

4/1/10 – 9/30/10 Specification Manual Changes



Admission Type

- Has been removed as a data element



Adult Smoking Counseling

- Clarification has been added that prison or law enforcement personnel can be considered the caregiver for a patient being discharged to prison/jail



Adult Smoking History

- Changes to 6th bullet, now reads:
 - 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).



Adult Smoking History

- Added Inclusions
 - 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”



Adult Smoking History

- Inclusions Removed
 - + smoker, type of product not identified
 - + tobacco use, type of product not identified
 - History of smoking and documentation that the patient quit “several months ago”



Adult Smoking History

- Exclusions added -
 - Examples of no smoking within past year:
 - “History: Smoker”
 - “History – Tobacco abuse”
 - “Most likely quit 3 months ago”
 - “Probable smoker”
 - “Smoke in the last year: ?”
 - “Tobacco – 2 packs per day X 22 yrs” (If no current context)
 - Changed: “Remote smoker (smoked in the past, but greater than one year ago)” to “Remote smoker”



Comfort Measures Only

- Restraint order sheet has been added as an excluded data source



Hospital Patient Identifier

- Allowable Values changed
 - “Up to 40 letters, numbers, and/or characters.”

NOTE: The only characters that will be allowed are spaces, hyphens, dashes and under-scores.”



Payment Source

- 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”.



Measure Information


- Updated rationales
- Updated references
- Changes to algorithms



Appendices


- Changes to
 - ICD code tables
 - Medication tables
 - Appendix H
 - Table 2.6: Maybe added to Qualifiers
 - Table 2.1: Inclusions added






AMI and HF Measures

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ACEI Prescribed at Discharge

- If two discharge summaries/medication reconciliation forms 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.
 - Two discharge summaries, one dated 5/22 (day of discharge) and one dated 5/27 – Use the 5/27 discharge summary
 - Two discharge med reconciliation forms, one not dated and one dated 4/24 (day of discharge) – Use both




ARB Prescribed at Discharge

- Added Notes for Abstraction
 - 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 medical reconciliation forms, one not dated and one dated 4/24 (day of discharge) – Use both



Aspirin Prescribed at Discharge

- Added Notes for Abstraction
 - 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 medical reconciliation forms, one not dated and one dated 4/24 (day of discharge) – Use both



Beta-Blocker Prescribed at Discharge

- Added Notes for Abstraction
 - 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 medical reconciliation forms, one not dated and one dated 4/24 (day of discharge) – Use both



Discharge Instructions Address...

- 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



Discharge Instructions Address Medications

- Added Notes for Abstraction
 - 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 medical reconciliation forms, one not dated and one dated 4/24 (day of discharge) – Use both



Initial ECG Interpretation

- Guidelines for Abstraction – Exclusion changes have been made to clarify that Inclusion terms described as “possible” should NOT be treated as Exclusions in the abstraction process.
 - Please review the exclusion table for the changes



Initial ECG Interpretation



- 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., “0.5-1mm ST-elevation”), should be disregarded. Other documentation of ST- elevation not described as old, etc. may still count as an Inclusion.



LVSD

- Additions to Guidelines for Abstraction – Exclusion
 - 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



Reason for Delay in Fibrinolytic Therapy

- 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



Reason for Delay in PCI

- System reasons for delay are not acceptable, regardless of any linkage to the delay in PCI/reperfusion.
 - Equipment-related (e.g., IV pump malfunction)
 - Staff-related (e.g., waiting 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)



Reasons for No ACEI and No ARB at Discharge

- 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”)



Reasons for No ACEI and No ARB at Discharge

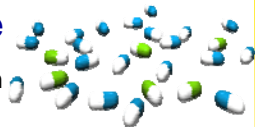
- Notes for Abstraction

Change:

- When conflicting information is documented in a medical record, a positive finding should take precedence over a negative finding (e.g., answer “Yes”), unless otherwise specified.

To:

- When conflicting information is documented in a medical record, select “Yes”.



Reason for No ASA at Discharge

- Notes for Abstraction

Change:

- When conflicting information is documented in a medical record, a positive finding should take precedence over a negative finding (e.g., answer “Yes”), unless otherwise specified.

To:

- When conflicting information is documented in a medical record, select “Yes”.



Reason for No ASA at Discharge

- When determining whether Coumadin/warfarin was prescribed at discharge (i.e., a reason for not prescribing ASA 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.



Reason for No ASA on Arrival

- Consider Coumadin/warfarin to be a pre-arrival medication (a reason for not prescribing ASA 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 conflicting information is documented in a medical record, select “Yes”



Reason for No Beta-Blocker at Discharge

- Notes for Abstraction
 - Change:
When conflicting information is documented in a medical record, a positive finding should take precedence over a negative finding (e.g., answer “Yes), unless otherwise specified.
 - To:
When conflicting information is documented in a medical record, select “Yes.”



Reason for No Lipid-Lowering Therapy

- Notes for Abstraction
 - Change:
When conflicting information is documented in a medical record, a positive finding should take precedence over a negative finding (e.g., answer “Yes), unless otherwise specified.
 - To:
When conflicting information is documented in a medical record, select “Yes.”





Another Suspected Source of Infection

- Data element name has been changed to *Another Source of Infection*
- Question now reads:
 - Was there another source of bacterial infection in addition to pneumonia within 24 hours after arrival?
- Allowable values:
 - (Yes) There was another source of bacterial infection in addition to pneumonia within 24 hours after arrival
 - (No) There was no other source of bacterial infection within 24 hours after arrival or unable to determine from medical record documentation



Another Source of Infection

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



Another Source of Infection

- 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 pneumophila*
 - Positive Polymerase Chain Reaction (PCR) test for *Legionella pneumophila*



Another Source of Infection

- This data element will accept both 'suspected' and 'diagnosed' infections
Examples:
 - In the ED, after arrival, there is PA documentation that she suspects the patient has a UTI, select 'Yes'
 - APN documents, 'suspect sepsis from decubitus ulcer', select 'Yes'
- If the medical record contains documentation of a positive culture performed anytime within a week prior to arrival, select 'Yes'



Another Source of Infection

- 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"
- Additions to suggested data sources include: admitting physician orders, lab results, physician admitting note, physician orders



Another Source of Infection

- Removed from Inclusions:
 - Intra-abdominal infections (e.g., cholecystitis, diverticulitis, cystitis, pyelonephritis)
 - Meningitis
 - Cellulitis
 - Prostatitis



Another Source of Infection

- Added Exclusions:
 - Any yeast, viral or fungal infections
 - Gram stain results. Examples: gram stain, positive cocci, gram negative rods, normal flora
 - Standing orders used to screen a population of patients or ALL patients
 - Tests performed with no mention of a pathogen within 24 hours after arrival



Blood Culture Collected



- First sentence of definition changed:
 - 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
- Question changed:
 - Did the patient have blood cultures collected the day prior to arrival, the day of arrival or within 24 hours after hospital arrival?
- Changes in the wording of allowable values 2, 3 and 4



Blood Culture Collected

- Multiple changes and additions to the Notes for Abstraction!!!
- For the purposes of this data element, any form of a 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.



Blood Culture Collected

- 1st bullet now states: If the ED patient had 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"
- 7th bullet now states: 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 hospital, select value "3"



Chest X-Ray



- Definition changed
 - Documentation of a chest x-ray or CT scan the day prior to hospital arrival through acute inpatient discharge.
- Question changed
 - Did the patient have a chest x-ray/CT scan the day prior to hospital arrival through acute inpatient discharge?



Chest X-Ray

- Allowable value changes
 - 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



Chest X-Ray

- Allowable value changes
 - 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
 - 4 – Has been removed



Chest X-Ray

- 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”



Chest X-Ray



- 1st bullet continued:
 - 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.”



Chest X-Ray

- 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.



Chest X-Ray

- Do not use the “history” or “indications” portion of the chest x-ray or CT scan, although the findings and impressions portions are both acceptable.
- Do NOT reference Appendix H, Table 2.6



Chest X-Ray

- 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 scan 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



Chest X-Ray

- 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



Chest X-Ray

Guidelines for Abstraction – Inclusion

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

– Added terms:

- Airspace process
- Interstitial changes
- Interstitial disease
- Interstitial edema
- Interstitial fibrosis
- Interstitial prominence
- Lung process
- Markings
- Pulmonary process



Compromised

- Added to 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



Healthcare Associated Pneumonia

- 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'



Identified Pathogen

This data element has been removed



Initial Blood Culture Collection Date/Time

- 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**).



Pneumonia Diagnosis: ED/Direct Admit

...an admit note or order with an admission diagnosis of pneumonia or a Pneumonia Pathway or equivalent, select "1".

Has been changed to:

...an admit note or order with an admission diagnosis of pneumonia or a Pneumonia Pathway or equivalent that was initiated upon admission, select "1".



Pneumonia Diagnosis: ED/Direct Admit

- 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
 - Added to subsections –
Medical Records that do not contain an ED form & Pneumonia Diagnosis on Admission-Direct Admit





SCIP Measures

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Anesthesia End Date

- Removed:
 - The *Anesthesia End Date* is the date associated with the anesthesia provider's sign-off after the principal procedure. This sign-off may occur after the patient leaves the OR, in the PACU or ICU.
- Added:
 - The *Anesthesia End Date* occurs when the operative anesthesia provider signs-off the care of the patient to the person assuming the post-op anesthesia care in the PACU, ICU or other non-PACU recovery area.



Anesthesia End Date

- Changes to suggested data source:

- Priority Source:
 - Anesthesia record
- Other Suggested Sources:
 - Intraoperative record
 - Circulator record
 - Post-anesthesia record
 - Operating room notes

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*.



Anesthesia End Time

- Deleted:

- The *Anesthesia End Time* is the time associated with the anesthesia provider's sign-off after the principal procedure. This sign-off may occur after the patient leaves the OR, in the PACU or ICU.

- Added:

- The *Anesthesia End Time* occurs when the operative anesthesia provider signs-off the care of the patient to the person assuming the post-op anesthesia care in the PACU, ICU or other non-PACU recovery area.



Anesthesia End Time

- Changes to suggested data source:

- Priority Source:
 - Anesthesia record
- Other Suggested Sources:
 - Intraoperative record
 - Circulator record
 - Post-anesthesia record
 - Operating room notes

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*.



Anesthesia Start Date

- Changes to suggested data source:
 - Priority Source:
 - Anesthesia record
 - Other Suggested Sources:
 - Intraoperative record
 - Circulator record
 - Post-anesthesia record
 - Operating room notes

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*.



Anesthesia Start Time

- Changes to suggested data source:
 - Priority Source:
 - Anesthesia record
 - Other Suggested Sources:
 - Intraoperative record
 - Circulator record
 - Post-anesthesia record
 - Operating room notes

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*.



Beta-Blocker Current Medication

- Definition changed:
 - Documentation in the medical record that the patient was on a **daily** beta-blocker therapy prior to arrival
- Question changed:
 - Is there documentation that the patient was on a **daily** beta-blocker therapy prior to arrival?



Beta-Blocker Current Medication

- 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 med and additional documentation indicates the beta-blocker was not taken daily, e.g., the med reconciliation form lists a beta-blocker as the home/current med, but documentation in the nurses notes state "patient denies taking beta-blocker every day", select "No"



Beta-Blocker Current Medication

- If there is documentation that the beta-blocker is on a schedule other than daily, select "No"



Catheter Removed

- Definition changed
 - 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.
- Question changed
 - Is there documentation that the urinary catheter was removed on POD 0 through POD 2 with the *Anesthesia End Date* being POD 0?



Catheter Removed

- References in Allowable Values have been changed from POD 1 or POD 2 to “POD 0 through POD 2”
- 3rd bullet now reads:
 - If the catheter was removed on POD 0 through POD 2, but had to be reinserted, select Value “1”



Clinical Trial

- 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



Date of Infection

- This data element has been removed and replaced with *Reasons to Extend Antibiotics*



Infection Prior to Anesthesia

- Added to Notes for Abstraction:
 - **EXCEPTION:**
Select 'Yes' if the current principal procedure was a joint revision **AND** there is documentation that a culture of the operative wound was taken prior to the administration time of the prophylactic antibiotic.
 - 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.



Infection Prior to Anesthesia

- **EXCEPTION: (cont)**
 - Specific documentation that the culture was taken prior to the administration of the prophylactic antibiotic is required. An order or note instructing to culture prior to antibiotic administration is not sufficient.
 - The documentation of the culture does not have to be physician documentation. The documentation that a culture was taken can be found in sources such as the intraoperative record or the operative record.



Infection Prior to Anesthesia

- Inclusions added:
 - Endometritis, Free air in abdomen, Perforation of bowel
- Exclusions changed:
 - Bacteria in urine (Bacteriuria)
 - “carditis” (such as pericarditis) without mention of an infection
 - Colonization or positive screens for MRSA, VTE or for other bacteria
 - Fungal infections
 - History of infection, recent infection or recurrent infection not documented as current or active infection
 - Viral infections



Infection Prior to Anesthesia

- Suggested Data Sources
 - Any documentation of an infection found in the Operative Report except documentation that an operative site culture was performed as noted in the Exception in the Notes for Abstraction



Intentional Hypothermia

- If there is physician/APN/PA/CRNA documentation of the patient undergoing cardiopulmonary bypass for the procedure, select “Yes”
- Perfusion record has been added as a suggested data source
- Cardiopulmonary bypass added to the inclusion list



Joint Revision

- This data element has been replaced with *Reasons to Extend Antibiotics*



Perioperative Death

- 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.



Postoperative Infections

- This data element has been replaced with *Reasons to Extend Antibiotics*



Preoperative Hair Removal

- Allowable Value added:
8 – Hair removal performed with a razor from the scrotal area
OR from the scalp after a current traumatic head injury



Reason for Not Administering Beta-Blocker Perioperative

- Deleted 4th and 5th bullets
- Added:
 - 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.”



Reason for Not Administering VTE Prophylaxis

- 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
- Added Exclusions:
 - Minimal or scant bleeding or oozing
 - Serosanguinous drainage from drain or surgical dressing
 - Chronic Anemia



Reason to Extend Antibiotics



New data element

- Replaces *Postoperative Infections, Date of Infection, and Joint Revision*
- 7 allowable values, select all that apply
- Physician/APN/PA documentation only
- Inclusion/Exclusion to be used for specific answer values
- 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



Reason to Extend Antibiotics

- 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
- See Specification Manual for more specific details on this new element



Surgical Incision Time



- Times designated as *Surgical Incision Time* or including the term incision time are to be taken as first priority terms
- **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 cysto. 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*



Surgical Incision Time



- **EXCEPTIONS:** (cont)
 - B. **Laparoscopy to Open:** If the procedure starts as a laparoscopic procedure and it is converted to an open procedure, abstract the *Surgical Incision Time* that is documented for the open procedure.
Example:
Surgical Incision Time for the laparoscopic procedure is 1300. The procedure is converted to an open procedure. *Surgical Incision Time* of the open procedure is 1400. Abstract 1400 for the *Surgical Incision Time*.



Surgical Incision Time



- **EXCEPTIONS:** (cont)
 - **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.
- Guidelines for Abstraction – Inclusion has been changed. Please see the specification manual for the revised list.



Temperature

- Active warming is limited to forced air-warming, conductive, over-the-body active warming, or warm water garments. If conductive warming blankets are used, there must be documentation that the resistive heating blanket was placed over the patient. If there is no documentation that the blanket was placed over the patient, do not select value "1"
- If the recorded temperature was not within the specified range but active warming with the specified modalities was used intraoperatively, select "1"



Temperature - Patient Warming Modalities

Inclusion

- Forced air warming
- Warm water garments
- Conductive, over-the-body active warming (such as resistive heating, over-the-patient blanket)

Exclusion

- Airway heaters or humidifiers
- Blood & fluid warmers
- Body cavity lavage
- Passive heating systems (space blankets or caps)
- Radiant heat sources
- Under-body warming
- Blankets heated in a blanket warmer



Urinary Catheter

- Note: The intraoperative period begins when the patient enters the operating room and ends when the patient leaves the operating room
- Urethral or suprapubic have been removed from Value 3
- Added Inclusions under Indwelling Catheter:
 - Suprapubic
 - Urethral



VTE Prophylaxis

- Added Allowable Value
 - 8 Oral Factor Xa Inhibitor
- Deleted 1st & 2nd bullets and added:
 - Collect any VTE prophylaxis that was ordered at anytime from hospital arrival to 24 hours after *Anesthesia End Time*.
 - 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 placed on the patient at anytime from hospital arrival to 24 hours after *Anesthesia End Time* as if there was an order for it.



VTE Prophylaxis Date

- If VTE prophylaxis was administered the day of and the day after hospital admission, select the date that the **initial** VTE prophylaxis was administered.



Thank You!

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