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Abstracting For Accuracy

Presented by [Robin Carlson] (108-minute Webinar) [01-12-2012]

Mary Montury: Hello everyone and welcome to the Stratis Health, Abstracting for Accuracy Conference Call. Robin Carlson is our speaker today. Robin has a broad background in medical record abstraction review on training. She has supervised medical records staff in acute care settings and has provided client support consulting for MediQual Systems, Inc.

In this capacity she evaluated client operations and provided training and medical record abstraction. In her current role, as Data Quality Specialist at Stratis Health, she provides support for data abstraction questions, assists hospitals and uses the CMS Clinical Abstraction and Reporting Tool, the Cart Tool, and coordinates the validation process for data submitted to the Quality Improvement Organization Clinical Warehouse.

Robin Carlson: HI everyone. This call is about the abstraction changes for the specification manual for version 4.0c for discharges beginning January 1, 2012, through June 30, 2012. What we’ll be talking about are changes to the collection of data elements for the AMI, heart failure, pneumonia, and SCIP measures and then we’ll go over the data elements for the emergency department and immunization measures.

Just a reminder, for every new version of the manual and any addendums that are added after the fact, like for this version, it’s your responsibility to review the release notes for a detailed description of the changes that were made to the manual.

I’ll go over the major abstraction changes, but in the interest of time, and we made this call 2 hours to try and get everything in, we will leave some time for questions—but I can’t hit everything. So again, it’s your responsibility to review the release notes for all the changes. As a reminder, information that has been removed from the manual if data elements were no longer collected is found only in the release notes. It’s simply removed from the manual, so you won’t have any notification that it was there. It’s now gone—not in the data dictionary section.

Changes from one manual to the next are highlighted to call attention to the change. So, when you get the initial new manual, the changes are in yellow and if there’s an addendum, the next changes are in blue, pink for the third, and this time orange for the most recent changes in the manual.

Hopefully, everyone received the pages that we’ll go over today, so I’m going to start. First I want to say that adult smoking, history, and counseling have been removed. That specific data element isn’t there anymore. CMS and the joint commission were looking for a more robust set of global smoking cessation measures and they felt that screening should occur in all patients, not just those with certain conditions. Therefore, the questions that were in those two smoking data elements before are now part of the tobacco treatment measure, which is one of the global national in-patient quality measures. At this time, it’s not required for CMS.
General updates, these are updates to the data elements that are for more than one measure. On pages 65-67, it’s the arrival date and there are some new notes for abstraction to clarify how to collect this data element. On page 66, I will read a few of these for you.

⇒ ‘Review the only acceptable sources...for this data element there are only acceptable sources, which means that’s the only place you can look for this information for abstraction.’

So review the only acceptable sources to determine the earliest date the patient arrived at the ED, nursing floor, or observation, or as a direct admit to the Cath Lab. Use the earliest date documented unless other documentation suggests the patient wasn’t at the hospital on that date. The intent is to utilize any documentation which reflects processes that occurred in the ED or hospital.

In determining if there is documentation which suggests the patient was not in the hospital on a given date, sources outside the only acceptable sources list can be referenced. However, do not use dates described as hospital arrival on those sources for arrival date. They’ve provided some examples. I won’t go through them because you can look at them.

⇒ The next bullet says 'the source emergency department record,' when they're telling you one of the source documents is the emergency department record, they mean any documentation from the time period the patient was an ED patient.

So you can use the ED face sheets, ED consent, authorization for treatment forms, ED outpatient registration, any form that’s considered to be from when the patient was in the ED Department. They broadly placed that under emergency department record.

⇒ Do not use preprinted dates on a vital sign graphic record.
⇒ The source procedure notes refer to procedures such as cardiac Cath, endoscopies and surgical procedures.
⇒ Procedure notes do not include ECG and x-ray reports.
⇒ The arrival date may differ from the admission date.

⇒ If the patient is in either an outpatient setting of the hospital other than observation status, for example, dialysis, chemotherapy or cardiac cath, or a skilled nursing facility unit of the hospital and is subsequently admitted to acute in-patient, use the date the patient arrived at the ED or on the floor for acute in-patient care as the arrival date.

On page 67, under direct admits, again I think it’s what we talked about in the notes or abstractions from the other page, but if the patient is a direct admit to the Cath Lab, use the earliest date the patient arrives at the Cath Lab as the arrival date. For direct admits to acute in-patient or observation, use the earliest date the patient arrived at the nursing floor on in observation as the arrival date.

⇒ If the patient was transferred from your hospital, satellite or free standing ED or from another hospital within your hospital's system and there is one medical record for the care provided at both facilities, use the arrival date at the first facility.

I need to point out something now under the suggested data sources. Again, the only acceptable source’s is the emergency department record. What has been removed from this is the face sheet. In the last version it said you could use the in-patient face sheet, but that’s no longer there.
When we were talking about the emergency department record and what constitutes the emergency department record, the ED face sheet would be part of the ED record. So if you have an ED face sheet you can use that, but if your patient is a direct admit then you can’t use just the in-patient face sheet.

Page 68-70 is about the arrival time and it’s the same instructions we talked about for arrival date. On page 69 they simply tried to clarify how you should figure out the time and it’s the same thing I read for above, so I won’t go over that again. Remember, face sheet for in-patient isn’t acceptable, but an ED face sheet which is considered part of the ED record, is acceptable.

I’m going to flip now to page 423 which is transfer from another hospital or ASC (ambulatory surgery center) they’ve changed this data element. Now it’s a yes or no allowable value. Yes the patient was received as a transfer from an in-patient, outpatient or emergency observation department of an outside hospital or from an ASC and no, the patient was not received as a transfer from any of those places.

The notes for abstraction, I want to read them because some of it is different from what we had before.

If a patient is transferred in from any emergency department or observation unit outside of your hospital select yes. This applies even if the emergency department or observation unit is part of your hospitals system, has a shared medical record to provide your or is within close proximity.

If the patient is transferred to your hospital from an outside hospital where they were an in-patient or outpatient, select yes. Select yes in the following types of transfers…

– Long-term acute care, so any long-term acute care hospital or unit.

– Acute rehabilitation, a rehab unit in an outside hospital, free standing rehab hospital facility outside your hospital or a rehab hospital inside your hospital.

On page 424, we’re still talking about when you can select yes. Psychiatric psyche unit in outside hospital, free standing psyche hospital facility, civilian outside your hospital or psyche hospital inside your hospital. I’m thinking some of the reasoning behind that is that sometimes those units have different CCN numbers with different billing, so that’s why they’d have us consider those as being transfers.

You’ll say yes if it was a cath lab, same day surgery or other outpatient department of an outside hospital. Or, if it was a transfer from a disaster medical assistance team, provides emergency medical assistance following catastrophic disaster or other major emergencies.

You’ll select no in the follow types of transfers…urgent care center, psych rehab unit inside your hospital, so if it’s just a psyche or rehab unit inside your hospital that would be a no, but the ones above, those were a rehab hospital or psyche hospital inside your hospital.

If I can get more clarification on that then we’ll get some information out to you. I think what most of you might have is a unit, like a psyche unit or rehab and that according to this would be a no.

Dialysis center, unless it’s documented as an outpatient department of an inside hospital. Same day surgery or other outpatient department inside your hospital or a clinic, Hospice, skilled nursing facility, those would not be transfers from another hospital.
If there’s conflicting documentation in the record and you’re unable to determine whether or not the patient was received as a transfer from in-patient, outpatient or ED department of an outside hospital or from an ASC, select no, unless there’s supporting documentation for one sitting over the other. In examples, one source reports a patient was transferred from an outside hospitals ED, whereas another source reports the patient was transferred in from an urgent care center. No additional documentation, select no.

Another example is if one source states the patient came from physicians’ office and another source reports patient was transferred from an outside hospitals ED and transfer records from the outside hospital are included in the record. You can select yes, because you have more information to let you know where they really came from.

If in cases other than conflicting documentation you are able to determine whether or not the patient was received as a transfer, you’ll select no. This is an example like where it says transferred from park meadows and there’s no documentation saying what park meadows is, than you’d have to say no.

We're going to look at some of the AMI data element changes now. On page 71-72 are the aspirin prescribed at discharge and the last bullet on page 72, disregard aspirin documented as recommended medication for discharge. For example, recommend sending patient home on aspirin. Documentation must be more clear than aspirin was actually prescribed at discharge.

All of these medications coming out, all the ones that we look at which are prescribed at discharge will have this new note for abstraction in there. So what must have been happening is that there must have been people seeing documentation of the record that says medication was going to be recommended or they were going to recommend sending the patient home on this and that’s not good enough to select a yes. We need to know that the medication was actually prescribed at discharge.

Page 73- aspirin received within 24 hours before or after hospital arrival and the notes for abstraction, they clarify some of the notes and guidelines were reworded to provide clarification on abstract cases when the patient was transferred in from another hospital. So, if you look at the notes for abstraction there, in the absence of explicit documentation that the patient received aspirin within 24 hours prior to arrival time, in cases where the patient was received as a transfer from another hospital, whether it was in-patient, outpatient or ED, if aspirin is listed as a home medication do not make inferences. Additional documentation is needed which clearly suggests the patient either took the aspirin at home or at the transferring facility within the 24 hours prior to arrival time.

In your non-transfer cases, so your patients were just being admitted at your facility, if aspirin is listed as a current or home medication it should be inferred as taken within 24 hours prior to arrival time, unless you have documentation that suggests otherwise. If aspirin is listed as a home med and last dose is noted as the day prior to arrival, but no time, then you can infer that aspirin was taken within 24 hours.
When aspirin is noted only as received prior to arrival, without information about the exact time it was received, infer that the patient took it within 24 hours prior to arrival time, unless you have documentation that suggests otherwise. Aspirin documented as a PRN current home medication, does not count unless documentation is clear that it was taken within 24 hours prior to arrival time. They’re really trying to make get us to know that it was taken within the 24 hours prior to arrival.

Page 84 - the beta blocker prescribed at discharge.

Page 85 - the two bullets...the first is what I mentioned before about discharge medication. You’ll disregard beta blocker medication documented only as a recommended medication for discharge. You want to know that it was actually prescribed. The next bullet says disregard documentation of beta blocker prescribed at discharge when noted only by a medication class. The beta blocker must be listed by name.

So, just the fact that a beta blocker was prescribed at discharge isn’t going to work. We need to know the name of the beta blocker.

Page 96 - clinical trials- and the reason we’re looking at this for the AMI changes is because on page 97, the only thing that’s different here, not really in anything you collect, under the AMI it says only capture patients enrolled in clinical trials studying patients with acute myocardial infarction, ST elevation myocardial infarction, non-ST elevation myocardial infarction, heart attack and now they’ve added acute coronary syndrome. So if it’s a clinical trial regarding that then it would be all right.

Page 229 - is initial ECG Interpretation

Page 230 - under the exceptions, where we’re talking about ST elevations, the new exception is a note for how to abstract ST elevation as previously seen. So if you have ST elevation on the ECG done closest to arrival and it’s described as previously seen on any ECG done by EMS or physician office prior to arrival, this may count as an exclusion. The documentation must be explicit within the ECG Interpretation itself. The example there is initial ECG shows ST elevation. Improved ECG done and FBld.

It’s talking about that it was previously seen but its saying that it was done in the field that way it might fit as an inclusion if everything else still works out and there are no exclusions. You still have to follow all the steps we had before. It does say abstract or should not make inferences based on documentation outside of the interpretation, context, sequence of events, etc. They want to know on the ECG that you’re reading that it was previously seen on an ECG, done by EMS or in a physician’s office prior to arrival.

Page 232 - these aren’t really any new findings, what they did was there were bullets for all these points before and now they’ve consolidated some bullets. All ST elevations in one interpretation is described in one or more of the following ways, so these were exclusions before, they’re just now under one bullet. They were trying to make the guidelines easier to follow and to reduce some exclusions for the ST elevations.

Page 249 - is the data element LDL, LDL C less than 100 milligrams DL. They changed the timeframe of the question. It used to be that the test had to be done within 24 hours after arrival, but now they’ve added within 30 days prior to hospital arrival. So if you look at the suggested data collection question, were any of the patients LDL C cholesterol levels less than 100 milligrams DL from testing done within the first 24 hours after hospital arrival or within 30 days prior to hospital arrival?

So they added that timeframe for us.
Next down to bullet 3, what else? This is a change, if there are no LDL C-values less than 100 from testing done within the first 24 hours after arrival time or within 30 days prior to arrival time, but there is a total cholesterol value that was less than 100 from testing done during this timeframe. Infer the LDL was less than 100 milligrams DL and select yes.

So if you don’t have a specific LDL c-value, in that timeframe we’re talking about but there is a total cholesterol value that’s less than 100 and has still been in the timeframe, then you can select yes.

The other thing, the last bullet I think hospital arrival equals arrival time, so when they’re talking about hospital arrival that’s going to be the time you put for arrival time.

Page 250- under suggested data sources they’ve added the transfer record there.

Page 313- reason for delay in fibril analytics therapy- what they’ve done if you look down about halfway at the second bullet, documentation must be made clear somewhere in the medical record that a hold delay and they’ve added deferral. Now we can look for the word deferral. Before it was just that you had to see that there was a hold, delay or a wait and now if they use deferral you can use that word.

Down at the bottom of the page where it has fibril analytic therapy initially deferred due to shock, that would now fit in here. So they’ve added deferral to the list of acceptance terminology that indicates a delay occurred.

Page 316- is the reason for delay in PCI and this is the same thing. If you’ll look down under the second bullet you’ll see that they’ve added deferral. So they’ve added deferral to the list of acceptance terminology that indicates a delay occurred.

Page 327- is the data element reason for no aspirin at discharge. They have added, if you look under the definition where it said Coumadin Warfarin, now they’ve added Pradaxa and Dabigatran. So if that was described at discharge that would be a reason for not prescribing aspirin and those are automatic reasons to not prescribe aspirin.

Page 328- if you look about halfway down under exceptions, they’ve clarified some reasons that don’t count for not prescribing aspirin at discharge. Discontinuation of a particular aspirin medication documented in combination with the start of a different aspirin medication does not count as a reason for not prescribing aspirin at discharge. Examples: stop Aspertab and start Ecotrin in the same physician order or change aspirin to buffered baby aspirin.

Discontinuation of an aspirin medication and particular dose, documented in combination with the start of a different dose of that aspirin does not count as a reason for not prescribing aspirin at discharge. So stop aspirin 325 mg and start aspirin 81 mg in the same order, that alone isn’t a reason for not prescribing it at discharge.

Page 331- reasons for no aspirin on arrival, again they’ve added the Pradaxa or Dabigatran as a pre-arrival medication.

Page 332- they clarified reasons that don’t count for not prescribing aspirin, same thing like I read before. Changing the different kinds of aspirin or changing the dose, that in and of itself is not a reason for not prescribing it at discharge.

Page 335- reasons for no beta blocker at discharge. Again here, what they did in the guidelines was to clarify reasons that don’t count as reasons for not prescribing a beta blocker at discharge. So, apparently we had people counting it as reasons for not picking up the aspirin if they just started a different medication or changed the dosage of the medication.
Then at the bottom of page 336- the top of 337- those are reasons that do not count as reasons for not prescribing a beta blocker at discharge.

Page 373- reasons for not prescribing statin medication at discharge...page 374 we have some exceptions. The first one is documentation of a conditional hold or discontinuation of a statin medication does not count as a reason for not prescribing a statin medication at discharge. Then you have the same type of reasons of the other ones that we talked about, discontinuation of a particular statin medication documented in combination with the start of a different statin medication doesn’t count and discontinuation of a statin medication at a particular dose, documented in combination with the start of a different dose of that statin does not count as a reason for not.

Then the second from the bottom bullet, recent documentation which refers to a more general medication class is not acceptable. So if it says no cholesterol reducer or hold all lipid lowering medication, that’s not acceptable. They want the specific name of the medication.

Page 376- under the inclusion guidelines for abstraction, it says examples there, they added the word example to show that this list is not all inclusive of reasons to not prescribe statin medication, they are just some of the ones you might find but its not all inclusive so these are just examples of some of the things.

They removed allergy, documentation of a statin allergy does not require specific physician linkage to the non-use of the statin as the other items in this list does. By that I mean, if you have a patient for example that’s had hepatic failure, you can’t make the assumption that because they have hepatic failure that that’s why they wouldn’t prescribe a statin at discharge. You have to have physician documentation of that. An allergy is okay. If you see there is one.

Page 392- statin medication prescribed at discharge.

Page 393- there’s just the two bullets again. This is a discharge med so you need to know that it can’t just be recommended medication for discharge you have to know that it was actually prescribed and you can’t have statins prescribed at discharged when only noted by a medication class. You can’t have just statin prescribed at discharge on a core measures form, which I think this is why this is in here because a lot of people were making forms and had a checkbox that said statin prescribed at discharge, beta blocker prescribed at discharge, ace prescribed at discharge and that isn’t going to work anymore. We need to have the statin, beta blocker or whatever listed by name.

Those were the data elements that just applied to AMI.

Now we’ll talk about the ones that apply to AMI and heart failure...

On page 9- the ace prescribed at discharge and again this is the same thing, but I want to point out that its there, which is why we added these page numbers so you could just see this. It’s the two same things we’ve been talking about. Disregard the ace medication document that only as a recommended medication and then disregard documentation of ace prescribed at discharge when noted only by medication class. The ace must be listed by name.

Page 64- that’s the, are prescribed at discharge, same thing.

Page 256- is LDSD and there’s not anything new in how to collect this one which is a good thing. They removed some terms from the exclusion list and put it under these bullets, which is what you have on page 257. The terms in yellow were removed from the exclusion list and are now just added as a note for abstraction. If you see any of this terminology just disregard it, its not an exclusion you would simply disregard it.
Disregard the following terminology when reviewing the record for documentation about LDSF/LDSD. If documented continue reviewing for LDSF/LDSD inclusion outlined in the inclusion list as directed in the abstraction guideline below. These types of diastolic dysfunctions don’t count as anything for us for our abstractions.

Page 321- is the reasons for no ace and no arb discharge and these are similar to what we talked about before with other discharge meds.

Page 323- you’ll find clarifications of reasons that don’t count for prescribing at discharge. If you have the discontinuation of a particular ace med documented in combination with the start of a different ace or you have discontinuation of an ace med at a particular dose documented in combination with the start of a different dose, those aren’t reason for not prescribing.

Those pertained to data elements for both AMI and heart failure.

There’s just one for heart failure this time, a change to the data element of discharge instructions address medications…

Page 132- down at the bottom under the exception where it’s talking about if you don’t have a comparison list available and you’re trying to compare all your discharge instructions to see about the meds, it’s talking about the written discharge instructions. If it has the name or initials of the physician or APN or PA signed on the form, presume the list of discharge medications and those instructions is complete.

However, acknowledging signatures that are dated or timed after discharge are not acceptable.

Page 133- we have a clarification for the insulin. It’s talking about it contradicting documentation regarding a specific insulin medication exists. That will still come as a mismatch. So the example there is if you have discharge notes, the date the patient was discharged on noaudible 50 units TID and then noaudible 50 units TID is discontinued on the discharge and medication reconciliation form, that’s contradictory information so that would be no.

Page 334- there’s a note about the medication can’t just be a recommended medication, you have to know that it was prescribed. That was the changes for heart failure and AMI.

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Now we’re going to look at the pneumonia ones…the reason we don’t want to stop for questions in between each topic, and I’m sorry if you have questions on AMI, it is because there’s a lot of stuff to cover this time and I need to make sure we cover it. You can always send me questions after the fact, but we only have the two hours to go through this.

Page 32- for use of pneumonia data elements, this is another source of infection and what they’ve done new here is to add to the definition under number one, position APN documentation. It always had a named bacterial infection outside the respiratory tract, but now they’ve added or, of an identified pathogen that’s documented as currently present.

They’ve added number two which is, suspicion or known infection with Tularemia or the pneumonic plague documented by a physician, APN or a PA. So they’ve added a couple more possibilities for another source of infection.

Under the allowable values you’ll see there are three now because they’ve made that addition that there was documentation of Tularemia or the pneumonic plague, in addition to pneumonia within 24 hours after arrival.
Notes for abstraction, the first bullet is if both values 1 & 2 apply, if you would have a situation where it would meet values 1 & 2, it says select value 1.

Page 33- bullet number four, if there is physician, APN or PA documentation of a known pathogen (the new thing added) you select value 1. The specific pathogen must be named and documented as currently present. Suspicion of or a history of a pathogen is unacceptable.

Page 34- they added some inclusions there, some diseases conditions like bubonic plague, deer fly fever, O'Hara fever (disease), so they added some additional inclusions there.

Page 35 thru 38- is antibiotic administration date.

Page 37- under the pneumonia because we're only talking about the antibiotic administration for this, the last bullet, if the patient is on IV antibiotics when they arrive at the hospital, collect the antibiotic name and route and use arrival date and arrival time as the date and time of antibiotic administration. So this is how you do it if the patient is arriving on IV antibiotics. This same notation is under antibiotic administration time.

Page 43 thru 47- is antibiotic administration time. What they did here was to add bullets to clarify how to abstract when a patient arrives at the hospital with an antibiotic infusing via IV.

Page 54- antibiotic received, they've added notes for abstraction to clarify how to abstract when a date or time was recorded in error.

Page 55 - look under pneumonia, the data elements arrival date and arrival time should be taken into consideration when determining if the antibiotic was given prior to arrival or during the stay. If a valid date or time for an antibiotic dose found during the current record is an obvious error and the correct date or time can be found on the same source, the correct date or time may be used to determine if the antibiotic was given prior to arrival or during the stay.

In the note there they say the ED record is considered the same data source. When they say ED record again, they're talking about all the different documentation that could be on ED forms. If the correct date or time for the antibiotic dose that was documented in error is not supported by other documentation in the same source, the chart must be abstracted at face value.

So the example they give there, the earliest time the patient arrived at the hospital is found to be 1400. The antibiotic is documented as been given at 1100 on the same date with no further documentation that this was given during this stay. The dose can not be abstracted as given during the hospital stay and should be used to abstract antibiotic received as value 1 or 2, as applicable.

Page 105- compromised, they added a bullet under notes for abstraction number four if the only documentation of HIV is in order for an HIV test then you still have to value four.

Page 106- at the top they just added the word conditions. Apparently it wasn't there before. The fifth bullet down they added the, and/or systemic immunosuppressant therapy. The sixth bullet is, if a medication is listed on both table 2.2, the immunosuppressant medication and 2.15, the systemic corticosteroid medication, consider the medication a systemic corticosteroid as documentation of chronic use is required for a systemic corticosteroid but not for an immunosuppressant.
Page 107 - compromising therapy’s within the last three months. These values were here before but they were listed under compromising conditions, where they added the word condition, but now they just put them out under compromising therapy’s within the last three months. However, they did add an addition there, radiation therapy.

I want to point out that the data element diagnostic uncertainty was removed.

Page 210 - ICU admission or transfer.

I’m reading under the definition and what they did was to expand the definition of an ICU to be consistent with the CDC and the inaudible patient safety project. So they’re telling you the definition of an ICU for purposes of the measure noted above is that used by the CDC and the inaudible patient safety project. An intensive care unit can be defined as a nursing care area that provides intensive observation, diagnosis and therapeutic procedures for adults and/or children who are critically ill. NICU excludes nursing areas that provide step down, intermediate care or telemetry only and specialty care areas.

The last bullet on this page, if there’s an order for an ICU and the patient was not moved to an ICU because the patient’s condition changed and didn’t require an ICU level of care, select value 2; however, if the patient is not moved to an ICU unit due to lack of a bed, select value 1.

I’m reading under pneumonia now because we’re only concerned with this data element. This is new… in order to select value 1, which is a yes for this data element, there must be a physician order for admission or transfer to the ICU and documentation that the patient was transferred or admitted to the ICU care within 24 hours, following hospital arrival. The 24 hour timeframe relates to the time from hospital arrival to arrival in the ICU unit, not the time that the physician ordered to admit or transfer to the ICU.

If documentation reflects ICU graphic sheets or ICU nursing notes and there is no physician order for ICU, you’ll select value 2 which is no. So now we need to have an order, a physician order for the ICU. You’ll notice the only acceptable sources, is physician orders. It tells you that you can look at these other sources to support admission or transfer, but you still need to have the order by a physician.

Page 212 - they’ve defined for us, under the exclusions, what a specialty care unit is. Bone marrow transplant solid, organ transplant in patient in acute dialysis, these are specialty care units and so they are not transfers to ICU.

Page 294 - everybody’s favorite pneumonia diagnosis ED direct admit. There are some new notes for abstraction. There are some new exclusions and inclusions, so when you start doing your first pneumonia cases you really have to read through this again. They tried to make it more clear to determine that what we really want and they’ve changed allowable values, now there are only the three.

There’s physician, advanced practice nurse, physician assistant documentation that pneumonia was a diagnosis or impression in the ED or as an admission diagnosis impression upon direct admit. So they rolled it up into one, either yes for the ED and the direct admit or no there wasn’t for the ED or the direct admit and then three is unable to determine.

The notes for abstraction, only accept documentation of a pneumonia diagnosis that is clearly described as a diagnosis, impression or plan to treat. Do not take anything that is labeled as a differential diagnosis and we’ve never been able to do that so that’s not new. If your hospital labels the differential diagnosis using a different name, if it would say first impression then it needs to be clear that this is only a differential diagnosis.
Page 295- there's still the information about aspiration pneumonia, we don't want that. It tells you patients seen in the ED, fourth bullet down, in the ED the diagnosis of pneumonia should be taken from a section that is specifically designated for the physician, APN, PA to list diagnosis or impressions. A pneumonia diagnosis written with a narrative documentation can be used but must be clearly documented as a diagnosis or impression or a plan to treat for pneumonia.

So for example, if a physician documents to start patient on inaudible to cover pneumonia, that could be value 1 because that's a plan to treat. If you're reading the narrative and it says physician documents patient has possible pneumonia or UTI, if that's a narrative then that's a 2, because that's not really a diagnosis. They're saying that's an example of narrative that's not showing a diagnosis or impression or plan to treat.

This is one that really depends on how your physicians document. You'll have to read through and I don't think you'll be able to say every time this fits and this one doesn't. Different doctors dictate in different ways, so this is one that really will depend on what you're looking at, at the time you're doing that chart.

You'll only select and able to determine value 3 if there's a place in the ED chart to document an ED diagnosis or impression and that area is left blank. If there's any area to document that and they're completed, then you'll select value 2 either one there was a diagnosis or two that there wasn't.

ED face sheets can only be used as signed by the physician, APN or PA.

Page 296- under the direct admits…the fourth bullet down…when a patient is a direct admit and is not seen in the ED, the diagnosis of pneumonia should be found on the following only acceptable sources. Select value 1 admitting notes, admitting physician orders, admit history and physical which must be written or dictated within 24 hours.

This is new and admit history and physical is an H&P labeled as such or contains documentation regarding admission. Before as you know we couldn't take H&Ps unless we were referred to the H&P, but now they're saying that an admit history and physical which was written or dictated within 24 hours of hospital arrival if it's called an admit history and physical or contains documentation regarding admission. I haven't been able to find anything that states what documentation regarding admission is.

This is one where you'll have to use your judgment.

Next, an admission note is any note labeled as such or contains documentation regarding admission. A history and physical can be used only if the physician, APN, PA documents on one of the only acceptable sources to see H&P or the H&P is an admit H&P written or dictated within 24 hours of arrival. It's important to note the third bullet from the bottom an undated and/or untimed admit to H&P is not an acceptable source.

Page 297- only acceptable sources, so both of these are saying these are the only places you can look. They've added some inclusions and terms. This list is all inclusive so you're only able to pick this up with the terms used below, the diagnosis used below and they've added some exclusions.

Page 309- the pseudomonas risk…the only thing they did was on page 310 the fourth bullet from the bottom of that were notes for abstraction. Corticosteroids and/or antibiotics listed as home or current meds are considered chronic unless there's documentation it's a one-time course or if listed as PRN. So they clarified that antibiotics that are listed as home meds can be considered to be chronic.

Risk factors for drug resistant pneumococcus, that's another data element that's gone. So those are all the pneumonia data elements.
Now we’ll talk about the changes for the skip.

Page 54- antibiotic received…these are notes for abstraction. They added examples to clarify how to abstract when the date or time was recorded in error.

Page 55- under the skip, the first bullet says the medical record must be abstracted as documented, taken as face value. When the documented date is an invalid date or time and no other documentation is found on that same source that provides this information the abstractor should consider that date or time at face value. So they are requiring this other information to be on the same source.

The example there, arrival time is documented at 1400 on 12/10 and an antibiotic is documented as given at 1352 on 12/10. No other documentation is found on that same source that provides this information so the dose can't be considered as given during the hospital stay and should be considered at face value to abstract 1 or 2, as applicable.

So you have to look for corresponding documentation on the same source.

If a valid date or time for an antibiotic dose is an obvious error and the correct date or time can be found on the same source, the correct date or time may be considered. Again, if the correct date or time can't be found on that same source, the date must be abstracted at face value.

The example they give on page 56- the anesthesia form is dated 12/10/2009, but other documentation on that same source supports that the correct date as 12/10/2010. Then you consider the correct date to be the correct date of 12/10/2010.

If the antibiotic administration time or antibiotic administration date are corrected using the same source document, antibiotic perceived should be abstracted to correlate with the corrected date or time.

Page 79 is beta blocker current medication…so they did some clarification here to help us on what is considered to be a home or current med.

Bullet six says if the beta blocker is listed as a daily home or current medication, but the physician writes an order to hold or discontinue the beta blocker before surgery because of a contraindication, then you would select no.

Page 80- the last three bullets… if the beta blocker is not listed as a daily home medication upon admission prior to surgery but a beta blocker is added during the hospitalization, that would be no. That’s not really considered to be a current medication it’s just being given there in the hospital just before the surgery.

If there’s documentation on one form that the patient is taking the beta blocker prior to arrival but another form does not list the beta blocker, select yes. An example on the history and physical, Atenolol is listed on the medication reconciliation form it’s not listed, select yes. So if we’ve got conflicting information in this case, they’re saying you can treat it as being that they’re on the meds. If there’s documentation that the patient is taking a daily beta blocker and it is specified as taken for non-cardiac reasons, that’s no.

If they’re on a beta blocker for migraines or they have benign essential tremor, you would say no. Then they’ve added that to the exclusions. Beta blockers taken daily for non-cardiac reasons – that’s not what we’re looking for here.

Page 82, this is beta blocker perioperative. They changed the allowable values on this data element. It isn’t a yes or no any longer. Now there’s 1-5 allowable values and you can select all that apply.
So you are now looking for there’s documentation that a beta blocker was received on the day prior to surgery, there’s documentation that the beta blocker was received on the day of surgery, there’s documentation that the beta blocker was received on post-op day one with the day of surgery being day zero, there’s documentation that a beta blocker was received on post-op day two with the day of surgery being day zero, or there’s no documentation that a beta blocker was received during the perioperative period or unable to determine from medical record documentation.

The notes for abstraction here, the second bullet, the perioperative period for the skip cardiac measure is defined as the day prior to the surgery through post-op day two, with the day of surgery being day zero. So that's the post-operative period – your definition right there.

Page 83, there must be documentation that reflects that the beta blocker was taken on the day specified and each allowable value – select that specific value. If the patient received a beta blocker on the day prior to surgery or the day of surgery, and also received a beta blocker on post-op day one or post-op day two, select the appropriate value. You can select one or more of the allowable values.

To select value five, there must be no documentation that a beta blocker was received during the perioperative period. If you’re selecting five, then you’re not going to have any other selections. They added to the suggested data sources the medication reconciliation record.

Page 91, is catheter removed? What they did here was they clarified which value to select if the patient’s catheter was removed and reinserted and which value to select if there was documentation of voiding. If we look at the bullets there, the second bullet, post-op day two ends at midnight of the second post-op date with the anesthesia end date being post-op day zero.

The third bullet, if the catheter was removed unintentionally or accidentally, such as by the patient, on post-op day zero through post-op day two, and if the catheter was left out or not reinserted, then you're going to select value one. If the catheter was removed unintentionally or accidentally, such as by the patient, on post-op day zero through post-op two and was reinserted and remained in beyond post-op day two, then you’re going to select value two.

The last bullet there, if there’s documentation that a catheter was inserted during the specified timeframe and there’s documentation that the patient voided on post-op day zero through post-op two after the time that the catheter was inserted, you're going to select value one.

I think these are all the things that people were finding they weren’t sure how to abstract it. You would have information that a catheter was inserted in one spot and then you would read that the patient was voiding, or we’d have the instances where the catheter was pulled out or whatever and so we weren’t really sure what to do. Now they’ve made these notes for abstract, so hopefully this will really clear up how we answer some of the data elements for this one.

Page 219, this is infection prior to anesthesia. The only thing different here is they added a couple of inclusions. They added Crohn's disease and all sorts of colitis. In exclusion, they added avascular necrosis because apparently that’s typically not caused by an infection. I think a lot of people were always asking about those, so those are two inclusions added and the one exclusion.

This is a good thing. The laparoscope data element is now gone. You don’t have to worry about trying to figure out and read through those op reports to see whether it was done totally by the scope or not. I don’t think we were getting that many that were totally done via the scopes anymore. The interventions for the lap procedures should mirror those done for the open procedures, so they removed that data element.
Page 270, this is the data element oral antibiotics. There really isn’t anything new here. They just tried to edit the notes for abstraction to clarify that this data element is used to prevent colon surgeries from being falsely excluded from the measure if the only oral antibiotics received on the day prior to the day of surgery or within 24 hours prior to surgery were one of the oral antibiotic combinations listed in this data element.

Hopefully, this is just reworded easier for us to understand. The first bullet there is kind of what I just read to you. This element is used to prevent colon surgeries from being excluded from the appropriate measures if the patient received either of these oral antibiotic combinations the day prior to the day of surgery or within 24 hours of surgery.

If there is documentation that one of the antibiotic combinations as listed above was received by the patient on the day prior to the day of surgery or within 24 hours prior to surgery, you’re going to select yes. If there is documentation that the patient was receiving an antibiotic other than these oral combinations of antibiotics the day prior to the day of surgery or within 24 hours prior to surgery, you’re going to select no.

This combination of oral meds can be received before hospitalization and/or during the hospital stay. If there is documentation that the patient received a combination of these oral antibiotics on the day prior to the day of surgery, assume it was given within 24 hours and select yes. A date and time is not needed.

Page 271, we’ve had the notes about the Nickel bowel prep before, so if you see that, that’s all prep contains one of the combinations of the oral antibiotics that we can pick, so that’s acceptable. They’ve added to the suggested data sources medication reconciliation records.

Page 272, this is other surgeries. On the second bullet down, they’ve added medication pumps to the pocketed devices. They’ve put medication pumps in there.

Page 273, they’ve changed the timeframe for calculating the three-day or the four-day for the CABG or other cardiac surgery, but calculating that window – it used to be anesthesia start and anesthesia end time. Now it’s anesthesia start and end date. Instead of worrying about the different times to making sure we were fitting – was this three days from this time, it’s a lot easier to worry about the date instead of the time.

Page 300, the data element names – preadmission, oral anticoagulation therapy – this used to be the data element preadmission Warfarin. Because they’ve added some other medications, so they’re not only looking for Warfarin anymore, so that’s why they changed the name on this data element. You’re just looking to see if there was documentation that the patient was on continuous oral anticoagulation therapy prior to admission.

Page 301, these are the medications that you’re looking for. The inclusion guidelines for abstraction – this list is all inclusive. These are the medications that you’re looking for. If the patient is on one of these, then you’d give it this data element.

Page 353, reasons for not administering beta blocker perioperative – this is another one that they changed. It used to be yes or no. Now there are values and they’ve listed some more reasons for not administering. If you look under definition, reasons for not administering a beta blocker during the perioperative period – bradycardia, a heart rate less than 50, which is what we’ve had in the past. Now they’ve added hypotension – if there’s a systolic of 100 or less or a concurrent use of intravenous anatrophic medications during the perioperative period.

Your values are 1-4. There is documentation of a reason for not administering a beta blocker on the day prior to surgery, there is documentation of a reason for not administering a beta blocker on the day of surgery, there is documentation of a reason for not administering a beta blocker on post-op day one, there is documentation of a
reason for not administering a beta blocker on post-op day two, or there’s no documentation of a reason for not administering a beta blocker during the perioperative period, which is the day prior to surgery through post-op day two, with the day of surgery being day zero.

The notes for abstraction just running through them, you can select one or more of the allowable values. You wouldn’t pick a value more than once, and if you’ve got value five you’re not going to pick anything else.

The perioperative period again is the day prior to surgery through post-op day two. Documentation of reasons for not administering a beta blocker must be found during the period defined in the allowable value to select that value. If the physician writes a specific reason for not administering beta blockers during the defined period, select the appropriate value.

For example, the physician documents on post-op day one will hold beta blockers today since the patient is hemodynamically unstable, you’re going to select value three because value three is there is documentation of a reason for not administering a beta blocker on post-op day one. You need to have the reason for not administering on that day.

The documentation must be made on the day corresponding to the value. There must be a reason documented for each day the beta blocker is held or not administered. Documentation to hold the beta blocker must include the reason it is being held. For example, hold beta blocker until cardiac consult.

Preoperative documentation, if the patient is NPO or due to NPO status alone, it is not acceptable to select value one or two. Documentation to hold all meds or to hold or PO meds alone is not acceptable. Select allowable values 1-4.

Bradycardia must be substantiated by documentation of a heart rate of less than 50 beats per minute during the perioperative period. Vital signs obtained while the patient is on a cardiopulmonary bypass machine cannot be used. Hypotension must be substantiated by documentation of a systolic pressure less than or equal to 100 during the perioperative period.

If the physician writes an order to hold the beta blocker when the patient’s vital signs are outside certain parameters and there is documentation that the beta blocker was held because the vital signs were outside the parameters during one of the periods specified in the allowable values, you can select the appropriate value, but the vital signs to support this documentation are required.

For example, if the physician writes the order hold the Atenolol for systolic BP less than 100 and the nurse documents that the Atenolol was held for a BP of 90 over 50 on post-op day two, you could select value four because that would be a reason for not administering the beta blocker on the post-op day two.

If it is apparent on the MAR that the medication was held during the perioperative period, a notation on the MAR or in the nursing narrative it is acceptable to select the appropriate value.

If intravenous use of anatrophic medication, which you’ve defined on Appendix C, Table 3.14, is initiated at any time during the time period represented in an allowable value, select the value that represents the timeframe in the perioperative period.

There’s going to be a table. In the specifications manual in the very last section are Appendices and this is where you’re going to find your drug tables and your medication tables. There’s a table there – Table 3.14. That’s going to be a comprehensive list of anatrophic medications.
Page 377, reasons for continuing the urinary cath. Now you can select more than one value. They’ve added notes for abstraction to clarify what is acceptable as documentation of reasons to continue the cath.

You can select all that apply. I think I just said that you can select more than one value. Value one does not require physician APN, PA documentation. If the patient is in the Intensive Care Unit on post-op day one or post-op day two and it’s documented that the patient received even one dose of diuretics, you would select value one.

If no diuretic is being administered for a patient in the ICU but there is physician APN, PA documentation on post-op day one or two or a reason for not removing the cath, then you’re going to select value two.

Page 378, these bullets here, this is where people were seeing so many different kinds of documentation about the caths being left in and there were tons of questions about would this be physician documentation, so they tried to maybe put these guidelines in here to see if this would be more helpful.

I’ll just read you these. To select value two, there must be documentation of a reason or plan to continue the urinary catheter. An order to keep the catheter alone is not sufficient. For example, keep catheter. That’s just not enough. The intent is that the physician will evaluate the patient on post-op day one and two and document regarding the necessity for continuing the catheter, such as a physician order to keep the catheter for a specific reason or timeframe.

Example, continue catheter due to total bed rest, or maintain fully until morning of discharge, or discontinue fully in a.m. at 0900. In this instance a.m. refers to beyond post-op day two, but that would be like a reason for continuing.

To select value two based on a medical staff-approved facility protocol, there must be physician documentation on post-op day zero, one or two ordering or instructing the nursing staff to follow the formal urinary catheter protocol, and there must be documentation on post-op day one or two of reason to continue urinary cath contained in the protocol found in the medical records. The reason may be documented by a nurse in this situation.

Patient refusal to have a cath removed does not have to be documented by a physician, APN, PA but must be documented on post-op day one or post-op day two. Now we can have that as a reason. The exception for patient refusal was removed, so patient refusal is now okay if it’s documented in the right timeframe and it can be documented by a nurse.

If there’s documentation on post-op day one or two that the patient refuses to have the catheter removed, or if there’s a patient request to leave the catheter, select value two. If you’ve got value three, you shouldn’t have anything else recorded.

Under allowable value two, that’s where they’ve added the medical staff-approved facility urinary catheter protocol. Then for inclusions and exclusions, they’ve kind of given some synonyms for ICUs, so BICU or Burn Intensive Care Unit, that would be acceptable.

Under exclusions, we have high risk of falls or risk of falls, so any risk of falls is still an exclusion. ICU synonyms, these are not considered to be ICU units for these purposes here.

Page 380, the reason to extend antibiotics, under allowable value three where it’s got the antibiotic administered post-operatively as prophylaxis of pneumocystis pneumonia, that T is an error there. It shouldn’t be there. They removed with a diagnosis of AIDS, so that’s no longer necessary.
If there was an antibiotic administered post-operatively as prophylaxis of pneumocystis pneumonia, then that’s okay. They’ve added one there, Demeclocycline was administered post-operative for the treatment or syndrome of inappropriate antidiuretic hormone, hyposcretion or hypometria. They’ve added that as a reason to extend antibiotics.

Page 381, for value three for reason to extend, they’ve just given you pneumocystis pneumonia may be referred to as PCP or pneumocystis carinii pneumonia or whatever. This is where you’ve got to look at Table 2.1, antimicrobial medications for the names of medications that are Demeclocycline.

Page 382 for value one, these are infections as reasons for extending antibiotics. They’ve added here the Crohn’s disease, the ulcerative colitis and as an exclusion they’ve added the avascular necrosis.

Page 427, this is urinary catheter. They’ve changed the allowable values here. This one they have made into a yes or no instead of having all the different values. Yes if there is documentation that an indwelling urethra catheter was placed and that one was still in place upon discharge from the recovery post-anesthesia care area. No if there is no documentation that an indwelling urethra catheter was placed and/or there is no documentation that one was still in place upon discharge from the recovery post-anesthesia care area or unable to determine.

For this data element, the specified timeframe is defined as from hospital arrival through discharge from the recovery or post-anesthesia care area. Let me just read these bullets because they changed the notes to try to clarify what documentation is needed for us to be able to abstract this.

On the third bullet down, to select yes there must be documentation of the insertion of an indwelling urethra catheter to determine that one was placed during the specified timeframe. If there is not documentation of the insertion of the catheter, do not select value yes.

For value yes to determine whether an indwelling catheter was still in place at discharge from the recovery area, there must be documentation within 24 hours after anesthesia end time that a catheter is still in place. For example, a catheter was placed in the operating room and notes in the PCU do not indicate whether or not the catheter was in place at discharge but later the nurse’s notes show that a catheter was present, that is sufficient documentation to show the catheter was still in place at discharge from the recovery area.

Page 428, if multiple indwelling urethra catheters are placed and removed prior to surgery and there is documentation that later an indwelling urethra catheter was placed during the specified timeframe and that one was still in place at the time of discharge from the recovery post-anesthesia care unit, select value yes.

If the patient had a urinary diversion or an indwelling urethra urinary catheter or was being intermittently catheterized prior to the specified timeframe, select value no.

For the skip data element changes, now I’d like to go over the data elements for the new ED measure. These data elements have been in prior spec manuals but they were voluntary submissions at that time. Now starting with your January 1, 2012 discharges, these are now required, so I think it would be a good thing if we went over these data elements.

Page 110 is the decision to admit date. This is the documented date the decision to admit occurred. What was the earliest documented month, day and year of the decision to admit? If the date of the decision to admit is unable to be determined, you’re going to record unable to determine. The medical record must be abstracted as documented,
when the date documented is obviously an error and no other documentation is found that provides this information, then you’re going to record unable to determine.

For example, the documentation indicates the decision to admit date was 03/42. If there’s no other documentation in the list of only acceptable sources that we got only acceptable sources for this data element. If no other acceptable sources provide a valid date, since the decision to admit date is outside of the range listed in the allowable values for date, it’s not a valid date and you would select unable to determine.

If the patient expires on 02/12 and the documentation within the only acceptable sources indicates the decision to admit date was 03/12, other documentation in the medical record supports the date of death as being accurate, since the decision to admit date is after the discharge date or when the patient died, it’s outside of the parameter of care and the abstractor should select unable to determine.

Page 111- the first bullet there- when reviewing ED records do not include any documentation from external sources. The intent is to utilize any documentation which reflects processes that occurred in the EDR hospital. If it can be determined that the patient arrived on the same date and departed on the same date, the arrival date can be used as the decision to admit date. If there are multiple dates documented for the decision to admit abstract the earliest date.

This next bullet I think is the big one here that we need to pay attention to. The purpose of this data element decision to admit date is the date on which the physician APN, PA makes the decision to admit the patient from the Emergency Department to the hospital as an inpatient.

This will not necessarily coincide with the date the patient is officially admitted to inpatient status. What we’re really looking for is if you had documentation from the physician saying on 3/12 I decided to admit this patient that would be great. That’s what we’re looking for, but if we don’t have that then we’re going to have to try to make do with what we’re looking for here – the date on which the physician makes the decision to admit the patient as an inpatient.

If the decision to admit the patient is made but the actual request for a bed is delayed until an inpatient is available, record the date the physician made the decision to admit. If the decision to admit date is dated prior to the date of patient arrival or after the date of departure, select unable to determine.

The inclusion and exclusion lists are not to be considered comprehensive lists of inclusions and exclusions. The only acceptable sources are Emergency Department records, so you’re looking for this in Emergency Department documentation. You can take the admit order date, so if you don’t have documentation that says my decision to admit date is, but there’s a date for the admit order date would be acceptable, or if they used terminology as disposition order date, that would be acceptable.

Exclusions would be direct admit patient seen in the ED because that’s not what we’re looking for. We’re not looking for the time they were admitted to the ED. It’s when the decision was made to admit them as an inpatient.

Page 112 is decision to admit time. You wanted the date. Now you want the time. Pretty much the notes for abstraction are the same. We’re just looking for the time now. Again I think that maybe what we’re really going to find is maybe an admit order time. That might be what maybe a lot of you will see, but again only acceptable source is Emergency Department record.

Page 141 is the ED departure date. They want to know what is the date the patient departed from the Emergency Department? It’s kind of the same thing about an example of how you would collect unable to determine if the value was incorrect.
Page 142, the third bullet down, if there's documentation that the patient left against medical advice and it cannot be determined what time the patient left against medical advice, select unable to determine. For patients who are placed into observation outside the services of the Emergency Department, abstract the date of departure from the Emergency Department.

For patients who are placed into observation under the services of the Emergency Department, abstract the date of departure from the observation services. I guess for your observation patients, it’s going to kind of depend in your facility is observation included in the services of the Emergency Department or not? The second and third to the last bullet on Page 142 is where you’re really going to have to look at if you’ve got people going into observation.

On 141 and 142 is ED departure date. On 143 to 145 is ED departure time. It's the same kind of thing. You’re looking for the date and the time.

Page 144, for the Emergency departure time, the third bullet down on Page 144, ED departure time is the time the patient physically left the Emergency Department. What they’re saying there is nurse's notes say 1800 transferred to floor, Room 300. Then you have other documentation which includes the time that the patient left the ED via stretcher, abstract a later time or nurse’s notes state 1800 transport to unit and other document includes the time that the patient actually left the ED to be transferred, abstract a later time.

So you’re really looking for the time the patient physically left the department because you could have an order for them to admit and for whatever reasons maybe the person doesn’t leave the Emergency Department right away, so you’re really looking – that’s the bullet. The third bullet from the bottom, do not use the time the discharge order was written because it may not represent the actual time of departure.

For this value, it can’t just be discharged from the ED or whatever because you really want the time they physically left the Emergency Department.

The last two bullets are what you’re going to pay attention to for your patients who are maybe placed into observation. Again it looks like from reading this it depends on whether your observation is considered to be outside the services of the Emergency Department – that’s the second to the last bullet – and then the last bullet is patients are placed into observation under the services of the Emergency Department.

When you're starting to track these now, these are new data elements, so you really need to become familiar with these notes for abstraction and the correct way to collect these. The only suggested data source, the only acceptable source is the Emergency Department records on Page 145.

On 146 is the question, ED patient and was this patient an ED patient at this facility? Yes there’s documentation that the patient was an ED patient, and no there’s no documentation that the patient was an ED patient.

The reason this question is in here is with new data element, remember who your population is here. This was a call we had in December or whenever we had the call about the global population – the Emergency Department and the immunization. Your population is virtually everybody who gets discharged from your acute care facility. The diagnosis doesn’t matter. The fact that they were seen in the ED or not seen in the ED does not matter when you’re picking this population.

This is why you have to have this question in because this is how the patient is going to be excluded from the measure.
You're not only going to have patients, when you're picking your ED population you might end up with a patients or a lot of patients who were never seen in the ED, but they're still the ones you have to abstract because that’s your population. That’s how you pick your population.

This is the question. Yes or no, was the patient an ED patient or not? The notes for abstraction, for the purpose of this data element an ED patient is defined as any patient receiving the care or services in the Emergency Department. Patients seen in urgent care, ER fast track, etc. are not considered an ED patient unless they received services in the Emergency Department at the facility.

Patients presenting to the ED who do not receive care or services in the ED, abstract as a no. If you have a patient who’s sent to the hospital from the physician’s office and presents to the ED just at triage and is instructed to proceed straight to the floor, that would be a no because they weren’t really receiving any services from the ED, but if you've got patients presenting to the ED for outpatient services, such as lab work, etc., then that last bullet says they should be a yes.

I’m reading under ED there, the first bullet. If a patient is transferred in from any Emergency Department or observation unit outside of your hospital, select no. If they're coming to your facility and they weren’t in the ED from somewhere else, we don’t care about that. We’re talking about where they were an ED patient at your facility.

If a patient is transferred in from any Emergency Department or observation unit outside of your hospital, it's going to be no, even if the patient transferred is seen in your facility’s ED.

If a patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient select no. You want that this patient was an ED patient in your facility.

Those are the values for your ED measure. Then we have the immunization measures. These are really just two big elements – the influenza vaccination status and the pneumococcal vaccination status. These are taken out of the pneumonia measure and now they’re made their own measure set.

Page 222, the influenza vaccination status, again these are going to be your population of patients with that global population and sampling, and how you’re determining that population is patients who were discharged from your facility, they were an acute inpatient in your facility and I think it was less than 145 days or some amount of days like that. It's going to be a big percent of your population, you’re checking for now the influenza vaccination status and the pneumococcal vaccination status.

What is the patient influenza vaccination status? You've got allowable values – (1) given during the hospitalization, (2) received prior to admission during the current flu season, (3) not during this hospitalization, (4) documentation of a patient or caregiver’s refusal.

There was documentation of an allergy or sensitivity to the influenza vaccine, anaphylactic latex allergy or anaphylactic allergy to eggs or it’s not likely to be affected because of a bone marrow transplant within the past six months or a history of Guillain–Barré syndrome within six weeks after a previous influenza vaccination, (5) none of the above, not documented, unable to determine or (6) only select this value if there’s documentation the vaccine has been ordered but has not been received the hospital due to problems with vaccine production or distribution and allowable values 1-5 are not selected.
Notes for abstraction, each year flu vaccine starts to become available usually in September and most influenza vaccine is administered in October-December, but the vaccine is recommended to be administered throughout the influenza season which can last until May in some years but for this project, the hospitals are only responsible for discharges October through March.

I think the rest of the notes there for abstraction are not new, so it's how we always collected these data elements. Page 224 they've added some more inclusions and the exclusions there, the discharge is April through September. You've got the anaphylactic allergy to eggs or an anaphylactic latex allergy. An exclusion is the pandemic monovalent vaccine. H1N1 is not an inclusion here. It's not the vaccine we're looking for here. Or patients with an organ transplant during the current hospitalization. For that you're going to look at Appendix A, Table 12.10 to see which transplants fit that.

Really how you're abstracting this data element isn't different. The difference is how you're determining the population. Before, it was only your pneumonia patients. Now it's pretty much everyone.

In 291 is pneumococcal vaccination, and the vaccination that they're talking about is the PPV-23. (1) Was the PPV-23 given during this hospitalization, (2) they received it anytime in the past, (3) documentation of refusal, (4) is there documentation of an allergy sensitivity or (5) is it not likely to be affected because of a bone marrow transplant within the past 12 months, or the last for patients six years of age who received a conjugate vaccine within the previous eight weeks. That's another allowable value.

I think that's it. One thing I would like to ask – and Mary will tell you about this. We usually have an online evaluation to fill out after these calls. There's not a specific question on this but if you would, maybe in one of the comments sections, I'm just kind of wondering we had a lot more people sign up for this call than we have in the past.

So we're wondering what we did differently this time that more people signed up. Had you never heard of these calls before? Was wherever we advertised it this time the first time you heard about it or is it just your first time listening? Are you a new abstractor? We would just like to get some idea of why. Maybe it's just because there are some new measures this time and you felt like listening in. I don't know.

If there's some reason because again we really had a lot more people sign up, so we just want to have an understanding of why, and that will help us figure out. Again any kind of comments that you have about what would be helpful. That's what we're going to use to determine whether we can maybe do more calls or do more of this kind of stuff. I think that does it. Let's open it up for questions now.

I've just totally shocked everybody and there are no questions and that's okay. Sometimes you have to try to do this stuff before you think up questions and maybe there just aren't any, so that's fine.

**Mary Montury:** Thank you for being with us. I'm going to send our email out today with the link to the evaluation and we do appreciate your filling that out and sending your comments back and there will be a Certificate of Participation also. If you have questions, you know how to reach me. Good-bye.

If you have questions, please contact us at [info@stratishealth.org](mailto:info@stratishealth.org).

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