

**California and Florida
“In the Know”
Inpatient Data Collection,
Reporting, and Validation**

**Module 2a: Specifications Manual Revisions
AMI, HF, Pneumonia**

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Topics

- *Specifications Manual, Version 3.2c Revisions*
 - Multi-Measure Data Elements
 - PN
 - AMI
 - HF
- Miscellaneous Reminders

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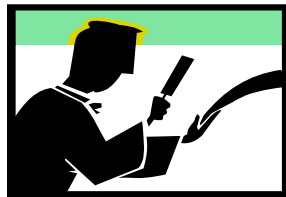


Specifications Manual

Version 3.2c

October 1, 2010 – December 31, 2010 Discharges

Additions and Revisions



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Specifications Manual Version 3.2 **Multi-Measure Revisions & Additions**

Comfort Measures Only

- Affects AMI, HF, and Pneumonia measures
- Added "brain dead" to Inclusion List
- Notes for Abstraction: Clarifies negative documentation. Must still consider all positive documentation!

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Specifications Manual Version 3.2 **Multi-Measure Revisions & Additions**

Comfort Measures Only, (cont.)

- Negative Inclusion term, Example 1:
 - Day 0: "Patient is not a hospice candidate"
 - Day 3: Physician orders hospice consult
 - Ignore Day 0 entry and abstract allowable value #2
(comfort measures documented day 2 or after)
- Negative Inclusion term, Example 2:
 - Day 1: "Patient is comfort measures only"
 - Day 2: "Patient is refusing CMO"
 - Ignore Day 2 entry and abstract allowable value #1
(comfort measures documented Day 0 or 1)

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Specifications Manual Version 3.2 **Multi-Measure Revisions & Additions**

Antibiotic Name

Antibiotic Administration Date, Time, Route

Antibiotic Received

- Definitions revised for clarity and simplification of abstraction
- Recommend abstractors review each data element definition in its entirety

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Help!!!

Is there any way you can give us simplified tips on what to enter in the antibiotic grid for the data elements *Antibiotic Name*, *Antibiotic Administration Date, Time, and Route*?

Which antibiotics do we have to consider as before/after arrival to abstract the data element *Antibiotic Received*?

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Antibiotic Data Elements

Abstractors are accountable for following the data element instructions listed in the appropriate version of the Specifications Manual Data Dictionary;

however,

We will try to provide some tips to assist abstractors in identifying critical antibiotic information that needs to be entered into the antibiotic grid and/or that might impact their abstraction of the “Antibiotic Received” data element.

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Antibiotic Data Elements

A couple of problems that we see with the current data element definitions...

- The definitions for these data elements have a lot of “overlapping” information...
- There are a lot of variations depending on if it is a SCIP case or a Pneumonia case...

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Antibiotic Abstraction Tips

- 1) Which antibiotics “count” for entering them into the abstraction antibiotic grid and/or abstracting *Antibiotic Received*?
- 2) What do you need to know to enter the Antibiotic Administration Name into the abstraction grid?
- 3) What do you need to know to enter the *Antibiotic Administration Route* into the abstraction grid?
- 4) What do you need to know to enter the *Antibiotic Administration Date* into the abstraction grid?
- 5) What do you need to know to enter the *Antibiotic Administration Time* into the abstraction grid?

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Antibiotic Abstraction Tips

1) Which antibiotics “count?”

- Appendix C, Table 2.1, is a crosswalk of trade and generic names of antibiotics that will be “recognized” by your abstraction software.
 - Does NOT include medications such as antivirals, antifungals, antituberculins, antiprotozoans, etc.
- “Antibiotic NOS” (not otherwise specified) is considered to be the antibiotic “name” if the actual name is missing, illegible, or not on Table 2.1. It is considered a “unique” antibiotic for entry into the grid or for abstracting *Antibiotic Received*.

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Antibiotic Abstraction Tips

1) Which antibiotics “count?”

- If the administration route of an antibiotic dose changes, consider this to be a “new” antibiotic and enter it on a new line. For example, enter *both* of the following:
 - Clindamycin PO given at 0600 on 9/13/10
 - Clindamycin IV given at 1400 on 9/13/10
- Antibiotic administration information should only be abstracted from documentation that demonstrates actual administration of a specific antibiotic, *but...*
- A dose given by one person and documented as being given by another *can* be abstracted if that dose is not documented by the person who actually administered it. For example...

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Antibiotic Abstraction Tips

1) Which antibiotics "count?"

- OR nurse, S. Smith RN, documents, "Cefazolin 1 gm IV given at 0500 per J. Doe, RN."
- This dose can be abstracted as given IF it was not documented by J. Doe, RN (the person who actually gave the dose).
- ONLY abstract antibiotics from an undated MAR if it has a patient sticker on it AND it is titled as the first day or initial MAR.
- Regardless of the format used for documenting actual administration, it must be clear to *anyone* that the antibiotic dose was actually administered!

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Antibiotic Abstraction Tips

1) Which antibiotics "count?"

- Info specific to **Pneumonia** abstractions:
 - Document the name of each antibiotic administered PO, IV, IM, or UTD **during the first 24 hours** after hospital **arrival**.
 - For antibiotics administered more than once by the same route during the first 24 hours after hospital arrival, only record the antibiotic name once.
 - Warning!** *If the antibiotic route is "unknown," be sure to consider it as a totally separate antibiotic and list the first "dose."*
 - **In** the ED, any narrative documentation of an antibiotic being administered may be abstracted. (Includes antibiotics that are hung, infusing, infused, etc.)
 - **Outside** the ED, narrative documentation can ONLY be abstracted if it is the ONLY documentation of a specific antibiotic found in the record.

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Antibiotic Abstraction Tips

1) Which antibiotics "count?"

- Info specific to **SCIP** abstractions:
 - If a test dose of antibiotic is given IV and the remainder of the dose is given later, abstract both entries of the antibiotic.
 - Do not abstract antibiotics from sources that do not represent actual administration. For example, do not abstract if:
 - Pre-Op Checklist states:
 - IV started at 1730
 - Pre-op Antibiotic given at 1800
 - Lab on chart
 - Operative report states: IV antibiotics were given prior to the procedure

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Antibiotic Abstraction Tips

1) Which antibiotics "count?"

- Info specific to **SCIP** abstractions:
 - Do not abstract antibiotics from narrative charting unless there is no other documentation that reflects that the same antibiotic was given during the specified time frame.
 - For example:
 - Narrative states: "Ancef 1 gram given IV prior to incision."
 - No other doses of Ancef are documented. The dose in the narrative should be abstracted using UTD for missing data.
 - **3-Dose Method:**
 - Collect 3 doses (or less) of each antibiotic administered** from hospital arrival through the first 48 hours (72 hours for CABG or Other Cardiac Surgery) after *Anesthesia End Time*.

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Antibiotic Abstraction Tips

1) Which antibiotics “count?”

- Info specific to **SCIP** abstractions:
 - **3-Dose Method, cont.:**
 - First:** Abstract the first dose of each specific antibiotic administered.
 - Second:** Abstract the dose of each specific antibiotic administered prior to and closest to *Surgical Incision Time*.
 - Third:** Abstract the last dose of each specific antibiotic administered within 48 hours (72 hours for CABG or Other Cardiac Surgery) after *Anesthesia End Time*.

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Antibiotic Grid Entry Tips

2) Info specific to Antibiotic Administration Name

- Only use “Antibiotic NOS” (not otherwise specified) for antibiotics not listed in Table 2.1, if the specific antibiotic name is missing, or if the antibiotic name is illegible.

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Antibiotic Grid Entry Tips

3) Info specific to Antibiotic Administration Route

- The route on the MAR for an antibiotic cannot be used as the route for a dose of that same antibiotic on another form.

*You have to abstract antibiotic information from the **same data source!***

- If all information for the antibiotic route, date, and time is not contained in a single data source for that specific antibiotic, abstract "UTD" for the missing information.

Remember! If the route on one source is "UTD," abstract this as a unique antibiotic dose!

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Antibiotic Grid Entry Tips

4) Info specific to Antibiotic Administration Date

- If an ED form has a stamp or sticker on each page that contains the date, this may be abstracted for the date for ED documentation only. If this is not the case, utilize "UTD" for the missing date.

- If an undated MAR is titled as the first day or initial MAR, but it does NOT have a patient sticker on it, abstract "UTD" for the date.

Remember: ONLY abstract antibiotics from an undated MAR if it has a patient sticker on it AND it is titled as the first day or initial MAR!

- If all information for the antibiotic route, date, and time is not contained in a single data source for that specific antibiotic, abstract "UTD" for the missing information.

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Antibiotic Grid Entry Tips

4) Info specific to Antibiotic Administration Date

- The medical record must be abstracted as documented (taken at "face value"). When documented date is an invalid date (not a valid format/range or outside of the parameter of care) **and** no other documentation is found on that same source that provides this information, abstract the date as "UTD."

Examples:

02-~~42~~-20XX: No other documentation on same source with valid date. Abstract as "UTD."

Patient was discharged on 02-12-20XX, but the antibiotic dose was documented as 03-12-20XX. Abstract as "UTD."

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Antibiotic Grid Entry Tips

5) Info specific to Antibiotic Administration Time

- "Hang time" or "infusion time" are acceptable as antibiotic administration time when other documentation cannot be found.
- The medical record must be abstracted as documented (taken at "face value"). When the time documented is an invalid time (not a valid format/range or outside of the parameter of care) **and** no other documentation is found on that same source that provides this information, abstract the time as "UTD."

Examples:

Antibiotic dose time documented as 2700 and no other documentation on same source provides valid time. Abstract as "UTD."

Patient discharged at 1200 and the antibiotic dose time was documented as 1430 on the same date. Abstract as "UTD."

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Antibiotic Grid Entry Tips

5) Info specific to Antibiotic Administration Time

- If a valid time for an antibiotic dose is an obvious error and the correct time can be found on the same source, the correct time may be entered. If the correct time cannot be found on that same source, the time must be abstracted as "UTD."

Examples:

Antibiotic dose time timed at 630, but other documentation on the same source supports the correct time was 1830. Abstract the correct time of 1830.

An arrival time of 0600 is documented, but the administration time is documented as 0545 for the same date. That dose **cannot** be abstracted as given during the hospital stay. (The 0545 dose should be used to abstract *Antibiotic Received*, if applicable.)

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Antibiotic Grid Entry Tips

5) Info specific to Antibiotic Administration Time

- Info that is specific to Antibiotic Administration Time and to SCIP:
 - When collecting the time for an antibiotic administered via infusion (IV), the Antibiotic Administration Time refers to the time the antibiotic infusion was started.
 - If there is documentation of an exact administration time in a **non-grid area** and it is apparent that a dose on a grid represents that same dose, abstract the non-grid time for the dose; for example:
 - Ancef is entered on the grid between 0700 and 0715.
 - Ancef is entered in the medication given area at 0705.
 - Abstract 0705 for the Antibiotic Administration Time.

Note: If grid times are used, follow the instructions in the General Abstraction Guidelines for reading grids.

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Antibiotic Received Tips

- Abstraction goals are to look for documentation of:
 - Antibiotics received within 24 hours or the day prior to arrival
 - Antibiotics received from time of hospital arrival through 24 hours (PN), 48 hours postop (SCIP, non-cardiac surgeries), or 72 hours postop (SCIP: CABG or Other Cardiac Surgery)
- Antibiotics listed as "current" or "home meds," etc. should be inferred as taken within 24 hours of arrival or the day prior to arrival, unless there is documentation they were **not** taken within the last 24 hours.
- If the medical record contains documentation of medication administration (i.e., "patient started on antibiotics two days ago"), but the antibiotic is **not listed as a current medication**, and there is **no specific documentation** to suggest the medication was taken within 24 hours of arrival or the day prior to arrival, **do not** consider it given within this time frame.

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Antibiotic Received Tips

- If there is other documentation to support that antibiotics were taken within 24 hours of arrival the day prior to arrival, consider it taken within 24 hours or the day prior to arrival.

Example: "Patient has been maintained on Rocephin for the last 5 days."
- If the date and/or time for an antibiotic dose is an obvious error, but it is a valid date and/or time and that is prior to the patient's arrival, the chart must be abstracted at face value and this information should be used to answer "yes" to antibiotics prior to arrival as applicable.

Example: Arrival time is documented as 1400 and the antibiotic is documented as given at 1352 on the same date. The dose cannot be abstracted as given during the hospital stay and should be used to abstract Antibiotic Received as allowable value #1 or #2 as applicable.

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Antibiotic Data Elements

Remember!

The preceding "tips" are not all inclusive!

Be sure you review the data element definition from the appropriate version of the Specifications Manual to be aware of all abstraction instructions.

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Specifications Manual Version 3.2 Multi-Measure Revisions & Additions

Transfer From Another Hospital or ASC

- Affects AMI and Pneumonia Measures
- Combines the previous data elements *Transfer from Another ED* and *Point of Origin*
- Definition: Documentation that the patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of another hospital or from an ambulatory surgery center (ASC)

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Specifications Manual Version 3.2

Multi-Measure Revisions & Additions

Transfer From Another Hospital or ASC (Cont.)

- Now has 5 allowable values including transfer from an:
 1. Inpatient department of another hospital
 2. Outpatient department of another hospital (excludes ED/observation units)
 3. ED/observation unit of another hospital
 4. Ambulatory surgery center
 5. None of above or UTD

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Multi-Measure Revisions & Additions

Transfer From Another Hospital or ASC (Cont.)

- New bullets in "Notes for Abstraction":
 - The emergency department includes free-standing and satellite emergency departments/rooms
 - If the medical record only reflects that the patient was received as a transfer from another hospital and the abstractor is unable to determine if the patient was in an inpatient or an outpatient department, select value "1"

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Specifications Manual, Version 3.2

Topic-Specific Revisions

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Pneumonia Revisions

Compromised

- Patient must currently be undergoing systemic chemotherapy or radiation therapy or received same within last 3 months in order to select value "1"
- Numerous other changes to clarify Notes for Abstraction and inclusions/exclusions

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Specifications Manual, Version 3.2 *Pneumonia Revisions*

ICU Admission or Transfer

- Exclusion Guidelines clarify intermediate care units
 - Step-down unit: a post-critical-care unit for patients who are hemodynamically stable who can benefit from close supervision...
 - Inpatient units with telemetry monitoring that are not intensive care units

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Specifications Manual, Version 3.2 *Pneumonia Revisions*

Influenza Vaccination Status

- Allowable value #3 now includes patient or caregiver's refusal of influenza vaccine
- Allowable value #4 modifications
 - Bone marrow transplant changed from within past 12 months to within past 6 months
 - Guillian-Barre syndrome now defined as within 6 weeks after a previous influenza vaccination

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Specifications Manual, Version 3.2 *Pneumonia Revisions*

Influenza Vaccination Status, (Cont.)

- “Pandemic vaccine, e.g., H1N1” was added to Exclusion Guidelines for Abstraction
 - Note: The 2010–2011 flu vaccine targets both seasonal influenza *and* the H1N1 influenza

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Specifications Manual, Version 3.2 *Pneumonia Revisions*

Pneumococcal Vaccination Status

- Allowable value #3 now includes patient or caregiver’s refusal of influenza vaccine
- Allowable value #4 modified to include patient receiving chemotherapy or radiation during this hospitalization or less than 2 weeks prior to the hospitalization

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Specifications Manual, Version 3.2 *Pneumonia Revisions*

Pneumonia Diagnosis: ED/Direct Admit

- Inclusion list is now all-inclusive (added "lower lobe pneumonia," "P," "PN," PNA," "PNE," etc.)
- Any Inclusions used with adjectives/phrases such as "need to evaluate for," "possible," "rule out," or "suspected" should be abstracted as value #1 (PN dx: ED) or #2 (PN dx: Direct Admit) as applicable
- Inclusions used with negative adjectives/phrases such as "doubt" or "no" should be abstracted as value #3 (no PN dx) unless criteria is met for #1 or #2

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Specifications Manual, Version 3.2 *Pneumonia Revisions*

Pneumonia Diagnosis: ED/Direct Admit, Cont.

Caution on Cases Billed as Direct Admits!

- *Patients who are billed as Direct Admits but who receive any treatment/care in the Emergency Department must be abstracted as though they were an ED patient!*
- *If you see any ED documentation in the patient record, abstract this data element according to the instructions for ED patients!*

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Specifications Manual, Version 3.2 *Pneumonia Revisions*

Pseudomonas Risk

- Clarified the definition (especially definition for interstitial lung disease and restrictive lung disease)
- “Repeated antibiotics” or multiple “rounds/courses” of antibiotics defined as those taken within the last 3 months prior to hospital arrival

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Specifications Manual, Version 3.2 *Pneumonia Revisions*

Risk Factors for Drug-Resistant Pneumococcus

- Added Inclusion words/terms:
 - Diabetic
 - DM
 - Injection drug user
 - Needles for drugs
 - Needle user

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Specifications Manual, Version 3.2 *Pneumonia Revisions*

Pneumonia Antibiotic Consensus Recommendations

- Pseudomonal risk choices for ICU patients were deleted
- Several changes to ICU recommendations
- Read carefully and share with physicians, PAs, APNs, and pharmacists

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Specifications Manual, Version 3.2 *Pneumonia Revisions*

PN Antibiotic Consensus Recommendations Questions & Dr. Dale Bratzler's Responses

- Question: *Patients who are admitted/transferred to the ICU who have beta-lactam allergies are excluded from the denominator for PN-6 [beginning with 2nd quarter 2010 discharges] so the antibiotic consensus recommendations don't cover this population any more. Why?*
- Dr. Bratzler's response was as follows:

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Specifications Manual, Version 3.2 *Pneumonia Revisions*

PN Antibiotic Consensus Recommendations Questions & Dr. Dale Bratzler's Responses (Cont.)

[Exclusion of ICU patients with beta-lactam allergies from PN-6]

There are no studies that provide a best practice. Guidelines recommend the use of a respiratory fluoroquinolone plus aztreonam, but that is based on opinion only. So, this population has been removed from the measure denominator.

This should be a very small number of patients excluded from the measure (only 1.7% of all pneumonia admissions nationally go to the ICU AND have a documented beta-lactam allergy).

As you think about your hospital protocol for treatment of this small CAP population that will no longer be in the measure, I can tell you that in discussing with experts on pneumonia care, they generally recommend 3 principles when treating an ICU patient with pneumonia:

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Specifications Manual, Version 3.2 *Pneumonia Revisions*

PN Antibiotic Consensus Recommendations Questions & Dr. Dale Bratzler's Responses (Cont.)

[Exclusion of ICU patients with beta-lactam allergies from PN-6:
3 principles for treating an ICU patient with pneumonia]

- 1. Cover *Streptococcus pneumoniae* (most common cause of CAP in all adult populations)*
- 2. Cover atypical organisms (*Legionella*, *Chlamydia*, etc.) – common cause of severe pneumonia (e.g., azithromycin or a fluoroquinolone)*
- 3. Use two antimicrobials. There is some research, particularly in patients with respiratory failure, that fluoroquinolone monotherapy may result in higher mortality rates.*

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Specifications Manual, Version 3.2 *Pneumonia Revisions*

PN Antibiotic Consensus Recommendations Questions & Dr. Dale Bratzler's Responses

- Beginning with 4th quarter 2010 discharges, changes were made to allow ICU patients to have antipneumococcal/antipseudomonal beta-lactams without documented risk factors for Pseudomonas.
- Question: *I have a physician asking why Ceftazidime is not included as an antipseudomonal beta-lactam? Is it because all of the others listed are antipneumococcal as well as antipseudomonal?*

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- Dr. Bratzler's response was as follows:

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Specifications Manual, Version 3.2 *Pneumonia Revisions*

PN Antibiotic Consensus Recommendations Questions & Dr. Dale Bratzler's Responses (Cont.)

[Antipneumococcal/antipseudomonal antibiotics]

Even in patients with risk factors for Pseudomonas infection (which is actually quite uncommon in community-acquired pneumonia patients), the most common cause of pneumonia is Streptococcus pneumoniae. So the only beta-lactams recommended for empiric treatment of pneumonia in a patient with Pseudomonas risk are the antipneumococcal, antipseudomonal beta-lactams (cefepime, imipenem, meropenem, piperacillin/tazobactam). Ceftazidime is not a good drug for S. pneumoniae.

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Topic Specific AMI/HF Revisions

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AMI-10 Statin Prescribed at Discharge

- CMS-only measure
- Not a **TEST** measure
- Current test measures will remain optional Oct. 1, 2010, through March 31, 2011:
 - AMI-T1a: LDL-Cholesterol Assessment
 - AMI-T2: Lipid-Lowering Therapy at Discharge

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Specifications Manual, Version 3.2 ***AMI-10 Statin Prescribed at Discharge***

Questions

- Will AMI-10 require all AMI records to have an LDL-c drawn within 24 hours of arrival?
- Do we have to start submitting for AMI-10 with October 1, 2010, discharges?

** See QualityNet Quest Questions and Heart Care Fact Sheet-AMI-10 in the Helpful Documents

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Specifications Manual, Version 3.2 ***AMI-10 Statin Prescribed at Discharge***

Questions (Cont.)

- Will a record with an LDL-c level less than 100 from a test after 24 hrs that did not have a statin prescribed at d/c pass the measure?
- Will AMI-10 accept **ALL** lipid lowering agents?

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Specifications Manual, Version 3.2 **AMI-10 Statin Prescribed at Discharge**

"A Walk Down the Algorithm"

- Data Elements given in algorithm order
 - 1st: *Comfort Measures Only*: Values "1, 2, 3" ⇒ Measure Category B (Not In Measure Population-Excludes Record)
 - 2nd: *Clinical Trial*: Value "Y" ⇒ Measure Category B (Not In Measure Population-Excludes Record)

See AMI-10 MIF Helpful Document for algorithm

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Specifications Manual, Version 3.2 **AMI-10 Statin Prescribed at Discharge**

"A Walk Down the Algorithm" (Cont.)

- Data Elements given in algorithm order:
 - 3rd: *Discharge Status*: Values "02, 07, 20, 43, 50, 51, 66" ⇒ Measure Category B (Not In Measure Population-Excludes Record)
 - 4th: *Statin Medication Prescribed at Discharge*: Value "Yes" ⇒ Category E (In Numerator Population-Passes) Abstraction stops

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Specifications Manual, Version 3.2 **AMI-10 Statin Prescribed at Discharge**

"A Walk Down the Algorithm" (Cont.)

- Data Elements given in algorithm order:
 - 5th: *LDL-c Less Than 100 Within 24 Hours After Arrival:*
Value "Yes" ⇒ Category B ((Not In Measure
Population-Excludes Record)
 - 6th: *Reason for Not Prescribing Statin Medication at
Discharge:* Value "Y" Category B (Not In Measure
Population-Excludes Record)

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Specifications Manual, Version 3.2 **ACEI/ARB/Aspirin/Beta-Blocker Prescribed at Discharge**

CONTRADICTION DOCUMENTATION

- If you find documentation of an ACEI/ARB/ASA/BB as a discharge medication in the record along with documentation to hold this same ACEI/ARB/ASA/BB after discharge, you will consider it "**contradictory**" **ONLY** if the time frame on the hold is **not defined**

** See Heart Care Fact Sheet Summary of AMI/HF
Changes for 10/1/10 Discharges (August 2010 version)

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Specifications Manual, Version 3.2

ACEI/ARB/Aspirin/Beta-Blocker Prescribed at Discharge

Contradictory Documentation

- Examples of holds with an **UNDEFINED** time frame:
 - Hold Zestril
 - Hold ASA
 - Hold Beta-blocker
 - Hold ARB

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Specifications Manual, Version 3.2

ACEI/ARB/Aspirin/Beta-Blocker Prescribed at Discharge

Contradictory Documentation

- If a **DEFINED** time frame is given for holding the medication, then this would **NOT** be considered "contradictory," and you would answer "Yes" to medication at discharge.
 - Examples of holds with a **DEFINED** time frame
 - "Hold ASA x 2 days"
 - "Hold Lopressor until after stress test"

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ACEI/ARB/Aspirin/Beta-Blocker Prescribed at Discharge (Cont.)

Contradictory Documentation Cont.

- If an ACEI/ARB/ASA/BB is **NOT** listed as a discharge medication, and there is only documentation of a hold or plan to delay initiation/restarting of an ACEI/ARB/ASA/BB after discharge select "No."
- This is with both a **DEFINED** and **UNDEFINED** time frame given for the hold

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Specifications Manual, Version 3.2

Reason for Not Prescribing ACEI/ARB/Aspirin/ Beta-Blocker at Discharge

- If a physician wrote/circled to discontinue any of these medications on the med rec form, but the patient was still put on the medication at discharge, the written/circled "discontinue" would still count as a reason for not prescribing on d/c.

** See QualityNet Quest Questions in the Helpful Documents

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Specifications Manual, Version 3.2 ***Discharge Instructions Address Medications***

The Abstraction of Plan to Start/Restart Medications After Discharge or Medications Documented as Hold Within the Record:

- If the medication is **NOT** listed elsewhere in the record as a discharge medication then it is **NOT** required in the discharge instructions
- If the medication is listed in the discharge instructions this is acceptable

** See Heart Care Fact Sheet Summary of AMI/HF Changes for 10/1/10 Discharges (August 2010 version)

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Specifications Manual, Version 3.2 ***Discharge Instructions Address Medications, Cont.***

The Abstraction of Plan to Start/Restart Medications After Discharge or Medications Documented as Hold Within the Record (Cont.)

- If the medication **IS** listed elsewhere in the record as a discharge medication, then it **IS** required in the discharge instructions

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Specifications Manual, Version 3.2

Discharge Instructions Address Medications (Cont.)

Credit Cannot Be Taken If:

- Instructions do not include the names of all the medications listed on the final compiled list
- There is contradictory documentation re a discharge medication (either between 2 sources used to compile the final list or between the compiled list and the discharge medication list given to the patient)
- There is no comparison list AND the physician/APN/PA did not sign the discharge medication list/instructions given to patient
- Documentation is not clear that the patient received a copy of the discharge medication list/instructions

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Specifications Manual, Version 3.2

Initial EKG Interpretation

- If initial EKG (one found closest to arrival) tracing is not signed, do not stop abstracting
 - If initial EKG is signed, yet does not have an exclusion term, do not stop abstracting
 - Review entire record for other interpretations of the **initial** EKG for exclusion terms
 - If any exclusion terms are found in any interpretation of the **initial** EKG, select "No" regardless of other documentation found
- ** See Heart Care Fact Sheet Abstraction of *Initial EKG Interpretation*-Effective April 1, 2010, through March 31, 2011, Discharges

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Specifications Manual, Version 3.2 ***Initial EKG Interpretation***

- Specific to the *Initial EKG Interpretation* data element, “Possible” is NOT a negative qualifier
- In Appendix H there is clarification that qualifiers in the negative qualifier list “should be abstracted as negative findings, **unless otherwise specified**”
- *Initial EKG Interpretation* abstraction guidelines specify, “If any Inclusion terms are described using the qualifier ‘possible,’ disregard that finding (neither Inclusion nor Exclusion)
- At the end of your review, if you have no Exclusions, and either the signed Initial ECG tracing or interpretations of this ECG include at least one Inclusion term, select “Yes”

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Specifications Manual, Version 3.2 ***Transfer From Another Hospital or ASC***

- New Data Element
- Replaces the old data elements
 - *Point of Origin for Admission or Visit*
 - *Transfer From Another ED*
- Used in these AMI measures:
 - Median Time to Fibrinolysis
 - Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
 - Median Time to Primary PCI
 - Primary PCI Received Within 90 Minutes of Hospital Arrival

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Specifications Manual, Version 3.2

Aspirin Received Within 24 Hours Before or After Hospital Arrival

- New change in the algorithm
- Previous steps
 - 1st *Comfort Measures Only*
 - 2nd *Clinical Trial*
 - 3rd *Point of Origin for Admission or Visit*
 - 4th *Transfer from Another ED*
 - 5th *Arrival Date*
 - 6th *Duration of Stay*
 - 7th *Aspirin Received Within 24 Hours Before or After Hospital Arrival*

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Specifications Manual, Version 3.2

Aspirin Received Within 24 Hours Before or After Hospital Arrival (Cont.)

- New change in the algorithm
- New steps
 - 1st *Comfort Measures Only*
 - 2nd *Clinical Trial*
 - 3rd *Arrival Date*
 - 4th *Duration of Stay*
 - 5th *Aspirin Received Within 24 Hours Before or After Hospital Arrival*

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Specifications Manual, Version 3.2 ***Aspirin Received Within 24 Hours Before or After*** ***Hospital Arrival***

- What does this mean?
- AMIs that were previously transferred in from another facility or Emergency Department were excluded from this measure
- Now they are included in the measure

** See Heart Care Fact Sheet Summary of AMI/HF Changes for 10/1/10 Discharges (August 2010 version)

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Miscellaneous ***Reminders***

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Future Inpatient Specifications Manual Publications

Manual Publication Date	Discharge Time Periods
October 2010	2 nd , 3 rd , and 4 th Quarters 2011
July 2011	1 st and 2 nd Quarters 2012
January 2012	3 rd and 4 th Quarters 2012

Beginning with January 1, 2012, discharges, the Inpatient *Specifications Manual* and Outpatient *Specifications Manual* publication schedule will be aligned. There will continue to be separate Inpatient and Outpatient Manuals.

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Helpful Documents

- AMI Diagnosed Late Fact Sheet
- AMI Initial ECG Fact Sheet
- AMI, Statin Fact Sheet
- HF, Discharge Instructions Fact Sheet
- Revised Quest Responses for April, May, June 2010
- RHQDAPU Calendar, July – September 2010
- Sampling Table, 4th Qtr 2010 to 1st Qtr 2011
- *Specifications Manual* 2011 Publishing Timeline

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Stay “In the Know”...

- Recorded Webinars will always be posted no later than the fourth week of:
 - January
 - April
 - July
 - Oct

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Questions?



- E-mail questions to Becky, Cassie, or Lawanna no later than **Friday, November 5, 2010**.
- Questions and answers will be distributed back to you in a Post-Presentation Q&A Fact Sheet via the FL & CA RHQDAPU E-mail List no later than November 19th.

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Stay "In the Know"...

Contact your QIO Project Coordinator:

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