PREPARING CRITICAL ACCESS HOSPITALS FOR THE NEW WORLD OF MEASUREMENT
Frequently Asked Questions
Prepared by Minnesota Department of Health

Additional Q&As February 10, 2010

Questions on data submission requirements for hospital compare measures:

1. Q: Prospective Payment System (PPS) hospitals are required to complete the population and sampling tool when submitting data on the hospital compare quality measures to the Center for Medicare & Medicaid Services (CMS). However, Critical Access Hospitals (CAHs) are not required to complete this step. Is this acceptable given the Minnesota Statewide Quality Reporting and Measurement System requirements?

The Minnesota Statewide Quality Reporting and Measurement System does not require CAHs to complete the population and sampling tool when submitting data on the hospital compare quality measures to CMS.

2. Q: When are hospitals required to begin reporting data on the hospital compare outpatient acute myocardial infarction (AMI), chest pain, and surgery measures?

The Minnesota Statewide Quality Reporting and Measurement System, created through Minnesota Rules, Chapter 4654, requires reporting for the hospital compare outpatient AMI, chest pain, and surgery measures beginning in January 2011. Therefore, hospitals need to begin submitting data to the Centers for Medicare & Medicaid Services (CMS) on the first data submission deadline after January 1, 2011. For the hospital compare outpatient measures, this would be February 1, 2011 for third quarter 2010 dates of service.

Questions on the Agency for Healthcare Quality and Research (AHRQ) quality indicators:

3. Q: Are hospitals required to submit present on admission (POA) information for the calculation of the Agency for Healthcare Research and Quality (AHRQ) quality indicators (QIs)?

No. At this point in time, hospitals are not required to submit POA information for the calculation of the AHRQ QIs.

Questions and Answers January 21, 2010

Questions on data submission requirements for hospital compare measures:

4. Q: CMS does not require a hospital with five or fewer acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), or surgical care improvement project (SCIP) discharges in a quarter to submit AMI, HF, PN, and SCIP data for that quarter, beginning with discharges occurring on or after January 1, 2009. Does the Minnesota Statewide Quality Reporting and Measurement System require hospitals to submit data for the AMI, HF, PN, and SCIP quality measures for all cases or only if a hospital has more than five discharges in a quarter?
Information about submission requirements for hospitals is included in the technical appendices to Minnesota Rules, Chapter 4654. Hospitals must submit data to the Centers for Medicare & Medicaid Services (CMS) for all cases for the hospital compare quality measures in order to satisfy their data submission requirements for these quality measures for the Minnesota Statewide Quality Reporting and Measurement System.

5. **Q:** My hospital submitted third quarter 2009 data to hospital compare prior to the adoption of Minnesota Rules, Chapter 4654. We did not submit data for measures where we had five or fewer discharges in the quarter. Does my hospital need to retroactively go back and enter these cases in order to comply with the Minnesota Statewide Quality Reporting and Measurement System?

No. The Minnesota Department of Health (MDH) appreciates that many hospitals already had processes established for submitting data for the hospital compare measures to CMS prior to the adoption of Minnesota Rules, Chapter 4654. MDH will not require hospitals that submitted their third quarter 2009 hospital compare data to CMS prior to the adoption of the administrative rule on December 28, 2009 to retroactively submit data for missing cases. However, data for all cases will be required for the hospital compare quality measures under the Minnesota Statewide Quality Reporting and Measurement System in all future data submissions, beginning with the fourth quarter 2009 data submission.

6. **Q:** My hospital contracted with a vendor for our third quarter 2009 heart failure (HF), pneumonia (PN), and surgical care improvement project (SCIP) data prior to the adoption of Minnesota Rules, Chapter 4654. We are not able to alter the contract with the vendor to include third quarter 2009 data for the acute myocardial infarction (AMI) quality measures. What should my hospital do?

The Minnesota Department of Health (MDH) appreciates that many hospitals already had processes established for submitting data for the hospital compare measures to CMS prior to the adoption of Minnesota Rules, Chapter 4654. MDH will not require hospitals that had vendor contracts in place for third quarter 2009 hospital compare data submission prior to the adoption of Minnesota Rules, Chapter 4654, to separately submit third quarter 2009 hospital compare data for the missing cases (in this example - data for the AMI quality measures) in order to comply with the Minnesota Statewide Quality Reporting and Measurement System requirements. However, data for all cases will be required for the hospital compare quality measures under the Minnesota Statewide Quality Reporting and Measurement System in all future data submissions, beginning with the fourth quarter 2009 data submission.

**Questions on the outpatient surgery center quality measures:**

7. **Q:** What are the data submission requirements for outpatient surgery centers?

The outpatient surgery department measures included in the Minnesota Statewide Quality Reporting and Measurement System are not required for 2010 reporting. Reporting will be required beginning in 2011. More information about data submission requirements for outpatient surgery centers will be included in the next iteration of the administrative rule, expected in late summer or early fall 2010.
### Measure Set | Data Source | How data collected | Currently publicly reported anywhere | For which hospitals | Readily available data | Patient population | Validation |
--- | --- | --- | --- | --- | --- | --- | --- |
**Acute Myocardial Infarction (AMI)**

- **Aspirin at arrival (AMI-1)**
  - Data Source: Administrative + medical record
  - How data collected: Vendor tool or CART
  - Currently publicly reported anywhere: Hospital Compare
  - For which hospitals: Required PPS and CAHs
  - Readily available data: Yes
  - Patient population: All patients 18 years and older
  - Validation: Required

- **Aspirin prescribed at discharge (AMI-2)**
  - Data Source: Administrative + medical record
  - How data collected: Vendor tool or CART
  - Currently publicly reported anywhere: Hospital Compare
  - For which hospitals: Required PPS and CAHs
  - Readily available data: Yes
  - Patient population: All patients 18 years and older
  - Validation: Required

- **ACEI or ARB for LVSD (AMI-3)**
  - Data Source: Administrative + medical record
  - How data collected: Vendor tool or CART
  - Currently publicly reported anywhere: Hospital Compare
  - For which hospitals: Required PPS and CAHs
  - Readily available data: Yes
  - Patient population: All patients 18 years and older
  - Validation: Required

- **Adult smoking cessation advice/counseling (AMI-4)**
  - Data Source: Administrative + medical record
  - How data collected: Vendor tool or CART
  - Currently publicly reported anywhere: Hospital Compare
  - For which hospitals: Required PPS and CAHs
  - Readily available data: Yes
  - Patient population: All patients 18 years and older
  - Validation: Required

- **Beta blocker prescribed at discharge (AMI-5)**
  - Data Source: Administrative + medical record
  - How data collected: Vendor tool or CART
  - Currently publicly reported anywhere: Hospital Compare
  - For which hospitals: Required PPS and CAHs
  - Readily available data: Yes
  - Patient population: All patients 18 years and older
  - Validation: Required

- **Fibrinolytic therapy received within 30 minutes of hospital arrival (AMI-7a)**
  - Data Source: Administrative + medical record
  - How data collected: Vendor tool or CART
  - Currently publicly reported anywhere: Hospital Compare
  - For which hospitals: Required PPS and CAHs
  - Readily available data: Yes
  - Patient population: All patients 18 years and older
  - Validation: Required

- **Primary PCI received within 90 minutes of hospital arrival (AMI-8a)**
  - Data Source: Administrative + medical record
  - How data collected: Vendor tool or CART
  - Currently publicly reported anywhere: Hospital Compare
  - For which hospitals: Required PPS and CAHs
  - Readily available data: Yes
  - Patient population: All patients 18 years and older
  - Validation: Required
### Heart Failure (HF)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Domain</th>
<th>Tool/Record</th>
<th>Method</th>
<th>Required PPS and CAHs</th>
<th>Required Policy</th>
<th>Age Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge instructions (HF-1)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>Hospital Compare</td>
<td>Yes</td>
<td>Required</td>
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<td>Evaluation of LVS function (HF-2)</td>
<td>Administrative + medical record</td>
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<td>Hospital Compare</td>
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<td>Required</td>
<td>All patients 18 years and older</td>
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<td>ACEI or ARB for LVSD (HF-3)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>Hospital Compare</td>
<td>Yes</td>
<td>Required</td>
<td>All patients 18 years and older</td>
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<tr>
<td>Adult smoking cessation advice/counseling (HF-4)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>Hospital Compare</td>
<td>Yes</td>
<td>Required</td>
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### Pneumonia

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<th>Activity</th>
<th>Domain</th>
<th>Tool/Record</th>
<th>Method</th>
<th>Required PPS and CAHs</th>
<th>Required Policy</th>
<th>Age Requirement</th>
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<tr>
<td>Pneumococcal vaccination (PN-2)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>Hospital Compare</td>
<td>Yes</td>
<td>Required</td>
<td>Pneumonia patients age 65 and older</td>
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<td>Blood cultures performed in emergency department prior to initial antibiotic received in hospital (PN-3b)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>Hospital Compare</td>
<td>Yes</td>
<td>Required</td>
<td>All patients 18 years and older</td>
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<tr>
<td>Adult smoking cessation advice/counseling (PN-4)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>Hospital Compare</td>
<td>Yes</td>
<td>Required</td>
<td>All patients 18 years and older</td>
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<td>Initial antibiotic received within 6 hours of hospital arrival (PN-5c)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>Hospital Compare</td>
<td>Yes</td>
<td>Required</td>
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<td>Initial antibiotic selection for community-acquired</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>Hospital Compare</td>
<td>Yes</td>
<td>Required</td>
<td>All patients 18 years and older</td>
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<tr>
<td>Measure Description</td>
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<td>Requirement Notes</td>
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<td>Pneumonia in immunocompetent patients (PN-6)</td>
<td>record</td>
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<td>Influenza vaccine (PN-7)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>Hospital Compare</td>
<td>Required PPS and CAHs</td>
<td>Yes</td>
<td>Pneumonia patients age 50 years and older hospitalized during October, November, December, January, February, or March</td>
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<td>Surgical Care Improvement Project (SCIP) Measures</td>
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<td>Prophylactic antibiotic received within one hour prior to surgical incision (SCIP-Inf-1)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>Hospital Compare</td>
<td>Required PPS and CAHs</td>
<td>Yes</td>
<td>All patients 18 years and older</td>
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<tr>
<td>Prophylactic antibiotic selection for surgical patients (SCIP-Inf-2)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>Hospital Compare</td>
<td>Required PPS and CAHs</td>
<td>Yes</td>
<td>All patients 18 years and older</td>
</tr>
<tr>
<td>Prophylactic antibiotics discontinued within 24 hours after surgery end time (SCIP-Inf-3)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>Hospital Compare</td>
<td>Required PPS and CAHs</td>
<td>Yes</td>
<td>All patients 18 years and older</td>
</tr>
<tr>
<td>Cardiac surgery patients with controlled 6 a.m. postoperative blood glucose (SCIP-Inf-4)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>Hospital Compare</td>
<td>Required PPS and CAHs</td>
<td>Yes</td>
<td>All patients 18 years and older</td>
</tr>
<tr>
<td>Surgery patients with appropriate hair removal (SCIP-Inf-6)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>Hospital Compare</td>
<td>Required PPS and CAHs</td>
<td>Yes</td>
<td>All patients 18 years and older</td>
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<tr>
<td>Colorectal surgery patients</td>
<td>Administrative</td>
<td>Vendor tool</td>
<td>Hospital</td>
<td>Required PPS</td>
<td>Yes</td>
<td>All patients 18 years and older</td>
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PREPARING CRITICAL ACCESS HOSPITALS FOR THE NEW WORLD OF HOSPITAL MEASUREMENT
MINNESOTA STATEWIDE QUALITY REPORTING AND MEASUREMENT SYSTEM
PUBLISHED IN FINAL RULE DECEMBER 2009

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<table>
<thead>
<tr>
<th>with immediate postoperative normothermia (SCIP-Inf-7)</th>
<th>+ medical record</th>
<th>or CART</th>
<th>Compare and CAHs</th>
<th>years and older</th>
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<tbody>
<tr>
<td>Surgery patients on beta blocker therapy prior to arrival who received a beta blocker during the perioperative period (SCIP-Card-2)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>Hospital Compare</td>
<td>Required PPS and CAHs</td>
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<tr>
<td>Surgery patients with recommended venous thromboembolism prophylaxis ordered (SCIP-VTE-1)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>Hospital Compare</td>
<td>Required PPS and CAHs</td>
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<tr>
<td>Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery (SCIP-VTE-2)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>Hospital Compare</td>
<td>Required PPS and CAHs</td>
</tr>
</tbody>
</table>

**Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI) and Patient Safety Indicators (PSI)**

<p>| Abdominal aortic aneurysm repair volume (IQI 4) and mortality rate (IQI 11) | Claims data | Hospital discharge data | Required PPS and CAHs | Yes | Patients 18 years and older | Required |
| Coronary artery bypass graft volume (IQI 5) and mortality rate (IQI 12) | Claims data | Hospital discharge data | Required PPS and CAHs | Yes | Patients 18 years and older | Required |
| Percutaneous transluminal coronary angioplasty volume (IQI 6) and mortality rate (IQI 30) | Claims data | Hospital discharge data | Required PPS and CAHs | Yes | Patients 18 years and older | Required |
| Hip fracture mortality (IQI 19) | Claims data | Hospital discharge data | Required PPS and CAHs | Yes | Patients 18 years and older | Required |
| Pressure ulcer (PSI 3) | Claims data | Hospital discharge | Required PPS and CAHs | Yes | Patients 18 years and | Required |</p>
<table>
<thead>
<tr>
<th>Medical Event</th>
<th>Data Source</th>
<th>Required PPS and CAHs</th>
<th>Older</th>
<th>Required Data</th>
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<tr>
<td>Death among surgical patients with serious treatable complications (PSI 4)</td>
<td>Claims data</td>
<td>Required PPS and CAHs</td>
<td>Yes</td>
<td>Patients 18 years and older</td>
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<tr>
<td>Postoperative pulmonary embolism or deep vein thrombosis (PSI 12)</td>
<td>Claims data</td>
<td>Required PPS and CAHs</td>
<td>Yes</td>
<td>Patients 18 years and older</td>
</tr>
<tr>
<td>Obstetric trauma – vaginal delivery with instrument (3rd and 4th degree lacerations) (PSI 18)</td>
<td>Claims data</td>
<td>Required PPS and CAHs</td>
<td>Yes</td>
<td>All vaginal delivery patients</td>
</tr>
<tr>
<td>Obstetric trauma – vaginal delivery without instrument (3rd and 4th degree lacerations) (PSI 19)</td>
<td>Claims data</td>
<td>Required PPS and CAHs</td>
<td>Yes</td>
<td>All vaginal delivery patients</td>
</tr>
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**Health Information Technology (HIT)**

Health Information Technology (HIT)

This survey is used to assess a hospital’s adoption and use of HIT in its clinical practice

Electronic survey from American Hospital Association (AHA) sent to the AHA survey contact person at each hospital (No date determined yet)

Required PPS and CAHs
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<thead>
<tr>
<th>Measure Set</th>
<th>Data Source</th>
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<th>For Which Hospitals</th>
<th>Readily Available Data</th>
<th>Patient Population</th>
<th>Validation</th>
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<tr>
<td><strong>Outpatient Acute Myocardial Infarction (AMI) and Chest Pain measures</strong></td>
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<tr>
<td>Median time to fibrinolysis (OP-1)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>No</td>
<td>Required PPS and CAHs</td>
<td>Yes</td>
<td>All patients 18 years and older</td>
<td>TBD</td>
</tr>
<tr>
<td>Fibrinolytic therapy received within 30 minutes of emergency department arrival (OP-2)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>No</td>
<td>Required PPS and CAHs</td>
<td>Yes</td>
<td>All patients 18 years and older</td>
<td>TBD</td>
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<tr>
<td>Median time to transfer to another facility for acute coronary intervention (OP-3)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>No</td>
<td>Required PPS and CAHs</td>
<td>Yes</td>
<td>All patients 18 years and older</td>
<td>TBD</td>
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<tr>
<td>Aspirin at arrival (OP-4)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>No</td>
<td>Required PPS and CAHs</td>
<td>Yes</td>
<td>All patients 18 years and older</td>
<td>TBD</td>
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<td>Median time to ECG (OP-5)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>No</td>
<td>Required PPS and CAHs</td>
<td>Yes</td>
<td>All patients 18 years and older</td>
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<tr>
<td><strong>Outpatient Surgery Department Measures</strong></td>
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<td>Timing of antibiotic prophylaxis (OP-6)</td>
<td>Administrative + medical record</td>
<td>Vendor tool or CART</td>
<td>No</td>
<td>Required PPS and CAHs</td>
<td>Yes</td>
<td>All patients 18 years and older</td>
<td>TBD</td>
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<tr>
<td>Prophylactic antibiotic selection for surgical patients</td>
<td>Administrative + medical</td>
<td>Vendor tool or CART</td>
<td>No</td>
<td>Required PPS and CAHs</td>
<td>Yes</td>
<td>All patients 18 years and older</td>
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### Preparing Critical Access Hospitals for the New World of Hospital Measurement

**Minnesota Statewide Quality Reporting and Measurement System**

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<thead>
<tr>
<th>Measure Set</th>
<th>Data Source</th>
<th>How data collected</th>
<th>Currently Publicly Reported Anywhere</th>
<th>For Which Hospitals</th>
<th>Readily Available Data</th>
<th>Patient Population</th>
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<tr>
<td>(OP-7)</td>
<td>record</td>
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</table>

**Patient Experience (Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS))**

- **Patient Experience of care (not required for hospitals with less than 500 admissions in the previous calendar year)**
  - Data Source: Survey of patients discharged
  - How data collected: Random selection of adult – vendor or hospital
  - Currently Publicly Reported Anywhere: Yes
  - For Which Hospitals: Required PPS and CAHs
  - Readily Available Data: Adults
  - Validation: No

**Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI), Patient Safety Indicators (PSI), and Pediatric Patient Safety Indicators (PDI)**

- **Mortality for selected conditions composite measure and component indicators:**
  - Data Source: Claims data
  - How data collected: Hospital discharge data
  - Currently Publicly Reported Anywhere: Required PPS and CAHs
  - For Which Hospitals: Yes
  - Readily Available Data: Patients 18 years and older
  - Patient Population: Required

- **Patient safety for selected indicators composite measure and component indicators:**
  - Data Source: Claims data
  - How data collected: Hospital discharge data
  - Currently Publicly Reported Anywhere: Required PPS and CAHs
  - For Which Hospitals: Yes
  - Readily Available Data: Patients 18 years and older
  - Patient Population: Required
# PREPARING CRITICAL ACCESS HOSPITALS FOR THE NEW WORLD OF HOSPITAL MEASUREMENT

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## Measure Set

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<tr>
<td>Iatrogenic pneumothorax (PSI 6)</td>
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<td>Selected infections due to medical care (PSI 7)</td>
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<td>Postoperative hip fracture (PSI 8)</td>
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<td>Postoperative pulmonary embolism or deep vein thrombosis (PSI 12)</td>
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<td>Accidental puncture or laceration (PSI 15)</td>
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<td>Pediatric patient safety for selected indicators composite measure and component indicators:</td>
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<td>Hospital discharge data</td>
<td>Required PPS and CAHs</td>
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<td>Patients under age 18</td>
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<td>Accidental puncture or laceration (PDI 1)</td>
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<td>Pressure ulcer (PDI 2)</td>
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<td>Postoperative sepsis (PDI 10)</td>
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</tbody>
</table>
Preparing Critical Access Hospitals For The New World of Hospital Measurement
Frequently Asked Questions from Critical Access Hospitals
February 25, 2010

Inpatient Measures

1. Do we need to sign a document giving MDH access to our hospital core measure data?

   MDH will pull the data from Hospital Compare. Since this data is public, another form will not need to be signed.

2. Will the CMS validation process suffice for the MDH requirements?

   The validation follows the current validation scheme that CMS has. However, CMS has changed their validation process. (See Validation Fact Sheet). Stratis Health and MDH are in discussion about these changes and how to approach validation in the future. We will keep you posted.

3. Are CAHs part of the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU)?

   Prospective payment system (PPS) hospitals receive DRG reimbursement and are subjected to more stringent requirements by CMS to be able to receive their Annual Payment Update (APU). CAHs are not considered part of the RHQDAPU program. However, with the new MN rule, CAHs must also report all the measures outlined in the appendices.

4. If a hospital elects to invoke the “5 or fewer” rule, and does not submit data for a measure (despite having an initial population identified), are they exempt also from public reporting? Or will you require hospitals to ignore the “5 or fewer” rule?


5. Should swing beds be abstracted?

   No, only acute inpatients should be abstracted and reported.

6. Do CAHs need to complete the population and sampling grid on QualityNet?

   See MDH answer dated February 10, 2010

7. Do CAHs need to complete the measure designation on QualityNet?

   Yes, this is important. If you have not indicated you want to submit a measure, even though you send the data to the warehouse, it will not place data for that measure in the warehouse. Stratis Health recommends you check all the measures even though you know you won’t have data for some of them.
Preparing Critical Access Hospitals For The New World of Hospital Measurement
Frequently Asked Questions from Critical Access Hospitals
February 25, 2010

8. Emphasize difference between CMS and state requirements

It is important to understand the difference between CMS and state requirements. In Minnesota, the state requirements will take precedence over the CMS requirements. CMS does not require CAHs to submit inpatient and outpatient data; however, the state does require data submission of these measures.

AHRQ Measures

9. Where do we send the AHRQ data?

No additional submission is needed for the AHRQ data. Every hospital sends their discharge claims data to MHA already and MHA will calculate the AHRQ measures.

10. I don't believe I've received notification as to how to log onto the website and input the AHRQ indicators as of yet. Will that be forthcoming?

You don't need to do anything further with the AHRQ measures. Your hospital already sends all claims data to the MN Hospital Association and they will do the calculations from that data. There is no additional registration for these measures.

11. How do they look at care for OB?

This is an AHRQ measure; therefore, the necessary data is taken from the claims data submitted to MHA. MHA does the calculation.

12. How is the AHRQ pressure ulcer measure calculated if excluding POA when CAHs don’t collect POA?

Addendum to MDH answer February 10, 2010.

Per Mark Sonneborn from MHA - The software will count any pressure ulcer not identified as POA as hospital-acquired. For this and many other reasons, we recommend that all hospitals send us POA data on all claims. However, it is not required by payers other than Medicare (and not at all for CAHs). So, we recognize this is an additional coding burden, and can only recommend you send it instead of requiring it. We believe it’s an extremely valuable bit of information that others are eventually going to start to require.
Preparing Critical Access Hospitals For The New World of Hospital Measurement
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Physician Clinic Measures

13. What is the website for clinics to register?

The website is www.mncm.org. This website has the portal for your facility to register. Registration has ended. If you still need to register please contact Jane Duncan at duncan@mncm.org

14. We have consulting docs come here and do outreach. We have cardiology, orthopedics, oncology, ENT, to name a few. Some are from MN and some from SD. We do the billing for some and others do their own billing. Do we have any obligation for quality measures for these outpatient outreach clinics?

Per Jane Duncan from MN Community Measurement - If physicians are seeing patients on site for a fee, the site needs to register and report data.

HOSPITAL OUTPATIENT MEASURES

15. Do I need to register again to be able to abstract and submit data for hospital outpatient.

If the facility already has QualityNet Security Administrators (SA) for inpatient, there is no additional paperwork needed to get the Outpatient roles added to the accounts. The facility may already have the Outpatient roles pushed out to their facility, and if this is the case, then the SA should be able to add these roles to the other users’ accounts. If the hospital has two QNet SAs assigned, they can set up roles for each other. If the hospital has only one SA assigned, please contact Stratis Health for assistance.

16. Question sent to Hospital Outpatient QIO by Stratis Health

Minnesota is requiring all hospitals (including CAHs) to begin abstracting and reporting outpatient data with 07/01/2010 encounters. One hospital sent me a memo she received about online pledging. In that memo I noted that all hospitals must set a designation by March 31, 2010 to get their data publicly reported. This is an important piece for us because if they don’t set this designation, the data will not be available for the state to pull down to meet their requirements. Since we don’t have access to most of the outpatient forms, could you please send me the form mentioned in this memo that hospitals need to sign? I am assuming they need to have QNet administrators and participation agreements before anything else, correct?
Preparing Critical Access Hospitals For The New World of Hospital Measurement
Frequently Asked Questions from Critical Access Hospitals
February 25, 2010

The deadline you mention is for pledging the 2011 calendar year. This can only be completed online, so there are no forms to send. The facilities will need to have a Qnet administrator and then have the HOP QDRP Pledge update role assigned to their account to be able to complete the pledge. Once this role is assigned, they will see a link on their My Tasks page to Manage Pledges which is where they will complete their online pledge.

NOTE: Your hospital should have two assigned QualityNet administrators. The QNet administrators can set these rights for each other. If you only have one QNet administrator, contact Stratis Health (Robyn rcarlson@stratishealth.org or Mary mmontury@stratishealth.org) and we will assign the rights.

17. Does a hospital have to complete participation and registration forms before they can go into My QualityNet and see outpatient items?

The forms and registration process must be complete before the facilities can enter My QualityNet. Then they can complete the pledges and assign user roles to accounts.

18. We don’t have to actually report until closer to calendar 2011 but the data will be from discharges starting July 1, 2010 – so we wouldn’t have to start submitted to Q-Net right away as I understand.

The encounters start with July 01, 2010. The first submission date for outpatient will be February 1, 2011.

HCAHPS

19. Do hospitals need to do the dry run for HCAHPS?

Dry runs take place the last month of each calendar quarter (March, June, September, December). There will, however, be no public reporting of a hospital’s dry run data. Should a hospital decide to participate, the hospital/survey vendor must contact HCAHPS to notify the HCAHPS Project Team of their intent to submit data as a dry run. Please note: participation in a dry run is voluntary.

20. How do we know if we have 500 or more discharges?

Use admission data from 2009 to calculate your total admissions. Hospitals with 500 or more admissions in calendar year 2009 must administer and report the HCAHPS survey.
Health Information Technology Survey

1. The data source for the Health Information Technology (HIT) measure refers to a survey from the American Hospital Association (AHA) sent to the AHA survey contact person at each hospital. Do you know who that contact is for us and if not how do I find this information?

   According to Mark Sonneborn from MHA each hospital has a contact person that receives AHA communications. This is the person who would get the survey. It might be the CEO. We would suggest this person be identified at your facility and made aware of the survey coming in the future.
Security Administrator Assignments

Ensure there are at least two Security Administrators (SAs) for your organization. Verify at least one of the SAs has HOP QDRP roles assigned.

New SAs can be registered by following the directions on www.qualitynet.org. New roles can be assigned to existing SAs by the alternate SA at a secure site, My QualityNet, found at www.qualitynet.org. Follow the directions found in the Manage Security section on My QualityNet task page to edit roles of the other SA.

Specifications Manual

2. Place cursor over Hospitals-Outpatient menu.
3. Click the Specifications Manual link to download the manual.
   Note: The version number of the Specifications Manual is specific to the effective encounter date range.
4. Click the link for the desired version of the Specifications Manual you intend to download.
   Note: You can view and/or download an individual section of the Specifications Manual OR download the entire manual.
5. Click the individual section to expand the section and view/download the section-specific information.
6. Click on Download Entire Manual to download and save the entire Specifications Manual in either PDF or EXE (ZIP) format.

Data Abstraction & Transmission

CART Tool

If a vendor is not transmitting your data, you will need to download CART from www.qualitynet.org.

2. Place cursor over Hospitals-Outpatient menu.
3. Click Data Collection (& CART) in the drop-down menu.
4. Click CART Downloads & Info.
5. Print and follow the installation instructions from one of the available options.
6. Follow instructions to download QMS.
   You MUST download the Installation directions and the User’s Guide for CART to obtain the web address for uploading the application and the initial user name and password.
   Note: Paper abstraction tools are also available at this site. These tools, arranged in alpha order by data element, can be customized to meet the abstractor’s needs and to match CART or your vendor’s program.

Measure Population Identification

All measure populations are based on outpatient status, patients aged 18 years or older.

Emergency Department patients must have:

- Evaluation & Management (E/M) code from Table 1.0.
- Acute Myocardial Infarction and/or Chest Pain ICD-9-CM code from Table 1.1 or 1.1a.

Surgery patients must have:

- A CPT code from Appendix A, Table 6.0.
  Note: The CPT codes found in Appendix A, Tables 6.0, are stratified into Tables 6.1 – 6.7 for ease in verifying correct antibiotic use.
  Note: Discharge/transfer status codes DO NOT apply to the surgery measures.

Vendor Authorization

The vendor must be authorized electronically to submit outpatient data on a hospital’s behalf.

2. Enter your ID and Password.
3. Click the Hospital: Outpatient Clinical in the Authorize Vendors to Submit Data task box.
   Note: The vendor authorization for outpatient is separate and distinct from the inpatient vendor authorization.

There is no deadline for completing the vendor authorization form, BUT your vendor cannot transmit data until you complete the Vendor Authorization process.

Note: Refer to the HOP QDRP Quick Start Guides: Vendor Authorization for detailed instructions.

For additional information, refer to the complete QualityNet User’s Guide online at www.qualitynet.org

This material was prepared by FMQAI under contract with the Centers for Medicare & Medicaid Services (CMS). FL20085NHODT5N36100759
QualityNet Reports

Options displayed in the Reports section on My QualityNet task page are dependent on the roles assigned to the user who signed in.

Reports are generated in PDF or CSV format; all reports can be downloaded and saved. CSV files may be saved as Excel worksheets.

The complete QualityNet Reports User’s Guide is available by clicking Help on the My QualityNet page.

Required Role: HOP QDRP Feedback Reports

Run Reports

A report requested for a time frame for which there are no data available will display only title and column headings

1 Go to www.qualitynet.org.
2 Select My QualityNet.
3 Click Run from the Reports task box on the My QualityNet page.
4 Select a Report Category from the drop-down list.
5 Click Go.

Note: Available Report Categories will depend on the roles assigned to the user who signed in.

Note: If the desired report is not listed in the drop-down list, contact the facility’s QualityNet Security Administrator (SA).

Note: If there is a question about a user’s assigned roles, a Registration Report can be run. (See the HOP QDRP Quick Start Guide: Manage Security.)

6 Available reports and report descriptions will display. Click the desired link from the Report Name list.

7 Enter the desired Parameters.
8 Click Request Report.

Note: Each report has unique parameters. Refer to the individual chapters in the QualityNet Report User’s Guide for details.

Note: Optional fields default to ALL if no parameters are entered.

9 A Report Submitted page displays
   • Click Run Reports to return to the reports selection page, OR
   • Click View Reports to access the Report Viewer, OR
   • Click Report Parameters to return to the Report Parameter Page.

View Reports

1 Click View from the Reports task box on the My QualityNet task page.
2 The Report Viewer defaults to the New Reports list and displays reports requested in the last seven days.

Note: Data displayed include Date and Time of Request, Report Name, Size, and Status. Once the Report Status is Complete, it is available for viewing, downloading, or deletion.

3 Click one of the Action buttons beside the requested report.
   • The Magnifying Glass = View Report.
   • The Down Arrow into a file = Download Report. You will be prompted to select a directory in which to save the file.
   • The Trash Can = Delete Report.

   Once deleted, a report is permanently deleted and will need to be requested again if needed.

4 New reports or previously downloaded reports can be searched by date or report name.

Required Role: HOP QDRP Report Auth Approval


Healthcare Systems and Vendors may request authorization to view their affiliated providers' reports. Providers must approve authorization before the Healthcare System or Vendor can access the reports.

Once approval to view a hospital’s reports is granted, the SA at the Healthcare System or Vendor will need to assign the necessary roles to the appropriate users within the organization.

Hospital user(s) with the OPPS Report Auth Approval role will receive an e-mail notification that a Report Authorization Request is awaiting approval.

1 Click Approve Access Requests from the Reports task box on the My QualityNet page.
2 The Approve Access Request page will open.
3 Click a check box under the report categories for which approval is being granted.

Note: If Deny Access is checked for the initiative, none of the check boxes within that initiative [for a particular report category] can be selected.

4 Click Continue.
5 Review information on the Approve Access Request page for accuracy.
6 Enter your Password and click Submit.

• An Approve Access Request confirmation page displays for provider.
• An e-mail notice that the Request has been processed displays for Healthcare System/Vendor.

For additional information, refer to the complete QualityNet User’s Guide online at www.qualitynet.org

This material was prepared by FMQAI under contract with the Centers for Medicare & Medicaid Services (CMS). FL.20086AH076A3510720
Validation Fact Sheet

- Hospitals have 45 calendar days to deliver requested medical records for validation to the CDAC. Hospitals will be sent a written notice if the CDAC has not received the records 30 days after the request was issued (which is approximately 15 days before the due date).
- Records received by the CDAC on or before the 45th day will be validated. Records received after the 45th day will not be validated. There will be no extensions.
- FY 2011 - The quarterly validation rate will be based on element matches and mismatches. Quarterly passing rate is 80%.
- FY 2011 - Validation and Confidence Interval (CI) calculation will occur as it has the past two years.
- FY2011 - Quarters 4Q08, 1Q09, 2Q09, and 3Q09 will be used for the CI calculation.
- FY2012 - Quarters 1Q10, 2Q10, and 3Q10 will be used for the CI calculation.
- FY2012 - 800 hospitals will be randomly selected for FY2012 validation in July 2010. CMS will notify selected hospitals of selection. The final process for this communication has not been determined, but will be communicated to hospitals in advance.
- Hospitals that meet ALL the following criteria in July 2010 are eligible to be one of the 800 hospitals selected:
  - Open status
  - Active pledge (Notice of Participation form) to participate in the RHQDAPU program
  - At least 100 total accepted case submissions for CY 2009 discharges
- FY2012 - Up to, but no more than, three cases per topic will be selected for each quarter’s validation, so there will be a maximum of 12 randomly-selected cases for a hospital per quarter. Selected records will be stratified by measure topic. If a hospital has fewer than three cases in one topic, then that hospital will have fewer than 12 cases validated. For example, if a heart-care hospital does not have any PN cases for a quarter, but has more than three HF, more than three AMI, and more than three SCIP cases, that hospital would be required to submit nine cases for validation for that quarter.
- FY2012 - The first validation record requests from the CDAC will occur following the 8/15/10 data submission deadline.
- FY2012 - The quarterly validation rate rate will be based on measure outcome matches and mismatches. For example, heart failure cases will have four measure outcomes to compare and the denominator will be four. The Final Rule changes the annual validation passing rate from 80% to 75%.
- FY2012 - Feedback will be available to all hospitals based on aggregate information from the 800 hospitals’ validated cases.
- FY2013 – At this time, CMS has not proposed validation requirements for FY 2013. Please review future CMS payment rules for any proposed updates to the CMS validation requirements.

Critical Access Hospitals and other hospitals not eligible for RHQDAPU will be exempt from the validation process. However, their submission reports will be available (no validation reports) and their measure data will be displayed on Hospital Compare unless suppressed by the hospital.

This material was prepared by IFMC, the RHQDAPU Quality Improvement Organization Support Center, under contract with the Centers for Medicare & Medicaid Services, (CMS), an agency of the U.S. Department of Health and Human Services. 9SoW-IA-HRPQIOSC-01/10-048
Box on lower right of page (Manage Measures) is where you go to edit Measure Designation – you need to be a registered QualityNet Security Administrator to log in here and do these changes.
This is where you put your hospital CCN - 241xxx number and go in to View/Edit Measure designation. This might automatically show up at your hospital not needing to enter your hospital CCN number.
Hospital Inpatient training sessions for various subjects on QualityNet

Hospital (Inpatient) Training

To learn more about the features and functions of QualityNet, choose from the following recorded training sessions. (All presentations are in WRF format, unless otherwise indicated.)

For All Users:
- QualityNet for New Users, 31 min. (07/02/08)
- QualityNet Enhancement Overview for All Users, 28 min. (02/22/08)
- QualityNet Registration and Setup Overview, 29 min. (01/22/07)
- QualityNet Report Access, 18 min. (02/22/08)
- Send and Receive Files, 28 min. (06/12/09)
  - Transcript, PDF - 63 KB

For users with special (authorized) roles
- Authorize Vendors to Submit Data, 10 min. (02/22/08)
- Auto Route, 11 min. (02/22/08)
- Manage Security, 30 min. (02/22/08)
- Reset Password for Selected User, 6 min. (02/22/08)

For hospitals, health care systems, hospital data vendors
- APU Dashboard Overview, 13 min. (01/08/09)
- HCAHPS Online Data Entry, 28 min. (04/23/09)
  - Transcript, PDF
- Hospital Inpatient Population and Sampling, 30 min. (04/16/09)
  - Transcript, PDF
- Slides, PDF
- Hospital Inpatient Measure Delineation, 12 min. (09/26/08)
- Report Authorization for HCAHPS, 12 min. (04/09/08)
- Request Report Access for Vendors and Health Care Systems, 7 min. (02/22/08)
- Structural Measures, 12 min. (06/22/09)
Hospital Outpatient Menu in QualityNet

Hospital Outpatient Quality Data Reporting Program (HOP QDRP)

Advisories
Registration
Data Collection (CHART)
Specifications Manual
Data Submission
Imaging Efficiency Measures
Resources - Program
Resources - Vendor
Support Contact
Training

Report HOP QDRP data

Hospital Outpatient Quality Data Reporting Program (HOP QDRP) requirements and receive reimbursement for Calendar Year 2008 services under the OPPS, hospitals must submit data for seven (7) quality measures for three (3) medical conditions: acute myocardial infarction, chest pain and surgical care improvement. Hospitals that participate in the HOP QDRP initiative and meet the HOP QDRP requirements will receive their full Outpatient Prospective Payment System Medicare Annual Payment Update for CY 2009.

More »
CART Downloads & Info
Version 1.3 for Encounters 01/01/2010 - 06/30/2010

CART-Outpatient: Version 1.3 for Encounters 01/01/2010 - 06/30/2010

*NOTE:* CART-Outpatient 1.3 is backward compatible with CART-Inpatient 1.2.x. On workstations with CART-Inpatient 1.2.x installed, follow the upgrade installation instructions. On workstations without CART-Inpatient 1.2.x, follow the new installation instructions. Users will also need to retain a previous version of CART on their workstations for use with historical data (regarding encounters before July 1, 2009).

CART-Outpatient 1.3 is compatible with CART-Inpatient 4.6 or greater and may be installed in the same directory. To install in the same location, read and follow the "On a workstation with CART-Inpatient 4.6 or greater" instructions below. To install in a different directory, read and follow the "Initial Installation Instructions."

Upgrading from CART-Outpatient 1.2.x

If CART-Outpatient 1.2.x is installed on the workstation:
1. Be sure that you’ve installed CART-Outpatient 1.2.x.
2. Read and follow the Upgrade Instructions, PDF - 204 KB
3. Download the CART-Outpatient 1.3 Upgrade, EXE - 51 MB

OR

Installing CART-Outpatient for the first time

Done

Start
More Hospital Outpatient CART Download information

OR

Installing CART-Outpatient for the first time
On a workstation with CART-Inpatient 4.6 or greater:

   Be sure that you've installed CART-Inpatient 4.6 or greater.
   Read and follow the Installation Instructions (with CART-Inpatient installed), PDF - 390 KB.
   Download CART-Outpatient 1.3, EXE - 51 MB.

On a workstation without CART-Inpatient 4.6 or greater:

   Read and follow the Initial Installation Instructions (without CART-Inpatient installed), PDF - 599 KB
   Download CART-Outpatient 1.3, EXE - 158 MB

Documentation

- Release Notes, PDF - 53 KB
- Edits, XLS - 218 KB
- User's Guide, PDF - 2.8 MB
Specifications Manual for Hospital Outpatient Department Quality Measures

The Specifications Manual for Hospital Outpatient Department Quality Measures was developed by the Centers for Medicare & Medicaid Services (CMS) to provide a uniform set of quality measures to be implemented in hospital outpatient settings. The primary purpose of these measures is to promote high quality care for patients receiving services in hospital outpatient settings.

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<tr>
<td>04/01/08 - 09/30/08</td>
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Timelines for Specifications Manuals, Release Notes

The timelines listed below outline the anticipated schedule for updates to the Specifications Manual for National Hospital Outpatient Quality Measures for the designated year:

- 2009 Timeline - Specifications Manual and Release Notes, PDF

Specifications Manual
for Hospital Outpatient Department Quality Measures, v3.0a

For use in submitting data for encounters from 01/01/10 through 06/30/10.

View and/or download individual sections of the Specifications Manual, [PDF documents, unless noted], listed below.

- Release Notes
- Introductory Materials
- Section 1 -- Measure Information
- Section 2 -- Data Dictionary
- Section 3 -- Missing and Invalid Data
- Section 4 -- Population and Sampling Specifications
- Section 5 -- Hospital Outpatient Department Quality Measure Data Transmission
- Appendices
- Download Entire Manual
## Alphabetical Data Element List

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<td>OP-7</td>
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<td>OP-6, OP-7</td>
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<td>OP-6, OP-7</td>
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<td>Antibiotic Timing</td>
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<td>Fibrinolytic Administration</td>
<td>34</td>
<td>OP-1, OP-2, OP-3</td>
</tr>
<tr>
<td>Fibrinolytic Administration Date and Time</td>
<td>35</td>
<td>OP-1, OP-2</td>
</tr>
<tr>
<td>First Name</td>
<td>37</td>
<td>All Records</td>
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</tbody>
</table>
Data Element Name: Probable Cardiac Chest Pain

Collected For: OP-4, OP-5

Definition: Documentation a nurse or physician/APN/PA presumed the patient’s chest pain to be cardiac in origin.

Suggested Data Collection Question: Was the patient’s chest pain presumed to be cardiac in origin?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
Y (Yes) There was nurse or physician/APN/PA documentation the chest pain was presumed to be cardiac in origin.

N (No) There was no nurse or physician/APN/PA documentation the chest pain was presumed to be cardiac in origin or unable to determine from medical record documentation.

Notes for Abstraction:
• If there is documentation of a differential/working diagnosis of acute myocardial infarction select “Yes.”
• Disregard documentation of inclusions/exclusions described with terms indicating the condition is not acute, such as “history of.”
Specifications Manual for Hospital Outpatient Department Quality Measures

Encounter dates 01-01-10 (1Q10) through 06-30-10 (2Q10) v 3.0a

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Guidelines for Abstraction:

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<th>Exclusion</th>
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<tr>
<td><strong>Acute Myocardial Infarction and Chest Pain Inclusions</strong></td>
<td>• Atypical Chest Pain</td>
</tr>
<tr>
<td>• Acute coronary syndrome</td>
<td>• Chest Pain musculoskeletal</td>
</tr>
<tr>
<td>• Acute myocardial infarction (AMI)</td>
<td>• Chest Pain qualified by a non-cardiac cause</td>
</tr>
<tr>
<td>• Angina</td>
<td>• Chest wall pain</td>
</tr>
<tr>
<td>• Cardiac</td>
<td>• Non Cardiac Chest Pain</td>
</tr>
<tr>
<td>• Cardiac Chest Pain</td>
<td>• Non-specific Chest Pain</td>
</tr>
<tr>
<td>• Chest Pain</td>
<td>• Traumatic Chest Pain</td>
</tr>
<tr>
<td>• Heart attack</td>
<td></td>
</tr>
</tbody>
</table>