

10/1/09 – 3/31/10 Specification Manual Changes



Section 2 – Measurement Information (MIFs)

- Stroke (STK), Venous Thromboembolism (VTE) and Emergency Department (ED) Through-put measure sets have been added
 - STK and VTE will be collected by The Joint Commission **only**
 - ED is for informational purposes only



General Abstraction Guidelines

- All documentation in the medical record must be legible, timed, dated, and authenticated
- Authentication may include written signatures, initials, computer key, or other codes
- “Rubber” stamped physician/Advanced Practice Nurse (APN)/Physician Assistant (PA) signatures are not acceptable on any document within the medical record
- Handwritten, electronic signatures or facsimiles of original written or electronic signatures are acceptable



Abstraction of Dates

- 00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the 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 date.



Discharge Status

- Value 01 has been modified:
 - “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.”
 - The reference to jail or law enforcement have been removed.
 - Independent living was added.



Discharge Status

- Allowable Value 04 has been changed to “discharged/transferred to a facility that provides custodial or supportive care”
- Usage note for 04 now states:
 - “Includes Intermediate Care Facilities (ICFs) if specifically designated at the state level. Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare or Medicaid certification and for discharges/transfers to Assisted Living Facilities.”



Discharge Status

- Value 21: Discharged/transferred to court/law enforcement has been added
 - Usage Note: Includes transfers to incarceration facilities such as jail, prison or other detention facilities
- Discharge status Code 21 has been added to the applicable algorithms in the measure information forms
- This element no longer affects the validation score – it is adjudicated but not scored



Appendix A

- Table 7.03 Venous Thromboembolism
 - ICD-9-CM code 453.8 has been removed
 - 453.87 and 453.89 have been added
- Multiple changes have been made to code descriptions to make them consistent with other tables



Appendix H

- Table 2.5 Discharge Status Disposition
 - Remove 'Assisted Living Facility and Court/Law Enforcement' from code 01
 - Add 'Assisted Living Facility' to code 04
 - 21 has been added as a new disposition code and includes 'Jail, Prison and Other detention facilities'
- *Discharge Status* is validated but not scored so selecting an incorrect code will not impact your validation score – be as accurate as possible

AMI and HF Measures



AMI Measure changes

AMI-7, AMI-7a, AMI-8, AMI-8a

- *Comfort Measures Only* has been removed as an exclusion
- “Balloon pump insertion” and “respiratory failure requiring intubation” have been added to the list of examples in the denominator exclusions:

Patients who did not receive fibrinolytic therapy/PCI within 30/90 minutes and had a reason for delay documented by a physician/APN/PA (e.g., social, religious, initial concern or refusal, cardiopulmonary arrest, balloon pump insertion, respiratory failure requiring intubation)



AMI Measure changes

AMI-7, AMI-7a, AMI-8, AMI-8a

- Changed description sections in the measure information forms (MIFs) to align with measure descriptions used in the ACC/AHA measures



Adult Smoking History

- Abstraction guidelines have been changed to clarify that to capture smoking history documentation as positive, it must be unquestionable
 - If there is not definitive documentation of current smoking or smoking within one year prior to arrival in any of the only acceptable sources, select “No” (e.g., “Smoked in last year: ?”)



Comfort Measures Only

- Abstraction guidance has been added which directs the abstractor to *no longer count* inclusion terms clearly written in the negative (e.g., “Not a hospice candidate”)
- The following exclusion terms have been added:
 - DNR-Comfort Care Arrest
 - DNR-CCA
 - DNRCC-A
 - DNRCC-Arrest
 - DNRCCA



Medication Prescribed at Discharge

- Abstraction guidelines have been changed for all medications prescribed at discharge to clarify that contradictory documentation includes cases where one source shows a “hold” on a discharge medication and other documentation indicates the medication is not on hold at discharge. When there is contradictory documentation, credit cannot be taken.



Discharge Instructions Address Medications

- An exception has been added directing the abstractor to disregard references to minerals (laxatives, antacids, vitamins, etc.). They are NOT required in the written instructions for the purposes of the discharge instructions measure – Potassium should no longer be disregarded
- Guideline has been changed to clarify that contradictory documentation includes cases where one source shows a “hold” on a discharge medication and other documentation indicates the medication is not on hold at discharge



Discharge Instructions Address Medications

- Clarification added on how to handle cases where there is only documentation of a plan to start/restart a medication after discharge (e.g., “Hold Lasix x 2 days,” “Start Plavix as outpatient”), and it is *not* listed as a discharge medication elsewhere (e.g., “Lasix,” “Plavix”)



LVF Assessment

- Shortened and simplified abstraction guidelines to make abstraction clearer and easier
- Inclusion lists from Appendix H, Table 1.2 has been imported into the data element so that instructions for the abstractor are all located in one place



LVF Assessment

- Guideline has been added clarifying if there is documentation of both a reason for not assessing LVSF *and* an LVSF assessment (or plan after discharge), select “Yes”
- “Other Test” Inclusion: Wall motion study has been deleted
- LVSF Inclusions modified: Akinesis, Dyskinesis , and Hypokinesis need to be described as left ventricular



LVSD

- Guideline clarification:
 - “Interpretation” and “Final Diagnosis” sections of test reports should be considered synonymous with “Impression”/“Conclusion” sections
- Inclusion list has been modified to address “systolic failure” terminology
- Minor rewording changes have been made to further clarify methodology in the Notes for Abstraction



Pre-Arrival Lipid-Lowering Agent

- The abstraction guideline directing the abstractor to look at the patient's medication regimen "prior to acute care treatment" has been deleted
 - The abstractor is to now select "Yes" if a patient was started on lipid-lowering medication at a transferring acute care hospital



Reason for Delay in Fibrinolysis Reason for Delay in PCI

- Changed guidelines to no longer require that a balloon pump insertion or intubation be specifically documented as the reason for a delay in PCI/fibrinolysis
- Physician/APN/PA documentation of balloon pump insertion or intubation occurring within 30/90 minutes automatically counts as an acceptable reason for delay



Reasons for No ACEI and No ARB at Discharge

- Guidance has been added that allows for nurse notation of a hold due to a blood pressure falling outside parameters set in a physician order (e.g., “Hold perindopril for SBP<100”) to *count* as a reason for not prescribing, consistent with SCIP’s *Reason for Not Administering Beta-Blocker- Perioperative*



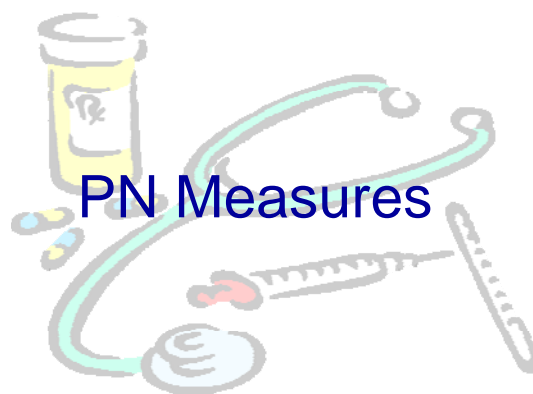
Reason for No Beta-Blocker at Discharge

- Bradycardia (HR < 60) on day of or day prior to discharge while not on a beta-blocker” is no longer an automatic contraindication.
 - The physician/APN/PA must now make the linkage (e.g., “HR running in 50s. Hold off on beta-blocker therapy.”)
- Guideline added which allows for nurse notation of hold due to a blood pressure or heart rate falling outside parameter set in a physician order (e.g., “Hold atenolol for HR < 60”) to count as a reason for not prescribing, consistent with SCIP’s *Reason for Not Administering Beta-Blocker - Perioperative*



Medication Tables, Appendix C

- Multiple changes to the medication tables adding and deleting medications



PN Measures

Adult Smoking History

- Allowable Value “Yes”
 - Any definitive documentation that the patient either currently smokes or is an ex-smoker that quit less than one year ago, select “Yes,” regardless of other documentation
- Allowable Value “No”
 - If there is NO definitive documentation of current smoking or smoking within the past year select “No”



Antibiotic Administration Date/Route Antibiotic Administration Time

- Bullet regarding ‘only using narrative charting if no other documentation was available’ was removed from the Notes for Abstraction
 - Can use narrative documentation if it is the best documentation



Blood Culture Collected

- Select value “2” for direct admit patients with blood cultures performed prior to arrival and within 24 hours after arrival



Chest X-Ray

- If a chest x-ray or CT is mentioned without documentation of the date performed, assume it was during the current hospitalization
- Remember to follow the priority order for sources and if no inclusion language is found go to the next source, and on to the next if no inclusion is found there either until either all sources have been found to have no inclusions or an inclusion is found



Comfort Measures Only

- Disregard any documentation with an inclusion term used in a negative context



Compromised

- Any physician documentation of a 'possible' inclusion (except corticosteroids) will abstract as "Yes", unless ruled out within 24 hours.
 - Example: "Thinks has HIV", unless ruled out in 24 hours



Diagnostic Uncertainty

- Documentation must be for delay of pneumonia diagnosis, not delay of antibiotic administration



Pneumonia Diagnosis: ED/Direct Admit

- Initial progress note cannot be used for PN diagnosis unless it has admission information





SCIP Measures

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SCIP Measure Changes

- SCIP Inf-2
 - Clindamycin and metronidazole monotherapy have been removed for hysterectomy patients with beta-lactam allergies
- SCIP Inf-7
 - Has been retired



New SCIP Measures

- SCIP Inf-9
 - Urinary catheter removed on postoperative day 1 (POD1) or postop day 2 (POD2) with day of surgery being day Zero
 - New data elements added: *Urinary Catheter, Catheter Removed* and *Reasons for Continuing Urinary Catheterization*
- SCIP Inf-10
 - Surgery patients with perioperative temperature management
 - Includes all patients, irregardless of age



SCIP Initial Patient Population

- Patients with an ICD-9-CM *Principal Procedure Code* as defined in Appendix A, Table 5.10 and a Length of Stay less than or equal to 120 days
- Initial Patient Population now includes all ages
- Age restriction of greater than or equal to 18 years of age has been moved to the SCIP measure algorithms, except for SCIP-Inf-10



Anesthesia Dates and Times

- 4 data elements were added to the manual:
 - *Anesthesia End Time, Anesthesia End Date, Anesthesia Start Date and Anesthesia Start Time*
- 3 data elements were retired:
 - *Surgery End Time, Surgery End Date and Surgery Start Date* were retired
 - *Surgery End Date* will no longer be used for SCIP



Anesthesia Type, Intentional Hypothermia and Temperature

- 3 data elements were added which are used for SCIP-Inf-10
 - *Anesthesia Type, Intentional Hypothermia and Temperature*
- The following data elements were retired:
 - *Neuraxial Anesthesia*
 - *Temperature Value*



Beta Blocker element changes

- *Beta-Blocker Perioperative, Reason for Not Administering Beta-Blocker Perioperative, Perioperative Death*
 - Instructions to determine the end of the perioperative period were clarified:
 - For patients discharged from surgery and admitted to PACU – the end of the perioperative period occurs when the patient is discharged from PACU
 - For patients discharged from surgery and admitted to locations other than the PACU (e.g., ICU) – the recovery period would end a maximum of six hours after arrival to the recovery area



Date of Infection

- Abstract only **postoperative** infections that are documented within 2 days (3 days for CABG or Other Cardiac Surgery) of *Anesthesia End Date* with the day of surgery being day zero



Glucose POD 1, Glucose POD 2

- 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



Infection Prior to Anesthesia Postoperative Infections

- If an infection is documented as “chronic,” there must be additional documentation that the infection is current or still present during the hospital stay
 - Two added exclusions:
 - “carditis” (such as pericarditis) without mention of infection
 - Perforation of bowel without documentation of fecal contamination or infection
 - Two added inclusions:
 - Aspiration pneumonia
 - Necrosis



Vancomycin

- Notes for Abstraction
 - A bullet was added: 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.
“9” No documented reason/Unable to determine



VTE Prophylaxis

- Notes for Abstraction
 - A bullet was added: No value should be selected more than once. If a value of “A” was selected, no other selections should be recorded.
“A” None of the above or not documented or unable to determine from medical record documentation



Thank You!

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