Prescribed at Discharge: Yes” on a core measures form). The ARB must be listed by name.

Suggested Data Sources:

- Discharge instruction sheet
- Discharge summary
- Medication reconciliation form
- Nursing discharge notes
- Physician orders sheet
- Transfer sheet

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 1.7 for a comprehensive list of ARBs.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Arrival Date*

Collected For: CMS/The Joint Commission: AMI-7a, AMI-8a, ED-1, STK-4, STK-5; **CMS Only:** PN-6; **The Joint Commission Only:** AMI-1, AMI-7, AMI-8, PN-3a, PN-6a, PN-6b; **CMS Voluntary Only:** AMI-1, AMI-7, AMI-8, PN-3a, PN-3b

Definition: The earliest documented month, day, and year the patient arrived at the hospital.

Suggested Data Collection Question: What was the **earliest** documented date the patient arrived at the hospital?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values: Enter the earliest documented date

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

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

  Examples:
  - Documentation indicates the *Arrival Date* was 03-**42**-20xx. No other documentation in the list of Only Acceptable Sources provides a valid date. Since the *Arrival Date* is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD."
  - Patient expires on 02-12-20xx and all documentation within the Only Acceptable Sources indicates the *Arrival Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *Arrival Date* is after the *Discharge Date* (death), it is outside of the parameter of care and the abstractor should select "UTD."

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

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

- The source “Procedure notes” refers to procedures such as cardiac caths, endoscopies, and surgical procedures. Procedure notes do not include ECG and x-ray reports.
- The arrival date may differ from the admission date.
- If the patient is in either an outpatient setting of the hospital other than observation status (e.g., dialysis, chemotherapy, cardiac cath) or a SNF unit of the hospital, and is subsequently admitted to acute inpatient, use the date the patient arrived at the ED or on the floor for acute inpatient care as the arrival date.
- **Observation status**:
  - If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient arrived at the ED or on the floor for observation care as the arrival date.
  - If the patient was admitted to observation from the ED of the hospital, use the date the patient arrived at the ED as the arrival date.
- **Direct Admits:**
  - If the patient is a “Direct Admit” to the cath lab, use the earliest date the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival date.
  - For “Direct Admits” to acute inpatient or observation, use the earliest date the patient arrived at the nursing floor or in observation (as documented in the Only Acceptable Sources) as the arrival date.
- If the patient was transferred from your hospital’s satellite/free-standing ED or from another hospital within your hospital’s system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival date at the first facility.

Suggested Data Sources:
ONLY ACCEPTABLE SOURCES:
- Emergency Department record
- Nursing admission assessment/admitting note
- Observation record
- Procedure notes
- Vital signs graphic record

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
Addressographs/Stamps

Data Element Name: *Arrival Time*

Collected For: CMS/The Joint Commission: AMI-7a, AMI-8a, ED-1, STK-4; **CMS Only:** PN-6; **The Joint Commission Only:** AMI-7, AMI-8, PN-3a, PN-6a, PN-6b; **CMS Voluntary Only:** AMI-7, AMI-8, PN-3a, PN-3b

Definition: The earliest documented time (military time) the patient arrived at the hospital.

Suggested Data Collection Question: What was the **earliest** documented time the patient arrived at the hospital?

Format:

Length: 5 - HH:MM (with or without colon) or UTD
Type: Time
Occurs: 1

Allowable Values: Enter the earliest documented time of arrival

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight - 00:00	Noon - 12:00
5:31 am - 05:31	5:31 pm - 17:31
11:59 am - 11:59	11:59 pm - 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *Arrival Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00 do not forget to change the *Arrival Date.*
Example:
Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:

- For times that include “seconds,” remove the seconds and record the time as is.
  Example:
  15:00:35 would be recorded as 15:00.
- If the time of arrival is unable to be determined from medical record documentation, select “UTD.”

- The medical record must be abstracted as documented (taken at "face value"). When the time documented is obviously in error (not a valid format/range) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Example:
  Documentation indicates the *Arrival Time* was 3300. No other documentation in the list of Only Acceptable Sources provides a valid time. Since the *Arrival Time* is outside of the range in the Allowable Values for "Hour," it is not a valid time and the abstractor should select "UTD."
  Note: Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *Arrival Time* allows the case to be accepted into the warehouse.
- Review the Only Acceptable Sources to determine the earliest time the patient arrived at the ED, nursing floor, or observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab for a direct admit.
- Documentation outside of the Only Acceptable Sources list should NOT be referenced (e.g., ambulance record, physician office record, H&P).
  Examples:
  - ED Triage Time 0800. ED rhythm strip 0830. EMS report indicates patient was receiving EMS care from 0805 through 0825. The EMS report is disregarded. Enter 0800 for *Arrival Time*.
  - ED noted arrival time of 0945. Lab report shows blood culture collected at 0830. It is not clear that the blood culture was collected in the ED because the lab report does not specify it was collected in the ED (unable to confirm lab report as an Only Acceptable Source). Enter 0945 for *Arrival Time*.
- Arrival time should NOT be abstracted simply as the earliest time in one of the Only Acceptable Sources, without regard to other substantiating documentation. When looking at the Only Acceptable Sources, if the earliest time documented appears to be an obvious error, this time should not be abstracted.
  Examples:
  - ED arrival time noted as 2300 on 10-28-20xx. ED MAR shows an antibiotic administration time of 0100 on 10-28-20xx. Surrounding documentation on the ED MAR makes clear that the 10-28-20xx date is an obvious error - Date was not changed to 10-29-20xx. The antibiotic administration date/time would be converted to 0100 on 10-29-20xx. Enter 2300 for *Arrival Time.*
  - ED face sheet lists arrival time of 13:20. ED Registration Time 13:25. ED Triage Time 13:30. ED consent to treat form has 1:17 time but "AM" is circled. ED record documentation suggests the 1:17 AM is an obvious error. Enter 13:20 for *Arrival Time*.
  - ED ECG timed as 1742. ED Greet Time 2125. ED Triage Time 2130. There is no documentation in the Only Acceptable Sources which suggests the 1742 is an obvious error. Enter 1742 for *Arrival Time.*

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

- 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.
- The source “Procedure notes” refers to procedures such as cardiac caths, endoscopies, and surgical procedures. Procedure notes do not include ECG and x-ray reports.
- The arrival time may differ from the admission time.
- If the patient is in either an outpatient setting of the hospital other than observation status (e.g., dialysis, chemotherapy, cardiac cath) or a SNF unit of the hospital, and is subsequently admitted to acute inpatient, use the time the patient arrived at the ED or on the floor for acute inpatient care as the arrival time.
- **Observation status**:
  - If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient arrived at the ED or on the floor for observation care as the arrival time.
  - If the patient was admitted to observation from the ED of the hospital, use the time the patient arrived at the ED as the arrival time.
- **Direct Admits:**
  - If the patient is a “Direct Admit” to the cath lab, use the earliest time the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival time.
  - For “Direct Admits” to acute inpatient or observation, use the earliest time the patient arrived at the nursing floor or in observation (as documented in the Only Acceptable Sources) as the arrival time.
- If the patient was transferred from your hospital’s satellite/free-standing ED or from another hospital within your hospital’s system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival time at the first facility.

Suggested Data Sources:
ONLY ACCEPTABLE SOURCES:
- Emergency Department record
- Nursing admission assessment/admitting note
- Observation record
- Procedure notes
- Vital signs graphic record

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
Addressographs/stamps

Data Element Name: *Aspirin Prescribed at Discharge*

Collected For: The Joint Commission Only: AMI-2; **CMS Voluntary Only:** AMI-2

Definition: Documentation that aspirin was prescribed at discharge. Aspirin reduces the tendency of blood to clot by blocking the action of a type of blood cell involved in clotting. Aspirin improves chances of surviving a heart attack and reduces the risk of recurrence in patients who have experienced a heart attack.

Suggested Data Collection Question: Was aspirin prescribed at discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Aspirin prescribed at discharge.
N (No)	Aspirin not prescribed at discharge or unable to determine from medical record documentation.

Notes for Abstraction:

- In determining whether aspirin was prescribed at discharge, it is not uncommon to see conflicting documentation amongst different medical record sources. For example, the discharge summary may list an aspirin medication that is not included in any of the other discharge medication sources (e.g., discharge orders). All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
  - In cases where there is aspirin in one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select "Yes") unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge - **Consider it a discharge medication in the absence of contradictory documentation.**
  - If documentation is contradictory (e.g., physician noted “d/c aspirin” in the discharge orders, but aspirin is listed in the discharge summary’s discharge medication list), or after careful examination of circumstances, context, timing, etc, documentation raises enough questions, the case should be deemed "unable to determine" (select "No”).
  - Consider documentation of a hold on aspirin after discharge in one location and a listing of aspirin as a discharge medication in another location as contradictory ONLY if the timeframe on the hold is not **defined** (e.g., “Hold ASA”). Examples of a hold with a defined timeframe include “Hold EC ASA x2 days” and “Hold aspirin until after endoscopy.”
  - If aspirin is NOT listed as a discharge medication, and there is only documentation of a hold or plan to delay initiation/restarting of aspirin after

discharge (e.g., “Hold EC ASA x2 days,” “Start baby aspirin as outpatient,” “Hold ASA”), select “No.”

- If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc.
  Examples:
  - Two discharge summaries, one dictated 5/22 (day of discharge) and one dictated 5/27 - Use the 5/27 discharge summary.
  - Two discharge medication reconciliation forms, one not dated and one dated 4/24 (day of discharge) - Use both.

- Disregard aspirin documented only as recommended medication for discharge (e.g., “Recommend sending patient home on ASA”). Documentation must be clearer that aspirin was actually prescribed at discharge.

Suggested Data Sources:

- Discharge instruction sheet
- Discharge summary
- Medication reconciliation form
- Nursing discharge notes
- Physician orders
- Transfer sheets

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 1.1 for a comprehensive list of Aspirin and Aspirin-Containing Medications.

Exclusion Guidelines for Abstraction:
Aggrenox (aspirin/dipyridamole)

Data Element Name: *Aspirin Received Within 24 Hours Before or After Hospital Arrival*

Collected For: The Joint Commission Only: AMI-1; **CMS Voluntary Only:** AMI-1

Definition: Aspirin received within 24 hours before or 24 hours after hospital arrival. Aspirin reduces the tendency of blood to clot by blocking the action of a type of blood cell involved in clotting. Aspirin improves chances of surviving a heart attack and reduces the risk of recurrence in patients who have experienced a heart attack.

Suggested Data Collection Question: Was aspirin received within 24 hours before or 24 hours after hospital arrival?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Aspirin received within 24 hours before or 24 hours after hospital arrival.
N (No)	Aspirin not received within 24 hours before or 24 hours after hospital arrival or unable to determine from medical record documentation.

Notes for Abstraction:

- In the absence of explicit documentation that the patient received aspirin within 24 hours prior to *Arrival Time*:
  - In cases where the patient was received as a transfer from another hospital (inpatient, outpatient, ED, observation):
    - Aspirin listed as “home" medication: Do **not** make inferences. Additional documentation is needed which clearly suggests the patient took aspirin at home within 24 hours prior to *Arrival Time.*
    - Aspirin listed as “current” medication:
      - If there is documentation that aspirin was a current medication at the transferring facility (e.g., aspirin noted on transfer summary, aspirin noted as “current medication” in your facility's H&P), then infer aspirin was taken within 24 hours prior to *Arrival Time*, unless documentation suggests otherwise.
      - If documentation suggests “current” aspirin refers to home regimen or documentation is not clear whether “current” means patient was on aspirin at the transferring facility or at home, do **not** make inferences. Additional documentation is needed which clearly suggests the patient either took aspirin at home or at the transferring facility within 24 hours

prior to *Arrival Time*.

- In non-transfer cases:
  - Aspirin listed as “current” or “home" medication should be inferred as taken within 24 hours prior to *Arrival Time*, unless documentation suggests otherwise (e.g., Documentation that aspirin is on hold prior to arrival for a scheduled procedure).
  - If ASA is listed as home medication and last dose is noted as the day prior to arrival but no time, then infer aspirin was taken within 24 hours.
- When aspirin is noted only as received prior to arrival, without information about the exact time it was received (e.g., "Baby ASA x4" per the "Treatment Prior to Arrival" section of the Triage Assessment), infer that the patient took it within 24 hours prior to *Arrival Time*, unless documentation suggests otherwise.
- Aspirin documented as a PRN current/home medication does not count unless documentation is clear it was taken within 24 hours prior to *Arrival Time*.

Suggested Data Sources

- Ambulance record
- Emergency Department record
- History and physical
- Medication administration record
- Medication reconciliation form
- Nursing admission assessment
- Transfer sheet

Inclusion Guidelines for Abstraction:

Refer to Appendix C, Table 1.1 for a comprehensive list of Aspirin and Aspirin-Containing Medications.

Exclusion Guidelines for Abstraction:

Aggrenox (aspirin/dipyridamole)

Data Element Name: *Assessed for Rehabilitation Services*

Collected For: CMS/The Joint Commission: STK-10

Definition: Documentation that the patient was assessed for or received rehabilitation services during this hospitalization. Rehabilitation is a treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible.

Suggested Data Collection Question: Was the patient assessed for and/or did the patient receive rehabilitation services during this hospitalization?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Patient was assessed for and/or received rehabilitation services during this hospitalization.
N (No)	Patient was not assessed for nor did patient receive rehabilitation services during this hospitalization, OR unable to determine from medical record documentation.

Notes for Abstraction:

- The assessment for rehabilitation services must be completed by a qualified provider. See the inclusion list for acceptable examples of documentation. The list is not all-inclusive.
- If a documented reason exists for not completing a rehabilitation assessment, select "Yes."
  Examples:
  - "Patient returned to prior level of function, rehabilitation not indicated at this time."
  - "Patient unable to tolerate rehabilitation therapeutic regimen."
  - Patient/family refusal
- Do not infer that documentation of symptoms resolved means that a rehabilitation assessment was completed, unless mentioned in the context of rehabilitation services.
  Example:
  "Symptoms resolved – no rehab needed."
- When an assessment is not found in the medical record but documentation indicates that rehabilitation services were initiated (i.e., Physical Therapy (PT), Occupational Therapy (OT), Speech Language Therapy (SLT), Neuropsychology) during the hospital stay, select "Yes."
  Examples:

- "PT x2 for range of motion (ROM) exercises at bedside."
- "Patient aphasic – evaluated by speech pathology"

- When patient is transferred to a rehabilitation facility or referred to rehabilitation services following discharge, select "Yes."

Suggested Data Sources:
PHYSICIAN/PT/OT/SLT OR NEUROPSYCHOLOGIST DOCUMENTATION ONLY FOR REHABILITATION ASSESSMENT:

- Consultation notes
- Discharge instruction sheet
- Discharge summary
- History and physical
- Occupational therapy notes
- Physical therapy notes
- Physician orders
- Progress notes
- Referral forms
- Rehabilitation records

Excluded Data Sources:

- Nursing assessments for activities of daily living (ADLs).
- Nursing notes

Inclusion Guidelines for Abstraction:

- Assessment/consult done by a member of the rehabilitation team.
- Patient received rehabilitation services from a member(s) of the rehabilitation team.
- Rehabilitation team members include:
  - Physician
  - Physiatrist
  - Neuro-psychologist
  - Physical therapist
  - Occupational therapist
  - Speech and language pathologist

Exclusion Guidelines for Abstraction:
Request/order for inpatient rehabilitation consult that was not performed

Data Element Name: *Atrial Fibrillation/Flutter*

Collected For: CMS/The Joint Commission: STK-3

Definition: Documentation that the patient has a history of any atrial fibrillation (e.g., remote, persistent, or paroxysmal) or atrial flutter in the past OR current atrial fibrillation or flutter on EKG.

Suggested Data Collection Question: Was history of atrial fibrillation/flutter or current finding of atrial fibrillation/flutter documented in the medical record?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	History of any atrial fibrillation/flutter or current finding of atrial fibrillation/flutter was documented.
N (No)	History of any atrial fibrillation/flutter or current finding of atrial fibrillation/flutter was not documented, OR unable to determine from medical record documentation.

Notes for Abstraction:

- Documented history or current findings of any condition described in the definition statement meets this data element.
- Documentation of atrial fibrillation or flutter on current EKG, select “Yes.”
- Diagnosis of current atrial fibrillation or flutter anywhere in the medical record, select “Yes.”
- Documented past history of atrial fibrillation/flutter anywhere in the medical record, select “Yes.”
- Documented history of ablation procedure, select “Yes.”
- See the inclusion list for acceptable examples of documentation. The list is not all-inclusive.
- Documented history of atrial fibrillation or flutter that terminated within 8 weeks following CABG, select “No.”
- Documented history of transient and entirely reversible episode of atrial fibrillation or flutter due to thyrotoxicosis, select “No.”

Suggested Data Sources:

- EKG report
- Face sheet
- Discharge instruction sheet
- Discharge summary
- History and physical

- Holter monitor report
- Problem list
- Progress notes
- Rhythm strip with documented interpretation of atrial fibrillation/flutter
- Transfer sheet

Inclusion Guidelines for Abstraction

- AF
- A-fib
- Atrial fibrillation
- Atrial flutter
- Persistent atrial fibrillation
- Paroxysmal atrial fibrillation
- PAF
- History of any remote episode of documented atrial fibrillation or flutter except within 8 weeks following CABG
- Discharges with an *ICD-9-CM Other Diagnosis Code* of 427.31 or 427.32

Exclusion Guidelines for Abstraction

- History of atrial fibrillation or flutter that terminated within 8 weeks following CABG
- History of transient and entirely reversible episode of documented atrial fibrillation or flutter due to thyrotoxicosis
- PAC
- Paroxysmal atrial tachycardia
- Paroxysmal supraventricular tachycardia
- PAT
- Premature atrial contraction
- PST

Data Element name: *Beta-Blocker Current Medication*

Collected For: CMS/The Joint Commission: SCIP-Card-2

Definition: Documentation in the medical record that the patient was on a daily beta-blocker therapy prior to arrival. Beta-blockers are agents which block beta-adrenergic receptors, thereby decreasing the rate and force of heart contractions, and reducing blood pressure.

Suggested Data Collection Question: Is there documentation that the patient was on a daily beta-blocker therapy prior to arrival?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that the patient was on a daily beta-blocker therapy prior to arrival.
N (No)	There is no documentation that the patient was on a daily beta-blocker therapy prior to arrival or unable to determine from medical record documentation.

Notes for Abstraction:

- If there is documentation that the beta-blocker was taken daily at "home" or as a "current" medication prior to arrival, select "Yes." If the patient was transferred from a facility where they were started on a beta blocker as a daily medication, select "Yes."
- If a beta-blocker is listed as a home medication without designation of how often or when it is taken, select "Yes."
- If a beta-blocker was a daily "home" or "current" medication, and the physician documents to discontinue or hold the beta-blocker before surgery along **WITH** a documented reason for not administering the beta-blocker, select "No."
- If a beta-blocker was a daily "home" or "current" medication, and the physician documents to hold or discontinue the beta-blocker before surgery **WITHOUT** a documented reason for not administering the beta-blocker, select "Yes."
- The use of hypotension as a reason must be substantiated by documentation that the blood pressure was $\leq$ 100 mm/Hg. The use of bradycardia as a reason must be substantiated with documentation that the heart rate was less than 50 bpm.
- If the patient stopped or was not taking the beta-blocker prior to arrival but was started on one in the hospital prior to surgery, select "No."
- A checklist does not take priority over specific documentation that a beta-blocker was or was not a home medication.

Example:
The home medication list shows a beta-blocker as a daily home medication and a checklist on the anesthesia form indicates: No. This is not sufficient to select "No."

- When conflicting documentation exists concerning whether or not the beta-blocker was being taken on a daily basis or if the patient stopped taking it at home, there must be clear documentation that they actually stopped or had not been taking the medication to select "No." Do not select "No" based on documentation that the patient did not take the beta-blocker "the day before" or "misses it sometimes."
- The lack of the beta-blocker on one form is not sufficient to select "No" if the beta-blocker is listed as a daily home medication on another form. Without specific documentation that a beta-blocker was not a daily home medication or that the patient was not taking it, select "Yes."
- If a list of medications is labeled as current medications but is clearly a list of current medications that were started during the hospital stay and not a list of current home medications, select "No."
- If there is documentation that the beta-blocker is on a schedule other than daily or was given on a "prn" basis for cardiac or non-cardiac reasons, select "No."
- A beta-blocker can be given more than once daily, the number of doses in a day does not affect abstraction.

Suggested Data Sources:

- Admitting record
- Anesthesia records
- Consultation notes
- Medication reconciliation form
- History and physical
- Nursing admission assessment
- Preoperative record
- Progress notes

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 1.3 for a comprehensive list of Beta-Blocker medications.

Exclusion Guidelines for Abstraction:

- Beta-blockers taken daily for non-cardiac reasons
- Eye drops containing beta-blocker (e.g., Cosopt)
- "PRN" beta-blocker

Data Element Name: *Beta-Blocker During Pregnancy*

Collected For: CMS/The Joint Commission: SCIP-Card-2

Definition: A pregnant patient taking a beta-blocker prior to arrival.

Suggested Data Collection Question: Was the patient taking the beta-blocker prior to arrival pregnant?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 (Yes)	There is documentation that the patient taking the beta-blocker prior to arrival was pregnant.
2 (No)	There is no documentation that the patient taking the beta-blocker prior to arrival was pregnant.
3 (UTD)	Unable to determine from medical record documentation that the patient taking the beta-blocker prior to arrival was pregnant.

Notes for Abstraction:
ICD-9-CM codes may not be a reliable source to determine that the patient was pregnant upon arrival. Therefore, it is recommended that abstractors refer to the Suggested Data Sources listed below.

Suggested Data Sources:

- Anesthesia evaluation
- Consultation notes
- History and physical
- Operating room record
- Operative report
- Physician orders
- Physician progress notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Beta-Blocker Perioperative*

Collected For: CMS/The Joint Commission: SCIP-Card-2

Definition: Beta-blocker was received during the perioperative period. Beta-blockers are agents which block beta-adrenergic receptors, thereby decreasing the rate and force of heart contractions, and reducing blood pressure. Beta-blockers given perioperatively reduce the risk of cardiovascular complications.

Suggested Data Collection Question: Is there documentation that a beta-blocker was received during the perioperative period?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1-4

Allowable Values:

Select all that apply:

1 There is documentation that a beta-blocker was received on the day prior to surgery.

2 There is documentation that the beta-blocker was received on the day of surgery.

3 There is documentation that a beta-blocker was received on POD 1 with day of surgery being day zero.

4 There is documentation that a beta-blocker was received on POD 2 with day of surgery being day zero.

5 There is NO documentation that a beta-blocker was received during the perioperative period (the day prior to surgery through POD 2 with day of surgery being day zero) or unable to determine from medical record documentation.

Notes for Abstraction:

- To select Value "1," there must be a date or other documentation that the last dose of the beta-blocker was taken on the day prior to the day of surgery. This can include a date for the last dose or specific documentation on the day of surgery that the patient took the beta-blocker on the day before surgery, such as "patient states they took beta-blocker last night before going to bed" or "states took beta-blocker yesterday."
- The perioperative period for the SCIP cardiac measure is defined as the day prior to surgery through postoperative day two (POD 2) with the day of surgery being day zero.

- There must be documentation that reflects that the beta-blocker was taken on the days specified in each allowable value to select that specific value.
- If the patient received a beta-blocker on the day prior to surgery or the day of surgery **and also** received a beta-blocker on POD 1 or POD 2, select the appropriate values. Abstractors have the opportunity to select one or more of the allowable values. No value should be recorded more than once.
- To select Value 5, there must be **NO** documentation that a beta-blocker was received during the perioperative period (the day prior to surgery through POD 2 with day of surgery being day zero). If Value 5 is selected, no other selections should be recorded.

Suggested Data Sources:
- Anesthesia records
- Consultation notes
- History and physical
- Medication administration record
- Medication reconciliation record
- Nursing admission assessment
- Operative report
- Preoperative record
- Procedure notes
- Progress notes

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 1.3 for a comprehensive list of Beta-Blocker medications.

Exclusion Guidelines for Abstraction:
Eye drops containing beta-blocker (e.g., Cosopt)

Data Element Name: *Beta-Blocker Prescribed at Discharge*

Collected For: The Joint Commission Only: AMI-5; **CMS Voluntary Only:** AMI-5

Definition: Documentation that a beta-blocker was prescribed at discharge. Beta-blockers are agents which block beta-adrenergic receptors, thereby decreasing the rate and force of heart contractions, and reducing blood pressure. Over time beta-blockers improve the heart's pumping ability.

Suggested Data Collection Question: Was a beta-blocker prescribed at discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Beta-blocker prescribed at discharge.
N (No)	Beta-blocker not prescribed at discharge or unable to determine from medical record documentation.

Notes for Abstraction:

- In determining whether a beta-blocker was prescribed at discharge, it is not uncommon to see conflicting documentation amongst different medical record sources. For example, the discharge summary may list a beta-blocker that is not included in any of the other discharge medication sources (e.g., discharge orders). All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
  - In cases where there is a beta-blocker in one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select "Yes") unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge - **Consider it a discharge medication in the absence of contradictory documentation.**
  - If documentation is contradictory (e.g., physician noted "d/c Coreg" in the discharge orders, but Coreg is listed in the discharge summary's discharge medication list), or after careful examination of circumstances, context, timing, etc, documentation raises enough questions, the case should be deemed "unable to determine" (select "No").
  - Consider documentation of a hold on a beta-blocker after discharge in one location and a listing of that beta-blocker as a discharge medication in another location as contradictory ONLY if the timeframe on the hold is not **defined** (e.g., "Hold Coreg"). Examples of a hold with a defined timeframe include "Hold Lopressor x2 days" and "Hold Propranolol until after stress test."

- If a beta-blocker is NOT listed as a discharge medication, and there is only documentation of a hold or plan to delay initiation/restarting of a beta-blocker after discharge (e.g., “Hold Lopressor x2 days,” “Start beta-blocker as outpatient,” “Hold Coreg”), select “No.”
- If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc.
  Examples:
  - Two discharge summaries, one dictated 5/22 (day of discharge) and one dictated 5/27 - Use the 5/27 discharge summary.
  - Two discharge medication reconciliation forms, one not dated and one dated 4/24 (day of discharge) - Use both.

- Disregard a beta-blocker medication documented only as a recommended medication for discharge (e.g., “Recommend sending patient home on sotalol”). Documentation must be clearer that a beta-blocker was actually prescribed at discharge.
- Disregard documentation of beta-blocker prescribed at discharge when noted only by medication class (e.g., “Beta-Blocker Prescribed at Discharge: Yes” on a core measures form). The beta-blocker must be listed by name.

Suggested Data Sources:
- Discharge instruction sheet
- Discharge summary
- Medication reconciliation form
- Nursing discharge notes
- Physician order sheet
- Transfer sheet

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 1.3 for a comprehensive list of Beta-Blocker medications.

Exclusion Guidelines for Abstraction:
Eye drops containing beta-blocker (e.g., Cosopt)

Data Element Name: *Birthdate*

Collected For: CMS/The Joint Commission: All Records

Definition: The month, day, and year the patient was born.

Note: Patient's age (in years) is calculated by *Admission Date* minus *Birthdate*. The algorithm to calculate age must use the month and day portion of admission date and birthdate to yield the most accurate age.

Suggested Data Collection Question: What is the patient's date of birth?

Format:

Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (1880-Current Year)

Notes for Abstraction:

Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the date of birth on the claim information.

Suggested Data Sources:

- Emergency Department record
- Face sheet
- Registration form
- UB-04, Field Location: 10

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Blood Culture Collected*

Collected For: The Joint Commission Only: PN-3a; **CMS Voluntary Only:** PN-3a, PN-3b

Definition: Documentation in the medical record that a blood culture was collected the day prior to arrival, the day of arrival, or within 24 hours after arrival to the hospital. This includes blood cultures drawn in the emergency room or in observation beds prior to admission order, as well as after the patient's admission to inpatient status. A blood culture can be defined as a culture of microorganisms from specimens of blood to determine the presence and nature of bacteremia.

Suggested Data Collection Question: Did the patient have blood cultures collected the day prior to arrival, the day of arrival or within 24 hours after hospital arrival?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 Initial documentation of the blood culture collected in the ED prior to admission order.

2 Initial documentation of the blood culture collected during this hospitalization but after admission order for ED patients (or within 24 hours after arrival for Direct Admits).

3 Documentation that the patient had a blood culture collected the day prior to arrival or the day of arrival up until the time of presentation to the hospital.

4 The patient did not have a blood culture collected the day prior to arrival, the day of arrival or within 24 hours after arrival or unable to determine from medical record documentation.

Notes for Abstraction:

- If the ED patient had initial documentation of a blood culture collected as an ED patient (regardless of location e.g. sent to radiology for tests) prior to an admission order (Observation or Inpatient), select "1." If a patient was held in the ED for a period of time following an admission order, and the initial documentation of a blood culture was collected while the patient was still in the ED but following the admission order, select "2."
- If a blood culture is ordered and there is an attempt to collect it, but the attempt results in failure to collect the specimen (too dehydrated to get a vein) or the specimen was contaminated during or after the draw, select “1” or “2.”

- For the purposes of this measure, a patient is no longer considered an ED patient after the admission order is written, regardless of location.
- If there are multiple admit orders, use the initial (earliest) one for this data element. For the purposes of this data element, any form of physician admit order can be used to determine admission time. This includes written physician order, nurse documentation of physician order (verbal or telephone), disposition or status change to admit.
- If no blood cultures are collected within 24 hours after arrival to the hospital, select "4."
- If it is evident a blood culture was performed after arrival to the hospital but from medical record documentation you are unable to determine if the blood culture was performed in the ED prior to admission or performed after admission, select "2."
- For patients with documentation of blood cultures performed the day prior to arrival or the day of arrival prior to presentation to hospital AND within 24 hours after arrival to the hospital, select value "3."
- If there is supportive documentation that a blood culture was collected and it is the earliest mention of a blood culture, this date and time can be used, e.g., "BC sent to lab," "blood culture received time."
- Do not use physician orders to determine a blood culture was collected, as they do not demonstrate collection of the blood culture.
- Documentation must specify **blood culture**.
  Example:
  "lab was at bedside- blood drawn" (does not demonstrate **blood culture**).

Suggested Data Sources:
- Emergency Department record
- History and physical
- Laboratory report
- Microbiology report
- Nursing notes
- Progress notes

Inclusion Guidelines for Abstraction:
- BC
- Blood cultures
- Blood cultures collected on patients in observation beds.
- Initial documentation of a blood culture collected within 24 hours after arrival to the hospital

Exclusion Guidelines for Abstraction:
- Cultures collected more than 1 day prior to arrival
- Initial documentation of a blood culture collected more than 24 hours after arrival to the hospital

Data Element Name: *Brief Intervention*

Collected For: The Joint Commission Only: SUB-2; **CMS Informational Only:** SUB-2

Definition: A single interaction between the qualified healthcare professional and the patient following a positive screening result for unhealthy alcohol use or alcohol use disorder (abuse or dependence). 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. Brief intervention corresponds directly with the 5 A's (Ask, Advise, Assess, Assist, Arrange) recommended for alcohol dependence.

Suggested Data Collection Question: Did patients with a positive screening result for unhealthy alcohol use or alcohol use disorder (abuse or dependence) receive a brief intervention prior to discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The patient received the components of a brief intervention.

2 The patient refused/declined the brief intervention.

3 Brief counseling was not offered to the patient during the hospital stay or unable to determine if a brief intervention was provided from medical record documentation.

Notes for Abstraction:

- A qualified healthcare professional may be defined as a physician, nurse, certified addictions counselor, psychologist, social worker, or health educator with training in brief intervention.
- If there is no documentation that a brief intervention was given to the patient, select value "3."
- Select value "3" if the documentation provided is not explicit enough to determine if the intervention provided contained the specific components or if it is determined that the intervention does not meet the intent of the measure.

Suggested Data Sources:

- Coding documents
- Consultation notes
- Nursing notes
- Physical progress notes
- Progress notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Catheter Removed*

Collected For: CMS/The Joint Commission: SCIP-Inf-9

Definition: There is documentation that the urinary catheter was removed on Postoperative Day Zero (POD 0) through Postoperative Day Two (POD 2) with the *Anesthesia End Date* being POD 0.

Suggested Data Collection Question: Is there documentation that the urinary catheter was removed on POD 0 through POD 2 with the *Anesthesia End Date* being POD 0?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 There is documentation that the urinary catheter was removed on POD 0 through POD 2.

2 There is no documentation that the urinary catheter was removed on POD 0 through POD 2.

3 Unable to determine (UTD) from medical record documentation whether the urinary catheter was removed on POD 0 through POD 2.

Notes for Abstraction:

- Postoperative Day 2 (POD 2) ends at midnight of the second postoperative day with *Anesthesia End Date* being POD 0.
- If there is documentation that the urinary catheter was removed after POD 2, select value "2."
- If the patient expires before the end of POD 2 prior to catheter removal select Value 1.
- If the catheter was discontinued or was unintentionally removed on POD 0 through POD 2 and was not reinserted, select value "1." This includes catheter removal by a patient.
- If the catheter was removed and was reinserted prior to the end of POD 2 due to an inability to void or to urinary retention, select value "1." This includes catheter removal by a patient.
- If the catheter was removed and was replaced or exchanged with a catheter that remained in place beyond POD 2, select value "2." This includes catheter removal by a patient.
- The documentation of catheter removal does NOT need to be found only within the perioperative period but must reflect that the catheter was removed on POD 0 through POD 2.

- If there is documentation that a catheter was inserted during the specified timeframe and there is documentation that the patient voided on POD 0 through POD 2, after the time that the catheter was inserted, select value “1.”

Suggested Data Sources:
- Discharge summary
- Graphic sheet (I&O form)
- Nurses notes
- Progress notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Chest X-Ray*

Collected For: CMS Only: PN-6; **The Joint Commission Only:** PN-3a, PN-6a, PN-6b; **CMS Voluntary Only:** PN-3a, PN-3b

Definition: Documentation of a chest x-ray or CT scan the day prior to hospital arrival through acute inpatient discharge.

Suggested Data Collection Question: Did the patient have a chest x-ray/CT scan the day prior to hospital arrival through acute inpatient discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 There is documentation the patient had an abnormal chest x-ray/CT scan the day prior to arrival through acute inpatient discharge.

2 There is documentation the patient had a normal or chronic chest x-ray/CT scan the day prior to arrival through acute inpatient discharge.

3 The patient did not have a chest x-ray/CT scan the day prior to arrival through acute inpatient discharge or Unable to Determine (UTD) from the medical record documentation if the patient had a chest x-ray/CT scan.

Notes for Abstraction:

- For purposes of this data element, an abnormal chest x-ray/CT scan is defined as the documentation of an Inclusion term, with exception of the following situations:
  - The documentation of an Inclusion term is clearly described as a negative, for example: “no infiltrate seen,” “chest x-ray negative for consolidation,” select value “2.”
  - The only documentation of an Inclusion term is prefaced with wording such as, “no significant” or “no definite,” select value “2.”
  - The only findings in the radiology report or physician/APN/PA documentation are chronic or normal, select value “2.” This includes inclusion terms defined as chronic, e.g. “The heart is difficult to assess because of a large area of consolidation and an infiltrate in the left lung field. All findings appear chronic.”
- Any documentation in the current chart may be used. The Suggested Data Sources have been placed in a recommended order for review of the medical record because these are the most likely places to find documentation of acceptable terms. If an Inclusion term is found, select value “1” and do not look any further. If an Inclusion term is not found continue to review the medical

record for physician/APN/PA documentation of Inclusion terms until the remainder of the chart has been reviewed.

- Do not use the “history” or “indications” portion of the chest x-ray or CT scan, although the findings and impression portions are both acceptable.
- In order to select value “1” an Inclusion term must be documented in reference to an x-ray/CT scan interpretation. If one of the following terms is documented by a physician/APN/PA you may assume a chest x-ray/CT was performed as the only way to know if one of these exists is via x-ray/scan: infiltrate, density, markings, haziness, opacity, patchiness, reticulonodular pattern.
- Both regular and portable chest x-ray results are acceptable.
- This data element only applies to x-rays and CT scans. As long as the x-ray or CT scan shows the chest or part of the chest, it can be used.
  Example:
  If “Infiltrate” is listed among other findings in the radiographic report of a CT scan of the abdomen, select value “1.”
- Do NOT reference Appendix H, Table 2.6.
- If there is mention of a chest x-ray or CT scan and there is no documentation that it was performed prior to the patient arrival or during the hospitalization, assume it was performed during the hospitalization.
  Examples:
  - H&P says “CXR performed last week at physician’s office.” Physician note states, “CXR shows infiltrate.” There is no documentation of a CXR performed during the hospitalization. This will be a value “3,” as there is mention of a CXR performed more than 24 hours prior to arrival.
  - Physician note states, “CXR shows infiltrate.” No mention of a CXR performed in the hospital or prior to arrival. Assume it was during the hospitalization and select value “1.”

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY
RECOMMENDED ORDER FOR THESE SOURCES

1. Chest x-ray report
2. Chest CT scan report
3. Other x-ray or CT scan with lung field findings
4. Physician’s notes
5. History & Physical
6. Remainder of current hospital record

Inclusion Guidelines for Abstraction:
ALL INCLUSIVE with the EXCEPTION of variations on terms in the list, e.g., density = dense, haziness = hazy, etc.

- Airspace disease
- Airspace process
- Air bronchogram
- Bronchopneumonia
- Consolidation
- Consolidative process
- Density

- Infection
- Infectious process
- Infiltrate
- Infiltration
- Infiltrative process
- Inflammation
- Inflammatory process
- Interstitial changes
- Interstitial disease
- Interstitial edema
- Interstitial fibrosis
- Interstitial pneumonia
- Interstitial process
- Interstitial prominence
- Haziness
- Lung process
- Markings
- Opacity
- Opacification
- Patchiness
- Pneumonia
- Pneumonic process
- Pneumonitis
- Positive infiltrate
- Pulmonary process
- Reticulonodular pattern

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Clinical Trial*

Collected For: CMS/Joint Commission: AMI-7a, AMI-8a, HF-2, SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-4, SCIP-Inf-9, SCIP-Card-2, SCIP-VTE-2, All STK Measures, All VTE Measures; **CMS Only:** PN-6; **The Joint Commission Only:** AMI-1, AMI-2, AMI-3, AMI-5, AMI-7, AMI-8, AMI-10, All CAC Measures, HF-3, PN-3a, PN-6a, PN-6b, SCIP-Inf-6; **CMS Voluntary Only:** AMI-1, AMI-2, AMI-3, AMI-5, AMI-7, AMI-8, AMI-10, HF-1, HF-3, PN-3a, PN-3b, SCIP-Inf-6

Definition: 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, HF, PN, SCIP, STK, VTE).

Suggested Data Collection Question: During this hospital stay, was the patient enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AMI, CAC, HF, PN, SCIP, STK, VTE)?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

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, HF, PN, 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, HF, PN, SCIP, STK, VTE), or unable to determine from medical record documentation.

Notes for Abstraction:

- To select "Yes" to this data element, BOTH of the following must be true:
  1. **There must be a signed consent form for clinical trial**. For the purposes of abstraction, a clinical trial is defined as an **experimental study** in which research subjects are recruited and assigned a treatment/intervention and their outcomes are measured based on the intervention received. Treatments/interventions most often include use of drugs, surgical procedures, and devices. Often a control group is used to compare with the treatment/intervention. Allocation of different interventions to participants is usually randomized.
  2. **There must be documentation on the signed consent form 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, HF, PN, SCIP, STK, VTE). Patients may either be newly enrolled in a clinical trial during the hospital stay or enrolled in a clinical trial prior to arrival and continued active participation in that clinical trial during this hospital stay.

- In the following situations, select "No:"
  1. **There is a signed patient consent form for an observational study only**. Observational studies are non-experimental and involve no intervention (e.g., registries). Individuals are observed (perhaps with lab draws, interviews, etc.), data is collected, and outcomes are tracked by investigators. Although observational studies may include the assessment of the effects of an intervention, the study participants are not allocated into intervention or control groups.
  2. **It is not clear whether the study described in the signed patient consent form is experimental or observational**.
  3. **It is not clear which study population the clinical trial is enrolling**. Assumptions should not be made if it is not specified.

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.

HF:
Only capture patients enrolled in clinical trials studying patients with heart failure (HF).

PN:
Only capture patients enrolled in clinical trials studying patients with pneumonia.

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.

STK:
Only capture patients enrolled in clinical trials studying patients with stroke.

VTE:
Only capture patients enrolled in clinical trials studying patients with VTE (prevention or treatment interventions).

Suggested Data Sources:
ONLY ACCEPTABLE SOURCES
Signed consent form for clinical trial

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Cognitive Impairment*

Collected For: The Joint Commission Only: All SUB Measures, All TOB Measures;
CMS Informational Only: All SUB Measures, All TOB Measures

Definition: Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set related to documentation that the patient cannot be screened for tobacco and alcohol use due to the impairment (e.g., comatose, obtunded, confused, memory loss) during the entire hospitalization.

Suggested Data Collection Question: Is there documentation in the medical record that indicates the patient was cognitively impaired during the entire hospitalization?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

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

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

Suggested Data Sources:

- Consultation notes
- History and physical
- Nursing admission assessment
- Nursing notes
- Progress notes

Inclusion Guidelines for Abstraction:

- Altered Level of Consciousness (LOC)
- Altered Mental Status
- Cognitive impairment
- Cognitively impaired

- Confused
- Memory loss
- Mentally retarded
- Obtunded

Exclusion Guidelines for Abstraction:
- Temporary cognitive impairment due to acute substance use (e.g., overdose or acute intoxication)

Data Element Name: *Comfort Measures Only*

Collected For: CMS/The Joint Commission: HF-2, STK-1, STK-2, STK-3, STK-5, STK-6, STK-8, STK-10, VTE-1, VTE-2, VTE-3, VTE-4, VTE-6; **CMS Only:** PN-6; **The Joint Commission Only:** AMI-1, AMI-2, AMI-3, AMI-5, AMI-10, HF-3, PN-3a, PN-6a, PN-6b, All SUB Measures, All TOB Measures; **CMS Voluntary Only:** AMI-1, AMI-2, AMI-3, AMI-5, AMI-10, HF-1, HF-3, PN-3a, PN-3b; **CMS Informational Only:** All SUB Measures, All TOB Measures

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

Suggested Data Collection Question: When is the earliest physician/APN/PA documentation of comfort measures only?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 **Day 0 or 1:** The earliest day the physician/APN/PA documented comfort measures only was the day of arrival (Day 0) or day after arrival (Day 1).

2 **Day 2 or after:** The earliest day the physician/APN/PA documented comfort measures only was two or more days after arrival day (Day 2+).

3 **Timing unclear:** There is physician/APN/PA documentation of comfort measures only during this hospital stay, but whether the earliest documentation of comfort measures only was on day 0 or 1 OR after day 1 is unclear.

4 **Not Documented/UTD:** There is no physician/APN/PA documentation of comfort measures only, or unable to determine from medical record documentation.

Notes for Abstraction:

- **Only accept terms identified in the list of inclusions. No other terminology will be accepted.**
- Physician/APN/PA documentation of comfort measures only (hospice, comfort care, etc.) mentioned in the following contexts suffices:

- Comfort measures only recommendation
- Order for consultation or evaluation by a hospice care service
- Patient or family request for comfort measures only
- Plan for comfort measures only
- Referral to hospice care service

- Determine the earliest day the physician/APN/PA DOCUMENTED comfort measures only in the ONLY ACCEPTABLE SOURCES. Do not factor in when comfort measures only was actually instituted.
  Examples:
  - "Discussed comfort care with family on arrival" noted in day 2 progress note – Select "2."
  - POLST order for comfort care dated prior to arrival – Select "1."
- If any of the inclusions are documented in the ONLY ACCEPTABLE SOURCES, select "1," "2," or "3" accordingly, unless otherwise specified in this data element.
- Documentation of an Inclusion term in the following situations should be disregarded. Continue to review the remainder of the ONLY ACCEPTABLE SOURCES for acceptable Inclusion terms. If the **ONLY** documentation found is an Inclusion term in the following situations, select value "4."
  - Documentation that is dated prior to arrival or documentation which refers to the pre-arrival time period (e.g., comfort measures only order in previous hospitalization record, "Pt. on hospice at home" in MD ED note).
    EXCEPTION:
    State-authorized portable orders (SAPOs). SAPOs are specialized forms, Out-of-Hospital DNR (OOH DNR) or Do Not Attempt Resuscitation (DNAR) orders, or identifiers authorized by state law, that translate a patient's preferences about specific-end-of-life treatment decisions into portable medical orders.
    Examples:
    - DNR-Comfort Care form
    - MOLST (Medical Orders for Life-Sustaining Treatment)
    - POLST (Physician Orders for Life-Sustaining Treatment)
  - Pre-printed order forms signed by the physician/APN/PA:
    - Disregard an Inclusion term in a statement that is not part of the order or that is not clearly selected (on a form that offers options to select from).
      Examples:
      - Inclusion term used only in the title of the form (e.g., "DNR-Comfort Care" form, option "Comfort Care" is not checked)
      - Inclusion term used only in the pre-printed instruction for completing the form (e.g., "Copy of form to hospice," "Instructions" section of the form further defines the option "Comfort care")
    - If there is a specific option for "Comfort Measures Only" (or other Inclusion term) that is **unchecked**, then disregard documentation on that form, regardless of whether that Inclusion term might be used in a different option that is checked.
      Example:

POLST form - The “Limited Additional Interventions” option checked is described as “In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, ….”

- Inclusion term clearly described as negative.
  Examples:
  - “No comfort care"
  - “Not a hospice candidate"
  - "Not appropriate for hospice care"
  - “I offered hospice care consult to discuss end of life issues. Family did not show any interest.”
  - “Patient declines hospice care at this time but I feel this will be an important plan of care when his condition deteriorates further”
  - “Comfort care would also be reasonable - defer decision for now”
- Comfort measures made conditional upon whether or not the patient arrests. Examples:
  - “DNRCCA” (Do Not Resuscitate – Comfort Care Arrest)
  - “Comfort Care Protocol will be implemented in the event of a cardiac arrest or a respiratory arrest”
  - “Family requests comfort measures only should the patient arrest.”

- Documentation of “CMO” should be disregarded if documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., “hx dilated CMO” – Cardiomyopathy context).
- If there is documentation of an Inclusion term clearly described as negative in one source and an Inclusion term NOT described as negative in another source, that second source would still count for comfort measures only.
  Examples:
  - On Day 0 the physician documents “The patient is not a hospice candidate.” On Day 3, the physician orders a hospice consult. Select “2.”
  - On Day 1 the physician documents the patient is comfort measures only. On Day 2 the physician documents “The patient is refusing CMO.” Select “1.”

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY IN THE FOLLOWING ONLY ACCEPTABLE SOURCES:

- Discharge summary
- DNR/MOLST/POLST forms
- Emergency Department record
- Physician orders
- Progress notes

Excluded Data Sources:
Restraint order sheet

Inclusion Guidelines for Abstraction:

- Brain dead
- Brain death
- Comfort care

- Comfort measures
- Comfort measures only (CMO)
- Comfort only
- DNR-CC
- End of life care
- Hospice
- Hospice care
- Organ harvest
- Terminal care

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Date Last Known Well*

Collected For: CMS/The Joint Commission: STK-4

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

Suggested Data Collection Question: What was the date at which the patient was last known to be well or at his or her baseline state of health?

Format:

Length: 10 - MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- If the date last known well is unable to be determined from medical record documentation, enter "UTD."
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid date/format) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Example:
  Documentation indicates the date last known well was 03-**42**-20xx. No other documentation in the medical record provides a valid date. Since the *Date Last Known Well* is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD."
  Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *Date Last Known Well* allows the case to be accepted into the warehouse.
- When an actual date is not documented but there is reference to the date described in the medical record (e.g., today, tonight, this evening, and this morning), assume that the *Date Last Known Well* is the same as the date for that timeframe preceding hospital arrival. The *Date Last Known Well* and the *Arrival Date* may be the same date or a different date.
  Examples:
  - "Wife reports patient normal this evening. Hospital arrival is 0030 on 12-10-20xx." *Date Last Known Well* is 12-09-20xx.

- "Patient states he felt perfectly fine earlier today. Arrives at hospital 3:59 PM on 12-10-20xx." *Date Last Known Well* is 12-10-20xx.

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

Suggested Data Sources:
- Ambulance record
- Emergency Department records
- History and physical
- IV flow sheets
- Medication administration record
- Nursing flow sheets
- Progress notes
- Transfer sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Decision to Admit Date*

Collected For: CMS/The Joint Commission: ED-2

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

Suggested Data Collection Question: What was the earliest documented month, day, and year of the decision to admit?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

Enter the documented date of the decision to admit
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- If the date of the decision to admit to observation or inpatient status is unable to be determined from medical record documentation, select "UTD."
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care [after the *Discharge Date*]) **and** no other documentation is found that provides this information, the abstractor should select "UTD."

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

  Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data

Warehouse. Use of "UTD" for *Decision to Admit Date* allows the case to be accepted into the warehouse.

- When reviewing ED records do NOT include any documentation from external sources (e.g., ambulance records, physician/advanced practice nurse/physician assistant [physician/APN/PA] office record, laboratory reports or ECGs) obtained prior to arrival. The intent is to utilize any documentation that reflects processes that occurred in the ED or hospital.
- For purposes of this data element, the source "Emergency Department record" includes any documentation from the time of ED arrival to the time the patient physically departed from the ED.
  Example:
  ED departure is at 11:00 on 3/12/20xx. The attending physician's admit orders written in the inpatient record at 10:00 on 3/12/20xx are considered part of the ED record.
- Disregard physician/APN/PA narrative documentation of a consult or orders for consult, transfer to another physician's service, or discussion with another physician since this does not reflect a decision was made.
- Use the date from the first documentation of decision to admit for either observation or inpatient. If there are multiple dates documented for the decision to admit to observation or inpatient status, abstract the earliest date.
  Example:
  The physician ordered "Admit Observation Service." Four hours later the physician wrote an order to admit the patient to inpatient status. These orders were written while the patient was still receiving care in the ED. Use the earlier order for Observation Services to abstract as date and time.
- If it can be determined that the patient arrived on the same date and departed on the same date, the arrival date can be used as the decision to admit to observation or inpatient status date.
- Data fields representing 'decision to admit' in electronic documentation for this specific episode of care are acceptable to use as long as they are the earliest physician/APN/PA documentation and clearly defined to capture the date an observation status or inpatient admit decision was documented. Information found in an electronically interfaced event log or Admit/Decision/Transfer (ADT) is acceptable provided this information is part of the submitted medical record covering the arrival to discharge date being abstracted.
  Examples:
  - Decision to Admit
  - Dispo
  - Disposition set to admit
- For purposes of this data element *Decision to Admit Date* is the date on which the physician/APN/PA makes the decision to admit the patient from the emergency department to the hospital. This will not necessarily coincide with the date the patient is officially admitted to inpatient status.
- If the decision to admit the patient to observation or inpatient status is made, but the actual request for a bed is delayed until an inpatient bed is available, record the date the physician/APN/PA communicated the decision to admit.
- If the decision to admit to observation or inpatient status date is dated prior to the date of patient arrival or after the date of departure, select "UTD."

- *Decision to Admit Date* includes physician/APN/PA documentation of a decision to send the patient to cath lab or surgery.
  Example:
  The ED physician documents that he/she is sending the patient to the OR for surgery. The decision to admit to observation or inpatient status date will abstract as the date this was documented.
- The inclusion and exclusion lists are not to be considered comprehensive lists of inclusions and exclusions.

Suggested Data Sources:
ONLY ACCEPTABLE SOURCES
PHYSICIAN/APN/PA DOCUMENTATION ONLY
Emergency Department record

Inclusion Guidelines for Abstraction:
- Admit Order Date
- Disposition Order Date

Exclusion Guidelines for Abstraction:
- Bed assignment Date
- Direct admit patients seen in the ED

Data Element Name: *Decision to Admit Time*

Collected For: CMS/The Joint Commission: ED-2

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

Suggested Data Collection Question: What was the earliest documented time of the decision to admit?

Format:

Length: 5 – HH:MM (with or without colon) or UTD
Type: Time
Occurs: 1

Allowable Values:

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight - 00:00	Noon - 12:00
5:31 am - 05:31	5:31 pm - 17:31
11:59 am - 11:59	11:59 pm - 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *Decision to Admit Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00, do not forget to change the *Decision to Admit Date.*
Example:
Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:

- For times that include “seconds,” remove the seconds and record the military time.
  Example:

15:00:35 would be recorded as 15:00.

- If the time of the decision to admit to observation or inpatient status is unable to be determined from medical record documentation, select "UTD."
- The medical record must be abstracted as documented (taken at "face value"). When the time documented is obviously in error (not a valid format/range) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Example:
  Documentation indicates the *Decision to Admit Time* was 3300. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid time. Since the *Decision to Admit Time* is outside of the range in the Allowable Values for "Hour," it is not a valid time and the abstractor should select "UTD."
  Note: Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *Decision to Admit Time* allows the case to be accepted into the warehouse.
- When reviewing ED records do NOT include any documentation from external sources (e.g., ambulance records, physician/advanced practice nurse/physician assistant [physician/APN/PA] office record, laboratory reports, or ECGs) obtained prior to arrival. The intent is to utilize any documentation which reflects processes that occurred in the ED or hospital.
- For purposes of this data element, the source "Emergency Department record" includes any documentation from the time of ED arrival to the time the patient physically departed from the ED.
  Example:
  ED departure is at 11:00 on 3/12/20XX. The attending physician's admit orders written in the inpatient record at 10:00 on 3/12/20XX are considered part of the ED record.
- Disregard physician/APN/PA narrative documentation of a consult or orders for consult, transfer to another physician's service, or discussion with another physician since this does not reflect a decision was made.
- For narrative documentation that clearly refers to the decision to admit to observation/inpatient status or that the patient will be going to cath lab or surgery, take the initial note time unless there is a later time specified within that note.
- Use the time from the first documentation for either observation or inpatient. If there are multiple times documented for the *Decision to Admit Time* abstract the earliest time.
  Example:
  The physician ordered "Admit Observation Services." Four hours later the physician wrote an order to admit the patient to inpatient status. These orders were written while the patient was still receiving care in the ED. Use the earlier order for Observation Services to abstract decision to admit time.
- Data fields representing 'decision to admit' in electronic documentation for this specific episode of care are acceptable to use as long as they are the earliest physician/APN/PA documentation and clearly defined to capture the time an observation status or inpatient admit decision was documented. Information found in an electronically interfaced event log or Admit/Decision/Transfer (ADT) is acceptable provided this information is part of the submitted medical record

covering the arrival to discharge time being abstracted.
Examples:
- Decision to Admit
- Dispo
- Disposition set to admit

- For purposes of this data element "*Decision to Admit Time*" is the time the physician/APN/PA communicates the decision to admit the patient to observation or inpatient status from the emergency department to the hospital . This will not necessarily coincide with the time the patient is officially admitted to inpatient status.
- If the decision to admit the patient to observation or inpatient status is made, but the actual request for a bed is delayed until an inpatient bed is available, record the time the physician/APN/PA communicated the decision to admit.
- If documentation of the decision to admit to observation or inpatient status time is prior to arrival or after departure from the ED, select, "UTD."
  Example:
  The APN saw the patient in the clinic and sent him/her to the ED for admission. Select UTD.
- *Decision to Admit Time* includes physician/APN/PA documentation of a decision to send the patient to cath lab or surgery.
  Example:
  The ED physician documents that he/she is sending the patient to the OR for surgery. The decision to admit to observation or inpatient status time will abstract as the time this was documented.
- The inclusion and exclusion lists are not to be considered comprehensive lists of inclusions and exclusions.

Suggested Data Sources:
ONLY ACCEPTABLE SOURCES
PHYSICIAN/APN/PA DOCUMENTATION ONLY
Emergency Department record

Inclusion Guidelines for Abstraction:
- Admit Order Time
- Disposition Time

Exclusion Guidelines for Abstraction:
- Bed assignment time
- Direct admit patients seen in the ED
- Report Called Time

Data Element Name: *Discharge Date*

Collected For: CMS/The Joint Commission: All Records; **Used in Algorithms for: CMS/The Joint Commission:** SCIP-Inf-4, SCIP-VTE-2; **CMS Only:** PN-6; **The Joint Commission Only:** AMI-1, PN-3a, PN-6a, PN-6b, All SUB Measures, All TOB Measures; **CMS Informational Only:** All SUB Measures, All TOB Measures; **CMS Voluntary Only:** AMI-1, PN-3a, PN-3b

Definition: The month, day, and year the patient was discharged from acute care, left against medical advice, or expired during this stay.

Suggested Data Collection Question: What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired?

Format:

Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)

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

Notes for Abstraction:

Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.

Suggested Data Sources:

- Discharge summary
- Face sheet
- Nursing discharge notes
- Physician orders
- Progress notes
- Transfer note
- UB-04, Field Location: 6

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Discharge Disposition*

Collected For: CMS/The Joint Commission: HF-2, IMM-2**,** STK-2, STK-3, STK-6, STK-8, STK-10, VTE-3, VTE-4, VTE-5; **The Joint Commission Only:** AMI-1, AMI-2, AMI-3, AMI-5, AMI-10, CAC-3, HF-3, SUB-3, SUB-4, TOB-3, TOB-4; **CMS Informational Only**: SUB-3, SUB-4, TOB-3, TOB-4; **CMS Voluntary Only:** AMI-1, AMI-2, AMI-3, AMI-5, AMI-10, HF-1, HF-3, IMM-1, PN-3b

Definition: The final place or setting to which the patient was discharged on the day of discharge.

Suggested Data Collection Question: What was the patient's discharge disposition on the day of discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 Home

2 Hospice - Home

3 Hospice – Health Care Facility

4 Acute Care Facility

5 Other Health Care Facility

6 Expired

7 Left Against Medical Advice/AMA

8 Not Documented or Unable to Determine (UTD)

Notes for Abstraction:

- **Only use documentation written on the day prior to discharge through 30 days after discharge** when abstracting this data element.
  Example:
  Documentation in the Discharge Planning notes on 04-01-20xx state that the patient will be discharged back home. On 04-06-20xx the physician orders and nursing discharge notes on the day of discharge reflect that the patient was being transferred to skilled care. The documentation from 04-06-20xx would be used to select value "5" (Other Health Care Facility).
- The medical record must be abstracted as documented (taken at "face value"). Inferences should not be made based on internal knowledge.

- If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract. If documentation is contradictory, use the latest documentation.
  Examples:
  - Discharge summary dictated 2 days after discharge states patient went "home." Physician note on day of discharge further clarifies that the patient will be going "home with hospice." Select value "2" ("Hospice - Home").
  - Discharge planner note from day before discharge states "XYZ Nursing Home." Discharge order from day of discharge states "Discharge home." Contradictory documentation, use latest. Select value "1" ("Home").
  - Physician order on discharge states "Discharge to ALF." Discharge instruction sheet completed after the physician order states patient discharged to "SNF." Contradictory documentation, use latest. Select value "5" ("Other Health Care Facility").
- If documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. See Inclusion lists for examples.
  - Acute Care Facility
  - Hospice – Health Care Facility
  - Hospice – Home
  - Other Health Care Facility
  - Home
- Hospice (values "2" and "3") includes discharges with hospice referrals and evaluations.
- If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select value "4" ("Acute Care Facility").
- If the medical record identifies the facility the patient is being discharged to by name only (e.g., "Park Meadows"), and does not reflect the type of facility or level of care, select value "5" ("Other Health Care Facility").
- If the medical record states only that the patient is being "discharged" and does not address the place or setting to which the patient was discharged, select value "1" ("Home").
- When determining whether to select value "7" ("Left Against Medical Advice/AMA"):
  - Explicit "left against medical advice" documentation is not required. E.g., "Patient is refusing to stay for continued care" – Select value "7."
  - Documentation suggesting that the patient left before discharge instructions could be given does not count.
  - A signed AMA form is not required, for the purposes of this data element.
  - Do not consider AMA documentation and other disposition documentation as "contradictory." If any source states the patient left against medical advice, select value "7," regardless of whether the AMA documentation was written last. E.g., AMA form signed and discharge instruction sheet states "Discharged home with belongings" – Select "7."

Suggested Data Sources:

- Discharge instruction sheet

- Discharge planning notes
- Discharge summary
- Nursing discharge notes
- Physician orders
- Progress notes
- Social service notes
- Transfer record

Excluded Data Sources:
- Any documentation prior to the last two days of hospitalization
- Coding documents
- UB-04

Inclusion Guidelines for Abstraction:
Home (Value 1):
- Assisted Living Facilities (ALFs) – Includes ALFs and assisted living care at nursing home, intermediate care, and skilled nursing facilities
- Court/Law Enforcement – includes detention facilities, jails, and prison
- Home – includes board and care, foster or residential care, group or personal care homes, retirement communities, and homeless shelters
- Home with Home Health Services
- Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs and Partial Hospitalization

Hospice – Home (Value 2):
- Hospice in the home (or other "Home" setting as above in Value 1)

Hospice – Health Care Facility (Value 3):
- Hospice - General Inpatient and Respite
- Hospice - Residential and Skilled Facilities
- Hospice - Other Health Care Facilities

Acute Care Facility (Value 4):
- Acute Short Term General and Critical Access Hospitals
- Cancer and Children's Hospitals
- Department of Defense and Veteran's Administration Hospitals

Other Health Care Facility (Value 5):
- Extended or Intermediate Care Facility (ECF/ICF)
- Long Term Acute Care Hospital (LTACH)
- Nursing Home or Facility including Veteran's Administration Nursing Facility
- Psychiatric Hospital or Psychiatric Unit of a Hospital
- Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
- Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed
- Transitional Care Unit (TCU)
- Veterans Home

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Discharge Instructions Address Activity*

Collected For: CMS Voluntary Only: HF-1

Definition: Written discharge instructions or other documentation of educational material given to patient/caregiver addressing the patient's activity level after discharge.

Suggested Data Collection Question: Did the WRITTEN discharge instructions or other documentation of educational material given to the patient/caregiver address the patient's activity level after discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	WRITTEN discharge instructions/educational material given to patient/caregiver address the patient's activity level after discharge.
N (No)	WRITTEN discharge instructions/educational material do not address activity or unable to determine from medical record documentation.

Notes for Abstraction:

- Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.
  - Documentation must clearly convey that the patient/caregiver was given a copy of the material to take home. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.
  - **Use only documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver.
- Written instructions given anytime during the hospital stay are acceptable.
- If the patient refused written discharge instructions/material which addressed activity, select "Yes."
- The caregiver is defined as the patient's family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:

- Discharge instruction sheet
- Home health referral form
- Nursing notes
- Physical therapy notes
- Teaching sheet

Inclusion Guidelines for Abstraction:
Activity level (examples)

- Activity as tolerated
- Cardiac rehab
- Exercise instructions
- No strenuous activity
- Physical therapy
- Regular activity
- Regular walking
- Rest
- Restrict activity

Exclusion Guidelines for Abstraction:
Unchecked checkbox next to instruction (e.g., blank checkbox on discharge instruction sheet next to “Up as tolerated”).

Data Element Name: *Discharge Instructions Address Compliance Issues*

Collected For: CMS/The Joint Commission: VTE-5

Definition: Written discharge instructions or other documentation of educational material given to patient/caregiver addressing compliance issues related to warfarin therapy prescribed after discharge.

Suggested Data Collection Question: Did the WRITTEN discharge instructions or other documentation of educational material given to the patient/caregiver address compliance issues related to warfarin therapy prescribed after discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	WRITTEN discharge instructions/educational material were given to the patient/caregiver that addressed compliance issues related to warfarin therapy prescribed after discharge.
N (No)	WRITTEN discharge instructions/educational material do not address compliance issues related to warfarin therapy prescribed after discharge or unable to determine from medical record documentation.

Notes for Abstraction:

- Documentation that addresses compliance issues must include **all** of the following, in order to select "Yes."
  - The importance of taking warfarin as instructed.
  - The importance of monitoring warfarin with scheduled PT/INR blood draws.
- Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.
- Documentation must clearly convey that the patient/caregiver was given a copy of the material to take home. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.
- **Use only documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver.
- Written instructions given anytime during the hospital stay are acceptable.

- If the patient refused written discharge instructions/material which addressed compliance issues, select “Yes.”
- The caregiver is defined as the patient’s family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:
- Discharge instruction sheet
- Home health referral form
- Nursing notes
- Teaching sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
Unchecked checkbox next to instruction (e.g., blank checkbox on discharge instruction sheet next to “The importance of taking warfarin as instructed.”).

Data Element Name: *Discharge Instructions Address Diet*

Collected For: CMS Voluntary Only: HF-1

Definition: Written discharge instructions or other documentation of educational material given to patient/caregiver addressing diet/fluid intake instructions after discharge.

Suggested Data Collection Question: Did the WRITTEN discharge instructions or other documentation of educational materials given to the patient/caregiver address diet/fluid intake after discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	WRITTEN discharge instructions/educational material given to patient/caregiver address diet/fluid intake instructions after discharge.
N (No)	WRITTEN discharge instructions/educational material do not address diet/fluid intake or unable to determine from medical record documentation.

Notes for Abstraction:

- Diet/fluid intake instructions do not need to be specific to heart failure: ANY diet or fluid intake instructions are acceptable.
- Acceptable materials include discharge instructions sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.
  - Documentation must clearly convey that the patient/caregiver was given a copy of the material to take home. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.
  - **Use only documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver.
- Written instructions given anytime during the hospital stay are acceptable.
- If the patient refused written discharge instructions/material which addressed diet, select “Yes.”

- The caregiver is defined as the patient's family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:
- Dietary notes
- Discharge instruction sheet
- Home health referral form
- Nursing notes
- Teaching sheet

Inclusion Guidelines for Abstraction:
Diet (examples)
- Continue same diet
- Diet as instructed
- Diet as tolerated (DAT)
- Reg diet
- Restrict fluids
- Specific diet (e.g., 2 gm Sodium diet, 1800 ADA diet) noted
- Tube feedings

Exclusion Guidelines for Abstraction:
Unchecked checkbox next to instruction (e.g., blank checkbox on discharge instruction sheet next to "Diet: No added salt").

Data Element Name: *Discharge Instructions Address Dietary Advice*

Collected For: CMS/The Joint Commission: VTE-5

Definition: Written discharge instructions or other documentation of educational material given to patient/caregiver addressing dietary advice related to warfarin therapy prescribed after discharge.

Suggested Data Collection Question: Did the WRITTEN discharge instructions or other documentation of educational material given to the patient/caregiver address dietary advice related to warfarin therapy prescribed after discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	WRITTEN discharge instructions/educational material were given to the patient/caregiver that addressed dietary advice related to warfarin therapy prescribed after discharge.
N (No)	WRITTEN discharge instructions/educational material do not address dietary advice related to warfarin therapy prescribed after discharge or unable to determine from medical record documentation.

Notes for Abstraction:

- Documentation that addresses dietary advice must include **all** of the following, in order to select, "Yes."
  - A "consistent amount" of foods with Vitamin K rather than avoidance should be advised.
  - Avoid major changes in dietary habits, or notify health professional before changing habits.
- Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.
- Documentation must clearly convey that the patient/caregiver was given a copy of the material to take home. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.
- **Use only documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver.

- Written instructions given anytime during the hospital stay are acceptable.
- If the patient refused written discharge instructions/material which addressed dietary advice, select “Yes.”
- The caregiver is defined as the patient’s family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:
- Discharge instruction sheet
- Home health referral form
- Nursing notes
- Teaching sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction
Unchecked checkbox next to instruction (e.g., blank checkbox on discharge instruction sheet next to “A consistent amount of foods with Vitamin K rather than avoidance should be advised.”)

Data Element Name: *Discharge Instructions Address Follow-up*

Collected For: CMS Voluntary Only: HF-1

Definition: Written discharge instructions or other documentation of educational material given to patient/caregiver addressing follow-up with a physician/advanced practice nurse/physician assistant (physician/APN/PA) after discharge.

Suggested Data Collection Question: Did the WRITTEN discharge instructions or other documentation of educational material given to the patient/caregiver address follow-up with a physician/APN/PA after discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	WRITTEN discharge instructions/educational material given to patient/caregiver address follow-up with a physician/APN/PA after discharge.
N (No)	WRITTEN discharge instructions/educational material do not address follow-up with a physician/APN/PA or unable to determine from medical record documentation.

Notes for Abstraction:

- In the absence of explicit documentation that follow-up involves contact with a physician/APN/PA, the abstractor may infer contact with a physician/APN/PA, unless documentation suggests otherwise (e.g., BP check, laboratory work only).
- Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.
  - Documentation must clearly convey that the patient/caregiver was given a copy of the material to take home. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.
  - **Use only documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver.
- Written instructions given anytime during the hospital stay are acceptable.
- If the patient refused written discharge instructions/material which addressed follow-up, select “Yes.”

- The caregiver is defined as the patient's family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:
- Discharge instruction sheet
- Home health referral form
- Nursing notes
- Teaching sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
- Follow-up prescribed on PRN or as needed basis
- Follow-up noted only as Not Applicable (N/A), None, or left blank
- Pre-printed follow-up appointment instruction with all fields left blank (e.g., "Please return for follow up appointment with Dr. [blank line] on [blank line]," "Make an appointment with your physician in [blank line] for follow up"), unless next to checked checkbox
- Unchecked checkbox next to instruction (e.g., blank checkbox on discharge instruction sheet next to "Call Dr.'s office for appointment within two weeks")

Data Element Name: *Discharge Instructions Address Follow-up Monitoring*

Collected For: CMS/The Joint Commission: VTE-5

Definition: Written discharge instructions or other documentation of educational material given to patient/caregiver addressing follow-up monitoring related to warfarin therapy prescribed after discharge.

Suggested Data Collection Question: Did the WRITTEN discharge instructions or other documentation of educational material given to the patient/caregiver address follow-up monitoring related to warfarin therapy prescribed after discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	WRITTEN discharge instructions/educational material were given to the patient/caregiver that addressed follow-up monitoring related to warfarin therapy prescribed after discharge.
N (No)	WRITTEN discharge instructions/educational material do not address follow-up monitoring related to warfarin therapy prescribed after discharge or unable to determine from medical record documentation.

Notes for Abstraction:

- Documentation that addresses follow-up monitoring must include the following in order to select, "Yes."
  - Information about plans to monitor warfarin post-discharge. For example, if "follow-up with Coumadin clinic in one week" is documented, select "Yes."
- If home health will be monitoring the warfarin, select "Yes."
- Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.
- Documentation must clearly convey that the patient/caregiver was given a copy of the material to take home. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.
- **Use only documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver.

- Written instructions given anytime during the hospital stay are acceptable.
- If the patient refused written discharge instructions/material which addressed follow-up monitoring, select “Yes.”
- The caregiver is defined as the patient’s family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:
- Discharge instruction sheet
- Home health referral form
- Nursing notes
- Teaching sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
Unchecked checkbox next to instructions (e.g., blank checkbox on discharge instruction sheet next to “Next date for PT/INR laboratory blood draw”).

Data Element Name: *Discharge Instructions Address Medications*

Collected For: CMS Voluntary Only: HF-1

Definition: Written discharge instructions or other documentation of educational material given to patient/caregiver addressing all discharge medications. Instructions must address at least the names of all discharge medications but may also include other usage instructions such as dosages, frequencies, side effects, etc.

Suggested Data Collection Question: Did the WRITTEN discharge instructions or other documentation of educational material given to the patient/caregiver address all discharge medications?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	WRITTEN discharge instructions/educational material given to patient/caregiver address discharge medications.
N (No)	WRITTEN discharge instructions/educational material do not address all discharge medications or unable to determine from medical record documentation.

Notes for Abstraction:

- Abstraction is a two-step process:
  1. Determine all of the medications being prescribed at discharge, based on available medical record documentation.
     - Discharge medication information included in a discharge summary dated after discharge should be used as long as it was added within 30 days after discharge.
     - If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc. Examples:
       - Two discharge summaries, one dictated 5/22 (day of discharge) and one dictated 5/27 - Use the 5/27 discharge summary.
       - Two discharge medication reconciliation forms, one not dated and one dated 4/24 (day of discharge) - Use both.
     - If discharge medications are noted using only references such as “continue home meds,” “resume other meds,” or “same

medications," rather than lists of the names of the discharge medications, the abstractor should use all sources to compile a list of medications the patient was on prior to arrival (or in the case of acute care transfers, use the medications the patient was on prior to arrival at the first hospital).

- Disregard all references to laxatives, antacids, vitamins, minerals (EXCEPT potassium), food supplements, and herbs, prn or not, AND disregard references to medications by class only (e.g., "calcium channel blocker") where the specific medication name is not specified. They are NOT required in the written instructions for the purposes of the Discharge Instructions measure (HF-1).
- PRN medications are required on the discharge instructions, with ONE exception: When discharge medications outside of the written discharge instructions are noted using ONLY references such as "continue current medications" or "continue present meds," rather than lists of the names of the discharge medications, and the abstractor is referencing what medications the patient was taking on the day of discharge (for comparison against the written discharge instructions, to confirm completeness of that list), medications which are clearly listed as prn (given on an as needed basis only) do NOT need to be included in the instructions.
- Oxygen should not be considered a medication**.**
- Medications which the patient will not be taking at home (and/or the caregiver will not be giving at home) are NOT required in the medication list included in the written discharge instructions (e.g., monthly B12 injections, intermittent IV dobutamine, Natrecor infusions, dialysis meds, chemotherapy).

2. Check this list against the written discharge instructions given to the patient to ensure that these instructions addressed at least the names of all of the discharge medications. If a list of discharge medications is not documented elsewhere in the record, and the completeness of the medication list in the instructions cannot be confirmed as complete, or it can be determined to be incomplete, select "No."
   - **EXCEPTION:** If a comparison list is not available, and the discharge list in the written discharge instructions cannot be determined to be complete or incomplete, but the written discharge instructions have the name or initials of the physician/advanced practice nurse/physician assistant (physician/APN/PA) signed on the form, presume the list of discharge medications in those instructions is complete. Signatures that are dated/timed after discharge are not acceptable.
   - In making medication name comparisons, consider two medications that are **brand/trade name vs. generic name** in nature or that have the **same generic equivalent** as matches.
     Examples of matches:
     - Vasotec vs. Enalapril
     - Toprol vs. Toprol XL
     - ASA vs. EC ASA

- Prinivil vs. Zestril
- Lopressor vs. Metoprolol
- Metoprolol vs. Metoprolol Succinate

Examples of mismatches:

- Lopressor vs. Toprol (metoprolol tartrate vs. metoprolol succinate)
- Prevacid vs. Protonix (lansoprazole vs. pantoprazole sodium)

- If there is documentation that the patient was discharged on insulin(s) of ANY kind, ANY reference to insulin as a discharge medication in the written discharge instructions can be considered a match, for the purposes of the Discharge Instructions measure (HF-1). E.g., D/C summary notes patient discharged on "Humulin Insulin" and "Insulin 70/30" is listed on the discharge instruction sheet – Consider this a match. However, contradictory documentation abstraction guidelines still apply to insulin cases (e.g., D/C summary notes patient discharged on "Novolog 50 units t.i.d." and "Novolog 50 units t.i.d." is discontinued on discharge medication reconciliation form – Select "No").

- In determining the medications prescribed at discharge (step 1 above), all discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
  - If there is a medication in one source that is not mentioned in other sources, take it as a discharge medication (i.e., required in the written discharge instructions) unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge - **Consider it a discharge medication in the absence of contradictory documentation.**
  - If documentation is contradictory (e.g., physician noted "d/c ASA" in the discharge orders, but it is listed in the discharge summary's discharge medication list), or after careful examination of circumstances, context, timing, etc., documentation raises enough questions about what medications are being prescribed at discharge, the case should be deemed "unable to determine" (select "No"), regardless of whether the medication in question is included in the written discharge instructions.
  - If there is documentation of a plan to start/restart a medication after discharge or a hold on a medication for a **defined** timeframe after discharge (e.g., "Start Plavix as outpatient," "Hold Lasix x 2 days," "Hold ASA until after endoscopy"):
    - If it is NOT listed as a discharge medication elsewhere (e.g., "Lasix," "Plavix"), it is not required in the discharge instructions (but if it is listed on the instructions, this is acceptable).
    - If it IS listed as a discharge medication elsewhere (e.g., "Lasix," "Plavix"), do not regard this as contradictory documentation, and require the medication in the discharge instructions.
  - Disregard a medication documented **only** as a recommended medication for discharge. E.g., "Recommend sending patient home on Vasotec" – Vasotec is not required in the discharge instructions (but if it is listed on

the instructions, this is acceptable). Documentation must be more clear that such a medication was actually prescribed at discharge.

- Do not give credit in cases where the patient was given written discharge medication instructions **only** in the form of written prescriptions.
- Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.
  - Documentation must clearly convey that the patient/caregiver was given a copy of the material to take home. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.
  - **Use only documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver.
- Written instructions given anytime during the hospital stay are acceptable.
- If the patient refused written discharge instructions/material which addressed discharge medications, select “Yes.”
- The caregiver is defined as the patient’s family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:

- Discharge instruction sheet
- Discharge progress notes
- Discharge summary
- Home health referral form
- Medication reconciliation form
- Nursing notes
- Teaching sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
Any general reference to a medication regimen (e.g., “continue home meds” listed on discharge instruction sheet), without specific documentation of medication names.

Data Element Name: *Discharge Instructions Address Potential for Adverse Drug Reactions and Interactions*

Collected For: CMS/The Joint Commission: VTE-5

Definition: Written discharge instructions or other documentation of educational material given to patient/caregiver addressing potential for adverse drug reactions and interactions related to warfarin therapy prescribed after discharge.

Suggested Data Collection Question: Did the WRITTEN discharge instructions or other documentation of educational material given to the patient/caregiver address potential for adverse drug reactions and interactions related to warfarin therapy prescribed after discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	WRITTEN discharge instructions/educational material were given to the patient/caregiver that addressed potential for adverse drug reactions and interactions related to warfarin therapy prescribed after discharge.
N (No)	WRITTEN discharge instructions/educational material do not address potential for adverse drug reactions and interactions related to warfarin therapy prescribed after discharge or unable to determine from medical record documentation.

Notes for Abstraction:

- Documentation that addresses potential for adverse drug reactions and interactions must include **all** of the following, in order to select, “Yes.”
  - Diet and medications can affect the PT/INR level.
  - Do not take or discontinue any medication or over-the-counter medication except on the advice of the physician or pharmacist.
  - Warfarin increases the risk of bleeding.
- Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.
- Documentation must clearly convey that the patient/caregiver was given a copy of the material to take home. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.

- **Use only documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver.
- Written instructions given anytime during the hospital stay are acceptable.
- If the patient refused written discharge instructions/material which addressed potential for adverse drug reactions and interactions, select "Yes."
- The caregiver is defined as the patient's family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:
- Discharge instruction sheet
- Home health referral form
- Nursing notes
- Teaching sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
Unchecked checkbox next to instruction (e.g., blank checkbox on discharge instruction sheet next to "Diet and medication can affect PT/INR").

Data Element Name: *Discharge Instructions Address Symptoms Worsening*

Collected For: CMS Voluntary Only: HF-1

Definition: Written discharge instructions or other documentation of educational material given to patient/caregiver addressing what to do if heart failure symptoms worsen after discharge.

Suggested Data Collection Question: Did the WRITTEN discharge instructions or other documentation of educational material given to the patient/caregiver address what to do if heart failure symptoms worsen after discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	WRITTEN discharge instructions/educational material given to patient/caregiver address what to do if heart failure symptoms worsen after discharge.
N (No)	WRITTEN discharge instructions/educational material do not address symptoms worsening or unable to determine from medical record documentation.

Notes for Abstraction:

- Include instructions which address what to do if heart failure symptoms recur or do not improve after discharge.
  Examples:
  - "Call the office if weight gain greater than 2 pounds."
  - "Come to the emergency room if you experience a problem with breathing."
  - "Call physician/APN/PA if edema recurs."
  - "Make an appointment if heart failure symptoms return."
- Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.
  - Documentation must clearly convey that the patient/caregiver was given a copy of the material to take home. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.
  - **Use only documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions

about what content may be covered in material documented as given to the patient/caregiver.

- Written instructions given anytime during the hospital stay are acceptable.
- If the patient refused written discharge instructions/material which addressed worsening heart failure symptoms, select "Yes."
- The caregiver is defined as the patient's family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:

- Discharge instruction sheet
- Home health referral form
- Nursing notes
- Teaching sheet

Inclusion Guidelines for Abstraction:
Heart failure symptoms

- Ankle/foot edema or swelling
- Breathing difficulty
- Decreased exercise tolerance
- Edema/swelling (location not specified)
- Fatigue
- Shortness of breath (SOB) or other breathing difficulty, in any context
- Weight gain

Exclusion Guidelines for Abstraction:

- Instructions on heart failure symptoms without mention of what to do if symptoms worsen
- Instructions on what to do to do if symptoms worsen, problems occur, the patient's condition changes or worsens, etc., without being specified or described as heart failure in nature (e.g., "Call physician if symptoms get worse," "Contact office with any problems")
- Instructions on what to do with worsening symptoms noted only as Not Applicable (N/A), None, or left blank
- Pre-printed instruction with all fields left blank (e.g., "If you gain more than [blank line] lbs. in [blank line] days, you need to call your doctor"), unless next to checked checkbox
- Unchecked checkbox next to instruction (e.g., blank checkbox on discharge instruction sheet next to "Notify your doctor if you experience swelling in your feet")

Data Element Name: *Discharge Instructions Address Weight Monitoring*

Collected For: CMS Voluntary Only: HF-1

Definition: Written discharge instructions or other documentation of educational material given to patient/caregiver addressing weight monitoring instructions after discharge.

Suggested Data Collection Question: Did the WRITTEN discharge instructions or other documentation of educational material given to the patient/caregiver address weight monitoring after discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	WRITTEN discharge instructions/educational material given to patient/caregiver address weight monitoring instructions after discharge.
N (No)	WRITTEN discharge instructions/educational material do not address weight monitoring or unable to determine from medical record documentation.

Notes for Abstraction:

- Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.
  - Documentation must clearly convey that the patient/caregiver was given a copy of the material to take home. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.
  - **Use only documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver.
- Written instructions given anytime during the hospital stay are acceptable.
- If the patient refused written discharge instructions/material which addressed weight monitoring, select “Yes.”
- The caregiver is defined as the patient’s family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:

- Discharge instruction sheet
- Home health referral form
- Nursing notes
- Teaching sheet

Inclusion Guidelines for Abstraction:
Weight monitoring (examples)

- Call in weights
- Check weight
- Contact physician/advanced practice nurse/physician assistant (physician/APN/PA) if sudden weight gain
- Daily weights
- Watch weight
- Weigh patient
- Weigh self
- Weight check

Exclusion Guidelines for Abstraction:

- Instructions directed toward weight loss only (e.g., "Lose weight" or "Report weight loss").
- Pre-printed instruction with all fields left blank (e.g., “Weigh yourself every [blank line] days,” “If you gain more than [blank line] lbs. in [blank line] days, you need to call your doctor”), unless next to checked checkbox.
- Unchecked checkbox next to instruction (e.g., blank checkbox on discharge instruction sheet next to “Weigh yourself daily”).

Data Element Name: *Drug Use Status Post Discharge – Quit Status*

Collected For: The Joint Commission Only: SUB-4; **CMS Informational Only:** SUB -4

Definition: This data element is used to determine the drug use status post discharge for patients identified with a drug disorder or addiction. Follow-up contact with the patient to determine post discharge status can be made anytime between the 7 and 30 day time frame specified by the measure.

Suggested Data Collection Question: What is the status of the patient's drug use at the time of the post discharge follow-up contact?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The patient has quit using drugs.

2 The patient has not quit using drugs.

3 Not applicable, the patient does not use drugs.

4 The patient refused to provide information relative to use status at the follow up contact.

5 Not documented or unable to determine(UTD) from follow-up information collected.

Notes for Abstraction:

- Quit is defined as not using drugs or alcohol in the previous 7 day timeframe.
- If the patient refuses to give information when contacted post discharge, select value 4.
- The counseling, medication, and use status information must relate to the follow-up contact date selected by the abstractor.
- If the patient was not identified during the hospital stay as having a drug disorder or addiction and drug use is not the substance of interest for follow up, select value 3.
- Select value 5 (UTD) if the patient was contacted post discharge and the patient was not questioned regarding their drug use post discharge.

Suggested Data Sources:

- Medical Record documentation dated within the follow-up time frame
  - Patient specific follow-up forms

- Other documentation as specified by the hospital

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *ED Departure Date*

Collected For: CMS/The Joint Commission: ED-1, ED-2

Definition: The month, day, and year at which the patient departed from the emergency department.

Suggested Data Collection Question: What is the date the patient departed from the emergency department?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

Enter the documented date of the ED Departure
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care [after the *Discharge Date*]) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Examples:
  - Documentation indicates the *ED Departure Date* was 03-**42**-20xx. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid date. Since the *ED Departure Date* is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD."
  - Patient expires on 02-12-20xx and all documentation within the ONLY ACCEPTABLE SOURCES indicates the *ED Departure Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *ED Depature Date* is after the *Discharge Date* (death), it is outside of the parameter of care and the abstractor should select "UTD."

  Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *ED Departure Date* allows the case to be accepted into the warehouse.

- If the date the patient departed is unable to be determined from medical record documentation, select “UTD.”
- If the date of departure is not documented, but the date can be determined from other documentation in the ED record, this is acceptable to use (the patient arrived and was transferred on the same day).
- If there is documentation the patient left against medical advice and it cannot be determined what time the patient left against medical advice, select “UTD.”
- Data fields representing *ED Departure Date* in electronic documentation for this specific episode of care are acceptable to use as long as the fields are easily understood to mean departure. Information found in an electronically interfaced event log or Admit/Decision/Transfer (ADT) is acceptable provided this information is part of the submitted medical record covering the arrival to discharge date being abstracted.
  Examples:
  - Patient departed
  - Patient transferred off the floor (OTF)
  - Check out time
  - Transported to
- For patients who are placed into observation outside the services of the emergency department, abstract the date of departure from the emergency department.
- For patients who are placed into observation under the services of the emergency department, abstract the date of departure from the observation services (e.g., patient is seen in the ED and admitted to an observation unit of the ED on 01-01-20xx then is discharged from the observation unit on 01-03-20xx abstract 01-03-20xx as the departure date).
- If there is a departure date listed within a disposition heading from the ED, this may be used for *ED Departure Date.*
- The inclusion list is not to be considered a comprehensive list of inclusions.

Suggested Data Sources:
ONLY ACCEPTABLE SOURCES:
Emergency Department record

Inclusion Guidelines for Abstraction:
- ED Checkout Date
- ED Departure Date
- ED Discharge Date
- ED Leave Date
- ED Transport Date

Exclusion Guidelines for Abstraction:
None

Data Element Name: *ED Departure Time*

Collected For: CMS/The Joint Commission: ED-1, ED-2

Definition: The time (military time) represented in hours and minutes at which the patient departed from the emergency department.

Suggested Data Collection Question: What is the time the patient departed from the emergency department?

Format:

Length: 5 – HH:MM (with or without colon) or UTD
Type: Time
Occurs: 1

Allowable Values:

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight - 00:00	Noon - 12:00
5:31 am - 05:31	5:31 pm - 17:31
11:59 am - 11:59	11:59 pm - 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *ED Departure Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00, do not forget to change the *ED Departure Date.*
Example:
Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:

- For times that include “seconds,” remove the seconds and record the military time.
  Example:
  15:00:35 would be recorded as 15:00.

- The intention is to capture the latest time at which the patient was receiving care in the emergency department, under the care of emergency department services.
- The medical record must be abstracted as documented (taken at "face value"). When the time documented is obviously in error (not a valid format/range) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Example:
  Documentation indicates the *ED Departure Time* was 3300. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid time. Since the *ED Departure Time* is outside of the range in the Allowable Values for "Hour," it is not a valid time and the abstractor should select "UTD."
  Note: Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *ED Departure Time* allows the case to be accepted into the warehouse.
- *ED Departure Time* is the time the patient physically left the emergency department (e.g., nurses notes state "18:00 transfer to floor-room 300" and other documentation includes a time that the patient left the ED via stretcher, abstract the later time or nurses notes state "18:00 transport to unit" and other documentation includes a time that the patient actually left the ED to be transferred, abstract the later time).
- If the time the patient departed is unable to be determined from medical record documentation, select, "UTD."
- When more than one acceptable emergency department departure/discharge time is documented abstract the latest time.
  Example:
  Two departure times are found in the nurse's notes: 12:03 via wheelchair and 12:20 via wheelchair. Select the later time of 12:20.
- Do not use the time the discharge order was written because it may not represent the actual time of departure.
- Data fields representing *ED Departure Time* in electronic documentation for this specific episode of care are acceptable to use as long as the fields are easily understood to mean departure. Information found in an electronically interfaced event log or Admit/Decision/Transfer (ADT) is acceptable provided this information is part of the submitted medical record covering the arrival to discharge time being abstracted.
  Examples:
  - Patient departed
  - Patient transferred off the floor (OTF)
  - Check out time
  - Transported to
- If there is a departure time listed within a disposition heading from the ED, this may be used for *ED Departure Time*.
- For patients who are placed into observation outside the services of the emergency department, abstract the time of departure from the emergency department.
  - If the patient is placed into observation services and remains in the ED or in a unit of the ED abstract the time they depart the ED or ED unit for the

floor/surgery etc. Do not abstract the time they are placed into observation services.

- For patients who are placed into observation under the services of the emergency department, abstract the time of departure from the observation services.
  - If a patient is seen in the ED and admitted to an observation unit of the ED, then discharged from the observation unit, abstract the time they depart the observation unit.
  - If the patient is placed into observation services and remains in the ED or in a unit of the ED abstract the time they depart the ED or ED unit for the floor/surgery etc. Do not abstract the time they are placed into observation services.
- The inclusion and exclusion lists are not to be considered comprehensive lists of inclusions and exclusions.

Suggested Data Sources:
ONLY ACCEPTABLE SOURCES:
Emergency Department record

Inclusion Guidelines for Abstraction:
- ED Check Out Time
- ED Departure Time
- ED Discharge Time
- ED Leave Time
- ED Transport Time

Exclusion Guidelines for Abstraction:
- Report Called Time

Data Element Name: *ED Patient*

Collected For: CMS/The Joint Commission: ED-1, ED-2, STK-4

Definition: Patient received care in a dedicated emergency department of the facility.

Suggested Data Collection Question: Was the patient an ED patient at the facility?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation the patient was an ED patient.
N (No)	There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation.

Notes for Abstraction:

- For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department.
- Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient).
- Patients presenting to the ED who do not receive care or services in the ED abstract as a "No" (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).
- Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a "Yes."

ED:

- If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select "No." This applies even if the emergency department or observation unit is part of your hospital's system (e.g., your hospital's free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select "No," even if the transferred patient is seen in this facility's ED.
- If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select "No." This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select "No'" even if the transferred patient is seen in this facility's ED.

Suggested Data Sources:

- Emergency Department record
- Face sheet
- Registration form

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

- Fast Track ED
- Terms synonymous with Urgent Care
- Urgent Care

Data Element Name: *Education Addresses Activation of Emergency Medical System (EMS)*

Collected For: CMS/The Joint Commission: STK-8

Definition: Documentation that the patient/caregiver received educational materials that address the need for activation of the emergency medical system (EMS) if signs or symptoms of stroke occur. Immediate activation of the emergency medical system by calling 911 or another EMS number improves hospital arrival time and the likelihood of thrombolytic administration.

Suggested Data Collection Question: Did the WRITTEN instructions or other documentation of educational material given to the patient/caregiver address activation of the emergency medical system (EMS) if signs or symptoms of stroke occur?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	WRITTEN instructions/educational material given to patient/caregiver address activation of the emergency medical system (EMS) if signs or symptoms of stroke occur.
N (No)	WRITTEN instructions/educational material given to patient/caregiver do not address activation of the emergency medical system (EMS) if signs or symptoms of stroke occur, OR unable to determine from medical record documentation.

Notes for Abstraction:

- Educational material must address activation of the emergency medical system if signs or symptoms of stroke occur.
  Example:
  "Call 911 immediately if sudden numbness or weakness of an extremity is noted."
- Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.
  - Documentation must clearly convey that the patient/caregiver was given a copy of the material to take home. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.
  - **Use only documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions

about what content may be covered in material documented as given to the patient/caregiver.

- Written instructions given anytime during the hospital stay are acceptable.
- If the patient refused written instructions/material which addressed activation of the emergency medical system (EMS) if signs or symptoms of stroke occur, select "Yes."
- If documentation indicates that written instructions/material on activation of the emergency medical system (EMS) were not given because the patient is cognitively impaired (e.g., comatose, obtunded, confused, short-term memory loss) and has no caregiver available, select "Yes."
- The caregiver is defined as the patient's family or any other person (e.g.,home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:

- Discharge instruction sheet
- Discharge summary
- Education record
- Home health referral form
- Nursing discharge notes
- Nursing notes
- Progress notes
- Teaching sheet

Inclusion Guidelines for Abstraction:

Emergency Medical System

- EMS
- 911

Warning Signs and Symptoms of Stroke

- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden severe headache with no known cause

Exclusion Guidelines for Abstraction:

Unchecked checkbox next to instruction (e.g., blank checkbox on discharge instruction sheet next to "Activation of the Emergency Medical System").

Data Element Name: *Education Addresses Follow-up After Discharge*

Collected For: CMS/The Joint Commission: STK-8

Definition: Documentation that the patient/caregiver received educational materials that address the need for continuing medical care after discharge. Patient education programs for specific chronic conditions have increased healthful behaviors, improved health status, and/or decreased health care costs of their participants.

Suggested Data Collection Question: Did the WRITTEN instructions or other documentation of educational material given to the patient/caregiver address follow-up with a physician/APN/PA after discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	WRITTEN instructions/educational material given to patient/caregiver address follow-up with a physician/APN/PA after discharge.
N (No)	WRITTEN instructions/educational material do not address follow-up with a physician/APN/PA or unable to determine from medical record documentation.

Notes for Abstraction:

- In the absence of explicit documentation that follow-up involves contact with a physician/APN/PA, the abstractor may infer contact with a physician/APN/PA, unless documentation suggests otherwise (e.g., BP check, laboratory work only).
- Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.
  - Documentation must clearly convey that the patient/caregiver was given a copy of the material to take home. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.
  - **Use only documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver.
- Written instructions given anytime during the hospital stay are acceptable.
- If the patient refused written instructions/material which addressed follow-up, select “Yes.”

- If documentation indicates that written instructions/material on follow-up after discharge were not given because the patient is cognitively impaired (e.g., comatose, obtunded, confused, short-term memory loss) and has no caregiver available, select “Yes.”
- The caregiver is defined as the patient’s family or any other person (e.g.,home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:
- Discharge instruction sheet
- Discharge summary
- Education record
- Home health referral form
- Nursing discharge notes
- Nursing notes
- Progress notes
- Teaching sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
- Follow-up prescribed on PRN or as needed basis
- Follow-up noted only as Not Applicable (N/A), None, or left blank
- Pre-printed follow-up appointment instruction with all fields left blank (e.g., “Please return for follow up appointment with Dr. [blank line] on [blank line],” "Make an appointment with your physician in [blank line] for follow up"), unless next to checked checkbox
- Unchecked checkbox next to instruction (e.g., blank checkbox on discharge instruction sheet next to “Call Dr.’s office for appointment within two weeks”)

Data Element Name: *Education Addresses Medications Prescribed at Discharge*

Collected For: CMS/The Joint Commission: STK-8

Definition: Documentation that the patient/caregiver received educational materials that address all medications prescribed at discharge. Instructions must address at least the names of all discharge medications but may also include other usage instructions such as dosages, frequencies, side effects, etc. The importance of medications prescribed to prevent a second stroke (e.g., Plavix) should be emphasized.

Suggested Data Collection Question: Did the WRITTEN instructions or other documentation of educational material given to the patient/caregiver address all discharge medications?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	WRITTEN instructions/educational material given to patient/caregiver address discharge medications.
N (No)	WRITTEN instructions/educational material do not address all discharge medications, OR unable to determine from medical record documentation.

Notes for Abstraction:

- Abstraction is a two-step process:
  1. Determine all of the medications being prescribed at discharge, based on available medical record documentation.
     - Discharge medication information included in a discharge summary dated after discharge should be used as long as it was added within 30 days after discharge.
     - If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc. Examples:
       - Two discharge summaries, one dictated 5/22 (day of discharge) and one dictated 5/27 - Use the 5/27 discharge summary.
       - Two discharge medication reconciliation forms, one not dated and one dated 4/24 (day of discharge) - Use both.

- If discharge medications are noted using only references such as "continue home meds," "resume other meds," or "same medications," rather than lists of the names of the discharge medications, the abstractor should use all sources to compile a list of medications the patient was on prior to arrival (or in the case of acute care transfers, use the medications the patient was on prior to arrival at the first hospital).
- Disregard all references to laxatives, antacids, vitamins, minerals (EXCEPT potassium), food supplements, and herbs, prn or not, AND disregard references to medications by class only (e.g., "heparinoids") where the specific medication name is not specified. They are NOT required in the written instructions for the purposes of the Stroke Education measure (STK-8).
- PRN medications are required on the discharge instructions, with ONE exception: When discharge medications outside of the written discharge instructions are noted using ONLY references such as "continue current medications" or "continue present meds," rather than lists of the names of the discharge medications, and the abstractor is referencing what medications the patient was taking on the day of discharge (for comparison against the written discharge instructions, to confirm completeness of that list), medications which are clearly listed as prn (given on an as needed basis only) do NOT need to be included in the instructions.
- Oxygen should not be considered a medication**.**
- Medications which the patient will not be taking at home (and/or the caregiver will not be giving at home) are NOT required in the medication list included in the written discharge instructions (e.g., monthly B12 injections, dialysis meds, chemotherapy).

2. Check this list against the written discharge instructions given to the patient to ensure that these instructions addressed at least the names of all of the discharge medications. If a list of discharge medications is not documented elsewhere in the record, and the completeness of the medication list in the instructions cannot be confirmed as complete, or it can be determined to be incomplete, select "No."
   - **EXCEPTION:** If a comparison list is not available, and the discharge list in the written discharge instructions cannot be determined to be complete or incomplete, but the written discharge instructions have the name or initials of the physician/advanced practice nurse/physician assistant (physician/APN/PA) signed on the form, presume the list of discharge medications in those instructions is complete. Signatures that are dated/ timed after discharge are not acceptable.
   - In making medication name comparisons, consider two medications that are **brand/trade name vs. generic name** in nature or that have the **same generic equivalent** as matches.
     Examples of matches:
     - Coumadin vs. Warfarin
     - ASA vs. EC ASA

- Plavix vs. Clopidogrel
- Mevacor vs. Lovastatin
- Lopressor vs. Metoprolol
- Metoprolol vs. Metoprolol Succinate

Example of a mismatch:

- Lopressor vs. Toprol

- If there is documentation that the patient was discharged on insulin(s) of ANY kind, ANY reference to insulin as a discharge medication in the written discharge instructions can be considered a match, for the purposes of the Stroke Education measure (STK-8). E.g., D/C summary notes patient discharged on "Humulin Insulin" and "Insulin 70/30" is listed on the discharge instruction sheet – Consider this a match. However, contradictory documentation abstraction guidelines still apply to insulin cases (e.g., D/C summary notes patient discharged on "Novolog 50 units t.i.d." and "Novolog 50 units t.i.d." is discontinued on discharge medication reconciliation form – Select "No").

- In determining the medications prescribed at discharge (step 1 above), all discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
  - If there is a medication in one source that is not mentioned in other sources, take it as a discharge medication (i.e., required in the written discharge instructions) unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge - **Consider it a discharge medication in the absence of contradictory documentation.**
  - If documentation is contradictory (e.g., physician noted "d/c ASA" in the discharge orders, but it is listed in the discharge summary's discharge medication list), or, after careful examination of circumstances, context, timing, etc., documentation raises enough questions about what medications are being prescribed at discharge, the case should be deemed "unable to determine" (select "No"), regardless of whether the medication in question is included in the written discharge instructions.
  - If there is documentation of a plan to start/restart a medication after discharge or a hold on a medication for a **defined** timeframe after discharge (e.g., "Start Plavix as outpatient," "Hold Lasix x 2 days," "Hold ASA until after endoscopy"):
    - If it is NOT listed as a discharge medication elsewhere (e.g., "Lasix," "Plavix"), it is not required in the discharge instructions (but if it is listed on the instructions, this is acceptable).
    - If it IS listed as a discharge medication elsewhere (e.g., "Lasix," "Plavix"), do not regard this as contradictory documentation, and require the medication in the discharge instructions.
  - Disregard a medication documented **only** as a recommended medication for discharge. E.g., "Recommend sending patient home on Vasotec" – Vasotec is not required in the discharge instructions (but if it is listed on the instructions, this is acceptable). Documentation must be more clear that such a medication was actually prescribed at discharge.

- Do not give credit in cases where the patient was given written discharge medication instructions **only** in the form of written prescriptions.
- Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.
    - Documentation must clearly convey that the patient/caregiver was given a copy of the material to take home. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.
    - **Use only documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver.
- Written instructions given anytime during the hospital stay are acceptable.
- If the patient refused written discharge instructions/material which addressed discharge medications, select “Yes.”
- If documentation indicates that written instructions/material on discharge medications were not given because the patient is cognitively impaired (e.g., comatose, obtunded, confused, short-term memory loss) and has no caregiver available, select “Yes.”
- The caregiver is defined as the patient’s family or any other person (e.g.,home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:
- Discharge instruction sheet
- Discharge progress notes
- Discharge summary
- Home health referral form
- Medication reconciliation form
- Nursing notes
- Teaching sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
Any general reference to a medication regimen (e.g., “continue home meds” listed on discharge instruction sheet), without specific documentation of medication names.

Data Element Name: *Education Addresses Risk Factors for Stroke*

Collected For: CMS/The Joint Commission: STK-8

Definition: Documentation that the patient/caregiver received educational materials that address risk factors for stroke. Patient education programs for specific chronic conditions have increased healthful behaviors, improved health status, and/or decreased health care costs of their participants.

Suggested Data Collection Question: Did the WRITTEN instructions or other documentation of educational material given to the patient/caregiver address risk factors for stroke?

Format:

Length: 1;
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	WRITTEN instructions/educational material given to patient/caregiver address risk factors for stroke.
N (No)	WRITTEN instructions/educational material given to patient/caregiver do not address risk factors for stroke, OR unable to determine from medical record documentation.

Notes for Abstraction:

- Educational material must specifically address risk factors for stroke:
  Example:
  Stroke Risk Factors:
  - Overweight
  - Smoking
  - Sedentary lifestyle
- See the inclusion list for acceptable risk factors for stroke. The list is not all-inclusive.
- **Individual risk factors that are not mentioned in the context of education provided on the risk factors for stroke, do not count** (e.g., discharge instruction to limit alcohol without explicit documentation that excessive alcohol consumption is a risk factor for stroke).
- Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.
  - Documentation must clearly convey that the patient/caregiver was given a copy of the material to take home. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the

patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.
    - **Use only documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver.
- Written instructions given anytime during the hospital stay are acceptable.
- If the patient refused written instructions/material which addressed risk factors for stroke, select "Yes."
- If documentation indicates that written instructions/material on risk factors for stroke were not given because the patient is cognitively impaired (e.g., comatose, obtunded, confused, short-term memory loss) and has no caregiver available, select "Yes."
- The caregiver is defined as the patient's family or any other person (e.g.,home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:
- Discharge instruction sheet
- Discharge summary
- Education record
- Home health referral form
- Nursing discharge notes
- Nursing notes
- Progress notes
- Teaching sheet

Inclusion Guidelines for Abstraction:
Risk Factors for Stroke:
- Age
- Atrial fibrillation
- Carotid artery stenosis
- Carotid/peripheral or other artery disease
- Cigarette smoking
- Diabetes mellitus
- Excessive alcohol consumption
- Heredity (family history)
- High blood pressure
- Other heart disease (e.g., coronary heart disease, heart failure, dilated cardiomyopathy)
- Overweight (BMI greater than or equal to 25)
- Physical inactivity
- Poor diet (e.g., high in saturated fat, trans fat, cholesterol or sodium)
- Prior stroke, TIA or heart attack
- Race
- Sex (gender)
- Sickle cell disease (also called sickle cell anemia)

Exclusion Guidelines for Abstraction:
Unchecked checkbox next to instruction (e.g., blank checkbox on discharge instruction sheet next to “Stroke Risk Factors teaching sheet given to patient”).

Data Element Name: *Education Addresses Warning Signs and Symptoms of Stroke*

Collected For: CMS/The Joint Commission: STK-8

Definition: Documentation that the patient/caregiver received educational materials that address the warning signs and symptoms of stroke. Patient education programs for specific chronic conditions have increased healthful behaviors, improved health status, and/or decreased health care costs of their participants.

Suggested Data Collection Question: Did the WRITTEN instructions or other documentation of educational material given to the patient/caregiver address warning signs and symptoms of stroke?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	WRITTEN instructions/educational material given to patient/caregiver address warning signs and symptoms of stroke.
N (No)	WRITTEN instructions/educational material given to patient/caregiver do not address warning signs and symptoms of stroke, OR unable to determine from medical record documentation.

Notes for Abstraction:

- Include instructions which address what to do if warning signs or symptoms of stroke are noted.
  Example:
  "Call 911 immediately if sudden numbness or weakness of an extremity is noted."
- Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.
  - Documentation must clearly convey that the patient/caregiver was given a copy of the material to take home. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.
  - **Use only documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver.
- Written instructions given anytime during the hospital stay are acceptable.

- If the patient refused written instructions/material which addressed warning signs and symptoms of stroke, select “Yes.”
- If documentation indicates that written instructions/material on warning signs and symptoms of stroke were not given because the patient is cognitively impaired (e.g., comatose, obtunded, confused, short-term memory loss) and has no caregiver available, select “Yes.”
- The caregiver is defined as the patient’s family or any other person (e.g.,home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:
- Discharge instruction sheet
- Discharge summary
- Education record
- Home health referral form
- Nursing discharge notes
- Nursing notes
- Progress notes
- Teaching sheet

Inclusion Guidelines for Abstraction:
Warning Signs and Symptoms of Stroke
- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden severe headache with no known cause

Exclusion Guidelines for Abstraction:
Unchecked checkbox next to instruction (e.g., blank checkbox on discharge instruction sheet next to “Warning Signs and Symptoms of Stroke”).

Data Element Name: *Elective Carotid Intervention*

Collected For: CMS/The Joint Commission: All STK Measures

Definition: Documentation demonstrates that the current admission is solely for the performance of an elective carotid intervention (e.g., elective carotid endarterectomy, angioplasty, carotid stenting).

Suggested Data Collection Question: Was this admission for the sole purpose of performance of an elective carotid intervention?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that this admission was solely for the performance of elective carotid intervention.
N (No)	There is no documentation that this admission was solely for the performance of elective carotid intervention, OR unable to determine from medical record documentation.

Notes for Abstraction:

- Patients admitted for an acute stroke are not considered to have been admitted solely for the purpose of the performance of elective carotid intervention.
- If the patient was admitted for an acute stroke, even if a carotid intervention was performed after admission, select "No."
- When documentation of the procedure is not linked with "elective," select "No."
- 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.

- 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.”

Suggested Data Sources:
- History and physical
- OR report
- Physician orders
- Progress notes

Inclusion Guidelines for Abstraction:
Patients with ICD-9-CM procedure codes on Table 8.3 Carotid Intervention Procedures, if medical record documentation states that the patient was admitted for the elective performance of the procedure. Refer to Appendix A, Table 8.3 Carotid Intervention Procedures for examples of acceptable ICD-9-CM procedure codes.
- Elective
    - Anticipated
    - Asymptomatic
    - Evaluation
    - Non-emergent
    - Planned
    - Pre-admission
    - Pre-arranged
    - Pre-planned
    - Pre-scheduled
    - Preventive
    - Previously arranged
    - Prophylactic
    - Scheduled
    - Work-up

Exclusion Guidelines for Abstraction:
Patients with ICD-9-CM procedure codes on Table 8.3 Carotid Intervention Procedures, if medical record documentation indicates that the patient is also being treated for an acute stroke during this hospitalization. Refer to Appendix A, Table 8.3 Carotid Intervention Procedures.

Data Element Name: *Fibrinolytic Administration*

Collected For: CMS/The Joint Commission: AMI-7a, AMI-8a; **The Joint Commission Only:** AMI-7, AMI-8; **CMS Voluntary Only:** AMI-7, AMI-8

Definition: The patient received primary fibrinolytic therapy during this hospital stay. Fibrinolytic therapy is the administration of a pharmacological agent intended to cause lysis of a thrombus (destruction or dissolution of a blood clot).

Suggested Data Collection Question: Was primary fibrinolytic therapy received during this hospital stay?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Primary fibrinolytic therapy administered during hospital stay.
N (No)	No primary fibrinolytic therapy administered during hospital stay, or unable to determine from medical record documentation.

Notes for Abstraction:

- In the event the patient was brought to the hospital via ambulance and fibrinolytic therapy was infusing at the time of arrival, select “Yes.”
- In the event the patient was brought to the hospital via ambulance and fibrinolytic therapy was infused during transport **but was completed** at the time of hospital arrival, select “No.”

Suggested Data Sources:

- Discharge summary
- Emergency Department record
- ICU/nursing flow sheets
- IV flow sheets
- Medication administration record
- Nursing notes

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 1.5 for a comprehensive list of Fibrinolytic Agents.

Exclusion Guidelines for Abstraction:
Fibrinolytics given during or after a PCI

Data Element Name: *Fibrinolytic Administration Date*

Collected For: CMS/The Joint Commission: AMI-7a; **The Joint Commission Only:** AMI-7; **CMS Voluntary Only:** AMI-7

Definition: The month, day, and year primary fibrinolytic therapy was administered at this facility. Fibrinolytic therapy is the administration of a pharmacological agent intended to cause lysis of a thrombus (destruction or dissolution of a blood clot).

Suggested Data Collection Question: What was the date primary fibrinolytic therapy was initiated during this hospital stay?

Format:

Length: 10 - MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- If the date primary fibrinolytic therapy was initiated is unable to be determined from medical record documentation, enter "UTD."
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid date/format) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Example:
  Documentation indicates the *Fibrinolytic Administration Date* was 03-**42**-20xx. No other documentation in the medical record provides a valid date. Since the *Fibrinolytic Administration Date* is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD."
  Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *Fibrinolytic Administration Date* allows the case to be accepted into the warehouse.
- If there are two or more different fibrinolytic administration dates (either different fibrinolytic episodes or corresponding with the same episode), enter the earliest date.
- In the event the patient was brought to the hospital via ambulance and fibrinolytic therapy was infusing at the time of hospital arrival, enter the date the patient arrived at this hospital.

Suggested Data Sources:

- Ambulance record
- Discharge summary
- Emergency Department record
- ICU/nursing flow sheets
- IV flow sheets
- Medication administration record
- Nursing notes
- Transfer sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
Fibrinolytics given during or after a PCI

Data Element Name: *Fibrinolytic Administration Time*

Collected For: CMS/The Joint Commission: AMI-7a; **The Joint Commission Only:** AMI-7; **CMS Voluntary Only:** AMI-7

Definition: The time (military time) that primary fibrinolytic therapy started. Fibrinolytic therapy is the administration of a pharmacological agent intended to cause lysis of a thrombus (destruction or dissolution of a blood clot).

Suggested Data Collection Question: What was the time primary fibrinolytic therapy was initiated during this hospital stay?

Format:

Length: 5 - HH:MM (with or without colon) or UTD
Type: Time
Occurs: 1

Allowable Values:

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight = 00:00	Noon = 12:00
5:31 am = 05:31	5:31 pm = 17:31
11:59 am = 11:59	11:59 pm = 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *Fibrinolytic Administration Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00 do not forget to change the *Fibrinolytic Administration Date.*

Example:
Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:

- For times that include “seconds,” remove the seconds and record the time as is.
  Example:

15:00:35 would be recorded as 15:00

- If the time primary fibrinolytic therapy was initiated is unable to be determined from medical record documentation, enter UTD.
- The medical record must be abstracted as documented (taken at "face value"). When the time documented is obviously in error (not a valid time/format) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Example:
  Documentation indicates the *Fibrinolytic Administration Time* was 3300. No other documentation in the medical record provides a valid time. Since the *Fibrinolytic Administration Time* is outside of the range listed in the Allowable Values for "Hour," it is not a valid time and the abstractor should select "UTD."
  Note: Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *Fibrinolytic Administration Time* allows the case to be accepted into the warehouse.
- If there are two or more different fibrinolytic administration times (either different fibrinolytic episodes or corresponding with the same episode), enter the earliest time.
- In the event the patient was brought to the hospital via ambulance and fibrinolytic therapy was infusing at the time of hospital arrival, enter the time the patient arrived at this hospital.

Suggested Data Sources:

- Ambulance record
- Emergency Department record
- ICU/nursing flow sheets
- IV flow sheets
- Medication administration record
- Nursing notes
- Transfer sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
Fibrinolytics given during or after a PCI

Data Element Name: *First Name*

Collected For: CMS Only: All Records (Optional Element)

Definition: The patient's first name.

Suggested Data Collection Question: What is the patient's first name?

Format:

Length: 30
Type: Character
Occurs: 1

Allowable Values:

Enter the patient's first name. Up to 30 letters, numbers, and/or special characters can be entered.

NOTE: Only the following special characters will be allowed:
~ ! @ # $ % ^ * ( ) _ + { } | : ? ` - = [ ] \ ; ‘ . , / and space

Notes for Abstraction:
None

Suggested Data Sources:

- Emergency Department record
- Face sheet
- History and physical

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *First PCI Date*

Collected For: CMS/The Joint Commission: AMI-8a; **The Joint Commission Only:** AMI-8; **CMS Voluntary Only:** AMI-8

Definition: The date associated with the time of the first percutaneous coronary intervention (PCI) done after hospital arrival. PCI is defined as the dilation of a coronary (heart) arterial obstruction by means of a balloon catheter inserted into a narrowed blood vessel and inflated to flatten plaque against the artery wall. This may be performed with or without a stent, a metal scaffold that is used to assist in establishing and maintaining vessel patency.

Suggested Data Collection Question: What is the date associated with the time of the first percutaneous coronary intervention (PCI) done after hospital arrival (i.e., date associated with *First PCI Time*)?

Format:

Length: 10 - MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

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

  Examples:
  - Documentation indicates the *First PCI Date* was 02-**42**-20xx. No other documentation in the medical record provides a valid date. Since the *First PCI Date* is outside of the range listed in Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD."
  - Patient expires on 02-12-20xx and documentation indicates the *First PCI Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *First PCI Date* is after the *Discharge Date* (death), it is outside of the parameters of care and the abstractor should select "UTD."

Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *First PCI Date* allows the case to be accepted into the warehouse.

- May pre-populate using PCI *ICD-9-CM Principal Procedure Date* or *ICD-9-CM Other Procedure Date*. The abstractor should validate the ICD-9-CM date and correct as appropriate.

Suggested Data Sources:

- Diagnostic test reports
- Operative notes
- Procedure notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *First PCI Time*

Collected For: CMS/The Joint Commission: AMI-8a; **The Joint Commission Only:** AMI-8; **CMS Voluntary Only:** AMI-8

Definition: The first time the lesion was accessed during the first PCI. PCI is defined as the dilation of a coronary (heart) arterial obstruction by means of a balloon catheter inserted into a narrowed blood vessel and inflated, to flatten plaque against the artery wall. This may be performed with or without a stent, a metal scaffold that is used to assist in establishing and maintaining vessel patency.

Suggested Data Collection Question: What was the time of the first percutaneous coronary intervention (PCI) done after hospital arrival?

Format:

Length: 5 - HH:MM (with or without colon) or UTD
Type: Time
Occurs: 1

Allowable Values:

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight - 00:00	Noon - 12:00
5:31 am - 05:31	5:31 pm - 17:31
11:59 am - 11:59	11:59 pm - 23:59

Note:
00:00 – midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *First PCI Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00 do not forget to change the *First PCI Date.*
Example:
Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:

- For times that include “seconds,” remove the seconds and record the time as is.
  Example:
  15:00:35 would be recorded as 15:00.
- If the PCI time is unable to be determined from medical record documentation, select “UTD.”
- The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range) **and** no other documentation is found that provides this information, the abstractor should select “UTD.”
  Example:
  Documentation indicates the *First PCI Time* was 3300. No other documentation in the medical record provides a valid time. Since the *First PCI Time* is outside of the range listed in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD.”
  Note: Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for *First PCI Time* allows the case to be accepted into the warehouse.
- Use the **earliest time** from the following allowable times:
  1. Time of the first balloon inflation (Inflate #1, Balloon inflated, # ATM for # minutes/seconds, Time balloon deployed). If, however, there is documentation of a time associated with a balloon but not of a specific time that the balloon was inflated or deployed (e.g., “11:35 XYZ balloon” only), infer this to be the time of use, unless documentation suggests otherwise.
  2. Time of the first stent deployment (Time stent deployed, Time stent placed, Time stent inserted, Time stent expanded). If, however, there is documentation of a time associated with a stent but not of a specific time that the stent was deployed, placed, etc. (e.g., “11:35 XYZ stent” only), infer this to be the time deployed, placed, etc., unless documentation suggests otherwise.
  3. Time of the first treatment of lesion with another device (Time thrombectomy device used, Time of aspiration, Time of suction, Time of device pass, Excimer time, Laser time, Time Rotablator used). If, however, there is documentation of a time associated with a device but not of a specific time that the device was used (e.g., “11:35 XYZ export cath” only), infer this to be the time of use, unless documentation suggests otherwise.
- The earliest time from the above allowable times should be used regardless of how many vessels were treated or which ones were successful vs. unsuccessful.
- Use the above allowable times regardless of the time of documentation of coronary blood flow (e.g., TIMI-3 flow, reperfusion).
- Disregard documentation on the procedure sheet of “lesion” accompanied solely by a time (e.g., “08:52 – RCA lesion”). Do NOT make the inference that this reflects lesion treatment time.

Suggested Data Sources:

- Diagnostic test reports

- Operative notes
- Procedure notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Follow-Up Contact*

Collected For: The Joint Commission Only: SUB-4, TOB-4; **CMS Informational Only:** SUB-4, TOB-4

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

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

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 A follow-up contact was made within the specified time frame post discharge.

2 A follow-up contact was made but not within the specified time frame post discharge.

3 A follow-up contact was not made within the specified time frame post discharge because the patient's residence is not in the USA, the patient was incarcerated, contact number was no longer valid, the patient had no phone, the patient was re-admitted to the hospital within 30 days post discharge, at least 3 unsuccessful attempts to contact the patient were made, or the patient refused permission for a third party to contact them on behalf of the hospital.

4 A follow-up contact was not made within the specified time frame post discharge or unable to determine from medical record documentation.

Notes for Abstraction:

- The specified time frame for post discharge contact for SUB and TOB are defined as follows:
  - TOB: A follow-up contact should be made between 15 and 30 days post-discharge.
  - SUB: A follow-up should be made between 7 and 30 days post discharge.
- If a follow-up contact was made, but outside the 30 day time frame, select value "2."

- If follow-up contact was made and contact was made with a family member or other person who answered the questions on behalf of the patient only, select value “1.”
- If information was obtained in person at the time of a clinic visit that occurred within the specified time frame post discharge, select value “1.”
- If follow-up contact is being made for a patient who screened positive for alcohol use or who was found to be alcohol or drug dependent, the contact must be made for the purpose of gaining information about their alcohol or drug use status post discharge.
- If follow-up contact is made by letter or e-mail and no response is received from patient within the specified time frame post discharge, select value “4.”
- If trying to contact the patient and at least 3 attempts were made but were unsuccessful, select value “3.” If less than 3 unsuccessful attempts were made select value “2.”
- If trying to contact the patient by mail or e-mail or phone and a return is received indicating the contact information is no longer valid, select value “3.”
- If the patient is readmitted following the initial hospitalization, select value “3” if the hospitalization continued into the specified time frame for follow-up.
- An example of a third party contacting the patient on behalf of the hospital includes, but is not limited to a Tobacco Quitline.
- The follow up contact information must be documented in the inpatient medical record regardless of whom performs the follow up.

Suggested Data Sources:

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

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Follow-Up Contact Date*

Collected For: The Joint Commission Only: SUB-4, TOB-4; **CMS Informational Only:** SUB-4, TOB-4

Definition: The month, day, and year that follow-up contact was made with the discharged patient to assess tobacco or substance use post discharge. The date must reflect live contact with the patient.

Suggested Data Collection Question: What is the date that follow-up contact was made with the discharged patient to assess tobacco or substance use post discharge?

Format:

Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01 -12)
DD = Day (01 – 31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- If multiple contacts are made with the discharged patient post discharge, select the date of the latest contact where information is received relative to treatment and quit status.
- If contact is made through e-mail or letter, select the date of receipt of the patient's alcohol, tobacco, or drug use post discharge status, not the date the e-mail or letter was sent.
- If follow-up contact is not made, select "UTD," do not leave the date field blank.
- The follow up contact date must be documented in the inpatient medical record regardless of whom performs the follow up.

Suggested Data Sources:

- Medical Record documentation within the follow-up time frame
  - Patient specific follow-up forms
  - Other documentation as specified by the hospital

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Glucose*

Collected For: CMS/The Joint Commission: SCIP-Inf-4

Definition: The blood glucose levels collected between 18 and 24 hours after *Anesthesia End Time.* If no blood glucose levels were collected during this timeframe, blood glucose levels collected between 12 and 18 hours after *Anesthesia End Time* are to be used.

Suggested Data Collection Question: Was the patient's blood glucose level controlled in the specified timeframe after *Anesthesia End Time?*

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 All blood glucose levels collected were ≤ 180 mg/dL in the specified timeframe.

2 A single blood glucose level collected was > 180 mg/dL but **ALL** other values after the higher value were ≤ 180 mg/dL prior to the endpoint of 24 hours after *Anesthesia End Time*.

3 A single blood glucose level collected was > 180 mg/dL and **NO** other values after the higher value were ≤ 180 mg/dL prior to the endpoint of 24 hours after *Anesthesia End Time*
OR
Two or more blood glucose levels were > 180 mg/dL in the specified timeframe.

4 No blood glucose levels were collected in the specified timeframe
OR
Any blood glucose level was unable to be determined from medical record documentation.

5 There is documentation that the patient experienced one or more of the following after surgery, prior to 24 hours after *Anesthesia End Time*:

- Patient was discharged
- Patient expired
- Patient left Against Medical Advice (AMA)
- Patient underwent cardiopulmonary resuscitation (CPR)
- Patient underwent another surgery after the ICD-9-CM Principal Procedure.

Notes for Abstraction:

- Review blood glucose levels obtained between 18 and 24 hours after *Anesthesia End time,* using any of the Only Allowable Sources*.* **Exception:** If no blood glucose levels were obtained during this timeframe, use blood glucose levels obtained between 12 and 18 hours after *Anesthesia End Time* to determine appropriate allowable values.
- If no blood glucose levels were collected between 12 and 24 hours after *Anesthesia End Time,* select Value "4."
- If blood glucose levels in the specified timeframe reflected one value > 180 mg/dL but all of the other values after that value were ≤ 180, select Value "2." To select Value "2," there must be at least one level ≤ 180 mg/dL after the single high value.
  Example:
  - 160, 185, 170, 175
  - 160, 170, 185, 175
- If no further blood glucose levels were collected after a single blood glucose level > 180 mg/dL in the specified timeframe, select Value "3."
  Example:
  - 174, 176, 177, 178, 182
  - 174, 182
- If two or more values in the specified time frame were > 180 mg/dL, select Value "3."
  Example:
  - 185, 170, 175, 190, 175
  - 174, 176, 177, 182, 185
  - 185, 190, 180, 179, 178
- If **any** blood glucose level during the timeframe of 18 to 24 hours after *Anesthesia End Time* is unable to be determined from medical record documentation, select Value "4."
- When the blood glucose level is recorded as "low" without a numerical value, consider the level to be ≤ 180 mg/dL. When the blood glucose level is recorded as "high" without a numerical value, consider the level to be > 180 mg/dL.
- If a blood glucose level reading is obtained and documented as being inaccurate due to equipment malfunction or user error and if the glucose level is documented as retaken, use the corrected blood glucose level.
- If there is no *Anesthesia End Time* documented, select Value "4" because the postoperative timeframe cannot be calculated.
- If the patient underwent CPR or another surgery, was discharged or expired after surgery **prior to** 24 hours after *Anesthesia End Time,* select Value "5." If the patient underwent CPR or another surgery, was discharged or expired **more than** 24 hours after *Anesthesia End Time,* review the glucose levels documented to select the appropriate Allowable Value.
- To select Value "5," the CPR must be documented as occurring in the specified timeframe after *Anesthesia End Time.* Do not consider documentation of resuscitation with medications only or defibrillation only.

Suggested Data Sources:
ONLY ALLOWABLE SOURCES

- Consultation notes
- Diabetic or finger stick blood sugar (FSBS) flow sheet
- Laboratory reports
- Nursing graphic sheets
- Nursing notes
- PACU/recovery room record
- Progress notes

Inclusion Guidelines for Abstraction:

- Blood glucose level
- Blood sugar
- Fasting glucose
- Fingerstick glucose
- Glucometer results
- Glucose
- Non-fasting glucose
- Random glucose
- Serum glucose

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Hispanic Ethnicity*

Collected For: CMS/The Joint Commission: All Records

Definition: Documentation that the patient is of Hispanic ethnicity or Latino.

Suggested Data Collection Question: Is the patient of Hispanic ethnicity or Latino?

Format:

Length: 1
Type: Character
Occurs: 1

Allowable Values:

Y (Yes)	Patient is of Hispanic ethnicity or Latino.
N (No)	Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation.

Notes for Abstraction:
The data element, *Race,* is required in addition to this data element.

Suggested Data Sources:
- Emergency Department record
- Face sheet
- History and physical
- Nursing admission assessment
- Progress notes

Inclusion Guidelines for Abstraction:
A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term “Spanish origin” can be used in addition to “Hispanic or Latino.”
Examples:
- Black-Hispanic
- Chicano
- H
- Hispanic
- Latin American
- Latino/Latina
- Mexican-American
- Spanish
- White-Hispanic

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Home Management Plan of Care Document Addresses Arrangements for Follow-up Care*

Collected For: The Joint Commission Only: CAC-3

Definition: Documentation exists that the Home Management Plan of Care (HMPC) document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, includes information that arrangements for referral or follow-up care with a healthcare provider has been made.

Suggested Data Collection Question: Does the HMPC document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, include information that arrangements for referral or follow-up care with a healthcare provider has been made?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The HMPC document includes documentation that an appointment for referral or follow-up care with a healthcare provider has been made.

2 The HMPC document includes documentation that the patient/caregiver has been given information (healthcare provider/clinic/office name and phone number) to make arrangements for follow-up care.

3 Documentation exists that the patient/caregiver refused an appointment/information for referral or follow-up care with a healthcare provider.

4 The HMPC document does not include:
- Documentation that an appointment for referral or follow-up care with a healthcare provider has been made;
- Documentation that the patient/caregiver has been given information (healthcare provider/clinic/office name and phone number) to make arrangements for follow-up care;
  OR
- Unable to determine from the medical record documentation.

Notes for Abstraction:

- The healthcare provider could be a primary care physician, an asthma specialist, an advance practice registered nurse (e.g., APN), or a physician assistant (PA) in order to select “1 or 2.”

- Documentation of appointment for referral or follow-up care must include **all** of the following in order to select “1” for the data element:
  - Provider/clinic/office name
  - Date of appointment
  - Time of appointment
- Documentation of information for referral or follow-up care must include **all** of the following in order to select “2” for the data element:
  - Provider/clinic/office name
  - Telephone number
  - Time frame for appointment for follow-up care, e.g., 7-10 days
- If the patient’s home is out of state or out of the country and there is documentation that provider contact information is not accessible to the health care organization, AND there is documentation that the patient/caregiver were given a time frame for appointment for follow-up care, select Allowable Value “2.” Example:
  Patient lives outside of US, unable to access provider contact information. Caregiver instructed to make appointment for follow-up care as soon as possible upon return home.
- The caregiver is defined as the patient’s family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:
HMPC document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Home Management Plan of Care Document Addresses Environmental Control and Control of Other Triggers*

Collected For: The Joint Commission Only: CAC-3

Definition: Documentation exists that the Home Management Plan of Care (HMPC) document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, includes written information on avoidance or mitigation of environmental and other triggers.

Suggested Data Collection Question: Does the HMPC document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, include written information on avoidance or mitigation of environmental and other triggers?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	The HMPC document includes written information on avoidance or mitigation of environmental and other triggers.
N (No)	The HMPC document does not include written information on avoidance or mitigation of environmental and other triggers or unable to determine from medical record documentation.

Notes for Abstraction:

- Specificity to the patient entails explicit information pertaining to the patient, i.e., the patient's specific controllers and relievers medication information (name, dose, frequency, and method of administration), environmental control and control of other triggers, and methods and timing of rescue actions specific to the patient, in order to select "Yes."
- HMPC must be a separate, stand-alone document, in order to select "Yes."
- Triggers are things in the environment or life circumstances that could lead to asthma attacks. Triggers could be allergens or irritants. Environmental triggers could be found indoors or outdoors. Indoor locations could be homes, schools, workplace, churches, concert halls, etc.
  Examples of environmental triggers:
  - Animal dander (from the skin, hair, or feathers of animals)
  - Dust mites (contained in house dust)
  - Cockroaches
  - Pollen from tree and grass
  - Mold (indoor and outdoor)
  - Cigarette or tobacco smoke

- Air pollutants (dust, house hold cleaners, hair sprays, other chemicals)
- Cold air or changes in weather
- Strong emotional expression (including crying or laughing hard)
- Stress

Other triggers may include:

- Medications such as aspirin and beta-blockers
- Sulfites in food (dried fruit) or beverages (wine)
- Infections and inflammatory conditions (i.e., flu, cold, rhinitis)
- Gastroesophageal reflux disease that causes heartburn and can worsen asthma symptoms, especially at night
- Emotional stress
- Exercise or strenuous activity

- Documentation must clearly convey that the patient was given a copy of the HMPC to take home.
- The HMPC does NOT need to be given at the time of discharge. A home management plan of care given at any time during the hospital stay is acceptable.
- If there is documentation of Triggers (environment or others), select "Yes."
- The caregiver is defined as the patient's family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:
HMPC document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Home Management Plan of Care Document Addresses Methods and Timing of Rescue Actions*

Collected For: The Joint Commission Only: CAC-3

Definition: Documentation exists that the Home Management Plan of Care (HMPC) document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, addresses what to do if asthma symptoms worsen after discharge, i.e., when to take action, what specific steps to take, and contact information to be used, when an asthma attack occurs or is about to occur.

Suggested Data Collection Question: Does the HMPC document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, included written information indicating when to take action, what specific steps to take, and contact information to be used, when an asthma attack occurs or is about to occur?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	The HMPC document includes written information including when to take action, what specific steps to take, and contact information to be used, when an asthma attack occurs or is about to occur.
N (No)	The HMPC document does not include written information indicating when to take action, what specific steps to take, and contact information to be used, when an asthma attack occurs or is about to occur or unable to determine from medical record documentation.

Notes for Abstraction:

- Specificity to the patient entails explicit information pertaining to the patient, i.e., the patient's specific controllers and relievers medication information (name, dose, frequency, and method of administration), environmental control and control of other triggers, and methods and timing of rescue actions specific to the patient, in order to select "Yes."
- HMPC must be a separate, stand-alone document, in order to select "Yes."
- Documentation that addresses methods and timing of rescue actions must include **all** of the following, in order to select "Yes:"
  1. When to take action, i.e., assessment of severity (e.g., peak flow meter reading, signs and symptoms to watch for).
  2. Steps to take, i.e., initial treatment instructions (e.g., inhaled relievers up to three treatments of 2-4 puffs by MDI at 20-minute intervals or single nebulizer treatment).

3. Contact information and when to contact the physician.

- Documentation must clearly convey that the patient was given a copy of the HMPC document to take home.
- The HMPC does NOT need to be given at the time of discharge. A home management plan of care document given at any time during the hospital stay is acceptable.
- The caregiver is defined as the patient's family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:
HMPC document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Home Management Plan of Care Document Addresses Use of Controllers*

Collected For: The Joint Commission Only: CAC-3

Definition: Documentation exists that the Home Management Plan of Care (HMPC) document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, includes information on the appropriate use of controllers. This information includes the medication name, dose, frequency, and method of administration, in order to adequately maintain control of asthma.

Controllers are long term asthma medications that reduce airway inflammation and prevent asthma exacerbations (asthma attacks or asthma episodes).

Suggested Data Collection Question: Does the HMPC document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, included information on the appropriate use of controllers?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	The HMPC document includes information on the appropriate use of controllers.
N (No)	The HMPC document does not include information on the appropriate use of controllers or unable to determine from the medical record documentation.

Notes for Abstraction:

- Specificity to the patient entails explicit information pertaining to the patient, i.e., the patient's specific controllers and relievers medication information (name, dose, frequency, and method of administration), environmental control and control of other triggers, and methods and timing of rescue actions specific to the patient, in order to select "Yes."
- HMPC must be a separate, stand-alone document, in order to select "Yes."
- If controller medications were prescribed, information must have been given on **all** of the following, in order to select "Yes" to this question:
  - medication name
  - dose
  - frequency
  - method of administration
- "Controller Not Specified (NOS)" can be used to answer "Yes" to this question in the following situations:

- For new controllers that are not yet listed in Table 6.1.
- When there is documentation that a controller was prescribed but unable to identify the name. It must be apparent that the medication is a controller.
  Example:
  On 2-12-08, the medical record contains the documentation, “Controller prescribed *name illegible, 75mcg (one inhalation)*, BID.” (If “Controller prescribed” had not been documented in this example, the medication could not be abstracted as Home Management Plan of Care Document Addresses Use of Controllers.)

- Documentation must clearly convey that the patient/caregiver was given a copy of the HMPC document to take home.
- The HMPC does NOT need to be given at the time of discharge. A HMPC document given at any time during the hospital stay is acceptable.
- The caregiver is defined as the patient’s family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:
HMPC document

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 6.1 for the comprehensive list of Controller Medications.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Home Management Plan of Care Document Addresses Use of Relievers*

Collected For: The Joint Commission Only: CAC-3

Definition: Documentation exists that the Home Management Plan of Care (HMPC) document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, includes written information on the appropriate use of relievers. This information includes the medication name, dose, frequency, method of administration, and a stepwise method of adjusting the dose, based on severity of symptoms, in order to quickly relieve the symptoms of asthma exacerbation (asthma attack or asthma episodes).

Relievers are medications that relax the bands of muscle surrounding the airways. They are also known as rescue, quick-relief, or short acting medications of choice to quickly relieve asthma exacerbations brought about by bronchoconstriction and exercise-induced bronchospasm.

Relievers do not reduce inflammation of the airways in a person with asthma and are, therefore, not useful for long term control.

Suggested Data Collection Question: Does the HMPC document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, included written information on the appropriate use of relievers?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	The HMPC document includes written information on the appropriate use of relievers.
N (No)	The HMPC document does not include written information on the appropriate use of relievers or unable to determine from the medical record documentation.

Notes for Abstraction:

- Specificity to the patient entails explicit information pertaining to the patient, i.e., the patient's specific controllers and relievers medication information (name, dose, frequency, and method of administration), environmental control and control of other triggers, and methods and timing of rescue actions specific to the patient, in order to select "Yes."
- HMPC must be a separate, stand-alone document, in order to select "Yes."

- If reliever medications were prescribed, information must have been given on **all** of the following, in order to select "Yes" to this question:
  - medication name
  - dose
  - frequency
  - method of administration
  - stepwise method of adjusting the dose and/or frequency, based on severity of symptoms
- "Reliever Not Specified (NOS)" can be used to answer "Yes" to this question in the following situations:
  - For new relievers that are not yet listed in Table 6.2
  - When there is documentation that a reliever was prescribed but unable to identify the name. It must be apparent that the medication is a reliever. Example:
    On 2-12-08, the medical record contains the documentation, "Reliever prescribed *name illegible,* 2.5 ml, PO, BID." (If "Reliever prescribed" had not been documented in this example, the medication could not be abstracted as Home Management Plan of Care Document Addresses Use of Relievers.)
- Documentation must clearly convey that the patient/ caregiver was given a copy of the HMPC document to take home.
- The HMPC does NOT need to be given at the time of discharge. A HMPC document given at any time during the hospital stay is acceptable.
- The caregiver is defined as the patient's family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:
HMPC document

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 6.2 for the comprehensive list of Reliever Medications.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Home Management Plan of Care Document Given to Patient/Caregiver*

Collected For: The Joint Commission Only: CAC-3

Definition: Documentation exists that the Home Management Plan of Care (HMPC) as a separate document, specific to the patient, was given to the patient/caregiver, prior to or upon discharge.

Suggested Data Collection Question: Does documentation exist that the HMPC as a separate document, specific to the patient, was given to the patient/caregiver, prior to or upon discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Documentation exists that the HMPC document was given to the patient/caregiver, prior to or upon discharge.
N (No)	Documentation does not exist that the HMPC document was given to the patient/caregiver, prior to or upon discharge, or unable to determine from the medical record documentation.
R (Refused)	Documentation exists that the HMPC document was refused by the patient/caregiver.

Notes for Abstraction:

- Specificity to the patient entails explicit information pertaining to the patient, i.e., the patient's specific controllers and relievers medication information (name, dose, frequency, and method of administration), environmental control and control of other triggers, and methods and timing of rescue actions specific to the patient, in order to select "Yes."
- HMPC must be a separate, stand-alone document, in order to select "Yes."
- Documentation must clearly convey that the patient/caregiver was given a copy of the HMPC to take home.
- The HMPC does NOT need to be given at the time of discharge. An HMPC given at any time during the hospital stay is acceptable.
- The caregiver is defined as the patient's family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources:

- Discharge instruction sheet
- Discharge summary
- HMPC document found in the Medical Record
- Nursing notes
- Progress notes
- Teaching sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Home Management Plan of Care Document Present*

Collected For: The Joint Commission Only: CAC-3

Definition: The Home Management Plan of Care (HMPC) document, separate and patient-specific should be a written instruction given to the patient/caregiver. The document must be present in the medical record, in the form of an explicit and separate document specific to the patient rather than components or segments of the plan spread across discharge instruction sheets, discharge orders, education sheets, or other instruction sheets.

Suggested Data Collection Question: Is there a separate, patient specific Home Management Plan of Care document present in the medical record?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is a separate, patient specific Home Management Plan of Care document present in the medical record.
N (No)	There is no separate, patient specific Home Management Plan of Care document present in the medical record or unable to determine from the medical record documentation.

Notes for Abstraction:

- The Home Management Plan of Care (HMPC) document could be in the form of a Daily Self-Management Plan or an Asthma Action Plan only if it is a separate, patient-specific document.
- This data element seeks to determine the presence and content of a patient specific document separate from the traditional discharge instructions.
- Specificity to the patient entails explicit information pertaining to the patient, i.e., the patient's specific controllers and relievers medication information (name, dose, frequency, and method of administration), environmental control and control of other triggers, and methods and timing of rescue actions specific to the patient, in order to select "Yes."

Suggested Data Sources:
Medical record

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *ICD-9-CM Other Diagnosis Codes*

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

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the diagnosis for this hospitalization.

Suggested Data Collection Question: What were the ICD-9-CM other diagnosis codes selected for this medical record?

Format:

Length: 6 (with or without decimal point)
Type: Alphanumeric
Occurs: 24

Allowable Values:

Any valid ICD-9-CM diagnosis code

Notes for Abstraction:
None

Suggested Data Sources:

- Discharge summary
- Face sheet
- UB-04, Field Locations: 67A-Q
  Note: Medicare will only accept codes listed in fields A-H

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *ICD-9-CM Other Procedure Codes*

Collected For: CMS/The Joint Commission: All Records; **Used in Algorithms for: CMS/The Joint Commission:** AMI-8a, HF-2, IMM-2; **The Joint Commission Only:** AMI-8, HF-3, SUB-3, SUB-4; **CMS Informational Only:** SUB-3, SUB-4; **CMS Voluntary Only:** AMI-8, HF-1, HF-3, IMM-1

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes identifying all significant procedures other than the principal procedure.

Suggested Data Collection Question: What were the ICD-9-CM code(s) selected as other procedure(s) for this record?

Format:

Length: 5 (with or without decimal point)
Type: Alphanumeric
Occurs: 24

Allowable Values:

Any valid ICD-9-CM procedure code

Notes for Abstraction:
None

Suggested Data Sources:

- Discharge summary
- Face sheet
- UB-04, Field Location: 74A-E

Inclusion Guidelines for Abstraction:
For inclusion in the algorithms listed above, refer to Appendix A, for ICD-9-CM Code Tables (AMI, HF, IMM, SUB).

Exclusion Guidelines for Abstraction:
None

Data Element Name: *ICD-9-CM Other Procedure Dates*

Collected For: CMS/The Joint Commission: All Records

Definition: The month, day, and year when the associated procedure(s) was (were) performed.

Suggested Data Collection Question: What were the date(s) the other procedure(s) were performed?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 24

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

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

  Examples:
  - Documentation indicates the *ICD-9-CM Other Procedure Dates* was 02-**42-**20xx. No other documentation in the medical record provides a valid date. Since the *ICD-9-CM Other Procedure Dates* is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD."
  - Patient expires on 02-12-20xx and documentation indicates the *ICD-9-CM Other Procedure Dates* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *ICD-9-CM Other Procedure Dates* is after the *Discharge Date* (death), it is outside of the parameters of care and the abstractor should select "UTD."

  Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *ICD-9-CM Other Procedure Dates* allows the case to be accepted into the warehouse.

Suggested Data Sources:

- Consultation notes
- Diagnostic test reports
- Discharge summary
- Face sheet
- Operative notes
- Procedure notes
- Progress notes
- UB-04, Field Location: 74A-E

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

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

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

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code associated with the diagnosis established after study to be chiefly responsible for occasioning the admission of the patient for this hospitalization.

Suggested Data Collection Question: What was the ICD-9-CM code selected as the principal diagnosis for this record?

Format:

Length: 6 (with or without decimal point)
Type: Alphanumeric
Occurs: 1

Allowable Values:

Any valid ICD-9-CM diagnosis code

Notes for Abstraction:
The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

Suggested Data Sources:

- Discharge summary
- Face sheet
- UB-04, Field Location: 67

Inclusion Guidelines for Abstraction:
Refer to Appendix A, for ICD-9-CM Code Tables (AMI, ED, HF, IMM, PN, STK, SUB, TOB, VTE).

Exclusion Guidelines for Abstraction:
Refer to Appendix A, for ICD-9-CM Code Tables (ED, SCIP, IMM).

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

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

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code that identifies the principal procedure performed during this hospitalization. The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

Suggested Data Collection Question: What was the ICD-9-CM code selected as the **principal** procedure for this record?

Format:

Length: 5 (with or without decimal point)
Type: Alphanumeric
Occurs: 1

Allowable Values:

Any valid ICD-9-CM procedure code

Notes for Abstraction:

The principal procedure as described by the Uniform Hospital Discharge Data Set (UHDDS) is one performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

Suggested Data Sources:

- Discharge summary
- Face sheet
- UB-04, Field Location: 74

Inclusion Guidelines for Abstraction:

For inclusion in the algorithms listed above, refer to Appendix A, for ICD-9-CM Code Tables (AMI, HF, SCIP, VTE, IMM, SUB).

Exclusion Guidelines for Abstraction:

None

Data Element Name: *ICD-9-CM Principal Procedure Date*

Collected For: CMS/The Joint Commission: All Records

Definition: The month, day, and year when the principal procedure was performed.

Suggested Data Collection Question: What was the date the principal procedure was performed?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

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

  Examples:
  - Documentation indicates the *ICD-9-CM Principal Procedure Date* was 02-**42-**20xx. No other documentation in the medical record provides a valid date. Since the *ICD-9-CM Principal Procedure Date* is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD."
  - Patient expires on 02-12-20xx and documentation indicates the *ICD-9-CM Principal Procedure Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *ICD-9-CM Principal Procedure Date* is after the *Discharge Date* (death), it is outside of the parameter of care and the abstractor should select "UTD."

  Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *ICD-9-CM Principal Procedure Date* allows the case to be accepted into the warehouse.

Suggested Data Sources:

- Consultation notes
- Diagnostic test reports
- Discharge summary
- Face sheet
- Operative notes
- Procedure notes
- Progress notes
- UB-04, Field Location: 74

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *ICU Admission or Transfer*

Collected For: CMS/The Joint Commission: VTE-1, VTE-2; **CMS Only:** PN-6; **The Joint Commission Only:** PN-3a, PN-6a, PN-6b; **CMS Voluntary Only:** PN-3a

Definition: Documentation that the patient was admitted or transferred to the intensive care unit (ICU) at this hospital. The definition of an ICU for the purpose of the measures noted above is that used by the CDC in the NHSN Patient Safety Project. An intensive care unit can be defined as a nursing care area that provides intensive observation, diagnosis, and therapeutic procedures for adults and/or children who are critically ill. An ICU excludes nursing areas that provide step-down, intermediate care or telemetry only and specialty care areas.

Suggested Data Collection Question: Was the patient admitted or transferred to the intensive care unit (ICU) during this hospitalization?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 (Yes)	The patient was admitted or transferred to the ICU during this hospitalization (at this hospital within the first 24 hours following arrival at this hospital for PN).
2 (No)	The patient was not admitted or transferred to an ICU during this hospitalization (at this hospital within the first 24 hours following arrival at this hospital for PN).
3 (UTD)	Unable to determine from medical record documentation if the patient was admitted or transferred to ICU during this hospitalization (at this hospital within the first 24 hours following arrival at this hospital for PN).

Notes for Abstraction:

- Direct admits, admissions via the emergency department, or transfers from lower levels of in-patient care are included.
- Do not use clinical judgment based on the type of care administered to the patient. The level of intensive care MUST be documented.
- PCU is not an inclusion for ICU, unless it is identified as a Pulmonary Care Unit, which can be considered synonymous with Respiratory Care Unit.
- If there is an order for ICU, but the patient was not moved to an ICU because the patient's condition changed and did not require an ICU level of care, select value "2." However, if the patient is not moved to an ICU unit due to lack of a bed, select value "1."

PN:

The patient was admitted or transferred to the intensive care unit (ICU) at this hospital within the first 24 hours following arrival at this hospital.

- In order to select value "1" (yes) for this data element there must be a physician order for admission or transfer to an ICU AND documentation that the patient was transferred or admitted to the ICU within 24 hours following hospital arrival.
- The 24-hour timeframe relates to the time from hospital arrival to arrival in the ICU unit, not the time of the physician order to admit or transfer to the ICU.
- If documentation reflects ICU graphic sheets or ICU nursing notes and there is no physician order for ICU, select value "2" (No).
- If other pneumonia related reasons for transfer or admission, such as septic shock, respiratory distress or failure, hypotension, tachypnea, hypoxemia or the need for a ventilator are documented, select value "1."
- If the patient was transferred or admitted to the ICU at this hospital within the first 24 hours after arrival to the hospital for reasons other than complications due to pneumonia, select value "2" to this question (i.e., a patient presents to the ED with pneumonia and shortly after arrival has a GI bleed or cardiac arrhythmia or the ICU may be the only place with monitored beds).
- If there is no other documented reason why the patient was transferred/admitted to the ICU at this hospital, assume it was for complications due to pneumonia.

VTE:

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

Suggested Data Sources:

ONLY ACCEPTABLE SOURCE (required)

- Physician/APN/PA orders

PN ONLY

Suggested data sources to support admission or transfer to ICU

- Emergency Department record
- ICU Nursing admission assessment
- ICU Nursing notes

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

- ED, OR, or procedure units as inpatient units.
- Intermediate care unit (IMCU)
  - Step-down unit : a post critical care unit for patients that are hemodynamically stable who can benefit from close supervision and monitoring such as frequent pulmonary toilet, vital signs, and/or neurological and neurovascular checks.
  - Inpatient units with telemetry monitoring that are not intensive care units.
- Post coronary care unit (PCCU)

- Specialty care units (hospital locations specializing in the following types of care)
  - Bone marrow transplant
  - Solid organ transplant
  - Inpatient acute dialysis
  - Hematology/Oncology
  - Long term acute care

Data Element Name: *ICU Admission or Transfer Date*

Collected For: CMS/The Joint Commission: VTE-1, VTE-2

Definition: The day, month and year that the order was written for the patient to be directly admitted **or** transferred (from a lower lever of care) to the intensive care unit (ICU).

Suggestion Data Collection Question: What is the date that the order was written for the ICU admission **or** transfer?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- The intent of this data element is to determine the date that the patient was actually admitted to ICU.
- For patients who are admitted to Observation status and subsequently admitted to ICU, abstract the date that the determination was made and the order written to admit to ICU. Do not abstract the date that the patient was admitted to Observation.
  Example: Medical record documentation reflects that the patient was admitted to observation on 04-05-20xx. On 04-06-20xx the physician writes an order to admit to ICU. The *ICU Admission or Transfer Date* would be abstracted as 04-06-20xx; the date the determination was made to admit to acute inpatient care and the order was written.
- If there are discrepancies in the physician's order date refer to the ICU admission or transfer vital signs, nurse's notes or progress notes to determine the date.
- If a patient has more than one admission to the ICU for more than one day, subsequent transfers back to an ICU during the same hospitalization will NOT be abstracted.
- If a patient is admitted to ICU on 10/19/xx and discharged to a medical floor on 10/20/xx, that is equal to one day, regardless of the number of hours. More than a day in ICU is when a patient is admitted to ICU on 10/19/xx and discharged on 10/21/xx, regardless of the number of hours.
- Abstract the date that the admission/transfer was ordered regardless of whether the patient is physically admitted to the ICU on the same date.

- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid date/format) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
- Documentation indicates the *ICU Admission or Transfer Date* was 03-**42**-20xx. No other physician order in the medical record provides a valid date. Since the *ICU Admission or Transfer Date* is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD." **Note:** Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" allows the case to be accepted into the warehouses.

Suggested Data Sources:
ALLOWABLE SOURCES:
- Physician/APN/PA orders

Inclusion Guidelines for Abstraction:
- Coronary care unit (CCU, CICU)
- Intensive care unit (ICU)
- Medical intensive care unit (MICU, MCU)
- Respiratory intensive care unit (RICU, RCU)
- Surgical intensive care unit (SCU, SICU)

Exclusion Guidelines for Abstraction:
- ED, OR, or procedure units as inpatient units
- Inpatient units with telemetry monitoring that are not intensive care units
- Intermediate care unit (IMCU)
- Post coronary care unit (PCCU)

Data Element Name: *ICU Discharge Date*

Collected For: CMS/The Joint Commission: VTE-1**,** VTE-2

Definition: The day, month and year that the order was written to discharge the patient from the intensive care unit (ICU), left against medical advice (AMA) or expired.

Suggested Data Collection Question: What date was the order written for the patient to be discharged from the ICU, left AMA or expired?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- The intent of this data element is to determine the date that the patient was actually discharged from the ICU.
- Discharge does not include a temporary transfer from an intensive care unit (e.g., for surgery, radiology or to the recovery room) or transfers between ICUs.
- A patient may have multiple ICU discharges within the same hospitalization. Select the discharge date that corresponds with the *ICU Admission or Transfer Date*.
- Abstract the date that the order to discharge was written regardless of whether the patient is physically discharged from ICU.
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid date/format) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Example:
  Documentation indicates the *ICU Discharge Date* was 03-**42**-20xx. No other documentation in the medical record provides a valid date. Since the *ICU Discharge Date* is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD."
  Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" allows the case to be accepted into the warehouses.

Suggested Data Sources:

- Physician orders

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name*: ICU VTE Prophylaxis*

Collected For: CMS/The Joint Commission: VTE-2

Definition: The type of venous thromboembolism (VTE) prophylaxis that was initially administered in the ICU. VTEs are the formation, development, or existence of a blood clot or thrombus within the venous system.

Suggested Data Collection Question: What type of VTE prophylaxis was initially administered in the ICU?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1-8

Allowable Values:

Select all that apply:

1	Low dose unfractionated heparin (LDUH)
2	Low molecular weight heparin (LMWH)
3	Intermittent pneumatic compression devices (IPC)
4	Graduated compression stockings (GCS)
5	Factor Xa Inhibitor
6	Warfarin
7	Venous foot pumps (VFP)
8	Oral Factor Xa Inhibitor
A	None of the above or not documented or unable to determine from medical record documentation

Notes for Abstraction:

- Abstract the initial ICU VTE prophylaxis(s) that was administered the day of or the day after ICU admission or the day of or the day after *Surgery End Date* for surgeries that start the day of or the day after ICU admission. If no ICU VTE prophylaxis was administered **during this timeframe**, select value “A” and check for a *Reason for No VTE Prophylaxis – ICU Admission*.
- Selection of allowable values 1-8 includes any prophylaxis that were initially administered on the same date.
  Example:

If a patient was admitted to ICU on 12/8/20xx and had bilateral GCS applied at 13:00 on 12/08/20xx and LMWH was administered at 22:00 on 12/8/20xx, select Values “2” and “4.”

- If one pharmacological medication is ordered and another medication is substituted (such as per pharmacy formulary substitution or protocol), abstract the medication administered. Note: No copy of the formulary or protocol is required in the medical record.
  Example:
  Lovenox is ordered and not received and is substituted with Arixtra, which is received by the patient. Abstract Arixtra as Value “5” for *ICU VTE Prophylaxis* and abstract the date is was administered for *ICU VTE Prophylaxis Date.*
- If the patient received one of the pharmacologic anticoagulation medications for other reasons, select the allowable value that was administered during the specified timeframe. For example: if the patient received warfarin for atrial fibrillation on the day of ICU admission, select Value “6.”
- Only select prophylaxis if there is documentation that it was administered. Documentation in the progress notes under assessment/Plan: “DVT prophylaxis – SCD/Teds” is not enough to select Values “3” and “4.”
- No value should be selected more than once. If a value of “A” is selected, no other selection should be recorded.

Suggested Data Sources:

- Circulator’s notes
- Graphic/flow sheets
- Medication administration record
- Nursing notes
- Operative notes
- Physician notes
- Preoperative nursing notes
- Progress notes

Inclusion Guidelines for Abstraction:
Refer to Appendix H, Table 2.1 VTE Prophylaxis Inclusion Table.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *ICU VTE Prophylaxis Date*

Collected For: CMS/The Joint Commission: VTE-2

Definition: The day, month and year that the **initial** VTE prophylaxis (mechanical and/or pharmacologic) option was administered after admission/transfer to the intensive care unit (ICU).

Suggested Data Collection Question: What date was the initial VTE prophylaxis administered in the ICU?

Format:

Length: 10 - MM-DD-YYYY (including dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- If VTE prophylaxis was administered the day of and the day after *ICU Admission or Transfer* or *Surgery End Date*, select the date that the **initial** VTE prophylaxis was administered.
  Example:
  If the patient was admitted on 12/8/20xx and bilateral GCS was applied at 13:00 on 12/8/20xx and LMWH was administered at 02:00 on 12/9/20xx, record the 12/8/20xx date.
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid date/format) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Example:
  Documentation indicates the *ICU VTE Prophylaxis Date* was 03-**42**-20xx. No other documentation in the medical record provides a valid date. Since the *ICU VTE Prophylaxis Date* is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD."
  Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" allows the case to be accepted into the warehouses.

Suggested Data Sources:

- Emergency Department record
- Medication administration record
- Nursing notes
- Physician orders
- Progress notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Infection Prior to Anesthesia*

Collected For: CMS/The Joint Commission: SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-4

Definition: Documentation the patient had an infection during this hospitalization prior to the principal procedure.

Suggested Data Collection Question: Did the patient have an infection during this hospitalization prior to the principal procedure?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation that the patient had an infection during this hospitalization prior to the principal procedure.
N (No)	There is no physician/APN/PA documentation that the patient had an infection during this hospitalization prior to the principal procedure, or unable to determine from medical record documentation.

Notes for Abstraction:

- If there is preoperative documentation of an infection or possible/suspected infection, select "Yes."
- Documentation of symptoms (example: fever, elevated white blood cells, etc.) should not be considered infections unless documented as an infection or possible/suspected infection.
- Do not assume infection if a wound/surgical site is described as reddened, swollen and hot, as other conditions can also cause these symptoms.
- The physician/APN/PA documentation of preoperative infection must be in place prior to surgery. Do not accept documentation of a preoperative infection documented any time after *Anesthesia Start Time.*
- If there are two or more history and physicals (H&Ps), use the most current. To select "Yes," an H&P, consult, pre-op clearance, pre-op Chest X-ray or other form that is dated prior to admission that includes documentation of an infection, must be updated after admission and prior to surgery. It must be noted that there have been no changes since the form was filled out previously.
- Preoperative information such as an Active Problem List or other assessment form listing infections must be supported with documentation to reflect that the infection is current. The following example is not sufficient to abstract as a current infection:

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

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

EXCEPTION:
Select "Yes" if the current principal procedure was a joint revision.

- To be considered a joint revision, the same joint as the principal procedure must have been operated on in a previous surgery that was a total or partial arthroplasty, **OR** there must be documentation that hardware was removed during the current principal procedure.

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Anesthesia record
- History and physical
- Progress notes

Excluded Data Sources:
Any documentation of an infection found in the Operative Report except documentation that a joint revision or hardware removal was performed as noted in the Exception in the Notes for Abstraction.

Note: Do NOT use Table 5.09 as a reference for *Infection Prior to Anesthesia*. This data element has an inclusion list to use as a guideline that provides the types of infection that are acceptable. Please reference this inclusion table when answering this data element.

Inclusion Guidelines for Abstraction:

- Abscess
- Acute abdomen
- Aspiration pneumonia
- Bloodstream infection
- Bone infection
- Cellulitis
- Chronic Obstructive Pulmonary Disease (COPD) acute exacerbation
- Crohn's Disease
- Endometritis
- Fecal Contamination
- Free air in abdomen
- Gangrene
- H. pylori
- Necrosis
- Necrotic/ischemic/infarcted bowel
- Osteomyelitis
- Other documented infection
- Perforation of bowel

- Penetrating abdominal trauma
- Purulence/pus
- Pneumonia or other lung infection
- Sepsis
- Surgical site or wound infection
- Systemic Inflammatory Response Syndrome (SIRS)
- Ulcerative colitis
- Urinary tract infection (UTI)

Exclusion Guidelines for Abstraction:

- Avascular necrosis
- Bacteria in urine (Bacteriuria)
- “carditis” (such as pericarditis) without mention of an infection
- Colonization or positive screens for MRSA, VRE, or for other bacteria
- Fistulas without documentation of abscess or fecal contamination
- Fungal infections
- History of infection, recent infection or recurrent infection not documented as a current or active infection
- Orders for preoperative tests or screens without documentation of an infection or suspected infection
- Viral infections

Data Element Name: *Influenza Vaccination Status*

Collected For: CMS/The Joint Commission: IMM-2

Definition: Documentation of the patient's vaccination status during this influenza season. If found to be a candidate for the influenza vaccine, documentation that the influenza vaccine was given during this hospitalization. Two main types of influenza vaccine are available: an attenuated (weakened) live vaccine given as a nasal spray and approved for healthy nonpregnant persons 2-49 years of age, or a killed (inactivated) influenza vaccine administered via intramuscular needle injection.

Suggested Data Collection Question: What is the patient's influenza vaccination status?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 Influenza vaccine was given during this hospitalization.

2 Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization.

3 Documentation of patient's or caregiver's refusal of influenza vaccine.

4 There was documentation of an allergy/sensitivity to influenza vaccine, anaphylactic latex allergy or anaphylactic allergy to eggs OR is not likely to be effective because of bone marrow transplant within the past 6 months OR history of Guillian-Barré syndrome within 6 weeks after a previous influenza vaccination.

5 None of the above/Not documented/Unable to determine from medical record documentation.

6 Only select this allowable value if there is documentation the vaccine has been ordered but has not yet been received by the hospital due to problems with vaccine production or distribution AND allowable values 1-5 are not selected.

Notes for Abstraction:

- Each year, flu vaccines start to become available usually in September and most influenza vaccine is administered in October – December, but the vaccine is recommended to be administered throughout the influenza season which can last

until May in some years. For the purposes of this project, the hospitals are only responsible for discharges October through March.

- The caregiver is defined as the patient's family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who is responsible for the care of the minor patient or the adult patient when that patient is unable to make this decision on his/her own.
- In order to select "Influenza vaccine was given during this hospitalization," there must be documentation either on the MAR, nursing notes, standing orders, etc., where the vaccine was dated and signed as administered.
- In situations where there is documentation that would support more than one of the allowable values, 1-4, select the smallest number.
  Example:
  Nurses' notes have documentation the patient refused. Vaccination order sheet has documentation that the patient was vaccinated during this hospitalization. You will select value "1," as it is the smallest number.
- If there is no documentation to support any of the allowable values 1-4, and there is physician documentation that they will administer the vaccine after discharge, select value "5."
- If there is documentation that the patient received the vaccine and only the current year is documented, i.e., no month or day, select value "2."
  Example:
  There is documentation the patient received the vaccine in 2009 and it is October 2009, select value "2."
- If there is documentation the patient received the vaccine the year prior to the current year and the discharge is not January, February or March, select value "5."
  Examples:
  - There is documentation the patient received the vaccine in 2008 and it is October 2009, select value "5."
  - There is documentation the patient received the vaccine in 2008 and it is January 2009, select value "2.'
- If it is documented in the chart that a patient is "up to date" on their vaccines, you may select Allowable Value "2." Note that documentation of the acronym "UTD" alone is not sufficient to select Allowable Value "2."

Suggested Data Sources:

- Consultation notes
- Discharge summary
- Emergency Department record
- Immunization assessment forms
- Medication administration record
- Nursing admission assessment
- Nursing notes
- Physician orders
- Physician progress notes
- Social service notes
- Transfer forms

- Vaccine order sheet

Inclusion Guidelines for Abstraction:
All patients discharged during October, November, December, January, February, or March

- Afluria
- FluMist
- FluLaval
- Flu shot
- Flu vaccine
- Fluarix
- Fluvirin
- Fluzone
- Fluzone High Dose
- Influenza virus vaccine
- Trivalent influenza vaccine

Exclusion Guidelines for Abstraction:

- All discharges from April through September
- 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.
- Pandemic monovalent vaccine, e.g. H1N1
- Patients with an organ transplant during the current hospitalization (Appendix A, Table 12.10)

Data Element Name: *Initial Blood Culture Collection Date*

Collected For: The Joint Commission Only: PN-3a; **CMS Voluntary Only:** PN-3a, PN-3b

Definition: The month, day, and year the initial documentation of a blood culture was collected within 24 hours after hospital arrival. A blood culture can be defined as a culture of microorganisms from specimens of blood to determine the presence and nature of bacteremia.

Suggested Data Collection Question: What is the date of the initial documentation of a blood culture collected within 24 hours after hospital arrival?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

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

  Examples:
  - Documentation indicates the *Initial Blood Culture Collection Date* was 02-**42**-20xx. No other documentation in the medical record provides a valid date. Since the *Initial Blood Culture Collection Date* is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD."
  - Patient expires on 02-12-20xx and documentation indicates the *Initial Blood Culture Collection Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *Initial Blood Culture Collection Date* is after the *Discharge Date*, it is outside of the parameter of care and the abstractor should select "UTD."

  Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data

Warehouse. Use of “UTD” for *Initial Blood Culture Collection Date* allows the case to be accepted into the warehouse.

- If a blood culture is ordered and there is an attempt to collect it but the attempt results in failure to collect the specimen (too dehydrated to get a vein) or the specimen was contaminated during or after the draw, enter the date of the attempted blood culture collection.
- Only collect dates for blood cultures within 24 hours after hospital arrival.
- If there is supportive documentation that a blood culture was collected and it is the earliest mention of a blood culture, this date and time can be used, e.g., “BC sent to lab,” “blood culture received time.”
- Do not use physician orders as they do not demonstrate collection of the blood culture.
- Documentation must specify **blood culture**.
  Example:
  “lab was at bedside –blood drawn” (does not demonstrate **blood culture**).

Suggested Data Sources:

- Emergency Department record
- History and physical
- Laboratory report
- Microbiology report
- Nursing notes
- Progress notes

Inclusion Guidelines for Abstraction:

- BC within 24 hours after hospital arrival
- Blood cultures within 24 hours after hospital arrival

Exclusion Guidelines for Abstraction:

Cultures collected prior to arrival

Data Element Name: *Initial Blood Culture Collection Time*

Collected For: The Joint Commission Only: PN-3a; **CMS Voluntary Only:** PN-3a, PN-3b

Definition: The time (military time) that the initial documentation of a blood culture was collected within 24 hours after hospital arrival. A blood culture can be defined as a culture of microorganisms from specimens of blood to determine the presence and nature of bacteremia.

Suggested Data Collection Question: What is the time of the initial documentation of a blood culture collected within 24 hours after hospital arrival?

Format:

Length: 5 - HH:MM (with or without colon) or UTD
Type: Time
Occurs: 1

Allowable Values:

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight = 00:00	Noon = 12:00
5:31 am = 05:31	5:31 pm = 17:31
11:59 am = 11:59	11:59 pm = 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *Initial Blood Culture Collection Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00 do not forget to change the *Initial Blood Culture Collection Date.*
Example:
Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:

- For times that include “seconds,” remove the seconds and record the time as is.
  Example:

15:00:35 would be recorded as 15:00.

- If the blood culture collection time is unable to be determined from medical record documentation, select "UTD."
- The medical record must be abstracted as documented (taken at "face value"). When the time documented is obviously in error (not a valid time) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Example:
  Documentation indicates the *Initial Blood Culture Collection Time* was 3300. No other documentation in the medical record provides a valid time. Since the *Initial Blood Culture Collection Time* is outside of the range listed in the Allowable Values for "Hour," it is not a valid time and the abstractor should select "UTD."
  Note: Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *Initial Blood Culture Collection Time* allows the case to be accepted into the warehouse.
- If a blood culture is ordered and there is an attempt to collect it but the attempt results in failure to collect the specimen (too dehydrated to get a vein) or the specimen was contaminated during or after the draw, enter the time of the attempted blood culture collection.
- If multiple times of collection are documented abstract the earliest (initial) time, providing documentation demonstrates collection.
- Only collect times for blood cultures within 24 hours after hospital arrival.
- If there is supportive documentation that a blood culture was collected and it is the earliest mention of a blood culture, this date and time can be used, e.g., "BC sent to lab," "blood culture received time."
- Do not use physician orders as they do not demonstrate collection of the blood culture.
- Documentation must specify **blood culture**.
  Example:
  "lab was at bedside –blood drawn" (does not demonstrate **blood culture**).

Suggested Data Sources:

- Emergency Department record
- History and physical
- Laboratory report
- Microbiology report
- Nursing notes
- Progress notes

Inclusion Guidelines for Abstraction:

- BC within 24 hours after hospital arrival
- Blood cultures within 24 hours after hospital arrival

Exclusion Guidelines for Abstraction:

Cultures collected prior to arrival

Data Element Name: *Initial ECG Interpretation*

Collected For: CMS/The Joint Commission: AMI-7a, AMI-8a; **The Joint Commission Only:** AMI-7, AMI-8; **CMS Voluntary Only:** AMI-7, AMI-8

Definition: ST-segment elevation or a left bundle branch block (LBBB) based on the documentation of the electrocardiogram (ECG) performed closest to hospital arrival. The normal ECG is composed of a P wave (atrial depolarization), Q, R, and S waves (QRS complex, ventricular depolarization), and a T wave (ventricular repolarization). The ST-segment, the segment between the QRS complex and the T wave, may be elevated when myocardial injury (AMI) occurs. A bundle branch block (BBB) results from impaired conduction in one of the branches of the conduction system between the atria and the ventricles, which in turn results in abnormal ventricular depolarization. In LBBB, left ventricular depolarization is delayed, resulting in a characteristic widening of the QRS complex on the ECG. LBBB may be an electrocardiographic manifestation of an AMI.

Suggested Data Collection Question: Is there documentation of ST-segment elevation or left bundle branch block (LBBB) on the electrocardiogram (ECG) performed closest to hospital arrival?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	ST-segment elevation or a LBBB on the interpretation of the 12-lead ECG performed closest to hospital arrival.
N (No)	No ST-elevation or LBBB on the interpretation of the 12-lead ECG performed closest to hospital arrival, no interpretation or report available for the ECG performed closest to hospital arrival or unable to determine from medical record documentation.

Notes for Abstraction:
Methodology:

1. Identify the ECG performed closest to arrival, either before or after hospital arrival, but not more than 1 hour prior to arrival. If unable to determine which ECG was performed closest to arrival, select “No.” Exception: If the pre-arrival ECG and the first ECG performed after arrival at the hospital are exactly the same amount of time away from hospital arrival (e.g., both ECGs are 10 minutes away from *Arrival Time)*, use the first ECG performed after hospital arrival.
2. Start with review of the SIGNED tracing. Determine if the terms or phrases are Inclusions or Exclusions. Evaluate findings line by line. Do not cross reference between lines except for those Exclusions with “with mention of” phrasing (e.g.,

LVH and ST-elevation noted on separate lines on the same ECG meets the Exclusion "ST-elevation with any mention of early repolarization, left ventricular hypertrophy (LVH), normal variant, pericarditis, or Printzmetal/Printzmetal's variant in one interpretation"). If you have an Exclusion, select “No,” regardless of other documentation, and there is no need to review further.

3. If there is no signed tracing, or in the absence of an Exclusion on the signed tracing, proceed to other interpretations that clearly refer to the ECG done closest to arrival. Only those terms specifically identified or referred to by the physician/APN/PA as **ECG findings** AND where documentation is clear it is from the ECG performed closest to arrival should be considered in abstraction (e.g., “STEMI” listed only as a physician diagnosis or impression would not be used). Do not cross reference findings between interpretations unless otherwise specified. If you encounter an Exclusion in any of the other interpretations, select “No,” regardless of other documentation, and there is no need to review further.
4. At the end of your review, if you have no Exclusions, and either the signed ECG tracing or interpretations of this ECG include at least one Inclusion, select “Yes.” Otherwise, select “No.”

- ECG interpretation is defined as:
  - 12-lead tracing with name/initials of the physician/advanced practice nurse/physician assistant (physician/APN/PA) who reviewed the ECG signed or typed on the report, or
  - Physician/APN/PA notation of ECG findings in another source (e.g., progress notes).
- Do not measure ST-segments or attempt to determine if there is an LBBB from the tracing itself.
- Consider a tracing 12-lead if it has the appropriate markings (the presence of at least 12 leads: I, II, III, AVR, AVL, AVF, V1-V6).
- If ECG documentation outside of a tracing is not specified as 12-lead, assume it is 12-lead unless documentation indicates otherwise.
- Disregard any description of an MI or ST segment that is not on either the Inclusion list or the Exclusion list.
- If documentation is contradictory within the same interpretation or between different interpretations, select “No.”
  Examples:
  - “ST-elevation” and “No ST-elevation”
  - "STEMI" and "not consistent with STEMI"
  - "Acute anterior MI" and "no acute MI"
    - Documentation such as "ST-elevation in anterior leads" and "not a STEMI" should not be considered contradictory, for the purposes of this data element.
- If at least one interpretation describes an LBBB as old, chronic, or previously seen, or states LBBB and "no changes," "unchanged," "no acute changes," "no new changes," or "no significant changes" when compared to a prior ECG, all LBBB findings should be disregarded.
- Notations which describe ST-elevation as old, chronic, or previously seen, or which state ST-elevation and "no changes," "unchanged," "no acute changes," "no new changes," or "no significant changes" when compared to a prior ECG should be disregarded. Other documentation of ST-elevation within the same

interpretation or a different interpretation may still count as an Inclusion or Exclusion.
EXCEPTION: When the ST-elevation on the ECG done closest to arrival is described as previously seen on an ECG done by EMS or physician office prior to arrival, this ST-elevation may count as an Inclusion. Documentation must be explicit **within the ECG interpretation** itself (e.g., “Initial ECG shows ST-elevation 1mm V1-V2. Improved from ECG done in the field.”). Abstractors should NOT make inferences based on documentation outside of the interpretation (context, sequence of events, etc.).

- Notations which describe ST-elevation as a range where it cannot be determined if elevation is less than 1 mm/.10mV (e.g., "0.5-1 mm ST-elevation,” ST >0.06 mV V2-V6), should be disregarded. Other documentation of ST-elevation within the same interpretation or a different interpretation may still count as an Inclusion or Exclusion.
- If any of the Inclusion terms are described using the qualifier “possible,” disregard that finding (neither Inclusion nor Exclusion).
- Do not consider “subendocardial” an MI “location” (e.g., “acute subendocardial MI” should be disregarded).

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Consultation notes
- ECG reports
- Emergency Department record
- History and physical
- Progress notes

Inclusion Guidelines for Abstraction:
ST-segment elevation

- Myocardial infarction (MI), with any mention of location or combinations of locations (e.g., anterior, apical, basal, inferior, lateral, posterior, or combination), IF DESCRIBED AS ACUTE/EVOLVING (e.g., “posterior AMI”)
- Q wave MI, IF DESCRIBED AS ACUTE/EVOLVING
- ST ↑
- ST, ST abnormality, or ST changes consistent with injury or acute/evolving MI
- ST-elevation (STE)
- ST-elevation myocardial infarction (STEMI)
- ST-segment noted as greater than or equal to .10mV
- ST-segment noted as greater than or equal to 1 mm
- “STEMI or equivalent”
- Transmural MI, IF DESCRIBED AS ACUTE/EVOLVING

Left bundle branch block (LBBB)

- Intraventricular conduction delay of LBBB type
- Variable LBBB

Exclusion Guidelines for Abstraction:
ST-segment elevation

- Non Q wave MI (NQWMI)
- Non ST-elevation MI (NSTEMI)
- ST-elevation (ST ↑) clearly described as confined to ONE lead
- ST-elevation (ST ↑) with any mention of early repolarization, left ventricular hypertrophy (LVH), normal variant, pericarditis, or Printzmetal/Printzmetal's variant in one interpretation
- ST, ST abnormality, or ST changes consistent with injury or acute/evolving MI OR any of the "myocardial infarction" (MI) Inclusion terms described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table (except "possible")
- ST-segment elevation, or any of the other ST-segment elevation Inclusion terms, with any mention of pacemaker/pacing (unless atrial only or nonfunctioning pacemaker) in one interpretation
- ALL ST-elevation (ST ↑, STE) in one interpretation is described in one or more of the following ways:
    - Minimal
    - Non-diagnostic
    - Non-specific
    - ST-elevation (or ST-segment noted as greater than or equal to .10mV/1 mm) described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table (except "possible")
    - ST-elevation or ST-segment noted as less than .10mV in elevation
    - ST-elevation or ST-segment noted as less than 1 mm in elevation

Left bundle branch block (LBBB)

- Incomplete left bundle branch block (LBBB)
- Left bundle branch block (LBBB), or any of the other left bundle branch block inclusion terms, described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table (except "possible")
- Left bundle branch block (LBBB), or any of the other left bundle branch block inclusion terms, with any mention of pacemaker/pacing (unless atrial only or nonfunctioning pacemaker) in one interpretation

Data Element Name: *INR Value*

Collected For: CMS/The Joint Commission: VTE-3

Definition: Documentation of an international normalized ratio (INR) value greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation therapy. This value correlates to the ability of the blood to clot.

Suggested Data Collection Question: Was there documentation of an INR value greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation of an INR result greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation therapy.
N (No)	There is no documentation of an INR result greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation therapy or unable to determine from medical record documentation.

Notes for Abstraction:
To determine the value for this data element, review the INR values the day of and the day prior to the discontinuation of the parenteral anticoagulation therapy. If any result is greater than or equal to 2, select "Yes."

Suggested Data Sources:

- Discharge summary
- Laboratory reports
- Nursing notes
- Progress notes

Inclusion Guidelines for Abstraction:
Refer to Appendix H, Table 2.3 VTE Parenteral Therapy Table.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Intentional Hypothermia*

Collected For: CMS Voluntary Only: SCIP-Inf-10

Definition: There is documentation in the medical record that intentional hypothermia was utilized during the perioperative period.

Suggested Data Collection Question: Was there documentation that intentional hypothermia was utilized during the perioperative period?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation of the use of intentional hypothermia during the perioperative period.
N (No)	There is no documentation of the use of intentional hypothermia during the perioperative period or unable to determine from medical record documentation.

Notes for Abstraction:

- The perioperative period for this data element is defined as 24 hours prior to surgical incision through discharge from the post anesthesia care/recovery area.
- Documentation must be found that intentional hypothermia was used during the perioperative period.
- **For patients discharged from surgery and admitted to locations other than PACU (e.g.,ICU):** The perioperative period ends a maximum of six hours after arrival to the recovery area.
- If there is documentation that the patient's body temperature was lowered to or stating to keep the temperature below 96.8° Fahrenheit/36° Celcius or lower, during the perioperative period select "Yes."
- If there is documentation that hypothermia was or must be maintained for the procedure, select "Yes."
- If there is documentation of the patient undergoing cardiopulmonary bypass for the procedure, select "Yes."

Suggested Data Sources:

- Anesthesia record
- History and physical
- Intraoperative Record
- Operative Report
- Perfusion Record
- Progress notes

Inclusion Guidelines for Abstraction:

- Intentional hypothermia
- Maintain body temperature less than 96.8° Fahrenheit/36° Celsius (or lower)
- Cardiopulmonary bypass

Exclusion Guidelines for Abstraction:

None

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

Collected For: CMS/The Joint Commission: STK-5

Definition: There is documentation in the record that the patient received intravenous (IV) or intra-arterial (IA) thrombolytic therapy (t-PA) at this hospital or within 24 hours prior to arrival. Antithrombotic administration within 24 hours of thrombolytic therapy (t-PA) is contraindicated.

Suggested Data Collection Question: Did the patient receive IV or IA thrombolytic (t-PA) therapy at this hospital or within 24 hours prior to arrival?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Patient received IV or IA thrombolytic (t-PA) therapy at this hospital or within 24 hours prior to arrival.
N (No)	Patient did not receive IV or IA (t-PA) thrombolytic therapy at this hospital or within 24 hours prior to arrival, OR unable to determine from medical record documentation.

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

Suggested Data Sources:

- Emergency room records
- Medication records
- Progress notes
- Transfer forms
- Medical transport records

Inclusion Guidelines for Abstraction:
Only Acceptable Thrombolytic Therapy for Stroke:

- Activase
- Alteplase
- Intra-arterial (IA) t-PA
- IV t-PA
- Recombinant t-PA Tissue plasminogen activator

Exclusion Guidelines for Abstraction:

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

Data Element Name: *IV Thrombolytic Initiation*

Collected For: CMS/The Joint Commission: STK-4

Definition: Intravenous (IV) thrombolytic therapy was initiated at this hospital. IV thrombolytics convert plasminogen to plasmin, which in turn breaks down fibrin and fibrinogen, thereby dissolving thrombus. IV t-PA is the only FDA-approved IV thrombolytic for stroke.

Suggested Data Collection Question: Is there documentation that IV thrombolytic therapy was initiated at this hospital?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	IV thrombolytic was initiated at this hospital.
N (No)	IV thrombolytic was not initiated at this hospital, OR unable to determine from medical record documentation.

Notes for Abstraction:

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

Suggested Data Sources:

- Emergency room records
- Medication records
- Progress notes

Inclusion Guidelines for Abstraction:
Only Acceptable Thrombolytic Therapy for Stroke:

- Activase
- Alteplase
- IV t-PA
- Recombinant t-PA Tissue plasminogen activator

Exclusion Guidelines for Abstraction:
Intra-arterial (IA) t-PA

Data Element Name: *IV Thrombolytic Initiation Date*

Collected For: CMS/The Joint Commission: STK-4

Definition: The month, date, and year that IV thrombolytic therapy was initiated to a patient with ischemic stroke at this hospital. IV thrombolytics convert plasminogen to plasmin, which in turn breaks down fibrin and fibrinogen, thereby dissolving thrombus.

Suggested Data Collection Question: What is the date that IV thrombolytic therapy was initiated for this patient at this hospital?

Format:

Length: 10 - MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- Use the date at which initiation of the IV thrombolytic was first documented. If a discrepancy exists in date documentation from different sources, choose nursing documentation first before other sources. If multiple dates are documented by the same individual, use the earliest date recorded by that person.
- If the date IV thrombolytic therapy was initiated is unable to be determined from medical record documentation, select "UTD."
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid date/format) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Example:
  Documentation indicates the IV thrombolytic initiation date was 03-**42**-20xx. No other documentation in the medical record provides a valid date. Since the IV thrombolytic initiation date is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD."
  Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *IV Thrombolytic Initiation Date* allows the case to be accepted into the warehouse.

Suggested Data Sources:

- Emergency Department record
- IV flow sheets
- Medication administration record
- Nursing flow sheets
- Progress Notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *IV Thrombolytic Initiation Time*

Collected For: CMS/The Joint Commission: STK-4

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

Suggested Data Collection Question: What was the time of initiation for IV thrombolytic therapy?

Format:

Length: 5 - HH-MM (with or without colon) or UTD
Type: Time
Occurs: 1

Allowable Values:

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight – 00:00	Noon – 12:00
5:31 am – 05:31	5:31 pm – 17:31
11:59 am – 11:59	11:59 p.m. – 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *IV Thrombolytic Initiation Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00 do not forget to change the *IV Thrombolytic Initiation Date.*
Example:
Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx.

Notes for Abstraction:

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

- For times that include “seconds,” remove the seconds and record the time as is.
  Example:
  15:00:35 would be recorded as 15:00
- The use of “hang time” or “infusion time” is acceptable as IV thrombolytic initiation time when other documentation cannot be found.
- IV thrombolytic initiation time refers to the time the thrombolytic bolus/infusion was started.
- Do not use physician orders unless there is documentation with the order that it was administered.
- If the time of IV thrombolytic initiation is unable to be determined from medical record documentation, select “UTD.”
- The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid time) **and** no other documentation is found that provides this information, the abstractor should select “UTD.”
  Example:
  Documentation indicates the IV thrombolytic initiation time was 3300. No other documentation in the medical record provides a valid time. Since the IV thrombolytic initiation time is outside of the range listed in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD.”
  Note: Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for *IV Thrombolytic Initiation Time* allows the case to be accepted into the warehouse.

Suggested Data Sources:
- Emergency Department record
- IV flow sheets
- Medication administration record
- Nursing flow sheets
- Progress Notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Last Known Well*

Collected For: CMS/The Joint Commission: STK-4

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

Suggested Data Collection Question: Is there documentation that the date and time of last known well was witnessed or reported?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

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

Notes for Abstraction:

- In order to abstract allowable value "Yes," both date and time of last known well must be documented.
- If a date and time of last known well is listed in the medical record, without reference to the circumstances preceding its detection, select "Yes."
- For patients with a documented date and time of witnessed onset of stroke signs and symptoms, select "Yes."
  Examples:
  - "Patient driving to work on 12/05/20xx. Felt left side go numb at approximately 8:15 A.M. Pulled over and called 911 from cell phone."
  - " Wife reports that while eating dinner with patient, right corner of mouth started to droop and speech slurred about 6:00 P.M this evening."
  - "Patient watching TV and complains to family of blurred vision in both eyes at 8:00 PM tonight."
- If there is documentation referencing that the patient was discovered with symptoms already present and the date or time of last known well cannot be determined, select "No."
  Example:
  "Patient OK last night. Went to bed and woke up in AM unable to move right arm and leg."
- If there is documentation that symptoms were not present at the time of hospital arrival and occurred at a later date or time following hospital arrival, select "No."

Example:
"Motor vehicle accident victim arrives in ED and sent for outpatient surgery. Observation status post-op and subsequently admitted following onset of stroke symptoms."

- If there is documentation that the date or time of last known well is unknown, select "No."
- The patient may self-report the date and time of last known well, OR the date and time may be reported by a family member, caregiver, or another third-party individual.

Suggested Data Sources:

- Emergency Department records
- History and physical
- Progress notes

Excluded Data Sources:

- Discharge summary

Inclusion Guidelines for Abstraction:
Signs and Symptoms of Stroke

- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden severe headache

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Last Name*

Collected For: CMS Only: All Records (Optional Element)

Definition: The patient's last name.

Suggested Data Collection Question: What is the patient's last name?

Format:

Length: 60
Type: Character
Occurs: 1

Allowable Values:

Enter the patient's last name. Up to 60 letters, numbers, and/or special characters can be entered.

NOTE: Only the following special characters will be allowed:
~ ! @ # $ % ^ * ( ) _ + { } | : ? ` - = [ ] \ ; ‘ . , / and space

Notes for Abstraction:
None

Suggested Data Sources:

- Emergency Department record
- Face sheet
- History and physical

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *LDL-c Greater Than or Equal to 100 mg/dL*

Collected For: CMS/The Joint Commission: STK-6

Definition: Value of LDL-cholesterol (LDL-c) was greater than or equal to 100 mg/dL. LDL is a complex of lipids and proteins, with greater amounts of lipid than protein that transports cholesterol in the blood. High levels are associated with an increased risk of atherosclerosis and coronary heart disease.

Suggested Data Collection Question: Was the patient's highest LDL-cholesterol (LDL-c) level greater than or equal to 100 mg/dL in the first 48 hours or within 30 days prior to hospital arrival?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	LDL-c greater than or equal to 100 mg/dL in the first 48 hours or within 30 days prior to hospital arrival.
N (No)	LDL-c less than 100 mg/dL in the first 48 hours or within 30 days prior to hospital arrival, OR unable to determine from medical record documentation.

Notes for Abstraction:

- For this measurement, look for the highest level from testing done within the first 48 hours after hospital arrival or within 30 days prior to hospital arrival.
- Direct and calculated (indirect) LDL-c values are both acceptable.
- Fasting and non-fasting LDL-c values are both acceptable.
- The medical record must be abstracted as documented (taken at "face value"). When the LDL-c value documented is obviously in error (not a valid number) and no other documentation is found that provides this information, the abstractor should select "No."
- If all LDL-c value(s) from testing done within the first 48 hours after hospital arrival or within 30 days prior to hospital arrival are reported as not calculated (e.g., high triglycerides render the LDL-c calculation inaccurate), select "No."
- If an LDL-c value on the laboratory report conflicts with that from another source of documentation for the same specimen, use the value from the laboratory report.
- If a laboratory report documents discrepant LDL-c values for the same specimen, use the highest value.
- If sources other than a laboratory report document discrepant LDL-c values for the same specimen, use the highest value.

- Disregard LDL-c values reported in units of mmol/L or any other unit of measurement other than mg/dL or mg/100 ml. If the unit of measurement is not documented, assume the unit of measurement is mg/dL.

Suggested Data Sources:
- Consultation notes
- Discharge summary
- Emergency Department record
- History and physical
- Laboratory reports
- Progress notes

Inclusion Guidelines for Abstraction:
LDL-cholesterol (LDL-c)
- Low den lipoprotein
- Low density lipoprotein (LDL)

Exclusion Guidelines for Abstraction:
LDL-cholesterol (LDL-c)
VLDL (very low density lipoprotein)

Data Element Name: *LDL-c Less Than 100 mg/dL*

Collected For: The Joint Commission Only: AMI-10; **CMS Voluntary Only:** AMI-10

Definition: Documentation of LDL-c cholesterol (LDL-c) level less than 100 mg/dL from test done within the first 24 hours after hospital arrival or within 30 days prior to hospital arrival. LDL is a complex of lipids and proteins, with greater amounts of lipid than protein that transports cholesterol in the blood. Higher levels are associated with an increased risk of atherosclerosis and coronary heart disease in patients without known cardiovascular disease as well as higher rates of recurrent cardiovascular events in patients who experience a first myocardial infarction.

Suggested Data Collection Question: Were any of the patient's LDL-c cholesterol (LDL-c) levels less than 100 mg/dL from testing done within the first 24 hours after hospital arrival or within 30 days prior to hospital arrival?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	LDL-c less than 100 mg/dL in the first 24 hours after hospital arrival or within 30 days prior to hospital arrival.
N (No)	LDL-c is not less than 100 mg/dL in the first 24 hours after hospital arrival or within 30 days prior to hospital arrival, no testing was done during this timeframe (or LDL-c values not available), OR unable to determine from medical record documentation.

Notes for Abstraction:

- If there is any LDL-c value less than 100 mg/dL from testing done within the first 24 hours after *Arrival Time* or within 30 days prior to *Arrival Time*, select "Yes."
- Direct and calculated (indirect) LDL-c values are both acceptable.
- If there are no LDL-c values less than 100 mg/dL from testing done within the first 24 hours after *Arrival Time* or within 30 days prior to *Arrival Time* but there is a total cholesterol (TC or "cholesterol") value less than 100 mg/dL from testing done during this timeframe, infer the LDL-c was less than 100 mg/dL and select "Yes."
- If all LDL-c value(s) from testing done within the first 24 hours after *Arrival Time* and within 30 days prior to *Arrival Time* are reported as not calculated (e.g., high triglycerides render the LDL-c calculation inaccurate), select "No."

Suggested Data Sources:

- Consultation notes
- Emergency Department record
- History and physical
- Laboratory reports
- Progress notes
- Transfer record

Inclusion Guidelines for Abstraction:
LDL-cholesterol (LDL-c)

- Low den lipoprotein
- Low density lipoprotein (LDL)

Exclusion Guidelines for Abstraction:
LDL-cholesterol (LDL-c)

- VLDL (very low density lipoprotein)

Data Element Name: *LDL-c Measured Within the First 48 Hours or 30 Days Prior to Hospital Arrival*

Collected For: CMS/The Joint Commission: STK-6

Definition: LDL-cholesterol (LDL-c) measurement obtained within the first 48 hours or 30 days prior to hospital arrival. Lipid levels drawn in the first 48 hours after a major vascular event are reliable predictors of baseline lipid profiles, but after that time may become unreliable.

Suggested Data Collection Question: Was the LDL-cholesterol (LDL-c) measured within the first 48 hours or 30 days prior to hospital arrival?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	LDL-c was measured within the first 48 hours or 30 days prior to hospital arrival.
N (No)	LDL-c was not measured within the first 48 hours or 30 days prior to hospital arrival, OR unable to determine from medical record documentation.

Notes for Abstraction:
If there is documentation that LDL-c testing was done within the first 48 hours after hospital arrival or within 30 days prior to hospital arrival but no LDL-c values are available, select “No.”

Suggested Data Sources:

- Consultation notes
- Discharge summary
- Emergency Department record
- History and physical
- Laboratory reports
- Progress notes

Inclusion Guidelines for Abstraction:
LDL-cholesterol (LDL-c)

- Low den lipoprotein
- Low density lipoprotein (LDL)

Exclusion Guidelines for Abstraction:
LDL-cholesterol (LDL-c)
VLDL (very low density lipoprotein)

Data Element Name: *LVF Assessment*

Collected For: CMS/The Joint Commission: HF-2

Definition: Documentation that left ventricular systolic function (LVSF) was assessed either prior to arrival, during hospitalization, or is planned for after discharge or reason documented by physician/advanced practice nurse/physician assistant (physician/APN/PA) for not assessing LVSF.

Suggested Data Collection Question: Is there documentation of at least one of the following:

- Left ventricular systolic function (LVSF) assessment at anytime prior to arrival or during this hospitalization
- A plan for LVSF assessment after discharge
- A reason documented by a physician/APN/PA for not assessing LVSF

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Documentation in the medical record that the LVSF was assessed prior to arrival, during the hospital stay, or is planned for after discharge.
N (No)	No documentation that LVSF was assessed either prior to arrival or during this hospital stay nor a plan to assess LVSF after discharge, AND there is no reason documented by a physician/APN/PA for not assessing LVSF, or unable to determine from medical record documentation.
R (Reason)	Reason documented by physician/APN/PA for not assessing LVSF prior to arrival, during hospital stay, or planned after discharge.

Notes for Abstraction:

- LVSF assessments done anytime prior to hospital arrival are acceptable (see Inclusion list).
- Infer a test was done if the patient's LVSF is documented (e.g., "Pt. admitted with severe LV dysfunction").
- In determining whether there is a reason documented by a physician/APN/PA for not assessing LVSF:
  - Reasons must be explicitly documented (e.g., "ESRD. Will not measure the ejection fraction," echo results reported as "Technically difficult study. LVSF could not be measured.") or clearly implied (e.g., "Patient refusing

echo," "Limited life expectancy. Will not do any further evaluation," "Ejection fraction measurement not indicated").
    - Physician/APN/PA deferral of LVSF assessment to another physician/APN/PA does NOT count as a reason for not assessing LVSF unless the reason/problem underlying the deferral is also noted (e.g., "Consulting cardiologist to evaluate pt. for echo," select "No").
- If there is documentation of both a reason for not assessing LVSF AND documentation that LVSF was assessed or that assessment is planned for after discharge, select "Yes."
- In determining whether there is a plan to assess LVSF after discharge, the plan must be documented as definitive (e.g., "Will measure EF next week"). Documentation which indicates only that an LVSF assessment after discharge will be considered (e.g., "May do echo in 1 month") is not sufficient.

Suggested Data Sources:
- Consultation notes
- Discharge instruction sheet
- Discharge summary
- History and physical
- Procedure notes
- Progress notes

Excluded Data Sources:
Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay).

Inclusion Guidelines for Abstraction:
Left ventricular systolic function (LVSF) assessment

Echocardiogram (echo)
- Cardiac ultrasound
- Transesophageal echo (TEE)
- Transthoracic echo (TTE)

Cardiac Catheterization (cath) with Left Ventriculogram (LV gram)
- Cardiac cath with mention of LVSF
- Cardiac/coronary angiogram/arteriogram with LV gram or mention of LVSF
- Left heart cath with mention of LVSF
- Left ventriculogram (LV gram)

Other LVSF Assessment Tests
- Cardiac MRI scan with mention of LVSF
- CT scan of chest with mention of LVSF
- Multiple gated acquisition scan (MUGA) or other cardiac imaging/testing described as gated or blood pool
- Other nuclear test (e.g., SPECT, PET) with mention of LVSF

Left Ventricular Systolic Function (LVSF)

- Akinesis described as left ventricular
- Diastolic dysfunction, failure, function, or impairment
- Dysfunction described as biventricular, left ventricular (LVD, LVSD), systolic, or ventricular
- Dyskinesis described as left ventricular
- Ejection fraction (EF, LVEF)
- Endstage cardiomyopathy
- Failure described as biventricular, left ventricular, systolic, or ventricular
- Function described as biventricular, left ventricular (LVF), systolic, or ventricular
- Hypokinesis described as left ventricular

Exclusion Guidelines for Abstraction:
Left ventricular systolic function (LVSF)

- Akinesis not described as left ventricular
- Cardiomyopathy not described as endstage
- Contractility/hypocontractility
- Dyskinesis not described as left ventricular
- Hypokinesis not described as left ventricular
- Left ventricular compliance
- Left ventricular dilatation/dilation
- Left ventricular hypertrophy (LVH)

Data Element Name: *LVSD*

Collected For: The Joint Commission Only: AMI-3, HF-3; **CMS Voluntary Only:** AMI-3, HF-3

Definition: Left ventricular systolic dysfunction (LVSD) documented in medical record. LVSD is defined as a left ventricular ejection fraction less than 40% or a narrative description consistent with moderate or severe systolic dysfunction.

LVSD is an impairment of left ventricular performance. An ejection fraction (EF) is an index of left ventricular systolic function (LVSF) and reflects the proportion of blood ejected during each ventricular contraction compared with the total ventricular filling volume.

Suggested Data Collection Question: Is the left ventricular systolic function (LVSF) documented as an ejection fraction (EF) less than 40% or a narrative description consistent with moderate or severe systolic dysfunction?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	LVSF is documented as an ejection fraction (EF) less than 40% or a narrative description consistent with moderate or severe systolic dysfunction.
N (No)	LVSF is not documented as an ejection fraction (EF) less than 40% or a narrative description consistent with moderate or severe systolic dysfunction, or unable to determine from medical record documentation (e.g., LVSF assessment was never done, "Echo done last March" [without mention of LVSF results]).

Notes for Abstraction:

- Results from in-hospital LVSF assessments filed into the chart after discharge should still be used.

A. Methodology:

- **Final findings take priority over preliminary findings**. Applies to test reports and findings noted outside of reports. If not labeled "preliminary," assume it is final.
- **Conclusion section of report takes priority over other sections**. Consider the "Impression," "Interpretation," and "Final Diagnosis" sections as equivalent with the "Conclusion" section.

- **Apply Section B Conflicting Documentation priority order** in ANY step in Methodology section when there are two or more different descriptions of Ejection Fraction/LVSF.
- Disregard the following terminology when reviewing the record for documentation of LVSF/LVSD. If documented, continue reviewing for LVSF/LVSD inclusions outlined in the Inclusion lists, as directed in the abstraction guidelines below.
  - o Diastolic dysfunction, failure, function, or impairment
  - o Ventricular dysfunction not described as left ventricular or systolic
  - o Ventricular failure not described as left ventricular or systolic
  - o Ventricular function not described as left ventricular or systolic

  E.g., Impression section of echo report states only "diastolic dysfunction." Findings section states "EF 35%." Disregard "diastolic dysfunction" in the Impression section and answer "Yes" due to EF 35%.

1. **If one or more in-hospital tests performed**:
   a. Use report from **most recent test*** (test done closest to discharge).
   b. If no report or no Ejection Fraction/LVSF findings noted in report, use other sources (e.g., progress notes) that **clearly reference** the **most recent** test*.
   c. If no Ejection Fraction/LVSF results from the **most recent test** are documented anywhere, use the **report** from the **second most recent test***.
   d. If no Ejection Fraction/LVSF findings from second **most recent test** are documented anywhere, use **other sources** (e.g., progress notes) that **clearly reference** the **second most recent test***. Continue working backwards (if greater than 2 tests) and use Ejection Fraction/LVSF from the **most recent test*** that has Ejection Fraction/LVSF findings, using the report over non-report sources as above.
   e. If no Ejection Fraction/LVSF results from any in-hospital test are documented anywhere, skip to step 2a below.

   ***If you cannot determine between two in-hospital tests which was performed closest to the time of discharge, use BOTH tests**:
   1) Use reports. Reports take priority over non-report sources.
   2) If no reports or no Ejection Fraction/LVSF findings on reports from any test, use other sources (e.g., progress notes) that **clearly reference** the tests.
   3) If no Ejection Fraction/LVSF results from either in-hospital test documented anywhere, go to step 2a below.

2. **If in-hospital test not done, no Ejection Fraction/LVSF results from any in-hospital test documented, OR documentation is not clear that one was done** (e.g., echo ordered but no documentation that it was done):
   a. Assume notations of Ejection Fraction/LVSF with no timeframe ("floating" Ejection Fractions/LVSFs) are from assessments done prior to arrival.
   b. If timeframe known for ALL pre-arrival Ejection Fractions/LVSFs (no "floaters"):

- Use results from the pre-arrival test known to be most recent (closest to hospital arrival). Use report over other sources, and Conclusion (Impression, etc.) over other sections of report, as above.

c. If one or more "floaters:"
   - Compile all Ejection Fractions/LVSFs and eliminate those that you can determine are not the most recent, resulting in a list of Ejection Fraction/LVSF "Possibles."
   - If Ejection Fraction/LVSF from one test in the "Possibles" list is referenced both in a report and in another source, use the report, and use the Conclusion (Impression, etc.) over other sections of the report, as above, to determine which Ejection Fraction/LVSF from this test to add to the list of "Possibles."
   - Select final Ejection Fraction/LVSF from list of "Possibles" based on the Conflicting Documentation rules below.

B. Conflicting Documentation:

Apply the following priority order in cases of conflicting documentation within ANY ONE STEP in Methodology above, where there are two or more different descriptions of Ejection Fraction/LVSF:

1. Use **lowest calculated ejection fraction**. Presume calculated unless described as estimated (e.g., "Ejection fraction 30%").
   - If calculated ejection fraction less than 40% select "Yes." If calculated ejection fraction greater than or equal to 40%, select "No."
2. Use **lowest estimated ejection fraction**. E.g., "Ejection fraction about 40%," "Ejection fraction approximately 30%," "Ejection fraction appears to be 35%," "Visually ejection fraction is 45%," "Ejection fraction 35-40%" (use mid-point), "Ejection fraction less than 40%."
   - If estimated ejection fraction less than 40%, select "Yes." If estimated ejection fraction greater than or equal to 40%, select "No."
3. Use **worst** narrative description with severity specified.
   - Select "Yes" if description is synonymous with term from Inclusion list A.
   - Select "No" if description with severity specified is NOT synonymous with term from Inclusion List A (e.g., normal, mild, preserved).
4. Use narrative description without severity specified. Select "Yes" if description is synonymous with term from Inclusion list B. Otherwise, select "No."

Suggested Data Sources:

- Consultation notes
- Discharge summary
- History and physical
- Procedure notes
- Progress notes

Inclusion Guidelines for Abstraction:
Inclusion list A: Moderate/severe LVSD

- Biventricular dysfunction described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe
- Biventricular heart failure described as moderate or severe
- Ejection fraction or left ventricular ejection fraction (LVEF) described as low, poor, or very low
- Endstage cardiomyopathy
- Hypokinesis described as diffuse, generalized, or global AND marked, moderate, moderate-severe, severe, significant, substantial, or very severe
- Left ventricular (LV) akinesis described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe
- Left ventricular (LV) hypokinesis described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe in one or more segments of left ventricle
- Left ventricular dysfunction (LVD), left ventricular systolic dysfunction (LVSD), or systolic dysfunction described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe
- Left ventricular function (LVF), left ventricular systolic function (LVSF), or systolic function described as low, poor, or very low
- Systolic failure described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe AND not described as right ventricular

Inclusion list B: LVSD – Severity not specified

- Biventricular dysfunction where severity is not specified
- Ejection fraction or left ventricular ejection fraction (LVEF) described as abnormal, compromised, decreased, depressed, diminished, impaired, or reduced
- Hypokinesis described as diffuse, generalized, or global where severity is not specified
- Left ventricular (LV) hypokinesis described as involving the entire left ventricle
- Left ventricular dysfunction (LVD), left ventricular systolic dysfunction (LVSD), or systolic dysfunction where severity is not specified
- Left ventricular function (LVF), left ventricular systolic function (LVSF), or systolic function described as abnormal, compromised, decreased, depressed, diminished, impaired, or reduced
- Systolic failure where severity is not specified AND not described as right ventricular

Exclusion Guidelines for Abstraction:
Moderate or severe systolic dysfunction

- Any term in Inclusion list A or B described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table
- Any term in Inclusion list A or B described as mild-moderate

Data Element Name: *Measure Category Assignment*

Collected For: The Joint Commission Only: Used in calculation of The Joint Commission's aggregate data and in the transmission of the Hospital Clinical Data file

Notes:

- Episode of care records that calculate with a *Measure Category Assignment* of "X" (missing data) for one or more measures will be rejected by the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Refer to the Missing and Invalid data section in this manual for more information.
- All hospital measures use this data element. The ORYX® Vendor's calculated *Measure Category Assignment* will be transmitted to The Joint Commission on a quarterly basis with the associated hospital clinical data. These measure results will be used in The Joint Commission's data quality analysis and continuous measure verification process. ORYX Vendors can refer to The Joint Commission's *ORYX Data Quality Manual* for more information.
- *Measure Category Assignment* must be transmitted to The Joint Commission but cannot be transmitted to CMS. Files transmitted to the QIO Clinical Warehouse that contain *Measure Category Assignment* will be rejected.

Definition: Calculated measures results for each episode of care (EOC) that is processed through a measure algorithm.

Used to summarize the outcome for an EOC that is processed through a specific measure algorithm.

Suggested Data Collection Question: Not Applicable

Format:

Length: 1
Type: Character
Occurs: One *Measure Category Assignment* per EOC is expected for every measure that a hospital is participating in.

Allowable Values:

B **Category B - Not in Measure Population**
For rate-based and continuous variable measures: EOC record is not a member of a measure's population.

D **Category D - In Measure Population**
For rate-based measures: EOC record is a member of the measure's population and there has not been an occurrence of the measure.

For continuous variable measures: EOC record is a member of the measure's population and has sufficient accurate and valid data to compute the measurement.

Note: For continuous variable measures, EOC records that have a *Measure Category Assignment* of “D” **will** have an associated *Measurement Value*.

E **Category E - In Numerator Population**
For rate-based measures: EOC record is a member of the measure's population and there has been an occurrence of the measure.

For continuous variable measures: Does not apply.

X **Category X – Data Are Missing**
For rate-based and continuous variable measures: Data are missing that is required to calculate the measure. The record will be rejected by the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse.

Y **Category Y – UTD Allowable Value Does Not Allow Calculation of The Measure**
For rate-based measures: Does not apply.

For continuous variable measures: EOC record contains a Date, Time, or Numeric data element with a value of “UTD.”

Note: For continuous variable measures, EOC records that have a *Measure Category Assignment* of “Y” **will not** have an associated *Measurement Value.*

Notes for Abstraction:
None

Suggested Data Sources:
Not Applicable

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Measurement Value*

Collected For: The Joint Commission Only: Used in the calculation of The Joint Commission's aggregate data, Continuous Variable Measures (AMI-7, AMI-8, ED-1, ED-2), and in the transmission of the Hospital Clinical Data file
Note:

- The ORYX® Vendor's calculated *Measurement Value* will be transmitted to The Joint Commission on a quarterly basis with the associated hospital clinical data. These measure results will be used in The Joint Commission's data quality analysis and continuous measure verification process. ORYX Vendors can refer to The Joint Commission's *ORYX Data Quality Manual* for more information.
- *Measurement Value* must be transmitted to The Joint Commission but cannot be transmitted to CMS. Files transmitted to the QIO Clinical Warehouse that contain *Measurement Value* will be rejected.

Definition: This data element is used to store the calculated results of the measurements that are outputs from continuous variable measure algorithms.

Note: Used in conjunction with Measure Category Assignment when its allowable value = "D" (In Measure Population).

Suggested Data Collection Question: Not Applicable

Format:

Length: 6
Type: Numeric
Occurs: One *Measurement Value* is expected per EOC for every continuous variable measure that a hospital is participating in.

Allowable Values:

Any valid number

Note: The allowable value range for each continuous variable measure is documented in that measure's algorithm. Each measure may have a different allowable value range.

Notes for Abstraction:
None

Suggested Data Sources:
Not Applicable

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Monitoring Documentation*

Collected For: CMS/The Joint Commission: VTE-4

Definition: Documentation that defined parameters such as a nomogram or protocol were used to manage the intravenous (IV) unfractionated heparin (UFH) AND platelet counts.

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

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

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

Notes for Abstraction:

- Pathways, orders or documentation that state that a nomogram or protocol was used to calculate the UFH therapy dosages and platelet count monitoring are acceptable.
- "Defined parameters" for managing UFH therapy may include documents labeled a nomogram or protocol.
- For orders that state that UFH therapy is ordered per pharmacy dosing or per pharmacy protocol select "Yes" if there is documentation that platelet counts were also monitored.
- If IV UFH was managed by a nomogram for less than 24 hours, but was discontinued prior to monitoring the platelet counts, select "Yes."

Suggested Data Sources:
PHYSICIAN/APN/PA or PHARMACIST DOCUMENTATION ONLY

- Physician orders
- Physician or Pharmacist notes

Exception:
Nursing documentation on pathways

Inclusion Guidelines for Abstraction:
Intravenous (IV) Unfractionated Heparin (UFH)

- HEP
- Heparin
- Heparin Na
- Heparin Sod
- Heparin Sodium

Exclusion Guidelines for Abstraction:
Route

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

Data Element Name: *Non-Primary PCI*

Collected For: CMS/The Joint Commission: AMI-8a; **The Joint Commission Only:** AMI-8; **CMS Voluntary Only:** AMI-8

Definition: Primary percutaneous coronary interventions (PCIs) are those performed as the initial approach to reperfusion for patients in the acute phase of STEMI with the goal of promptly restoring blood flow and function to the portion of the heart that is jeopardized by an acute coronary artery occlusion. The benefits of primary PCI are sensitive to the speed with which PCI is performed. In contrast, some patients with STEMI may undergo a PCI during hospitalization that is not considered primary. For example, some may undergo PCI after either successful or failed fibrinolysis (i.e., a secondary approach to reperfusion); others after presenting days after symptom onset; and others later in the hospitalization because their ST-segment elevation and symptoms resolved early (i.e., where acute reperfusion was not deemed necessary but subsequent PCI was pursued). In order for a PCI to be excluded from the measures as non-primary, physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation must clearly describe the procedure as not primary. If the documentation does not specifically describe the PCI in this manner, it is assumed to be primary.

Suggested Data Collection Question: Does the physician/APN/PA describe the first PCI as NOT primary?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Physician/APN/PA documentation describes the first PCI as NOT primary.
N (No)	Physician/APN/PA documentation does NOT describe the first PCI as non-primary, or unable to determine from medical record documentation.

Notes for Abstraction:

- Use only physician/APN/PA documentation which **describes** the first PCI. Do NOT attempt to determine whether the PCI was non-primary based on symptomatology, circumstances, timing, etc.
- If ANY documentation referring to the first PCI describes the procedure as non-primary (see Inclusion list), select “Yes.”
  Examples:
  - “Will schedule elective PCI”
  - "Patient did not need to go to the cath lab emergently"
  - "No indication for immediate PCI"

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Consultation notes
- Diagnostic test reports
- Discharge summary
- Emergency Department record
- History and physical
- Operative notes
- Procedure notes
- Progress notes

Excluded Data Sources: Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay).

Inclusion Guidelines for Abstraction:

- Elective
- Not emergent
- Not immediate
- Not primary
- Not urgent
- Secondary

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Oral Antibiotics*

Collected For: CMS/The Joint Commission: SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3

Definition: Documentation that a combination of oral Neomycin Sulfate + Erythromycin Base **OR** a combination of oral Neomycin Sulfate + Metronidazole was administered the day prior to the day of surgery or within 24 hours prior to surgery.

Suggested Data Collection Question: Is there documentation that a combination of oral Neomycin Sulfate + Erythromycin Base **OR** a combination of oral Neomycin Sulfate + Metronidazole was administered the day prior to the day of surgery or within 24 hours prior to surgery?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	A combination of oral Neomycin Sulfate + Erythromycin Base **OR** a combination of oral Neomycin Sulfate + Metronidazole was administered the day prior to the day of surgery or within 24 hours prior to surgery.
N (No)	A combination of oral Neomycin Sulfate + Erythromycin Base OR a combination of oral Neomycin Sulfate + Metronidazole was not administered the day prior to the day of surgery or within 24 hours prior to surgery, or unable to determine from medical record documentation.

Notes for Abstraction:

- This element is used to prevent colon surgeries from being excluded from the appropriate measures if the patient receives either of these oral antibiotic combinations the day prior to the day of surgery or within 24 hours of surgery. If there is documentation that one of the antibiotic combinations, as listed above, was received by the patient on the day prior to the day of surgery or within 24 hours prior to surgery, select “Yes.”
- If there is documentation that the patient was receiving any antibiotic other than these oral combinations of antibiotics the day prior to the day of surgery or within 24 hours prior to surgery, select “No.”
- The combination of oral medications can be received before hospitalization and/or during this hospital stay.
- If there is documentation that the patient received a combination of these oral antibiotics on the day prior to the day of surgery, assume it was given within 24 hours and select “Yes.” A time and date is not needed.

- If there is documentation of a Nichol's Bowel Prep used the day prior to the day of surgery or within 24 hours prior to surgery, select "Yes." A Nichol's Bowel Prep contains one of the combinations of oral antibiotics as listed above.
- If there is documentation that instructions or prescriptions were given to the patient in regard to the oral antibiotic combinations listed above or for a Nichol's Bowel Prep, to be taken on the day prior to the day of surgery or within 24 hours prior to surgery, select "Yes."

Suggested Data Sources:
- Consultation notes
- Emergency Department record
- History and physical
- Medication administration record
- Medication reconciliation record
- Nursing admission assessment
- Nursing notes

Inclusion Guidelines for Abstraction:
- Erythromycin Base
- Metronidazole
- Neomycin Sulfate

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Other Surgeries*

Collected For: CMS/The Joint Commission: SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3

Definition: Other procedures requiring general or spinal/epidural anesthesia that occurred within three days (four days for CABG or Other Cardiac Surgery) prior to or after the principal procedure during this hospital stay.

Suggested Data Collection Question: Were there any other procedures requiring general or spinal/epidural anesthesia that occurred within three days (four days for CABG or Other Cardiac Surgery) prior to or after the principal procedure during this hospital stay?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation of another procedure requiring general or spinal/epidural anesthesia that occurred within three days (four days for CABG or Other Cardiac Surgery) prior to or after the principal procedure during this hospital stay.
N (No)	There is no documentation of any other procedure requiring general or spinal/epidural anesthesia that occurred within three days (four days for CABG or Other Cardiac Surgery) prior to or after the principal procedure during this hospital stay or unable to determine from medical record documentation.

Notes for Abstraction:

- This data element is used to exclude cases that have another major surgical procedure (requiring an incision and general or spinal/epidural anesthesia) performed within three days (four days for CABG and Other Cardiac Surgery) prior to or after the principal procedure during this hospital stay.
- For the purposes of this data element, if pocketed devices (pacemakers, defibrillators, pulse generators, medication pumps, etc.) are implanted during this hospital stay and within three days (four days for CABG and Other Cardiac Surgery) prior to or after the principal procedure, select “Yes.” The prophylactic antibiotics given for the implanted device could interfere with the prophylaxis for the principal procedure.
- The following are two scenarios that must be clarified:
  - If multiple procedures are performed during the **same surgical episode**, select “No.”
  - If other procedures are performed during **separate surgical episodes** requiring general or spinal/epidural anesthesia and occur within three days

(four days for CABG or Other Cardiac Surgery) of the principal procedure during this hospital stay, select “Yes.”

- For other surgical procedures requiring general or spinal/epidural anesthesia performed **prior** to the principal procedure during this hospital stay, the three day (four day for CABG or Other Cardiac Surgery) window begins at the *Anesthesia End Date* of the earlier procedure and ends at the *Anesthesia Start Date* of the principal procedure.
- For other surgical procedures requiring general or spinal/epidural anesthesia that occur **after** the principal procedure during this hospital stay, the three day (four day for CABG or Other Cardiac Surgery) window begins at the *Anesthesia End Date* of the principal procedure and ends at the *Anesthesia Start Date* of the subsequent procedure.

Suggested Data Sources:

- Admitting physician orders
- Admitting progress notes
- Consultation notes
- Discharge summary
- Emergency Department record
- History and physical
- Nursing notes
- Operative notes/reports
- Physician admission notes
- Physician progress notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Overlap Therapy*

Collected For: CMS/The Joint Commission: VTE-3

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

Suggested Data Collection Question: Were parenteral anticoagulation therapy and warfarin both administered on the same day anytime during the hospitalization?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

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

Notes for Abstraction:

- To Select "Yes," both parenteral anticoagulation therapy and warfarin must be administered and documented on the same calendar day at least one time.
- Substitution of one parenteral anticoagulation drug for another parenteral anticoagulation drug is still considered sufficient therapy.
- If conflicting documentation is present whether or not both warfarin and parenteral anticoagulation therapy were administered on the same day, select "No."
- If there is documentation that the warfarin therapy is on a schedule other than daily or it is not clear that one dose was given along with parenteral therapy, select "No."

Suggested Data Sources:

- Ambulance record
- Consultation notes
- Discharge summary
- Emergency Department record
- History and physical
- Medication administration record
- Medication reconciliation form
- Nursing admission assessment
- Nursing notes

- Progress notes
- Transfer sheet

Inclusion Guidelines for Abstraction:
Refer to Appendix H, Table 2.3 VTE Parenteral Therapy Table and Appendix C, Table 1.4 Warfarin Therapy.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Overlap Therapy Start Date*

Collected For: CMS/The Joint Commission: VTE-3

Definition: The **first** date that the parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation therapy and warfarin were administered.

Suggested Data Collection Question: What was the **first** date that parenteral anticoagulation therapy AND warfarin were both administered?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- Select "UTD" if unable to determine the date that both medications were administered.
- For patients admitted for VTE who were on warfarin at home and took a dose the day of admission, select the day of admission as the *Overlap Therapy Start Date* if the parenteral anticoagulant was started the day of admission. For example, patient admitted on 9/12 and lovenox was started that day. If there is documentation in the MAR that the "patient took Coumadin earlier the same day, (9/12)," select 9/12 as the *Overlap Therapy Start Date.*
- For patients diagnosed with VTE while in the ED that had overlap therapy started prior to admission, enter the date that both medications were administered prior to the admission date.
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid date/format) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Example:
  Documentation indicates the *Overlap Therapy Start Date* was 03-**42**-20xx. No other documentation in the medical record provides a valid date. Since the *Overlap Therapy Start Date* is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD."
  Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *Overlap Therapy Start Date* allows the case to be accepted into the warehouses.

Suggested Data Sources:

- Consultation notes
- Discharge summary
- Medication administration record
- Nursing notes
- Progress notes

Inclusion Guidelines for Abstraction:
Refer to Appendix H, Table 2.3 VTE Parenteral Therapy Table and Appendix C, Table 1.4 Warfarin Therapy.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Parenteral Anticoagulant End Date*

Collected For: CMS/The Joint Commission: VTE-3

Definition: The **last** date that a parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulant medication was administered.

Suggested Data Collection Question: What was the **last** date that a parenteral anticoagulant medication was administered?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- Select "UTD" if unable to determine the last date that a parenteral anticoagulant medication was administered.
- The *Parenteral Anticoagulant End Date* is the last date that the medication was administered during hospitalization. This may be the same day as the discharge day.
- For patients with non-consecutive medication administration, use the last day the parenteral medication was given. For example, if LMWH was given from 4/9 to 4/11, resumed from 4/13 to 4/15, use 4/15 as the end date.
- If the parenteral medications are changed during overlap therapy, the end date is when the last dose of the parenteral medication is given during hospitalization. For example, if the patient receives 2 days of LMWH on 11/1 and 11/2 and is changed to Arixtra on 11/3, 11/4 and 11/5, the parenteral end date would be 11/5.
- If reviewing an electronic health record (EHR) for parenteral end date, use the actual date that the last parenteral medication was administered. This may not be the same time as the stop time indicated on the initial electronic order entry.
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid date/format) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Example:
  Documentation indicates the *Parenteral Anticoagulant End Date* was 03-**42**-20xx. No other documentation in the medical record provides a valid date. Since the

Parenteral Anticoagulant End Date is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD." **Note:** Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *Parenteral Anticoagulant End Date* allows the case to be accepted into the warehouses.

Suggested Data Sources:

- Consultation notes
- Discharge summary
- Medication administration record
- Nursing notes
- Progress notes

Inclusion Guidelines for Abstraction:
Refer to Appendix H, Table 2.3 VTE Parenteral Therapy Table.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Parenteral Anticoagulant Prescribed at Discharge*

Collected For: CMS/The Joint Commission: VTE-3

Definition: Documentation that a parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulant medication was prescribed at discharge.

Suggested Data Collection Question: Was a parenteral anticoagulant medication prescribed at discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that a parenteral anticoagulant medication was prescribed at discharge.
N (No)	There is no documentation that a parenteral anticoagulant medication was prescribed at discharge or unable to determine from medical record documentation.

Notes for Abstraction:

- In determining whether a parenteral anticoagulant was prescribed at discharge, it is not uncommon to see conflicting documentation amongst different medical record sources. For example, the discharge summary may list a parenteral anticoagulant that is not included in any of the other discharge medication sources (e.g., discharge orders). All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
  - In cases where there is a parenteral anticoagulant in one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select "Yes") unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge - **Consider it a discharge medication in the absence of contradictory documentation.**
  - If documentation is contradictory (e.g., physician noted “d/c LMWH” in the discharge orders, but LMWH is listed in the discharge summary’s discharge medication list), or after careful examination of circumstances, context, timing, etc., documentation raises enough questions, the case should be deemed "unable to determine" (select "No").
  - Consider documentation of a hold on a parenteral anticoagulant after discharge in one location and a listing of that parenteral anticoagulant as a discharge medication in another location as contradictory ONLY if the timeframe on the hold is not **defined** (e.g., “Hold LMWH”). Examples of a

hold with a defined timeframe include “Hold LMWH x 2 days” and “Hold LMWH until after procedure.”

- If a parenteral anticoagulant is NOT listed as a discharge medication, and there is only documentation of a hold or plan to delay initiation/restarting of anticoagulation therapy after discharge (e.g., “Hold LMWH x 2 days,” “Start LMWH as outpatient,” “Hold LMWH”), select “No.”
- If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc.
  Examples:
  - Two discharge summaries, one dictated 5/22 (day of discharge) and one dictated 5/27 - Use the 5/27 discharge summary.
  - Two discharge medication reconciliation forms, one not dated and one dated 4/24 (day of discharge) - Use both.

Suggested Data Sources:

- Discharge instruction sheet
- Discharge progress notes
- Discharge summary
- Home health referral form
- Nursing notes
- Teaching sheet

Inclusion Guidelines for Abstraction:
Refer to Appendix H, Table 2.3 VTE Parenteral Therapy Table.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Patient HIC#*

Collected For: CMS Only: Collected by CMS for patients who have a standard HIC number.

Definition: The patient's Medicare health insurance claim number.

Suggested Data Collection Question: What is the patient's Medicare/HIC number?

Format:

Length: 7-12
Type: Character
Occurs: 1

Allowable Values:

General Rules

- No embedded dashes or spaces or special characters
- Must have both alpha and numeric characters
- Alpha characters must be upper case
- Length cannot be more than 12 or less than 7 characters
- For alphanumeric values, do not allow all numeric values to be 9's For example do not allow 1 alpha + 999999999, etc.

If First Character is Numeric

Suffix rules: If the **first character is numeric, (0-9)**, then the first 9 characters must be numeric. For example:

HIC # length	Rule
10	9 numeric + 1 alpha
11	9 numeric + 1 alpha + 1 numeric Or 9 numeric + 2 alpha

If First Character is Alpha

Prefix rules: If the **first character is alpha**, there must be 1-3 alpha characters followed by 6 or 9 numbers. For example:

HIC # length	Rule
7	1 alpha + 6 numeric
8	2 alpha + 6 numeric
9	3 alpha + 6 numeric
10	1 alpha + 9 numeric
11	2 alpha + 9 numeric
12	3 alpha + 9 numeric

Notes for Abstraction:

- *Patient HIC#* is required for data transmission of all cases that have a standard HIC#.

- Refer to the CMS National Hospital Quality Measure Data Transmission sub-section, within the Transmission section, for further guidance.

Suggested Data Sources:
- Emergency Department record
- Face sheet
- UB-04, Field Location: 60A, B or C, whichever line corresponds to the Medicare entry

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Patient Identifier*

Collected For: CMS Only: All Records

NOTE: Refer to the Hospital Clinical Data XML File Layout in the Transmission section of this manual.

Definition: The number used by the hospital to identify this patient's stay. The number provided will be used to identify the patient in communications with the hospital, e.g., Medical Record Number, Account Number, Unique Identifiable Number as determined by the facility, etc.

A patient identifier is required for data submitted to the QIO Clinical Data Warehouse.

Suggested Data Collection Question: What was the number used by the hospital to identify this patient's stay?

Format:

Length: 40
Type: Character
Occurs: 1

Allowable Values:

Up to 40 letters, numbers, and/or characters.

NOTE: The only characters that will be allowed are spaces, hyphens, dashes and under-scores.

Notes for Abstraction:
None

Suggested Data Sources:
None

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Payment Source*

Collected For: CMS/The Joint Commission: All Records

Definition: The source of payment for this episode of care.

Suggested Data Collection Question: What is the patient's source of payment for this episode of care?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 Source of payment is Medicare.

2 Source of payment is Non-Medicare.

Notes for Abstraction:

- If Medicare is listed as the primary, secondary, tertiary, or even lower down on the list of payers, select "1."
- If the patient has Medicaid only or Medicaid and another insurance type, other than Medicare, select "2." If the patient has Medicaid and Medicare, select "1."
- If the patient is an Undocumented Alien or Illegal immigrant, select "1." Undocumented Alien: Section 1011 of the Medicare Modernization Act of 2003 allows for reimbursement for services rendered to patients who are: Undocumented or illegal aliens (immigrants), Aliens who have been paroled into a United States port of entry and Mexican citizens permitted to enter the United States on a laser visa.

Suggested Data Sources:

- Face sheet
- UB-04, Field Location: 50A, B or C

Inclusion Guidelines for Abstraction:

Medicare includes, but is not limited to:

- Black Lung
- End Stage Renal Disease (ESRD)
- Medicare Fee for Service (includes DRG or PPS)
- Medicare HMO/Medicare Advantage
- Medicare Secondary Payer
- Railroad Retirement Board (RRB)

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Perioperative Death*

Collected For: CMS/The Joint Commission: SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-9, SCIP-Card-2, SCIP-VTE-2

Definition: The patient expired during the timeframe from surgical incision through discharge from the post anesthesia care/recovery area.

Suggested Data Collection Question: Is there documentation that the patient expired during the timeframe from surgical incision through discharge from the post anesthesia care/recovery area?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that the patient expired during the timeframe from surgical incision through discharge from the post anesthesia care/recovery area.
N (No)	There is no documentation that the patient expired during the timeframe from surgical incision through discharge from the post anesthesia/recovery area or unable to determine from medical record documentation.

Notes for Abstraction:

- For this data element, the timeframe for *Perioperative Death* is from surgical incision through discharge from the post anesthesia care/recovery area. Examples:
  - The patient expired while undergoing vascular surgery (repair of aneurysm); select "Yes."
  - The patient died while in the post anesthesia care/recovery area; select "Yes."
  - A discharge order from the post anesthesia care/recovery area was written for a surgery patient at 11:05 a.m. and at 11:17 a.m. the patient developed a complication and ultimately expired. The order for discharge was written, but the patient did not leave the recovery area; select "No."
  - The patient was not discharged from the post anesthesia care/recovery area, developed a complication and then expired; select "Yes."
  - The patient was discharged from the post anesthesia care/recovery area and on the way to the floor, developed complications and expired; select "No."
- **For patients discharged from surgery and admitted to the PACU:** The end of the perioperative period occurs when the patient is discharged from the PACU.

- **For patients discharged from surgery and admitted to locations other than the PACU (e.g., ICU):** The perioperative period would end a maximum of six hours after arrival to the recovery area.

Suggested Data Sources:
- Anesthesia record
- Consultation notes
- Nursing notes
- Operating room record
- Operative report
- PACU/Recovery room record
- Progress notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Physician 1*

Collected For: CMS Only: All Records (Optional Element)

Definition: The first physician identifier

Suggested Data Collection Question: What is the first physician identifier?

Format:

Length: 50
Type: Character
Occurs: 1

Allowable Values:

Enter the first physician identifier, as directed. Up to 50 letters, numbers, and/or special characters can be entered.

NOTE: Only the following special characters will be allowed:
~ ! @ # $ % ^ * ( ) _ + { } | : ? ` - = [ ] \ ; ‘ . , / and space

Notes for Abstraction:
This data element may be used to capture physician information that might be helpful in internal analysis. This information is for internal analysis only and will not be shared with any external parties in any data output.

Suggested Data Sources:
None

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Physician 2*

Collected For: CMS Only: All Records (Optional Element)

Definition: A second physician identifier

Suggested Data Collection Question: What is the second physician identifier?

Format:

Length: 50
Type: Character
Occurs: 1

Allowable Values:

Enter the second physician identifier, as directed. Up to 50 letters, numbers, and/or special characters can be entered.

NOTE: Only the following special characters will be allowed:
~ ! @ # $ % ^ * ( ) _ + { } | : ? ` - = [ ] \ ; ‘ . , / and space

Notes for Abstraction:
This data element may be used to capture physician information that might be helpful in internal analysis. This information is for internal analysis only and will not be shared with any external parties in any data output.

Suggested Data Sources:
None

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Pneumococcal Vaccination Status*

Collected For: CMS Voluntary Only: IMM-1

Definition: Documentation of the patient's pneumococcal vaccination status. If found to be a candidate for the vaccine, documentation that the pneumococcal vaccine was given during this hospitalization. A vaccine is a suspension of an attenuated (weakened) or killed microorganism, such as bacteria or virus, administered for the prevention, amelioration, or treatment of infectious diseases.

Suggested Data Collection Question: What is the patient's pneumococcal vaccine status?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 Pneumococcal vaccine was given during this hospitalization.

2 The patient received pneumococcal vaccine anytime in the past.

3 Documentation of patient's or caregiver's refusal of pneumococcal vaccine.

4 There is documentation of:
- an allergy/sensitivity to pneumococcal vaccine

OR
- is not likely to be effective because of a bone marrow transplant within the past 12 months

OR
- currently receiving a scheduled course of chemotherapy or radiation therapy, or received chemotherapy or radiation during this hospitalization or less than 2 weeks prior

OR
- received the shingles vaccine (Zostavax) within the last 4 weeks

OR
- for patients 5 - 18 years of age who received a conjugate vaccine within the previous 8 weeks.

5 None of the above/Not documented/UTD.

Notes for Abstraction:
- In order to select "Pneumococcal vaccine was given during this hospitalization," there must be documentation either on the MAR, nursing notes, standing orders, etc. where the vaccine was dated and signed as administered.

- In situations where there is documentation that would support more than one of the allowable values 1-4, select the smallest number.
  Example:
  Nurse's notes have documentation the patient refused. Vaccination order sheet has documentation that the patient was vaccinated during this hospitalization. You will select value "1," as it is the smallest number.
- If there is no documentation to support any of the allowable values 1-4, and there is physician documentation that they will administer the vaccine after discharge, select value "5."
- The caregiver is defined as the patient's family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who is responsible for the care of the minor patient or the adult patient when that patient is unable to make this decision on his/her own.
- Autologous stem cell transplant and ASCT are other names for a bone marrow transplant.
- In children 5 -18 years of age who receive either PCV 13 or PPSV 23 during this hospitalization, select value "1."
- If it is documented in the chart that a patient is "up to date" on their vaccines, you may select Allowable Value "2." Note that documentation of the acronym "UTD" alone is not sufficient to select Allowable Value "2."

Suggested Data Sources:
- Consultation notes
- Discharge summary
- Emergency Department record
- History and physical
- Immunization assessment forms
- Medication sheets
- Nursing admission assessment
- Nursing notes
- Physician orders
- Progress notes
- Social service notes
- Transfer forms
- Vaccine order sheet

Inclusion Guidelines for Abstraction:
- PCV
- PCV 13
- PPSV
- PPSV 23
- Pneumococcal conjugate
- Pneumococcal vaccine
- Pneumonia shot
- Pneumonia vaccine
- Pneumovax
- Pneumovax 23

- Pnu-imune 23
- Polyvalent pneumonia vaccine
- Prevnar
- Prevnar 13

Exclusion Guidelines for Abstraction:

- Patients with specific documented allergy/sensitivity (should be accompanied by the exact complication) to vaccine, including hypersensitivity to any component in the vaccine. Also, sizable local reaction at injection site (greater than 10.2 cm), or the occurrence of any type of an immediate or delayed hypersensitivity reaction or the occurrence of neurological signs and symptoms following administration. (May not be based solely on physician/APN/PA's preference.)
- Patients with an organ transplant during the current hospitalization (Appendix A, Table 12.10)

Data Element Name: *Pneumonia Diagnosis: ED/Direct Admit*

Collected For: CMS Only: PN-6; **The Joint Commission Only:** PN-3a, PN-6a, PN-6b; **CMS Voluntary Only:** PN-3a, PN-3b

Definition: Documentation of the diagnosis of pneumonia either as the Emergency Department diagnosis/impression, or as an admission diagnosis/impression for the direct admit patient.

Suggested Data Collection Question: Was there documentation of the diagnosis of pneumonia either as an Emergency Department diagnosis/impression, or as an admission diagnosis/impression for the direct admit patient?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 There is physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation that pneumonia was a diagnosis/impression in the ED or as an admission diagnosis/impression upon direct admit.

2 There is no physician/APN/PA documentation that pneumonia was a diagnosis/impression in the ED, or as an admission diagnosis/impression upon direct admit.

3 Unable to determine from medical record documentation.

Notes for Abstraction:

- Only accept documentation of a pneumonia diagnosis that is clearly described as a diagnosis, impression or plan to treat. Do not take anything that is labeled as a differential diagnosis.
- If your hospital labels the differential diagnosis using a different name (e.g. first impression), it must be clear that this is only a differential diagnosis.
- Pneumonia need not be the primary or only diagnosis. However, if the diagnosis of pneumonia is documented as a differential diagnosis (DDx), select value “2.” Examples:
  - Under a heading of Diagnosis/Impression, the physician documents COPD vs. pneumonia – select value “1.”
  - In the ED narrative the physician documents: DDx – pancreatitis vs. acute alcoholic hepatitis vs. PUD vs. abdominal perforation vs. UTI/pyelo vs. PNA – select value “2.”
- Diagnosis of pneumonia cannot be taken from the chest x-ray, discharge summary, coding or billing documents.

- Inclusions used with adjectives or phrases such as “need to evaluate for,” “possible,” “questionable, “ “rule out” or “suspected” should be answered with a value “1.” Negative adjectives or phrases such as “doubt” or “no” would be a value “2.”
- If there is any documentation of a diagnosis of “aspiration pneumonia” on an ONLY ACCEPTABLE SOURCE, select value “2.”
  Example:
  ED final diagnosis “Pneumonia vs. aspiration pneumonia.”
- If the admit orders refer to a Pneumonia Pathway or equivalent, or the Pneumonia Pathway contains orders to admit, select value “1.” Do not select value “1” if the Pneumonia Pathway is being used for a different diagnosis.
  Example:
  Pneumonia/Bronchitis Pathway with COPD written as the diagnosis. Since pneumonia was not written in or selected as an admitting diagnosis, select value “2.”

Patients seen in the Emergency Department

- For purposes of this data element, an ED admit is any patient who receives treatment, care or evaluation in the ED.
- For patients admitted to observation from the ED, who later result in inpatient status, a diagnosis/impression of pneumonia must be documented while the patient was in the ED.
- For the purposes of this data element, the “ED form” is the document within the ED record which contains the final diagnosis/impression.
- In the ED, the diagnosis of pneumonia should be taken from a section that is specifically designated for the physician/APN/PA to list diagnoses or impressions.
- A pneumonia diagnosis written within narrative documentation can be used, but it must be clearly documented as a diagnosis/impression or a plan to treat for pneumonia.
  Examples:
  - Physician documents “Start patient on Levaquin to cover pneumonia,” select value “1.”
  - Physician documents patient has possible pneumonia or UTI, select value “2.”
- Only select UTD (value “3”) if there is a place in the ED chart to document an ED diagnosis/impression and this area is left blank. However, if there are multiple areas to document an ED diagnosis/impression and any are completed, select value “1” or “2” as applicable.
- ED face sheets can only be used if signed by a physician/APN/PA.
- If pneumonia is listed as a diagnosis/impression on the ED form by any physician/APN/PA, select value “1” No further review of additional suggested data sources is needed (e.g., the admit order or admit note).
- If the same emergency room physician/APN/PA who completed the ED forms did not include pneumonia as a diagnosis or impression but completes an admit note or order with an admission diagnosis of pneumonia or a Pneumonia Pathway or equivalent that was initiated upon admission, select value “1.”

- If the ED physician does not document a diagnosis/impression of pneumonia and a hospitalist, attending physician or consultant **admits** the patient for pneumonia, select value "2."
- Those cases where the patient is seen in the emergency department but the medical record does not contain an ED form, which is different than just leaving the form blank (e.g., the physician treating the patient in the ED documented everything on an admit note) are limited to the following ONLY ACCEPTABLE SOURCES: Admitting notes, Admitting physician orders, Admit H&P written or dictated within 24 hours of arrival.

Direct Admits

- For the purposes of this data element, a direct admit is any patient who does not receive treatment, care or evaluation in the ED.
- For patients who are a direct admit to observation, who later result in inpatient status, a diagnosis/impression of pneumonia must be documented upon admission to observation.
- Pneumonia need not be the primary or only diagnosis/impression but included in the ONLY ACCEPTABLE SOURCES for a Direct Admit as a diagnosis/impression.
- When the patient is a direct admit and is not seen in the ED, the diagnosis of pneumonia should be found on the following ONLY ACCEPTABLE SOURCES to select value 1: Admitting notes, Admitting physician orders, Admit History & Physical (H&P) written or dictated within 24 hours.
- An Admit History & Physical (H&P) is an H&P labeled as such or contains documentation regarding admission. A History & Physical can be used ONLY if the physician/APN/PA documents on one of the ONLY ACCEPTABLE SOURCES to "see H&P," or the H&P is an Admit H&P written or dictated within 24 hours of arrival.
- An admission note is any note labeled as such or contains documentation regarding admission.
- The initial progress note is not one of the ONLY ACCEPTABLE SOURCES for a Direct Admit and not considered an admission note unless it contains documentation regarding admission.
- Any of the ONLY ACCEPTABLE SOURCES can be used without a date or time except for an Admit H&P for a direct admit patient. This must be written or dictated within 24 hours of hospital arrival.
- An undated and/or untimed Admit H&P is not an acceptable source.
- Only select UTD (value "3") if there is no documentation of ANY diagnosis in any of the ONLY ACCEPTABLE SOURCES. If there is ANY diagnosis mentioned select value "1" or "2" as applicable.

Suggested Data Sources:
ONLY ACCEPTABLE SOURCES
PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Direct Admit
  - Admit History & Physical (H&P) written or dictated within 24 hours of hospital arrival
  - Admitting notes

- Admitting physician orders
- Physician admission note

- Emergency Department record
  - ED admitting notes
  - ED face sheet – only if signed by the physician/APN/PA
  - ED form
  - ED history and physical
  - ED physician orders

Inclusion Guidelines for Abstraction: This list is ALL Inclusive

- Admission Pneumonia Diagnosis Codes (except for aspiration pneumonia)
- Admission Pneumonia Pathway (or equivalent)
- BOOP (bronchiolitis obliterans organizing pneumonia)
- CAP (community acquired pneumonia)
- COP (cryptogenic organizing pneumonia)
- HAP or HCAP (healthcare acquired pneumonia)
- Infiltrate
- Lower respiratory infection
- Lower respiratory tract infection
- Lower lobe infection
- Lower lung infection
- NAP (nosocomial pneumonia)
- PCP (*pneumocystis carinii* pneumonia)
- Persistent pneumonia
- PN
- PNA
- PNE
- Pneu
- Pneumonia
- Pneumonic process
- Pneumonitis
- Resolving pneumonia
- VAP (ventilator acquired pneumonia)

Exclusion Guidelines for Abstraction:

- Aspiration pneumonia
- Chronic infiltrate
- Chronic pneumonia
- History of any of the Inclusion terms with no current context
- Pneumonia caused by chemical agents or aerosolized medications
- Post-obstructive pneumonia
- Recent pneumonia
- Recurrent pneumonia
- S/P (status post) pneumonia

Data Element Name: *Postal Code*

Collected For: CMS Only: All Records

Definition: The postal code of the patient's residence. For the United States zip codes the hyphen is implied. If the patient is determined to not have a permanent residence, then the patient is considered homeless.

Suggested Data Collection Question: What is the postal code of the patient's residence?

Format:

Length: 9
Type: Character
Occurs: 1

Allowable Values:

Any valid five or nine digit postal code or "HOMELESS" if the patient is determined not to have a permanent residence. If the patient is not a resident of the United States, use "NON-US."

Notes for Abstraction:
If the postal code of the patient is unable to be determined from medical record documentation, enter the provider's postal code.

Suggested Data Sources:

- Face sheet
- UB-04, Field Location: 09 (line 2d)

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Preadmission Oral Anticoagulation Therapy*

Collected For: CMS/The Joint Commission: SCIP-VTE-2

Definition: Documentation that the patient was receiving oral anticoagulation therapy prior to admission.

Suggested Data Collection Question: Is there documentation that the patient was on continuous oral anticoagulation therapy prior to admission?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that the patient was on continuous oral anticoagulation therapy prior to admission.
N (No)	There is no documentation that the patient was on continuous oral anticoagulation therapy prior to admission or unable to determine from medical record documentation.

Notes for Abstraction:

- The intent of this data element is to exclude patients on continuous oral anticoagulation therapy prior to hospitalization.
- If there is documentation that an oral anticoagulant was a "home" or "current" medication, select "Yes."
- If an oral anticoagulant was listed as a "home" or "current" medication, but placed on hold the day prior to surgery, select "Yes." **If the oral anticoagulant was placed on hold greater than 7 days prior to surgery, select "No."**
- If it is apparent from the documentation that the physician ordered one dose of an oral anticoagulant to be taken at home in the 24 hours prior to incision, select "No."
- See the inclusion list for a list of oral anticoagulant medications.

Suggested Data Sources:

- Consultation notes
- History and physical
- Medication administration record
- Nursing admission assessment
- Pre-anesthesia evaluation
- Preoperative record
- Procedure notes
- Progress notes

Inclusion Guidelines for Abstraction: This list is all inclusive

- Direct thrombin inhibitors
- Factor Xa inhibitors
- Warfarin Sodium

The oral anticoagulants above may include, but are not limited to:

Direct thrombin inhibitors

- Dabigatran
- Dabigatran Etexilate
- Pradaxa

Factor Xa inhibitors

- Rivaroxaban
- Xarelto

Warfarin Sodium

- Coumadin
- Jantoven
- Warfarin

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Pre-Arrival Lipid-Lowering Agent*

Collected For: CMS/The Joint Commission Only: STK-6

Definition: Documentation in the medical record that the patient was on a lipid-lowering medication prior to hospital arrival.

Suggested Data Collection Question: Is there documentation that the patient was on a lipid-lowering medication prior to hospital arrival?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that the patient was on a lipid-lowering medication prior to hospital arrival.
N (No)	There is no documentation that the patient was on a lipid-lowering medication prior to hospital arrival or unable to determine from medical record documentation.

Notes for Abstraction:

- If there is documentation that the patient was on a lipid-lowering medication at home but there is indication it was on temporary hold or the patient has been non-compliant/self-discontinued their medication (e.g., refusal, side effects, cost), select "Yes."
- When conflicting information is documented in a medical record, select "Yes."

Suggested Data Sources:

- Consultation notes
- Emergency Department record
- History and physical
- Medication reconciliation form
- Nursing admission assessment
- Progress notes
- Transfer sheet

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 1.6 for a comprehensive list of Lipid-Lowering Medications.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Preoperative Hair Removal*

Collected For: The Joint Commission Only: SCIP-Inf-6; **CMS Voluntary Only:** SCIP-Inf-6

Definition: The method of surgical site hair removal performed in the hospital prior to the principal procedure.

Suggested Data Collection Question: What method of surgical site hair removal was performed prior to the principal procedure?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1-6

Allowable Values:

Select all that apply:

1 No documented hair removal or no hair removal performed

2 Razor

3 Clippers/Scissors

4 Depilatory

5 Other

6 Patient performed their own hair removal

7 Unable to determine method

8 Hair removal with a razor from the scrotal area *OR* from the scalp after a current traumatic head injury

Notes for Abstraction

- If hair removal was not required for the procedure and there is no documentation of hair removal, select Value "1."
- If "shaved" is documented as the method of hair removal, select Value "2."However, if the surgeon documents in the operative note that the patient was "shaved and prepped in the usual fashion," do not collect as documentation of actual hair removal.
- If more than one method is documented, select all of the methods that are documented. Abstractors have the opportunity to select one or more of the allowable values. No value should be recorded more than once. If a value of "1" or "7" is selected, no other selections should be recorded.

Example:
The preoperative record has documentation of hair removal by clippers. The intraoperative record has “N/A” documented for hair removal. Select only Value “3” because Value “1” cannot be combined with another value.

- If there is documentation that a “shave prep was done with clippers” or “clippers were used to perform the shave prep” select Value “3.”
- If the method of hair removal is not listed in the Allowable Values, select Value “5.”

Suggested Data Sources:
Surgical site hair removal should only be abstracted from data sources that document actual hair removal.

- Nursing notes
- Operating room record
- OR nurses record
- Preoperative checklist
- Preoperative report
- Surgical checklist

Inclusion Guidelines for Abstraction:
Examples of depilatories:

- Nair™
- Neet™
- One Touch Hair Removal™
- Other brands of depilatory not mentioned above
- Surgi-Lotion Hair Removal™

Exclusion Guidelines for Abstraction:

- Hair removal not at surgical site
- Hair removal involved in daily hygiene

Data Element Name: *Prescription for Alcohol or Drug Disorder Medication*

Collected For: The Joint Commission Only: SUB-3; **CMS Informational Only:** SUB-3

Definition: Documentation that an FDA-approved medication for alcohol or drug disorder was prescribed at hospital discharge.

Suggested Data Collection Question: Was one of the FDA-approved medications for alcohol or drug disorder prescribed at discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 A prescription for an FDA-approved medication for alcohol or drug disorder was given to the patient at discharge.

2 A prescription for an FDA-approved medication for alcohol or drug disorder was offered at discharge and the patient refused.

3 A prescription for an FDA-approved medication for alcohol or drug disorder was not offered at discharge because the patient's residence is not in the USA.

4 A prescription for an FDA-approved medication for alcohol or drug disorder was not offered at discharge, or unable to determine from medical record documentation.

Notes for Abstraction

- In determining whether a medication for alcohol or drug disorder was prescribed at discharge, it is not uncommon to see conflicting documentation among different medical record sources. For example, the discharge summary may list Disulfiram but this is not included in any of the other discharge medications sources, e.g., discharge orders. All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
- In cases where there is a medication for alcohol or drug disorder in one source and it is not mentioned on other sources, it should be interpreted as a discharge medication, select value "1" unless documentation elsewhere in the medical record suggests that it was not prescribed at discharge.
- If documentation is contradictory (physician noted "d/c Antabuse" or "hold Antabuse" in the discharge orders, but Antabuse is listed in the discharge summary's discharge medication list), or after careful examination of

circumstances, context, timing, etc., documentation raises enough questions, the case should be deemed unable to determine, select value “4.”

Suggested Data Sources:

- Discharge Instruction Sheet
- Discharge summary
- Medication Reconciliation Form
- Nursing Discharge notes
- Physician Orders Sheet
- Transfer sheet

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 9.2 for a comprehensive list of FDA-approved medications for alcohol and drug dependence

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Prescription for Tobacco Cessation Medication*

Collected For: The Joint Commission Only: TOB-3, TOB-4; **CMS Informational Only:** TOB-3, TOB-4

Definition: Documentation that an FDA-approved tobacco cessation medication was prescribed at hospital discharge.

Suggested Data Collection Question: Was an FDA-approved tobacco cessation medication prescribed at discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 A prescription for an FDA-approved tobacco cessation medication was given to the patient at discharge.

2 A prescription for an FDA-approved tobacco cessation medication was offered at discharge and the patient refused.

3 A prescription for an FDA-approved tobacco cessation medication was not offered because the patient's residence is not in the USA.

4 A prescription for an FDA-approved tobacco cessation medication was not offered at discharge or unable to determine from medical record documentation.

Notes for Abstraction

- 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). All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
- In cases where there is tobacco cessation medication in one source that is not mentioned on other sources, it should be interpreted as a discharge medication. 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., documentation raises enough questions, 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 such as the quit line, if the medication is listed on the discharge medication list this would be sufficient to select value “1.”

Suggested Data Sources:

- Discharge instruction sheet
- Discharge summary
- Medication reconciliation form
- Nursing discharge notes
- Physician order sheet
- Transfer sheet

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 9.1 for a comprehensive list of FDA-approved tobacco cessation medications

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Pseudomonas Risk*

Collected For: CMS Only: PN-6; **The Joint Commission Only:** PN-6b

Definition: Risk of pseudomonas is defined as any patient who has documentation of one of the following by the physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist:

- Bronchiectasis documented as a possible consideration. Bronchiectasis is defined as chronic dilatation of a bronchus or bronchi, with a secondary infection that usually involves the lower portion of the lung. Dilatation may be in an isolated segment or spread throughout the bronchi.
- Physician/APN/PA or pharmacist documented pseudomonal risk.
- Structural lung disease **AND** documented history of repeated antibiotics or long term/chronic systemic corticosteroid use within the last 3 months.
- For the purposes of this data element, structural lung disease includes:
  - Chronic Bronchitis
  - COPD
  - Emphysema
  - Interstitial lung disease – any of a group of diseases that affect the tissue and space around the air sacs of the lungs and may lead to progressive scarring of lung tissue
  - Restrictive lung disease – any of a group of diseases that result in reduced lung volume

Suggested Data Collection Question: Does the patient have risk of pseudomonas?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	The patient has risk of pseudomonas as indicated by documentation of one or more of the above conditions.
N (No)	The patient has no risk of pseudomonas as indicated by none of the above conditions being documented in the medical record or unable to determine from medical record documentation.

Notes for Abstraction:

- Physician documentation of risk for pseudomonas, select yes. Examples: “will cover for pseudomonas,” “suspect pseudomonas.”
- If there is documentation of a history of, current or suspected bronchiectasis, select yes. Examples: “rule out bronchiectasis,” “need to evaluate for bronchiectasis.”
- Documentation of doubt for bronchiectasis or pseudomonas will abstract as a no.

- If there is a preprinted form, such as a PN pathway with a heading of Pseudomonas Risk, selection of antibiotics alone is not sufficient to select yes. However, if there is a marked checkbox next to the heading, this will abstract as yes.
- Repeated antibiotics and/or systemic corticosteroid (chronic or long term) can be for any reason. It does not have to be linked to the structural lung disease. There must be documentation of both repeated antibiotics and/or (chronic or long term) systemic corticosteroid therapy taken within the last 3 months AND structural lung disease in order to select yes.
  Example:
  "Patient is taking chronic steroids for Lupus and they also have COPD."
- Reactive lung diseases such as asthma should not be considered for this data element.
- One time use or one course of antibiotics or systemic corticosteroids is not considered chronic.
- Corticosteroids and/or antibiotics listed as "home meds" or "current meds," are considered "chronic," unless there is documentation it is a one time course, or if it is listed as "PRN."
- "Repeated antibiotics" are defined as documentation of multiple "rounds" or "courses" of antibiotics taken within the last 3 months prior to hospital arrival.
- If there is documentation of chronic "steroids," select "Yes."
- Refer to Appendix C Table 2.15 for a comprehensive list of Systemic Corticosteroids.

Suggested Data Sources:
PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION ONLY:
- Admitting physician orders
- Admitting progress notes
- Consultation notes
- Emergency Department record
- History and physical
- Physician admission note
- Progress notes

EXCEPTION: "Home meds" or "current meds" **do not** require documentation by a physician/APN/PA, or pharmacist; other data sources may be used.

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Race*

Collected For: CMS/The Joint Commission: All Records

Definition: Documentation of the patient's race.

Suggested Data Collection Question: What is the patient's race?

Format:

Length: 1
Type: Character
Occurs: 1

Allowable Values:
Select one:

1 **White:** Patient's race is White or the patient has origins in Europe, the Middle East, or North Africa.

2 **Black or African American:** Patient's race is Black or African American.

3 **American Indian or Alaska Native:** Patient's race is American Indian/Alaska Native.

4 **Asian:** Patient's race is Asian.

5 **Native Hawaiian or Pacific Islander:** Patient's race is Native Hawaiian/Pacific Islander.

6 **RETIRED VALUE** (effective 07-01-05 discharges)

7 **UTD:** Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).

Notes for Abstraction:

- The data element *Hispanic Ethnicity* is required in addition to this data element.
- If documentation indicates the patient has more than one race (e.g., Black-White, Indian-White), select the first listed race.
- Although the terms "Hispanic" and "Latino" are actually descriptions of the patient's ethnicity, it is not uncommon to find them referenced as race. If the patient's race is documented only as Hispanic/Latino, select "White." If the race is documented as mixed Hispanic/Latino with another race, use whatever race is given (e.g., Black-Hispanic – select "Black"). Other terms for Hispanic/Latino include Chicano, Cuban, H (for Hispanic), Latin American, Latina, Mexican, Mexican-American, Puerto Rican, South or Central American, and Spanish.

Suggested Data Sources:

- Emergency Department record
- Face sheet
- History and physical
- Nursing admission assessment
- Progress notes

Inclusion Guidelines for Abstraction:

Black or African American: A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American.”

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment (e.g., any recognized tribal entity in North and South America [including Central America], Native American).

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., Caucasian, Iranian, White).

Native Hawaiian or Pacific Islander: A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Reason for Alternative Empiric Antibiotic Therapy*

Collected For: CMS Only: PN-6; **The Joint Commission Only:** PN-6a, PN-6b

Definition: *Reason for Alternative Empiric Antibiotic Therapy* includes ONLY the following concepts:

1. The patient has a clinical condition that could cause an impaired immune system or is on a therapy that puts them at a higher risk for infection (compromised).
2. The patient has a condition that justifies an alternative antimicrobial regimen as listed below:
    - Physician/APN/PA or pharmacist documented prolonged QT interval within 24 hours of hospital arrival
    - Risk for Healthcare-Associated PN
        - Acute care hospitalization within the last 90 days.
        - Residence in a nursing home or extended care facility for any amount of time within the last 90 days
        - Chronic dialysis within the last 30 days prior to this hospitalization
        - Wound care, tracheostomy care or ventilator care provided by a health care professional within the last 30 days
    - Physician/APN/PA or pharmacist documentation the patient has healthcare associated pneumonia.

Suggested Data Collection Question: Is there documentation of a reason the patient received alternative empiric antibiotic therapy*?*

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation of a compromising condition or a condition that justifies an alternative empiric antimicrobial regimen.
N (No)	There is no documentation of a compromising condition or a condition that justifies an alternative empiric antimicrobial regimen or unable to determine from medical record documentation.

Notes for Abstraction:

Compromised

- If there is physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist documentation the patient is immunocompromised, select “Yes.”
- If there is no timeframe documented in the medical record to indicate the condition has been present within the last 3 months (e.g., “history of,”etc.), do not select “Yes.”

- The patient must currently be undergoing systemic chemotherapy or radiation therapy or received chemotherapy or radiation therapy within the last 3 months in order to select "Yes."
- If there is physician/APN/PA documentation of "significant" or "marked" neutropenia, select "Yes."
- If the only documentation of HIV is an order for an HIV test, select "No."
- If there is physician documentation of a possible or suspected condition listed in the Inclusions, select "Yes" unless there is documentation that the condition was ruled out within 24 hours of arrival.
- If there is documentation of chronic steroid use, select "Yes."
    - One- time use or one course of systemic corticosteroids is not considered chronic.
    - Systemic corticosteroid/prednisone and/or systemic immunosuppressant therapy must have occurred within the last three months prior to this hospitalization.
    - Systemic corticosteroids listed as home meds or current meds are considered chronic, unless there is documentation it is a one-time course, or if it is listed as "PRN."
    - If a medication is listed on both Table 2.2 (Immunosuppressant Medications) and Table 2.15 (Systemic Corticosteroid Medications) consider the medication a systemic corticosteroid. Documentation of chronic use is required for a systemic corticosteriod but not for an immunosuppressant.
    - Steroid therapy that is NOT systemic (e.g. inhaler, eyedrops, or topical) or administered via epidural/ spinal injections, select "No."

Healthcare-Associated Pneumonia (HCAP) or Risk of HCAP

- If there is physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist documentation that the patient has "healthcare-associated pneumonia," "HCAP" or "nosocomial pneumonia," select "Yes."
- If there is a preprinted form, such as a PN Pathway, with a heading of HCAP, selection of antibiotics alone is not sufficient documentation to select "Yes." However, if there is a marked checkbox next to the HCAP heading, select "Yes."
- For the purpose of this data element, chronic dialysis is defined as ESRD (End Stage Renal Disease) with peritoneal dialysis or hemodialysis.
- For the purpose of this data element, an extended care facility is a non-apartment based institutional setting where 24-hour nursing care is provided. This INCLUDES – Nursing Homes, Skilled Nursing Facilities, ECF, ICF, Hospice Facilities, SNF Rehab Units, Sub-acute Care, Transitional Care, Respite Care, Inpatient Rehab Unit or Facility and VA Nursing Facilities. This EXCLUDES – Assisted Living, Board and Care, Group Homes, Personal Care Homes, Residential Care, Chemical Dependency Treatment, Drug Rehab, Psych Unit or Facility or Hospice at home.
- Do not make an assumption as to the patient's admission or hospitalization based on the procedure performed. Only use documentation such as "in the hospital last month," etc.

- In order to select "Yes," the patient must be discharged from an acute care facility for inpatient care to a non-acute setting (e.g., home, SNF, ICF or rehabilitation facility) prior to the current admission.
- For purposes of this data element, if there is documentation of a "hospitalization" or "admission," assume it was an acute care hospitalization unless there is documentation that states otherwise.
- If "wound care" is documented in the medical record but with no timeframe to ascertain that the wound care was provided within the last 30 days, select "No."

Other Reasons

- Physician/APN/PA or pharmacist documentation within 24 hours of hospital arrival that the patient has a "prolonged" QT interval (QTc).

Suggested Data Sources:

- Admission face sheet
- Consultation notes
- Discharge summary
- Emergency Department record
- History and physical
- Nurse admission notes
- Progress notes

Inclusion Guidelines for Abstraction:

The only acceptable conditions are those found on the inclusion list.

Healthcare-Associated Pneumonia

Occurred within the last 30 days prior to hospitalization:

- Continuous arterio-venous hemofiltration (CAVH)
- Continuous veno-venous hemofiltration (CVVH)
- Hemodialysis
- Peritoneal dialysis
- Wound care provided by a health care professional
- Tracheostomy care provided by a health care professional
- Ventilator care provided by a health care professional

Physician/APN/PA Documentation

- Healthcare acquired pneumonia (HCAP)
- Hospital acquired pneumonia
- Healthcare associated pneumonia
- Hospital associated pneumonia
- Nosocomial pneumonia

Compromised

Compromising Conditions Within the Last 3 Months prior to or during hospitalization:

- Leukemia
- Lymphocytic leukemia

- Lymphoma
- Marked neutropenia
- Myelogenic leukemia
- Myeloma
- Myelodysplasia
- Pancytopenia
- Significant neutropenia

Compromising Therapies Within the Last 3 Months prior to hospitalization:
- Systemic Chemotherapy/Radiation Therapy
- Systemic Corticosteroid/Prednisone therapy
- Systemic Immunosuppressive therapy

Compromising Conditions with No Timeframe Necessary
- Acquired Immune Deficiency Syndrome (AIDS)
- AIDS Related Complex (ARC)
- Any "Immunodeficiency Syndrome"
- Chronic Lymphocytic Leukemia (CLL)
- Congenital or hereditary Immunodeficiency
- Human Immunodeficiency Virus (HIV)
- HIV Positive
- Organ Transplant

Refer to Appendix C, Table 2.2 for a comprehensive list of Immunosuppressive medications and Table 2.15 for a list of Systemic Corticosteroids.

Exclusion Guidelines for Abstraction:
Reasons not defined in this data element

Compromised
All terms other than those on the inclusion list

Data Element Name: *Reason for Delay in Fibrinolytic Therapy*

Collected For: CMS/The Joint Commission: AMI-7a; **The Joint Commission Only:** AMI-7; **CMS Voluntary:** AMI-7

Definition: Documentation of a reason for a delay in initiating fibrinolytic therapy after hospital arrival by a physician/advanced practice nurse/physician assistant (physician/APN/PA). **System reasons for delay are NOT acceptable.**

Suggested Data Collection Question: Is there a reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival.
N (No)	No reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival, or unable to determine from medical record documentation.

Notes for Abstraction:

- **System reasons for delay are not acceptable, regardless of any linkage to the delay in fibrinolysis/reperfusion.**
  - Equipment-related (e.g., IV pump malfunction)
  - Staff-related (e.g., waiting for fibrinolytic agent from pharmacy)
  - Consultation with other clinician that is not clearly linked to a patient-centered (non-system) reason for delay.
- Documentation must be made clear **somewhere** in the medical record that (1) a "hold," "delay," "deferral," or "wait" in initiating fibrinolysis/reperfusion actually occurred, AND (2) that the underlying reason for that delay was non-system in nature. Abstractors should NOT make inferences from documentation of a sequence of events alone or otherwise attempt to interpret from documentation. Clinical judgment should not be used in abstraction.
  Examples of **ACCEPTABLE** documentation:
  - "Hold on fibrinolytics. Will do CAT scan to rule out bleed."
  - "Patient waiting for family and clergy to arrive – wishes to consult with them before thrombolysis."
  - "Fibrinolysis delayed due to need to control blood pressure before administering fibrinolysis."
  - "Hold fibrinolytics. Need to consult with neurology regarding bleeding risk."
  - "Fibrinolytic therapy initially deferred due to shock."

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

- **If unable to determine whether a documented reason is system in nature, select "No."**
- Reasons for a delay in fibrinolytic therapy should be collected regardless of how soon after arrival it was ultimately initiated or how minimal the delay.

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Code sheet (if signed by physician/APN/PA)
- Consultation notes
- Discharge summary
- Emergency Department record
- History and physical
- Physician orders
- Progress notes

Excluded Data Sources:
Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay).

Inclusion Guidelines for Abstraction:
Cardiopulmonary arrest

- Cardiac arrest
- Cardiopulmonary resuscitation (CPR)
- Defibrillation
- Respiratory arrest
- Ventricular fibrillation (V-fib)

Intubation

- Endotracheal intubation (ETI)
- Mechanical ventilation
- Nasotracheal intubation (NTI)
- Orotracheal intubation

Mechanical circulatory assist devices

- Aortic balloon pump
- Biventricular assist device (BiVAD)

- Intra-aortic balloon (IAB)
- Intra-aortic balloon counterpulsation (IABC)
- Intra-aortic balloon pump (IABP)
- Intra-aortic counterpulsation (IAC)
- Intra-aortic counterpulsation balloon pump (IACBP)
- Left ventricular assistive device (LVAD)
- Percutaneous ventricular assist device (PVAD)
- Ventricular assist device (VAD)

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Reason for Delay in PCI*

Collected For: CMS/The Joint Commission: AMI-8a; **The Joint Commission Only:** AMI-8; **CMS Voluntary Only:** AMI-8

Definition: Documentation of a reason for a delay in doing the first percutaneous coronary intervention (PCI) after hospital arrival by a physician/advanced practice nurse/physician assistant (physician/APN/PA). **System reasons for delay are NOT acceptable.**

Suggested Data Collection Question: Is there a reason documented by a physician/APN/PA for a delay in doing the first percutaneous coronary intervention (PCI) after hospital arrival?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Reason documented by a physician/APN/PA for a delay in doing the first PCI after hospital arrival.
N (No)	No reason documented by a physician/APN/PA for a delay in doing the first PCI after hospital arrival, or unable to determine from medical record documentation.

Notes for Abstraction:

- **System reasons for delay are not acceptable, regardless of any linkage to the delay in PCI/reperfusion.**
  - Equipment-related (e.g., unavailability, malfunction)
  - Staff-related (e.g., waiting for cath lab staff)
  - Consultation with other clinician that is not clearly linked to a patient-centered (non-system) reason for delay
  - Cath lab unavailability (e.g., no open cath lab)
- Documentation must be made clear **somewhere** in the medical record that (1) a "hold," "delay," "deferral," or "wait" in doing PCI/reperfusion/cath/transfer to cath lab actually occurred, AND (2) that the underlying reason for that delay was non-system in nature. Abstractors should NOT make inferences from documentation of a sequence of events alone or otherwise attempt to interpret from documentation. Clinical judgment should not be used in abstraction.
  Examples of **ACCEPTABLE** documentation:
  - "Hold on PCI. Will do TEE to rule out aortic dissection."
  - "Patient waiting for family and clergy to arrive - wishes to consult with them before PCI."

- "Thrombectomy catheter did not cross lesion. Balloon catheter successfully crossed the stenosis. Flow reestablished after 30 min. delay."
- "PCI delayed due to intermittent hypotensive episodes when crossing lesion."
- "Hold PCI. Need to consult with neurology regarding bleeding risk."
- "Cath initially deferred due to shock."

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

- **If unable to determine whether a documented reason is system in nature, select "No."**
- Reasons for a delay in PCI should be collected regardless of how soon after arrival it was ultimately done or how minimal the delay.

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Code sheet (if signed by physician/APN/PA)
- Consultation notes
- Diagnostic test reports
- Discharge summary
- Emergency Department record
- History and physical
- Operative notes
- Physician orders
- Procedure notes
- Progress notes

Excluded Data Sources:
Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay).

Inclusion Guidelines for Abstraction:
Cardiopulmonary arrest

- Cardiac arrest
- Cardiopulmonary resuscitation (CPR)
- Defibrillation
- Respiratory arrest
- Ventricular fibrillation (V-fib)

Intubation

- Endotracheal intubation (ETI)
- Mechanical ventilation
- Nasotracheal intubation (NTI)
- Orotracheal intubation

Mechanical circulatory assist devices

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

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Reason for Discontinuation of Parenteral Therapy*

Collected For: CMS/The Joint Commission: VTE-3

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

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

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

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

Notes for Abstraction:

- Reasons for discontinuation of parenteral therapy must be explicitly documented (e.g., “GI Bleed – Discontinue Lovenox”) or clearly implied (e.g., “Severe anemia, discontinue Heparin,” or “Actively Bleeding- Anticoagulation Contraindicated”).
- If reasons are not mentioned in the context of the discontinuation of the parenteral therapy, do not make inferences (e.g., Do not assume that Lovenox is not prescribed at discharge because of the patient's history of anemia).
- Patient refusal of medication during hospitalization or at discharge is a reason for discontinuation and may be documented by a nurse.
- Substitution of one parenteral drug for another parenteral drug is not considered discontinuation of parenteral therapy.
  Example, if patient was on Heparin subcutaneous and was changed to Arixtra subcutaneous on day 3, the patient is still on a parenteral anticoagulant. Select “Yes.”
- For patients with five or more days of overlap therapy and INR <2.0, explicit documentation of a reason for discontinuation of the parenteral therapy is needed to select “Yes.”
- For patients with less than five days of overlap therapy and discharged without parenteral anticoagulation therapy, explicit reason for discontinuation of the parenteral therapy is needed to select “Yes.”
- Overlap therapy days are calculated by taking the *Parenteral Anticoagulant End Date* minus the *Overlap Therapy Start Date.*

- Reasons for discontinuation of overlap therapy must be documented by a Physician/APN/PA or pharmacist within the same day that the parenteral therapy was discontinued.
  Examples of Physician/APN/PA documentation include:
  - Discontinue Lovenox therapy, INR 1.75, patient is actively bleeding. Select "Yes."
  - Discontinue Lovenox therapy, INR 1.75, home on warfarin. Select "No."
  - Discontinue Lovenox therapy, INR 6.0. Select "Yes."
- Abstractors are not to infer reasons based on laboratory values alone, ONLY Physician/APN/PA or Pharmacist documentation of the specified reason is acceptable.
- If rivaroxaban (Xarelto) is ordered or administered during hospitalization or prescribed at discharge, select "Yes."

Suggested Data Sources:
ONLY PHYSICIAN/APN/PA or PHARMACIST DOCUMENTATION OF A REASON FOR DISCONTINUING PARENTERAL THERAPY
- Consultation notes
- Discharge summary
- Emergency Department record
- History and physical
- Operative notes
- Physician orders
- Procedure notes
- Progress notes

SUGGESTED DATA SOURCES FOR PATIENT REFUSAL (other than physician/APN/PA or pharmacist documentation of a reason for discontinuing parenteral therapy):
- Medication administration record
- Nurses notes

Excluded Data Sources:
Any documentation dated/timed after discharge, except discharge summary.

Inclusion Guidelines for Abstraction:
ONLY PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION OF A REASON FOR DISCONTINUING OF PARENTERAL THERAPY:
Acceptable terms synonymous with:
- Bleeding risk
- "High" INR value, supratherapeutic, INR >3.0
- Patient has severe anemia
- Patient is actively bleeding
- Patient not a candidate for long-term anticoagulation
- Patient previously on warfarin
- Patient received blood during overlap therapy
- Patient scheduled for surgery

- Patient/caregiver refusal
- Thrombocytopenia
- Use of oral anticoagulants other than warfarin (such as Xarelto or rivaroxaban for treatment of VTE)

Exclusion Guidelines for Abstraction:

- A therapeutic INR value equal to 2.0-3.0 (target range of 2.5) without additional documentation that notes a decision was made to discontinue parenteral therapy.
- Discontinuation of parenteral medication without additional documentation.

Data Element Name: *Reason for No ACEI and No ARB at Discharge*

Collected For: The Joint Commission Only: AMI-3, HF-3; **CMS Voluntary Only:** AMI-3, HF-3

Definition: Reasons for not prescribing either an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) at discharge:

- ACEI allergy AND ARB allergy
- Moderate or severe aortic stenosis
- Other reasons documented by physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist for not prescribing an ACEI AND not prescribing an ARB at discharge.
  Note: Documentation of a reason for not prescribing one class (either ACEI or ARB) should be considered implicit documentation of a reason for not prescribing the other class for the following five conditions only:
  - Angioedema
  - Hyperkalemia
  - Hypotension
  - Renal artery stenosis
  - Worsening renal function/renal disease/dysfunction
- Reason documented by physician/APN/PA or pharmacist for not prescribing an ARB at discharge AND an ACEI allergy
- Reason documented by physician/APN/PA or pharmacist for not prescribing an ACEI at discharge AND an ARB allergy

ACEIs and ARBs widen or dilate blood vessels, lowering blood pressure and making it easier for the heart to pump blood. They also inhibit the adverse effects of neurohormonal activation on the heart. These effects help reduce the risk of adverse outcomes such as death or hospitalization.

Suggested Data Collection Question: Is there documentation of BOTH a reason for not prescribing an ACEI at discharge AND a reason for not prescribing an ARB at discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation of BOTH a reason for not prescribing an ACEI at discharge AND a reason for not prescribing an ARB at discharge.
N (No)	There is no documentation of BOTH a reason for not prescribing an ACEI at discharge AND a reason for not prescribing an ARB at

discharge, or unable to determine from medical record documentation.

Notes for Abstraction:

- An “allergy” or “sensitivity” documented at anytime during the hospital stay counts as an allergy regardless of what type of reaction might be noted (e.g., “Allergies: ACEIs – Cough” – consider as ACEI allergy).
- Documentation of an allergy/sensitivity to one particular ACEI is acceptable to take as an allergy to the entire class of ACEIs. Same for ARBs (e.g., “Allergic to Valsartan”- consider as ARB allergy).
- When conflicting information is documented in a medical record, select “Yes.”
- In the absence of explicit documentation that the patient has current moderate/severe aortic stenosis, this should be inferred when there is documentation of a history of moderate/severe aortic stenosis without mention of repair or replacement, valvuloplasty, or commissurotomy.
- When determining whether there is a reason documented by a physician/APN/PA or pharmacist for not prescribing an ACEI or an ARB at discharge:
  - Documentation of a reason for not prescribing one class (either ACEI or ARB) should be considered implicit documentation of a reason for not prescribing the other class for the following five conditions ONLY:
    - Angioedema
    - Hyperkalemia
    - Hypotension
    - Renal artery stenosis
    - Worsening renal function/renal disease/dysfunction

    Examples of statements that count as a reason for not prescribing ACEI and a reason for not prescribing ARB at discharge:
    - “Creatinine high. Hold losartan.”
    - “Hx angioedema with ACEIs.”
    - “No ACEI. Bilateral renal artery stenosis.”
    - “BPs running low. Discontinue losartan.”
    - “Potassium 5.5 – No ACEI.”
    - “Severe hypotension with ACEIs in past.”
    - “Add ARB if hyperkalemia resolves.”
  - Reasons for no ACEIs and reasons for no ARBs must be explicitly documented (e.g., “POTASSIUM 5.5 – No ACEI”) or clearly implied (e.g., “Severe hypotension with ACEIs in past,” “Hx ACEI-induced cough,” “ARBs contraindicated,” “Pt. refusing all medications,” “Supportive care only – no medications,” “ACEI therapy not indicated,” ACEI on pre-printed order form is crossed out, “No ACEI/ARB” [reason not given]). If reasons are not mentioned in the context of ACEIs/ARBs, do not make inferences (e.g., Do not assume that an ACEI/ARB is not prescribed because of the patient's chronic renal disease alone).
  - Physician/APN/PA or pharmacist documentation of a hold on an ACEI or discontinuation of an ACEI that occurs during the hospital stay constitutes a “clearly implied” reason for not prescribing an ACEI at discharge. A

hold/discontinuation of all p.o. medications counts if an ACEI p.o. was on order at the time of the notation. Same for ARBs.

EXCEPTIONS:

- Documentation of a conditional hold/discontinuation of an ACEI/ARB does not count as a reason for not prescribing an ACEI/ARB at discharge UNLESS (1) it exists as an **order** to hold/discontinue the ACEI/ARB if the blood pressure (BP) falls outside certain parameters, AND (2) the ACEI/ARB was held due to a BP outside the parameters. Nursing documentation is acceptable. E.g., "Hold perindopril for SBP less than 100" ordered and the nurse documents that the perindopril was held for a BP of 90/50 – select "Yes."
- Discontinuation of a particular ACEI medication documented in combination with the start of a different ACEI medication (i.e., switch in type of ACEI medication) does not count as a reason for not prescribing an ACEI at discharge. Same for ARBs.
  Examples:
  - "Stop benazepril" and "Start captopril 50 mg po bid" in same physician order
  - "Change Diovan to Verdia" in progress note
  - "Do not continue after discharge" checked for Lotensin and "Continue after discharge" checked for Zestril on a physician-signed discharge medication reconcilliation form
- Discontinuation of an ACEI medication at a particular dose documented in combination with the start of a different dose of that ACEI (i.e., change in dosage) does not count as a reason for not prescribing an ACEI at discharge. Same for ARBs.
  Examples:
  - "Stop lisinopril 20 mg po q am" and "Start lisinopril 30 mg po q am" in same physician order
  - "Increase Altace 5 mg to 10 mg" in progress note
  - "Do not continue after discharge" check for Cozaar 25 mg and "Continue after discharge" checked for Cozaar 50 mg on a physician-signed discharge medication reconcilliation form

o Reason documentation which refers to a more general medication class is not acceptable (e.g., "Hold all BP meds").

o Deferral of an ACEI from one physician/APN/PA or pharmacist to another does NOT count as a reason for not prescribing an ACEI at discharge unless the problem underlying the deferral is also noted. Same for ARBs.
Examples:
- "Consulting cardiologist to evaluate pt. for ACEI therapy" - select "**No**" (Do NOT consider as reason for not prescribing ACEI at discharge).
- "Pt. hypotensive. Start ARB if OK with cardiology." - select "**Yes**" (Consider as reason for not prescribing ACEI and reason for not prescribing ARB at discharge).

o If there is documentation of a plan to initiate/restart an ACEI, and the reason/problem underlying the delay in starting/restarting the ACEI is also

noted, this constitutes a “clearly implied” reason for not prescribing ACEI at discharge. Same for ARBs.

Acceptable examples (select “Yes”):

- "Pt. hemodynamically unstable. May start ACEI/ARB as outpatient.”
- “Add ARB if hyperkalemia resolves.”

Unacceptable examples (select “No”):

- “Consider starting Cozaar in a.m.” (Do NOT consider as reason for not prescribing ARB at discharge).
- “May add accupril when pt. can tolerate” (Do NOT consider as reason for not prescribing ACEI at discharge).

  - Reasons do NOT need to be documented at discharge or otherwise linked to the discharge timeframe: Documentation of reasons anytime during the hospital stay are acceptable (e.g., mid-hospitalization note stating “no ACEIs due to acute renal failure” - consider as reason for not prescribing ACEI and reason for not prescribing ARB at discharge, even if documentation indicates that the acute renal failure had resolved by the time of discharge and ACEI was restarted).
  - Crossing out of an ACEI counts as a "clearly implied reason" for not prescribing an ACEI at discharge only if on a pre-printed form. Same for ARBs.
  - ACEIs/ARBs are sometimes described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors. Documentation of a reason for not prescribing "RAS" or "RAAS" blockers or inhibitors should be considered implicit documentation of a reason for no ACEI and no ARB at discharge (e.g., "Hold all RAS blockers").

- When the current record includes documentation of a pre-arrival reason for no ACEI or no ARB, the following counts regardless of whether this documentation is included in a pre-arrival record made part of the current record or whether it is noted by hospital staff during the current hospital stay:
  - Pre-arrival ACEI allergy (reason for not prescribing ACEI) or ARB allergy (reason for not prescribing ARB).
  - Pre-arrival moderate/severe aortic stenosis (reason for not prescribing an ACEI and a reason for not prescribing an ARB).
  - Pre-arrival hold/discontinuation of an ACEI or notation such as "No ACEIs" IF the underlying reason/problem is also noted (e.g., “Prinivil held in transferring hospital due to hypotension”). Same for ARBs.
  - Pre-arrival "other reason" (other than hold/discontinuation or notation of "No ACEIs") (e.g., "Hx severe hypotension with enalapril" in transferring ED record). Same for ARBs.

Suggested Data Sources:

- Consultation notes
- Diagnostic test reports
- Discharge instruction sheet
- Discharge summary
- Emergency Department record
- History and physical
- Medication administration record

- Nursing notes
- Physician orders
- Progress notes
- Transfer sheet

Excluded Data Sources:
Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay).

Inclusion Guidelines for Abstraction:
Angioedema
- Angioneurotic edema
- Edema of the eyelid, glottis, larynx, nasopharynx, or pharynx
- Periorbital edema described as acute

Hyperkalemia
- Patient's potassium (K+) level noted (e.g., "Last Potassium 6.5. Will hold off on ACEI therapy")
- Potassium level described as elevated
- References to potassium not specified or described as hyperkalemia (e.g., "Hold off on ACEI therapy. Check potassium.," "Start candesartan once potassium improved")

Hypotension
- Blood pressure (BP) described as low
- Patient's blood pressure measurement noted (e.g., "BP systolic running in 80s. Will not prescribe ARBs at this time")
- References to blood pressure not specified or described as hypotension (e.g., "Hold off on ACEI therapy. Check BP in a.m.," "Start candesartan after BP normalizes")
- Shock

Moderate/severe aortic stenosis (AS)
- Aortic stenosis described as 3+, 4+, critical, or significant
- Aortic stenosis, degree of severity not specified
- Aortic valve area of less than 1.0 square cms
- Subaortic stenosis, moderate/severe or degree of severity not specified

Worsening renal function/renal disease/dysfunction
- Acute kidney injury (AKI)
- Azotemia
- Chronic kidney disease (CKD)
- Dialysis
- End stage renal disease (ESRD)
- Nephritis
- References to creatinine not specified or described as elevated (e.g., "Hold off on ACEI therapy. Check creatinine.," "Start candesartan once creatinine improved")

- References to renal/renal function not specified or described as renal dysfunction (e.g., “Hold on ACEI pending kidney function panel in a.m.”)
- Renal failure, acute or chronic (ARF, RF, CRF)
- Renal insufficiency (RI, CRI)
- Renal/kidney transplant (RT, RTx, s/p renal transplant, KT)
- Serum creatinine (Cr, Cre) level described as abnormal or elevated
- Serum creatinine (Cr, Cre) noted (e.g., “No ACEIs. Creatinine 2.0”)

Refer to Appendix C, Table 1.2 for a comprehensive list of ACEIs and Table 1.7 for a comprehensive list of ARBs.

Exclusion Guidelines for Abstraction:
ACEI allergy
ACEI allergy described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table

ARB allergy
ARB allergy described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table

Moderate/severe aortic stenosis (AS)
- Aortic insufficiency only
- Aortic regurgitation only
- Aortic stenosis described as 1+ or 2+
- Moderate/severe aortic stenosis, or any of the other moderate/severe aortic stenosis inclusion terms, described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table

Data Element Name: *Reason for No Aspirin at Discharge*

Collected For: The Joint Commission Only: AMI-2; **CMS Voluntary Only:** AMI-2

Definition: Reasons for not prescribing aspirin at discharge:

- Aspirin allergy
- One or more of the medications listed in the Inclusion list were prescribed at discharge
- Other reasons documented by physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist

Aspirin reduces the tendency of blood to clot by blocking the action of a type of blood cell involved in clotting. Aspirin improves chances of surviving a heart attack and reduces the risk of recurrence in patients who have experienced a heart attack.

Suggested Data Collection Question: Is there documentation of a reason for not prescribing aspirin at discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation of a reason for not prescribing aspirin at discharge.
N (No)	There is no documentation of a reason for not prescribing aspirin at discharge or unable to determine from medical documentation.

Notes for Abstraction:

- Aspirin "allergy" or "sensitivity" documented at anytime during the hospital stay counts as an allergy regardless of what type of reaction might be noted (e.g., "Allergies: ASA – Upsets stomach" – select "Yes").
- Documentation of an allergy/sensitivity to one particular type of aspirin is acceptable to take as an allergy to the entire class of aspirin-containing medications (e.g., "Allergic to Empirin").
- When determining whether a medication listed in the Inclusion list was prescribed at discharge (i.e., a reason for not prescribing aspirin at discharge):
  - Include a medication on hold at discharge but there is documentation of a plan to restart it after discharge. E.g., "Resume Coumadin after INR normalizes."
  - If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to

discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc.

Examples:

- Two discharge summaries, one dictated 5/22 (day of discharge) and one dictated 5/27 - Use the 5/27 discharge summary.
- Two discharge medication reconciliation forms, one not dated and one dated 4/24 (day of discharge) - Use both.

- When conflicting information is documented in a medical record, select "Yes."
- When determining whether there is a reason documented by a physician/APN/PA or pharmacist for not prescribing aspirin at discharge:
  - Reasons must be explicitly documented (e.g., "Chronic hepatitis – No ASA") or clearly implied (e.g., "GI bleeding with aspirin in past," "ASA contraindicated," "Pt. refusing all medications," "Supportive care only – no medications," "Aspirin not indicated," aspirin on pre-printed order form is crossed out, "No aspirin" [no reason given]). If reasons are not mentioned in the context of aspirin, do not make inferences (e.g., Do not assume that aspirin is not being prescribed because of the patient's history of PUD alone).
  - Physician/APN/PA or pharmacist documentation of a hold on aspirin or discontinuation of aspirin that occurs during the hospital stay constitutes a "clearly implied" reason for not prescribing aspirin at discharge. A hold/discontinuation of all p.o. medications counts if aspirin p.o. was on order at the time of the notation.

    EXCEPTIONS:

    - Documentation of a conditional hold or discontinuation of aspirin does not count as a reason for not prescribing aspirin at discharge (e.g., "Hold ASA if positive Occult Blood stool," "Stop aspirin if blood in urine recurs").
    - Discontinuation of a particular aspirin medication documented in combination with the start of a different aspirin medication (i.e., switch in type of aspirin medication) does not count as a reason for not prescribing aspirin at discharge.

      Examples:

      - "Stop aspirtab" and "Start Ecotrin 81 mg po q am" in same physician order
      - "Change ASA to buffered baby ASA" in progress note
      - "Do not continue after discharge" checked for aspirin and "Continue after discharge" checked for Aspirin Low Dose on a physician-signed discharge medication reconciliation form
    - Discontinuation of an aspirin medication at a particular dose documented in combination with the start of a different dose of that aspirin (i.e., change in dosage) does not count as a reason for not prescribing aspirin at discharge.

      Examples:

      - "Stop aspirin 325 mg po q am" and "Start aspirin 81 mg po q am" in same physician order
      - "Increase aspirin 81 mg to 325 mg" in progress note

        - "Do not continue after discharge" checked for aspirin 325 mg and "Continue after discharge" checked for aspirin 81 mg on a physician-signed discharge medication reconciliation form
    - Reason documentation which refers to a more general medication class is not acceptable (e.g., "Hold all anticoagulants"). Exception: Documentation of a reason for not prescribing "antiplatelets" should be considered implicit documentation of a reason for no aspirin at discharge (e.g. "Antiplatelet therapy contraindicated").
    - Deferral of aspirin from one physician/APN/PA or pharmacist to another does NOT count as a reason for not prescribing aspirin at discharge unless the problem underlying the deferral is also noted.
      Examples:
      - "Consulting cardiologist to evaluate pt. for ASA." - select "**No**."
      - "Rule out intracranial bleed. Start ASA if OK with neurology." - select "**Yes**."
    - If there is documentation of a plan to initiate/restart aspirin, and the reason/problem underlying the delay in starting/restarting aspirin is also noted, this constitutes a "clearly implied" reason for not prescribing aspirin at discharge.
      Acceptable examples (select "Yes"):
      - "Stool Occult Blood positive. May start Bayer EC as outpatient."
      - "Add buffered aspirin if hematuria subsides"

      Unacceptable examples (select "No"):
      - "Consider starting Ecotrin in a.m."
      - "May add ASA when pt. can tolerate"
    - Reasons do NOT need to be documented at discharge or otherwise linked to the discharge timeframe: Documentation of reasons anytime during the hospital stay are acceptable (e.g., mid-hospitalization note stating "no aspirin due to rectal bleeding" - select "Yes," even if documentation indicates that the rectal bleeding has resolved by the time of discharge and aspirin was restarted).
    - Crossing out of aspirin counts as a "clearly implied reason" for not prescribing aspirin at discharge only if on a pre-printed form.
- When the current record includes documentation of a pre-arrival reason for no aspirin, the following counts regardless of whether this documentation is included in a pre-arrival record made part of the current record or whether it is noted by hospital staff during the current hospital stay:
    - Pre-arrival aspirin allergy
    - Pre-arrival hold/discontinuation or notation such as "No aspirin" IF the underlying reason/problem is also noted (e.g., "ASA held in transferring hospital due to possible GI bleed").
    - Pre-arrival "other reason" (other than hold/discontinuation or notation of "No aspirin") (e.g., "Hx GI bleeding with aspirin" in transferring ED record).

Suggested Data Sources:

- Consultation notes
- Discharge instruction sheet
- Discharge summary

- Emergency Department record
- History and physical
- Medication administration record
- Medication reconciliation form
- Nursing notes
- Physician orders
- Progress notes
- Transfer sheet

Excluded Data Sources:
Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay).

Inclusion Guidelines for Abstraction:
Discharge medications that count as an automatic reason for no aspirin:
- Apixaban
- Coumadin
- Dabigatran
- Eliquis
- Jantoven
- Pradaxa
- Rivaroxiban
- Warfarin
- Warfarin Sodium
- Xarelto

Refer to Appendix C, Table 1.1 for a comprehensive list of Aspirin and Aspirin-Containing medications.

Exclusion Guidelines for Abstraction:
Aspirin allergy described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table.

Data Element Name: *Reason for No Aspirin on Arrival*

Collected For: The Joint Commission Only: AMI-1; **CMS Voluntary Only:** AMI-1

Definition: Reasons for not administering aspirin on arrival:

- Aspirin allergy
- One or more of the medications listed in the Inclusion list as pre-arrival medication
- Other reasons documented by physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist

Aspirin reduces the tendency of blood to clot by blocking the action of a type of blood cell involved in clotting. Aspirin improves chances of surviving a heart attack and reduces the risk of recurrence in patients who have experienced a heart attack.

Suggested Data Collection Question: Is there documentation of a reason for not administering aspirin on arrival?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation of a reason for not administering aspirin on arrival.
N (No)	There is no documentation of a reason for not administering aspirin on arrival or unable to determine from medical record documentation.

Notes for Abstraction:

- Aspirin “allergy” or “sensitivity” documented at anytime during the hospital stay counts as an allergy regardless of what type of reaction might be noted (e.g., “Allergies: ASA – Upsets stomach” – select “Yes”).
- Documentation of an allergy/sensitivity to one particular type of aspirin is acceptable to take as an allergy to the entire class of aspirin-containing medications (e.g., “Allergic to Empirin”).
- When conflicting information is documented in a medical record, select “Yes.”
- Consider a medication listed in the Inclusion list to be a pre-arrival medication (a reason for not prescribing aspirin on arrival) if there is documentation the patient was on it prior to arrival, regardless of setting. Include cases where there is indication the medication was on temporary hold or the patient has been non-compliant/self-discontinued their medication (e.g., refusal, side effects, cost).
- When determining whether there is a reason documented by a physician/APN/PA or pharmacist for not administering aspirin on arrival:

- Reasons must be explicitly documented (e.g., “Chronic hepatitis – No ASA”) or clearly implied (e.g., “GI bleeding with aspirin in past,” “ASA contraindicated,” “Pt. refusing all medications,” “Supportive care only – no medications," “Aspirin not indicated,” aspirin on pre-printed order form is crossed out, “No aspirin” [no reason given]). If reasons are not mentioned in the context of aspirin, do not make inferences (e.g., Do not assume that aspirin is not being prescribed because of the patient's history of PUD alone).
- Physician/APN/PA or pharmacist documentation of a hold on aspirin or discontinuation of aspirin that occurs within the first 24 hours after arrival constitutes a “clearly implied” reason for no aspirin on arrival. A hold/discontinuation of all p.o. medications counts if aspirin p.o. was on order at the time of the notation.

  EXCEPTIONS:
  - Documentation of a conditional hold or discontinuation of aspirin does not count as a reason for no aspirin on arrival (e.g., “Hold ASA if positive Occult Blood stool,” “Stop aspirin if blood in urine recurs”).
  - Discontinuation of a particular aspirin medication documented in combination with the start of a different aspirin medication (i.e., switch in type of aspirin medication) does not count as a reason for not prescribing aspirin on arrival.

    Examples:
    - “Stop aspirtab” and “Start Ecotrin 81 mg po q am” in admission order set
    - “Change ASA to buffered baby ASA” in admitting progress note
  - Discontinuation of an aspirin medication at a particular dose documented in combination with the start of a different dose of that aspirin (i.e., change in dosage) does not count as a reason for not prescribing aspirin on arrival.

    Examples:
    - “Stop aspirin 325 mg po q am” and “Start aspirin 81 mg po q am” in admission order set
    - “Increase aspirin 81 mg to 325 mg” in admitting progress note
- Reason documentation which refers to a more general medication class is not acceptable (e.g., “Hold all anticoagulants”). Exception: Documentation of a reason for not prescribing “antiplatelets” should be considered implicit documentation of a reason for no aspirin on arrival (e.g. “Antiplatelet therapy contraindicated”).
- Deferral of aspirin from one physician/APN/PA or pharmacist to another does NOT count as a reason for not administering aspirin on arrival unless the problem underlying the deferral is also noted.

  Examples:
  - “Consulting cardiologist to evaluate pt. for ASA.” - select “**No**.”
  - “rule out intracranial bleed. Start ASA if OK with neurology.” - select "**Yes**.”

- If there is documentation of a plan to initiate/restart aspirin, and the reason/problem underlying the delay in starting/restarting aspirin is also noted, this constitutes a “clearly implied” reason for not administering aspirin on arrival.
  Acceptable examples (select “Yes”):
  - "Stool Occult Blood positive. May start Bayer EC on nursing floor.”
  - “Add buffered aspirin if hematuria subsides”

  Unacceptable examples (select “No”):
  - “Consider starting Ecotrin in a.m.”
  - “May add ASA when pt. can tolerate”
- Documentation must be clear that the given reason applies to the first 24 hour time period (e.g., “Hold buffered aspirin” per note dated/timed within 24 hours, “Unable to start aspirin until now due to hematuria” per note dated 3 days after arrival).
- Crossing out of aspirin counts as a "clearly implied reason" for not administering aspirin on arrival only if on a pre-printed form.

- When the current record includes documentation of a pre-arrival reason for no aspirin, the following counts regardless of whether this documentation is included in a pre-arrival record made part of the current record or whether it is noted by hospital staff during the current hospital stay:
  - Pre-arrival aspirin allergy
  - Pre-arrival hold/discontinuation or notation such as "No aspirin" IF the underlying reason/problem is also noted (e.g., “ASA held two weeks ago due to possible GI bleed”).
  - Pre-arrival "other reason" (other than hold/discontinuation or notation of "No aspirin") (e.g., "Hx GI bleeding with aspirin" in previous hospitalization record made part of the current chart).

Suggested Data Sources:
- Consultation notes
- Discharge summary
- Emergency Department record
- History and physical
- Medication administration record
- Medication reconciliation form
- Nursing notes
- Physician orders
- Progress notes

Excluded Data Sources:
Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay).

Inclusion Guidelines for Abstraction:
Pre-arrival medications that count as an automatic reason for no aspirin:
- Apixaban
- Coumadin
- Dabigatran

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

Refer to Appendix C, Table 1.1 for a comprehensive list of Aspirin and Aspirin-Containing medications.

Exclusion Guidelines for Abstraction:
Aspirin allergy described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table.

Data Element Name: *Reason for No Beta-Blocker at Discharge*

Collected For: The Joint Commission Only: AMI-5; **CMS Voluntary Only:** AMI-5

Definition: Reasons for not prescribing a beta-blocker at discharge:

- Beta-blocker allergy
- Second or third-degree heart block on ECG on arrival or during hospital stay and does not have a pacemaker
- Other reasons documented by physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist

Beta-blockers are agents which block beta-adrenergic receptors, thereby decreasing the rate and force of heart contractions, and reducing blood pressure. Over time beta-blockers improve the heart's pumping ability.

Suggested Data Collection Question: Is there documentation of a reason for not prescribing a beta-blocker at discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation of a reason for not prescribing a beta-blocker at discharge.
N (No)	There is no documentation of a reason for not prescribing a beta-blocker at discharge or unable to determine from medical record documentation.

Notes for Abstraction:

- A beta-blocker "allergy" or "sensitivity" documented at anytime during the hospital stay counts as an allergy regardless of what type of reaction might be noted (e.g., "Allergies: Beta-blockers – Impotence" – select "Yes").
- Documentation of an allergy/sensitivity to one particular beta-blocker is acceptable to take as an allergy to the entire class of beta-blockers (e.g., "Allergic to Lopressor").
- When conflicting information is documented in a medical record, select "Yes."
- When determining whether there is second or third-degree heart block on ECG on arrival or during hospital stay AND does not have pacemaker:
  - Consider this true if (1) there are findings of second or third-degree heart block on the ECG AND this same ECG does NOT show pacemaker findings, OR (2) There is documentation of a finding of second or third-degree heart block (not specifically referenced as an ECG finding) without mention of the presence of pacemaker findings (e.g., "Second-degree heart block" per ER report).

- Disregard pacemaker findings if documentation suggests the patient has a non-functioning pacemaker.
- Second or third-degree heart block and pacemaker ECG findings can be taken from unsigned ECG reports. Physician/APN/PA documentation is not required.
- Second or third-degree heart block findings and pacemaker findings from telemetry and rhythm strips are acceptable.
- In cases where ECG findings of second- or third-degree heart block are referenced and documentation does not address the presence or absence of pacemaker findings, infer no pacemaker findings. E.g., "ECG on arrival showed second-degree heart block" per H&P.

- When determining whether there is a reason documented by a physician/APN/PA or pharmacist for not prescribing a beta-blocker at discharge:
  - Reasons must be explicitly documented (e.g., "COPD - No BBs," "HR running in 50s. Hold off on beta-blocker therapy") or clearly implied (e.g., "Severe hypotension with beta-blockers in past," "BBs contraindicated," "Pt. refusing all medications," "Supportive care only – no medications," "BBs not indicated," beta-blocker on pre-printed order form is crossed out, "No beta-blockers" [no reason given]). If reasons are not mentioned in the context of beta-blockers, do not make inferences (e.g., Do not assume that a beta-blocker is not being prescribed because of the patient's history of Peripheral Vascular Disease alone).
  - Physician/APN/PA or pharmacist documentation of a hold on a beta-blocker or discontinuation of a beta-blocker that occurs during the hospital stay constitutes a "clearly implied" reason for not prescribing a beta-blocker at discharge. A hold/discontinuation of all p.o. medications counts if beta-blocker p.o. was on order at the time of the notation.
    EXCEPTIONS:
    - Documentation of a conditional hold/discontinuation of a beta-blocker does not count as a reason for not prescribing a beta-blocker at discharge UNLESS (1) it exists as an **order** to hold/discontinue the beta-blocker if the blood pressure (BP) or heart rate (HR) falls outside certain parameters, AND (2) the beta-blocker was held due to a BP/HR outside the parameters. Nursing documentation is acceptable. E.g., "Hold atenolol for SBP less than 100" ordered and the nurse documents that the atenolol was held for a BP of 90/50 – select "Yes."
    - Discontinuation of a particular beta-blocker medication documented in combination with the start of a different beta-blocker medication (i.e., switch in type of beta-blocker medication) does not count as a reason for not prescribing a beta-blocker at discharge.
      Examples:
      - "Stop sotalol" and "Start Tenormin 50 mg po qd" in same physician order
      - "Change Lopressor to Coreg" in progress note
      - "Do not continue after discharge" checked for metoprolol and "Continue after discharge" checked for Bystolic on a physician-signed discharge medication reconciliation form

- Discontinuation of a beta-blocker medication at a particular dose documented in combination with the start of a different dose of that beta-blocker (i.e., change in dosage) does not count as a reason for not prescribing a beta-blocker at discharge.
  Examples:
  - "Stop Inderal 40 mg po bid" and "Start Inderal 40 mg po tid" in same physician order
  - "Increase Lopressor 50 mg to 100 mg" in progress note
  - "Do not continue after discharge" checked for Coreg 3.125 mg and "Continue after discharge" checked for Coreg 6.25 mg on a physician-signed discharge medication reconciliation form

- Reason documentation which refers to a more general medication class is not acceptable (e.g., "Hold all BP meds").
- Reason documentation which refers to eye drops containing beta-blocker is not acceptable (e.g., "Dc Timolol drops").
- Deferral of a beta-blocker from one physician/APN/PA or pharmacist to another does NOT count as a reason for not prescribing a beta-blocker at discharge unless the problem underlying the deferral is also noted.
  Examples:
  - "Consulting cardiologist to evaluate pt. for BB treatment" - select "**No**."
  - "Pt. hypotensive. Start beta-blocker if OK with cardiology." - select "**Yes**."
- If there is documentation of a plan to initiate/restart a beta-blocker, and the reason/problem underlying the delay in starting/restarting the beta-blocker is also noted, this constitutes a "clearly implied" reason for not prescribing a beta-blocker at discharge.
  Acceptable examples (select "Yes"):
  - "BPs running low. May start Atenolol as outpatient."
  - "Add Toprol if HR stabilizes"

  Unacceptable examples (select "No"):
  - "Consider starting Corgard in a.m."
  - "May add beta-blockers when pt. can tolerate"
- Reasons do NOT need to be documented at discharge or otherwise linked to the discharge timeframe: Documentation of reasons anytime during the hospital stay are acceptable (e.g., mid-hospitalization note stating "no beta-blockers due to hypotension" - select "Yes," even if documentation indicates that the hypotension had resolved by the time of discharge and the beta-blocker was restarted).
- Crossing out of a beta-blocker counts as a "clearly implied reason" for not prescribing a beta-blocker at discharge only if on a pre-printed form.

- When the current record includes documentation of a pre-arrival reason for no beta-blocker, the following counts regardless of whether this documentation is included in a pre-arrival record made part of the current record or whether it is noted by hospital staff during the current hospital stay:
  - Pre-arrival beta-blocker allergy
  - Pre-arrival hold/discontinuation or notation such as "No beta-blockers" IF

the underlying reason/problem is also noted (e.g., “Atenolol discontinued in transferring hospital secondary to hypotension”).

- o Pre-arrival "other reason" (other than a hold/discontinuation or notation of "No beta-blockers") (e.g., "Hx severe hypotension with Lopressor" in transferring ED record).

Suggested Data Sources:

- Consultation notes
- Discharge summary
- ECG reports
- Emergency Department record
- History and physical
- Medication administration record
- Nursing notes
- Physician orders
- Progress notes
- Transfer sheet
- Vital signs graphic record

Excluded Data Sources:
Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay).

Inclusion Guidelines for Abstraction:
2nd/3rd degree heart block (HB)
Note: The following inclusive terms may stand alone or be modified by “variable” or “intermittent.”

- Atrioventricular (AV) block described as 2 to 1, 3 to 1, second-degree, or third-degree
- Atrioventicular (AV) dissociation
- Heart block (HB) described as 2 to 1, 3 to 1, complete (CHB), high degree, high grade, second-degree, or third-degree
- Mobitz Type 1 or 2
- Wenckebach

Pacemaker findings

- Paced rhythm
- Paced spikes
- Pacing described as atrial, AV, dual chamber, or ventricular

Refer to Appendix C, Table 1.3 for a comprehensive list of Beta-Blockers.

Exclusion Guidelines for Abstraction:
Beta-blocker allergy

- Allergy to beta-blocker eye drops (e.g., Cosopt)
- Beta-blocker allergy described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table

2nd/3rd degree heart block (HB)

- 2nd/3rd degree heart block (HB), or any of the other 2nd/3rd degree heart block inclusion terms, described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table
- Atrial flutter
- Atrioventricular (AV) block or conduction block, type/degree not specified
- First-degree atrioventricular (AV) block
- First-degree heart block (HB)
- Heart block, type/degree not specified
- Intraventricular conduction delay (IVCD)

Data Element Name: *Reason for No Overlap Therapy*

Collected For: CMS/The Joint Commission: VTE-3

Definition: Physician/APN/PA/Pharmacist documentation of a reason why parenteral anticoagulation therapy and warfarin were not administered on the same day.

Suggested Data Collection Question: Is there Physician/APN/PA or Pharmacist documentation of a reason why parenteral anticoagulation therapy and warfarin were not administered?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is Physician/APN/PA/Pharmacist documentation of a reason why parenteral anticoagulation therapy and warfarin were not administered on the same day.
N (No)	There is no Physician/APN/PA/Pharmacist documentation of a reason why parenteral anticoagulation therapy and warfarin were not administered on the same day or unable to determine from medical record documentation.

Notes for Abstraction:

- To determine the value for this data element, the abstractor must first locate the confirmation of the venous thromboembolism (VTE), and then review the chart to ascertain if there is documentation of a reason why no overlap therapy was administered. Documentation of the reason for no overlap therapy must be written after the VTE was confirmed.
- Documentation of a reason is acceptable when written after arrival but prior to admission if the VTE is confirmed in the above time period.
- Reasons must be explicitly documented or clearly implied.
  Examples:
  - "No overlap therapy"
  - "No bridge therapy"
  - "Intolerance to parenteral anticoagulation therapies"
  - "Pt not a candidate for anticoagulation therapy"
- Patient/family refusal of any or all forms of overlap therapy is acceptable to select "Yes." Patient/family refusal may be documented by a nurse, but should be documented within the same timeframe as the reason for no overlap therapy. For example, "patient refused heparin," select "Yes."
- The list of reasons for not administering overlap therapy is not all inclusive.

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

Suggested Data Sources:
PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION ONLY:
- Anesthesia record
- Consultation notes
- Discharge summary
- Emergency Department record
- History and physical
- Physician orders
- Progress notes

SUGGESTED DATA SOURCES FOR PATIENT REFUSAL (other than physician/APN/PA or pharmacist documentation of a reason for not administering Overlap Therapy as above):
- Medication administration record
- Nursing notes

Inclusion Guidelines for Abstraction:
- Bleeding complications
- Explicit documentation that the patient does not need Overlap Therapy
- Patient/family refusal
- Surgical procedure
- Use of oral anticoagulants other than warfarin (such as Xarelto or rivaroxaban for treatment of VTE)

Refer to Appendix H, Table 2.3 VTE Parenteral Therapy Table and Appendix C, Table 1.4 Warfarin Therapy.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Reason for No Tobacco Cessation Medication at Discharge*

Collected For: The Joint Commission Only: TOB-3; **CMS Informational Only:** TOB-3

Definition: Reasons for not prescribing an FDA-approved tobacco cessation medication at discharge include:

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

Suggested Data Collection Question: Is there documentation of a reason for not prescribing one of the FDA-approved tobacco cessation medications at discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation of a reason for not prescribing an FDA-approved cessation medication at discharge.
N (No)	There is no documentation of a reason for not prescribing an FDA-approved cessation medication at discharge or unable to determine from medical record documentation.

Notes for Abstraction

- Reasons for 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.
- When conflicting information is documented in the medical record, select the appropriate value for the indicated reasons present for not prescribing the tobacco cessation medications.

Suggested Data Sources:

- Anesthesia record
- Consultation record
- Discharge summary

- Emergency Department record
- History and physical
- Medication administration record (MAR)
- Physician orders
- Progress notes
- Transfer form

Inclusion Guidelines for Abstraction:
- Allergy or sensitivity
- Refer to Appendix C, Table 9.1 for a list of FDA-approved tobacco cessation medications

Exclusion Guidelines for Abstraction:
- Medication allergy using a negative modifier or qualifier (questionable, risk of, suspect, etc.)

Data Element Name: *Reason for No Tobacco Cessation Medication During the Hospital Stay*

Collected For: The Joint Commission Only: TOB-2; **CMS Informational Only:** TOB-2

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

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

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

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

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

Notes for Abstraction

- Reasons for 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.
- When conflicting information is documented in the medical record, select the appropriate value for the indicated reasons present for not administering the tobacco cessation medications.

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

Suggested Data Sources:
- Anesthesia record
- Consultation record
- Discharge summary
- Emergency Department record
- History and physical
- Medication administration record (MAR)
- Physician orders
- Progress notes
- Transfer form

Inclusion Guidelines for Abstraction:
- Allergy or sensitivity
- Refer to Appendix C, Table 9.1 for a list of FDA-approved tobacco cessation medications

Exclusion Guidelines for Abstraction:
- Medication allergy using a negative modifier or qualifier (questionable, risk of, suspect, etc.)

Data Element Name: *Reason for No VTE Prophylaxis – Hospital Admission*

Collected For: CMS/The Joint Commission: STK-1, VTE-1

Definition: Documentation why mechanical AND pharmacological VTE prophylaxis was not administered at hospital admission.

Suggested Data Collection Question: Is there documentation why VTE prophylaxis was not administered at hospital admission?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation why VTE prophylaxis was not administered at hospital admission.
N (No)	There is no documentation why VTE prophylaxis was not administered at hospital admission or unable to determine from medical record documentation.

Notes for Abstraction:

- To select "Yes" for this data element, documentation of a reason for not administering mechanical AND pharmacological VTE prophylaxis must be dated from arrival, to the day after hospital admission or surgery end date.
- Documentation written after arrival but prior to admission is acceptable.
- Reasons for not administering VTE prophylaxis must be documented by a physician/APN/PA or pharmacist.
- For patients documented to be **AT RISK FOR VTE** (All patients NOT documented to be "low risk") documentation of a contraindication of mechanical and pharmacological prophylaxis must be addressed.

  Examples:
  - o If there is physician documentation of "bleeding, no pharmacologic prophylaxis," review the chart for documentation about mechanical prophylaxis such as "no mechanical prophylaxis needed" to select "Yes."
  - o Reasons must be explicitly documented (e.g., "Active GI bleed – low molecular weight heparin (LMWH) contraindicated, No mechanical prophylaxis needed" select "Yes."
  - o "No enoxaparin, no mechanical prophylaxis needed," select "Yes."
- **If reasons are not mentioned in the context of VTE prophylaxis, do not make inferences** (e.g., do not assume that VTE Prophylaxis was not administered because of a bleeding disorder unless documentation explicitly states so).

Example:
"Bleeding risk," review the chart for documentation about reasons for no mechanical AND pharmacological VTE Prophylaxis.

- Documentation that the patient is ambulating without mention of VTE prophylaxis is insufficient. Do not infer that VTE prophylaxis is not needed unless explicitly documented.
- For patients with a reason for no pharmacologic or no mechanical prophylaxis and an order for ANY prophylaxis that was **not** administered without a reason (e.g. patient refusal), select "No."
- Reasons for not administering VTE prophylaxis must be documented by a physician/APN/PA or pharmacist.
  EXECPTIONS:
  - Risk Assessment form may be completed by a nurse.
  - Patient/family refusal may be documented by a nurse, but should be documented within the same timeframe as the reason for no VTE prophylaxis. Patient/family refusal of any form of prophylaxis is acceptable to select "Yes." For example, "patient refused heparin," select "Yes."
- For patients determined to be **AT LOW RISK** for VTE:
  - If documentation of "No VTE Prophylaxis needed" is written, then it will be inferred that both mechanical and pharmacological options were not indicated for the patient, select "Yes."
  - A completed risk assessment within this timeframe is an acceptable source for this data element.
  - If it is documented that the patient is at low risk for VTE and does not need VTE prophylaxis, select "Yes."
    Example:
    "Low Risk, No VTE Prophylaxis"
- If there are multiple completed risk assessments with conflicting outcomes within this timeframe, select "No."

Exceptions

- For patients on continuous IV heparin therapy the day of or day after hospital admission, select "Yes."
- For patients on warfarin therapy prior to admission, but placed on hold due to "high INR," select "Yes."
- For patients receiving anticoagulant therapy other than warfarin for atrial fibrillation or other conditions the day of or the day after hospital admission, select "Yes."
- If *Comfort Measures Only* (CMO) was documented the day after arrival (Day 1) but by the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission, select "Yes."
  Examples:
  - Patient arrives in the ED on 06/01/20xx but is in observation until admission to the hospital on 06/03/20xx. If CMO is documented by 06/04/20xx, select "Yes."
  - The patient was admitted on 5/31/20xx and the surgery end date was 06/01/20xx, select "Yes" if CMO was documented by 06/02/xx.

- 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."

STK

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

SUGGESTED DATA SOURCES:
ONLY PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION OF A REASON FOR NOT ADMINISTERING VTE PROPHYLAXIS:

- Anesthesia record
- Consultation notes
- Emergency Department record
- History and physical
- Physician orders
- Physician progress notes
- Risk assessment form
- Transfer form

NURSES:
Risk assessment form

SUGGESTED DATA SOURCES FOR PATIENT REFUSAL (other than physician/APN/PA or pharmacist documentation of a reason for not administering VTE prophylaxis as above):

- Medication administration record
- Nurses notes

Inclusion Guidelines for Abstraction:
Reasons for not administering any mechanical or pharmacologic prophylaxis:

- Patient at low risk for VTE
- Explicit documentation that the patient does not need VTE prophylaxis
- Patient/family refusal

Exclusion Guidelines for Abstraction:
Aspirin

Data Element Name: *Reason for No VTE Prophylaxis – ICU Admission*

Collected For: CMS/The Joint Commission: VTE-2

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

Suggested Data Collection Question: Is there documentation why VTE prophylaxis was not administered at ICU admission or transfer?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation why VTE prophylaxis was not administered at ICU admission/transfer.
N (No)	There is no documentation why VTE prophylaxis was not administered at ICU admission/transfer or unable to determine from medical record documentation.

Notes for Abstraction:

- To select "Yes" for this data element, documentation of a reason for not administering mechanical AND pharmacological VTE prophylaxis must be dated from arrival to the day after ICU admission/transfer or surgery end date for those surgeries that start the day of or the day after ICU admission/transfer.
- Documentation written after arrival to the ICU, but prior to the decision to admit is acceptable.
- If a patient did not receive VTE prophylaxis on the medical unit due to physician documentation and is transferred to the ICU, another reason (even if it is the same reason) must be documented if no VTE prophylaxis was administered upon admission/transfer to ICU.
- If there is conflicting information about the need for prophylaxis, select "No."
- For patients documented to be **AT RISK FOR VTE** (All patients NOT documented to be "low risk") documentation of a contraindication of mechanical and pharmacological prophylaxis must be addressed.
  Examples:
  - If there is physician documentation of "bleeding, no pharmacological prophylaxis," review the chart for documentation about mechanical prophylaxis such as "no mechanical prophylaxis needed" to select "Yes."
  - Reasons must be explicitly documented (e.g., "Active GI bleed –low molecular weight heparin (LMWH) contraindicated, No mechanical prophyhlaxis needed" select "Yes."
  - "No enoxaparin, no mechanical prophylaxis needed," select "Yes."

- **If reasons are not mentioned in the context of VTE prophylaxis, do not make inferences** (e.g., do not assume that VTE Prophylaxis was not administered because of a bleeding disorder unless documentation explicitly states so).

  Example:
  "Bleeding risk" , review the chart for documentation about reasons for no mechanical AND pharmacological VTE Prophylaxis.
- Documentation that the patient is ambulating without mention of VTE prophylaxis is insufficient. Do not infer that VTE prophylaxis is not needed unless explicitly documented.
- Reasons for not administering VTE prophylaxis must be documented by a physician/APN/PA or pharmacist.
  EXCEPTIONS:
  - Risk Assessment form may be completed by a nurse.
  - Patient/family refusal may be documented by a nurse, but should be documented within the same timeframe as the reason for no VTE prophylaxis. Patient/family refusal of any form of prophylaxis is acceptable to select "Yes." For example, "patient refused heparin," select "Yes."
- For patients documented to be **AT LOW RISK** for VTE:
  - If documentation of "No VTE Prophylaxis needed" is written, then it will be inferred that both mechanical and pharmacological options were not indicated for the patient, select "Yes."
  - A completed nursing risk assessment within this timeframe is an acceptable source for this data element.
  - If it is documented that the patient is at low risk for VTE and does not need VTE prophylaxis, select "Yes."
    Example:
    "Low Risk, No VTE Prophylaxis," select "Yes."
- If there are multiple completed risk assessments with conflicting outcomes within this timeframe, select "No."
  EXCEPTIONS:
  - For patients on continuous IV heparin therapy the day of or day after ICU admission, select "Yes."
  - For patients on warfarin therapy prior to ICU admission, but placed on hold due to "high INR," select "Yes."
  - For patients receiving anticoagulant therapy other than warfarin for atrial fibrillation or other conditions the day of or the day after ICU admission/transfer, select "Yes."
  - If *Comfort Measures Only* (CMO) was documented after the day after arrival (Day 1) but by the day after ICU admission or surgery end date for surgeries that start the day of or the day after ICU admission, select "Yes."
    Examples:
    - Patient arrives in the ED on 06/01/20xx but is in observation until admission to the ICU on 06/03/20xx. If CMO is documented by 06/04/20xx, select "Yes."
    - The patient was admitted on 05/31/20xx and the surgery end date was 06/01/20xx, select "Yes" if CMO was documented by 06/02/20xx

Suggested Data Sources:
ONLY PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION OF A REASON FOR NOT ADMINISTERING VTE PROPHYLAXIS:

- Anesthesia record
- Consultation notes
- Emergency Department record
- History and physical
- Physician orders
- Physician progress notes
- Risk assessment form
- Transfer form

NURSES:
Risk assessment form

SUGGESTED DATA SOURCES FOR PATIENT REFUSAL (other than physician/APN/PA or pharmacist documentation of a reason for not administering VTE prophylaxis as above):

- Medication administration record
- Nurses notes

Inclusion Guidelines for Abstraction:
Reasons for not administering any mechanical AND pharmacologic prophylaxis:

- Explicit documentation that the patient does not need VTE prophylaxis
- Patient at low risk for VTE
- Patient/family refusal

Exclusion Guidelines for Abstraction:
Aspirin

Data Element Name: *Reason for Not Administering Antithrombotic Therapy by End of Hospital Day 2*

Collected For: CMS/The Joint Commission: STK-5

Definition: Reason for not administering antithrombotic therapy by end of hospital day 2. Antithrombotic therapy is administered to reduce morbidity, mortality, and recurrence rate in stroke.

Suggested Data Collection Question: Is there documentation by a physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist in the medical record of a reason for not administering antithrombotic therapy by end of hospital day 2?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is physician/APN/PA or pharmacist documentation of a reason for not administering antithrombotic therapy by end of hospital day 2.
N (No)	There is no physician/APN/PA or pharmacist documentation of a reason for not administering antithrombotic therapy by end of hospital day 2 or unable to determine from the medical record documentation.

Notes for Abstraction:

- Documentation for allowable value "Yes" must be found within the timeframe of arrival to the end of hospital day 2. It is not necessary to review documentation outside of this timeframe to answer this data element.
- To compute end of hospital day 2, count the arrival date as hospital day 1. If a reason for not administering antithrombotic therapy was documented by 11:59 P.M. of hospital day 2, select "Yes" for this data element.
- Reasons for not administering antithrombotic therapy must be documented by a physician/APN/PA or pharmacist with one exception: Patient/family refusal of any form of antithrombotic therapy (e.g., "ASA refused," "Patient refusing antithrombotic therapy") may be documented by a nurse. However, it must be documented in the timeframe of arrival to the end of hospital day 2.
  Example:
  Patient arrived on 03/01/xx. Nursing notes on 03/02/20XX indicates that patient refused antithrombotic therapy, select "Yes."
- **If reasons are not mentioned in the context of antithrombotics, do not make inferences** (e.g., do not assume that antithrombotic therapy was not

administered because of a bleeding disorder unless documentation explicitly states so).
    - Reasons must be explicitly documented (e.g., “Hemorrhagic transformation – do not give aspirin,” “Active GI bleed – antithrombotic therapy contraindicated,” “H/O bleeding disorder – anticoagulation therapy contraindicated,” “Low platelet count - do not give antiplatelet medications,” “No ASA” [no reason given]).
    - Physician/APN/PA or pharmacist documentation of a hold on an antithrombotic medication or discontinuation of an antithrombotic medication that occurs the day of or day after hospital arrival constitutes a “clearly implied” reason for not administering antithrombotic therapy by end of hospital day 2. A hold/discontinuation of all p.o. medications counts if an antithrombotic was on order at the time of the notation.
- An allergy or adverse reaction to one type of antithrombotic would NOT be a reason for not administering all antithrombotics. Another medication can be ordered.
- For patients on warfarin therapy prior to hospital arrival, but placed on hold the day of or after arrival due to “high INR,” select “Yes.”

Suggested Data Sources:
ONLY PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION OF A REASON FOR NOT ADMINISTERING ANTITHROMBOTIC THERAPY:
- Consultation notes
- Emergency room records
- History and physical
- Medication reconciliation form
- Progress Notes

SUGGESTED DATA SOURCES FOR PATIENT/FAMILY REFUSAL (other than physician/APN/PA or pharmacist documentation of a reason for not administering antithrombotic therapy as noted above):
- Medication Administration Record
- Nurses notes

Excluded Data Sources:
Any documentation dated/timed prior to hospital arrival or after hospital day 2.

Inclusion Guidelines for Abstraction:
Examples:
- Allergy to all antithrombotic medications
- Aortic dissection
- Bleeding disorder
- Brain/CNS cancer
- CVA, hemorrhagic
- Extensive/metastatic CA
- Hemorrhage, any type
- Intracranial surgery/biopsy

- Patient/family refusal
- Peptic ulcer
- Planned surgery within 7 days following discharge
- Risk of bleeding
- Unrepaired intracranial aneurysm

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

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Reason for Not Administering Beta-Blocker - Perioperative*

Collected For: CMS/The Joint Commission: SCIP-Card-2

Definition: Reasons for not administering a beta-blocker during the perioperative period:

- Bradycardia (heart rate less than 50 bpm)
- Hypotension (systolic ≤ 100 mm/Hg)
- Concurrent use of intravenous inotropic medications during the perioperative period
- Other reasons documented by physician/APN/PA or pharmacist

Beta-blockers are agents which block beta-adrenergic receptors, thereby decreasing the rate and force of heart contractions, and reducing blood pressure. Over time beta-blockers improve the heart's pumping ability.

Suggested Data Collection Question: Was there documentation of reasons for not administering a beta-blocker during the perioperative period?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1-4

Allowable Values:

Select all that apply:

1 There is documentation of a reason for not administering a beta-blocker on the day prior to surgery.

2 There is documentation of a reason for not administering a beta-blocker on the day of surgery.

3 There is documentation of a reason for not administering a beta-blocker on postoperative day 1 (POD 1).

4 There is documentation of a reason for not administering a beta-blocker on postoperative day 2 (POD 2).

5 There is NO documentation of a reason for not administering a beta-blocker during the perioperative period (day prior to surgery through POD 2 with day of surgery being day zero) or unable to determine from medical record documentation.

Notes for Abstraction:

- No value should be recorded more than once. If value "5" is selected, no other selections should be recorded.

- The perioperative period for the SCIP cardiac measure is defined as the day prior to surgery through postoperative day two (POD 2) with the day of surgery being day zero.
- Documentation of reasons for not administering a beta-blocker must be found during the period defined in the allowable value to select that value. If the physician writes a specific reason for not administering beta-blockers during the defined period, select the appropriate value.
  Example:
  The physician documents on POD 1: Will hold beta-blockers today since the patient is hemodynamically unstable, select value "3." The documentation must be made on the day corresponding to the value. There must be a reason documented for **each day** the beta-blocker is held or not administered.
- If the beta-blocker was held on the day prior to hospital arrival and prior to the day of surgery, the reason it was held or not taken can be documented on the day of surgery. There must be a reason documented for **each day** the beta-blocker is held or not administered, to select the corresponding value.
- Preoperative documentation that the patient is NPO or due to NPO status alone is not acceptable to select values 1- 4.
- If the physician writes an order to hold the beta-blocker when the patient's vital signs are outside certain parameters and there is documentation that the beta blocker was held because the vital signs were outside the parameters during one of the periods specified in the allowable values, select the appropriate value. The vital signs to support this documentation are required and must be documented as present during the timeframe for the value being selected.
  Example:
  The physician writes the order, "Hold atenolol for SBP less than 120" and the nurse documents that the atenolol was held for a SBP of 110/50 on POD 2, select value "4." If it is apparent on the MAR that the medication was held based on physician parameters during the specified timeframe, a notation on the MAR or in the nursing narrative is acceptable to select the appropriate value.
- Documentation of hypotension as a reason must be substantiated by documentation of a blood pressure $\leq$ 100 mm/Hg during the timeframe for the value. Documentation of bradycardia as a reason must be substantiated by a heart rate of less than 50 bpm during the timeframe for the value.
- If intravenous use of inotropic medication (Appendix C, Table 3.14) is administered at any time during the time period represented in an allowable value, select the value that represents that timeframe in the perioperative period.
- Vital signs obtained while patient is on cardiopulmonary bypass machine or while being removed from bypass cannot be used to determine bradycardia.
- A documented systolic blood pressure of less than 100 mm/Hg and/or a heart rate less than 50 bpm during the time period represented in the value being abstracted is sufficient to select that value.
- Patient refusal does not have to be documented by a physician/APN/PA, but it must be documented in the timeframe corresponding to the timeframe for the value being abstracted.

Suggested Data Sources:

- Anesthesia record
- Consultation notes
- Discharge summary
- ECG reports
- Emergency Department record
- History and physical
- Medication administration record
- Nursing notes
- Physician orders
- Progress notes
- Vital signs/graphic record

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 1.3 for a comprehensive list of Beta-Blockers.
Refer to Appendix C, Table 3.14 for a comprehensive list of inotropic medications.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Reason for Not Administering Relievers*

Collected For: The Joint Commission Only: CAC-1

Definition: Reasons for not administering relievers during this hospitalization:
- Allergy to relievers
- Other reasons documented by physician/APN/PA or pharmacist

Relievers are medications that relax the bands of muscle surrounding the airways and are used to quickly alleviate bronchoconstriction and prevent exercise-induced bronchospasm. Relievers are also known as rescue, quick-relief, or short acting medications of choice to quickly relieve asthma exacerbations.

Suggested Data Collection Question: Is there documentation of a reason for not administering relievers during this hospitalization?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation of a reason for not administering relievers during this hospitalization.
N (No)	There is no documentation of a reason for not administering relievers during this hospitalization or unable to determine from medical record documentation.

Notes for Abstraction:
- When there is documentation of an “allergy,” “sensitivity,” “intolerance,” “adverse or side effects,” cardiac dysrhythmias, etc., regard this as documentation of a reason for not administering relievers regardless of what type of reaction might be noted. Do not attempt to distinguish between true allergies, sensitivities, intolerances, adverse or side effects, cardiac dysrhythmias, etc. (e.g., “Allergies: Relievers – select “Yes”).
- When conflicting information is documented in a medical record, select “Yes.”
- When determining whether there is a reason documented by a physician/APN/PA or pharmacist for not administering relievers during this hospitalization:
  - Reasons must be explicitly documented or clearly implied (e.g., intolerance to relievers” or “problems with relievers in past”).

Suggested Data Sources:

- Consultation notes
- Discharge summary
- Emergency Department record
- History and physical
- Medication administration record (MAR)
- Medication reconciliation form
- Nursing notes
- Physician orders
- Progress notes

Inclusion Guidelines for Abstraction:

- Allergies/sensitivities/intolerance
- Cardiovascular side effects
- Cardiac dysrhythmias or arrhythmias
- Side effects

Refer to Appendix C, Table 6.2 for a comprehensive list of Reliever Medications.

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Reason for Not Administering Systemic Corticosteroids*

Collected For: The Joint Commission Only: CAC-2

Definition: Reasons for not administering systemic corticosteroids during this hospitalization:

- Allergy to systemic corticosteroids
- Oral, IM, or intravenous (systemic) corticosteroids were administered to the patient within 24 hours prior to arrival AND patient was not a candidate to receive an additional dose during this hospitalization
- Other reasons documented by physician/APN/PA or pharmacist

Corticosteroids are a family of potent anti-inflammatory medications produced either naturally by the adrenal cortex or manufactured synthetically, in inhaled, topical, oral, IM, and intravenous forms.

Suggested Data Collection Question: Is there documentation of a reason for not administering systemic corticosteroids during this hospitalization?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation of a reason for not administering systemic corticosteroids during this hospitalization.
N (No)	There is no documentation of a reason for not administering systemic corticosteroids during this hospitalization or unable to determine from medical record documentation.

Notes for Abstraction:

- When there is documentation of an “allergy,” “sensitivity,” “intolerance,” “adverse or side effects,” regard this as documentation of a reason for not administering systemic corticosteroids regardless of what type of reaction might be noted. Do not attempt to distinguish between true allergies, sensitivities, intolerances, adverse or side effects, etc. (e.g., “Allergies: Systemic Corticosteroids – select “Yes”).
- When conflicting information is documented in a medical record, select “Yes.”
- When determining whether there is a reason documented by a physician/APN/PA or pharmacist for not administering oral, IM, or intravenous (systemic) corticosteroids during this hospitalization.
    - Reasons must be explicitly documented or clearly implied (e.g., “intolerance to systemic corticosteroids” or “problems with systemic corticosteroids in past”).

Suggested Data Sources:

- Ambulance record
- Consultation notes
- Discharge summary
- Emergency Department record
- History and physical
- Medication administration record (MAR)
- Medication reconciliation form
- Nursing notes
- Physician orders
- Progress notes
- Records from physician's office, clinic, or transferring facility (must be a part of this current medical record)

Inclusion Guidelines for Abstraction:

- Allergies/sensitivities/intolerance
- Side effects

Refer to Appendix C, Table 6.3 for a comprehensive list of Systemic Corticosteroids.

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Reason for Not Administering VTE Prophylaxis*

Collected For: CMS/The Joint Commission: SCIP-VTE-2

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

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

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

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

Notes for Abstraction:

- To select "Yes," there must be physician/APN/PA or pharmacist documentation of reasons for not administering BOTH mechanical and pharmacological prophylaxis.
- Physician documentation of the VTE risk level alone is not sufficient as a reason. The physician/APN/PA or pharmacist must document an inclusion or a specific reason for not administering pharmacological and mechanical VTE prophylaxis.
  EXCEPTION:
  For General Surgeries only: If there is documentation of a Roger's VTE risk factor score < 7 or a Caprini VTE risk factor score of 0 (zero), select value "Yes." Refer to Appendix A, Table 5.19, General Surgery.
- Reasons for not administering VTE prophylaxis must be documented within the timeframe of arrival to 24 hours after *Anesthesia End Time.* It is not necessary to review documentation outside of this timeframe to answer this data element.
- To select "Yes" based on patient refusal, there must be documentation that the patient refused both pharmacological and mechanical prophylaxis. Patient refusal does not have to be documented by a physician/APN/PA or pharmacist, but it must be documented in the timeframe from arrival to 24 hours after *Anesthesia End Time.*

- See the inclusion list for examples of acceptable reasons for not administering prophylaxis. See the exclusion list for examples of unacceptable reasons for not administering prophylaxis. These lists are not all-inclusive.
- An allergy or adverse reaction to one type of pharmacological prophylaxis is NOT sufficient as a reason for not administering all pharmacological prophylaxis. Another medication can be ordered.
  Example:
  Physician documentation of, "No coumadin due to allergy." This is not sufficient as a reason for not administering all pharmacological VTE prophylaxis.
- If the physician orders a transfusion and the blood products are administered in the timeframe of arrival to 24 hours after *Anesthesia End Time*, it is sufficient as a reason for not administering pharmacological VTE prophylaxis.
- Re-infusion of blood products collected with blood recovery systems, plasma or volume expanders and platelet gels are not considered sufficient as a reason for not administering pharmacological VTE prophylaxis.
- Blood or blood products documented on the anesthesia record or in the operative report as administered intraoperatively (during surgery), do not require a physician order to be sufficient as a reason for not administering pharmacological VTE prophylaxis.
- For patients on continuous IV heparin therapy within 24 hours before or after surgery, select "Yes."
- Physician documentation of a bleeding risk or active bleeding in reference to the normal risk of bleeding or to the normal bleeding associated with surgery, is not sufficient as a reason for not administering pharmacological VTE prophylaxis.
- A timeframe for starting or holding VTE prophylaxis is not sufficient as a reason for not administering VTE prophylaxis in the allowable timeframe.
  Example:
  "Hold heparin 48 hours postop." This is an order to hold but does not include a reason.
- There must be documentation indicating which type, pharmacological or mechanical prophylaxis, the reason applies to. Whether or not the reason applies to either or to both mechanical and pharmacological prophylaxis must be indicated in the documentation.
  Example:
  "No heparin due to bleeding risk." It is clear that this reason applies only to pharmacological prophylaxis.
- If pharmacological VTE prophylaxis is not administered based on physician parameters, there must be substantiating documentation.
  Example:
  Hold heparin for INR > 2.5. To be sufficient as a reason, there must be documentation that the heparin was held due to an INR value > 2.5 during that same timeframe.

Suggested Data Sources:
ONLY PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION OF A REASON FOR NOT ADMINISTERING VTE PROPHYLAXIS:

- Anesthesia record
- Consultation notes

- Discharge summary
- History and physical
- Physician orders
- Physician progress notes

SUGGESTED DATA SOURCES FOR PATIENT REFUSAL (other than physician/APN/PA documentation of a reason for not administering VTE Prophylaxis as above):

- Medication Administration Record
- Nurses notes

Inclusion Guidelines for Abstraction:
Reasons for not administering mechanical prophylaxis:

- Arterial insufficiency of lower extremities
- Bilateral amputee
- Bilateral lower extremity trauma
- Patient refusal
- Patients on continuous IV heparin therapy within 24 hours before or after surgery

Reasons for not administering pharmacological prophylaxis:

- Active bleeding (gastrointestinal bleeding, cerebral hemorrhage, retroperitoneal bleeding)
- Bleeding risk
- GI bleed
- Hemorrhage
- Patient refusal
- Patients on continuous IV heparin therapy within 24 hours before or after surgery
- Risk of bleeding
- Thrombocytopenia

Exclusion Guidelines for Abstraction:
Orders to hold prophylaxis without a documented reason

Reasons for not administering pharmacological prophylaxis:

- Bleeding risk described in the informed consent process
- Chronic Anemia
- History (Hx) of bleeding
- Minimal or scant bleeding or oozing
- Re-infusion of blood products collected with blood recovery systems
- Serosanguinous drainage from drain or surgical dressing

Data Element Name: *Reason for Not Initiating IV Thrombolytic*

Collected For: CMS/The Joint Commission: STK-4

Definition: Reason for not initiating IV thrombolytic.

- Intravenous (IV) or intra-arterial (IA) thrombolytic was initiated for this stroke prior to hospital arrival.
- Other reasons documented by physician/APN/PA or pharmacist.

Suggested Data Collection Question: Is there documentation by a physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist in the medical record of a reason for not initiating IV thrombolytic?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is physician/APN/PA or pharmacist documentation of a reason for not initiating IV thrombolytic.
N (No)	There is no physician/APN/PA or pharmacist documentation of a reason for not initiating IV thrombolytic, OR unable to determine from the medical record documentation.

Notes for Abstraction:

- Reasons for not initiating IV thrombolytic therapy must be documented by a physician/APN/PA or pharmacist with three exceptions: Patient/family refusal, NIHSS score of zero, and initiation of IV or IA thrombolytic at a transferring hospital. These three exceptions may be documented by a nurse. Reason documentation must refer to the timeframe for thrombolytic therapy.
- **If reasons are not mentioned in the context of IV thrombolytics, do not make inferences** (e.g., do not assume that IV thrombolytic was not initiated because of a bleeding disorder unless documentation explicitly states so).
- Documentation of the initiation of IV or IA thrombolytic at a transferring hospital is a stand-alone reason and sufficient to meet the intent of this data element. No further documentation of it as the reason for not initiating IV t-PA at this hospital is needed.
- If documentation indicates a National Institute of Health Stroke Scale (NIHSS) score of zero, select “Yes.” Score documentation must refer to the timeframe for thrombolytic therapy.
- Reason documentation which refers to intravenous medications only (e.g., “Hold IV medications,” “No IVs”), is not acceptable.

Suggested Data Sources:
ONLY PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION OF A REASON FOR NOT INITIATING IV THROMBOLYTIC:

- Consultation notes
- Emergency room records
- History and physical
- Medication reconciliation form
- Progress Notes

Excluded Data Sources:
Discharge summary

ADDITIONAL SUGGESTED DATA SOURCES FOR PATIENT/FAMILY REFUSAL, NIHSS SCORE OF ZERO, AND INITIATION OF IV or IA THROMBOLYTIC AT A TRANSFERRING HOSPITAL ONLY:

- Medical transport records
- Nurses notes
- Transfer forms

Inclusion Guidelines for Abstraction:

- IV or IA t-PA given at a transferring hospital
- NIHSS score of zero
- Patient/family refusal

(See table of **Conditions Making the Administration of IV Thrombolytic Therapy Inadvisable**, STK-4)

Exclusion Guidelines for Abstraction:

- Delay in hospital arrival greater than 2 hours
- Orders to hold IV thrombolytic without a documented reason

Data Element Name: *Reason for Not Prescribing **Anticoagulation** Therapy at Discharge*

Collected For: CMS/The Joint Commission: STK-3

Definition: Reason for not prescribing **anticoagulation** therapy at hospital discharge.

- Hemorrhagic stroke
- Other reason documented by physician/APN/PA or pharmacist

The administration of anticoagulation therapy, unless there are contraindications, is an established effective strategy in preventing recurrent stroke in high stroke risk-atrial fibrillation patients with TIA or prior stroke.

Suggested Data Collection Question: Is there documentation by a physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist in the medical record of a reason for not prescribing anticoagulation therapy at hospital discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation of a reason for not prescribing **anticoagulation** therapy at hospital discharge.
N (No)	There is no documentation of a reason for not prescribing **anticoagulation** therapy at hospital discharge, OR unable to determine from the medical record documentation.

Notes for Abstraction:

- Reasons for not prescribing anticoagulation therapy at hospital discharge must be documented by a physician/APN/PA or pharmacist.
- **If reasons are not mentioned in the context of anticoagulation therapy, do not make inferences** (e.g., do not assume that anticoagulation therapy was not prescribed because of a bleeding disorder unless documentation explicitly states so).
  - Reasons must be explicitly documented (e.g., “Active GI bleed – anticoagulation therapy contraindicated,” “No warfarin” [no reason given]).
  - Physician/APN/PA or pharmacist documentation of a hold on an anticoagulant medication or discontinuation of an anticoagulant medication that occurs during the hospital stay constitutes a “clearly implied” reason for not prescribing anticoagulation therapy at discharge. A hold/discontinuation of all p.o. medications counts if an oral anticoagulant medication (e.g., warfarin) was on order at the time of the notation.

EXCEPTIONS:

- Documentation of a conditional hold or discontinuation of an anticoagulant medication does not count as a reason for not prescribing an anticoagulant medication at discharge (e.g., “Hold Coumadin if guaiac positive,” “Stop warfarin if rash persists,” “No warfarin for 24 hours following thrombolytic therapy”).
- Discontinuation of a particular anticoagulant medication documented in combination with the start of a different anticoagulant medication (i.e., switch type of anticoagulant medication) does not count as a reason for not prescribing an anticoagulant medication at discharge.
  Examples:
  - “Stop warfarin” and “Start warfarin 2 mg po daily” in same physician order
  - “Change Coumadin to Pradaxa” in progress note
  - “Do not continue after discharge” checked for warfarin and “Continue after discharge” checked for Coumadin on a physician-signed discharge medication reconciliation form
- Discontinuation of an anticoagulant medication at a particular dose documented in combination with the start of a different dose of that anticoagulant (i.e., change in dosage) does not count as a reason for not prescribing an anticoagulant medication at discharge.
  Examples:
  - “Stop warfarin 5 mg po daily” and “Start warfarin 2.5 mg po daily” in same physician order
  - “Decrease dabigatran 150 mg po BID to 75 mg po BID” in progress note
  - “Do not continue after discharge” checked for Coumadin 5 mg and “Continue after discharge” check for Coumadin 2.5 mg on a physician-signed discharge medication reconciliation form

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

o If there is documentation of a plan to initiate/restart anticoagulation therapy, and the reason/problem underlying the delay in starting/restarting anticoagulation therapy is also noted, this constitutes a “clearly implied” reason for not prescribing anticoagulation therapy at discharge.
  Acceptable examples (select “Yes”):
  - “Stool Occult Blood positive. May start Coumadin as outpatient.”
  - “Start warfarin if hematuria subsides.”

  Unacceptable examples (select “No”):

    - “Consider starting Coumadin in a.m.”
    - “May add warfarin when pt. can tolerate”
  - Reasons do NOT need to be documented at discharge or otherwise linked to the discharge timeframe: Documentation of reasons anytime during the hospital stay are acceptable (e.g., mid-hospitalization note stating “no warfarin due to rectal bleeding” - select “Yes,” even if documentation indicates that the rectal bleeding has resolved by the time of discharge and warfarin was restarted).
  - Crossing out of an anticoagulant medication counts as a "clearly implied reason" for not prescribing anticoagulation therapy at discharge only if on a pre-printed form.
- An allergy or adverse reaction to one type of anticoagulant would NOT be a reason for not administering all anticoagulants. Another medication can be ordered.
- When conflicting information is documented in a medical record, select “Yes.”
- When the current record includes documentation of a pre-arrival reason for no anticoagulation therapy, the following counts regardless of whether this documentation is included in a pre-arrival record made part of the current record or whether it is noted by hospital staff during the current hospital stay:
  - Pre-arrival hold/discontinuation or notation such as "No Coumadin" IF the underlying reason/problem is also noted (e.g., “Coumadin held in transferring hospital due to possible GI bleed”).
  - Pre-arrival "other reason" (other than hold/discontinuation or notation of "No warfarin") (e.g., "Hx GI bleeding with warfarin" in transferring ED record).

Suggested Data Sources:
ONLY PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION OF A REASON FOR NOT PRESCRIBING ANTICOAGULATION THERAPY AT HOSPITAL DISCHARGE:

- Consultation notes
- Discharge summary
- Emergency Department record
- History and physical
- Medication administration record
- Medication reconciliation form
- Physician orders
- Progress Notes

Excluded Data Sources:
Any documentation dated/timed after discharge, except discharge summary.

Inclusion Guidelines for Abstraction:
Examples:

- Allergy to all anticoagulant medications
- Aortic dissection
- Bleeding disorder

- Brain/CNS cancer
- CVA, hemorrhagic
- Extensive/metastatic CA
- Hemorrhage, any type
- Intracranial surgery/biopsy
- Patient/family refusal
- Peptic ulcer
- Planned surgery within 7 days following discharge
- Risk of bleeding
- Unrepaired intracranial aneurysm

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

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Reason for Not Prescribing **Antithrombotic** Therapy at Discharge*

Collected For: CMS/The Joint Commission: STK-2

Definition: Reason for not prescribing **antithrombotic** therapy at hospital discharge.

- Hemorrhagic stroke
- Other reason documented by physician/APN/PA or pharmacist

Antithrombotic therapy is administered to reduce morbidity, mortality, and recurrence rate in stroke.

Suggested Data Collection Question: Is there documentation by a physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist in the medical record of a reason for not prescribing antithrombotic therapy at hospital discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation of a reason for not prescribing **antithrombotic** therapy at hospital discharge.
N (No)	There is no documentation of a reason for not prescribing **antithrombotic** therapy at hospital discharge, OR unable to determine from the medical record documentation.

Notes for Abstraction:

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

EXCEPTIONS:

- Documentation of a conditional hold or discontinuation of an antithrombotic medication does not count as a reason for not prescribing an antithrombotic medication at discharge (e.g., "Hold ASA if guaiac positive," "Stop Plavix if rash persists," "No ASA for 24 hours following thrombolytic therapy").
- Discontinuation of a particular antithrombotic medication documented in combination with the start of a different antithrombotic medication (i.e., switch type of antithrombotic medication) does not count as a reason for not prescribing an antithrombotic medication at discharge.
  Examples:
  - "Stop Plavix" and "Start Plavix 75 mg po daily" in same physician order
  - "Change Plavix to aspirin" in progress note
  - "Do not continue after discharge" checked for Plavix and "Continue after discharge" checked for clopidogrel on a physician-signed discharge medication reconciliation form
- Discontinuation of an antithrombotic medication at a particular dose documented in combination with the start of a different dose of that antithrombotic (i.e., change in dosage) does not count as a reason for not prescribing an antithrombotic medication at discharge.
  Examples:
  - "Stop Ecotrin 300 mg po daily" and "Start Ecotrin 325 mg po daily" in same physician order
  - "Increase Ectotrin 81 mg to 325 mg daily" in progress note
  - "Do not continue after discharge" checked for Ecotrin 300 mg and "Continue after discharge" checked for Ecotrin 325 mg on a physician-signed discharge medication reconciliation form

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

o If there is documentation of a plan to initiate/restart antithrombotic therapy, and the reason/problem underlying the delay in starting/restarting antithrombotic therapy is also noted, this constitutes a "clearly implied" reason for not prescribing antithrombotic therapy at discharge.
  Acceptable examples (select "Yes"):
  - "Stool Occult Blood positive. May start Coumadin as outpatient."
  - "Start ASA if hematuria subsides."

  Unacceptable examples (select "No"):

- "Consider starting Coumadin in a.m."
- "May add Plavix when pt. can tolerate"

  - Reasons do NOT need to be documented at discharge or otherwise linked to the discharge timeframe: Documentation of reasons anytime during the hospital stay are acceptable (e.g., mid-hospitalization note stating "no ASA due to rectal bleeding" - select "Yes," even if documentation indicates that the rectal bleeding has resolved by the time of discharge and ASA was restarted).
  - Crossing out of an antithrombotic medication counts as a "clearly implied reason" for not prescribing antithrombotic therapy at discharge only if on a pre-printed form.

- An allergy or adverse reaction to one type of antithrombotic would NOT be a reason for not administering all antithrombotics. Another medication can be ordered.
- When conflicting information is documented in a medical record, select "Yes."
- When the current record includes documentation of a pre-arrival reason for no antithrombotic therapy, the following counts regardless of whether this documentation is included in a pre-arrival record made part of the current record or whether it is noted by hospital staff during the current hospital stay:
  - Pre-arrival hold/discontinuation or notation such as "No Coumadin" IF the underlying reason/problem is also noted (e.g., "Coumadin held in transferring hospital due to possible GI bleed").
  - Pre-arrival "other reason" (other than hold/discontinuation or notation of "No ASA") (e.g., "Hx GI bleeding with ASA" in transferring ED record).

Suggested Data Sources:
ONLY PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION OF A REASON FOR NOT PRESCRIBING ANTITHROMBOTIC THERAPY AT HOSPITAL DISCHARGE:

- Consultation notes
- Discharge summary
- Emergency Department record
- History and physical
- Medication administration record
- Medication reconciliation form
- Physician orders
- Progress Notes

Excluded Data Sources:
Any documentation dated/timed after discharge, except discharge summary.

Inclusion Guidelines for Abstraction:
Examples:

- Allergy to all antithrombotic medications
- Aortic dissection
- Bleeding disorder
- Brain/CNS cancer

- CVA, hemorrhagic
- Extensive/metastatic CA
- Hemorrhage, any type
- Intracranial surgery/biopsy
- Patient/family refusal
- Peptic ulcer
- Planned surgery within 7 days following discharge
- Risk of bleeding
- Unrepaired intracranial aneurysm

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

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Reason for Not Prescribing Statin Medication at Discharge*

Collected For: CMS/The Joint Commission: STK-6; **The Joint Commission Only:** AMI-10; **CMS Voluntary Only:** AMI-10

Definition: Reasons for not prescribing a statin medication at discharge:
- Statin medication allergy
- Other reasons documented by physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist

Statins are a class of pharmaceutical agents that modify LDL cholesterol by blocking the action of an enzyme in the liver which is needed to synthesize cholesterol thereby decreasing the level of cholesterol circulating in the blood.

Suggested Data Collection Question: Is there documentation of a reason for not prescribing a statin medication at discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation of a reason for not prescribing a statin medication at discharge.
N (No)	There is no documentation of a reason for not prescribing a statin medication at discharge, OR unable to determine from medical record documentation.

Notes for Abstraction:
- A statin medication "allergy" or "sensitivity" documented at anytime during the hospital stay counts as an allergy regardless of what type of reaction might be noted (e.g., "Allergies: Atorvastatin – Nausea" – select "Yes").
- Documentation of an allergy/sensitivity to one particular statin medication is acceptable to take as an allergy to the entire class of statin medications (e.g., "Allergic to Lipitor").
- When conflicting information is documented in a medical record, select "Yes."
- In determining whether there is a reason documented by physician/APN/PA or pharmacist for not prescribing a statin medication at discharge:
  - Reasons must be explicitly documented (e.g., "Chronic liver failure – Statins contraindicated," "Hx muscle soreness with statins in past") or clearly implied (e.g., "No evidence of atherosclerosis – no statin therapy," "Pt. refusing all medications," "Supportive care only – no medication," statin medication on pre-printed order form is crossed out, "Statins not indicated," "No statin medications" [no reason given]). If reasons are not

mentioned in the context of statin medications, do not make inferences (e.g., do not assume that a statin medication is not being prescribed because of the patient's history of alcoholism or severe liver disease alone).

- Physician/APN/PA or pharmacist documentation of a hold on a statin medication or discontinuation of a statin medication that occurs during the hospital stay constitutes a "clearly implied" reason for not prescribing a statin medication at discharge. A hold/discontinuation of all p.o. medications counts if statin medication p.o. was on order at the time of the notation.

  EXCEPTIONS:

  - Documentation of a conditional hold or discontinuation of a statin medication does not count as a reason for not prescribing a statin medication at discharge (e.g., "Hold Zocor if severe diarrhea persists," "Stop atorvastatin if myalgias persist").
  - Discontinuation of a particular statin medication documented in combination with the start of a different statin medication (i.e., switch in type of statin medication) does not count as a reason for not prescribing a statin medication at discharge.

    Examples:

    - "Stop lovastatin" and "Start atorvastatin 80 mg po q hs" in same physician order
    - "Change Crestor to Lipitor" in progress note
    - "Do not continue after discharge" checked for Vytorin and "Continue after discharge" checked for Advicor on a physician-signed discharge medication reconciliation form
  - Discontinuation of a statin medication at a particular dose documented in combination with the start of a different dose of that statin (i.e., change in dosage) does not count as a reason for not prescribing a statin medication at discharge.

    Examples:

    - "Stop Simvastatin 20 mg po q hs" and "Start Simvastatin 40 mg po q hs" in same physician order
    - "Increase Pravachol 40 mg to 80 mg" in progress note
    - "Do not continue after discharge" checked for Zocor 40 mg and "Continue after discharge" checked for Zocor 80 mg on a physician-signed discharge medication reconciliation form
- Reason documentation which refers to a more general medication class is not acceptable (e.g., "No cholesterol-reducers," "Hold all lipid-lowering medications").
- Deferral of statin medication from one physician/APN/PA or pharmacist to another does NOT count as a reason for not prescribing a statin medication unless the problem underlying the deferral is also noted.

  Examples:

  - "Consulting neurologist to evaluate pt. for statin therapy" - select "No."
  - "Severe diarrhea. Start statin if OK with neurology." - select "Yes."

- If there is documentation of a plan to initiate/restart a statin medication, and the reason/problem underlying the delay in starting/restarting the medication is also noted, this constitutes a “clearly implied” reason for not prescribing a statin medication at discharge.
  Acceptable examples (select “Yes”):
  - “Liver enzymes high. May start lovastatin as outpatient.”
  - “Add statin if myalgias resolve”

  Unacceptable examples (select “No”):
  - “Consider starting statins in a.m.”
  - “May add Zocor when pt. can tolerate.”
- Reasons do NOT need to be documented at discharge or otherwise linked to the discharge timeframe: Documentation of reasons anytime during the hospital stay are acceptable (e.g., mid-hospitalization note stating “no statin medications due to abnormal liver enzymes” - select “Yes,” even if documentation indicates that the liver enzyme levels normalized by the time of discharge and the lipid-lowering medication was restarted).
- Crossing out of a statin medication counts as a "clearly implied reason" for not prescribing statin medication at discharge only if on a pre-printed form.
- Statin medications may also be referred to as HMG CoA reductase inhibitors

- When the current record includes documentation of a pre-arrival reason for no statin medication, the following counts regardless of whether this documentation is included in a pre-arrival record made part of the current record or whether it is noted by hospital staff during the current hospital stay:
  - Pre-arrival statin medication allergy.
  - Pre-arrival hold/discontinuation or notation such as "No stain medications" IF the underlying reason/problem is also noted (e.g., “Lipitor discontinued in transferring hospital secondary to severe diarrhea”).
  - Pre-arrival "other reason" (other than hold/discontinuation or notation of "No statin medications") (e.g., "Hx muscle soreness to statins in past" in transferring ED record).

Suggested Data Sources:
- Consultation notes
- Discharge summary
- Emergency Department record
- History and physical
- Medication administration record
- Medication reconciliation form
- Physician orders
- Progress Notes

Excluded Data Sources:
Any documentation dated/timed after discharge, except discharge summary.

Inclusion Guidelines for Abstraction:
Examples:
- Hepatic failure

- Hepatitis
- Myalgias
- Patient/family refusal
- Rhabdomyolysis

Refer to Appendix C, Table 8.1 for a comprehensive list of Statin Medications.

Exclusion Guidelines for Abstraction:
Statin medication allergy described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table.

Data Element Name: *Reason for Oral Factor Xa Inhibitor*

Collected For: CMS/The Joint Commission: STK-1, VTE-1

Definition: Documentation why Oral Factor Xa Inhibitor was administered for VTE prophylaxis.

Suggested Data Collection Question: Is there physician/APN/PA documentation why Oral Factor Xa Inhibitor was administered for VTE prophylaxis?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is physician/APN/PA documentation why Oral Factor Xa Inhibitor was administered for VTE Prophylaxis.
N (No)	There is no physician/APN/PA documentation why Oral Factor Xa Inhibitor was administered for VTE Prophylaxis, OR unable to determine from the medical record documentation.

Notes for Abstraction:

- **Only acceptable reasons identified in the list of inclusions. No other reasons will be accepted**.
- History of atrial fibrillation/flutter or current finding of atrial fibrillation/flutter, select "Yes."
- History of hip or knee replacement surgery, select "Yes."
- When conflicting information is documented in the medical record, select "Yes."
- History of treatment for venous thromboembolism or current treatment for venous thromboembolism, select "Yes."

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY IN THE FOLLOWING ONLY ACCEPTABLE SOURCES:

- Anesthesia record
- Consultation notes
- Emergency Department record
- History and physical
- Operative Note
- Physician orders
- Progress notes
- Risk assessment form
- Transfer sheet

Inclusion Guidelines for Abstraction: This list is all inclusive

- AF
- A-fib
- Atrial fibrillation
- Atrial flutter
- Persistent atrial fibrillation
- Paroxysmal atrial fibrillation
- PAF
- History of any remote episode of documented atrial fibrillation or flutter except within 8 weeks following CABG
- *ICD-9-CM Principal/Other Diagnosis Code* of 427.31 or 427.32
- Total hip arthroplasty
- Partial hip arthroplasty
- Total hip replacement
- Partial hip replacement
- THR
- Total knee arthroplasty
- Total knee replacement
- TKR
- *ICD-9-CM Other Procedure Codes* of 81.51, 81.52, 81.53, 81.54 or 81.55
- Treatment of venous thromboembolism

Exclusion Guidelines for Abstraction:

- Hip fracture
- History of atrial fibrillation or flutter that terminated within 8 weeks following CABG
- History of transient and entirely reversible episode of documented atrial fibrillation or flutter due to thyrotoxicosis
- PAC
- Paroxysmal atrial tachycardia
- Paroxysmal supraventricular tachycardia
- PAT
- Premature atrial contraction
- PST

Data Element Name: *Reason for Oral Factor Xa Inhibitor- ICU Admission*

Collected For: CMS/The Joint Commission: VTE-2

Definition: Documentation why Oral Factor Xa Inhibitor was administered for ICU VTE prophylaxis.

Suggested Data Collection Question: Is there physician/APN/PA documentation why Oral Factor Xa Inhibitor was administered for ICU VTE prophylaxis?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is physician/APN/PA documentation why Oral Factor Xa Inhibitor was administered for ICU VTE Prophylaxis.
N (No)	There is no physician/APN/PA documentation why Oral Factor Xa Inhibitor was administered for ICU VTE Prophylaxis, OR unable to determine from the medical record documentation.

Notes for Abstraction:

- **Only acceptable reasons identified in the list of inclusions. No other reasons will be accepted**.
- History of atrial fibrillation/flutter or current finding of atrial fibrillation/flutter, select "Yes."
- History of hip or knee replacement surgery, select "Yes."
- When conflicting information is documented in the medical record, select "Yes."
- History of treatment for venous thromboembolism or current treatment for venous thromboembolism, select "Yes."

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY IN THE FOLLOWING ONLY ACCEPTABLE SOURCES:

- Anesthesia record
- Consultation notes
- Emergency Department record
- History and physical
- ICU Flowsheet
- Physician orders
- Progress notes
- Risk assessment form
- Transfer sheet

Inclusion Guidelines for Abstraction: This list is all inclusive

- AF
- A-fib
- Atrial fibrillation
- Atrial flutter
- History of any remote episode of documented atrial fibrillation or flutter except within 8 weeks following CABG
- *ICD-9-CM Other Procedure Code* of 81.51, 81.52, 81.53, 81.54 or 81.55
- *ICD-9-CM Principal/Other Diagnosis Code* of 427.31 or 427.32
- PAF
- Paroxysmal atrial fibrillation
- Partial hip arthroplasty
- Partial hip replacement
- Persistent atrial fibrillation
- THR
- TKR
- Total hip arthroplasty
- Total hip replacement
- Total knee arthroplasty
- Total knee replacement
- Treatment of venous thromboembolism

Exclusion Guidelines for Abstraction:

- Hip fracture
- History of atrial fibrillation or flutter that terminated within 8 weeks following CABG
- History of transient and entirely reversible episode of documented atrial fibrillation or flutter due to thyrotoxicosis
- PAC
- Paroxysmal atrial tachycardia
- Paroxysmal supraventricular tachycardia
- PAT
- Premature atrial contraction
- PST

Data Element Name: *Reasons for Continuing Urinary Catheterization*

Collected For: CMS/The Joint Commission: SCIP-Inf-9

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

Suggested Data Collection Question: Was there documentation of reason(s) for not removing the urinary catheter postoperatively?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1-2

Allowable Values:

Select all that apply:

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

2 There is physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation of reasons for not removing the urinary catheter postoperatively.

3 There is no physician/APN/PA documentation of reasons for not removing the urinary catheter postoperatively or unable to determine from medical record documentation.

Notes for Abstraction:

- Value "1" does not require physician/APN/PA documentation. If the patient is in the intensive care unit (ICU) on POD 1 or POD 2 **AND** it is documented that the patient received even one dose of diuretics OR vasopressors/inotropics OR paralytics, select value "1."
- If no diuretic OR vasopressor/inotropic OR paralytic is being administered for a patient in the ICU, but there is physician/APN/PA documentation on POD 1 or POD 2 of a reason for not removing the urinary catheter, select value "2."
- The Medication Administration Record (MAR) can be used to determine whether the patient in the ICU is receiving a diuretic OR vasopressor/inotropic OR paralytic. There must be documentation of administration, not just a physician order for diuretics OR vasopressors/inotropics OR paralytics.
- To select value "2," there must be physician/APN/PA documentation of reasons for not removing the urinary catheter. A physician order to leave the catheter in place is not sufficient documentation of reasons for not removing the urinary

catheter. There must be documentation such as “Continue catheter. Patient is on total bed rest.”

- The documentation of reasons for not removing the urinary catheter must be found on POD 1 or POD 2.
- To select value “2,” there must be documentation of a reason or plan to continue the urinary catheter. An order to keep the catheter, alone, is not sufficient.
  Example:
  “Keep catheter.” The intent is that the physician will evaluate the patient on POD 1 and POD 2 and document regarding the necessity for continuing the catheter such as, a physician order to keep the catheter for a specific reason or timeframe.
  Examples: “Continue catheter due to total bed rest.” or “Maintain foley until morning of discharge.” or “DC foley in AM at 0900.” (If “in AM” refers to beyond POD 2.)
- To select value “2,” based on a medical staff-approved facility protocol, there must be physician documentation on POD 0, POD 1, or POD 2 ordering or instructing the nursing staff to follow the formal urinary catheter protocol ***AND*** there must be documentation on POD 1 or POD 2 of a reason to continue urinary catheterization contained in the protocol found in the medical record. The reason may be documented by a nurse in this situation.
- Patient refusal to have a catheter removed does not have to be documented by a physician/APN/PA, but must be documented on POD 1 or POD 2. If there is documentation on POD 1 or 2, that the patient refuses to have the catheter removed, or if there is a patient request to leave the catheter, select value “2.”
- If value “3” is selected, no other selections should be recorded. No value should be selected more than once.

Suggested Data Sources:
Allowable Value 1:

- ICU flow sheet
- Medication Administration Record
- Nurses notes
- Progress notes

Allowable Value 2:
PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Medical staff-approved facility urinary catheter protocol
- Operative report
- Physician orders
- Progress notes

Inclusion Guidelines for Abstraction:
ICU synonyms:

- Burn intensive care unit (BICU)
- Coronary care unit (CCU, CICU)
- Intensive care unit (ICU)
- Medical intensive care unit (MICU, MCU)

- Respiratory intensive care unit (RICU, RCU)
- Surgical intensive care unit (SCU, SICU)

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

Exclusion Guidelines for Abstraction:

- ED, OR, PACU or Inpatient acute care/surgical care units
- Intermediate care units (IMCU)
- High risk of falls
- Long term acute care units
- Post coronary care units (PCCU)
- Risk of falls – Any ICU synonyms
- Specialty care units not specified as intensive care units
- Step-down units
- Telemetry units not specified as intensive care units

Data Element Name: *Reasons to Extend Antibiotics*

Collected For: CMS/The Joint Commission: SCIP-Inf-3

Definition: The reason for extending the postoperative duration of antibiotic administration.

Suggested Data Collection Question: What reason was documented by a physician/APN/PA for extending the duration of the antibiotic administration past 24 hours (48 hours for CABG or Other Cardiac Surgery) after *Anesthesia End Time*?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1-3

Allowable Values:

Select all that apply:

1 There is physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation that the patient had an infection postoperatively following the principal procedure.

2 The principal procedure was a lower extremity original or revision arthroplasty and there is physician/APN/PA documentation of a current benign or malignant bone tumor of the operative extremity.

3 There is physician/APN/PA documentation of any of (and only) the following reasons to extend antibiotics:

- Erythromycin was administered postoperatively for the purpose of increasing gastric motility.
- An antibiotic was administered postoperatively for the treatment of hepatic encephalopathy.
- An antibiotic was administered postoperatively for the treatment of pulmonary fibrosis.
- An antibiotic was administered postoperatively as prophylaxis of *Pneumocystis pneumonia (PCP).*
- Demeclocycline was administered postoperatively for the treatment of syndrome of inappropriate antidiuretic hormone hypersecretion (SIADH) or hyponatremia.
- An antibiotic was administered postoperatively for the treatment of acne or rosacea.

4 No documented reason/Unable to Determine.

Notes for Abstraction:

- If a value of “4” is selected, no other selections should be recorded.

For Value 1:

- If documentation of an infection occurs more than 2 days (3 days for CABG or Other Cardiac Surgery) after *Anesthesia End Date* DO NOT abstract value "1."
- There must be documentation of a current infection or current possible/suspected infection.
- Documentation of symptoms (example: fever, elevated white blood cells, wound condition, etc.) should not be considered infections unless documented as a current infection or current possible/suspected infection.

Note: Do NOT use Table 5.09 as a reference for identifying infections. This data element has an inclusion list to use as a guideline that provides the types of infection that are acceptable. Please reference this inclusion list when answering this data element.

For Value 2:

- Documentation of a current bone tumor can be found preoperatively or postoperatively.
- Documentation of a current bone tumor of the lower extremity includes but is not limited to the examples listed in the inclusion list.
- The lower extremity includes the hip, knee and foot joints.

For Value 3:

- Documentation of these reasons can be found preoperatively or postoperatively.
- The physician/APN/PA documentation must include reasons that that are specific to the conditions in value "3."
- Documentation of other terms for "increasing gastric motility" may include but is not limited to: treatment of gastroparesis, treatment of delayed gastric emptying, postoperative ileus, decreased gastric motility or a prokinetic effect.
- Please reference Table 2.1 Antimicrobial Medications for the names of medications that are erythromycin.
- Documentation of *Pneumocystis pneumonia* can include but is not limited to: *pneumocystis carinii pneumonia* or PCP in a patient with a diagnosis of AIDS.
- *Pneumocystis pneumonia* may be referred to as PCP or *pneumocystis carinii pneumonia* or *pneumocystis jiroveci pneumonia*.
- Please reference Table 2.1 Antimicrobial Medications for the names of medications that are demeclocycline.

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Anesthesia record
- Consultation notes
- Discharge summary
- Operative Report
- Physician order forms
- Progress notes

Excluded Data Sources:
For Value 1:

- Any postoperative documentation of infection from pathology reports
- Any preoperative documentation

Inclusion Guidelines for Abstraction:
For Value 1:

- Abscess
- Acute abdomen
- Aspiration pneumonia
- Bloodstream infection
- Bone infection
- Cellulitis
- Chronic Obstructive Pulmonary Disease (COPD)
- Crohn's Disease
- Endometritis
- Fecal Contamination
- Free air in abdomen
- Gangrene
- *H. pylori*
- Necrosis
- Necrotic/ischemic/infarcted bowel
- Osteomyelitis
- Other documented infection
- Penetrating abdominal trauma
- Perforation of bowel
- Pneumonia or other lung infection
- Purulence/pus
- Sepsis
- Surgical site or wound infection
- Systemic Inflammatory Response Syndrome (SIRS)
- Ulcerative colitis
- Urinary tract infection (UTI)

For Value 2: Current benign or malignant bone tumors may be represented by the following documentation:

- Bony tumor of lower operative extremity
- Sarcoma of lower operative extremity
- Primary malignancy of lower operative extremity
- Metastatic malignancy of lower operative extremity

Exclusion Guidelines for Abstraction:
For Value 1:

- Avascular necrosis
- Bacteria in urine (Bacteriuria)
- "carditis" (such as pericarditis) without mention of an infection

- Colonization or positive screens for MRSA, VRE, or for other bacteria
- Fistulas without documentation of abscess or fecal contamination
- Fungal infections
- History of infection, recent infection or recurrent infection not documented as a current or active infection
- Orders for tests or screens without documentation of an infection or suspected infection
- Viral infections

Data Element Name: *Referral for Addictions Treatment*

Collected For: The Joint Commission Only: SUB-3; **CMS Informational Only:** SUB-3

Definition: Documentation that a referral was made at discharge for addictions treatment by a physician or non-physician (such as nurse, psychologist, or counselor). A referral may be defined as an appointment made by the provider either through telephone contact, fax or e-mail. The referral may be to an addictions treatment program, to a mental health program or mental health specialist for follow-up for substance use or addiction treatment, or to a medical or health professional for follow-up for substance use or addiction.

Suggested Data Collection Question: Was a referral for addictions treatment made for the patient prior to discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The referral to addictions treatment was made by the healthcare provider prior to discharge.

2 Referral information was given to the patient at discharge but the appointment was not made by the provider prior to discharge.

3 The patient refused the referral for addictions treatment and the referral was not made.

4 The referral for addictions treatment was not offered because the patient's residence is not in the USA.

5 The referral for addictions treatment was not offered at discharge or unable to determine from the medical record documentation.

Notes for Abstraction

A referral to Alcoholics Anonymous (AA) or similar mutual support groups does not meet the intent of the measure, select value "3" if such a referral is given to the patient.

Suggested Data Sources:

- Discharge instruction sheet
- Discharge summary
- Nursing discharge notes
- Physician order sheet

- Transfer sheet

Inclusion Guidelines for Abstraction:
- Group counseling
- Individual counseling
  - Addictions counselor
  - Personal physician
  - Psychiatrist
  - Psychologist

Exclusion Guidelines for Abstraction:
- Self-help interventions (brochures, videotapes, audiotapes, reactive hotlines/help lines)
- Support groups that are not considered treatment such as Alcoholics Anonymous (AA)

Data Element Name: *Referral for Outpatient Tobacco Cessation Counseling*

Collected For: The Joint Commission Only: TOB-3, TOB-4; **CMS Informational Only:** TOB-3, TOB-4

Definition: Documentation that a referral was made at discharge for ongoing evidence-based counseling with clinicians (physician or non-physician such as nurse, psychologist, counselor). Outpatient counseling may include proactive telephone counseling, group counseling, individual counseling and/or e-health and internet intervention. A counseling referral may be defined as an appointment made by the healthcare provider or hospital either through telephone contact, fax or e-mail. For quitline referrals, the healthcare provider or hospital can either fax or e-mail a quitline referral or assist the patient in directly calling the quitline prior to discharge.

Suggested Data Collection Question: Did the patient receive a referral for Outpatient Tobacco Cessation Counseling?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The referral to outpatient tobacco cessation counseling treatment was made by the healthcare provider prior to discharge.

2 Referral information was given to the patient at discharge but the appointment was not made by the provider prior to discharge.

3 The patient refused the referral for outpatient tobacco cessation counseling treatment and the referral was not made.

4 The referral for outpatient tobacco cessation counseling treatment was not offered because the patient's residence is not in the USA.

5 The referral for outpatient tobacco cessation counseling treatment was not offered at discharge or unable to determine from the medical record documentation.

Notes for Abstraction

- 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 is provided with contact information for e-health or internet smoking cessation programs which tailor program content to the tobacco user's needs (collect information from the tobacco user and use 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 it cannot be determined if a referral for outpatient cessation counseling was made or if it is unclear if the absence of the referral was due to a patient refusal or it simply was not offered.

Suggested Data Sources:

- Discharge instruction sheet
- Discharge summary
- Nursing discharge notes
- Physician order sheet
- Transfer sheet

Inclusion Guidelines for Abstraction:

- Group counseling
- E-health
- Individual counseling
- Internet structured programs
- Quitline

Exclusion Guidelines for Abstraction:

Self-help interventions (brochures, videotapes, audiotapes)

Data Element Name: *Relievers Administered*

Collected For: The Joint Commission Only: CAC-1

Definition: Documentation that the patient received reliever medication(s) for asthma exacerbation during this hospitalization. Inpatient hospitalization includes the time from arrival to the emergency department (ED) or observation area until discharge from the inpatient setting.

Relievers are medications that relax the bands of muscle surrounding the airways and are used to quickly alleviate bronchoconstriction and prevent exercise-induced bronchospasm.

Suggested Data Collection Question: Did the patient receive a reliever medication(s) during this hospitalization?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	The patient received a reliever medication(s) during this hospitalization.
N (No)	The patient did not receive a reliever medication(s) during this hospitalization or unable to determine from the medical record documentation.

Notes for Abstraction:

- For the purposes of the CAC measures, inpatient hospitalization includes the time of arrival to the emergency department (ED) or observation area until discharge from the inpatient setting.
- For reliever medication(s) administered in the Emergency Department observation area which was given prior to the inpatient admission, select "Yes."
- "Reliever Not Specified (NOS)" can be used to answer "Yes" to this question in the following situations:
  - For new relievers that are not yet listed in Table 6.2.
  - When there is documentation that a reliever was administered but unable to identify the name. It must be apparent that the medication is a reliever. Example:
    On 2-12-20xx, the ED record contains the documentation, "Reliever started *name illegible,* 2.5 ml, PO, 0200-JM." In the reliever grid, "Reliever NOS" would be entered for the name, PO for the route, 0200 for the time and 2-12-20xx for the date. (If "Reliever started" had not been

documented in this example, the medication could not be abstracted as *Relievers Administered*.)

Suggested Data Sources:

- Emergency Department record
- Medication administration record (MAR)
- Nursing flow sheet
- Nursing notes

Inclusion Guidelines for Abstraction:

Refer to Appendix C, Table 6.2 for a comprehensive list of Reliever Medications.

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Sample*

Collected For: CMS/The Joint Commission: All Records (Used in transmission of The Joint Commission's aggregate data file and the Hospital Clinical Data file.)

Notes:
- Required for transmission of individual case data to the QIO Clinical Warehouse. Refer to the Hospital Clinical Data XML File Layout in the Transmission section of this manual.
- Required for transmission of aggregate data to The Joint Commission. Refer to the ORYX Technical Implementation Guide for more information.

Definition: Indicates if the data being transmitted for a hospital has been sampled, or represent an entire population for the specified time period.

Suggested Data Collection Question: Does this case represent part of a sample?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	The data represents part of a sample.
N (No)	The data is not part of a sample; this indicates the hospital is performing 100 percent of the discharges eligible for this measure set.

Notes for Abstraction:
When *Sampling Frequency* equals "3" (No, the hospital is not sampling) or "4" (N/A, submission of patient level data is not required), then abstract *Sample* as "No."

Suggested Data Sources:
Not Applicable

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Sex*

Collected For: CMS/The Joint Commission: All Records; **Used in Algorithms For: CMS/The Joint Commission:** SCIP-Card-2

Definition: The patient's documented sex on arrival at the hospital.

Suggested Data Collection Question: What was the patient's sex on arrival?

Format:

Length: 1
Type: Character
Occurs: 1

Allowable Values:

M = Male
F = Female
U = Unknown

Notes for Abstraction:

- Collect the documented patient's sex at admission or the first documentation after arrival.
- Consider the sex to be unable to be determined and select "Unknown" if:
  - The patient refuses to provide their sex.
  - Documentation is contradictory.
  - Documentation indicates the patient is a Transexual.
  - Documentation indicates the patient is a Hermaphrodite.

Suggested Data Sources:

- Consultation notes
- Emergency Department record
- Face sheet
- History and physical
- Nursing admission notes
- Progress notes
- UB-04, Field Location: 11

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Statin Medication Prescribed at Discharge*

Collected For: CMS/The Joint Commission: STK-6; **The Joint Commission Only:** AMI-10; **CMS Voluntary Only:** AMI-10

Definition: Documentation that a statin medication was prescribed at hospital discharge. Statins are a class of pharmaceutical agents that modify LDL cholesterol by blocking the action of an enzyme in the liver which is needed to synthesize cholesterol thereby decreasing the level of cholesterol circulating in the blood.

Suggested Data Collection Question: Was a statin medication prescribed at discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Statin medication prescribed at discharge.
N (No)	Statin medication not prescribed at discharge OR unable to determine from medical record documentation.

Notes for Abstraction:

- In determining whether a statin medication was prescribed at discharge, it is not uncommon to see conflicting documentation amongst different medical record sources. For example, the discharge summary may list a statin medication that is not included in any of the other discharge medication sources (e.g., discharge orders). All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
  - In cases where there is a statin medication in one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select "Yes") unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge - **Consider it a discharge medication in the absence of contradictory documentation.**
  - If documentation is contradictory (e.g., physician noted “d/c lovastatin” in the discharge orders, but lovastatin is listed in the discharge summary’s discharge medication list), or after careful examination of circumstances, context, timing, etc, documentation raises enough questions, the case should be deemed "unable to determine" (select "No").
  - Consider documentation of a hold on a statin medication after discharge in one location and a listing of that statin medication as a discharge medication in another location as contradictory ONLY if the timeframe on the hold is not **defined** (e.g., “Hold lovastatin”). Examples of a hold with a

defined timeframe include “Hold Vytorin x2 days” and “Hold lovastatin until ALT/AST normalize.”

- If a statin medication is NOT listed as a discharge medication, and there is only documentation of a hold or plan to delay initiation/restarting of a statin medication after discharge (e.g., “Hold Vytorin x2 days,” “Start statins as outpatient,” “Hold lovastatin”), select “No.”
- If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc.
  Examples:
  - Two discharge summaries, one dictated 5/22 (day of discharge) and one dictated 5/27 - Use the 5/27 discharge summary.
  - Two discharge medication reconciliation forms, one not dated and one dated 4/24 (day of discharge) - Use both.

- Disregard a statin medication documented only as a recommended medication for discharge (e.g., “Recommend sending patient home on lovastatin”). Documentation must be more clear that a statin was actually prescribed at discharge.
- Disregard documentation of statin prescribed at discharge when noted only by medication class (e.g., “Statin Prescribed at Discharge: Yes” on a core measures form). The statin must be listed by name.

Suggested Data Sources:

- Consultation notes
- Discharge summary
- Medication reconciliation form
- Physician orders
- Progress notes

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

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Surgery End Date*

Collected For: CMS/The Joint Commission: VTE-1

Definition: The date the surgical procedure ended after hospital admission.

Suggested Data Collection Question: On what date did the surgical procedure end after hospital admission?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- Select "UTD" if unable to determine the surgical end date.
- If a patient leaves the operating room with an open incision (for closure at a later date/time), use the *Surgery End Date* of the initial procedure. Do NOT use the date the patient returns to the OR for closure.
- When the date documented is obviously invalid (not a valid format/range), e.g., a date after the *Discharge Date*, before the *Surgery End Date*, or in an invalid format (12-**39**-20xx) **and if** no other documentation is found that provides the correct information, the abstractor should select "UTD."
  Example:
  Patient expires on 02-12-20xx and documentation indicates the *Surgery End Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *Surgery End Date* is outside of the parmeter for care (after the *Discharge Date* [death]), the abstractor should select "UTD."
- If the *Surgery End Date* is incorrect (in error) but it is a valid date and the correct date can be found and supported with other documentation in the medical record, use the correct date for *Surgery End Date.* If supporting documentation of the correct date cannot be found, the medical record must be abstracted as documented (at "face value.")
  Examples:
  - The anesthesia form is dated 12-10-2007 and other documentation in the medical record supports that the correct date was 12-10-2009; use the correct date as the *Surgery End Date.*
  - A *Surgery End Date* of 11-20-20xx and the *Anesthesia Start Date* was 11-10-20xx and no other documentation can be found to support the correct

date for the *Surgery End Date*, then it must be abstracted as 11-20-20xx, at face value.

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

Suggested Data Sources:

- Anesthesia record
- Operating room notes
- Operative report

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Surgery End Date – ICU Admission*

Collected For: CMS/The Joint Commission: VTE-2

Definition: The date the surgical procedure ended after ICU admission or transfer.

Suggested Data Collection Question: On what date did the surgical procedure end after ICU admission or transfer?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- Select "UTD" if unable to determine the *Surgery End Date – ICU Admission*.
- Select the surgery end date with the associated surgical procedure performed the day of or the day after ICU admission or transfer.
- If a patient leaves the operating room with an open incision (for closure at a later date/time), use the *Surgery End Date - ICU Admission* of the initial procedure. Do NOT use the date the patient returns to the OR for closure.
- When the date documented is obviously invalid (not a valid format/range), e.g., a date after the *Discharge Date*, before the *Surgery End Date – ICU Admission*, or in an invalid format (12-**39**-20xx) **and if** no other documentation is found that provides the correct information, the abstractor should select "UTD."
  Example:
  Patient expires on 02-12-20xx and documentation indicates the *Surgery End Date – ICU Admission* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *Surgery End Date – ICU Admission* is outside of the parmeter for care (after the *Discharge Date* [death]), the abstractor should select "UTD."
- If the *Surgery End Date – ICU Admission* is incorrect (in error) but it is a valid date and the correct date can be found and supported with other documentation in the medical record, use the correct date for *Surgery End Date – ICU Admission.* If supporting documentation of the correct date cannot be found, the medical record must be abstracted as documented (at "face value").
  Examples:
  - The anesthesia form is dated 12-10-2007 and other documentation in the medical record supports that the correct date was 12-10-2009; use the correct date as the *Surgery End Date – ICU Admission.*

- o A *Surgery End Date – ICU Admission* of 11-20-20xx and the *Anesthesia Start Date* was 11-10-20xx and no other documentation can be found to support the correct date for the *Surgery End Date – ICU Admission*, then it must be abstracted as 11-20-20xx, at face value.

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

Suggested Data Sources:

- Anesthesia record
- Operating room notes
- Operative report

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Surgical Incision Date*

Collected For: CMS/The Joint Commission: SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3

Definition: The date the initial incision was made for the principal procedure.

Suggested Data Collection Question: On what date was the incision for the principal procedure made?

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- If the date that the incision was made is not specified, use surrounding documentation to determine the date the incision was made.
  Examples:
  - The *Anesthesia Start Date* is 03-16-20xx, the *Anesthesia Start Time* is 0800, the *Surgical Incision Time* is 0810. Use 03-16-20xx as the *Surgical Incision Date* because it is clear by using data from the surrounding documentation that the date of incision was the same date as the anesthesia started.
  - The *Anesthesia Start Date* is 05-08-20xx, the *Anesthesia Start Time* is 2355, the *Surgical Incision Time* is 0010. Use 05-09-20xx as the *Surgical Incision Date* because it is obvious that the date would change if the incision was made after midnight.
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid time/format) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Example:
  Documentation indicates the *Surgical Incision Date* was 05-33-2010. No other documentation in the medical record provides a valid date. Since the *Surgical Incision date* is outside of the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD."
- If the date the surgical incision that was made cannot be determined from medical record documentation, select "UTD."

Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *Surgical Incision Date* allows the case to be accepted into the warehouse.

EXCEPTIONS:

A. **Cystoscopy:** If a patient has a cystoscopy after 00:00 (midnight) prior to the principal procedure during the same surgical episode, AND antibiotics were given prior to this procedure, use the start date for the cystoscopy. If no antibiotics were given prior to the start of the cystoscopy, use the date that the principal procedure began as the *Surgical Incision Date.*
Example:
Anesthesia start date and time is 01-01-20xx at 2300. Antibiotics are given at 2345. Cysto is started at 0015. Abstract the *Surgical Incision Date* as 01-02-20xx as it is clear that the date would change if the cysto was started after 00:00.

B. **Laparoscopy to Open:** If the first procedure is a laparoscopic procedure or a procedure performed with a scope (ex: colonoscopy) **AND** antibiotics were given prior to the first procedure and it is followed by an open procedure, abstract the start/begin date (or other synonym) that is documented for the first procedure.

If the procedure starts as a laparoscopic procedure or a procedure performed with a scope (ex: colonoscopy) **AND** antibiotics were NOT given prior to this procedure and it is followed by an open procedure, abstract the *Surgical Incision Date* that is documented for the open procedure.

C. **Multiple Procedures:** If multiple procedures occur during the **same surgical episode** and the incision for the principal procedure is not the first incision made, the S*urgical Incision Date* captured will be the date that the first incision occurs.

Suggested Data Sources:

- Anesthesia record
- Circulation record/ OR nurses record
- Operative report

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Surgical Incision Time*

Collected For: CMS/The Joint Commission: SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3

Definition: The time the initial incision was made for the principal procedure.

Suggested Data Collection Question: At what time was the initial incision made for the principal procedure?

Format:

Length: 5 - HH:MM (with or without colon) or UTD
Type: Time
Occurs: 1

Allowable Values:

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight - 00:00	Noon - 12:00
5:31 am - 05:31	5:31 pm - 17:31
11:59 am - 11:59	11:59 pm - 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *Anesthesia Start Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00 do not forget to change the *Anesthesia Start Date.*
Example:
Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:

- For times that include “seconds,” remove the seconds and record the time as is.
  Example:
  15:00:35 would be recorded as 15:00.
- Times designated as *Surgical Incision Time* or including the term incision time are to be taken as first priority terms.

- If the initial incision time is unable to be determined from medical record documentation, select "UTD."
- The medical record must be abstracted as documented (taken at "face value"). When the time documented is obviously in error (not a valid time/format) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Example:
  Documentation indicates the *Surgical Incision Time* was 3300. No other documentation in the medical record provides a valid time. Since the *Surgical Incision Time* is outside of the Allowable Values for "Hour," it is not a valid time and the abstractor should select "UTD."
  Note: Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *Surgical Incision Time* allows the case to be accepted into the warehouse.
- If the incision time is obviously an erroneous time and there is additional documentation of the correct time associated with the same priority term, the correct time should be abstracted.
  Example:
  The time to OR is documented correctly as 1400. There are two documents with incision times of 1115 and 1415. Both are associated with the term incision. Abstract the incision time as 1415.

EXCEPTIONS:

A. **Cystoscopy:** If a patient has a cystoscopy prior to the principal procedure, during the same surgical episode, AND antibiotics were given prior to this procedure, use the start/begin time (or other synonym) for the cystoscopy.

   If no antibiotics were given prior to the start of the cystoscopy, use the time that the principal procedure began as the *Surgical Incision Time.*

B. **Laparoscopy to Open:** If the first procedure is a laparoscopic procedure or a procedure performed with a scope (ex: colonoscopy) **AND** antibiotics were given prior to the first procedure and it is followed by an open procedure, abstract the start/begin time (or other synonym) that is documented for the first procedure.

   If the procedure starts as a laparoscopic procedure or as a procedure performed with a scope (ex: colonoscopy) **AND** antibiotics were NOT given prior to this procedure and it is followed by an open procedure, abstract the *Surgical Incision Time* that is documented for the open procedure.

C. **Multiple Procedures:** If multiple procedures occur during the **same surgical episode** and the incision for the principal procedure is not the first incision made, the *Surgical Incision Time* captured will be for the incision that occurs first and the *Anesthesia End Time* will be the end time that occurs last.

Suggested Data Sources:

- Anesthesia record

- Circulation record/ OR nurses record
- Operative report

Inclusion Guidelines for Abstraction:
NOTES:
- Follow the priority order within the Inclusion Lists below.
- Priority order applies to items in the inclusion tables, not to the source documents.
- The terms/synonyms in the priority lists are alphabetized, not prioritized.
- If multiple times are found, use earliest time among the highest priority.

First priority:
- ***Surgical Incision Time***
- Incision (with a time)
- Incision Began
- Incision Made
- Incision Start
- Incision Time

Second priority
- Surgery begin time
- Operation start time
- Procedure start time
- Start of surgery (SOS)
- Surgery start time
- Symbol or letters used on graph or grid to represent incision time

Third priority:
- Chest time
- Leg time
- Skin time
- Sternotomy time

Fourth priority:
- Anesthesia begin time
- Anesthesia start time
- Operating room start time

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Surgical Procedure*

Collected For: CMS/The Joint Commission: VTE-1

Definition: A surgical procedure was performed using general or neuraxial anesthesia the day of or the day after hospital admission.

Suggested Data Collection Question: Was a surgical procedure performed using general or neuraxial anesthesia the day of or the day after hospital admission?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that a surgical procedure was performed using general or neuraxial anesthesia the day of or the day after hospital admission.
N (No)	There is no documentation that a surgical procedure was performed using general or neuraxial anesthesia the day of or the day after hospital admission or unable to determine from medical record documentation.

Notes for Abstraction:
If unable to determine if the patient had a surgical procedure and/or whether general or neuraxial anesthesia was used from medical record documentation, select "No."

Suggested Data Sources:

- Anesthesia record
- Intraoperative record
- Operating room notes
- Operative report
- PACU/recovery room record
- Preop checklist
- Procedure note

Inclusion Guidelines for Abstraction:

- General Anesthesia
  - Endotracheal
  - Inhaled gases
  - Intravenous
  - Laryngeal mask airway or anesthesia (LMA)
  - Total Intravenous Anesthesia (TIVA)

- Neuraxial Anesthesia
  - Epidural block
  - Spinal anesthesia
  - Spinal block
  - Subarachnoid blocks

Exclusion Guidelines for Abstraction:

- Conscious sedation
- Deep sedation
- Local with sedation
- Local with stand-by
- Monitored anesthesia care (MAC)
- Peripheral nerve blocks
- Saddle block

Data Element Name: *Surgical Procedure - ICU Admission*

Collected For: CMS/The Joint Commission: VTE-2

Definition: A surgical procedure was performed using general or neuraxial anesthesia the day of or the day after ICU Admission or transfer.

Suggested Data Collection Question: Was a surgical procedure performed using general or neuraxial anesthesia the day of or the day after ICU admission or transfer?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that a surgical procedure was performed using general or neuraxial anesthesia the day of or the day after ICU Admission or Transfer.
N (No)	There is no documentation that a surgical procedure was performed using general or neuraxial anesthesia the day of or the day after ICU Admission or Transfer or unable to determine from medical record documentation.

Notes for Abstraction:
If unable to determine if the patient had a surgical procedure and/or whether general or neuraxial anesthesia was used from medical record documentation, select “No.”

Suggested Data Sources:

- Anesthesia record
- Intraoperative record
- Operating room notes
- Operative report
- PACU/recovery room record
- Preop checklist
- Procedure note

Inclusion Guidelines for Abstraction:

- General Anesthesia
  - Endotracheal
  - Inhaled gases
  - Intravenous
  - Laryngeal mask airway or anesthesia (LMA)
  - Total Intravenous Anesthesia (TIVA)

- Neuraxial Anesthesia
  - Epidural block
  - Spinal anesthesia
  - Spinal block
  - Subarachnoid blocks

Exclusion Guidelines for Abstraction:

- Conscious sedation
- Monitored anesthesia care (MAC)
- Local with sedation
- Local with stand-by
- Peripheral nerve blocks
- Saddle block
- Deep sedation

Data Element Name: *Systemic Corticosteroids Administered*

Collected For: The Joint Commission Only: CAC-2

Definition: Documentation that the patient received oral, IM, or intravenous (systemic) corticosteroids for asthma exacerbation during this inpatient hospitalization. Inpatient hospitalization includes the time from arrival to the emergency department (ED) or observation area until discharge from the inpatient setting.

Systemic corticosteroids (oral, IM, or intravenous corticosteroids) are recommended as short term or rescue medications to relieve bronchoconstriction rapidly, making them useful in gaining quick initial control of asthma and in treatment of moderate to severe asthma exacerbations.

Suggested Data Collection Question: Did the patient receive oral, IM, or intravenous corticosteroids during this hospitalization?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	The patient received oral, IM, or intravenous corticosteroids during this hospitalization.
N (No)	The patient did not receive oral, IM, or intravenous corticosteroids during this hospitalization or unable to determine from the medical record documentation.

Notes for Abstraction:

- For the purpose of the CAC measures, inpatient hospitalization includes the time of arrival to the emergency department (ED) or observation area until discharge from the inpatient setting.
- For systemic corticosteroids (oral, IM, or intravenous) administered in the Emergency Department/observation area which was given prior to the inpatient admission, select “Yes.”
- “Systemic Corticosteroid Not Specified (NOS)” can be used to answer “Yes” to this question in the following situations:
  - For new systemic corticosteroids that are not yet listed in Table 6.3.
  - When there is documentation that a systemic corticosteroid was administered but unable to identify the name. It must be apparent that the medication is a systemic corticosteroid.
    Example:
    On 2-12-20xx, the ED record contains the documentation, “Systemic corticosteroid started name illegible, 100 mg, IV, 0200-JM.” In the reliever

grid, “Systemic corticosteroid NOS” would be entered for the name, IV for the route, 0200 for the time and 2-12-20xx for the date. (If “Systemic corticosteroid started” had not been documented in this example, the medication could not be abstracted as *Systemic Corticosteroid Administered*.)

Suggested Data Sources:
- Emergency Department record
- Medication administration record (MAR)
- Nursing flow sheet
- Nursing notes

Inclusion Guidelines for Abstraction:
Include corticosteroids given:
PO/NG/PEG tube:
- Any kind of feeding tube, e.g., percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy, gastrostomy tube
- By mouth
- Gastric tube
- G-tube
- Jejunostomy
- J-tube
- Nasogastric tube
- PO
- P.O.

Intramuscular:
- IM

Intravenous:
- Bolus
- Infusion
- IV
- I.V.
- IV Piggyback (IVP)

Refer to Appendix C, Table 6.3 for a comprehensive list of oral, IM, or intravenous Systemic Corticosteroids.

Exclusion Guidelines for Abstraction:
- Inhalation
- Nasal sprays

Data Element Name: *Temperature*

Collected For: CMS Voluntary Only: SCIP-Inf-10

Definition: Documentation of active warming used intraoperatively **OR** at least one body temperature equal to or greater than 96.8° Fahrenheit/36° Celsius within the 30 minutes immediately prior to or the 15 minutes immediately after *Anesthesia End Time* is found in the medical record.

NOTE: For active warming, the timeframe for the intraoperative period is from *Anesthesia Start Time* through *Anesthesia End Time*.

Suggested Data Collection Question: Was there documentation of active warming used intraoperatively **OR** at least one body temperature equal to or greater than 96.8° Fahrenheit/36° Celsius within the 30 minutes immediately prior to or the 15 minutes immediately after *Anesthesia End Time* in the medical record?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1-2

Allowable Values:

Select all that apply:

1 Active warming was performed intraoperatively.

2 There is documentation of at least one body temperature greater than or equal to 96.8° Fahrenheit/36° Celsius within the 30 minutes immediately prior to or the 15 minutes immediately after *Anesthesia End Time.*

3 There is no documentation of Allowable Values 1 **AND** 2.

4 Unable to determine from the medical record documentation.

Notes for Abstraction:

- Active warming is limited to forced-air warming, conductive warming, warm-water garments, and resistive warming.
- Active warming can be performed at any time from *Anesthesia Start Time* through *Anesthesia End Time*. If the patient had a warming device on any time during the intraoperative period, select value “1.”The warming device can be placed prior to the *Anesthesia Start Time*, but should be documented as used during the intraoperative period.
- The temperature can be any temperature value recorded within the 30 minutes immediately prior to or the 15 minutes immediately after *Anesthesia End Time*.
- If the recorded temperature was not within the specified range but active warming with the specified modalities was used intraoperatively, select value “1.”

- If the recorded temperature was lower than the specified range AND no active warming was used, select value “3.”
- If active warming was performed intraoperatively AND there is documentation of at least one body temperature greater than or equal to 96.8° Fahrenheit/36° Celsius within the 30 minutes immediately prior to or the 15 minutes immediately after *Anesthesia End Time,* select values “1” and “2.”
- If values “3” or “4” are selected, no other value should be selected. No value should be selected more than once.
- Temperature values that need converting, such as axillary temperature values, should be converted **prior** to recording in the medical record for the purposes of abstraction.

Suggested Data Sources:
- Anesthesia record
- Operative note
- Operative record
- PACU/recovery room record
- Vital signs graphic record

Inclusion Guidelines for Abstraction:
Temperature:
- Axillary temperature
- Bladder probe
- Core temp
- Esophageal temperature
- Oral/PO/by mouth
- Rectal temp
- Rectally (R)
- Skin surface temperatures
- T/R
- Temporal artery temperatures
- Tympanic (tymp) temperature

Patient Warming Modalities:
- Conductive warming
- Forced air warming
- Resistive warming
- Warm water garments

Exclusion Guidelines for Abstraction:
Patient Warming Modalities:
- Airway heaters or humidifiers
- Blankets heated in a blanket warmer
- Blood and fluid warmers
- Body cavity lavage
- Passive heating systems (space blankets or caps)
- Radiant heat sources

Data Element Name: *Time Last Known Well*

Collected For: CMS/The Joint Commission: STK-4

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

Suggested Data Collection Question: At what time was the patient last known to be well or at his or her prior baseline state of health?

Format:

Length: 5 - HH-MM (with or without colon) or UTD
Type: Time
Occurs: 1

Allowable Values:

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight – 00:00	Noon – 12:00
5:31 am – 05:31	5:31 pm – 17:31
11:59 am – 11:59	11:59 p.m. – 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *Date Last Known Well* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00 do not forget to change the *Date Last Known Well.*
Example:
Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx.

Notes for Abstraction:

- For times that include “seconds,” remove the seconds and record the time as is.
  Example:
  15:00:35 would be recorded as 15:00

- If the time last known well is unable to be determined from medical record documentation, select “UTD.”
- The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid time) **and** no other documentation is found that provides this information, the abstractor should select “UTD.”
  Example:
  Documentation indicates the time last known well was 3300. No other documentation in the medical record provides a valid time. Since the time last known well is outside of the range listed in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD.”
  Note: Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for *Time Last Known Well* allows the case to be accepted into the warehouse.
- If the time last known well is documented as being a specific number of hours prior to arrival (e.g., felt left side go numb 2 hours ago) rather than a specific time, subtract that number from the time of ED arrival and enter that time as the time last known well.
- If the time last known well is noted to be a range of time prior to ED arrival (e.g., felt left side go numb 2-3 hours ago), assume the maximum time from the range (e.g., 3 hours), and subtract that number of hours from the time of arrival to compute the time last known well.
- If there are multiple times of last known well documented, use the time recorded according to the following hierarchy:
  1. Neurology
  2. Admitting physician
  3. Emergency department physician
  4. ED nursing notes
  5. EMS
- If multiple times of last known well are documented by the same provider, use the earliest time recorded by that provider.

Suggested Data Sources:
- Ambulance record
- Emergency Department records
- History and physical
- IV flow sheets
- Medication administration record
- Nursing flow sheets
- Progress notes
- Transfer sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Tobacco Use Status*

Collected For: The Joint Commission Only: All TOB Measures; **CMS Informational Only:** All TOB Measures

Definition: Documentation of the adult patient's tobacco use status within the past 30 days prior to the day of hospital admission. Tobacco use includes all forms of tobacco including cigarettes, smokeless tobacco products, pipe, and cigars. A tobacco use screen should identify the type of tobacco product used, the volume used, and the timeframe of use.

Suggested Data Collection Question: What is the patient's tobacco use status?

Format:

Length: 2
Type: Alphanumeric
Occurs: 1

Allowable Values:

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.

Notes for Abstraction

- If there is definitive documentation that the patient either currently uses tobacco products or is an ex-user that quit less than 30 days prior to arrival, select the appropriate allowable value for the type of product used, **regardless of whether or not there is conflicting documentation**.
- 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 allowable value “1” indicating the heaviest usage.
- If the medical record indicates the patient smokes cigarettes and the volume is not documented or is unknown, assume smoking at the heaviest level and select allowable value “1.”
- The tobacco use status screening timeframe must have occurred within the first three days of admission. The day after admission is defined as the first day.

Suggested Data Sources:

- Emergency Department record
- History and physical
- Nursing admission assessment
- Nursing admission notes
- Physician progress notes
- Respiratory therapy notes

Inclusion Guidelines for Abstraction:

- Chewing (spit) tobacco
- Dry snuff
- Moist snuff
- Plug tobacco
- Redman
- Smokeless tobacco
- Snus
- Twist

Exclusion Guidelines for Abstraction:

- E-cigarettes
- Hookah pipe
- Illegal drug use only (e.g., marijuana)

Data Element Name: *Tobacco Use Status Post Discharge - Counseling*

Collected For: The Joint Commission Only: TOB-4; **CMS Informational Only**: TOB-4

Definition: This data element is used to determine if the patient is attending the prescribed outpatient tobacco cessation counseling following discharge. Counseling can include any of the following: telephone-based counseling, in-person counseling, and/or group counseling. Follow up contact to determine post discharge status can be made with the patient anytime between the 15 to 30 day timeframe specified by the measure.

Suggested Data Collection Question: Is the patient attending outpatient tobacco cessation counseling post discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The patient is attending outpatient tobacco cessation counseling post discharge.

2 The patient is not attending outpatient tobacco cessation counseling post discharge.

3 The patient refused to provide information relative to post discharge counseling attendance.

4 Not documented or unable to determine from follow-up information.

Notes for Abstraction

- If the first counseling session has not occurred at the time of the post discharge follow-up contact and the patient intends to attend the scheduled appointment, select value “1.”
- If follow-up contact is made with the patient but no post discharge tobacco use status information is collected, select value “4” UTD.
- The counseling, medication and use status information must relate to the follow up contact date selected by the abstractor.

Suggested Data Sources:

- Medical Record documentation dated within the follow-up time frame
  - Patient specific follow-up forms
  - Other documentation as specified by the hospital

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Tobacco Use Status Post Discharge - Medication*

Collected For: The Joint Commission Only: TOB-4; **CMS Informational Only**: TOB-4

Definition: This data element is used to determine if the patient is taking the recommended tobacco cessation medication following discharge. Follow- up contact to determine post discharge status can be made with the patient anytime between the 15 to 30 day timeframe specified by the measure.

Suggested Data Collection Question: Is the patient taking the recommended cessation medication post discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The patient is taking the recommended tobacco cessation medication post discharge.

2 The patient is not taking the recommended tobacco cessation medication post discharge.

3 The patient refused to provide information relative to medication use post discharge.

4 Not documented or unable to determine from follow-up information.

Notes for Abstraction

- If the patient is not taking tobacco cessation medication because a prescription for the medication was not given to the patient prior to discharge, select value 2.
- If the patient is taking an over the counter tobacco cessation product not requiring a prescription, select value 1.
- If an over the counter tobacco cessation medication was listed on the discharge medication list and the patient is not taking the medication, select value 2.
- The counseling, medication and use status information must relate to the follow up contact date selected by the abstractor.

Suggested Data Sources:

- Medical Record documentation dated within the follow-up time frame
  - Patient specific follow-up forms
  - Other documentation as specified by the hospital

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Tobacco Use Status Post Discharge – Quit Status*

Collected For: The Joint Commission Only: TOB-4; **CMS Informational Only:** TOB-4

Definition: This data element is used to determine the patient's tobacco use status following discharge. Follow-up contact to determine post discharge status can be made with the patient anytime between the 15 to 30 day timeframe specified by the measure.

Suggested Data Collection Question: Has the patient quit using tobacco products post discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The patient has quit using tobacco products post discharge.

2 The patient has not quit using tobacco products post discharge.

3 The patient refused to provide information relative to use status at the follow up contact.

4 Not documented or unable to determine from follow-up information collected.

Notes for Abstraction

- If the patient has reduced the amount of tobacco products used but has not quit using, select value 2.
- If the patient has not used any tobacco products in the past 7 days prior to the time of follow-up contact, select value 1.
- If the patient has initiated a quit attempt but has been tobacco free for less than 7 days prior to the follow-up contact, select value 2.
- The counseling, medication and use status information must relate to the follow up contact date selected by the abstractor.

Suggested Data Sources:

- Medical Record documentation dated within the follow-up time frame
  - Patient specific follow-up forms
  - Other documentation as specified by the hospital

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Tobacco Use Treatment FDA-Approved Cessation Medication*

Collected For: The Joint Commission Only: TOB-2; **CMS Informational Only:** TOB-2

Definition: The FDA-approved tobacco cessation medications may be referenced in Appendix C on Table 9.1.

Suggested Data Collection Question: Did the patient receive one of the FDA-approved tobacco cessation medications during the first three days after admission?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The patient received one of the FDA-approved tobacco cessation medications during the first three days after admission.

2 The patient refused the FDA-approved tobacco cessation medications during the first three days after admission.

3 FDA-approved tobacco cessation medications were not offered to the patient during the first three days after admission or unable to determine from medical record documentation.

Notes for Abstraction

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

Suggested Data Sources:

- Medication administration record (MAR)
- Physician orders

Inclusion Guidelines for Abstraction:

Refer to Appendix C, Table 9.1 for the list of FDA-approved tobacco cessation medications

Exclusion Guidelines for Abstraction:

For Medication

- Light smokers (5 or less cigarettes per day)
- Pregnant smokers
- Smokeless tobacco user (chewing [spit] tobacco)

Data Element Name: *Tobacco Use Treatment Practical Counseling*

Collected For: The Joint Commission Only: TOB-2; **CMS Informational Only:** TOB-2

Definition: The components of practical counseling require interaction with the patient to address the following: recognizing danger situations, developing coping skills, and providing basic information about quitting.

Suggested Data Collection Question: Did the patient receive all of the components of practical counseling during the first three days after admission?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The patient received all components of practical counseling during the first three days after admission.

2 The patient refused/declined practical counseling during the first three days after admission.

3 Practical counseling was not offered to the patient during the first three days after admission or unable to determine if tobacco use treatment was provided from medical record documentation.

Notes for Abstraction

- 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.
- 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.).
- If there is not 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.
- The timeframe for receiving practical counseling must have occurred within the first three days of admission. The day after admission is defined as the first day.

Suggested Data Sources:

- Medication administration record (MAR)
- Nursing notes
- Physician progress notes
- Respiratory therapy notes

Inclusion Guidelines for Abstraction:
Referral to Quitline

Exclusion Guidelines for Abstraction:
Severe cognitive impairment

Data Element Name: *Transfer From Another Hospital or ASC*

Collected For: CMS/The Joint Commission: AMI-7a, AMI-8a; **CMS Only:** PN-6; **The Joint Commission Only:** AMI-7, AMI-8, PN-3a, PN-6a, PN-6b; **CMS Voluntary Only:** AMI-7, AMI-8, PN-3a

Definition: Documentation that the patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center (ASC).

Suggested Data Collection Question: Was the patient received as a transfer from an inpatient, outpatient or emergency/observation department of an outside hospital or from an ambulatory surgery center?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center.
N (No)	Patient was not received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center, or unable to determine from medical record documentation.

Notes for Abstraction:

- If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select "Yes." This applies even if the emergency department or observation unit is part of your hospital's system (e.g., your hospital's free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity.
- If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select "Yes." This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record.
- Select "**Yes**" in the following types of transfers:
  - Long term acute care (LTAC): Any LTAC hospital or unit (outside or inside your hospital)
  - Acute rehabilitation: Rehab unit in outside hospital, free-standing rehab hospital/facility/pavilion outside your hospital, OR rehab **hospital** inside your hospital
  - Psychiatric: Psych unit in outside hospital, free-standing psych hospital/facility/pavilion outside your hospital, OR psych **hospital** inside your hospital

- Cath lab, same day surgery, or other outpatient department of an outside hospital
- Disaster Medical Assistance Team (DMAT): Provides emergency medical assistance following catastrophic disaster or other major emergency

- Select "**No**" in the following types of transfers:
  - Urgent care center
  - Psych or rehab unit inside your hospital
  - Dialysis center (unless documented as an outpatient department of an outside hospital)
  - Same Day Surgery or other outpatient department inside your hospital
  - Clinic (outside or inside your hospital)
  - Hospice facility (outside or inside your hospital)
  - Skilled nursing facility (SNF) care: Any facility or unit (outside or inside your hospital) providing SNF level of care to patient
- If there is conflicting documentation in the record, and you are unable to determine whether or not the patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center, select "No" UNLESS there is supporting documentation for one setting over the other.
  Examples:
  - One source reports patient was transferred from an outside hospital's ED, another source reports patient was transferred in from an urgent care center. No additional documentation. Select "No."
  - One source states patient came from physician office, another source reports patient was transferred from an outside hospital's ED, and transfer records from the outside hospital's ED are included in the record. Select "Yes."
- If, in cases other than conflicting documentation, you are unable to determine whether or not the patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center, select "No." (E.g., "Transferred from Park Meadows" documented – Documentation is not clear whether Park Meadows is a hospital or not.)

Suggested Data Sources:

- Ambulance record
- Any DMAT documentation
- Emergency Department record
- Face sheet
- History and physical
- Nursing admission assessment
- Progress notes
- Transfer sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *UFH Therapy Administration*

Collected For: CMS/The Joint Commission: VTE-4

Definition: Unfractionated heparin (UFH) administered intravenously (IV).

Suggested Data Collection Question: Was IV UFH administered?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that IV UFH was administered.
N (No)	There is no documentation that IV UFH was administered or unable to determine from medical record documentation.

Notes for Abstraction:

- If patient had orders for UFH therapy, but no documentation of administration, select "No."
- If unable to determine route, select "No."
- Review heparin administration in proximity to this VTE event.

Suggested Data Sources:

- Ambulance record
- Emergency Department record
- Nursing notes
- Medication administration record
- Progress notes

Inclusion Guidelines for Abstraction:
Intravenous (IV) Unfractionated Heparin (UFH)

- HEP
- Heparin
- Heparin Na
- Heparin Sod
- Heparin Sodium

Exclusion Guidelines for Abstraction:
Route

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

Data Element Name: *Urinary Catheter*

Collected For: CMS/The Joint Commission: SCIP-Inf-9

Definition: There is documentation that a urinary catheter was placed during the specified timeframe and that it was still in place upon discharge from the recovery/post-anesthesia care area.

Suggested Data Collection Question: Is there documentation that a urinary catheter was placed during the specified timeframe and that it is still in place upon discharge from the recovery/post-anesthesia care area?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Yes	There is documentation that an indwelling urethral catheter was placed ***AND*** that one was still in place upon discharge from the recovery/post-anesthesia care area.
No	There is no documentation that an indwelling urethral catheter was placed ***AND/OR*** there is no documentation that one was still in place upon discharge from the recovery/post-anesthesia care area, or unable to determine from medical record documentation.

Notes for Abstraction:

- For the data element, *Urinary Catheter*, the specified timeframe is defined as from hospital arrival through discharge from the recovery/post-anesthesia care area.
- **For patients discharged from surgery and admitted to locations other than the PACU (e.g., ICU):** The specified timeframe ends a maximum of six hours after arrival to the recovery area.
- To select value “Yes,” there must be documentation of the insertion of an indwelling urethral catheter to determine that one was placed during the specified timeframe. If there is not documentation of the insertion of the catheter, do not select value “Yes.”
- For value “Yes,” to determine whether an indwelling catheter was still in place at discharge from the recovery area, there must be documentation within 24 hours after *Anesthesia End Time* that a catheter was still in place.
  Example:
  A catheter was placed in the operating room and notes in the PACU do not indicate whether or not the catheter was in place at discharge but later the nurses’ notes show that a catheter was present, that is sufficient documentation to show the catheter was still in place at discharge from the recovery area.

- If multiple indwelling urethral catheters are placed and removed prior to surgery and there is documentation that later an indwelling urethral catheter was placed during the specified timeframe AND that one was still in place at the time of discharge from the recovery/post-anesthesia care area, select value “Yes.”
- If the patient had a urinary diversion (Ex: urostomy, ileal conduit or suprapubic catheter) ***OR*** had an indwelling urethral urinary catheter ***OR*** was being intermittently catheterized prior to the specified timeframe select value “No.”

Suggested Data Sources:
- Graphic sheet (I & O)
- Intraoperative record
- Nurses notes
- Operative report
- PACU record

Inclusion Guidelines for Abstraction:
Indwelling urethral catheter

Intermittent:
None

Exclusion Guidelines for Abstraction:
- External catheter
- Texas catheter

Data Element Name: *Vancomycin*

Collected For: CMS/The Joint Commission: SCIP-Inf-2

Definition: Documented rationale for using vancomycin as antimicrobial prophylaxis.

Suggested Data Collection Question: What reason was documented for using vancomycin?

Format:

Length: 2
Type: Alphanumeric
Occurs: 1-10

Allowable Values:

Select all that apply:

1 Documentation of beta-lactam (penicillin or cephalosporin) allergy.

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

3 Documentation of patient being high-risk due to acute inpatient hospitalization within the last year.

4 Documentation of patient being high-risk due to nursing home or extended care facility setting within the last year, prior to admission.

5 Physician/APN/PA or pharmacist documentation of increased MRSA rate, either facility-wide or operation-specific.

6 Physician/APN/PA or pharmacist documentation of chronic wound care or dialysis.

7 Documentation of continuous inpatient stay more than 24 hours prior to the principal procedure.

8 Other physician/APN/PA or pharmacist documented reason.

9 No documented reason/Unable to Determine.

10 Physician/APN/PA or pharmacist documentation of patient undergoing valve surgery.

11 Documentation of patient being transferred from another inpatient hospitalization after a 3-day stay.

Notes for Abstraction:

- For this data element, documentation by an infection control practitioner is acceptable (in addition to physician/APN/PA or pharmacist documentation) if it is specifically designated as "infection control" documentation. An infection control practitioner may be a medical technician, nurse, physician/APN/PA, or pharmacist.
- Physician/APN/PA, pharmacist or infection control practitioner documentation of the reason for the use of *Vancomycin* as prophylaxis must have been entered into the medical record preoperatively to select values "5," "6," "8," and "10." If the documentation was not entered preoperatively, select value "9"- No documented reason/Unable to Determine.
- In order to select value "1," Documentation of beta-lactam (penicillin or cephalosporin) allergy, the answer to the data element *Antibiotic Allergy* must be "Yes."
- If the medical record contains preprinted orders (signed by a physician) prescribing vancomycin for all valve surgeries, select value "10."
- No value should be selected more than once. A maximum of 10 entries should be recorded. If a value of "9" is selected, no other selections should be recorded.

Suggested Data Sources:
WHERE SPECIFIED IN ALLOWABLE VALUES ABOVE, PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION ONLY IS ALLOWED.

- Anesthesia record
- Emergency Department record
- History and physical
- ICU flowsheet
- IV flowsheet
- Laboratory reports
- Medication administration record
- Nurses notes
- Operating room record
- PACU/recovery room record
- Physician's orders
- Progress notes

Inclusion Guidelines for Abstraction:
Hospitalization

- Acute inpatient
- Federal or VA facility
- Hospice- Acute facility
- Long-term care hospital
- Inpatient drug rehabilitation
- Inpatient rehabilitation unit or facility

Nursing Home or Extended Care Facility

- Hospice- Skilled/Respite
- Intermediate care facility (ICF)

- Respite care
- Skilled nursing facility (SNF) or SNF rehabilitation unit
- Sub-acute care
- Swing bed/unit
- Transitional care unit (TCU)

Exclusion Guidelines for Abstraction:

- Assisted Living
- Board and Care
- Group home/personal care homes
- Hospice at home
- Residential care
- Residential or outpatient chemical dependency treatment
- Psychiatric unit or facility

Data Element Name: *VTE Confirmed*

Collected For: CMS/The Joint Commission: VTE-3, VTE-4, VTE-5, VTE-6

Definition: Documentation by a physician/advanced practice nurse/physician assistant (physician/APN/PA) that a diagnosis of VTE [deep vein thrombosis (DVT) and/or pulmonary embolism (PE)] was confirmed in a defined location.

Suggested Data Collection Question: Is there documentation that the patient had a diagnosis of VTE confirmed in one of the defined locations?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that the patient had a diagnosis of VTE confirmed in one of the defined locations.
N (No)	There is no documentation that the patient had a diagnosis of VTE confirmed in one of the defined locations or unable to determine from medical record documentation.

Notes for Abstraction:

- This data element includes patients who are diagnosed with VTE on arrival or during hospitalization. For example: A patient may have documentation that VTE was confirmed on arrival or the patient may have been admitted without VTE, but there is documentation that the patient developed VTE after admission.
- If a patient had confirmed VTE in one of the defined locations, prior to hospitalization but was the reason for the admission, select “Yes.”
- If the patient was transferred from another acute care hospital, and there is no documentation related to the VTE location, select “No.”
- Recurrent VTE may be considered a VTE diagnosis if the patient has documentation of an “acute VTE.” For example: If a patient had a history of VTE, but diagnostic testing found a new VTE in the proximal vein of the lower extremity, select “Yes.”
- For tests that confirm a diagnosis of only “chronic” or “a history of VTE,” select “No.”
- If more than one diagnostic test was performed, select the earliest test that confirmed VTE in one of the defined locations.
- For patients with “low probability” or “inconclusive test results,” select “No.”
- For patients with a nuclear medicine VQ scan to rule-out PE; if the result was documented as “high probability,” select “Yes.” For all other impressions (e.g., “low probability,” “intermediate,” “intermediate to high probability” or “inconclusive test results”), select “No.”

- If there is conflicting information regarding whether the patient had VTE, select "No." For example, if the diagnostic test did not confirm VTE, but there is documentation of a DVT, select "No."
- If VTE is diagnosed in any veins within the defined locations, select "Yes." For example, documentation of a "non-occlusive thrombus to the right popliteal," select "Yes."
- Any documentation used other than radiology reports must reflect the time frame related to this hospitalization to select "Yes."
- Any documentation used other than radiology reports must have documentation that supports the clinician's confirmation of VTE.
  Example:
  Physician Notes: "Venous Doppler positive for DVT left popliteal" select "Yes."

Suggested Data Sources:
PHYSICIAN/APN/PA/ DOCUMENTATION ONLY
- Admission notes
- Consult notes
- Emergency Department record
- History and physical
- Physician notes
- Radiology report

Inclusion Guidelines for Abstraction:
THIS LIST IS ALL INCLUSIVE

VTE Location
VTE Confirmed is defined as DVT located in the proximal leg veins, including the inferior vena cava (IVC), iliac, femoral or popliteal veins, or to pulmonary emboli (PE). The data element does not apply to other sites of venous thrombosis unless a proximal leg DVT or PE are also involved.

Exclusion Guidelines for Abstraction:
Patients with VTE in the following areas:
- Intracranial venous thrombosis
- Isolated calf vein thrombosis
- Hepatic/portal/splenic/mesenteric thrombosis
- Not in the defined locations
- Ovarian vein thrombosis
- Renal vein thrombosis
- Upper extremity thrombosis

Data Element Name: *VTE Diagnostic Test*

Collected For: CMS/The Joint Commission: VTE-3, VTE-4, VTE-5, VTE-6

Definition: Documentation that a diagnostic test for VTE was performed.

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

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that a diagnostic test for VTE was performed.
N (No)	There is no documentation that a diagnostic test for VTE was performed or unable to determine from medical record documentation.

Notes for Abstraction:

- This data element includes patients who are diagnosed with VTE on arrival or during hospitalization. For example: A patient may have documentation that VTE was confirmed on arrival or the patient may have been admitted without VTE, but there is documentation that the patient developed VTE after admission.
- If the diagnostic test performed is related to this hospitalization, select "Yes." For example, if a patient arrives at the emergency department and a venous Doppler is performed on 12/1/xx, and admitted on 12/3/xx, select "Yes."
- Any documentation other than radiology reports must reflect the time frame related to this hospitalization to select "Yes."
- Any documentation used other than radiology reports must have documentation that supports the clinician's confirmation of VTE.
  Example:
  Physician Notes: "Venous Doppler positive for DVT left popliteal" select "Yes."
- If a diagnostic test for VTE was performed that is not on the inclusion list, select "No." For example: If an echo was done that confirmed a PE, select "No."

Suggested Data Sources:

- Admission notes
- Consult notes
- Emergency Department record
- History and physical
- Nursing notes

- Physician notes
- Radiology report

Inclusion Guidelines for Abstraction:
Diagnostic testing includes the following:
THIS LIST IS ALL INCLUSIVE

- Compression Ultrasound/Vascular Ultrasound/Duplex Ultrasound (DUS)/Venous Doppler
- Computed tomography (CT) of thorax (chest), abdomen/pelvis, or lower extremity leg veins with contrast
- Magnetic resonance imaging (MRI or MRV) of the thorax (chest), abdomen/pelvis, or lower extremity leg veins
- Nuclear Medicine Pulmonary Scan/ventilation/perfusion (V/Q) lung scan
- Pulmonary arteriography/angiography
- Venography/Venogram of pelvic, femoral and other lower extremity veins using contrast material

Exclusion Guidelines for Abstraction:

- Patients with VTE confirmation by only D-dimer tests
- Patients with VTE diagnosed by tests not listed

Data Element Name: *VTE Present at Admission*

Collected For: CMS/The Joint Commission: VTE-6

Definition: Documentation by a physician/advanced practice nurse/physician assistant (physician/APN/PA) that VTE was diagnosed or suspected on admission.

Suggested Data Collection Question: Was there any documentation by the physician/APN/PA that VTE was diagnosed or suspected on admission?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation by the physician/APN/PA that VTE was diagnosed or suspected on admission.
N (No)	There is no documentation by the physician/APN/PA that VTE was diagnosed or suspected on admission or unable to determine from medical record documentation.

Notes for Abstraction:

- The term "on admission" includes any documentation of a test to be performed to rule out VTE (pulmonary embolism or deep vein thrombosis) or diagnosis or suspicion of VTE written from arrival to admission date.
  Example:
  If a patient arrived on 10/1/20xx with documentation that a Pulmonary Emboli (PE) was suspected and a test was ordered to rule out PE, select "Yes."
- If documentation is insufficient or there is conflicting information regarding whether VTE was present or suspected at admission, select "No." Please refer to above bullet for sufficient documentation.
- *VTE Present at Admission* includes hospital or ICU admission depending on the earliest documentation or admission.
- For patients diagnosed with VTE prior to admission and already on treatment at admission, select "Yes."
- If the patient was admitted and has surgery on day of or day after hospital admission, and there was no documentation of diagnosed/suspected VTE prior to surgery, VTE is not considered present on admission. Select "No."
- Inclusion list is not all-inclusive.

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Consultation notes
- Emergency Department record

- History and physical
- Radiology report
- Observation notes
- Outpatient surgery notes
- Physician notes

Inclusion Guidelines for Abstraction

- DVT located in the proximal leg veins, including the inferior vena cava (IVC), iliac, femoral or popliteal veins.
- Pulmonary Embolism and Infarction
- Phlebitis and Thrombophlebitis of deep vessels of lower extremities - Femoral vein (deep)
- Phlebitis and Thrombophlebitis of iliac vein
- Venous embolism and thrombosis of deep vessels of proximal lower extremity

Exclusion Guidelines for Abstraction:

None

Data Element Name: *VTE Prophylaxis*

Collected For: CMS/The Joint Commission: SCIP-VTE-2, STK-1, VTE-1

Definition: The type of venous thromboembolism (VTE) prophylaxis documented in the medical record.

Suggested Data Collection Question: What type of VTE prophylaxis was documented in the medical record?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1-9

Allowable Values:

Select all that apply:

1	Low dose unfractionated heparin (LDUH)
2	Low molecular weight heparin (LMWH)
3	Intermittent pneumatic compression devices (IPC)
4	Graduated compression stockings (GCS)
5	Factor Xa Inhibitor
6	Warfarin
7	Venous foot pumps (VFP)
8	Oral Factor Xa Inhibitor
9	Aspirin
A	None of the above or not documented or unable to determine from medical record documentation

Notes for Abstraction:

ALL

- No value should be selected more than once. If a value of "A" is selected, no other selection should be recorded.
  Example:
  Lovenox is ordered and substituted with Fragmin. Only abstract value "2" once, as both are LMWH.
- Application of mechanical prophylaxis may be documented by any personnel.
  Example:

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

SCIP

- For the purposes of abstraction, mechanical VTE prophylaxis does not require a physician order to be abstracted; there is no order or copy of hospital protocol required. Abstract any form of mechanical VTE prophylaxis that is documented as ordered or as placed on the patient at any time from hospital arrival to 24 hours after *Anesthesia End Time.*
- Abstract any pharmacological VTE prophylaxis that was ordered/substituted at any time from hospital arrival to 24 hours after *Anesthesia End Time*. If one pharmacological medication is ordered and another medication is substituted (such as per pharmacy formulary substitution or protocol), abstract both medications for *VTE Prophylaxis* and for *VTE Timely*. Note: No copy of the formulary or protocol is required in the medical record.
  Examples:
  - Lovenox is ordered and not received and is substituted with Arixtra, which is received by the patient. Abstract Lovenox as value "2" for *VTE Prophylaxis* and "No" for *VTE Timely*. Abstract Arixtra as value "5" for *VTE Prophylaxis* and abstract *VTE Timely* accordingly.
  - Lovenox is ordered and not received; Heparin is ordered and is received. SCD's are placed. Abstract Lovenox as value "2" for *VTE Prophylaxis* and "No" for *VTE Timely*. Abstract Heparin as value "1" and SCD's as value "3" for *VTE Prophylaxis* and abstract *VTE Timely* accordingly.
- To select value”9,” there must be an order for aspirin for VTE prophylaxis. For hip and knee arthroplasties, aspirin must be received in the timeframe specified for *VTE Timely*.

VTE

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

STK

- Abstract the initial VTE prophylaxis(s) that was administered the day of or the day after hospital admission. If no VTE prophylaxis was administered during this timeframe, select A and check for a *Reason for No VTE Prophylaxis*.

VTE or STK

- Selection of allowable values 1-9 includes any prophylaxis that was initially administered on the same date.
  Example:
  If a patient was admitted on 12/8/20xx and had bilateral GCS applied at 13:00 on 12/08/20xx and LMWH was administered at 22:00 on 12/8/20xx, select values “2” and “4.”

- Only select prophylaxis if there is documentation that it was administered. Documentation in the physician progress notes under assessment/Plan: "DVT prophylaxis – IPC" is not enough to select value "3."
- If one pharmacological medication is ordered and another medication is substituted (such as per pharmacy formulary substitution or protocol), abstract the medication administered. Note: No copy of the formulary or protocol is required in the medical record.
  Example:
  Lovenox is ordered, but not received and is substituted with Arixtra, which is received by the patient. Abstract Arixtra as value "5" for *VTE Prophylaxis* and abstract the date is was administered for *VTE Prophylaxis Date*.
- Aspirin is not an approved medication for prophylaxis in the VTE and STK population. If aspirin is the only source of prophylaxis found in the record, select "A," and check for a *Reason for No VTE Prophylaxis.*

Suggested Data Sources:
SCIP
ONLY ACCEPTABLE SOURCE FOR
PHARMACOLOGIC PROPHYLAXIS:
Physician orders

MECHANICAL PROPHYLAXIS:
- Circulator notes
- Graphic/flow sheets
- Medication administration record
- Nursing notes
- Operative notes
- Physician notes
- Preoperative nursing notes
- Progress notes

STK or VTE
PHARMACOLOGICAL AND MECHANICAL
- Circulator notes
- Emergency Department record
- Graphic/flow sheets
- Medication administration record
- Nursing notes
- Operative notes
- Physician notes
- Preoperative nursing notes
- Progress notes

Inclusion Guidelines for Abstraction:
Refer to Appendix H, Table 2.1 VTE Prophylaxis Inclusion Table.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *VTE Prophylaxis Date*

Collected For: CMS/The Joint Commission: STK-1, VTE-1

Definition: The month, day, and year that the **initial** VTE prophylaxis (mechanical and/or pharmacologic) was administered **after hospital admission**.

Suggested Data Collection Question: What date was the initial VTE prophylaxis administered **after hospital admission**?

Format:

Length: 10 - MM-DD-YYYY (including dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (1-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:
STK or VTE
The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid date/format) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
Example:
Documentation indicates the *VTE Prophylaxis Date* was 03-**42**-20xx. No other documentation in the medical record provides a valid date. Since the *VTE Prophylaxis Date* is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD."

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

Suggested Data Sources:

- Consultation notes
- Emergency Department record
- History and physical
- Radiology report
- Observation notes
- Outpatient surgery notes
- Physician notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *VTE Prophylaxis Status*

Collected For: CMS/The Joint Commission: VTE-6

Definition: Documentation of VTE prophylaxis (mechanical and/or pharmacologic) administration between the hospital admission date and the day before the VTE diagnostic test order date.

Suggested Data Collection Question: Was VTE prophylaxis administered between the admission day and the day before the VTE diagnostic test order date?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 There is documentation that VTE prophylaxis was administered between the day of admission and the day before the VTE diagnostic test order date.

2 There is no documentation that VTE prophylaxis was administered between the day of admission and the day before the VTE diagnostic test order date or unable to determine from medical record documentation.

3 There is physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist documentation of a reason for not administering mechanical and pharmacological VTE prophylaxis during hospitalization.

Notes for Abstraction:

- To determine the value for this data element, the abstractor must locate the diagnostic test order date and then review the chart to ascertain if VTE prophylaxis was administered before the test was ordered. If any VTE prophylaxis was given within the specified timeframe, select value "1."
- The VTE diagnostic test order date is the date the order was written to determine whether the patient developed VTE during hospitalization, not the date the test was completed.
  Example:
  On 10/11/20xx a CT of the thorax is ordered, but not completed until 10/12/20xx. Use 10/11/20xx as the diagnostic test order date to determine if any prophylaxis was administered before that date.
- If more than one diagnostic test (from the inclusion list) was ordered to rule out VTE, and both confirmed VTE, select the first diagnostic test that confirmed VTE to determine if the patient received VTE prophylaxis.
  Example:

A doppler was ordered 11/1/20xx to rule out DVT, and another test was ordered on 11/5/20xx to rule out PE. Determine if any prophylaxis was administered anytime between the hospital admission date and before 11/1/20xx. If no prophylaxis was given, select value "2."

- For patients that have documentation that "No VTE prophylaxis--patient was at low risk for VTE," select value "2."
- To select value "3," there must be documentation of a reason for not administering BOTH mechanical and pharmacological prophylaxis. For example: If there is physician documentation of "No VTE Prophylaxis due to active bleeding and fractured femurs bilaterally," select value "3."
- The inclusion list of reasons is not all inclusive.
- Patient/family refusal of prophylaxis may be documented by a nurse. If the patient refused the prophylaxis that was ordered, select value "3."
- If the patient was on IV heparin between the hospital arrival date and the day before the VTE diagnostic test order date, select value "3."
- For patients receiving anticoagulant therapy other than warfarin for atrial fibrillation or other conditions, select "3."

Suggested Data Sources:
Allowable Values 1 or 2:

- Consultation notes
- Discharge summary
- Emergency Department record
- Medication administration record
- Nursing notes
- Progress notes

Allowable Value 3:
ONLY PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION OF A REASON FOR NOT ADMINISTERING <u>BOTH</u> MECHANICAL AND PHARMACOLOGIC VTE PROPHYLAXIS

- Anesthesia record
- Consultation notes
- Discharge summary
- History and physical
- Physician orders
- Physician progress notes

SUGGESTED DATA SOURCES FOR PATIENT REFUSAL (other than physician/APN/PA or pharmacist documentation of a reason for not administering any type of VTE prophylaxis as above):

- Medication administration record
- Nurses notes

Inclusion Guidelines for Abstraction:
THIS LIST IS ALL INCLUSIVE
Diagnostic testing includes the following:

- Compression Ultrasound/Vascular Ultrasound/Duplex Ultrasound (DUS) /Venous Doppler
- Computed tomography (CT) of thorax (chest), abdomen/pelvis, or lower extremity leg veins with contrast
- Magnetic resonance imaging (MRI or MRV) of the thorax (chest), abdomen/pelvis, or lower extremity veins
- Nuclear Medicine Pulmonary Scan/ventilation/perfusion (V/Q) lung scan
- Pulmonary arteriography/ angiography
- Venography/Venogram of pelvic, femoral and other lower extremity veins using contrast material

Reasons for not administering mechanical prophylaxis:
Acceptable terms synonymous with:

- Bilateral amputee
- Bilateral lower extremity trauma
- Patient/family refusal

Reasons for not administering pharmacological prophylaxis:
Acceptable terms synonymous with:

- Active bleeding (gastrointestinal bleeding, cerebral hemorrhage, retroperitoneal bleeding)
- Anticoagulant therapy other than warfarin for atrial fibrilation or other conditions.
- Bleeding risk
- Hemorrhage
- Patient/family refusal
- Patients on IV heparin therapy
- Thrombocytopenia
- Received blood transfusion after arrival and prior to *VTE Diagnostic Test*

Refer to Appendix H, Table 2.1 VTE Prophylaxis Inclusions.

Exclusion Guidelines for Abstraction:
Reasons for not administering pharmacological prophylaxis:

- Bleeding risk described in the informed consent process
- History (Hx) of bleeding
- IV heparin bolus or IVP heparin
- Re-infusion of blood products collected with blood recovery systems

Reasons for not administering mechanical or pharmacologic prophylaxis:

- Patient at low risk for VTE or VTE prophylaxis not needed.

Data Element Name: *VTE Timely*

Collected For: CMS/The Joint Commission: SCIP-VTE-2

Definition: Documentation of venous thromboembolism (VTE) prophylaxis received within 24 hours prior to *Anesthesia Start Time* to 24 hours after *Anesthesia End Time*. VTEs are the formation, development, or existence of a blood clot or thrombus within the venous system.

Suggested Data Collection Question: Is there documentation that the ordered VTE prophylaxis was received within 24 hours prior to *Anesthesia Start Time* to 24 hours after *Anesthesia End Time*?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1-9

Allowable Values:

Y (Yes)	There is documentation the patient received the ordered VTE prophylaxis within 24 hours prior to *Anesthesia Start Time* to 24 hours after *Anesthesia End Time*.
N (No)	There is no documentation the patient received the ordered VTE prophylaxis within 24 hours prior to *Anesthesia Start Time* to 24 hours after *Anesthesia End Time* or unable to determine from medical record documentation.

Notes for Abstraction:

- If the VTE prophylaxis was ordered and not administered, select “No.”
- If the VTE prophylaxis was ordered and not administered within the defined timeframe, select “No.”

Suggested Data Sources:

- Graphic/flow sheets
- Medication administration record
- Nursing notes
- Progress notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Warfarin Administration*

Collected For: CMS/The Joint Commission: VTE–3

Definition: Documentation that warfarin was administered during hospitalization. Warfarin is an oral anticoagulant that inhibits the synthesis of clotting factors that prevents blood clot formation. It also prevents extension of clots already formed, and is used to minimize the risk of blood clot embolization to other vital organs such as the lungs and brain.

Suggested Data Collection Question: Was warfarin administered during hospitalization?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that warfarin was administered during hospitalization.
N (No)	There is no documentation that warfarin was administered during hospitalization or unable to determine from the medical record documentation.

Notes for Abstraction:

- If warfarin was ordered, but not administered, select "No."
- If VTE was diagnosed prior to the hospitalization and warfarin was administered, select "Yes."

Suggested Data Sources:

- Medication administration record
- Nursing notes
- Physician notes

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 1.4 Warfarin Therapy.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Warfarin Prescribed at Discharge*

Collected For: CMS/The Joint Commission: VTE-5

Definition: Documentation that warfarin was prescribed at hospital discharge. Warfarin is an oral anticoagulant that prevents extension of clots already formed and is used to minimize the risk of blood clot embolization to other vital organs such as the lungs and brain.

Suggested Data Collection Question: Was warfarin prescribed at discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that warfarin was prescribed at discharge.
N (No)	There is no documentation that warfarin was prescribed at discharge or unable to determine from medical record documentation.

Notes for Abstraction:

- In determining whether warfarin was prescribed at discharge, it is not uncommon to see conflicting documentation amongst different medical record sources. For example, the discharge summary may list warfarin that is not included in any of the other discharge medication sources (e.g., discharge orders). All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
  - In cases where there is warfarin in one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select "Yes") unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge - **Consider it a discharge medication in the absence of contradictory documentation.**
  - If documentation is contradictory (e.g., physician noted “d/c warfarin” in the discharge orders, but warfarin is listed in the discharge summary’s discharge medication list), or after careful examination of circumstances, context, timing, etc., documentation raises enough questions, the case should be deemed "unable to determine" (select "No").
  - If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc.

Examples:
  - Two discharge summaries, one dictated 5/22 (day of discharge) and one dictated 5/27 - Use the 5/27 discharge summary.
  - Two discharge medication reconciliation forms, one not dated and one dated 4/24 (day of discharge) - Use both.
- If Coumadin/warfarin is on hold at discharge but there is documentation of a plan to restart it after discharge (e.g., “Resume Coumadin after INR normalizes”), select “Yes.”
- If there are instructions to follow-up with the coumadin clinic, or have a PT/INR drawn, select “Yes.”

Suggested Data Sources:
- Discharge instruction sheet
- Discharge summary
- Home health referral form
- Medication reconciliation form
- Nursing discharge orders
- Physician orders sheet
- Transfer sheet

Excluded Data Sources:
Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay).

Inclusion Guidelines for Abstraction:
Refer to Appendix C, Table 1.4 Warfarin Therapy.

Exclusion Guidelines for Abstraction:
None