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	1-65	STK-2[1]
ARB Prescribed at Discharge	1-67	AMI-3, HF-3
Arrival Date	1-69	AMI-1, AMI-7, AMI-7a, AMI-8, AMI-8a, ED-1[5], PN-3a, PN-3b, PN-5[1], PN-5c, PN-6[2], PN-6a[1], PN-6b[1], STK-4[1], STK-5[1]
Arrival Time	1-72	AMI-7, AMI-7a, AMI-8, AMI-8a, ED-1[5], PN-3a, PN-3b, PN-5[1], PN-5c, PN-6[2], PN-6a[1], PN-6b[1], STK-4[1]
Aspirin Prescribed at Discharge	1-75	AMI-2
Aspirin Received Within 24 Hours Before or After Hospital Arrival	1-77	AMI-1
Assessed for Rehabilitation Services	1-79	STK-10[1]
Atrial Fibrillation/Flutter	1-81	STK-3[1]
Beta-Blocker Current Medication	1-83	SCIP-Card-2
Beta-Blocker During Pregnancy	1-85	SCIP-Card-2
Beta-Blocker Perioperative	1-86	SCIP-Card-2
Beta-Blocker Prescribed at Discharge	1-88	AMI-5
Birthdate	1-90	All Records
Blood Culture Collected	1-91	PN-3a, PN-3b
Catheter Removed	1-94	SCIP-Inf-9
Chest X-Ray	1-96	All PN Measures
Clinical Trial	1-99	All AMI, CAC[1], HF, PN, STK[1], VTE[1] Measures, SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-4, SCIP-Inf-6, SCIP-Inf-9, SCIP-Card-2, SCIP-VTE-1, SCIP-VTE-2
Comfort Measures Only	1-102	AMI-1, AMI-2, AMI-3, AMI-4, AMI-5, AMI-9[1], AMI-10, AMI-T1a[1], AMI-T2[1], All HF Measures, All PN Measures, STK-1[1], STK-2[1], STK-3[1], STK-5[1], STK-6[1], STK-8[1], STK-10, VTE-1[1], VTE-2[1], VTE-3[1], VTE-4[1], VTE-6[1]
Compromised	1-105	PN-6[2], PN-6a[1], PN-6b[1]
Date Last Known Well	1-108	STK-4[1]
Decision to Admit Date	1-110	ED-2[5]
Decision to Admit Time	1-112	ED-2[5]
Diagnostic Uncertainty	1-114	PN-5[1], PN-5c
Discharge Date	1-116	All Records
Discharge Instructions Address Activity	1-118	HF-1
Discharge Instructions Address Compliance Issues	1-120	VTE-5[1]

Element Name	Page #	Collected For:
Discharge Instructions Address Diet	1-122	HF-1
Discharge Instructions Address Dietary Advice	1-124	VTE-5[1]
Discharge Instructions Address Follow-up	1-126	HF-1
Discharge Instructions Address Follow-up Monitoring	1-128	VTE-5[1]
Discharge Instructions Address Medications	1-130	HF-1
Discharge Instructions Address Potential for Adverse Drug Reactions and Interactions	1-134	VTE-5[1]
Discharge Instructions Address Symptoms Worsening	1-136	HF-1
Discharge Instructions Address Weight Monitoring	1-138	HF-1
Discharge Status	1-140	All Records
ED Departure Date	1-144	ED-1[5], ED-2[5]
ED Departure Time	1-146	ED-1[5], ED-2[5]
ED Patient	1-149	ED-1[5], ED-2[5], STK-4[1]
Education Addresses Activation of Emergency Medical System (EMS)	1-151	STK-8[1]
Education Addresses Follow-up After Discharge	1-153	STK-8[1]
Education Addresses Medications Prescribed at Discharge	1-155	STK-8[1]
Education Addresses Risk Factors for Stroke	1-159	STK-8[1]
Education Addresses Warning Signs and Symptoms of Stroke	1-162	STK-8[1]
Elective Carotid Intervention	1-164	All STK Measures[1]
Fibrinolytic Administration	1-166	AMI-7, AMI-7a, AMI-8, AMI-8a
Fibrinolytic Administration Date	1-167	AMI-7, AMI-7a
Fibrinolytic Administration Time	1-169	AMI-7, AMI-7a
First In-Hospital LDL-Cholesterol Qualitative Description	1-171	AMI-T2[2]
First In-Hospital LDL-Cholesterol Value	1-173	AMI-T2[2]
First Name	1-175	All Records[2]
First PCI Date	1-176	AMI-8, AMI-8a
First PCI Time	1-178	AMI-8, AMI-8a
Glucose POD 1	1-181	SCIP-Inf-4
Glucose POD 2	1-183	SCIP-Inf-4

Element Name	Page #	Collected For:
Healthcare Associated PN	1-185	PN-6[2], PN-6a[1], PN-6b[1]
Hispanic Ethnicity	1-187	All Records[2]
Home Management Plan of Care Document Addresses Arrangements for Follow-up Care	1-189	CAC-3[1]
Home Management Plan of Care Document Addresses Environmental Control and Control of Other Triggers	1-191	CAC-3[1]
Home Management Plan of Care Document Addresses Methods and Timing of Rescue Actions	1-193	CAC-3[1]
Home Management Plan of Care Document Addresses Use of Controllers	1-195	CAC-3[1]
Home Management Plan of Care Document Addresses Use of Relievers	1-197	CAC-3[1]
Home Management Plan of Care Document Given to Patient/Caregiver	1-199	CAC-3[1]
Home Management Plan of Care Document Present	1-201	CAC-3[1]
Hospital Patient Identifier	1-203	All Records[2]
ICD-9-CM Other Diagnosis Codes	1-204	All Records
ICD-9-CM Other Procedure Codes	1-205	All Records
ICD-9-CM Other Procedure Dates	1-206	All Records
ICD-9-CM Principal Diagnosis Code	1-208	All Records
ICD-9-CM Principal Procedure Code	1-209	All Records
ICD-9-CM Principal Procedure Date	1-210	All Records
ICU Admission Date	1-212	VTE-1[1], VTE-2[1]
ICU Admission or Transfer	1-214	PN-3a, PN-6[2], PN-6a[1], PN-6b[1], VTE-1[1], VTE-2[1]
ICU Discharge Date	1-216	VTE-1[1], VTE-2[1]
ICU VTE Prophylaxis	1-218	VTE-2[1]
ICU VTE Prophylaxis Date	1-220	VTE-2[1]
In-Hospital LDL-Cholesterol Test	1-222	AMI-T1a[2], AMI-T2[2]
Infection Prior to Anesthesia	1-225	SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-4
Influenza Vaccination Status	1-228	PN-7, Prev-Imm-2[3]
Initial Blood Culture Collection Date	1-231	PN-3a, PN-3b
Initial Blood Culture Collection Time	1-233	PN-3a, PN-3b
Initial ECG Interpretation	1-235	AMI-7, AMI-7a, AMI-8, AMI-8a
INR Value	1-239	VTE-3[1]
Intentional Hypothermia	1-240	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*	1-242	STK-5[1]
IV Thrombolytic Initiation	1-244	STK-4[1]
IV Thrombolytic Initiation Date	1-246	STK-4[1]
IV Thrombolytic Initiation Time	1-248	STK-4[1]
Laparoscope	1-250	SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-4, SCIP-Inf-6, SCIP-Inf-9, SCIP-Card-2, SCIP-VTE-1, SCIP-VTE-2
Last Known Well	1-252	STK-4[1]
Last Name	1-254	All Records[2]
LDL-c Greater Than or Equal to 100 mg/dL	1-255	STK-6[1]
LDL-c Less Than 100 Within 24 Hours After Arrival	1-257	AMI-10
LDL-c Measured Within the First 48 Hours or 30 Days Prior to Hospital Arrival	1-259	STK-6[1]
Lipid-Lowering Agent Prescribed at Discharge	1-261	AMI-T2[2]
LVF Assessment	1-263	HF-2
LVSD	1-266	AMI-3, HF-3
Measure Category Assignment	1-270	Used in the calculation of the Joint Commission's aggregate data and in the transmission of the Hospital Clinical Data file[1,4], ED-1[5], ED-2[5], Prev-Imm-1[3], Prev-Imm-2[3]
Measurement Value	1-272	Used in the calculation of the Joint Commission's aggregate data Continuous Variable Measures (AMI-7, AMI-8, PN-5[1]), and in the transmission of the Hospital Clinical Data file[1,4], ED-1[5], ED-2[5]
Monitoring Documentation	1-273	VTE-4[1]
Non-Primary PCI	1-275	AMI-8, AMI-8a
Observation Services	1-277	ED-1[5], ED-2[5]
Oral Antibiotics	1-279	SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3
Other Surgeries	1-281	SCIP-Inf-1, SCIP-Inf-3, SCIP-Inf-9
Overlap Therapy Start Date	1-283	VTE-3[1]
Parenteral Anticoagulant Administration	1-285	VTE-3[1]
Parenteral Anticoagulant End Date	1-286	VTE-3[1]

Element Name	Page #	Collected For:
Parenteral Anticoagulant Prescribed at Discharge	1-288	VTE-3[1]
Patient HIC#	1-290	Collected by CMS for patients with a standard HIC#
Payment Source	1-292	All Records
Perioperative Death	1-294	SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-4, SCIP-Inf-9, SCIP-Card-2, SCIP-VTE-1, SCIP-VTE-2
Physician 1	1-296	Optional for All Records[2]
Physician 2	1-297	Optional for All Records[2]
Plan for LDL-Cholesterol Test	1-298	AMI-T1a[2]
Pneumococcal Vaccination Status	1-300	PN-2, Prev-Imm-1[3]
Pneumonia Diagnosis: ED/Direct Admit	1-302	PN-3a, PN-3b, PN-5[1], PN-5c, PN-6[2], PN-6a[1], PN-6b[1]
Postal Code	1-307	All Records[2]
Preadmission Warfarin	1-308	SCIP-VTE-1, SCIP-VTE-2
Pre-Arrival LDL-Cholesterol Qualitative Description	1-310	AMI-T1a[2], AMI-T2[2]
Pre-Arrival LDL-Cholesterol Test	1-312	AMI-T1a[2], AMI-T2[2]
Pre-Arrival LDL-Cholesterol Value	1-315	AMI-T1a[2], AMI-T2[2]
Pre-Arrival Lipid-Lowering Agent	1-317	AMI-T1a[2], STK-6[1]
Preoperative Hair Removal	1-318	SCIP-Inf-6
Pseudomonas Risk	1-320	PN-6[2], PN-6b[1]
Race	1-322	All Records[2]
Reason for Delay in Fibrinolytic Therapy	1-324	AMI-7, AMI-7a
Reason for Delay in PCI	1-327	AMI-8, AMI-8a
Reason for Discontinuation of Overlap Therapy	1-330	VTE-[1]
Reason for No ACEI and No ARB at Discharge	1-332	AMI-3, HF-3
Reason for No Aspirin at Discharge	1-338	AMI-2
Reason for No Aspirin on Arrival	1-341	AMI-1
Reason for No Beta-Blocker at Discharge	1-344	AMI-5
Reason for No LDL-Cholesterol Testing	1-348	AMI-T1a[2]
Reason for No Lipid-Lowering Therapy	1-350	AMI-T2[2]
Reason for No VTE Prophylaxis – Hospital Admission	1-353	STK-1[1], VTE-1[1]
Reason for No VTE Prophylaxis – ICU Admission	1-355	VTE-2[1]

Element Name	Page #	Collected For:
Reason for Not Administering Antithrombotic Therapy by End of Hospital Day 2	1-357	STK-5[1]
Reason for Not Administering Beta-Blocker-Perioperative	1-359	SCIP-Card-2
Reason for Not Administering Relievers	1-361	CAC-1[1]
Reason for Not Administering Systemic Corticosteroids	1-363	CAC-2[1]
Reason for Not Administering VTE Prophylaxis	1-365	SCIP-VTE-1, SCIP-VTE-2
Reason for Not Initiating IV Thrombolytic	1-368	STK-4[1]
*Reason for Not Prescribing **Anticoagulation** Therapy at Discharge*	1-370	STK-3[1]
*Reason for Not Prescribing **Antithrombotic** Therapy at Discharge*	1-372	STK-2[1]
Reason for Not Prescribing Statin Medication at Discharge	1-374	AMI-10, STK-6[1]
Reasons for Continuing Urinary Catheterization	1-377	SCIP-Inf-9
Reasons to Extend Antibiotics	1-379	SCIP-Inf-3
Relievers Administered	1-383	CAC-1[1]
Risk Factors for Drug-Resistant Pneumococcus	1-385	PN-6[2], PN-6b[1]
Sample	1-387	Used in transmission of the Joint Commission's aggregate data file and the Hospital Clinical Data file
Sex	1-388	All Records
Statin Medication Prescribed at Discharge	1-389	AMI-10, STK-6[1]
Surgery End Date	1-391	VTE-1[1]
Surgery End Date – ICU Admission	1-393	VTE-2[1]
Surgical Incision Date	1-395	SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3
Surgical Incision Time	1-397	SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3
Surgical Procedure	1-400	VTE-1[1]
Surgical Procedure – ICU Admission	1-402	VTE-2[1]
Systemic Corticosteroids Administered	1-404	CAC-2[1]
Temperature	1-406	SCIP-Inf-10
Time Last Known Well	1-409	STK-4[1]

Element Name	Page #	Collected For:
Transfer From Another Hospital or ASC	1-411	AMI-7, AMI-7a, AMI-8, AMI-8a, AMI-9[1], PN-3a, PN-5[1], PN-5c, PN-6[2], PN-6a[1], PN-6b[1]
UFH Therapy Administration	1-413	VTE-4[1]
Urinary Catheter	1-414	SCIP-Inf-9
Vancomycin	1-416	SCIP-Inf-2
VTE Confirmed	1-419	VTE-3[1], VTE-4[1], VTE-5, VTE-6[1]
VTE Diagnostic Test	1-421	VTE-3[1], VTE-4[1], VTE-5[1], VTE-6[1]
VTE Present at Admission	1-423	VTE-6[1]
VTE Prophylaxis	1-425	SCIP-VTE-1, SCIP-VTE-2, STK-1[1], VTE-1[1]
VTE Prophylaxis Date	1-429	STK-1[1], VTE-1[1]
VTE Prophylaxis Status	1-431	VTE-6[1]
VTE Timely	1-434	SCIP-VTE-2
Warfarin Administration	1-435	VTE-3[1]
Warfarin Prescribed at Discharge	1-436	VTE-5[1]

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

Data Element Name: *ACEI Prescribed at Discharge*

Collected For: CMS/The Joint Commission: 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 x 2 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 x 2 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. If one or both are not dated, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms.

  Examples:
  - Two discharge summaries, one dated 5/22 (day of discharge) and one dated 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 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 (2001-Current Year)

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 is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.
- A patient of a hospital is considered an inpatient upon issuance of written doctor's orders to that effect. (Refer to the Medicare Claims Processing Manual, Chapter 3, Section 40.2.2.)
- 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.
- For patients that are admitted for surgery and/or a procedure, if the admission order states the date the orders were written and they are effective for the surgery/procedure date, then the date of the surgery/procedure would be the admission date. If the medical record reflects that the admission order was written prior to the actual date the patient was admitted and there is no reference to the date of the surgery/procedure, then the date the order was written would be the admission date.

Suggested Data Sources:
PRIORITY ORDER FOR THESE SOURCES

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

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:

- Admit to observation
- Arrival date

Data Element Name: *Adult Smoking Counseling*

Collected For: CMS/The Joint Commission: AMI-4, HF-4, PN-4

Definition: Documentation in the medical record that smoking cessation advice or counseling was given during this hospital stay.

THE JOINT COMMISSION NOTE: This data is only populated if the *Adult Smoking History* is entered Y (Yes).

Suggested Data Collection Question: Was the adult patient/caregiver given smoking cessation advice or counseling during this hospital stay?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Patient/caregiver received smoking cessation advice/counseling during hospital stay.
N (No)	Smoking cessation advice/counseling not given or unable to determine from medical record documentation.

Notes for Abstraction:

- If the patient refused smoking cessation advice or counseling during this hospital stay, select “Yes.”
- If the patient has a history of cigarette smoking within the year prior to the arrival date but the patient does not currently smoke, they should be advised to continue not smoking. For these patients, if this advice/counseling was not done, select “No.”
- If the patient is prescribed Wellbutrin/bupropion, it should not be assumed that this is a smoking cessation aid unless specifically noted as such. It is sometimes used as an antidepressant unrelated to smoking.
- In cases where a document provides a checkbox for this information and the checkbox is left unchecked, credit for giving smoking cessation counseling to the patient/caregiver should not be taken. E.g., Checkbox on discharge instruction sheet which reads, “For more information on quitting smoking classes, please contact 1-800-xxx-xxxx “ is left unchecked – select “No.”
- 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:

- Consultation notes
- Discharge instruction sheet
- Discharge summary
- Emergency department record
- History and physical
- Medication administration record
- Nursing notes
- Progress notes
- Respiratory therapy notes
- Teaching 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:

- Direct discussion with patient/caregiver about stopping smoking (e.g., “advised patient to stop smoking”)
- Prescription of smoking cessation aid (e.g., Habitrol, NicoDerm, Nicorette, Nicotrol, Prostep, Zyban) during hospital stay or at discharge
- Prescription of Wellbutrin/bupropion during hospital stay or at discharge, if prescribed as smoking cessation aid
- Referral to smoking cessation class/program
- Smoking cessation brochures/ handouts/ video

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Adult Smoking History*

Collected For: CMS/The Joint Commission: AMI-4, HF-4, PN-4

Definition: Documentation that the adult patient has smoked cigarettes anytime during the year prior to hospital arrival.

Suggested Data Collection Question: Did the adult patient smoke cigarettes anytime during the year prior to hospital arrival?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that the adult patient smoked cigarettes anytime during the year prior to hospital arrival.
N (No)	There is no documentation that the adult patient smoked cigarettes anytime during the year prior to hospital arrival, or unable to determine from medical record documentation.

Notes for Abstraction:

- If there is definitive documentation anywhere in the ONLY ACCEPTABLE SOURCES that the patient either currently smokes or is an ex-smoker that quit less than one year prior to arrival, select “Yes,” **regardless of whether or not there is conflicting documentation.**
- If there is NO definitive documentation of current smoking or smoking within one year prior to arrival in any of the ONLY ACCEPTABLE SOURCES select “No.”
- Classify a form as a nursing admission assessment if the content is typical of nursing admission assessments (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.
- 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. Additional documentation such as a "history" or "physical" existing only as a sub-section within a progress note or consultation note should NOT be used.
- Disregard documentation of smoking history or history of tobacco use if current smoking status or timeframe that patient quit is not defined (e.g., “20 pk/yr smoking history”, “History of tobacco abuse”).
- If there is documentation in one of the ONLY ACCEPTABLE SOURCES of current smoking or tobacco use, or smoking or tobacco use within one year prior

to arrival, and the type of product is not specified, assume this refers to cigarette smoking and select "Yes" unless another of the ONLY ACCEPTABLE SOURCES suggests that the tobacco product is pipe, cigar, or chewing tobacco (e.g., "Current smoker" per H&P, "Tobacco history: Smokes 5-6 cigars/day" per nursing admission assessment).

- 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 smoking status is indeterminable.

Suggested Data Sources:
ONLY ACCEPTABLE SOURCES:

- Emergency department record
- History and physical
- Nursing admission assessment/nursing admission notes
- Respiratory Therapy notes

Excluded Data Sources:
Documentation from a transferring facility or a previous admission

Inclusion Guidelines for Abstraction:
Examples of smoking within past year:

- "Positive tobacco use" (if no history context - e.g., "History" section of H&P)
- "Former smoker. Quit recently."
- "History - Quit smoking 7 months ago"
- "Quit smoking several months ago"
- "Social Habits = current smoking"
- "Tobacco history: current cigarette smoker"

Exclusion Guidelines for Abstraction:
Examples of no smoking within past year:

- Chewing tobacco use only
- Cigar smoking only
- "History: Smoker"
- "History - Tobacco abuse"
- Illegal drug use only (e.g., marijuana)
- "Most likely quit 3 months ago"
- Oral tobacco use only
- Pipe smoking only
- "Probable smoker"
- "Remote smoker"
- "Smoked in the last year: ?"
- "Tobacco – 2 packs per day x 22 yrs" (if no current context)

Data Element Name: *Anesthesia End Date*

Collected For: CMS/The Joint Commission: SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-4, SCIP-Inf-9, SCIP-Inf-10, SCIP-VTE-1, SCIP-VTE-2

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 (2001-Current Year)
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:
- Intraoperative record
- Circulator record
- Post-anesthesia evaluation record
- Operating room notes

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-Inf-10, SCIP-VTE-1, SCIP-VTE-2

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:
- Intraoperative record
- Circulator record
- Post-anesthesia evaluation record
- Operating room notes

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: All SCIP Measures; **The Joint Commission Only:** VTE-2

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 (2001-Current Year)
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:

- Intraoperative record
- Circulator record
- Post-anesthesia evaluation record
- Operating room notes

Inclusion Guidelines for Abstraction
None

Exclusion Guidelines for Abstraction
None

Data Element Name: *Anesthesia Start Time*

Collected For: CMS/The Joint Commission: SCIP-Inf-10, SCIP-VTE-1, SCIP-VTE-2

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 i*s 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:
- Intraoperative record
- Circulator record
- Post-anesthesia evaluation record
- Operating room notes

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.*

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Anesthesia Type*

Collected For: CMS/The Joint Commission: SCIP-Inf-10, SCIP-VTE-1, SCIP-VTE-2

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

Inclusion Guidelines for Abstraction:
- General Anesthesia
  - Inhaled anesthetic gases
  - Endotracheal
  - Laryngeal mask airway or anesthesia (LMA)
- Neuraxial Anesthesia
  - Spinal block
  - Epidural block
  - Spinal anesthesia
  - 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
- Paravertebral blocks

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) A named bacterial infection outside of the respiratory tract documented by a Physician/APN/PA
2) 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:

Y (Yes)	There was another source of bacterial infection in addition to pneumonia within 24 hours after arrival.
N (No)	There was no other source of bacterial infection within 24 hours after arrival or unable to determine from medical record documentation.

Notes for Abstraction:

- 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 “Yes.”
  - Advanced Practice Nurse documents “suspect sepsis from decubitus ulcer”, select “Yes.”
- There must be documentation of an infection/suspected infection, other than pneumonia, within 24 hours after arrival in order to select “Yes” 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 "Yes."
- 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 "No."
  - 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 "No."
- 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 "No."
- Gram stain results alone are not acceptable. Example: Sputum reveals gram positive cocci, select "No."

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

- Admit Notes
- Admitting physician orders
- Consult Notes
- ED Records
- History and Physical
- Lab results
- Physician admitting note
- Physician's Notes
- Physician Orders
- Progress Notes

Inclusion Guidelines for Abstraction:

- Abscess outside of the lung
- Infected skin ulcer
- Osteomyelitis or septic joint (infective arthritis)

- Urinary Tract infection

Exclusion Guidelines for Abstraction:

- Any infection in the Respiratory Tract (sinusitis, laryngitis, bronchitis, pleurisy, other lung infections)
- 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)
- 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: PN-3b, PN-5c, SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3; **CMS Only:** PN-6; **The Joint Commission Only:** PN-5, PN-6a, PN-6b

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 (2001-Current Year)
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.*
  Examples:
  - 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.
  - An *Admission Date* of 11-20-20XX is documented but the *Antibiotic Administration Date* is documented as 11-19-20xx. If documentation cannot be found on that same source to support the correct date, that dose cannot be abstracted as given during the hospital stay but should be used to abstract *Antibiotic Received,* as applicable.
- 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 JDoe 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:

- If a test dose of antibiotic is given IV and the remainder of the dose is given later, abstract both entries of the antibiotic. Only abstract test doses if they are given IV.
- 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, 12:00, 15:30, 17:00, and 19:00 on 04-02-20XX.
Abstract:
First dose: cefazolin 08:00 4-02-20XX IV
Second dose: cefazolin 12:00 4-02-20XX IV
Last dose: cefazolin 19:00 4-02-20XX IV

Suggested Data Sources:

- Emergency department record
- 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: PN-3b, PN-5c, SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3; **CMS Only:** PN-6; **The Joint Commission Only:** PN-5, PN-6a, PN-6b

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 JDoe 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:

- If a test dose of antibiotic is given IV and the remainder of the dose is given later, abstract both entries of the antibiotic. Only abstract test doses if they are given IV.
- 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, 12:00, 15:30, 17:00, and 19:00 on 04-02-20XX.
  Abstract:
  First dose: cefazolin 08:00 4-02-20XX IV
  Second dose: cefazolin 12:00 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: PN-3b, PN-5c, SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3; **CMS Only:** PN-6; **The Joint Commission Only:** PN-5, PN-6a, PN-6b

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 JDoe 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:

- If a test dose of antibiotic is given IV and the remainder of the dose is given later, abstract the times for both entries of the antibiotic. Only abstract test doses if they are given IV.
- 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, 12:00, 15:30, 17:00, and 19:00 on 04-02-20XX.
  Abstract:
  First dose: cefazolin 08:00 4-02-20XX IV
  Second dose: cefazolin 12:00 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,” select “Yes.”
- If a physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist documents a specific reason not to give penicillin, beta-lactams, or cephalosporins, select “Yes.”

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: PN-3b, PN-5c, SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3; **CMS Only:** PN-6; **The Joint Commission Only:** PN-5, PN-6a, PN-6b

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 JDoe 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:

- If a test dose of antibiotic is given IV and the remainder of the dose is given later, abstract both entries of the antibiotic. Only abstract test doses if they are given IV.
- 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, 12:00, 15:30, 17:00, and 19:00 on 04-02-20XX.
Abstract:
First dose: cefazolin 08:00 4-02-20XX IV
Second dose: cefazolin 12:00 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: PN-3b, PN-5c, SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3; **CMS Only:** PN-6; **The Joint Commission Only:** PN-5, PN-6a, PN-6b

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 the day prior to arrival, do not consider it given within this time frame.
  Example:
  “Patient started on antibiotics two days ago.”
- If there is other documentation to support that antibiotics were taken within 24 hours of arrival the day prior to arrival consider it taken within 24 hours of or the day prior to arrival.
  Example:
  “Patient has been maintained on Rocephin for the last 5 days.”
- If the date and/or time for an antibiotic dose is an obvious error but it is a valid date and/or time and that is prior to the patient’s arrival, the chart must be abstracted at face value and this information should be used to answer yes to antibiotics prior to arrival as applicable.
  Example:
  An arrival time is documented as 1400 and the antibiotic is documented as given at 1352 on the same date. 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.

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: The Joint Commission Only: STK-3

Definition: Documentation that anticoagulation therapy was prescribed at hospital discharge. 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: 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 X 2 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 X 2 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. If one or both are not dated, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms.

  Examples:
  - Two discharge summaries, one dated 5/22 (day of discharge) and one dated 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:

- 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 SQ
- Heparin Flush
- Hep-Lock

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

Collected For: The Joint Commission Only: STK-5

Definition: Documentation that antithrombotic therapy was administered by the end of hospital day 2. Antithrombotic therapy is administered to reduce morbidity, mortality, and recurrence rate in stroke.

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.
- 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.”
- 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.

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 SQ
- Heparin Flush
- Hep-Lock

Data Element Name: *Antithrombotic Therapy Prescribed at Discharge*

Collected For: The Joint Commission Only: STK-2

Definition: Documentation that antithrombotic therapy was prescribed at hospital discharge. Antithrombotic therapy is administered to reduce morbidity, mortality, and recurrence rate in stroke.

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 X 2 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 X 2 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. If one or both are not dated, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms.

  Examples:
  - Two discharge summaries, one dated 5/22 (day of discharge) and one dated 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:

- 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 SQ
- Heparin Flush
- Hep-Lock

Data Element Name: *ARB Prescribed at Discharge*

Collected For: CMS/The Joint Commission: 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 x 2 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 x 2 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. If one or both are not dated, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms.

  Examples:
  - Two discharge summaries, one dated 5/22 (day of discharge) and one dated 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 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-1, AMI-7, AMI-7a, AMI-8, AMI-8a, PN-3a, PN-3b, PN-5c; **CMS Only:** PN-6; **The Joint Commission Only:** PN-5, PN-6a, PN-6b, STK-4, STK-5; **CMS Voluntary Only:** ED-1

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 (2001 – Current Year)
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 only the acceptable sources to determine the earliest date the patient arrived at the hospital. This may differ from the admission date.
  Note: Medical record documentation from all of the "ONLY ACCEPTABLE SOURCES" should be carefully examined in determining the most correct date of arrival. Arrival date should NOT be abstracted simply as the earliest date in the acceptable sources, without regard to other (i.e., ancillary services) substantiating documentation. If documentation suggests that the earliest date in the acceptable sources does not reflect the date the patient arrived at the hospital, this date should not be used.
- 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.
- If the patient is in an outpatient setting of the hospital, except for observation status, (e.g., undergoing dialysis, chemotherapy, cardiac cath) and is subsequently admitted to acute inpatient, use the date the patient presents to the ED or arrives on the floor for inpatient care as arrival date.
- If the patient is in an observation status and is subsequently admitted to the hospital:
  - If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient presents to the ED or arrived 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 presented to the ED as the arrival date.
  - If the patient was a direct admit to observation, use the earliest date the patient arrived at the hospital.
- If the patient is a "Direct Admit" to the cath lab, as a transfer from another ED or acute care hospital, use the date the patient presents to the cath lab as the arrival date.
- For "Direct Admits" to acute inpatient, use the earliest date the patient arrives at the hospital.
- The source "Any ED documentation" includes ED vital sign record, ED/Outpatient Registration form, triage record and ECG reports, laboratory reports, x-ray reports, etc., if these ancillary services were rendered while the patient was an ED patient.
- The source "Procedure notes" refers to formal documents that describe a procedure that was done (e.g., endoscopy, cardiac cath). ECG and x-ray reports should NOT be considered procedures notes.

Suggested Data Sources:
ONLY ACCEPTABLE SOURCES:

- Any ED documentation
- Nursing admission assessment/admitting note
- Observation record
- Procedure notes
- Vital signs graphic record

For “Direct Admits,” in addition to the above suggested data sources, the following may also be utilized:
Face sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
Addressographs/Stamps

Data Element Name: *Arrival Time*

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

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 only the acceptable sources to determine the earliest time the patient arrived at the hospital. This may differ from the admission time.
  Note: Medical record documentation from all of the "ONLY ACCEPTABLE SOURCES" should be carefully examined in determining the most correct time of arrival. Arrival time should NOT be abstracted simply as the earliest time in the acceptable sources, without regard to other (i.e., ancillary services) substantiating documentation. If documentation suggests that the earliest time in the acceptable sources does not reflect the time the patient arrived at the hospital, this time should not be used.
- 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.
- If the patient is in an outpatient setting of the hospital, except for observation status, (e.g., undergoing dialysis, chemotherapy, cardiac cath) and is subsequently admitted to acute inpatient, use the time the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival time.
- If the patient is in an observation status and is subsequently admitted to the hospital:
  - If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient presents to the ED or arrived 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 presented to the ED as the arrival time.
  - If the patient was a direct admit to observation, use the earliest time the patient arrived at the hospital.
- If the patient is a "Direct Admit" to the cath lab, as a transfer from another ED or acute care hospital, use the time the patient presents to the cath lab as the arrival time.

- For “Direct Admits” to acute inpatient, use the earliest time the patient arrives at the hospital.
- The source “Any ED documentation” includes ED vital sign record, ED/Outpatient Registration form, triage record and ECG reports, laboratory reports, x-ray reports, etc., if these ancillary services were rendered while the patient was an ED patient.
- The source “Procedure notes” refers to formal documents that describe a procedure that was done (e.g., endoscopy, cardiac cath). ECG and x-ray reports should NOT be considered procedure notes.

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

For “Direct Admits,” in addition to the above suggested data sources, the following may also be utilized:
Face sheet

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
Addressographs/stamps

Data Element Name: *Aspirin Prescribed at Discharge*

Collected For: CMS/The Joint Commission: 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 x 2 days” and “Hold aspirin until after endoscopy.”

- o 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 x 2 days,” “Start baby aspirin as outpatient,” “Hold ASA”), select “No.”
- o If two discharge summaries are included in the medical record, use the one with the latest date. If one or both are not dated, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms.
  Examples:
  - Two discharge summaries, one dated 5/22 (day of discharge) and one dated 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 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:
None

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

Collected For: CMS/The Joint Commission: 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:

- When unable to determine for certain whether aspirin was received within 24 hours prior to arrival (e.g., last dose noted as 02-27-20XX and patient arrived at hospital on 02-28-20XX at 09:00), select “No.”
  EXCEPTIONS:
  - When aspirin is listed only as a home or "current" medication, and the exact timing of the last dose the patient took is not noted, infer that the patient took aspirin within the 24 hour timeframe, unless documentation suggests otherwise.
  - When aspirin is noted only as received prior to arrival, without information about the exact time it was received (e.g., "Baby ASA X 4" per the "Treatment Prior to Arrival" section of the Triage Assessment), infer that the patient took aspirin within the 24 hour timeframe, unless documentation suggests otherwise.

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:
None

Data Element Name: *Assessed for Rehabilitation Services*

Collected For: The Joint Commission Only: 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:

- 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 the patient was seen by a member of the rehabilitation team (e.g., PT, OT, Speech Pathology) during the hospital stay, select "Yes."
  Examples:
  - "PT X 2 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:
- Consultation notes
- Discharge instruction sheet
- Discharge summary
- History and physical
- Nursing notes
- Occupational therapy notes
- Physical therapy notes
- Physician orders
- Progress notes
- Referral forms
- Rehabilitation records

Excluded Data Sources:
Notes written by a certified nursing assistant (CNA) or health care technician (HCT)

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.
- Examples of rehabilitation team members include:
  - 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: The Joint Commission Only: 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:

- Face sheet
- Discharge instruction sheet
- Discharge summary

- History and physical
- EKG report
- 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 is a “current” 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 there is documentation that the beta-blocker is a home/current medication and additional documentation indicates the beta-blocker was not taken daily, e.g., the medication reconciliation form lists a beta-blocker as a home/current medication, but documentation in the nurses notes state “patient denies taking beta-blocker every day", select “No.”
- If there is documentation that the beta-blocker is on a schedule other than daily, select “No.”
- If there is documentation that the beta-blocker was given on a “prn” basis for cardiac or non-cardiac reasons, select “No.”
- If a beta-blocker is listed as a daily “home” or “current” medication, but the physician does not continue it after arrival, select “Yes.”
- If a beta-blocker is listed as a daily “home” or “current” medication and is continued after arrival but is discontinued prior to surgery, select “Yes.”

- If the patient stopped taking the beta-blocker prior to arrival but was started on one in the hospital prior to surgery, select “No.”
- If there is documentation that the patient is not taking the beta-blocker prior to arrival, select “No.”
  Example: On the patient’s list of medications from home, Atenolol is listed, but the nurse notes that the patient is not taking the medication. Select “No.”

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:
- 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.

NOTE: The perioperative period for the SCIP cardiac measures is defined as 24 hours prior to surgical incision through discharge from the post anesthesia care/recovery area.

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

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that a beta-blocker was received during the perioperative period.
N (No)	There is no documentation that a beta-blocker was received during the perioperative period or unable to determine from medical record documentation.

Notes for Abstraction:

- If it is documented that the patient took a beta-blocker prior to arrival, there must be a time to indicate when the last dose of the beta-blocker was taken, unless there is documentation that it was taken on the day of surgery.
- **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 records
- Consultation notes
- History and physical
- Medication administration 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: CMS/The Joint Commission: 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 x 2 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 x 2 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. If one or both are not dated, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms.

  Examples:
  - Two discharge summaries, one dated 5/22 (day of discharge) and one dated 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 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: CMS/The Joint Commission: 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:

- Initial documentation of a blood culture collected more than 24 hours after arrival to the hospital.
- Cultures collected more than 1 day prior to arrival.

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:

- If there is documentation that the urinary catheter was removed after POD 2, select value "2."
- Postoperative Day 2 (POD 2) ends at midnight of the second postoperative day.
- If the catheter was removed on POD 0 through POD 2, but had to be reinserted, select Value "1."
- 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 the patient voided/urinated on POD 0 through POD 2, select Value "1."
- If the patient expires on POD 0 - POD 2 prior to removal of the indwelling urinary catheter, select Value "1."

Suggested Data Sources:

- Progress Notes
- Nurses Notes
- Discharge Summary
- Graphic Sheet (I&O form)

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Chest X-Ray*

Collected For: CMS/The Joint Commission: PN-2, PN-3a, PN-3b, PN-4, PN-5c, PN-7; **CMS Only:** PN-6; **The Joint Commission Only:** PN-5, PN-6a, PN-6b

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 “2.”
  - The only documentation of an Inclusion term is prefaced with wording such as, “no significant” or “no definite”, select “2.”
  - The only findings in the radiology report or physician/APN/PA documentation are chronic or normal, select “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 “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 “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
- 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-1, AMI-2, AMI-3, AMI-4, AMI-5, AMI-7, AMI-7a, AMI-8, AMI-8a, AMI-10, All HF Measures, PN-2, PN-3a, PN-3b, PN-4, PN-5c, PN-7, SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-4, SCIP-Inf-6, SCIP-Inf-9, SCIP-Card-2, SCIP-VTE-1, SCIP-VTE-2; **CMS Only**: AMI-T1a (Optional Test Measure), AMI-T2 (Optional Test Measure), PN-6; **The Joint Commission Only:** AMI-9, All CAC, PN-5, PN-6a, PN-6b, All STK Measures, All VTE Measures

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), or heart attack.

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: *Comfort Measures Only*

Collected For: CMS/The Joint Commission: AMI-1, AMI-2, AMI-3, AMI-4, AMI-5, AMI-10, All HF Measures, PN-2, PN-3, PN-3a, PN-4, PN-5c, PN-7; **CMS Only:** AMI-T1a (Optional Test Measure), AMI-T2 (Optional Test Measure), PN-6; **The Joint Commission Only:** AMI-9, PN-5, PN-6a, PN-6b, STK-1, STK-2, STK-3, STK-5, STK-6, STK-8, STK-10, VTE-1, VTE-2, VTE-3, VTE-4, VTE-6

Definition: Physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation of comfort measures only. Commonly referred to as “palliative care” in the medical community and “comfort care” by the general public. Palliative care includes attention to the psychological and spiritual needs of the patient and support for the dying patient and the patient's family. Comfort Measures Only are not equivalent to the following: Do Not Resuscitate (DNR), living will, no code, no heroic measure.

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.**

- Determine the earliest day the physician/APN/PA DOCUMENTED comfort measures only. Do not factor in when comfort measures only was actually instituted. E.g., “Discussed comfort care with family on arrival” noted in day 2 progress note – Select “2.”
- Consider comfort measures only documentation in the discharge summary as documentation on the last day of the hospitalization, regardless of when the summary is dictated.
- Do not use 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 H&P).
  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)
- If any of the inclusions are documented, select “1,” “2,” or “3” accordingly, unless otherwise specified.
- Physician/APN/PA documentation of comfort measures only (hospice, palliative care, etc.) mentioned in the following contexts suffices:
  - Comfort measures only recommendation
  - Order for consultation or evaluation by a hospice/palliative care service
  - Patient or family request for comfort measures only
  - Plan for comfort measures only
  - Referral to hospice/palliative care service
- Disregard documentation of comfort measures only when clearly described as negative (e.g., "No comfort care," "Not a hospice candidate," "Declines palliative care," "Not appropriate for hospice care"). Other comfort measures only notations should still be considered in abstraction. 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.”
- If DNR-CC is documented, select “4,” unless there is documented clarification that CC stands for “comfort care.”

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY
- Admitting physician orders
- Consultation notes
- Discharge summary
- Emergency department record

- History and physical
- Physician admitting note
- 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
- End of life care
- Hospice
- Hospice care
- Organ harvest
- Palliative care
- Palliative measures
- Terminal care

Exclusion Guidelines for Abstraction:
DNR-Comfort Care Arrest (All-Inclusive)
- DNR-CCA
- DNRCC-A
- DNRCC-Arrest
- DNRCCA

Data Element Name: *Compromised*

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

Definition: For the purposes of PN-6, PN-6a and PN-6b, *Compromised* includes 2 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.
2. A prior hospitalization within 14 days. The intent is to exclude possible nosocomial infections, i.e., The patient was discharged from an acute care facility for inpatient care to a non-acute setting (e.g., home, SNF, ICF or rehabilitation hospital), before the second admission to the same or different acute care facility.

Suggested Data Collection Question: Is there documentation the patient had a compromising condition?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1	A compromising condition
2	Prior hospitalization within 14 days
3	Both 1 and 2
4	None of the above/Unable to Determine

Notes for Abstraction:

- If there is physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation the patient is immunocompromised, select value "1."
- The only acceptable compromising conditions are those found on the inclusion list.
- All conditions listed in the inclusions list can be documented within the last three months OR as diagnosed for the first time during this hospital visit with the exception of HIV, AIDS, Immunodeficiency syndromes, and organ transplants. These do not require a timeframe, as once they are present they are always present.
- 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 value "1."

- If there is physician documentation of “possible”, “suspected”, etc., in reference to any of the Inclusions select value “1” unless there is documentation that the Inclusion was ruled out within 24 hours of arrival.
- One time use or one course of systemic corticosteroids is not considered compromised.
- 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 there is documentation of chronic steroids, select value 1.
- Systemic corticosteroid/prednisone therapy must have occurred within the last three months prior to this hospitalization.
- 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 value “1.”
- Steroid therapy that is NOT systemic (e.g. inhaler, eyedrops, topical etc) or administered via epidural/ spinal injections, select value 4.
- In order to select value “2”, 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) before the second admission to the same or different acute care facility.
- 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 there is physician/APN/PA documentation of “significant” or “marked” neutropenia, select “Yes.”

Suggested Data Sources:
- Admission face sheet
- Consultation notes
- Discharge summary
- Emergency department record
- History and physical
- Nurse admission notes

Inclusion Guidelines for Abstraction:
Compromising Conditions Within the Last 3 Months:
- Leukemia
- Lymphocytic leukemia
- Lymphoma
- Marked neutropenia
- Myelogenic leukemia
- Myeloma
- Myelodysplasia
- Pancytopenia
- Significant neutropenia

Compromising Conditions No Timeframe Necessary

- Acquired Immune Deficiency Syndrome
- AIDS
- AIDS Related Complex
- Any “Immunodeficiency Syndrome”
- ARC
- Chronic Lymphocytic Leukemia (CLL)
- Congenital or hereditary Immunodeficiency
- HIV Positive
- HIV
- 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:
All terms other than those on the inclusion list

Data Element Name: *Date Last Known Well*

Collected For: The Joint Commission Only: 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 (2001-Current Year)
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 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:

- o “Wife reports patient normal this evening. Hospital arrival is 0030 on 12-10-20XX.” *Date Last Known Well* is 12-09-20XX.
- o “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.

Suggested Data Sources:
- Emergency Department records
- History and Physical
- Progress notes

Inclusion Guidelines for Abstraction:
None

Inclusion Guidelines for Abstraction:
None

Data Element Name: *Decision to Admit Date*

Collected For: CMS Voluntary Only: ED-2

Definition: The documented date the decision to admit occurred. 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 as an inpatient.

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 (2001-Current Year)
UTD = Unable to Determine

Notes for Abstraction:

- If the date of the decision to admit 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. 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, which reflects processes that occurred in the ED or hospital.
- 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 date.
- If there are multiple dates documented for the decision to admit abstract the earliest date.
- 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 as an inpatient. This will not necessarily coincide with the date the patient is officially admitted to inpatient status.
- If the decision to admit the patient is made, but the actual request for a bed is delayed until an inpatient bed is available, record the date the physician/APN/PA made the decision to admit.
- If the decision to admit date is dated prior to the date of patient arrival or after the date of departure, select "UTD."
- 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:
None

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

Data Element Name: *Decision to Admit Time*

Collected For: CMS Voluntary Only: ED-2

Definition: The documented time (military time) the decision to admit occurred. Decision to admit time is the time at which the physician/APN/PA makes the decision to admit the patient from the emergency department to the hospital as an inpatient.

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 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. 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.
- If there are multiple times documented for the *Decision to Admit Time* abstract the earliest time.
- For purposes of this data element "decision to admit time" is the time the physician/APN/PA communicates the decision to admit the patient from the emergency department to the hospital as an inpatient. This will not necessarily coincide with the time the patient is officially admitted to inpatient status.
- If the decision to admit the patient is made, but the actual request for a bed is delayed until an inpatient bed is available, record the time the physician/APN/PA communicated the decision to admit.
- If documentation of the decision to admit time is prior to arrival or after departure from the ED, select, "UTD."
- Do not use admit order time for the Decision to Admit Time unless documentation clearly indicates this is the time the provider made the decision. If the documentation does not clearly indicate this was the time of the decision, do not use and select, "UTD."
- 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:
None

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

- Bed assignment time
- Admit Orders Time
- Report Called Time
- Admit to Observation Time

Data Element Name: *Diagnostic Uncertainty*

Collected For: CMS/The Joint Commission: PN-5c; **The Joint Commission Only:** PN-5

Definition: Specific documentation of a reason(s) that despite being seen by the physician/advanced practice nurse/physician assistant (physician/APN/PA), the patient's initial clinical picture was questionable, unclear or not suggestive of pneumonia, which caused a delay in the diagnosis of pneumonia at the time of admission.

Suggested Data Collection Question: Is there documentation of a reason(s) that despite being seen by the physician/APN/PA, the patient's initial clinical picture was questionable, unclear or not suggestive of pneumonia which resulted in a delay in the diagnosis of pneumonia at the time of admission?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation of a reason(s) that despite being seen by the physician/APN/PA, the patient's initial clinical picture was questionable, unclear or not suggestive of pneumonia which resulted in a delay in the diagnosis of pneumonia at the time of admission.
N (No)	There is no documentation of a reason(s) that despite being seen by the physician/APN/PA, the patient's initial clinical picture was questionable, unclear or not suggestive of pneumonia which resulted in a delay in the diagnosis of pneumonia at the time of admission, or unable to determine from medical record documentation.

Notes for Abstraction:

- Always select "No" for this data element if the answer to the data element *Pneumonia Diagnosis: ED/Direct Admit* is answered with allowable value 3 which is equivalent to "No" diagnosis of pneumonia at admission.
- The initial clinical picture is defined for the purposes of this data element as the clinical picture from arrival to admission for ED patients and as the clinical picture on admission for direct admits.
- The primary intent of this data element is to determine if the physician/APN/PA identified clinical circumstances that would delay the diagnosis of pneumonia.

- Physician/APN/PA must specifically document both of the following required elements to select “Yes”:
  1) The initial clinical picture was questionable, unclear or not suggestive of pneumonia, etc.
     AND
  2) This resulted in a delay in the diagnosis of pneumonia at the time of admission. (There must be documentation of a delay. It cannot be inferred there was a delay.)
- If the timeframe from arrival in the hospital until the time the patient is seen by the physician/APN/PA, is greater than 6 hours, this is not appropriate documentation to answer “yes” to this data element, i.e., a long wait to be seen/triaged is not appropriate documentation of diagnostic uncertainty.
- Documentation of the delay should refer to the pneumonia diagnosis and not to antibiotic administration.

Suggested Data Sources:
ONLY ACCEPTABLE SOURCES
PHYSICIAN/APN/PA DOCUMENTATION ONLY
- Emergency department record (ED admits)
- Physician admitting note (Direct admits)

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
- Radiology reports or consultation
- Systems reasons for delays in the administration of antibiotics, Examples: antibiotic not available in ED, patient had to sit in the waiting room for 5 hours, chest x-ray delayed

Data Element Name: *Discharge Date*

Collected For: CMS/The Joint Commission: All Records; **Used in Algorithms for: CMS/The Joint Commission:** AMI-1, PN-3a, PN-3b, PN-5c, PN-7, SCIP-Inf-4, SCIP-VTE-1, SCIP-VTE-2; **CMS Only:** PN-6; **The Joint Commission Only:** PN-5, PN-6a, PN-6b,

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 (2001 – Current Year)

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 Instructions Address Activity*

Collected For: CMS/The Joint Commission: 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: The Joint Commission Only: 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/The Joint Commission: 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: The Joint Commission Only: 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/The Joint Commission: 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: The Joint Commission Only: 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 **all** of the following, in order to select, "Yes."
  - Name and phone number of health professional/clinic or office, monitoring the anticoagulation therapy.
  - Next date for PT/INR laboratory blood draw.
- 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.
- Select "Yes", if the next date for PT/INR is documented as "follow-up with coumadin clinic in one week."

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/The Joint Commission: 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. If one or both are not dated, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms.
       Examples:
       - Two discharge summaries, one dated 5/22 (day of discharge) and one dated 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.
   - 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 in the written discharge instructions is sufficient, 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.

- 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.
  - In cases in which there was a therapeutic substitution of a medication (e.g., per hospital formulary Protonix substituted for Prilosec) and it is not

clear which medication the patient is being discharged on, select "No" regardless of which medication is included in the written discharge instructions.

- 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: The Joint Commission Only: 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/The Joint Commission: 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/The Joint Commission: 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: *Discharge Status*

Collected For: CMS/The Joint Commission: All Records; **Used in Algorithms For: CMS/The Joint Commission:** AMI-1, AMI-2, AMI-3, AMI-4, AMI-5, AMI-10, All HF Measures, PN-2, PN-3b, PN-4, PN-5c, PN-7; **CMS Only:** AMI-T1a (Optional Test Measure), AMI-T2 (Optional Test Measure); **The Joint Commission Only:** AMI-9, PN-5, CAC-3, STK-2, STK-3, STK-6, STK-8, STK-10, VTE-5

Definition: The place or setting to which the patient was discharged.

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

Format:

Length: 2
Type: Alphanumeric
Occurs: 1

Allowable Values:

01	**Discharged to home care or self care (routine discharge)** Usage Note: Includes discharge to home; home on oxygen if DME only; any other DME only; group home, foster care, independent living, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs.
02	**Discharged/transferred to a short term general hospital for inpatient care**
03	**Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care** Usage Note: Medicare-indicates that the patient is discharged/transferred to a Medicare certified nursing facility. For hospitals with an approved swing bed arrangement, use Code 61-Swing Bed. For reporting other discharges/transfers to nursing facilities, see 04 and 64.
04	**Discharged/transferred to a facility that provides custodial or supportive care** Usage Note: Includes intermediate care facilities (ICFs) if specifically designated intermediate care facilities. Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to state designated Assisted Living Facilities.

05 **Discharged/transferred to a designated cancer center or children's hospital**
Usage Note: Transfers to non-designated cancer hospitals should use Code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at http://www3.cancer.gov/cancercenters/centerslist.html

06 **Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care**
Usage Note: Report this code when the patient is discharged/transferred to home **with a written plan of care** (tailored to the patient's medical needs) **for home care services.**

07 **Left against medical advice or discontinued care**

20 **Expired**

21 **Discharged/transferred to court/law enforcement**
Usage Note: Includes transfers to incarceration facilities such as jail, prison, or other detention facilites.

43 **Discharged/transferred to a federal health care facility**
Usage Note: Discharges and transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.

50 **Hospice - home**

51 **Hospice - medical facility (certified) providing hospice level of care**

61 **Discharged/transferred to hospital-based Medicare approved swing bed**
Usage Note: Medicare-used for reporting patients discharged/ transferred to a SNF level of care within the hospital's approved swing bed arrangement.

62 **Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital**

63 **Discharged/transferred to a Medicare certified long term care hospital (LTCH)**

Usage Note: For hospitals that meet the Medicare criteria for LTCH certification.

64 **Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare**

65 **Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital**

66 **Discharged/transferred to a Critical Access Hospital (CAH)**

70 **Discharged/transferred to another type of health care institution not defined elsewhere in this code list (See Code 05)**

Note: CMS and The Joint Commission are aware that there are additional UB-04 allowable values for this data element; however, they are not used for the national quality measures set at this time.

Notes for Abstraction:

- The values for *Discharge Status* are taken from the National Uniform Billing Committee (NUBC) manual which is used by the billing/HIM to complete the UB-04.
- Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the UB-04 value is what is reflected in the medical record. For abstraction purposes, it is important that the medical record reflect the appropriate discharge status. If the abstractor determines through chart review that the claim information discharge status is not what is reflected in the medical record, she/he should correct and override the downloaded value.
- It would be appropriate to work with your billing office to develop processes that can be incorporated to improve medical record documentation to support the appropriate discharge status and to ensure consistency between the claim information discharge status and the medical record.

Suggested Data Sources:

- Discharge instruction sheet
- Discharge summary
- Face sheet
- Nursing discharge notes
- Physician orders
- Progress notes
- Social service notes
- Transfer record
- UB-04, Field Location: 17

Inclusion Guidelines for Abstraction:
Refer to Appendix H, Table 2.5 Discharge Status Disposition.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *ED Departure Date*

Collected For: **CMS Voluntary Only:** 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 (2000-Current)
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. 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 you are able to determine the date from other documentation this is acceptable (e.g., you are able to identify from documentation 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."
- 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.
- 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 Departure Date
- ED Discharge Date
- ED Leave Date

Exclusion Guidelines for Abstraction:
None

Data Element Name: *ED Departure Time*

Collected For: **CMS Voluntary Only:** 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 Time* 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 Time.*
Example:
Midnight or 24:00 on 11-24-20XX = 00:00 on 11-25-20XX

Notes for Abstraction:

- 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, or awaiting transport to services/care.

- 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. 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.
- If patient expired in the ED, use the time of death as the departure time.
- Do not use the time the discharge order was written because it may not represent the actual time of departure.
- 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 Leave Time
- ED Discharge Time
- ED Departure Time
- ED Check Out Time

Exclusion Guidelines for Abstraction:
Report Called Time

Data Element Name: *ED Patient*

Collected For: The Joint Commission Only: STK-4; **CMS Voluntary Only:** ED-1, ED-2

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.”

Suggested Data Sources:

- Emergency department record
- Face sheet
- Registration form

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:

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

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

Collected For: The Joint Commission Only: 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: The Joint Commission Only: 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: The Joint Commission Only: 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. If one or both are not dated, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms.
       Examples:
       - Two discharge summaries, one dated 5/22 (day of discharge) and one dated 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.
   - 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 in the written discharge instructions is sufficient, 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.

- 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.
  - In cases in which there was a therapeutic substitution of a medication (e.g., per hospital formulary Atorvastatin substituted for Mevacor) and it is not clear which medication the patient is being discharged on, select "No” regardless of which medication is included in the written discharge instructions.
- 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: The Joint Commission Only: 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: The Joint Commission Only: 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 symtoms of stroke.
N (No)	WRITTEN instructions/educational material given to patient/caregiver do not address warning signs and symtoms 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: The Joint Commission Only: 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.”
- If the patient was admitted following elective carotid intervention performed as an outpatient, select “No.”
- When conflicting information is documented in a medical record, e.g., internist documents “elective” and surgeon documents “non-elective” or unspecified, select “No.”
- 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”), select “Yes.”

Suggested Data Sources:

- History and physical
- OR report
- Physician orders

- Progress notes

Inclusion Guidelines for Abstraction:
Patients with the following ICD-9-CM procedure codes, if medical record documentation states that the patient was admitted for the elective performance of this procedure:

- 00.61 Percutaneous angioplasty or arthrectomy of carotid
- 00.63 Percutaneous insertion of carotid artery stents
- 38.02 Carotid embolectomy/ thrombectomy
- 38.12 Carotid endarterectomy
- 38.22 Percutaneous angioscopy
- 38.3 Resection of carotid with anastomosis
- 38.42 Resection of carotid aneurysm
- 88.41 Arteriography
- Elective
  - Anticipated
  - Evaluation
  - Non-emergent
  - Planned
  - Pre-admission
  - Pre-arranged
  - Pre-planned
  - Pre-scheduled
  - Previously arranged
  - Scheduled
  - Work-up

Exclusion Guidelines for Abstraction:
Patients with the following ICD-9-CM procedure codes, if medical record documentation indicates that the patient is also being treated for an acute stroke during this hospitalization:

- 00.61 Percutaneous angioplasty or arthrectomy of carotid
- 00.63 Percutaneous insertion of carotid artery stents
- 38.02 Carotid embolectomy/ thrombectomy
- 38.12 Carotid endarterectomy
- 38.22 Percutaneous angioscopy
- 38.3 Resection of carotid with anastomosis
- 38.42 Resection of carotid aneurysm
- 88.41 Arteriography

Data Element Name: *Fibrinolytic Administration*

Collected For: CMS/The Joint Commission: AMI-7, AMI-7a, AMI-8, AMI-8a

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-7, AMI-7a

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 (2001 – Current Year)
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-7, AMI-7a

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 In-Hospital LDL-Cholesterol Qualitative Description*

Collected For: CMS Only: AMI-T2 (Optional Test Measure)

Definition: Qualitative description of the results from first LDL-cholesterol (LDL-c) test performed after hospital arrival.

Suggested Data Collection Question: How did the physician/advanced practice nurse/physician assistant (physician/APN/PA) qualitatively describe the results of the first LDL-cholesterol (LDL-c) test performed after hospital arrival?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1	**Elevated LDL-c:** Physician/APN/PA qualitatively described the results of the first LDL-c test performed after hospital arrival in terms, consistent with elevated LDL-c.
2	**No Elevated LDL-c:** Physician/APN/PA qualitatively described the results of the first LDL-c test performed after hospital arrival in terms, which are NOT consistent with elevated LDL-c.
3	**Not Documented:** Physician/APN/PA did not qualitatively describe the results of the first LDL-c test performed after hospital arrival in any manner, or unable to determine from medical record documentation.

Notes for Abstraction:

- If unable to determine which LDL-c test was performed first, select “Elevated LDL-c” if any of the descriptions are consistent with elevated LDL-c.
- If there are discrepant qualitative descriptions documented for the same specimen (e.g., one description consistent with elevated LDL-c and one not consistent with elevated LDL-c), select “Elevated LDL-c.”

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Consultation notes
- Discharge summary
- Emergency department record
- History and physical
- Progress notes

Inclusion Guidelines for Abstraction:
LDL-cholesterol (LDL-c)

- Low den lipoprotein
- Low density lipoprotein (LDL)

Elevated LDL-c

- Cholesterol described as elevated, high, or a symbol that represents an increased value
- Dyslipidemia
- Dyslipoproteinemia
- Hyperbetalipoproteinemia
- Hypercholesterolemia
- Hyperlipemia
- Hyperlipidemia
- Hyperlipoproteinemia
- LDL above goal or target
- LDL described as elevated, high, or a symbol that represents an increased value
- LDL-cholesterol (LDL-c) described as elevated, high, or a symbol that represents an increased value
- Lipids described as elevated, high, or a symbol that represents an increased value

Exclusion Guidelines for Abstraction:
LDL-cholesterol (LDL-c)
VLDL (very low density lipoprotein)

Elevated LDL-c

- Alpha lipoproteinemia
- Elevated LDL-c, or any of the other elevated LDL-c 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: *First In-Hospital LDL-Cholesterol Value*

Collected For: CMS Only: AMI-T2 (Optional Test Measure)

Definition: Value of first LDL-cholesterol (LDL-c) performed after hospital arrival.

Suggested Data Collection Question: What is the patient's LDL-cholesterol (LDL-c), in mg/dL or mg/100 ml, from the first LDL-c test performed after hospital arrival?

Format:

Length: 1 - 3 or UTD with no leading zeros or decimals
Type: Numeric
Occurs: 1

Allowable Values:

Enter the patient's LDL-c value, in mg/dL or mg/100 ml, from the first LDL-c test performed after hospital arrival.

UTD = Unable to Determine

Notes for Abstraction:

- If unable to determine which LDL-c test was performed first, enter the highest value.
- The medical record must be abstracted as documented (taken at "face value"). When the value documented is obviously in error (not a valid number or greater than 999) and no other documentation is found that provides this information, the abstractor should select "UTD."
  Example:
  Documentation indicates the *First In-Hospital LDL-Cholesterol* Value was 1000 mg/dL. No other documentation in the medical record provides a valid value. Since the First In-Hospital LDL-Cholesterol Value is outside of the range listed in Format Length (greater than 999), it is not a valid value and the abstractor should select "UTD."
  Note: Transmission of a case with an invalid value will be rejected from the QIO Clinical Warehouse. Use of "UTD" for *First In-Hospital LDL-Cholesterol Value* allows the case to be accepted into the warehouse.
- Direct and calculated (indirect) LDL-c values are acceptable. If both direct and calculated LDL-c values are documented for the same specimen date/time, enter the direct LDL-c value.
- If the indirect LDL-c is reported as not calculated because high triglycerides render the LDL-c calculation inaccurate, consider the calculated LDL-c value equal to 0 (zero).
- If an LDL-c value on the laboratory report conflicts with that from another source of documentation for the same specimen, enter the value from the laboratory report.

- If a laboratory report documents discrepant LDL-c values for the same specimen, enter the highest value.
- If sources other than a laboratory report document discrepant LDL-c values for the same specimen, enter 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.
- If unable to determine from medical record documentation (e.g., LDL-c testing was done but no values are available), enter "UTD."

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: *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-8, AMI-8a

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 (2001 – Current Year)
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-8, AMI-8a

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 Voyager 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 Cypher 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 Angiojet or other 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 Angiojet” 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: *Glucose POD 1*

Collected For: CMS/The Joint Commission: SCIP-Inf-4

Definition: The blood glucose level on postoperative day one (POD 1) with *Anesthesia End Date* being postoperative day zero (POD 0), drawn closest to 6:00 A.M. (06:00). Glucose is a monosaccharide, simple sugar that the body uses directly for energy. It is the major energy source in the body and is monitored in the blood in many disorders, including diabetes mellitus. The concentration of glucose in the blood is measured in milligrams of glucose per deciliter of blood.

Suggested Data Collection Question: What was the patient's blood glucose level on postoperative day one (POD 1) closest to 6:00 A.M.?

Format:

Length: 1 - 4 or UTD with no leading zeros or decimals
Type: Numeric
Occurs: 1

Allowable Values:

1-3000 mg per dL
UTD = Unable to Determine

Notes for Abstraction:

- If the blood glucose level 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 value 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 *Glucose POD 1* was 30000. No other documentation in the medical record provides an valid value. Since the *Glucose POD 1* value is outside of the range listed in Format Length (greater than four numeric characters), it is not a valid value and the abstractor should select "UTD."
  Note: Transmission of a case with an invalid value will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *Glucose POD 1* allows the case to be accepted into the warehouse.
- Abstract the value closest to 06:00 (whether prior to or after 06:00).
  Example:
  On POD 1 there is documentation of a glucose value of "99" at 05:30 and a value of "120" at 06:15; select the 06:15 value of "120."
- When two or more values qualify as the closest to 06:00, select the earliest time.

Example:
On POD 1 there is documentation of a glucose value of “99” at 05:00 and a value of “120” at 07:00; select the 05:00 glucose value of “99.”

- Laboratory obtained values take precedence over bedside values when those results qualify as the closest to 06:00.
- When the value is recorded as being less than (<) or greater than (>) a limiting value, the abstractor should record the value at the corresponding lower limit (1) or upper limit (3000) of the allowable values.
  Examples:
  - The record states “less than 20 mg per dL,” enter “1.”
  - The record states “greater than 500 mg per dL,” enter “3000.”
- When the value recorded is “low” enter the lowest limit of the allowable values, “1.” When the value recorded is “high” enter the highest limit of the allowable values, “3000.”
- When two values are recorded with the same time, abstract the lowest value.
  Example:
  On POD 1 there are two values recorded at 05:00 (82 and 75). Enter the lowest value “75.”
- If an incorrect glucose reading is obtained that is due to equipment malfunction or user error and the glucose value is documented as retaken, the corrected value should be abstracted.

Suggested Data Sources:

- Consultation notes
- Diabetic flow sheet
- Laboratory reports
- Nursing graphic sheets
- Nursing notes
- PACU/recovery room record
- Progress notes

Inclusion Guidelines for Abstraction:

- Blood sugar
- Fasting glucose
- Finger stick glucose
- Glucometer results
- Glucose
- Non-fasting glucose
- Random glucose
- Serum glucose

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Glucose POD 2*

Collected For: CMS/The Joint Commission: SCIP-Inf-4

Definition: The blood glucose level on postoperative day two (POD 2) with *Anesthesia End Date* being postoperative day zero (POD 0), drawn closest to 6:00 A.M. (06:00). Glucose is a monosaccharide, simple sugar that the body uses directly for energy. It is the major energy source in the body and is monitored in the blood in many disorders, including diabetes mellitus. The concentration of glucose in the blood is measured in milligrams of glucose per deciliter of blood.

Suggested Data Collection Question: What was the patient's blood glucose level on postoperative day two (POD 2) closest to 6:00 A.M.?

Format:

Length: 1 - 4 or UTD with no leading zeros or decimals
Type: Numeric
Occurs: 1

Allowable Values:

1-3000 mg per dL
UTD = Unable to Determine

Notes for Abstraction:

- If the blood glucose level 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 value 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 *Glucose POD 2* was 30000. No other documentation in the medical record provides a valid value. Since the *Glucose POD 2* value is outside of the range listed in Format Length (greater than four numeric characters), it is not a valid value and the abstractor should select "UTD."
  Note: Transmission of a case with an invalid value will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for G*lucose POD 2* allows the case to be accepted into the warehouse.
- Abstract the value closest to 06:00 (whether prior to or after 06:00)
  Example:
  On POD 2 there is documentation of a glucose value of "99" at 05:30 and a value of "120" at 06:15; select the 06:15 value of "120."
- When two or more values qualify as the closest to 06:00, select the earliest time.

Example:
On POD 2 there is documentation of a glucose value of “99” at 05:00 and a value of “120” at 07:00; select the 05:00 glucose value of “99.”

- Laboratory obtained values take precedence over bedside values when those results qualify as the closest to 06:00.
- When the value is recorded as being less than (<) or greater than (>) a limiting value, the abstractor should record the value at the corresponding lower limit (1) or upper limit (3000) of the allowable values.
  Examples:
  - The record states “less than 20 mg per dL,” enter “1.”
  - The record states “greater than 500 mg per dL,” enter “3000.”
- When the value recorded is “low” enter the lowest limit of the allowable values, “1.” When the value recorded is “high” enter the highest limit of the allowable values, “3000.”
- When two values are recorded with the same time, abstract the lowest value.
  Example:
  On POD 2 there are two values recorded at 05:00 (82 and 75). Enter the lowest value “75.”
- If an incorrect glucose reading is obtained that is due to equipment malfunction or user error and the glucose value is documented as retaken, the corrected value should be abstracted.

Suggested Data Sources:

- Consultation notes
- Diabetic flow sheet
- Laboratory reports
- Nursing graphic sheets
- Nursing notes
- PACU/recovery room record
- Progress notes

Inclusion Guidelines for Abstraction:

- Blood sugar
- Fasting glucose
- Finger stick glucose
- Glucometer results
- Glucose
- Non-fasting glucose
- Random glucose
- Serum glucose

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Healthcare Associated PN*

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

Definition: Documentation that the patient had risk for healthcare associated pneumonia prior to admission for this hospital episode as determined by the presence of at least one of the following:

1) Acute care hospitalization within the last 90 days (calendar days)
2) Residence in a nursing home or extended care facility for any amount of time within the last 90 days
3) Chronic dialysis within the last 30 days prior to this hospitalization
4) Wound care, tracheostomy care or ventilator care provided by a health care professional within the last 30 days

Suggested Data Collection Question: Is there documentation the patient had risk for healthcare associated pneumonia?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	The patient has documented risk for healthcare associated pneumonia.
N (No)	The patient has no documented risk for healthcare associated pneumonia or unable to determine from medical record documentation.

Notes for Abstraction:

- 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 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, this will be a "Yes."
- For the purpose of the Pneumonia Project, 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 previous length of stay based on the procedure they received. Only use dates or phrases such as "in the hospital a couple of days last month," etc.
- If the hospital abstractor determines that a patient had resided at an extended care facility/nursing home within the 90 days prior to hospital arrival, that determination will not be challenged during validation unless there is contradictory information in the medical record.
- If there is physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation that the patient has "healthcare associated pneumonia", "HCAP" or "nosocomial pneumonia", select "Yes."
- 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, (i.e., "history of", "about a month ago", etc.) select "No."

Suggested Data Sources:

- Admission face sheet
- Consultation notes
- Discharge summary
- Emergency department record
- History and physical
- Nursing admission notes
- Progress notes

Guidelines for Abstraction:

- CAVH
- Continuous arterio-venous hemofiltration
- Continuous veno-venous hemofiltration
- CVVH
- Hemodialysis
- Peritoneal dialysis

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Hispanic Ethnicity*

Collected For: CMS Only: 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
- 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 anytime 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 anytime 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 anytime 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 anytime 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 anytime 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 found in the Medical Record
- Discharge instruction sheet
- Discharge summary
- 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: *Hospital 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: *ICD-9-CM Other Diagnosis Codes*

Collected For: CMS/The Joint Commission: All Records; **Used in Algorithms for: CMS/The Joint Commission:** PN-2, PN-3a, PN-3b, PN-4, PN-5c, PN-7; **CMS Only:** PN-6; **The Joint Commission Only:** AMI-9, PN-5, PN-6a, PN-6b, All VTE Measures; **Informational Only:** Prev-Imm-1, Prev-Imm-2

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: 17

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-8, AMI-8a, HF-1, HF-2, HF-3, HF-4; **Informational Only:** Prev-Imm-2

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: 5

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, Prev).

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: 5

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2001 – Current Year)
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: The Joint Commission Only:** STK-2, STK-3, STK-4, STK-5, STK-6, All VTE Measures; **CMS Voluntary Only:** ED-1, ED-2; **Informational Only:** Prev-Imm-1, Prev-Imm-2

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, PN, STK, VTE, Prev).

Exclusion Guidelines for Abstraction:
Refer to Appendix A, for ICD-9-CM Code Tables (ED, SCIP, Prev).

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-8, AMI-8a, HF-1, HF-2, HF-3, HF-4, All SCIP Records; **The Joint Commission Only:** VTE-1, VTE-2; **Informational Only:** Prev-Imm-2

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, Prev).

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 (2001 – Current Year)
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 Date*

Collected For: The Joint Commission Only: VTE-1, VTE-2

Definition: The date that the patient was a direct admission **or** transfer (from a lower level of care) to the intensive care unit (ICU) for more than one day AND was physically admitted to a bed in an ICU.

Suggestion Data Collection Question: What is the date of 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 (2001-Current Year)
UTD = Unable to Determine

Notes for Abstraction:

- If there are discrepancies in the ICU admission/transfer date refer to the ICU admission/transfer vital signs, nurse's notes or progress notes to determine the date.
- If a patient was a direct admit to the ICU for more than one day, subsequent transfers back to an ICU during the same hospitalization will NOT be abstracted for VTE-2.
- If the patient had more than one ICU admission/transfer greater than one day during hospitalization, select the ICU admission date that was closest to the hospital admission date.
- 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 Admission Date* was 03-**42**-20XX. No other documentation in the medical record provides a valid date. Since the *ICU Admission 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 Joint Commission's Data Warehouse. Use of "UTD" for *ICU Admission Date* allows the case to be accepted into the warehouse.

Suggested Data Sources:

- Emergency department record
- History and physical
- ICU logs
- Nursing admission assessment
- Nursing notes
- Physician orders
- Progress notes

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 Admission or Transfer*

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

Definition: Documentation that the patient was admitted or transferred to the intensive care unit (ICU) at this hospital.

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 or for more than one day for VTE).
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 or for more than one day for VTE).
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 or for more than one day for VTE).

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.

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.

- 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 “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 "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 an order for ICU, but not moved to an ICU unit due to a lack of a bed, select "1."
- 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 (from a lower level of care) to the intensive care unit (ICU) during this hospitalization for more than one day.
If there is an order for ICU, but not moved to an ICU unit due to a lack of a bed, select "2."

Suggested Data Sources:
- Emergency department record
- History and physical
- Nursing admission assessment
- Nursing notes
- Physician orders
- Progress 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)

Data Element Name: *ICU Discharge Date*

Collected For: The Joint Commission Only: VTE-1**,** VTE-2

Definition: The day, month and year the patient was physically discharged from the intensive care unit (ICU), left against medical advice (AMA) or expired.

Suggested Data Collection Question: What date was the patient physically 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 (2001-Current Year)
UTD = Unable to Determine

Notes for Abstraction:

- 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 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 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 Joint Commission's Data Warehouse. Use of "UTD" for *ICU Discharge Date* allows the case to be accepted into the warehouse.

Suggested Data Sources:

- Discharge summary
- Face sheet
- ICU logs
- Nursing discharge notes
- Physician orders

- Progress notes
- Transfer note

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 VTE Prophylaxis*

Collected For: The Joint Commission Only: 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:

- 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 “2” and “4.”

- Prophylaxis must be **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/transfer to be included in the numerator.
- 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: The Joint Commission Only: 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 (2001-Current Year)
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 Joint Commission's Data Warehouse. Use of "UTD" for *ICU VTE Prophylaxis Date* allows the case to be accepted into the warehouse.

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: *In-Hospital LDL-Cholesterol Test*

Collected For: CMS Only: AMI-T1a (Optional Test Measure), AMI-T2 (Optional Test Measure)

Definition: LDL-cholesterol (LDL-c) test performed during this hospital stay.

Suggested Data Collection Question: Was an LDL-cholesterol (LDL-c) test performed during this hospital stay?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	LDL-c test was performed during this hospital stay.
N (No)	LDL-c test was not performed during this hospital stay or unable to determine from medical record documentation.

Notes for Abstraction:

- In the absence of explicit documentation that an LDL-c test was or was not performed during this hospital stay, it should be inferred that a test was done if:
  - There is documentation of an LDL-c value from a test performed during this hospital stay, or
  - There is physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation which qualitatively describes the results of an LDL-c test performed during this hospital stay (e.g., “lipids elevated”), or
  - There is documentation that lipid testing was performed during this hospital stay.
- Do not include an LDL-c value, LDL-c qualitative description, or lipid testing if it cannot be determined that the testing was actually done during this hospital stay. Examples:
  - “Impression: Elevated cholesterol” noted in consultation report done on day of admission.
  - “Hypercholesterolemia” noted as discharge diagnosis in discharge summary, with no evidence that any lipid testing was done during the hospital stay.
  - Physician/APN/PA writes “Labs within normal range except for cholesterol,” with no evidence that any lipid testing was done during the hospital stay.

- Do not include lipid testing or qualitative descriptions of lipid test results if it can be determined that LDL-c measurement was not part of the lipid testing.
  Example:
  "Lipid profile done on day 2" per discharge summary, but the laboratory report lists only cholesterol and triglyceride values. Physician/APN/PA notes "Labs: elevated cholesterol," but the laboratory report lists only a total cholesterol value.

Suggested Data Sources:
- Consultation notes
- Discharge summary
- Emergency department record
- History and physical
- Laboratory report
- Progress notes

Inclusion Guidelines for Abstraction:
LDL-cholesterol (LDL-c)
- Low den lipoprotein
- Low density lipoprotein (LDL)

Qualitative description of LDL-c test results
- Cholesterol level qualitatively described (e.g., low, normal, elevated, ↑)
- Dyslipidemia (presence or absence)
- Dyslipoproteinemia (presence or absence)
- Hyperbetalipoproteinemia (presence or absence)
- Hypercholesterolemia (presence or absence)
- Hyperlipemia (presence or absence)
- Hyperlipidemia (presence or absence)
- Hyperlipoproteinemia (presence or absence)
- LDL level qualitatively described (e.g., low, normal, elevated, above goal, below Target, ↑)
- LDL-cholesterol (LDL-c) level qualitatively described (e.g., low, normal, elevated, ↑)
- Lipid levels qualitatively described (e.g., low, normal, elevated, ↑)

Lipid testing
- Cholesterol analysis
- Cholesterol check (✓)
- Cholesterol panel
- Cholesterol profile
- Cholesterol testing
- Fasting lipids
- LDL: HDL
- LDL: HDL ratio
- Lipid analysis

- Lipid check (✓)
- Lipid panel
- Lipid profile
- Lipids
- Lipoprotein analysis

Exclusion Guidelines for Abstraction:
LDL-cholesterol
VLDL (very low density lipoprotein)

Qualitative description of LDL-c test results
Alpha lipoproteinemia (presence or absence)

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.*
- H&Ps dated prior to arrival must reflect that an infection or possible/suspected infection is current. If an infection is documented as “chronic,” there must be additional documentation that the infection is current or still present preoperatively, during the hospital stay. If an infection is only documented as “chronic” without other documentation that the infection is still present preoperatively, select “no.”

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 table 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
- 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
- Urinary tract infection (UTI)

Exclusion Guidelines for Abstraction:

- Bacteria in urine (Bacteriuria)
- “carditis” (such as pericarditis) without mention of an infection
- Colonization or positive screens for MRSA, VRE, or for other bacteria
- Fungal infections
- History of infection, recent infection or recurrent infection not documented as a current or active infection
- Viral infections

Data Element Name: *Influenza Vaccination Status*

Collected For: CMS/The Joint Commission: PN-7; **Informational Only:** Prev-Imm-2

Definition: Documentation of the patient's vaccination status during this flu season. If found to be a candidate for the vaccine, documentation that the influenza 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 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 OR is medically contraindicated 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:

- The current flu season begins when this season's flu vaccine is made available to the public (i.e., if the vaccine is available in September, the flu season is September to March. However, for the purposes of this project, the hospitals are only responsible for discharges October to 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 patient when the 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 "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 "2."
  Example:
  There is documentation the patient received the vaccine in 2009 and it is October 2009, select "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 "5."
  Examples:
  - There is documentation the patient received the vaccine in 2008 and it is October 2009, select "5."
  - There is documentation the patient received the vaccine in 2008 and it is January 2009, select "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

- Flu immune
- Flu shield
- Flu shot
- Flu vaccine
- Fluax
- Fluogen
- Fluvirin
- Fluzone
- Influenza virus vaccine
- Trivalent influenza vaccine

Exclusion Guidelines for Abstraction:

- All discharges from April to September
- Patients allergic to eggs 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 vaccine, e.g. H1N1

Data Element Name: *Initial Blood Culture Collection Date*

Collected For: CMS/The Joint Commission: 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 (2001 – Current Year)
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: CMS/The Joint Commission: 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-7, AMI-7a, AMI-8, AMI-8a

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.”
2. Start with review of your SIGNED tracing. Evaluate the findings line by line. Determine if the terms or phrases are Inclusions or Exclusions. 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 you can say clearly refer to the ECG

done closest to arrival. Documentation which cannot be tied to the ECG performed closest to arrival should 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 multiple 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 (e.g., "ST-elevation" and "No ST-elevation"), select "No."
- If at least one interpretation describes an LBBB as old, chronic, or previously seen, all LBBB findings should be disregarded.
- Notations which describe ST-elevation as old, chronic, or previously seen, or as a range where it cannot be determined if elevation is less than 1 mm/.10mV (e.g., "0.5-1 mm ST-elevation"), should be disregarded. Other documentation of ST-elevation not described as such may still count as an Inclusion.
- 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
- 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 ↑) described as minimal, less than .10mV, less than 1 mm, non-diagnostic, or non-specific either in ALL leads noted to have ST-elevation or in GENERAL terms, where lead(s) are NOT specified (e.g., “minimal ST-elevation”)
- ST-elevation (ST ↑) with mention of early repolarization, left ventricular hypertrophy (LVH), normal variant, pericarditis, or Printzmetal/Printzmetal's variant
- ST-segment elevation, ST ↑, ST-elevation (STE), or ST-segment noted as greater than or equal to .10mV or greater than or equal to 1 mm described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table (except “possible”) either in ALL leads noted to have ST-elevation or in GENERAL terms, where lead(s) are NOT specified (e.g., “questionable ST-elevation”)
- 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 mention of pacemaker/pacing (unless atrial only or nonfunctioning pacemaker)

Left bundle branch block (LBBB)

- Incomplete left bundle branch block (LBBB)
- Intraventricular conduction delay (IVCD) or block
- 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 mention of pacemaker/pacing (unless atrial only or nonfunctioning pacemaker)

Data Element Name: *INR Value*

Collected For: The Joint Commission Only: 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/The Joint Commission: 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
- Intraoperative Record
- Operative Report
- Perfusion Record

- History and physical
- 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: The Joint Commission Only: 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
- Altepase
- Intra-arterial (IA) t-PA
- IV t-PA
- Recombinant t-PA Tissue plasminogen activator

Exclusion Guidelines for Abstraction:
None

Data Element Name: *IV Thrombolytic Initiation*

Collected For: The Joint Commission Only: 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:

- If IV thrombolytic was initiated at this hospital, select “Yes.”
- 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.”

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: The Joint Commission Only: 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 (2001-Current Year)
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 the earliest date. If there are two or more different IV thrombolytic initiation dates (either different IV thrombolytic episodes or corresponding with the same episode), enter the earliest date.
- 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 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: The Joint Commission Only: STK-4

Definition: The time (military time) for which 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.

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 the earliest time. If there are two or more different IV thrombolytic initiation times

(either different IV thrombolytic episodes or corresponding with the same episode), enter the earliest time.

- 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 as they do not demonstrate initiation of the IV thrombolytic (in the ED this may be used if signed/initialed by a nurse).
- 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 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: *Laparoscope*

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

Definition: A surgical procedure performed entirely with a laparoscope or other fiber optic scope.

Suggested Data Collection Question: Was the procedure performed entirely by laparoscope or other fiber optic scope?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 (Yes)	There is documentation the surgical procedure was performed entirely by laparoscope or other fiber optic scope.
2 (No)	There is documentation the surgical procedure was not performed entirely by laparoscope or other fiber optic scope.
3 (UTD)	Unable to determine from medical record documentation that the surgical procedure was performed entirely by laparoscope or other fiber optic scope.

Notes for Abstraction:

- If the only incisions made were those used to insert the laparoscopic equipment, select “Yes.”
- If an additional incision, a hand insertion, or an extension of the laparoscopic insertion sites is made, select “No.”
- If drains are inserted and there are no other incisions except those to insert the laparoscopic equipment, select “Yes."
  Examples:
  - Patient had a laparoscopic cholecystectomy with no incision other than those to insert the laparoscopic equipment, select 1, “Yes.”
  - Patient had a laparoscopically-assisted vaginal hysterectomy; select 2, “No.”
  - Patient had a “hand-assisted” or “laparoscopically assisted” colon resection, where the laparoscopic insertion sites were extended (incision was extended or an additional incision was made); select 2, “No.”
  - The procedure was coded as performed entirely laparoscopically, but the operative report indicates that the surgeon converted to an open procedure; select 2, “No.”

- ICD-9-CM codes may not be a reliable source to determine if the procedure was performed entirely by laparoscope or other fiber optic scope. Therefore, it is recommended that abstractors refer to the following Suggested Data Sources.

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

Inclusion Guidelines for Abstraction:
- Endoscope
- Fiber optic scope
- Thoracoscope

Exclusion Guidelines for Abstraction:
- Bowel exteriorized/extra-corporealized
- Hand access devices/ports
- Hand-assisted laparoscopic surgery (HAL)
- Laparoscopically-assisted procedures
- Stoma creation
- Wound protectors (device used to protect wound and prevent CO2 loss)

Data Element Name: *Last Known Well*

Collected For: The Joint Commission Only: 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 date, time, or both date and time are unknown.

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

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: The Joint Commission Only: 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 in the first 48 hours or within 30 days prior to hospital arrival. Direct and calculated (indirect) LDL-c values are 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 or greater than 999) and no other documentation is found that provides this information, the abstractor should select "No."
  Example:
  Documentation indicates the LDL-cholesterol value in the first 48 hours was 1000 mg/dL. No other documentation in the medical record provides a valid value. Since this value is not a valid value, the abstractor should 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 Within 24 Hours After Arrival*

Collected For: CMS/The Joint Commission: 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. 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: Was the patient's lowest LDL-c cholesterol (LDL-c) level from testing done within the first 24 hours after hospital arrival less than 100 mg/dL?

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.
N (No)	LDL-c is not less than 100 mg/dL in the first 24 hours after hospital arrival, no testing was done in the first 24 hours after hospital arrival (or LDL-c values not available), OR unable to determine from medical record documentation.

Notes for Abstraction:

- Determine the lowest LDL-c from all LDL-c testing done within the first 24 hours after hospital arrival. If there is more than one value documented for the same specimen, use the lowest value.
- Direct and calculated (indirect) LDL-c values are both acceptable.
- If all LDL-c value(s) from testing done within the first 24 hours after hospital arrival are reported as not calculated because 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

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: The Joint Commission Only: 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 (e.g., LDL-c testing was done within 48 hours but no values are available).

Notes for Abstraction:
If there is documentation that LDL-c testing was done within the first 48 hours 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: *Lipid-Lowering Agent Prescribed at Discharge*

Collected For: CMS Only: AMI-T2 (Optional Test Measure)

Definition: Documentation that a lipid-lowering medication was prescribed at hospital discharge.

Suggested Data Collection Question: Was a lipid-lowering medication prescribed at discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

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

Notes for Abstraction:

- In determining whether a lipid-lowering 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 lipid-lowering 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 lipid-lowering 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 lipid-lowering medication after discharge in one location and a listing of that lipid-lowering 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 x 2 days” and “Hold Lopid until ALT/AST normalize.”

- o If a lipid-lowering medication is NOT listed as a discharge medication, and there is only documentation of a hold or plan to delay initiation/restarting of a lipid-lowering medication after discharge (e.g., “Hold Vytorin x 2 days,” “Start lipid-lowering therapy as outpatient,” “Hold lovastatin”), select “No.”
- o If two discharge summaries are included in the medical record, use the one with the latest date. If one or both are not dated, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms.
  Examples:
  - Two discharge summaries, one dated 5/22 (day of discharge) and one dated 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 summary
- Medication reconciliation form
- Nursing discharge notes
- Physician orders
- 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: *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").
- Consider LVSF assessment as planned for after discharge only if a definitive plan is documented (e.g., "Will do echo as outpatient"). Documentation which indicates only that an LVSF assessment after discharge will be considered is not sufficient.

- 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 the ejection fraction after discharge”). 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: CMS/The Joint Commission: 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 contractile 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.

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
- Diastolic dysfunction, failure, function, or impairment
- Ventricular dysfunction not described as left ventricular
- Ventricular failure not described as left ventricular
- Ventricular function not described as left ventricular

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;
Informational Only: Prev-Imm-1, Prev-Imm-2

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.

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, PN-5), and in the transmission of the Hospital Clinical Data file; **CMS Voluntary Only:** ED-1, ED-2

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.

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: The Joint Commission Only: 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 were monitored according to the defined specifications.

Suggested Data Collection Question: Was there 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 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 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 or orders that state that a nomogram or protocol was used to calculate the UFH therapy dosages are acceptable. The pathways or orders must specify that the platelet counts were being monitoring within the defined specifications.
- "Defined parameters" for managing UFH therapy may include documents labeled a nomogram or protocol.
- Platelet count monitoring must be within the defined specifications of the inclusion guidelines in order to select "Yes."
- For orders that state that UFH therapy is ordered per pharmacy dosing or per pharmacy protocol select "Yes" if the platelet counts were also monitored within the defined specifications.

Suggested Data Sources:
PHYSICIAN/APN/PA or PHARMACIST DOCUMENTATION ONLY

- Physician orders

NURSES

- Pathways

Inclusion Guidelines for Abstraction:
The defined platelet count monitoring specifications are as follows:

- Baseline platelet count the day of (must be drawn before initiation of UFH) or the day before initiation of UFH.
- Repeat platelet count the day following the initiation of UFH.
- Platelet count at least three non-consecutive days within the first seven days (this includes the repeat platelet count day following the initiation of UFH therapy) and on at least three non-consecutive days between days 7 and 14 or until UFH is discontinued (whichever is first).

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

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Non-Primary PCI*

Collected For: CMS/The Joint Commission: AMI-8, AMI-8a

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:
- o “Will schedule elective PCI”
- o "Patient did not need to go to the cath lab emergently"
- o "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: *Observation Services*

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

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

Suggested Data Collection Question: Was there documentation the patient was placed in observation services during the encounter or hospitalization?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There was documentation the patient was placed into observation services in this facility's emergency department.
N (No)	There was no documentation the patient was placed into observation services in this facility's emergency department or unable to determine from medical record documentation.

Notes for Abstraction:

- If there is documentation the patient was placed into observation services and received care in observation provide by the emergency department or an observation unit of the emergency department, select "Yes."
- If there is documentation the patient is being admitted for observation outside the emergency department, select "No."
- If there is no documentation the patient received services in observation either in the emergency department or was to be admitted to another department for observation, select "No."
- The intent is to capture emergency department patients placed into observation services prior to admission to the facility as an inpatient.

Suggested Data Sources:
ONLY ALLOWABLE SOURCES:
Emergency Department record

Inclusion Guidelines for Abstraction:
None

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 the only antibiotic combinations administered prior to hospital arrival or more than 24 hours prior to incision were either oral Neomycin Sulfate + Erythromycin Base or oral Neomycin Sulfate + Metronidazole.

Suggested Data Collection Question: Were the only antibiotic combinations administered prior to hospital arrival or more than 24 hours prior to incision either oral Neomycin Sulfate + Erythromycin Base or oral Neomycin Sulfate + Metronidazole?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	The only antibiotics administered prior to hospital arrival or more than 24 hours prior to incision were either oral Neomycin Sulfate + Erythromycin Base or oral Neomycin Sulfate + Metronidazole.
N (No)	Oral Neomycin Sulfate + Erythromycin Base or oral Neomycin Sulfate + Metronidazole were not the only antibiotics administered prior to hospital arrival, or more than 24 hours prior to incision, or unable to determine from medical record documentation.

Notes for Abstraction:

- If there is documentation of a Nichol's Bowel Prep used prior to hospital arrival or prior to incision **and** there is no mention of other antibiotics administered prior to hospitalization or more than 24 hours prior to incision, select "Yes." Nichol's Bowel Prep contains the recommended oral antibiotics for Colon Surgery.
- If there is documentation of instructions or that prescriptions were given to the patient in regard to the oral antibiotics listed above and these are the only antibiotics administered prior to arrival or more than 24 hours prior to incision, assume the medications were given. Select "Yes."
- Oral antibiotics may be given less than 24 hours prior to incision, but this data element is only concerned with those given GREATER than 24 hours prior to incision.

Suggested Data Sources:

- Consultation notes
- Emergency department record
- History and physical
- Medication administration record

- Nursing admission assessment
- Nursing notes

Inclusion Guidelines for Abstraction:
- Erythromycin Base
- Metronidazole
- Neomycin Sulfate

Refer to Appendix C, Table 3.3 and Table 3.4 for a comprehensive list of Colon-Oral Antibiotics.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Other Surgeries*

Collected For: CMS/The Joint Commission: SCIP-Inf-1, SCIP-Inf-3, SCIP-Inf-9

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 cardiac devices (pacemakers, defibrillators, pulse generators, 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 cardiac 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 days (four days for CABG or Other Cardiac Surgery) window begins at the *Anesthesia End Time* of the earlier procedure and ends at the *Anesthesia Start Time* 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 days (four days for CABG or Other Cardiac Surgery) window begins at the *Anesthesia End Time* of the principal procedure and ends at the *Anesthesia Start Time* 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 Start Date*

Collected For: The Joint Commission Only: 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 (2001-Current Year)
UTD = Unable to Determine

Notes for Abstraction:

- Select "UTD" if unable to determine the date that both medications were administered.
- Review dates close to when VTE was diagnosed. It is not necessary to look outside of this timeframe to answer this data element.
- 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 Joint Commission's Data Warehouse. Use of "UTD" for *Overlap Therapy Start Date* allows the case to be accepted into the warehouse.

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 Administration*

Collected For: The Joint Commission Only: VTE-3

Definition: Documentation that a parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulant medication was administered.

Suggested Data Collection Question: Was a parenteral anticoagulant medication administered?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that a parenteral anticoagulant medication was administered.
N (No)	There is no documentation that a parenteral anticoagulant medication was administered or unable to determine from the medical record.

Notes for Abstraction:

- If a parenteral anticoagulant medication was ordered, but not administered, select “No.”
- Review dates close to when VTE was diagnosed. It is not necessary to look outside of this timeframe to answer this data element.

Suggested Data Sources:

- Medication administration record
- Nursing notes
- Physician notes
- Physician orders

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 End Date*

Collected For: The Joint Commission Only: 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 (2001-Current Year)
UTD = Unable to Determine

Notes for Abstraction:

- Select "UTD" if unable to determine the last date that a parenteral anticoagulant medication was administered.
- Review dates close to when VTE was diagnosed. It is not necessary to look outside of this timeframe to answer the data element.
- 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 Joint Commission's Data Warehouse. Use of "UTD" for *Parenteral Anticoagulant End Date* allows the case to be accepted into the warehouse.

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: The Joint Commission Only: 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. If one or both are not dated, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms.

  Examples:
  - Two discharge summaries, one dated 5/22 (day of discharge) and one dated 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
- Home health referral form
- Nursing notes
- Teaching sheet
- Discharge summary

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: *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:

- Medicare Fee for Service (includes DRG or PPS)
- Black Lung
- End Stage Renal Disease (ESRD)
- Railroad Retirement Board (RRB)
- Medicare Secondary Payer
- Medicare HMO/Medicare Advantage

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Perioperative Death*

Collected For: CMS/The Joint Commission: SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-4, SCIP-Inf-9, SCIP-Card-2, SCIP-VTE-1, 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: *Plan for LDL-Cholesterol Test*

Collected For: CMS Only: AMI-T1a (Optional Test Measure)

Definition: Documentation of a plan to do LDL-cholesterol (LDL-c) testing after discharge.

Suggested Data Collection Question: Is there a plan to do LDL-cholesterol (LDL-c) testing after discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Documentation of a plan to do LDL-c testing after discharge.
N (No)	No documentation of a plan to do LDL-c testing after discharge or unable to determine from medical record documentation.

Notes for Abstraction:

- There must be documentation of a definitive plan to do LDL-c testing after discharge (e.g., "Will do cholesterol testing after discharge"). Documentation, which indicates only that LDL-c testing after discharge will be considered (e.g., "May do cholesterol testing at next office visit"), is not sufficient.
- In the absence of explicit documentation of a plan to do LDL-c testing after discharge, it should be inferred that LDL-c testing is planned if there is documentation of a plan to do lipid testing after discharge.

Suggested Data Sources:

- Consultation notes
- Discharge instruction sheet
- Discharge planning notes
- Discharge summary
- 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:
LDL-cholesterol (LDL-c)

- Low den lipoprotein
- Low density lipoprotein (LDL)

Lipid testing

- Cholesterol analysis
- Cholesterol check (✓)
- Cholesterol panel
- Cholesterol profile
- Cholesterol testing
- Fasting lipids
- LDL: HDL
- LDL: HDL ratio
- Lipid analysis
- Lipid check (✓)
- Lipid panel
- Lipid profile
- Lipids
- Lipoprotein analysis

Exclusion Guidelines for Abstraction:
LDL-cholesterol (LDL-c)
VLDL (very low density lipoprotein)

Data Element Name: *Pneumococcal Vaccination Status*

Collected For: CMS/The Joint Commission: PN-2; **Informational Only**: Prev-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 medically contraindicated 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.
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:
  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 "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 patient when the 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.

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:
- Pneumococcal vaccine
- Pneumonia shot
- Pneumonia vaccine
- Pneumovax
- Pneumovax 23
- Pnu-imune 23
- Polyvalent pneumonia vaccine

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, including thimerosal. 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.)

Data Element Name: *Pneumonia Diagnosis: ED/Direct Admit*

Collected For: CMS/The Joint Commission: PN-3a, PN-3b, PN-5c; **CMS Only:** PN-6; **The Joint Commission Only:** PN-5, PN-6a, PN-6b

Definition: Documentation of the diagnosis of pneumonia either as the Emergency Department final 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 final diagnosis/impression, or as an admission diagnosis/impression for the direct admit patient?

Format:

Length: 1
Type: Alphanumeric

+ Occurs: 1

Allowable Values:

1	Pneumonia Diagnosis in the Emergency Department: There is physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation that pneumonia was a final diagnosis/impression on the ED form.
2	Pneumonia Diagnosis on Admission-Direct Admit: There is physician/APN/PA documentation that pneumonia is listed as an initial diagnosis/impression.
3	There is no physician/APN/PA documentation of pneumonia as a final diagnosis/impression on the ED form, or listed as an initial diagnosis/impression upon direct admit.
4	Unable to determine from medical record documentation.

Notes for Abstraction:

Pneumonia Diagnosis in the Emergency Department

- For the purposes of this data element, an ED admit is any patient who receives treatment, care or evaluation in the ED.
- Pneumonia need not be the primary or only diagnosis.
- For the purpose of this data element, the "ED form" is the document within the ED record which contains the final diagnosis/impression.
- 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, using the following guidelines.

- Do not use medical student, intern, resident, attending physician/APN/PA, etc. documentation of a differential diagnosis.
- Only select "4" if there is a place in the ED chart to document the final ED diagnosis/impression and this area is left blank. However, if there are multiple areas to document the final ED diagnosis/impression and any are completed, do not select "4."
- Diagnosis of pneumonia cannot be taken from the chest x-ray, discharge summary, coding or billing documents, or face sheet.
- 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" or "2" as applicable. Negative adjectives or phrases such as 'doubt' or 'no' would be a value "3."
- If any of the inclusions are documented, select value "1" or "2", accordingly
  Example:
  BOOP (bronchiolitis obliterans organizing pneumonia) will be value "1" or "2" as applicable because the 'P' stands for pneumonia.

Medical Records containing an ED form completed by the ED physician:

- If pneumonia is listed as the final diagnosis/impression on the ED form by any physician/APN/PA, select "1." No further review of additional suggested data sources is needed (e.g., the admit order or admit note).
- If there is documentation of aspiration PN as an ED final diagnosis/impression on an ED form or listed as an initial diagnosis for a direct admit in any of the allowable sources for direct admits, select "3."
  Example:
  ED final diagnosis "Pneumonia vs aspiration pneumonia", select "3."
- If the same emergency room physician/APN/PA who completed the ED forms did not include pneumonia as a final 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 "1."
  Example: The emergency room physician/APN/PA completes the ED form and the final diagnosis or impression is not pneumonia.
  - If that same physician/APN/PA wrote the admit orders or admit note with a diagnosis of pneumonia, select "1."
  - If the admit orders or admit note completed by that same physician/APN/PA does not include a diagnosis of pneumonia, select "3."
  - If a hospitalist, attending physician/APN/PA or consultant documents a diagnosis of pneumonia (whether the patient is still in the ED or not), select "3."

Medical Records containing an ED form completed by a hospitalist, attending physician/APN/PA or consultant:

- If pneumonia is listed as the final diagnosis/impression on the ED form by any physician/APN/PA, select "1." No further review of additional suggested data sources is needed (e.g., the admit order or admit note).

- If there is documentation of aspiration PN as an ED final diagnosis/impression on an ED form or listed as an initial diagnosis for a direct admit in any of the allowable sources for direct admits, select "3."
  Example:
  ED final diagnosis "Pneumonia vs aspiration pneumonia", select "3."
- If the hospitalist, attending physician/APN/PA or consultant who completed the ED forms did not include pneumonia as a final 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 "1."
  Example:
  The hospitalist, attending physician/APN/PA or consultant comes to the emergency room and completes the ED form, and the final diagnosis or impression is not pneumonia.
  - If that same physician/APN/PA wrote the admit orders or admit note with a diagnosis of pneumonia, select "1."
  - If the admit orders or admit note completed by that same physician/APN/PA does not include a diagnosis of pneumonia, select "3."

Medical Records that do not contain an ED form:

- A History & Physical can be used ONLY if the physician/APN/PA documents on one of the ONLY ACCEPTABLE SOURCES to "see H&P."
- Do not use an H&P labeled Admit H&P or an H&P that contains an admit note or order within the body of text
- If pneumonia is documented as a diagnosis/impression on ANY of the ONLY ACCEPTABLE SOURCES, select "1."
- Any of the ONLY ACCEPTABLE SOURCES can be used without a date or time.
- 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.
- If there is documentation of aspiration PN as an ED final diagnosis/impression on an ED form or listed as an initial diagnosis for a direct admit in any of the ONLY ACCEPTABLE SOURCES for direct admits, select "3."
  Example:
  ED final diagnosis "Pneumonia vs aspiration pneumonia", select "3."

Pneumonia Diagnosis on Admission-Direct Admit

- 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 as a diagnosis/impression.

- If pneumonia is documented as an impression/diagnosis on ANY of the ONLY ACCEPTABLE SOURCES, select “2.”
- Any of the ONLY ACCEPTABLE SOURCES can be used without a date or time.
- A History & Physical can be used ONLY if the physician/APN/PA documents on one of the ONLY ACCEPTABLE SOURCES to “see H&P.”
- Do not use an H&P labeled Admit H&P or an H&P that contains an admit note or order within the body of text
- If the admit orders refer to a Pneumonia Pathway or equivalent, or the Pneumonia Pathway contains orders to admit, select “2.”
- Diagnosis of pneumonia cannot be taken from the chest x-ray, discharge summary, coding or billing documents, or face sheet.
- If there is documentation of aspiration PN as an ED final diagnosis/impression on an ED form or listed as an initial diagnosis for a direct admit in any of the ONLY ACCEPTABLE SOURCES for direct admits, select “3.”
  Example:
  ED final diagnosis “Pneumonia vs aspiration pneumonia”, select “3.”
- The initial progress note is not an acceptable Data Source and not considered an admission note unless it contains documentation regarding admission.
- 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” or “2” as applicable. Negative adjectives or phrases such as ‘doubt’ or ‘no’ would be a value “3.”
- If any of the inclusions are documented, select value “1” or “2,” accordingly
  Example:
  BOOP (bronchiolitis obliterans organizing pneumonia) will be value “1” or “2” as applicable because the ‘P’ stands for pneumonia.

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Emergency Department
  - ED admitting notes
  - ED history and physical
  - ED physician orders
  - ED record
- Direct Admit – **ONLY ACCEPTABLE SOURCES**
  - Admitting notes
  - Admitting physician orders
  - Physician admission note

Inclusion Guidelines for Abstraction: This list is ALL Inclusive

- Infiltrate
- Lower Respiratory infection
- Lower lobe infection
- Admission Pneumonia Pathway (or equivalent)
- Pneumonitis
- P

- PN
- PNA
- PNE
- Pneu
- Pneumonia

Exclusion Guidelines for Abstraction:

- Aspiration pneumonia
- Chronic infiltrate
- Pneumonia caused by chemical agents or aerosolized medications

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 Warfarin*

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

Definition: Documentation that the patient was receiving warfarin prior to admission.

Suggested Data Collection Question: Is there documentation that the patient was on continuous warfarin prior to admission?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that the patient was on continuous warfarin prior to admission.
N (No)	There is no documentation that the patient was on continuous warfarin 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 warfarin therapy prior to hospitalization.
- If there is documentation that warfarin was a “home” or “current” medication, select “Yes.”
- If warfarin was listed as a “home” or “current” medication, but placed on hold the day prior to surgery, select “Yes.” **If the warfarin 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 warfarin to be taken at home in the 24 hours prior to incision, answer “no” as this is considered appropriate prophylaxis for some procedures.

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:
Refer to the first column of Table 2.1 in Appendix H, VTE Prophylaxis Inclusions, for a list of synonyms for warfarin.

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Pre-Arrival LDL-Cholesterol Qualitative Description*

Collected For: CMS Only: AMI-T1a (Optional Test Measure), AMI-T2 (Optional Test Measure)

Definition: Qualitative description of the results from the patient's LDL-cholesterol (LDL-c) test done in the past year.

Suggested Data Collection Question: How did the physician/advanced practice nurse/physician assistant (physician/APN/PA) qualitatively describe the patient's LDL-cholesterol (LDL-c) from the test performed within one year prior to arrival?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1	**Elevated LDL-c:** Physician/APN/PA qualitatively described the patient's LDL-c from the test performed within one year prior to arrival in terms consistent with elevated LDL-c (e.g., "Labs done last month showed elevated lipids").
2	**No Elevated LDL-c:** Physician/APN/PA qualitatively described the patient's LDL-c from the test performed within one year prior to arrival in terms, which are NOT consistent with elevated LDL-c (e.g., "Lipid levels normal in April").
3	**Not Documented:** Physician/APN/PA did not qualitatively describe the patient's LDL-c from the test performed within one year prior to arrival in any manner, or unable to determine from medical record documentation.

Notes for Abstraction:

- When more than one qualitative description of the patient's LDL-c from the past year is documented, use the description of the LDL-c from the test performed closest to the time of hospital arrival. If unable to determine which qualitative description refers to the LDL-c closest to the time of hospital arrival, select "Elevated LDL-c" if any of the descriptions are consistent with elevated LDL-c.
- If there are discrepant qualitative descriptions documented for the same pre-arrival specimen (e.g., one description consistent with elevated LDL-c and one not consistent with elevated LDL-c), select "Elevated LDL-c."

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Consultation notes
- Discharge summary
- Emergency department record
- History and physical
- Progress notes

Inclusion Guidelines for Abstraction:
LDL-cholesterol (LDL-c)

- Low den lipoprotein
- Low density lipoprotein (LDL)
- Value described as “bad cholesterol”

Elevated LDL-c

- Cholesterol described as elevated, high, or ↑
- Dyslipidemia
- Dyslipoproteinemia
- Hyperbetalipoproteinemia
- Hypercholesterolemia
- Hyperlipemia
- Hyperlipidemia
- Hyperlipoproteinemia
- LDL above goal or target
- LDL described as elevated, high, or ↑
- LDL-cholesterol (LDL-c) described as elevated, high, or ↑
- Lipids described as elevated, high, or ↑

Exclusion Guidelines for Abstraction:
LDL-cholesterol (LDL-c)
VLDL (very low density lipoprotein)

Elevated LDL-c

- Alpha lipoproteinemia
- Elevated LDL-c, or any of the other elevated LDL-c 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: *Pre-Arrival LDL-Cholesterol Test*

Collected For: CMS Only: AMI-T1a (Optional Test Measure), AMI-T2 (Optional Test Measure)

Definition: LDL-cholesterol (LDL-c) test was performed within one year prior to hospital arrival.

Suggested Data Collection Question: Was an LDL-cholesterol (LDL-c) test performed within one year prior to hospital arrival?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	LDL-c test was performed within one year prior to hospital arrival.
N (No)	LDL-c test was not performed within one year prior to hospital arrival or unable to determine from medical record documentation.

Notes for Abstraction:

- If there is documentation that LDL-c/lipid testing was done prior to arrival but the exact timeframe is not specified or determinable, select "No."
  EXCEPTION:
  If documentation describes the LDL-c/lipid testing as having been done in the "recent" past, it should be inferred that it was done within one year prior to arrival.
- In the absence of explicit documentation that an LDL-c test was or was not performed within one year prior to hospital arrival, it should be inferred that a test was done within one year if:
  - There is documentation of an LDL-c value from a test performed within one year prior to hospital arrival (e.g., "LDL-c 135 in November"), or
  - There is physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation which qualitatively describes the patient's LDL-c from a test performed within one year prior to hospital arrival (e.g., "Labs last month showed elevated lipids," "CABG in June. Cholesterol levels now good on Lipitor"), or
  - There is documentation that lipid testing was performed within one year prior to hospital arrival (e.g., "Cholesterol testing done in April").
- Documentation must suggest that the qualitative description of LDL-c is **from a test** done within one year prior to arrival: Do not make assumptions. In the following examples, "No" should be selected:
  - "Lipids have been good - patient on Zocor" per H&P
  - Physician/APN/PA notes "Risk factor - dyslipidemia" in progress note

- "Pt. denies hypercholesterolemia" per physician/APN/PA progress note
- ER physician/APN/PA notes "No hx hyperlipidemia"

- Do not include pre-arrival lipid testing or qualitative descriptions of pre-arrival lipid test results if it can be determined that LDL-c measurement was not part of the lipid testing. In the following examples, "No" should be selected:
  - Lipid profile done during hospitalization 6 months ago, per H&P, but the laboratory report from the hospitalization included in the chart lists only cholesterol and triglyceride values.
  - Physician/APN/PA notes "Labs from office visit on 04-03-20XX showed elevated cholesterol," but the 04-03-20XX laboratory report from the outpatient records included in the chart lists only a total cholesterol value.

Suggested Data Sources:

- Consultation notes
- Discharge summary
- Emergency department record
- History and physical
- Pre-arrival laboratory reports
- Progress notes

Inclusion Guidelines for Abstraction:
LDL-cholesterol (LDL-c)

- Low den lipoprotein
- Low density lipoprotein (LDL)
- Value described as "bad cholesterol"

Qualitative description of LDL-c

- Cholesterol level qualitatively described (e.g., low, normal, elevated, ↑)
- Dyslipidemia (presence or absence)
- Dyslipoproteinemia (presence or absence)
- Hyperbetalipoproteinemia (presence or absence)
- Hypercholesterolemia (presence or absence)
- Hyperlipemia (presence or absence)
- Hyperlipidemia (presence or absence)
- Hyperlipoproteinemia (presence or absence)
- LDL level qualitatively described (e.g., low, normal, elevated, above goal, below target, ↑)
- LDL-cholesterol (LDL-c) level qualitatively described (e.g., low, normal, elevated, ↑)
- Lipid levels qualitatively described (e.g., low, normal, elevated, ↑)

Lipid testing

- Cholesterol analysis
- Cholesterol check (✓)
- Cholesterol panel

- Cholesterol profile
- Cholesterol testing
- Fasting lipids
- LDL: HDL
- LDL: HDL ratio
- Lipid analysis
- Lipid check (✓)
- Lipid panel
- Lipid profile
- Lipids
- Lipoprotein analysis

Exclusion Guidelines for Abstraction:
LDL-cholesterol
VLDL (very low density lipoprotein)

Qualitative description of LDL-c
Alpha lipoproteinemia (presence or absence)

Data Element Name: *Pre-Arrival LDL-Cholesterol Value*

Collected For: CMS Only: AMI-T1a (Optional Test Measure), AMI-T2 (Optional Test Measure)

Definition: LDL-c cholesterol (LDL-c) value from test done in the past year.

Suggested Data Collection Question: What is the patient's LDL-cholesterol (LDL-c), in mg/dL or mg/100 ml, from the LDL-c test performed within one year prior to hospital arrival?

Format:

Length: 1 - 3 or UTD with no leading zeros or decimals
Type: Numeric
Occurs: 1

Allowable Values:

- Enter the patient's LDL-c value, in mg/dL or mg/100 ml, from the LDL-c test performed within one year prior to hospital arrival.
- UTD = Unable to Determine

Notes for Abstraction:

- When more than one LDL-c value from the past year is documented, enter the LDL-c from the test performed closest to the time of hospital arrival. If unable to determine which value was drawn closest to hospital arrival time, enter the highest value.
- Direct and calculated (indirect) LDL-c values are acceptable. If both direct and calculated LDL-c values are documented for the same specimen date/time, enter the direct LDL-c value.
- If the indirect LDL-c is reported as not calculated because high triglycerides render the LDL-c calculation inaccurate, consider the calculated LDL-c value equal to 0 (zero).
- If an LDL-c value on the pre-arrival laboratory report conflicts with that from another source of documentation for the same specimen, enter the value from the laboratory report.
- If a pre-arrival laboratory report documents discrepant LDL-c values for the same specimen, enter the highest value.
- If sources other than a laboratory report document discrepant LDL-c values for the same specimen, enter 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.
- If an LDL-c value from the LDL-c test performed within one year prior to hospital arrival is not documented or if unable to determine from medical record

documentation (e.g., LDL-c testing was done within the past year but no values are available), select “UTD.”

- The medical record must be abstracted as documented (taken at “face value”). When the value documented is obviously in error (not a valid number or greater than 999) **and** no other documentation is found that provides this information, the abstractor should select “UTD.”
  Example:
  Documentation indicates the *Pre-Arrival LDL-Cholesterol Value* was 1000 mg/dL. No other documentation in the medical provides a valid value. Since the *Pre-Arrival LDL-Cholesterol Value* is outside of the range listed in the Format Length (greater than 999), it is not a valid value and the abstractor should select “UTD.”
  Note: Transmission of a case with an invalid value will be rejected from the QIO Clinical Warehouse. Use of “UTD” for *Pre-Arrival LDL-Cholesterol Value* allows the case to be accepted into the warehouse.

Suggested Data Sources:

- Consultation notes
- Discharge summary
- Emergency department record
- History and physical
- Pre-arrival laboratory reports
- Progress notes

Inclusion Guidelines for Abstraction:
LDL-cholesterol (LDL-c)

- Low den lipoprotein
- Low density lipoprotein (LDL)
- Value described as “bad cholesterol”

Exclusion Guidelines for Abstraction:
LDL-cholesterol (LDL-c)
VLDL (very low density lipoprotein)

Data Element Name: *Pre-Arrival Lipid-Lowering Agent*

Collected For: CMS Only: AMI-T1a (Optional Test Measure); **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:

- Include cases where there is documentation that the patient was prescribed 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).
- 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: CMS/The Joint Commission: 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: *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 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 Only: 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 Delay in Fibrinolytic Therapy*

Collected For: CMS/The Joint Commission: AMI-7, AMI-7a

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," 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."

EXCEPTIONS:
Physician/APN/PA documentation that a cardiopulmonary arrest, balloon pump insertion, 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," or "wait" in initiating fibrinolysis actually occurred. In order for cardiopulmonary arrest, balloon pump insertion, 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:
Balloon pump

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

Cardiopulmonary arrest

- Cardiac arrest
- Cardiopulmonary resuscitation (CPR)
- Code
- Defibrillation
- Respiratory arrest
- Ventricular fibrillation (V-fib)

Intubation

- Endotracheal intubation (ETI)
- Mechanical ventilation
- Nasotracheal intubation (NTI)
- Orotracheal intubation

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Reason for Delay in PCI*

Collected For: CMS/The Joint Commission: AMI-8, AMI-8a

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," 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."

- "SVG Angiojet cath did not cross lesion. XMI 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."

EXCEPTIONS:
Physician/APN/PA documentation that a cardiopulmonary arrest, balloon pump insertion, 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," or "wait" in doing the PCI actually occurred. In order for cardiopulmonary arrest, balloon pump insertion, 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:
Balloon pump

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

Cardiopulmonary arrest

- Cardiac arrest
- Cardiopulmonary resuscitation (CPR)
- Code
- Defibrillation
- Respiratory arrest
- Ventricular fibrillation (V-fib)

Intubation

- Endotracheal intubation (ETI)
- Mechanical ventilation
- Nasotracheal intubation (NTI)
- Orotracheal intubation

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Reason for Discontinuation of Overlap Therapy*

Collected For: **The Joint Commission:** VTE-3

Definition: Documentation of a reason for discontinuation of the overlap 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 overlap 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 overlap therapy.
N (No)	There is no reason documented by a physician/APN/PA or pharmacist for discontinuation of the overlap therapy or unable to determine from medical record documentation.

Notes for Abstraction:

- Patient refusal may be documented by a nurse.

Suggested Data Sources:
PHYSICIAN/APN/PA or PHARMACIST DOCUMENTATION ONLY

- Consultation notes
- 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.

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Reason for No ACEI and No ARB at Discharge*

Collected For: CMS/The Joint Commission: 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., "POTASSIUM5.5 – 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.

EXCEPTION:

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.”

- Reason documentation which refers to a more general medication class is not acceptable (e.g., “Hold all BP meds”).
- 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).
- 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.”, “Start candesartan after nephrology sees”)
- 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: CMS/The Joint Commission: AMI-2

Definition: Reasons for not prescribing aspirin at discharge:
- Aspirin allergy
- Coumadin/warfarin 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 Coumadin/warfarin was prescribed at discharge (i.e., a reason for not prescribing aspirin at discharge):
  - Include Coumadin/warfarin 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. If one or both are not dated, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms.
    Examples:

- Two discharge summaries, one dated 5/22 (day of discharge) and one dated 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.

    EXCEPTION:

    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”).
  - Reason documentation which refers to a more general medication class is not acceptable (e.g., “Hold all anticoagulants”).
  - 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:
Refer to Appendix C, Table 1.1 for a comprehensive list of Aspirin and Aspirin-Containing medications.

Refer to Appendix C, Table 1.4 for a comprehensive list of Warfarin 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: CMS/The Joint Commission: AMI-1

Definition: Reasons for not administering aspirin on arrival:

- Aspirin allergy
- Coumadin/warfarin 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 Coumadin/warfarin 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 Coumadin/warfarin 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.
  EXCEPTION:
  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”).
- Reason documentation which refers to a more general medication class is not acceptable (e.g., “Hold all anticoagulants”).
- 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:
Refer to Appendix C, Table 1.1 for a comprehensive list of Aspirin and Aspirin-Containing medications.

Refer to Appendix C, Table 1.4 for a comprehensive list of Warfarin 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: CMS/The Joint Commission: 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.
    EXCEPTION:
    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."
  - 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").
  - 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 LDL-Cholesterol Testing*

Collected For: CMS Only: AMI-T1a (Optional Test Measure)

Definition: Documentation of a reason for not doing LDL-cholesterol (LDL-c) testing.

Suggested Data Collection Question: Is there a reason documented by a physician/advanced practice nurse/physician assistant (physician/APN/PA) for not doing LDL-cholesterol (LDL-c) testing?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	Reason documented by a physician/APN/PA for not doing LDL-c testing.
N (No)	No reason documented by a physician/APN/PA for not doing LDL-c testing, or unable to determine from medical record documentation.

Notes for Abstraction:
In determining whether there is a reason documented by physician/APN/PA for not doing LDL-c testing:

- Reasons must be explicitly documented (e.g., “ESRD, life expectancy less than 1 month - Will not do LDL: HDL”) or clearly implied (e.g., “Patient refusing labs,” “Limited life expectancy, will not do any further evaluation,” “Lipid testing not indicated”). If reasons are not mentioned in the context of LDL-c testing, do not make inferences (e.g., do not assume that the physician/APN/PA is not doing LDL-c testing because the patient is of advanced age). If the physician/APN/PA documents that he is deferring the LDL-c testing to another physician/APN/PA, this should NOT count as a reason for not doing LDL-c testing unless the reason/problem underlying the deferral is also noted (e.g., Select "No" if “Consulting cardiologist to evaluate pt. for cholesterol testing” or "Pt. to follow up with physician/APN/PA re: measuring lipids as outpatient").
- When a physician/APN/PA documents a reason for not doing lipid testing (e.g., “On Lipitor, Chol. testing not needed at this time”), this should be construed as a reason for not doing LDL-c testing.

Suggested Data Sources:
PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Consultation notes
- Discharge summary

- Emergency department record
- History and physical
- 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:
LDL-cholesterol (LDL-c)
- Low den lipoprotein
- Low density lipoprotein (LDL)

Lipid testing
- Cholesterol analysis
- Cholesterol check (✓)
- Cholesterol panel
- Cholesterol profile
- Cholesterol testing
- Fasting lipids
- LDL: HDL
- LDL: HDL ratio
- Lipid analysis
- Lipid check (✓)
- Lipid panel
- Lipid profile
- Lipids
- Lipoprotein analysis

Exclusion Guidelines for Abstraction:
LDL-cholesterol (LDL-c)
VLDL (very low density lipoprotein)

Data Element Name: *Reason for No Lipid-Lowering Therapy*

Collected For: CMS Only: AMI-T2 (Optional Test Measure)

Definition: Reasons for not prescribing a lipid-lowering medication at discharge:
- Lipid-lowering medication allergy
- Other reasons documented by physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist

Suggested Data Collection Question: Is there documentation of a reason for not prescribing a lipid-lowering medication at discharge?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation of a reason for not prescribing a lipid-lowering medication at discharge.
N (No)	There is no documentation of a reason for not prescribing a lipid-lowering medication at discharge or unable to determine from medical record documentation.

Notes for Abstraction:
- A lipid-lowering 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 lipid-lowering medication is acceptable to take as an allergy to the entire class of lipid-lowering 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 lipid-lowering medication at discharge:
  - Reasons must be explicitly documented (e.g., "Active PUD - Lipid lowering therapy contraindicated") or clearly implied (e.g., "Hx muscle soreness to statins in past," "Lipid lowering agents contraindicated," "Pt. refusing all medications," "Supportive care only – no medication," lipid-lowering medication on pre-printed order form is crossed out, "Lipid agents not indicated," "No cholesterol medications" [no reason given]). If reasons are not mentioned in the context of lipid-lowering medications, do not make inferences (e.g., do not assume that a lipid-lowering 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 lipid-lowering medication or discontinuation of a lipid-lowering medication that occurs during the hospital stay constitutes a “clearly implied” reason for not prescribing a lipid-lowering medication at discharge. A hold/discontinuation of all p.o. medications counts if lipid-lowering medication p.o. was on order at the time of the notation.
  EXCEPTION:
  Documentation of a conditional hold or discontinuation of a lipid-lowering medication (e.g., “Hold Zocor if severe diarrhea persists,” “Stop atorvastatin if myalgias persist”).
- Deferral of lipid-lowering medication from one physician/APN/PA or pharmacist to another does NOT count as a reason for not prescribing a lipid-lowering medication unless the problem underlying the deferral is also noted.
  Examples:
  - “Consulting cardiologist to evaluate pt. for lipid therapy” - select “**No.**”
  - “Severe diarrhea. Start statin if OK with cardiology.” - select "**Yes**."
- If there is documentation of a plan to initiate/restart a lipid-lowering 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 lipid-lowering 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 Zetia 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 lipid-lowering 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 lipid-lowering medication counts as a "clearly implied reason" for not prescribing lipid-lowering medication at discharge only if on a pre-printed form.
- Lipid-lowering medications may also be referred to as bile acid sequestrants, fibric acid derivatives, fibrates, HMG CoA reductase inhibitors (statins), resin drugs, and nicotinic acid (e.g., “Problems with statins in past”).

- When the current record includes documentation of a pre-arrival reason for no lipid-lowering 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 lipid-lowering medication allergy.

- Pre-arrival hold/discontinuation or notation such as "No lipid-lowering 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 lipid-lowering 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
- 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:
Refer to Appendix C, Table 1.6 for a comprehensive list of Lipid-Lowering medications.

Exclusion Guidelines for Abstraction:
Lipid-lowering medication allergy described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table

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Last Updated: Version 3.2

Data Element Name: *Reason for No VTE Prophylaxis – Hospital Admission*

Collected For: The Joint Commission Only: STK-1, VTE-1

Definition: Documentation why mechanical or pharmacologic VTE prophylaxis was not administered at hospital admission.

Suggested Data Collection Question: Is there documentation why prophylaxis was not administered at hospital admission?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation why prophylaxis was not administered at hospital admission.
N (No)	There is no documentation why prophylaxis was not administered at hospital admission or unable to determine from medical record documentation.

Notes for Abstraction:

- Documentation of the reason for no VTE prophylaxis must be located within the timeframe of the day of or the day after hospital admission. It is not necessary to review documentation outside of this timeframe to answer this data element. A completed risk assessment within this timeframe is an acceptable source for this data element, if it is clear that the patient is at low risk for VTE and does not need VTE prophylaxis.
- 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."
- Both the pharmacological and mechanical approaches must be assessed to answer "Yes" to this data element. For example, if there is physician documentation of "bleeding, no pharmacologic prophylaxis needed", there must also be documentation of a reason why no mechanical prophylaxis was administered to select "Yes." If either type of prophylaxis was administered, then no reason is required with one exception: GCS as the sole form of prophylaxis for STK requires a documented reason.
- Patient refusal may be documented by a nurse, but should be documented within the same timeframe as the reason for no VTE prophylaxis.

VTE:
Surgical patients who have procedures with general or neuraxial anesthesia the day of or the day after admission, have until the day after the *Surgery End Date* to document the reason for no VTE prophylaxis. It is not necessary to review documentation outside of this timeframe to answer this data element.

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

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

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Reason for No VTE Prophylaxis – ICU Admission*

Collected For: The Joint Commission Only: VTE-2

Definition: Documentation why mechanical or pharmacologic VTE prophylaxis was not administered at ICU admission/transfer.

Suggested Data Collection Question: Is there documentation why prophylaxis was not administered at ICU admission or transfer?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation why prophylaxis was not administered at ICU admission/transfer.
N (No)	There is no documentation why prophylaxis was not administered at ICU admission/transfer or unable to determine from medical record documentation.

Notes for Abstraction:

- Documentation of the reason for no VTE prophylaxis must be located within the timeframe of the day of or the day after ICU admission/transfer. It is not necessary to review documentation outside of this timeframe to answer this data element. A completed risk assessment within this timeframe is an acceptable source for this data element, if it is clear that the patient is at low risk for VTE and does not need VTE prophylaxis.
- 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."
- Both the pharmacological and mechanical approaches must be assessed to answer "Yes" to this data element. For example, if there is physician documentation of "bleeding, no pharmacologic prophylaxis needed", there must also be documentation of a reason why no mechanical prophylaxis was administered to select "Yes." If either type of prophylaxis was administered, then no reason is required.
- Patients who have procedures with general or neuraxial anesthesia the day of or the day after admission, have until the day after the *Surgery End Date* to document the reason for no prophylaxis. It is not necessary to review documentation outside of this timeframe to answer this data element.

- Patient refusal may be documented by a nurse, but should be documented within the same timeframe as the reason for no prophylaxis.

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

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Reason for Not Administering Antithrombotic Therapy by End of Hospital Day 2*

Collected For: The Joint Commission Only: 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:

- 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 does not have to be documented by a physician/APN/PA or pharmacist but it must be documented in the timeframe of arrival to the end of hospital day 2.
- **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).
- See the inclusion list for acceptable reasons for not administering antithrombotic therapy. The list is not all-inclusive.

- 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.
- 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.

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:
Reason for not administering antithrombotic therapy by the end of hospital day 2:
- Allergy to or complication related to antithrombotic
- 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
- Other documented by physician/APN/PA or pharmacist

Exclusion Guidelines for Abstraction:
Orders to hold antithrombotic therapy without a documented reason

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 are clearly documented in the medical record. Reasons for not administering beta-blockers may include bradycardia (heart rate less than 50 beats per minute [bpm]) or other reasons documented by physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist.

- Bradycardia (heart rate less than 50 bpm)
- 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.

Note: The perioperative period for the SCIP cardiac measures is defined as 24 hours prior to surgical incision through discharge from the post anesthesia care/recovery area.

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

Allowable Values:

Y (Yes)	There is documentation that the patient has one or more reasons for not administering a beta- blocker during the perioperative period.
N (No)	There is no documentation of reasons for not administering a beta-blocker during the perioperative period or unable to determine from medical record documentation.

Notes for Abstraction:

- Documentation of reasons for not administering a beta-blocker must **apply** to the perioperative period. The documentation does NOT need to be found **only within** the perioperative period.
- If the physician writes a specific reason/reasons for not administering beta-blockers during the perioperative period, select "Yes."
  Example:
  The physician documents: Will hold beta-blockers since the patient is hemodynamically unstable.

- Documentation that the patient is NPO or due to NPO status alone is not acceptable, select “No.”
- Documentation to hold all meds or to hold all PO meds, alone, is not acceptable, select “No.”
- Documentation of “bradycardia” alone is not acceptable. Bradycardia must be substantiated by documentation of a heart rate of less than 50 bpm. Vital signs obtained while patient is on cardiopulmonary bypass machine cannot be used to determine bradycardia.
- 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 the perioperative period, select “Yes.” Example: The physician writes the order, “Hold atenolol for SBP less than 100” and the nurse documents that the atenolol was held for a blood pressure of 90/50 during the perioperative period, select “Yes.”
- **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
- 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.

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 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, 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 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-1, SCIP-VTE-2

Definition: Reason for not administering pharmacological and/or mechanical 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 pharmacological and/or mechanical VTE prophylaxis?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1	There is physician/APN/PA or pharmacist documentation of a reason for not administering mechanical VTE prophylaxis.
2	There is physician/APN/PA or pharmacist documentation of a reason for not administering pharmacological VTE prophylaxis.
3	There is physician/APN/PA or pharmacist documentation of a reason for not administering both mechanical and pharmacological VTE prophylaxis.
4	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:

- Documentation for allowable values 1-3 must be found 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.
- See the inclusion list for acceptable reasons for not administering prophylaxis. The list is not all-inclusive.
- An allergy or adverse reaction to one type of pharmacological prophylaxis would NOT be a reason for not administering all pharmacological prophylaxis. Another medication can be ordered.
- A physician-documented contraindication to one type of prophylaxis does not mean the patient has a reason for not administering all prophylaxis.

Example:
The physician documents “Patient is at risk for bleeding, no anticoagulants.” Select “2.”

- The physician documents “Patient is allergic to coumadin.” Do NOT select that the patient has a reason for not administering all pharmacological prophylaxis because that is not documented. Select “4.”
- If the physician orders a transfusion and the blood products are administered in the timeframe of arrival to 24 hours after *Anesthesia End Time*, select “2.”
  - Blood or blood products administered intraoperatively (during surgery) and documented on the anesthesia record or in the operative report should be considered an order for transfusion. Select Value “2.”
- Re-infusion of blood products collected with blood recovery systems should not be considered for this element.
- For patients on continuous IV heparin therapy within 24 hours before or after surgery, select Value “3.”
- To select value “3”, there must be documentation of reasons for not administering BOTH mechanical and pharmacological prophylaxis. Example: There is physician documentation that a trauma patient has active bleeding and fractured femurs bilaterally. Select “3.”
- Patient refusal does not have to be documented by a physician/APN/PA, but it must be documented in the timeframe of 24 hours prior to surgery to 24 hours after *Anesthesia End Time.*
- If there is physician documentation of bleeding risk associated with surgery, do not consider this a reason for not administering pharmacological VTE prophylaxis.
  Example:
  The physician documents, “Discussion of risks and benefits included risk of infection and bleeding.”
- Physician documentation of bleeding risk or active bleeding in reference to the normal risk of bleeding or to the normal bleeding associated with surgery, is not considered a contraindication to pharmacological VTE prophylaxis.

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:
- 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:
- History (Hx) of bleeding
- Bleeding risk described in the informed consent process
- Re-infusion of blood products collected with blood recovery systems
- Minimal or scant bleeding or oozing
- Serosanguinous drainage from drain or surgical dressing
- Chronic Anemia

Data Element Name: *Reason for Not Initiating IV Thrombolytic*

Collected For: The Joint Commission Only: 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.

IV thrombolytics convert plasminogen to plasmin, which in turn breaks down fibrin and fibrinogen, thereby dissolving thrombus.

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 do not have to be documented by a physician/APN/PA or pharmacist.
- **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 measure. 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.”

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

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:

- Orders to hold IV thrombolytic without a documented reason.
- Delay in hospital arrival greater than 2 hours

Data Element Name: *Reason for Not Prescribing **Anticoagulation** Therapy at Discharge*

Collected For: The Joint Commission Only: STK-3

Definition: Reason for not prescribing **anticoagulation** therapy at hospital discharge.

- Anticoagulant medication allergy
- 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).
- See the inclusion list for acceptable reasons for not prescribing anticoagulation therapy. The list is not all-inclusive.
- 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.

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
- History and physical
- Medication reconciliation form
- Progress Notes

Excluded Data Sources:
Any documentation dated/timed after discharge, except discharge summary.

Inclusion Guidelines for Abstraction:
Reasons for not PRESCRIBING anticoagulation therapy at hospital discharge:

- Allergy to or complication related to anticoagulant
- 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
- Other documented by physician/APN/PA or pharmacist

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Reason for Not Prescribing **Antithrombotic** Therapy at Discharge*

Collected For: The Joint Commission Only: STK-2

Definition: Reason for not prescribing **antithrombotic** therapy at hospital discharge.
- Antithrombotic medication allergy
- 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).
- See the inclusion list for acceptable reasons for not prescribing antithrombotic therapy. The list is not all-inclusive.
- 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.

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
- History and physical
- Medication reconciliation form
- Progress Notes

Excluded Data Sources: Any documentation dated/timed after discharge, except discharge summary.

Inclusion Guidelines for Abstraction:
Reasons for not PRESCRIBING antithrombotic therapy at hospital discharge:

- Allergy to or complication related to antithrombotic
- 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
- Other documented by physician/APN/PA or pharmacist

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Reason for Not Prescribing Statin Medication at Discharge*

Collected For: CMS/The Joint Commission: AMI-10; **The Joint Commission Only:** STK-6

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.

  EXCEPTION:

  Documentation of a conditional hold or discontinuation of a statin medication (e.g., "Hold Zocor if severe diarrhea persists," "Stop atorvastatin if myalgias persist").
- 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
- History and physical
- Medication reconciliation form
- Progress Notes

Excluded Data Sources: Any documentation dated/timed after discharge, except discharge summary.

Inclusion Guidelines for Abstraction:
Reasons for not PRESCRIBING statin medication at hospital discharge:
- Allergy to or complication related to statins
- Arrhythmias
- Hepatic failure
- Hepatitis
- Hypoglycemia
- Patient/family refusal
- Rectal Hemorrhage
- Rhabdomyolosis

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: *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 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

Allowable Values:

1	There is documentation that the patient was in the intensive care unit (ICU) AND receiving diuretics.
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:

- Allowable 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 is receiving diuretics, select “1.”
- The Medication Administration Record (MAR) can be used to determine whether the patient in the ICU is receiving a diuretic. There must be documentation of administration not just a physician order for diuretics.
- 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.

- If no diuretic 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 "2."

Suggested Data Sources:
Allowable Value 1:
- ICU flow sheet
- Medication Administration Record
- Nurses notes
- Progress notes

Allowable Value 2:
PHYSICIAN/APN/PA DOCUMENTATION ONLY
- Physician orders
- Operative report
- Progress notes

Inclusion Guidelines for Abstraction:
ICU synonyms:
- 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)

ICU placement AND diuretic therapy (see Appendix C, Table 3.13 for a list of common diuretics).

Exclusion Guidelines for Abstraction:
- Patient refusal of catheter removal
- High risk of falls

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 postoperatively by the 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: 1-6

Allowable Values:

Select all that apply:

1	There is physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation within 2 days (3 days for CABG or Other Cardiac Surgery) following the principal procedure with the day of surgery being day zero that erythromycin was administered postoperatively for the purpose of increasing gastric motility.
2	There is physician/APN/PA documentation within 2 days (3 days for CABG or Other Cardiac Surgery) following the principal procedure with the day of surgery being day zero that an antibiotic was administered postoperatively for the treatment of hepatic encephalopathy.
3	There is physician/APN/PA documentation within 2 days (3 days for CABG or Other Cardiac Surgery) following the principal procedure with the day of surgery being day zero that an antibiotic was administered postoperatively as prophylaxis of Pneumocystis pneumonia (PCP) to a patient with a diagnosis of AIDS.
4	There is physician/APN/PA documentation within 2 days (3 days for CABG or Other Cardiac Surgery) following the principal procedure with the day of surgery being day zero that the patient had an infection.
5	There is physician/APN/PA documentation within 2 days following the principal procedure with the day of surgery being day zero that the patient has a current malignancy of the lower extremity

involving the same extremity as the principal procedure that was an original arthroplasty or a joint revision surgery.

6 There is documentation within 2 days following the principal procedure with the day of surgery being day zero that the principal procedure was a joint revision surgery.

7 No documented reason/Unable to Determine.

Notes for Abstraction:

- Only documentation written or dictated after incision and within 2 days (3 days for CABG or Other Cardiac Surgery) postoperatively with the day of surgery being day zero, may be used to abstract this data element.
- The reason for extending the antibiotic must be correlated with the physician's decision to extend the use of the antibiotic past 24 hours (48 hours for CABG or Other Cardiac Surgery) after *Anesthesia End Time.*
- If a value of "7" is selected, no other selections should be recorded.

For Value 1:

- 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.

For Value 3:

- Documentation of Pneumocystis pneumonia can include but is not limited to: pneumocystis carinii pneumonia or PCP in a patient with a diagnosis of AIDS.

For Value 4:

- 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 table to use as a guideline that provides the types of infection that are acceptable. Please reference this inclusion table when answering this data element.

For Value 5:

- There must be documentation that the current principal procedure is an original joint revision (arthroplasty) or is a revision of a previous joint revision (arthroplasty).
- Documentation of lower extremity malignancies include but are not limited to the examples listed in the inclusion list.

- The lower extremity includes the hip, knee and foot joints.

For Value 6:
- There must be documentation that the current principal procedure was a joint revision. The same joint must have been operated on in a previous surgery that was an arthroplasty, total or partial, ***OR*** there must be documentation that hardware was removed during the current principal procedure.
- Documentation for this value may be found intraoperatively or postoperatively.

Suggested Data Sources:
For Values 1 through 5:
PHYSICIAN/APN/PA DOCUMENTATION ONLY
- Anesthesia record
- Consultation notes
- Discharge summary
- Operative Report
- Physician order forms
- Progress notes

For Value 6:
- Discharge summary
- Intraoperative Record
- Operative Report
- Progress notes

For Values 1-6: Excluded Data Source: Any preoperative documentation.

For Value 4: Excluded Data Sources:
- Any postoperative documentation of infection from pathology reports.
- Discharge summaries not dictated or written within 2 days (3 days for CABG or Other Cardiac Surgery) postoperatively with the day of surgery being day zero.

Inclusion Guidelines for Abstraction:
For Value 4:
- Abscess
- Acute abdomen
- Aspiration pneumonia
- Bloodstream infection
- Bone infection
- Cellulitis
- 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
- Urinary tract infection (UTI)

For Value 5: Current malignancy of the same lower extremity 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 4:

- Bacteria in urine (Bacteriuria)
- "carditis" (such as pericarditis) without mention of an infection
- Colonization or positive screens for MRSA, VRE, or for other bacteria
- Fungal infections
- History of infection, recent infection or recurrent infection not documented as a current or active infection
- Viral infections

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: *Risk Factors for Drug-Resistant Pneumococcus*

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

Definition: Documentation of a risk factor(s) for drug-resistant pneumococcus. For the purposes of the Pneumonia Measures, the risk factors are:

- Patients 65 and over
- ICU Patients – within 24 hours of arrival
- Alcoholism – any mention in chart
- Systemic antibiotic therapy in the last 3 months prior to arrival
- Medical co-morbidities
- Exposed to child in daycare
- Injection drug user – only illicit drugs

Suggested Data Collection Question: Did the patient have a documented risk factor(s) for drug-resistant pneumococcus?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation the patient had risk factors for drug-resistant pneumococcus.
N (No)	There is no documentation the patient had risk factors for drug-resistant pneumococcus or unable to determine from medical record documentation.

Notes for Abstraction:

- For the purposes of this data element, medical co-morbidities are defined as:
  - Renal, heart, lung or liver disease documented within the last 3 months
  - Diabetes mellitus
  - Asplenia
  - Malignancies documented within the last 3 months
- For the purposes of this data element, 'Exposed to child in daycare' would consist of living with a child who attends daycare or working at a daycare. Casual contact or visiting a family with a child who has been in daycare is not considered "exposure."

Suggested Data Sources:

- History and Physical
- Nurse's notes

- Physician's notes
- Progress notes

Inclusion Guidelines for Abstraction:
- Alcoholism
- Alcoholic
- Alcohol abuse
- Asplenia
- Diabetes
- Diabetes Mellitus
- Diabetic
- DM
- Injection drug user
- IVDU
- IV user
- Needles for drugs
- Needle user
- Malignancy - current

See Appendix C, Table 2.1 for a comprehensive list of antimicrobial 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; **The Joint Commission Only:** AMI-9

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: AMI-10; **The Joint Commission Only:** STK-6

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 X 2 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 X 2 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. If one or both are not dated, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms.

  Examples:
  - Two discharge summaries, one dated 5/22 (day of discharge) and one dated 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:

- 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: The Joint Commission Only: 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 (2001 – Current Year)
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), ex: 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 Joint Commission's Data Warehouse. Use of "UTD" for *Surgery End Date* allows the case to be accepted into the warehouse.

Suggested Data Sources:

- Anesthesia record
- Operative report
- Operating room notes

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Surgery End Date – ICU Admission*

Collected For: **The Joint Commission Only:** 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 (2001 – Current Year)
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), ex: 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*.
- 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 Joint Commission's Data Warehouse. Use of "UTD" for *Surgery End Date – ICU Admission* allows the case to be accepted into the warehouse.

Suggested Data Sources:

- Anesthesia record
- Operative report
- Operating room notes

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 (2001 – Current Year)
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-XXXX, the *Anesthesia Start Time* is 0800, the *Surgical Incision Time* is 0810. Use 03-16-XXXX 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-XXXX, the *Anesthesia Start Time* is 2355, the *Surgical Incision Time* is 0010. Use 05-09-XXXX 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-XXXX. 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, enter "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) with stent placement, 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 stents were placed OR if no antibiotics were given prior to the start of the Principal Procedure, use the date that the Principal Procedure began as the *Surgical Incision Date.*

Example:

Anesthesia start date and time is 01-01-XXXX at 2300. Antibiotics are given at 2345. Cysto with stent placement is started at 0015. Abstract the *Surgical Incision Date* as 01-02-XXXX as it is clear that the date would change if the cysto was started after 00:00.

B. Laparoscopy to Open: If the procedure starts as a laparoscopic procedure **AND** antibiotics were given prior to this procedure and it is converted to an open procedure, abstract the *Surgical Incision Date* that is documented for the laparoscopic procedure.

If the procedure starts as a laparoscopic procedure **AND** antibiotics were NOT given prior to this procedure and it is converted to 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 Principal Procedure is not the first of those, the *Surgical 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.

EXCEPTIONS:

A. **Cystoscopy:** If a patient has a cystoscopy with stent placement 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 stents were placed OR if no antibiotics were given prior to the start of the Principal Procedure, use the time that the Principal Procedure began as the *Surgical Incision Time.*

B. **Laparoscopy to Open:** If the procedure starts as a laparoscopic procedure **AND** antibiotics were given prior to this procedure and it is converted to an open procedure, abstract the *Surgical Incision Time* that is documented for the laparoscopic procedure.

If the procedure starts as a laparoscopic procedure **AND** antibiotics were NOT given prior to this procedure and it is converted to 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 Principal Procedure is not the first of those, the *Surgical Incision Time* captured will be 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: The Joint Commission Only: 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
- Operative report
- Operating room notes
- PACU/recovery room record
- Preop checklist
- Procedure note

Inclusion Guidelines for Abstraction:

- General Anesthesia
  - Inhaled gases
  - Intravenous
  - Endotracheal
  - Laryngeal mask airway or anesthesia (LMA)

- Neuraxial Anesthesia
  - Spinal block
  - Epidural block
  - Spinal anesthesia
  - 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: *Surgical Procedure - ICU Admission*

Collected For: **The Joint Commission Only:** 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 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
- Operative report
- Operating room notes
- PACU/recovery room record
- Preop checklist
- Procedure note

Inclusion Guidelines for Abstraction:

- General Anesthesia
  - Inhaled gases
  - Intravenous
  - Endotracheal
  - Laryngeal mask airway or anesthesia (LMA)

- Neuraxial Anesthesia
  - Spinal block
  - Epidural block
  - Spinal anesthesia
  - 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 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 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 or intravenous corticosteroids during this hospitalization?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes)	The patient received oral or intravenous corticosteroids during this hospitalization.
N (No)	The patient did not receive oral 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 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.

Intravenous:
- Bolus
- Infusion
- IV
- I.V.
- IV Piggyback (IVP)

Refer to Appendix C, Table 6.3 for a comprehensive list of oral or intravenous Systemic Corticosteroids.

Exclusion Guidelines for Abstraction:
- Inhalation
- Nasal sprays

Data Element Name: *Temperature*

Collected For: CMS/The Joint Commission: 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 “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 “1.”
- If the recorded temperature was lower than the specified range AND no active warming was used, select “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 “1” and “2.”
- If Allowable Values “3” or “4” are selected, no other value should be selected.
- 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
- Blood and fluid warmers
- Body cavity lavage

- Passive heating systems (space blankets or caps)
- Radiant heat sources
- Blankets heated in a blanket warmer

Data Element Name: *Time Last Known Well*

Collected For: The Joint Commission Only: STK-4

Definition: The time (military 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 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 earliest time recorded.

Suggested Data Sources:
- Emergency department records
- History and physical
- Progress Notes

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name: *Transfer From Another Hospital or ASC*

Collected For: CMS/The Joint Commission: AMI-7, AMI-7a, AMI-8, AMI-8a, PN-3a, PN-5c; **CMS Only:** PN-6; **The Joint Commission Only:** AMI-9, PN-5, PN-6a, PN-6b

Definition: Documentation that the patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of another 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 another hospital or from an ambulatory surgery center?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1	Patient received as a transfer from an inpatient department of another hospital.
2	Patient received as a transfer from an outpatient department of another hospital (excludes emergency/observation departments).
3	Patient received as a transfer from the emergency/observation department of another hospital.
4	Patient received as a transfer from an ambulatory surgery center.
5	Patient was not received as a transfer from an inpatient, outpatient, or emergency/observation department of another 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 the emergency department or observation unit of ANY outside hospital, select value "3", regardless of whether the two hospitals are close in proximity, part of the same hospital system, have a shared medical record or provider number, etc.
- If a patient is transferred in from a Disaster Medical Assistance Team (DMAT), which provides emergency medical assistance following a catastrophic disaster or other major emergency, select value "3."
- The emergency department includes free-standing and satellite emergency departments/rooms.

- If the medical record reflects only that the patient was received as a transfer from another hospital and the abstractor is unable to determine if the patient was in an inpatient or an outpatient department, select value “1.”

Suggested Data Sources:
- 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: The Joint Commission Only: 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 dates close to when VTE was diagnosed. It is not necessary to look outside of this timeframe to answer the data element.

Suggested Data Sources:

- Emergency department record
- Nursing notes
- Medication administration record
- 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: *Urinary Catheter*

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

Definition: There is documentation that a urinary catheter was placed during the perioperative 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 the patient had a urinary catheter placed in the perioperative timeframe and that it was still in place at the time of discharge from the recovery/post-anesthesia care area?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1	There is documentation that an indwelling urethral catheter was placed perioperatively and was still in place at the time of discharge from the recovery/post-anesthesia care area.
2	There is no documentation that an indwelling urethral catheter was placed perioperatively and was still in place at the time of discharge from the recovery/post-anesthesia care area.
3	There is documentation that the patient had an indwelling urethral or suprapubic catheter or was being intermittently catheterized prior to the perioperative timeframe.
4	There is documentation that the patient had a suprapubic catheter placed perioperatively and it was still in place at the time of discharge from the recovery/post-anesthesia care area or the patient was being intermittently catheterized during the perioperative period.
5	Unable to determine from documentation in the medical record.

Notes for Abstraction:

- For the data element, *Urinary Catheter*, the perioperative timeframe is defined as from hospital arrival through discharge from the recovery/post-anesthesia care area.
- If the patient had an ileal conduit or urinary diversion prior to the perioperative period, or if the patient had an ileal conduit or urinary diversion prior to the

perioperative period and had an indwelling urethral catheter placed perioperatively, select “3.”

- **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.
- If the patient had an indwelling urethral or suprapubic catheter or was being intermittently catheterized **prior** to the perioperative timeframe **AND** there is also documentation that an indwelling catheter was placed (or replaced) **perioperatively** and it was still in place at the time of discharge from the recovery/post-anesthesia care area, select "3."
- If the patient had a suprapubic catheter placed **perioperatively** and it was still in place at the time of discharge from the recovery/post-anesthesia care area **OR** if the patient was intermittently catheterized **perioperatively AND** there is also documentation that an indwelling catheter was placed **perioperatively** and was still in place at the time of discharge from the recovery/post-anesthesia care area, select “4.”
- Intermittent catheterization is defined as when a catheter is inserted to drain the bladder and removed once the bladder is emptied (in and out catheterization). This can include multiple periodic catheterizations. The catheter is not inserted and left in place as it is with an indwelling urethral catheter. Note: A one-time catheterization, such as done for a urine culture, does not represent catheterization and should not be considered for this data element.

Suggested Data Sources:

- Graphic sheet (I & O)
- Intraoperative record
- Nurses Notes
- Operative report
- PACU record

Inclusion Guidelines for Abstraction:
Indwelling catheter:
None

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	Physician/APN/PA or pharmacist documentation of MRSA colonization or infection.
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.
  Examples:
  - In the progress notes, it is documented, "Patient has a history of MRSA" and it is signed by Nancy Nurse, RN, CIC.
  - In the progress notes, under the heading "Infection Control," a physician/APN/PA or pharmacist documents that vancomycin is used because of the hospital's high MRSA rate.
- 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 Allowable Values "2", "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 allowable 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 allowable 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
- 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 rehabilitation unit or facility
- Inpatient drug rehabilitation

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
- Residential care
- Residential or outpatient chemical dependency treatment
- Psychiatric unit or facility
- Hospice at home

Data Element Name: *VTE Confirmed*

Collected For: The Joint Commission Only: 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.”

Suggested Data Sources:
PHYSICIAN/APN/PA/ DOCUMENTATION ONLY

- Admission notes
- Consult notes
- Emergency department record
- History and physical
- Nursing notes
- Physician notes
- Radiology report

Inclusion Guidelines for Abstraction:
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:

- Isolated calf vein thrombosis
- Upper extremity thrombosis
- Intracranial venous thrombosis
- Hepatic/portal/splenic/mesenteric thrombosis
- Renal vein thrombosis
- Ovarian vein thrombosis
- Not in the defined locations

Data Element Name: *VTE Diagnostic Test*

Collected For: The Joint Commission Only: 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?

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:

- Select "Yes" only if the diagnostic test was performed on the day of admission/transfer or anytime during hospitalization.
- If the patient was transferred from another acute care hospital, and there is no documentation about which test was performed to diagnose VTE, select "No."
- If a diagnostic test for VTE was performed that is not an included 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:

- Compression Ultrasound/Vascular Ultrasound/Duplex Ultrasound (DUS)/Venous Doppler

- Venography/Venogram of femoral and other lower extremity veins using contrast material
- Computed tomography (CT) of thorax with contrast
- Magnetic resonance imaging (MRI or MRV) of the thorax or lower extremity leg veins
- Pulmonary arteriography/angiography
- Nuclear Medicine Pulmonary Scan/ventilation/perfusion (V/Q) lung scan

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: The Joint Commission Only: VTE-6

Definition: Documentation by a physician/advanced practice nurse/physician assistant (physician/APN/PA) that VTE was diagnosed or suspected on hospital 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:

- If documentation is insufficient to determine if VTE was present or suspected at admission, select "No."
- *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."
- Documentation of suspected or possible DVT, PE or VTE is acceptable, but must be written the day of or the day after hospital admission date for non-surgical patients. For example: If a patient was admitted on 10/1/20XX with documentation that a PE was suspected and test ordered to rule out PE, select "Yes."
- If the patient was admitted for a surgical procedure and there was no documentation of diagnosed/suspected VTE prior to surgery, VTE is not considered present on admission.

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
Possible VTE Diagnoses

- 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-1, SCIP-VTE-2; **The Joint Commission Only:** 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: 1-8

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:

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 anytime from hospital arrival to 24 hours after *Anesthesia End Time.*

- Abstract any pharmacological VTE prophylaxis that was ordered/substituted at anytime 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.
- 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.

VTE

VTE Prophylaxis must be <u>administered</u> 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.

- Select the initial prophylaxis that was administered.
- Selection of allowable values 1-8 includes any prophylaxis that was initially administered on the same date.
  Example:
  If a patient was admitted on 12/8/20XX and had bilateral GCS applied at 13:00 on 12/08/20XX and LMWH was administered at 22:00 on 12/8/20XX, select “2” and “4.”
- If the patient received one of the pharmacologic anticoagulation medications for other reasons, select the allowable value that was administered during the specified timeframe.
- No value should be selected more than once. If a value of “A” is selected, no other selections should be recorded.

STK

Stroke VTE Prophylaxis must be <u>administered</u> the day of or the day after hospital admission.

- Select the initial prophylaxis that was administered.
- Selection of allowable values 1-8 includes any prophylaxis that was initially administered on the same date.

Examples:

- If a patient was admitted on 12/8/20XX and had bilateral GCS applied at 13:00 on 12/08/20XX and LMWH was administered at 22:00 on 12/8/20XX, select only value "2."
- If a patient was admitted on 12/8/20XX and had bilateral IPC applied at 13:00 on 12/8/20XX and LMWH was administered at 22:00 on 12/8/20XX, select "2" and "3."

- If GCS was the only prophylaxis administered the day of and/or the day after hospital admission, select "4." If a value of "4" is selected, no other selections should be recorded.
- If bilateral GCS are administered on the day of admission and another form of prophylaxis was administered the day after admission, select the value of the prophylaxis other than GCS.

  Examples:

  - If bilateral GCS are administered at 1300 on 12/08/20XX and LMWH at 0200 on 12/09/20XX, select "2."
  - If bilateral GSC are administered on the day of admission and IPC is administered the day after admission, select "3."
- No value should be selected more than once. If a value of "A" is selected, no other selections should be recorded.

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: The Joint Commission Only: 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 (2001-Current Year)
UTD = Unable to Determine

Notes for Abstraction:

- If VTE prophylaxis was administered the day of and the day after hospital admission, select the date that the **initial** VTE prophylaxis was administered.
  Example:
  If the patient was admitted on 12/8/20XX and bilateral GCS was applied at 13:00 on 12/8/20XX and LMWH was administered at 02:00 on 12/9/20XX, use the 12/8/20XX date with one exception.
  Note: For STK cases, use the date of the other form of prophylaxis as the initial date of VTE prophylaxis when GCS was applied the day of hospital admission and another form the day after hospital admission.
- 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 Joint Commission's Data Warehouse. Use of "UTD" for *VTE Prophylaxis Date* allows the case to be accepted into the warehouse."

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: The Joint Commission Only: 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 “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 "2."
- Patients that have documentation that VTE prophylaxis was not administered because the patient was at low risk for VTE, select "2."
- To select value "3," there must be documentation of a reason for not administering BOTH mechanical and pharmacological prophylaxis. For example: There is physician documentation that a trauma patient has active bleeding and fractured femurs bilaterally, select "3."
- The inclusion list of reasons is not all inclusive.
- Patient refusal of all prophylaxis may be documented by a nurse. If the patient refused BOTH types of prophylaxis, 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 BOTH 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:
Diagnostic testing includes the following:

- Compression Ultrasound/Vascular Ultrasound/Duplex Ultrasound (DUS) /Venous Doppler
- Venography/Venogram of femoral and other lower extremity veins using contrast material
- Computed tomography (CT) of thorax with contrast
- Magnetic resonance imaging (MRI or MRV) of the thorax or lower extremity veins
- Pulmonary arteriography/ angiography
- Nuclear Medicine Pulmonary Scan/ventilation/perfusion (V/Q) lung scan

Reasons for not administering mechanical prophylaxis:

- 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

Refer to Appendix H, Table 2.1 VTE Prophylaxis Inclusions.

Exclusion Guidelines for Abstraction:
Reasons for not administering pharmacological prophylaxis:

- History (Hx) of bleeding
- Bleeding risk described in the informed consent process
- 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: 1-8

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: The Joint Commission Only: 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.”
- Review dates close to when VTE was diagnosed. It is not necessary to look outside of this timeframe to answer this data element.

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: The Joint Commission Only: 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. If one or both are not dated, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms.

Examples:
  - Two discharge summaries, one dated 5/22 (day of discharge) and one dated 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