Release Notes for the 2017A Manual

Measure Information Forms

Section	Rationale	Description
CSTK-01	This measure received National Quality Forum (NQF) initial measure endorsement in October 2016.	**Add:** Adoption Status (header note): NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE
CSTK-03	Denominator statement changed to align with CSTK-01 denominator statement. This measure received National Quality Forum (NQF) initial measure endorsement in October 2016.	**Change** Denominator Statement: From: SAH and ICH stroke patients who arrive at this hospital emergency department To: SAH and ICH stroke patients **Algorithm Change:** Denominator statement changed to align with CSTK-01 denominator statement From: SAH and ICH stroke patients who arrive at this hospital emergency department To: SAH and ICH stroke patients **Add** Adoption Status (header note): NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE
CSTK-04	Maintain current evidence.	Selected References: **Add** 3. Frontera JA, Lewin JJ 3rd, Rabinstein AA, Aisiku IP, Alexandrov AW, Cook AM, del Zoppo GJ, Kumar MA, Peerschke EI, Stiefel MF, Teitelbaum JS, Wartenberg KE, Zerfoss CL. Guideline for reversal of antithrombotics in intracranial hemorrhage: a statement for healthcare professionals from the Neurocritical Care Society and Society of Critical Care Medicine. Neurocrit Care. 2016;24(1):6-46.
CSTK-05		

	Prevent false inclusion if an IA thrombolytic agent other than alteplase (tPA) is administered	**Data Elements:** **Add**: IV Thrombolytic Initiation to CSTK-05 and CSTK-05a measures **Algorithm Change:** **Add**: IV Thrombolytic Initiation decision point in IV only path Under IVO connector, add decision point IV Thrombolytic Initiation If IV Thrombolytic Initiation = Y, cases flow down to IV Thrombolytic Initiation Date decision point If IV Thrombolytic Initiation = N, cases flow to right and will be excluded from the measure population If IV Thrombolytic Initiation = missing, cases flow to left and will be rejected
CSTK-06	This measure received National Quality Forum (NQF) initial measure endorsement in October 2016.	**Add:** Adoption Status (header note): NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE
PC	To clarify the required data elements for the newborn initial patient population.	**Add** *Birth Weight* to the list of elements required for the PC Newborn sub-population
PC-01	Due to a change in ICD-10-CM coding guidelines that no longer allow the use of an ICD-10-CM code to identify cases with history of stillbirth a new Data Element *History of Stillbirth* has been added to identify and exclude these cases.	**Add** to Denominator Excluded Populations: • History of prior stillbirth **Add** New Data Element: *History of Stillbirth* Algorithm Change: **Add** a new branch of *History of Stillbirth* when *Gestational Age* is >= 37 and < 39 • when *History of Stillbirth* is missing, case goes to Category Assignment X • when *History of Stillbirth* equal to Y, case goes to Category Assignment B • when *History of Stillbirth* equal to N, case continue processing to check *ICD-10-CM Principal or Other Diagnosis Codes*

Data Elements

Section	Rationale	Description
Anticoagulation Therapy Prescribed at Discharge	Changes were made to align with terminology used in the EHR / eCQM.	Definition: **Change** **From** "Documentation that anticoagulation therapy was prescribed at hospital discharge. Anticoagulant medications prevent the clotting of blood." **To** "Documentation that anticoagulation therapy was prescribed or continued at hospital discharge. Anticoagulant medications prevent the clotting of blood." Notes for Abstraction: **Add** new first bullet • If there is documentation in the medical record that an anticoagulant medication was prescribed at discharge, then select "Yes". Documentation that the patient should **continue to take an anticoagulant medication** that was administered during the hospital stay or taken prior to hospital admission (e.g., home medication) is also acceptable. At minimum, the name of the anticoagulant medication must be documented. Suggested Data Sources **Add** • After Visit Summary (AVS)
Antithrombotic Therapy Prescribed at Discharge	Changes were made to align with terminology used in the EHR / eCQM.	Definition: **Change** **From** "Documentation that antithrombotic therapy was prescribed at hospital discharge. Antithrombotics include both anticoagulant and antiplatelet drugs." **To** "Documentation that antithrombotic therapy was prescribed or continued at hospital discharge. Antithrombotics include both anticoagulant and antiplatelet drugs." Notes for Abstraction: **Add** new first bullet • If there is documentation in the medical record that an antithrombotic medication was prescribed at discharge, then select "Yes". Documentation that the patient should **continue to take an antithrombotic medication** that was administered

		during the hospital stay or taken prior to hospital admission (e.g., home medication) is also acceptable. At minimum, the name of the antithrombotic medication must be documented. Suggested Data Sources: **Add** • After Visit Summary (AVS)
Arrival Date	Align with CSTK abstraction guideline.	Notes for Abstraction: **Change** last bullet EXCEPTION **From** **CSTK MEASURES ONLY** EXCEPTION: Use the arrival date at the comprehensive stroke center. **To** **CSTK AND STK MEASURES ONLY** EXCEPTION: Use the arrival date at the comprehensive stroke center/primary stroke center.
Arrival Time	Align with CSTK abstraction guideline	Notes for Abstraction: **Change** last bullet EXCEPTION **From** **CSTK MEASURES ONLY** EXCEPTION: Use the arrival time at the comprehensive stroke center. **To** **CSTK AND STK MEASURES ONLY** EXCEPTION: Use the arrival time at the comprehensive stroke center/primary stroke center.
Assessed for Rehabilitation Services	Change made to align with terminology used in the EHR / eCQM.	Suggested Data Sources: **Add** • After Visit Summary (AVS)
Bloodstream Infection Confirmed	Revisions made to clarify notes for abstraction, update links and to provide additional guidance for abstraction.	**Change: Notes for Abstraction:** **From:** Confirmation of BSI is based on criteria from the Centers for Disease Control and Prevention (CDC) available at: http://www.cdc.gov/nhsn/inpatient-rehab/clabsi/

		To: Confirmation of BSI is based on Bloodstream Infection Event criteria from the Centers for Disease Control and Prevention (CDC) available at: https://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html Hospital infection prevention and control professionals should be consulted to assist with confirmation of BSI. For patients who die or transfer to another facility prior to the completion of a 7 day course of antibiotics, when there is a confirmed BSI and a 7 day course of antibiotics was planned, select Yes.
Education Addresses Activation of Emergency Medical System	Change made to align with terminology used in the EHR / eCQM.	Suggested Data Sources: **Add** • After Visit Summary (AVS)
Education Addresses Follow-up After Discharge	Change made to align with terminology used in EHR / eCQM.	Suggested Data Sources: **Add** • After Visit Summary (AVS)
Education Addresses Medication Prescribed at Discharge	Change made to align with terminology used in EHR / eCQM.	Suggested Data Sources: **Add** • After Visit Summary (AVS)
Education Addresses Risk Factors for Stroke	Change made to align with terminology used in EHR / eCQM.	Suggested Data Sources: **Add** • After Visit Summary (AVS)
Education Addresses Warning Signs and Symptoms of Stroke	Change made to align with terminology used in the EHR / eCQM.	Suggested Data Sources: **Add** • After Visit Summary (AVS)
Gestational Age	Changes made to clarify and align the acceptable sources in order of	**Change: ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE:** **From:**

	preference with the notes for abstraction.	• Delivery record, note or summary • Operating room record, note or summary **To:** • Delivery or Operating room record, note or summary
History of Stillbirth	Due to a change in ICD-10-CM coding guidelines that no longer allow the use of an ICD-10-CM code to identify cases with history of stillbirth a new Data Element *History of Stillbirth* has been added to identify and exclude these cases.	**Add** new data element *History of Stillbirth*
Labor	Clarification was added for acceptable documentation for labor.	**Change: Notes for Abstraction:** Bullet number three **From:** • Documentation of regular contractions with or without cervical change, e.g.: ◦ contractions every 4 to 5 minutes ◦ regular contractions and dilation ◦ effacement 50% with contractions every 3 minutes ◦ steady contractions **To:** • Documentation of regular contractions with or without cervical change, without mention of labor may be used to answer "yes" to labor. For example: ◦ contractions every 4 to 5 minutes ◦ regular contractions and dilation ◦ effacement 50% with contractions every 3 minutes ◦ steady contractions
		Change: ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE:

Number of Previous Live Births	Changes made to clarify and align the acceptable sources in order of preference with the notes for abstraction.	**From:** • Delivery record, note or summary • Operating room record, note or summary **To:** • Delivery or Operating room record, note or summary
Patient Status at Discharge	Allowable values 1 and 2 are being updated to provide additional detail for data abstraction. Notes for abstraction are being updated with bullets added to provide additional detail and clarity for data abstraction.	**Change** allowable value 1 **From:** The medical record contains documentation that the patient was discharged from the hospital-based inpatient psychiatric care setting AND hospital system at the same time **To:** The medical record contains documentation that the patient was discharged from the inpatient psychiatric care setting under these circumstances: • Patient is leaving the psychiatric unit within the acute care hospital AND the hospital facility completely. • Patient is leaving the freestanding inpatient psychiatric facility completely. **Change** last bullet in allowable value 2 **From:** • the patient was discharged from the hospital to another level of care outside of the hospital system from a setting other than a Psychiatric Care Setting **To:** • the patient was transferred/discharged from the inpatient psychiatric unit in an acute care setting to another level of care, (i.e. medical unit), and subsequently discharged from that level of care **Notes for Abstraction** **Add** as first bullet: The intent of this data element is to identify and exclude patients with an unplanned departure resulting in discharge. • Patients who discharge or transfer to another level of care in the same hospital are excluded from the measure population since they have not yet been discharged from the hospital.

		• Patients who are discharged from the psychiatric setting are included in the measure population. **Add** as third bullet: For patients discharged from free-standing psychiatric facilities, select allowable value 1.
Reason for Not Prescribing **Antithrombotic** Therapy at Discharge	Change made to align with terminology used in the EHR/ eCQM.	Suggested Data Sources: **Add** • After Visit Summary (AVS)
Reason for Not Prescribing **Anticoagulation** Therapy at Discharge	Change made to align with terminology used in the EHR / eCQM.	Suggested Data Sources: **Add** • After Visit Summary (AVS)
Reason for Not Prescribing Statin Medication at Discharge	Change made to align with terminology used in the EHR / eCQM.	Suggested Data Sources: **Add** • After Visit Summary (AVS)
Skin Puncture	Provide clarification for abstractor	Inclusion Guidelines for Abstraction: **Add** Arterial access
Statin Medication Prescribed at Discharge	Changes were made to align with terminology used in the EHR / eCQM.	Definition: **Change** **From** "Documentation that a statin medication was prescribed at hospital discharge. Statins are a class of pharmaceutical agents that modify LDL cholesterol by blocking the action of an enzyme in the liver which is needed to synthesize cholesterol thereby decreasing the level of cholesterol circulating in the blood." **To** "Documentation that a statin medication was prescribed or continued at hospital discharge. Statins are a class of pharmaceutical agents that modify LDL cholesterol by blocking the action of an enzyme in the liver which is needed to synthesize cholesterol thereby decreasing the level of cholesterol circulating in the blood." Notes for Abstraction: **Add** new first bullet

		• If there is documentation in the medical record that a statin medication was prescribed at discharge, then select "Yes". Documentation that the patient should **continue to take a statin medication** that was administered during the hospital stay or taken prior to hospital admission (e.g., home medication) is also acceptable. At minimum, the name of the statin medication must be documented. Suggested Data Sources: **Add** • After Visit Summary (AVS)

Supplemental Materials

Section	Rationale	Description
Appendix A - ICD-10 Code Tables	Based on questions received from the field and discussion with the PC technical advisory panel, codes for acute cholecystitis are being added. Based on questions received from the field and discussion with the PC technical advisory panel, these codes for other malpresentation of fetus are being added in order to capture footling breech.	**Add** to Table 11.07: Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation K810 Acute cholecystitis K812 Acute cholecystitis with chronic cholecystitis **Add** to Table Number 11.09: Multiple Gestations and Other Presentations O328XX0 Maternal care for other malpresentation of fetus, not applicable or unspecified O328XX1 Maternal care for other malpresentation of fetus, fetus 1 O328XX2 Maternal care for other malpresentation of fetus, fetus 2 O328XX3 Maternal care for other malpresentation of fetus, fetus 3 O328XX4 Maternal care for other malpresentation of fetus, fetus 4 O328XX5 Maternal care for other malpresentation of fetus, fetus 5 O328XX9 Maternal care for other malpresentation of fetus, other fetus
Transmission of Data	To align with Data Dictionary changes	**Add** new data element: *History of Stillbirth* for PC-1 **Add** CSTK-5 for *IV Thrombolytic Initiation* data element

		Change Allowable Value 1 and last bullet in allowable value 2 for *Patient Status at Discharge* data element

General Release Notes

Rationale	Description