



# Specifications Manual for National Hospital Inpatient Quality Measures, Version 3.3

## Changes Effective for 4/1/11 – 12/31/11 Discharges

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# Manual Date Change

- The Specifications Manual for National Hospital Inpatient Quality Measures, Version 3.3, will be in effect for discharges 4/1/2011 through the end of 2011
- Future manuals will cover six-month periods of time (1/1/2012 – 6/30/12, 7/1/2012 – 12/31/12)
  - Adjustment made so that changes and time frames of inpatient and outpatient manuals coincide

# Presentation Overview

- Manual changes
  - Section 1: Data Dictionary (DD)
    - Retired data measures/element
    - New data element
    - Alphabetical data elements by projects
  - Section 2: Measure Information
  - Section 10: CMS Outcome Measures (Claims-based)
  - Appendices
- Reminders

# **MANUAL CHANGES**

## **Section 1: Data Dictionary**

# Retired Measures and Data Element

- Measures
  - AMI-T1a
  - AMI-T2
- Data element
  - Discharge status

# New Data Element

## Discharge Disposition

- Definition: The final place or setting to which the patient was discharged on the day of discharge
- Collected 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
- The Joint Commission Only:
  - AMI-9, PN-5, CAC-3, STK-2, STK-3, STK-6, STK-8, STK-10, VTE-3, VTE-4, VTE-5
- Informational Only:
  - Prev-1, Prev-2

# New Data Element

## Discharge Disposition

- Suggested Data Sources:
  - Discharge instruction sheet, discharge planning notes, discharge summary, nursing discharge notes, physician orders, progress notes, social service notes, transfer record
- Excluded Data Sources:
  - Any documentation prior to the day of or day before discharge, UB-04

# New Data Element

## Discharge Disposition (cont'd)

- What was the patient's discharge disposition on the day of discharge?

### 1. Home

- Assisted living facilities; Court/law enforcement detention facilities, jails, and prison; board and care, foster or residential care, group or personal care homes, and homeless shelters; home with home health services; outpatient services, including outpatient procedures at another hospital, outpatient chemical dependency programs, partial hospitalization

### 2. Hospice – Home

# New Data Element

## Discharge Disposition (cont'd)

### 3. Hospice – Healthcare Facility

- General inpatient and respite, residential and skilled facilities, other healthcare facilities (**excludes home**)

### 4. Acute Care Facility

- Acute short term general and critical access hospitals, cancer and children's hospitals, Department of Defense and Veteran's Administration (VA) hospitals

# New Data Element

## Discharge Disposition (cont'd)

### 5. Other Healthcare Facility

- Extended or immediate care facility (ECF/ICF); long term acute care hospital (LTACH); nursing home or facility, including VA nursing facility; psychiatric hospital or psychiatric unit of a hospital; rehabilitation facility, including inpatient rehabilitation facility/hospital, rehabilitation unit of a hospital; skilled nursing facility (SNF), subacute care or swing bed; transitional care unit (TCU)

### 6. Expired

### 7. Left Against Medical Advice/AMA

- Must have explicit documentation that the patient left against medical advice

### 8. Not Documented or Unable to Determine (UTD)

# New Data Element

## Discharge Disposition (cont'd)

### ■ Abstraction Notes

- Use documentation from the day of or the day before discharge
- Consider discharge disposition in the discharge summary or a post-discharge addendum as day of discharge documentation, regardless of when it was dictated/written
- If contradictory documentation, use the latest documentation. If there is documentation that further clarifies the level of care, that documentation should be used to determine the correct value to abstract

# New Data Element

## Discharge Disposition (cont'd)

- Select “5,” other healthcare facility, if nursing documentation states patient is being discharged to “XYZ” hospital and Social Service notes from the day before the discharge clarify that the patient will be transferred to the rehab unit of “XYZ” hospital
- Select “4,” acute care facility, if documentation only states that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving

# Alphabetical Data Elements: All Projects

# Admission Date

- If the abstractor determines through chart review that the date **from billing** is incorrect, for purposes of abstraction, he/she should correct and override the downloaded value

# Admission Date (cont'd)

- For admissions 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 placed in outpatient Observation

# Admission Date (cont'd)

**Example:** Documentation that the patient was admitted to observation on 04-05-20XX. On 04-06-20XX, physician writes an order to admit to acute inpatient effective 04-05-20XX. *The Admission Date would be abstracted as 04-06-20XX—the date the determination was made to admit to acute inpatient care and the order was written.*

# Admission Date (cont'd)

- **ONLY ALLOWABLE SOURCES**

- Physician orders
- Face sheet
- UB-04, Field Location: 12

- **Excluded Data Sources:**

- UB-04, Field Location: 06

# Admission Date (cont'd)

- If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted
  - Admission date should not be abstracted from the earliest admission order without regard to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used

**Example:** Preoperative orders dated as 04-06-20XX with an order to admit to inpatient. Postoperative orders, dated 05-01-20XX, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 05-01-20XX.

*Admission date would be 05-01-20XX.*

# Adult Smoking History

- One addition to **ONLY ACCEPTABLE SOURCES**:
  - Smoking/tobacco use assessment

# Comfort Measures Only

- Addition to ONLY ACCEPTABLE SOURCES:
  - DNR/MOLST/POLST forms
- *Inclusion added:* DNR-CC
- *Exclusion added:*
  - **DNR-Comfort Care Arrest (Only terms listed below count as an Exclusion. Other arrest terminology would NOT count as Exclusion – e.g., “Comfort Care Protocol will be implemented in the event of a cardiac arrest or a respiratory arrest.”)**
    - DNR-CCA, DNR-Comfort Care Arrest, DNRCC-A, DNRCC-Arrest, DNRCCA

# Comfort Measures Only (cont'd)

- If there is documentation of an Inclusion term clearly described as negative in one source and an Inclusion term NOT described as negative in another source, that second source would still count for comfort measures only
- Documentation of an Inclusion term in the following situations should be disregarded. Continue to review the remainder of the **ONLY ACCEPTABLE SOURCES** for Inclusion terms

# Comfort Measures Only (cont'd)

- Select Value “4” (Not Determined/UTD) if the ONLY documentation found is an Inclusion term in the following situations:
  - 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 discharge summary)

## **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)

# Comfort Measures Only (cont'd)

- Select Value “4” (Not Determined/UTD) if the ONLY documentation found is an Inclusion term in the following situations: (cont'd)
  - Inclusion term not clearly selected on order form signed by the physician/advanced practice nurse (APN)/physician assistant (PA)

## **Examples:**

- “DNR-Comfort Care” order form – The only option checked is “DNR/Allow Natural Death” (option “Comfort Care” remains unchecked)
- “Home Health/Hospice” order form – “Hospice” has not been circled in the title or selected on the form
- Inclusion term listed in preprinted instruction for completing the form

# Comfort Measures Only (cont'd)

- Select Value “4” (Not Determined/UTD) if the ONLY documentation found is an Inclusion term in the following situations: (cont'd)

- Inclusion term clearly described as negative

## **Examples:**

- “No comfort care”
- “Not a hospice candidate”
- “Declines palliative care”
- “Not appropriate for hospice care”
- “I offered palliative care consult to discuss end-of-life issues. Family did not show any interest”
- “Patient declines hospice care at this time, but I feel this will be an important plan of care when his condition deteriorates further”
- “Palliative care would also be reasonable – defer decision for now”

# Comfort Measures Only (cont'd)

- Select Value “4” (Not Determined/UTD) if the ONLY documentation found is an Inclusion term in the following situations: (cont'd)
  - Comfort care when explicitly documented in any of the formats listed in the Exclusion list

## **Example:**

- “DNR-CCA” box is checked on order form
  - **Disregard (“DNR-CCA” is a listed Exclusion)**

# Alphabetical Data Elements: AMI/HF

# All Medication Prescribed at Discharge/Discharge Instructions

- If two discharge summaries are included in the medical record, use the one with the latest date/**time**. If one or both are not dated **or timed**, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. **Use the dictated date/time over transcribed date/time, file date/time, etc.**

# Alphabetical Data Elements: AMI

# Aspirin Received Within 24 Hours Before or After Hospital Arrival

- Aspirin listed as “current” or “home” medication should be inferred as taken within 24 hours prior to arrival, unless documentation suggests otherwise
  - **EXCEPTION:** Aspirin documented as a PRN medication does not count unless documentation is clear it was taken within 24 hours prior to arrival
- 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 “Treatment Prior to Arrival” section of the Triage Assessment), infer that the patient took aspirin within the 24-hour time frame, unless documentation suggests otherwise

# Initial ECG Interpretation

- Added notes for abstraction
  - Only those terms specifically identified or referred to by the physician/APN/PA as **ECG findings AND where documentation is clear it is from the ECG performed closest to arrival should be considered in abstraction** (e.g., “STEMI” listed only as a physician diagnosis or impression would not be used)
  - If at least one interpretation describes an LBBB as old, chronic, or previously seen, or states LBBB and “no changes,” “unchanged,” “no acute changes,” “no new changes,” or “no significant changes” when compared to a prior ECG, all LBBB findings should be disregarded

# Initial ECG Interpretation (cont'd)

- Added notes for abstraction (cont'd)
  - Notations which describe ST-elevation as old, chronic, or previously seen, **or which state ST-elevation and “no changes,” “unchanged,” “no acute changes,” “no new changes,” or “no significant changes” when compared to a prior ECG should be disregarded. Other documentation of ST-elevation not described as such may still count as an Inclusion**

# Reason for No Aspirin at Discharge/Reason for No Aspirin on Arrival

- When determining whether there is a reason documented by a physician/APN/PA or pharmacist for not prescribing aspirin at discharge
  - Reason documentation that refers to a more general medication class is not acceptable (e.g., “Hold all anticoagulants.”)  
*Exception:* Documentation of a reason for not prescribing “antiplatelets” should be considered implicit documentation of a reason for no aspirin at discharge (e.g., “antiplatelet therapy contraindicated”)

# Reason for Not Prescribing Statin Medication at Discharge

- Additional Suggested Data Sources:
  - Emergency department (ED) record
  - Medication administration record
  - Physician orders
- Additional Inclusion guidelines for reasons for not **PRESCRIBING** statin medication at hospital discharge:
  - Myalgias

# Alphabetical Data Elements: PN

# Another Source of Infection

- Addition To Suggested Data Sources:

- Lab results

## **Reminder:**

Physician/APN/PA documentation only

# Compromised

- Select “1” – Compromising Condition
  - If there is physician/APN/PA documentation of “significant” or “marked” neutropenia
- Additional Inclusion guidelines compromising conditions within the last three months:
  - Systemic chemotherapy
  - Systemic corticosteroid/prednisone therapy
  - Systemic immunosuppressive therapy

# Diagnostic Uncertainty

- Documentation of the delay **can** refer to **either** the pneumonia diagnosis **or** to antibiotic administration

# Healthcare-associated PN

- Do not make an assumption as to the patient's previous **admission or hospitalization** based on the procedure he/she received. Only use phrases such as “in the hospital last month,” etc.

# Pneumococcal Vaccination Status

- Addition to Value “4”
  - Received the shingles vaccine (Zostavax) within the last four weeks

# Pneumonia Diagnosis: ED/Direct Admit

- Additional note for diagnosis in the ED
  - ED face sheets can only be used if signed by a physician/APN/PA
- Inclusion Guidelines for Abstraction:
  - *Addition:* Admission Pneumonia Diagnosis Codes (except for aspiration pneumonia)
  - *Reminder:* List is ALL-INCLUSIVE

# Alphabetical Data Elements: SCIP

# Reasons to Extend Antibiotics

- **Select all that apply:**

1. There is physician/APN/PA documentation that the patient had an infection postoperatively following the principal procedure.
2. The principal procedure was a lower-extremity original or revision arthroplasty and there is physician/APN/PA documentation of a current benign or malignant bone tumor of the operative extremity.

# Reasons to Extend Antibiotics (cont'd)

## ■ **Select all that apply: (cont'd)**

3. There is physician/APN/PA documentation of any of (and only) the following reasons to extend antibiotics:
  - Erythromycin was administered postoperatively for the purpose of increasing gastric motility **or**
  - An antibiotic was administered postoperatively for the treatment of hepatic encephalopathy **or**
  - An antibiotic was administered postoperatively as prophylaxis of Pneumocystis pneumonia (PCP) to a patient with a diagnosis of AIDS
4. No documented reason/unable to determine.
  - If “4” is selected, no other selections should be recorded

# Reasons to Extend Antibiotics (cont'd)

## ■ For Value 1:

- There must be documentation of a current infection or current possible/suspected infection
- Documentation of symptoms (*Example*: fever, elevated white blood cells, wound condition, etc.) should not be considered infections unless documented as a current infection or current possible/suspected infection
- *DO NOT abstract Value 1*
  - If documentation of an infection occurs more than two days (three days for CABG or Other Cardiac Surgery) after *Anesthesia End Time*

# Reasons to Extend Antibiotics (cont'd)

## ■ For Value 1: (cont'd)

- Do NOT use Table 5.09 as a reference for identifying infections
- The data element Inclusion table is to be used as a guideline that provides the types of infection that are acceptable

### **Excluded Data Sources:**

- Any postoperative documentation of infection from pathology reports, any preoperative documentation

# Reasons to Extend Antibiotics (cont'd)

- **For Value 2:**

- Documentation of a current bone tumor can be found preoperatively or postoperatively
- Documentation of a current bone tumor of the lower extremity includes, but is not limited to, the examples listed in the Inclusion list
- The lower extremity includes the hip, knee, and foot joints

# Reasons to Extend Antibiotics (cont'd)

## ■ For Value 3:

- Documentation of these reasons can be found preoperatively or postoperatively
- The physician/APN/PA documentation must include reasons that are specific to the three conditions in Value 3
- Documentation of “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

# Reasons to Extend Antibiotics (cont'd)

- **For Value 3: (cont'd)**
  - Reference Table 2.1, Antimicrobial Medications, for the names of medications that are erythromycin
  - Documentation of “Pneumocystis pneumonia” may include, but is not limited to, Pneumocystis carinii pneumonia, or PCP, in a patient with a diagnosis of AIDS

# **MANUAL CHANGES**

## **Section 2: Measure Information**

# Acute Myocardial Infarction

- Addition of selected references

# PN 3a

## **Blood Cultures Performed Within 24 Hours Prior to or 24 Hours After Hospital Arrival for Patients Who Were Transferred or Admitted to the ICU Within 24 Hours of Hospital Arrival**

- Pneumonia patients transferred or admitted to the ICU within 24 hours of hospital arrival, who had blood cultures performed within 24 hours prior to the ICU **or the day prior to hospital arrival, the day of arrival, or within 24 hours after arrival** to the hospital
- Replace community-acquired pneumonia (CAP) with pneumonia

# PN-6: Pneumonia Antibiotic Consensus Recommendations

- Table can be found in Section 2.3 – Pneumonia (PN) of the Specifications Manual, Version 3.3, available on QualityNet

# **MANUAL CHANGES**

## **Section 10:**

### **CMS Outcome Measures (Claims-based)**

# Section 10.1

## Risk-Standardized 30-Day Mortality Measures

- Revisions to numerator and denominator statements
- Additions to measure calculations
- Additions and removals from excluded populations
- Addition of selected references

# MANUAL CHANGES

## Appendices

# Appendix A:

## ICD-9 Code Tables

- Code removals in Tables 5.08, 5.10, 5.11, 5.25
- Code additions
  - Table 5.16
    - 45.95 – Anal Anastomosis
    - 46.03 – Large Bowel Exteriorization
  - Table 5.25
    - 38.18 – Lower Limb Endarterect

# Appendix C:

## Medication Tables Additions

- Table 2.1 Antimicrobial Medications
  - Prevpac: Lansoprazole/amoxicillin/clarithromycin
  - Utira C: Methenamine
- Table 2.10 Tetracyclines
  - Tygacil: Tigecycline
- Table 1.7 ARBS (angiotensin receptor blocker)
  - Olmesartan/amlodipine/hydrochlorothiazide
  - Tribenzor

# Appendix H:

## Miscellaneous Tables

- Table 2.1 VTE prophylaxis Inclusion table
  - VTE prophylaxis
    - Remove oral factor XA inhibitor
  - Inclusion/synonyms
    - Remove Rivaroxaban (oral)
      - Not FDA approved

# **REMINDER**

## **Prevention Measures**

### **Discharges 1/1/2012**

# Prevention (Prev)

- Population included in the Global Flu Immunization and Global Pneumonia Immunization measures beginning with January 1, 2012, discharges (the middle of the 2011-2012 influenza season). The Prevention measure set includes all patients six months and older with length of stay less than or equal to 120 days
  - ***Prev-Imm-1: Pneumococcal Immunization***
    - *Numerator Statement:* Inpatient discharges who were screened for pneumococcal vaccine status and were vaccinated prior to discharge, if indicated
    - *Denominator Statement:* Inpatient discharges 65 years of age and older and 5-64 years of age who have a high-risk condition

# Prev (cont'd)

## – *Prev-Imm-2: Influenza Immunization*

- *Numerator Statement:* Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge, if indicated
- *Denominator Statement:* Acute care hospitalized inpatients age six months and older discharged during October, November, December, January, February, or March

# Prev (cont'd)

- Inpatient discharges 65 years of age and older and 5-64 years of age who have a high-risk condition
  - **Prev-Imm-1a**      **Pneumo Immunization – Overall Rate**
  - **Prev-Imm-1b**      **Pneumo Immunization – Age 65 and greater**
  - **Prev-Imm-1c**      **Pneumo Immunization – High Risk Populations (Age 5 through 64 years)**
  - **Prev-Imm-1d**      **Pneumo Immunization – Received During Hospitalization**
  - **Prev-Imm-1e**      **Pneumo Immunization – Received in Past**
  - **Prev-Imm-1f**      **Pneumo Immunization – Patient Refused**
  - **Prev-Imm-1g**      **Pneumo Immunization – Medical Contraindications**

# Prev (cont'd)

- Acute care hospitalized inpatients age 6 months and older discharged during October, November, December, January, February or March
  - **Prev-Imm-2a**      **Influenza Immunization – Overall Rate**
  - **Prev-Imm-2b**      **Influenza Immunization – Received During Hospitalization**
  - **Prev-Imm-2c**      **Influenza Immunization – Received in Past**
  - **Prev-Imm-2d**      **Influenza Immunization – Patient Refused**
  - **Prev-Imm-2e**      **Influenza Immunization – Medical Contraindications**
  - **Prev-Imm-2f**      **Influenza Immunization - Unable to Determine**

**REMINDER**  
**Emergency Department (ED)**  
**Discharges 1/1/2012**

# ED

- There are two ED measures for inpatient collection also known as “Emergency Department Throughput Measures”:
  - **ED-1:** Median Time from ED Arrival to ED Departure for Admitted ED Patients
  - **ED-2:** Admit Decision Time to ED Departure Time for Admitted Patients

# Questions?

