

Release Notes for the 2012A Manual

Section	Rationale	Description
Active Labor	To clarify documentation requirements.	<p>Change the Definition from:</p> <p>Documentation that the patient was in active labor with regular uterine contractions with cervical change before medical induction and/or cesarean section.</p> <p>TO:</p> <p>Documentation that the patient was in active labor or presented with regular uterine contractions with cervical change before medical induction and/or cesarean section.</p> <p>Change the Suggested Data Collection Question from:</p> <p>Is there documentation that the patient was in active labor with regular uterine contractions with cervical change before medical induction and/or cesarean section?</p> <p>TO:</p> <p>Is there documentation that the patient was in active labor or presented with regular uterine contractions with cervical change before medical induction and/or cesarean section?</p> <p>Change the Allowable Values from:</p> <p>Y (Yes) There is documentation that the patient was in active labor with regular uterine contractions with cervical change before medical induction and/or cesarean section.</p> <p>N (No) There is no documentation that the patient was in active labor with regular uterine contractions with cervical change before medical induction and/or cesarean section OR unable to determine from medical record documentation.</p> <p>TO:</p> <p>Y (Yes) There is documentation that the patient was in active labor or presented with regular uterine contractions with cervical change before medical induction and/or cesarean section.</p>

		N (No) There is no documentation that the patient was in active labor or presented with regular uterine contractions with cervical change before medical induction and/or cesarean section OR unable to determine from medical record documentation.
Admission Date	To align with NHQM.	Add under Suggested Data Sources: <ul style="list-style-type: none"> • UB-04, Field Location: 12
Antenatal Steroids	To clarify measure population.	<p>Change Description from: Patients at risk of preterm delivery at 24-32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns</p> <p>TO: Patients at risk of preterm delivery at 24 0/7-32 0/7 weeks gestation receiving antenatal steroids prior to delivering preterm newborns</p> <p>Change denominator statement from: Patients delivering preterm newborns with 24-32 weeks gestation completed</p> <p>TO: Patients delivering live preterm newborns with 24 0/7-32 0/7 weeks gestation completed</p> <p>Rationale: To clarify measure population</p> <p>Algorithm Change:</p> <p>Change the Denominator Statement from: Patients delivering live preterm newborns with 24-32 weeks gestation completed</p> <p>TO: Patients delivering live preterm newborns with 24 0/7 -32 0/7 weeks gestation completed</p>
Appropriate Justification for Multiple Antipsychotic Medications	To clarify intent of allowable value 4.	Add to the Notes for Abstraction: Only allowable values 1, 2 and 3 are supported by an evidence base which will allow the case to pass the measure. Allowable value 4 can be used as part of an internal performance improvement activity, but the case will not pass the measure.

<p>CMS Certification Number</p>	<p>CMS Certification Number is now allowed and optional for all Joint Commission measure sets.</p>	<p>Change the Note under the Definition from:</p> <p>Note: This data element is not used by the HBIPS measure set. It is remaining in the data dictionary to support the common Initial Patient Population and Sample XML file layout. If data is transmitted for this data element associated to the HBIPS measure set, all edits and rules associated to this data element will be applied to the HBIPS data.</p> <p>TO:</p> <p>Note: This data element is optional. If data is transmitted in Hospital Clinical Data (HCD) or Population and Sampling (PaS) all edits and rules associated to this data element will be applied to the data.</p>
<p>Continuing Care Plan-Discharge Medications</p>	<p>To add additional examples of methods for transmission.</p>	<p>Change in the Notes for Abstraction from:</p> <p>Methods for transmitting the post-discharge continuing care plan include, but are not limited to: U.S. mail, email, fax, EMR access. Giving a copy of the continuing care plan to the patient does not comprise transmission.</p> <p>TO:</p> <p>Methods for transmitting the post-discharge continuing care plan include, but are not limited to: U.S. mail, email, fax, EMR access, doctor's mailbox, ambulance transport personnel. Giving a copy of the continuing care plan to the patient does not comprise transmission.</p>
<p>Continuing Care Plan-Next Level of Care</p>	<p>To add additional examples of methods for transmission.</p>	<p>Change in the Notes for Abstraction from:</p> <p>Methods for transmitting the post-discharge continuing care plan include, but are not limited to: U.S. mail, email, fax, EMR access. Giving a copy of the continuing care plan to the patient does not comprise transmission.</p> <p>TO:</p> <p>Methods for transmitting the post-discharge continuing care plan include, but are not limited to: U.S. mail, email, fax, EMR access, doctor's mailbox, ambulance transport personnel. Giving a copy of the continuing care plan to the patient does not comprise transmission.</p>

Continuing Care Plan-Principal Discharge Diagnosis	To add additional examples of methods for transmission.	<p>Change in the Notes for Abstraction from: Methods for transmitting the post-discharge continuing care plan include, but are not limited to: U.S. mail, email, fax, EMR access. Giving a copy of the continuing care plan to the patient does not comprise transmission.</p> <p>TO:</p> <p>Methods for transmitting the post-discharge continuing care plan include, but are not limited to: U.S. mail, email, fax, EMR access, doctor's mailbox, ambulance transport personnel. Giving a copy of the continuing care plan to the patient does not comprise transmission.</p>
Continuing Care Plan-Reason for Hospitalization	To add additional examples of methods for transmission.	<p>Change in the Notes for Abstraction from: Methods for transmitting the post-discharge continuing care plan include, but are not limited to: U.S. mail, email, fax, EMR access. Giving a copy of the continuing care plan to the patient does not comprise transmission.</p> <p>TO:</p> <p>Methods for transmitting the post-discharge continuing care plan include, but are not limited to: U.S. mail, email, fax, EMR access, doctor's mailbox, ambulance transport personnel. Giving a copy of the continuing care plan to the patient does not comprise transmission.</p>
Exclusive Breast Milk Feeding	To exclude newborns transferred to another hospital and premature newborns.	<p>Add to Denominator Excluded Populations:</p> <ul style="list-style-type: none"> • Patients transferred to another hospital • <i>ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes</i> for premature newborns as defined in Appendix A, Table 11.23 <p>Algorithm change:</p> <p>Remove Discharge Status = 02, 05 from the going down branch.</p> <p>Add Discharge Status = 02, 05 to the exclusion branch.</p>
Gestational Age	To clarify how to determine gestational age	<p>Change the Notes for Abstraction from:</p> <p>The history and physical should be reviewed first for gestational age. If gestational age is not</p>

and prioritize data sources.

recorded in the history and physical, then continue to review the data sources in the following order: prenatal forms, delivery or operating room record and clinician admission progress note until a positive finding for gestational age is found. In cases where there is conflicting data, the gestational age found in the first document according to the order listed above should be used. The phrase "estimated gestational age" is an acceptable descriptor for gestational age.

TO:

The delivery or operating room record should be reviewed first for gestational age. If gestational age is not recorded in the delivery or operating room record, then continue to review the data sources in the following order: history and physical, prenatal forms, clinician admission progress note and discharge summary until a positive finding for gestational age is found. In cases where there is conflicting data, the gestational age found in the first document according to the order listed above should be used. The phrase "estimated gestational age" is an acceptable descriptor for gestational age.

Add to the Notes for Abstraction:

Gestational age should be documented by the clinician as a numeric value between 1-50. The clinician, not the abstractor, should perform the calculation to determine gestational age based on the first day of the last normal menstrual period (not presumed time of conception) and the date of delivery.

If the gestational age entered by the clinician in the first document listed above is obviously incorrect (in error) but it is a valid number and the correct number can be supported with other documentation in the other acceptable data sources in the medical record, the correct number may be entered.

Change the Other Suggested Data Sources from:

ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE:

- History and physical
- Prenatal forms
- Delivery room record
- Operating room record

		<ul style="list-style-type: none"> • Admission clinician progress notes <p>TO:</p> <p>ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE:</p> <ul style="list-style-type: none"> • Delivery room record • Operating room record • History and physical • Prenatal forms • Admission clinician progress notes • Discharge summary
Health Care Organization Identifier	The Joint Commission now requires the HCO-id to be submitted and saved in the database for use in validation of the aggregate data.	<p>Change under Collected For from:</p> <p>Used in transmission of the Joint Commission’s aggregate data file, and the Hospital Initial Patient Population Data file</p> <p>TO:</p> <p>Used in transmission of the Joint Commission’s aggregate data file, the Hospital Initial Patient Population Data file and Hospital Clinical Data.</p>
Hospital Based Inpatient Psychiatric Services	To correct typo	<p>Change Table 10.1 to Table 10.01 in the initial patient population description and algorithm for the discharge measures. Note this typo also appears in manual V2011A.</p>
Parity	To clarify how to determine parity and prioritize data sources.	<p>Change the Notes for Abstraction from:</p> <p>The history and physical should be reviewed first for parity. If parity is not recorded in the history and physical, then continue to review the data sources in the following order: prenatal forms, delivery or operating room record and clinician admission progress note until a positive finding for parity is found. In cases where there is conflicting data, parity found in the first document according to the order listed above should be used.</p> <p>TO:</p> <p>The delivery or operating room record should be reviewed first for parity. If parity is not recorded in the delivery or operating room record, then continue to review the data sources in the following order: history and physical, prenatal forms, clinician admission progress note and discharge summary until a positive finding for parity is found. In cases where there is conflicting data, parity</p>

		<p>found in the first document according to the order listed above should be used.</p> <p>Add to the Notes for Abstraction:</p> <p>If parity entered by the clinician in the first document listed above is obviously incorrect (in error) but it is a valid number and the correct number can be supported with other documentation in the other acceptable data sources in the medical record, the correct number may be entered.</p> <p>The previous delivery of twins or any multiple gestation is considered one parous event.</p> <p>Change the Other Suggested Data Sources from:</p> <p>ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE:</p> <ul style="list-style-type: none"> • History and physical • Prenatal forms • Delivery room record • Operating room record • Admission clinician progress note <p>TO:</p> <p>ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE:</p> <ul style="list-style-type: none"> • Delivery room record • Operating room record • History and physical • Prenatal forms • Admission clinician progress note • Discharge summary
Patient Referral to Next Level of Care Provider	To clarify releases from court hearings.	Add to the Notes for Abstraction: When a patient is released from a psychiatric inpatient stay directly after a court hearing, select allowable value 3.
Perinatal Care	To exclude premature newborns.	Add a new exclusion to the algorithm and paragraph describing the population of Newborns with Breast Feeding as: <i>NO ICD-9-CM Principal or Other Diagnosis Code as defined in Appendix A, Table 11.23.</i>
Reason for Not Administering	To clarify implied reasons for not administering	Change the Notes for Abstraction from: When determining whether there is a reason documented by a physician/APN/PA or CNM for

Antenatal Steroid	antenatal steroids.	<p>not administering the full course of antenatal steroids, reasons must be explicitly documented (e.g., "fetal distress required emergency cesarean section - unable to complete full course of antenatal steroids") or clearly implied (e.g., "delivery is imminent-only one dose of steroid given"). If reasons are not mentioned in the context of antenatal steroid administration, do not make inferences (e.g., Do not assume that the patient did not receive the full course of antenatal steroids because the patient was in active labor upon arrival to the unit.)</p> <p>TO:</p> <p>When determining whether there is a reason documented by a physician/APN/PA or CNM for not administering the full course of antenatal steroids, reasons must be explicitly documented (e.g., "patient had an adverse reaction to the medication - unable to complete full course of antenatal steroids") or clearly implied (i.e., there is documentation the delivery occurred before the repeat dose of steroids could be given, there is documentation the fetus has anomalies which are not compatible with life). If reasons are not mentioned in the context of antenatal steroid administration, do not make inferences (e.g., Do not assume that the patient did not receive the full course of antenatal steroids because the patient was in active labor upon arrival to the unit.)</p>
Reason for Not Exclusively Feeding Breast Milk	To update inclusions.	<p>Change under Suggested Data Sources from:</p> <p>PHYSICIAN/APN/CNM DOCUMENTATION ONLY</p> <p>TO:</p> <p>PHYSICIAN/APN/CNM/LACTATION CONSULTANT DOCUMENTATION ONLY</p> <p>Add under the Inclusions:</p> <ul style="list-style-type: none"> • Admission to Intensive Care Unit (ICU) post-partum
Vendor Tracking Identifier	The Joint Commission now allows the HCO-id to be submitted and saved in the	<p>Change the last sentence in the first paragraph in the definition from:</p> <p>It is a fictitious identifier generated by the ORYX Vendor to differentiate between individual patient records across hospitals.</p>

	<p>database for use in validation of the aggregate data.</p> <p>To be able to identify all measure sets submitted for each patient episode of care.</p>	<p>TO:</p> <p>It is a fictitious identifier generated by the ORYX Vendor to differentiate between individual patient records in each hospital.</p> <p>Change the first sentence in the third paragraph from:</p> <p>Since this identifier is transmitted to The Joint Commission, ORYX Vendors must be able to link this tracking identifier to the original record (patient and hospital) in the event that data quality issues arise.</p> <p>TO:</p> <p>Since this identifier is transmitted to The Joint Commission, ORYX Vendors must be able to link this tracking identifier to the original record (patient) in the event that data quality issues arise.</p> <p>Add to Notes for Abstraction: For each patient episode of care, the Vendor Tracking Identifier should match for each Measure Set that is submitted. For example, if the hospital submits a separate XML file for AMI, ED and TOB, the Vendor Tracking Identifier should be the same in each XML file.</p>
<p>e. Sampling</p>	<p>To clarify sampling instructions.</p> <p>To ensure that hospitals are using the correct sampling methodology and submitting the same case for all applicable measure sets under the Global Initial Patient Population.</p>	<p>Change last paragraph in Sampling from:</p> <p>Sampling is done by national quality inpatient measure set, except for Perinatal Care (PC), and Hospital-Based Inpatient Psychiatric Services (HBIPS) which are done by strata or sampling group. For measures requiring medical record abstraction, sampling must be done using available databases that contain all discharges for the transmission quarter.</p> <p>TO:</p> <p>Sampling is done by national quality inpatient measure set; however, for Perinatal Care (PC), and Hospital-Based Inpatient Psychiatric Services (HBIPS) are done by strata or sampling group. For measures requiring medical record abstraction, sampling must be done using available databases that contain all discharges for the transmission quarter.</p>

		<p><u>Order of Data Flow</u> There have been significant changes made. Please refer to the Population and Sampling document.</p>
<p>g1. Transmission of Data</p>	<p>The Joint Commission now allows the HCO-id to be submitted and saved in the database for use in validation of the aggregate data.</p> <p>To align with NHQM and the updated Population and Sampling Specifications for hospitals collecting data for any measure set that utilizes the Global Initial Patient Population.</p>	<p>Changes in Transmission document, Hospital Clinical XML Layout, Hospital ICD Population XML Layout :</p> <p>Note: Please review the documents carefully as they have changed significantly.</p> <p><u>Joint Commission Data Transmission – Aggregate Data</u></p> <p>Change 3rd bullet</p> <p>From:</p> <p>Stratified national hospital quality inpatient measures: Although a stratified measure will often be referred to as a single measure (such as measure SCIP-Inf-1), the overall rate, and the individual strata measures will actually be transmitted to The Joint Commission in the aggregate HCO-level data as a series of measures, using a number of pre-determined transmission ID numbers.</p> <p>To:</p> <p>Stratified national hospital quality inpatient measures and Sub-measures: Although a stratified measure or sub-measure will often be referred to as a single measure (such as measure SCIP-Inf-1 and SUB-2), the overall rate, sub-measures, and the individual strata measures will actually be transmitted to The Joint Commission in the aggregate HCO-level data as a series of measures, using a number of pre-determined transmission ID numbers.</p> <p><u>Hospital Clinical Data</u></p> <p>Change 1st paragraph</p> <p>From: Hospital clinical data is required to be submitted to The Joint Commission no less than on a quarterly basis. All HBIPS and PC patient-level data submitted to The Joint Commission must adhere to the Hospital Clinical Data XML File Layout specifications and guidelines provided later in this section. The hospital clinical data submitted to The Joint Commission is anonymous because no hospital identifiers or direct patient identifiers are included in the Hospital Clinical Data XML File.</p> <p>To:</p> <p>Hospital clinical data is required to be submitted to The Joint Commission no less than on a quarterly basis. All HBIPS and PC patient-level data</p>

submitted to The Joint Commission must adhere to the Hospital Clinical Data XML File Layout specifications and guidelines provided later in this section. The hospital clinical data submitted to The Joint Commission is anonymous because no direct patient identifiers are included in the Hospital Clinical Data XML File.

Change

Additional information:

From:

* Unique Key Identifier for Discharge Measures (e.g., HBIPS-1, HBIPS-4, PC-01):

- o Performance Measurement System Identifier – not part of the file, captured at the point the file is uploaded to The Joint Commission
- o Vendor Tracking ID – fictitious identifier generated by the measurement system to differentiate between individual patient records across their client hospitals
- o Admission Date
- o Discharge Date
- o Measure Set

* Unique Key Identifier for Event Measures (e.g., HBIPS-2 and HBIPS-3):

- o Performance Measurement System Identifier – not part of the file, captured at the point the file is uploaded to The Joint Commission
- o Vendor Tracking ID – fictitious identifier generated by the ORYX Vendor to differentiate between individual patient records across their client hospitals
- o Admission Date
- o Event Date
- o Event Type
- o Measure Set Refer to the ORYX Technical Implementation Guide for more information concerning the Performance Measurement System Identifier.

To:

Additional information:

For more information concerning the Performance Measurement System Identifier, refer to the ORYX Technical Implementation Guide . For more information concerning the Vendor Tracking ID and Health Care Organization Identifier, refer to the Transmission Alpha Data Dictionary in this manual.

* Unique Key Identifier for Discharge Measures (e.g., HBIPS-1, HBIPS-4, PC-01):

- o Performance Measurement System Identifier –

not part of the file, captured at the point the file is uploaded to The Joint Commission

- o Vendor Tracking ID – fictitious identifier generated by the measurement system to differentiate between individual patient records from each hospital
- o Admission Date
- o Discharge Date
- o Measure Set
- o Health Care Organization Identifier

* Unique Key Identifier for Event Measures (e.g., HBIPS-2 and HBIPS-3):

- o Performance Measurement System Identifier – not part of the file, captured at the point the file is uploaded to The Joint Commission
- o Vendor Tracking ID – fictitious identifier generated by the ORYX Vendor to differentiate between individual patient records from each hospital
- o Admission Date
- o Event Date
- o Event Type
- o Measure Set
- o Health Care Organization Identifier

Change Measure Selection

From:

Data that passes all edits and contains all data required to calculate the measures will be accepted as long as at least one hospital has selected the measure set for the reporting quarter with the ORYX Vendor that is submitting the data.

To:

Data that passes all edits and contains all data required to calculate the measures will be accepted as long as the hospital (identified by the Health Care Organization Identifier) has selected the measure set for the reporting quarter with the ORYX Vendor that is submitting the data.

Remove from the Data Elements Not Accepted by The Joint Commission:

- o CMS Certification Number (CCN)
- o Healthcare Organization Identifier

Change 2nd paragraph (bullet) under Data Elements Required by The Joint Commission

From:

A fictitious identifier is generated by the ORYX

Vendor to differentiate between individual patient records across their client hospitals because the Joint Commission's data are blinded as to whom the hospital and patient are. The following data element is used to transmit this fictitious identifier.

* Vendor Tracking ID

This identifier is unique to a patient. For the HBIPS measure set, if the patient has multiple events, each event record must be transmitted with the same Vendor Tracking ID. In addition, the discharge record must also be transmitted with the same ID. Refer to the Transmission Alpha Data Dictionary for more information concerning this data element.

To:

A fictitious identifier is generated by the ORYX Vendor to differentiate between individual patient records from each hospital because the Joint Commission's data are blinded as to whom the patient is. The following data element is used to transmit this fictitious identifier.

* Vendor Tracking ID

This identifier is unique to a patient.

Joint Commission Guidelines for Submission of Hospital Clinical Data

Remove from the Data Elements Not Accepted by The Joint Commission:

- o CMS Certification Number (CCN)
- o Healthcare Organization Identifier

Change under the Unique Record Key:

From:

Discharge Measures: Performance Measurement System Identifier, Vendor Tracking Identifier, Admission Date, Discharge Date, and Measure Set

Event Measures:

Performance Measurement System Identifier, Vendor Tracking Identifier, Admission Date, Event Date, Event Type, and Measure Set

Note: Refer to the ORYX Technical Implementation Guide for more information concerning the Performance Measurement System Identifier.

To:

Discharge Measures: Performance Measurement System Identifier, Vendor Tracking Identifier, Admission Date, Discharge Date, Health Care

Organization Identifier, and Measure Set

For each patient episode of care the following patient identifiers should match for each Measure Set that is submitted for Discharge Measures (e.g., HBIPS-1, HBIPS-4, PC-01). For example, if the hospital submits a separate XML file for AMI, PC, HBIPS, and TOB, the above identifiers should be the same in each of the discharge XML files.

1. Vendor Tracking ID
2. Admission Date
3. Discharge Date
4. Birthdate
5. Health Care Organization Identifier

Event Measures:

Performance Measurement System Identifier, Vendor Tracking Identifier, Admission Date, Event Date, Event Type, Health Care Organization Identifier, and Measure Set

For HBIPS records, if the patient has multiple events(e.g., HBIPS-2 and HBIPS-3), the following patient identifiers should match for each event record transmitted. In addition, the discharge record must also be transmitted with the same identifiers.

1. Vendor Tracking ID
2. Admission Date
3. Birthdate
4. Health Care Organization Identifier

Refer to the Transmission Alpha Data Dictionary for more information concerning the Vendor Tracking ID and Health Care Organization Identifier. Note: Refer to the ORYX Technical Implementation Guide for more information concerning the Performance Measurement System Identifier.

Change the unique key identifiers under Submission in the Patient-Level Clinical XML File Layout

From:

Performance Measurement System Identifier*, Vendor Tracking ID, Admission Date, Discharge Date, and Measure Set

To:

Performance Measurement System Identifier*,

		<p>Vendor Tracking ID, Admission Date, Discharge Date, Measure Set, and Health Care Organization Identifier.</p> <p><u>Joint Commission Guidelines for Submission of Hospital Initial Patient Population Data</u> Change last sentence in 1st paragraph From: In addition, The Hospital Initial Inpatient Population Data file must be transmitted to the Joint Commission's Data Warehouse even if the hospital has elected to not report the patient data for the Discharge measures (e.g., HBIPS1, 4, PC-01) when they have five or fewer cases for the set during the quarter. To: In addition, The Hospital Initial Inpatient Population Data file must be transmitted to the Joint Commission's Data Warehouse even if the hospital has elected to not report the patient data for the Discharge measures (e.g., HBIPS1, 4, PC-01) when they have five or fewer cases for an appropriate measure set during the quarter.</p>
g3. Transmission Data Processing Flow: Clinical	<p>1- CMS Certification Number is now allowed and is optional</p> <p>2- HCOID is added to Hospital Clinical Data and is required for all records.</p> <p>3- AMI-9 is retired. Risk adjustment statements are more general</p>	<p>Change in Step 2: 'CMS Certification Number' is removed from PHI elements. This element is now optional</p> <p>Add to Step 4: 'Healthcare Organization Identifier' is added. This will be used to validate that the hospital has selected the measure set with the vendor for the appropriate time period, i.e., <i>Discharge Date</i>.</p> <p>Change Step 13 to : The case is accepted into the Joint Commission's Data Warehouse. If any of the measures in the measure set is Risk Adjusted:</p> <ul style="list-style-type: none"> • If yes, then execute the measure risk model on xml file and then stop processing. • If no, stop processing.
z. Appendix A - ICD-9-CM Code Tables	To update code tables.	Add Table 11.23, Premature Newborns.

z. Appendix B - Medication Tables	To update medication table with new antipsychotic medications.	Add Invega Sustenna Injectable (Paliperidone Palmitate) and Zyprexa Relprevv Injectable (Olanzapine) to Table 10.0, Antipsychotic Medications.
z. Appendix C - Glossary of Terms	To align with NHQM.	<p>Add the following terms:</p> <p>global Global is an umbrella term for all measure sets that share the same Initial Patient Population definition.</p> <p>subset measure(s) A subset measure contains overlapping sets of patients. For example, the patients in the TOB-2a measure are a subset of those in the TOB-2 measure, i.e., the two measures have overlapping populations. This is distinctly different from measures that contain mutually exclusive sets of patients such as seen in the pneumonia measure set. For PN-6, the ICU patients are entirely separate from the non-ICU patients.</p> <p>Change the following terms from:</p> <p>critical access hospital (CAH) Is a rural public, non-profit or for-profit hospital: a hospital that was closed within the previous ten years; or is a rural health clinic that was downsized from a hospital that is located in a State that has established a State plan with CMS for the Medicare Rural Hospital Flexibility Program. A CAH makes available 24-hour emergency care services 7 days per week and are, by definition, located more than a 35 mile drive from any other hospital or CAH (in mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles); or is certified by the State in the State plan as being a necessary provider of health care services to residents in the area. They provide no more than 15 beds for acute (hospital-level) inpatient care and provide an annual average length of stay of 96 hours per facilities. An exception to the 15-bed requirement is made for swing-bed facilities, which are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or SNF-level care, provided that not more than 15 beds are used at any one time for acute care. Hospitals certified by the Secretary of the Department of Health and Human Services (DHHS) as critical access hospitals are eligible for cost-based reimbursement</p>

from Medicare if they meet a specific set of federal Conditions of Participation (COPs).

TO:

critical access hospital (CAH) A facility that meets the following criteria may be designated by CMS as a CAH:

- Is located in a State that has established with CMS a Medicare rural hospital flexibility program; and
- Has been designated by the State as a CAH; and
- Is currently participating in Medicare as a rural public, non-profit or for-profit hospital; or was a participating hospital that ceased operation during the 10-year period from November 29, 1989 to November 29, 1999; or is a health clinic or health center that was downsized from a hospital; and
- Is located in a rural area or is treated as rural; and
- Is located more than a 35-mile drive from any other hospital or CAH (in mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles); and
- Maintains no more than 25 inpatient beds; and
- Maintains an annual average length of stay of 96 hours per patient for acute inpatient care; and
- Complies with all CAH Conditions of Participation, including the requirements to make available 24-hour emergency care services 7 days per week.
- A CAH may also be granted “swing-bed” approval to provide post-hospital Skilled Nursing Facility-level care in its inpatient beds. In the case of hospice care, a hospice may contract with a CAH to provide the Medicare hospice hospital benefit. Reimbursement from Medicare is made to the hospice. The CAH may dedicate beds to the hospice, but the beds must be counted toward the 25-bed maximum. However, the hospice patient is not included in the calculation of the 96-hour annual average length of stay. The hospice patient can be admitted to the CAH for any care involved in their treatment plan or for respite care. The CAH negotiates reimbursement through an

		<p>agreement with the hospice. In addition to the 25 inpatient CAH beds, a CAH may also operate a psychiatric and/or a rehabilitation distinct part unit of up to 10 beds each. These units must comply with the Hospital Conditions of Participation.</p> <p>measure information form Tool to provide specific clinical and technical information on a measure. The information contained includes: performance measure name, description, rationale, numerator/denominator/continuous variable statements, included populations, excluded populations, data elements, risk adjustment, sampling, data accuracy, and selected references.</p> <p>TO:</p> <p>measure information form Tool to provide specific clinical and technical information on a measure. The information contained includes: measure set, performance measure name, description, rationale, type of measure, improvement noted as, numerator/denominator/continuous variable statements, included populations, excluded populations, data elements, risk adjustment, data collection approach, data accuracy, measure analysis suggestions, sampling, data reported as, and selected references.</p> <p>measure-specific data elements Data elements used by one specific measure or several measures in one specific measure set, such as <i>Laparoscope</i> in the SCIP measures.</p> <p>TO:</p> <p>measure-specific data elements Data elements used by one specific measure or several measures in one specific measure set, such as <i>Infection Prior to Anesthesia</i> in the SCIP measures.</p>
z. Appendix E - Miscellaneous Tables	New Global Measure Sets added	<p>Add to Table 2.7:</p> <p>ED (Emergency Department), IMM (Immunization), TOB (Tobacco Treatment) and SUB (Substance Abuse) measure sets.</p>