Release Notes for the 2015A Manual

Measure Information Forms

Section	Rationale	Description
AMI	Measure added to manual.	All updated.
AMI-1	The Acute Myocardial Infarction (AMI) measure set has measures specified in both the aligned Specifications Manual for National Hospital Inpatient Quality Measures and the Specifications Manual for Joint Commission National Quality Core Measures. The Measure Information Form shell has been added to provide the link to the aligned Specifications Manual for National Hospital Inpatient Quality Measures.	Added the Measure Information Form shell.
AMI-10	Measure added to manual.	All updated.
AMI-2	Measure added to manual.	All updated.

AMI-3	The Acute Myocardial Infarction (AMI) measure set has measures specified in both the aligned Specifications Manual for National Hospital Inpatient Quality Measures and the Specifications Manual for Joint Commission National Quality Core Measures. The Measure Information Form shell has been added to provide the link to the aligned Specifications Manual for National Hospital Inpatient Quality Measures.	Added the Measure Information Form shell.
AMI-5	The Acute Myocardial Infarction (AMI) measure set has measures specified in both the aligned Specifications Manual for National Hospital Inpatient Quality Measures and the Specifications Manual for Joint Commission National Quality Core Measures. The Measure Information Form shell has been added to provide the link to the	Added the Measure Information Form shell.

	aligned Specifications Manual for National Hospital Inpatient Quality Measures.	
AMI-7	The Acute Myocardial Infarction (AMI) measure set has measures specified in both the aligned Specifications Manual for National Hospital Inpatient Quality Measures and the Specifications Manual for Joint Commission National Quality Core Measures. The Measure Information Form shell has been added to provide the link to the aligned Specifications Manual for National Hospital Inpatient Quality Measures.	Added the Measure Information Form shell.
AMI-7a	The Acute Myocardial Infarction (AMI) measure set has measures specified in both the aligned Specifications Manual for National Hospital Inpatient Quality Measures and the Specifications Manual for Joint Commission	Added the Measure Information Form shell.

	National Quality Core Measures. The Measure Information Form shell has been added to provide the link to the aligned Specifications Manual for National Hospital Inpatient Quality Measures.	
AMI-8	The Acute Myocardial Infarction (AMI) measure set has measures specified in both the aligned Specifications Manual for National Hospital Inpatient Quality Measures and the Specifications Manual for Joint Commission National Quality Core Measures. The Measure Information Form shell has been added to provide the link to the aligned Specifications Manual for National Hospital Inpatient Quality Measures.	Added the Measure Information Form shell.
AMI-8a	The Acute Myocardial Infarction (AMI) measure set has measures specified in both the aligned Specifications	Added the Measure Information Form shell.

	Manual for National Hospital Inpatient Quality Measures and the Specifications Manual for Joint Commission National Quality Core Measures. The Measure Information Form shell has been added to provide the link to the aligned Specifications Manual for National Hospital Inpatient Quality Measures.	
HBIPS	Pharmacy logs will be used, when available, during population determination to increase the accuracy of HBIPS-4 and HBIPS-5 measures rates.	The HBIPS population logic has been modified to incorporate use of pharmacy logs. HBIPS-Discharge (HBIPS-DSC) is replaced with 2 sub-populations, HBIPS-RX and HBIPS-NORX. Sub-population HBIPS-RX would include measures HBIPS-4 and HBIPS-5 Sub-population HBIPS-NORX would include measures HBIPS-1, HBIPS-6 and HBIPS-7.
HBIPS-1	Update of Measure Category Assignments for stratification.	**Add** to the top of the measure information form: NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE Algorithm change: Flow Overall Rate Category Assignment of 'X' down same as 'D' and 'E'. Remove from 1st processing box of strata page the sentence 'The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-1a) Measure Category Assignment'
HBIPS-2	Update of Measure Category Assignments for stratification.	Algorithm change: Set the Measure Category Assignment for all strata measures (b-e) = 'U'. Flow Overall Rate Category Assignment of 'X' down same as 'E' and 'Y'. Remove from 2nd processing box of strata page the sentence 'The rest of the

		algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-2a) Measure Category Assignment'.
HBIPS-3	Update of Measure Category Assignments for stratification.	Algorithm change: Set the Measure Category Assignment for all strata measures (b-e) = 'U'. Flow Overall Rate Category Assignment of 'X' down same as 'E' and 'Y'. Remove from 2nd processing box of strata page the sentence 'The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-3a) Measure Category Assignment'.
HBIPS-4	Appendix B was changed to Appendix C for medication tables to align with NHQM. To provide additional exclusions to the measure. Update of Measure Category Assignments for stratification.	**Remove *NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE*** **Change** the denominator included populations to: • Patients with *ICD-9-CM Principal or Other Diagnosis Codes* for Mental Disorders as defined in Appendix A, Table 10.01 discharged on one or more routinely scheduled antipsychotic medications (refer to Appendix C, Table 10.0-Antipsychotic Medications). **Add** under the denominator excluded populations: • Patient's residence is not in the USA, and they are returning to another country after discharge Algorithm change: Flow Overall Rate Category Assignment of 'X' down same as 'D' and 'E'. Remove from 1st processing box of strata page the sentence 'The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-4a) Measure Category Assignment'
HBIPS-5	To provide additional exclusions to the measure. Update of Measure Category Assignments for stratification.	**Add** under denominator excluded populations: • Patient's residence is not in the USA, and they are returning to another country after discharge Algorithm change: Flow Overall Rate Category Assignment of 'X' down same as 'D' and 'E'. Remove from 1st processing box of strata page the sentence 'The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall

		rate's (HBIPS-5a) Measure Category Assignment'.
HBIPS-6	To provide additional exclusions to the measure. Update of Measure Category Assignments for stratification.	**Add** under denominator excluded populations: • Patients readmitted to the same facility within 5 days after discharge • Patient's residence is not in the USA, and they are returning to another country after discharge Algorithm change: Flow Overall Rate Category Assignment of 'X' down same as 'D' and 'E'. Remove from 1st processing box of strata page the sentence 'The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-6a) Measure Category Assignment'.
HBIPS-7	To provide additional exclusions to the measure. Update of Measure Category Assignments for stratification.	**Add** under denominator excluded populations: • Patients readmitted to the same facility within 5 days after discharge • Patient's residence is not in the USA, and they are returning to another country after discharge Algorithm change: Flow Overall Rate Category Assignment of 'X' down same as 'D' and 'E'. Remove from 1st processing box of strata page the sentence 'The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-7a) Measure Category Assignment'.
HF	Measure added to manual.	All updated.
HF-2	The Heart Failure (HF) measure set has measures specified in both the aligned Specifications Manual for National Hospital Inpatient Quality Measures and the Specifications Manual for	Added the Measure Information Form shell.

	Joint Commission National Quality Core Measures. The Measure Information Form shell has been added to provide the link to the aligned Specifications Manual for National Hospital Inpatient Quality Measures.	
HF-3	Measure added to manual.	All updated.

PC-01	Spontaneous rupture of membranes which do not result in labor are captured with ICD-9 CM diagnosis codes on Table 11.07. This will exclude the case from the measure, so a data element is no longer necessary. Cases with an allowable value of UTD for *Gestational Age* are now excluded, since this is typically a result of no prenatal care.	**Change** the numerator included populations to: *ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes* for one or more of the following:
		• Medical induction of labor as defined in Appendix A, Table 11.05
		• Cesarean section as defined in Appendix A, Table 11.06 and all of the following:
		  • not in *Labor*
		  • no history of a *Prior Uterine Surgery*
		Remove the numerator data element *Spontaneous Rupture of Membranes*.
		Change the last bullet under denominator excluded populations to:
		• *Gestational Age* < 37 or >= 39 weeks or UTD
		Algorithm Changes:
		Change the condition of *Gestational Age* to:
		<37 or >=39 or UTD
		Remove the branch of *Spontaneous Rupture of Membranes*.

PC-02	Table 11.09 was renamed to reflect the intent of the measure to include only singletons in a vertex presentation. Cases with	**Change** the first bullet under denominator excluded populations to: • *ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes* for multiple gestations and other presentations as defined in Appendix A, Table 11.09 **Change** the last bullet under denominator excluded populations to: *Gestational Age* < 37 or UTD

	an allowable value of UTD for *Gestational Age* are now excluded, since this is typically a result of no prenatal care.	**Algorithm Changes**: **Change** the condition of *Gestational Age* to: <37 or UTD
PC-03	Appendix B was changed to Appendix C for medication tables to align with NHQM. The gestational age range for corticosteroids was revised to follow new ACOG practice guidelines. Cases with an allowable value of UTD for *Gestational Age* are now excluded, since this is typically a result of no prenatal care.	**Change** the description to: Patients at risk of preterm delivery at >=24 and <34 weeks gestation receiving antenatal steroids prior to delivering preterm newborns **Change** the rationale to: The National Institutes of Health 1994 recommendation is to give a full course of corticosteroids to all pregnant women between 24 weeks and 34 weeks of gestation who are at risk of preterm delivery. Repeated corticosteroid courses should not be used routinely, because clinical trials show decreased brain size, decreased birth weight, and adrenal insufficiency in newborns exposed to repeated doses. Treatment should consist of two doses of 12 mg of betamethasone given intramuscularly 24 hours apart or four doses of 6 mg dexamethasone given intramuscularly every 12 hours. A single course of corticosteroids should be given at 24 0/7 to 33 6/7 weeks gestation (NIH, 2000). A Cochrane meta-analysis reinforces the beneficial effect of this therapy regardless of membrane status and further concludes for all preterm deliveries the single course of corticosteroids should be routinely administered (Roberts & Dalziel, 2006). **Change** numerator included populations to: Antenatal steroid therapy initiated (refer to Appendix C, Table 11.0, antenatal steroid medications) **Change** the denominator statement to: Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed **Change** the last bullet under denominator excluded populations to: • *Gestational Age* < 24 or >= 34 weeks or UTD **Add** the following references: • American College of Obstetricians and Gynecologists. (ACOG). (2013). Practice

		Bulletin: Clinical Management Guidelines for Obstetrician-Gynecologists for Premature rupture of membranes. • NIH Consensus Statement: *Antenatal corticosteroids revisited: repeat courses*.2000. 17(2)1-18. • Roberts, D. & Dalziel, S.R. (2010) *Antenatal corticosteroids for accelerating fetal lung maturation for women at risk of preterm birth (Review)*. The Cochrane Collaboration. Issue 9. **Algorithm Changes**: **Change** the denominator statement to: Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed. **Change** the condition of *Gestational Age* to: • If *Gestational Age* <24 or >=34 or UTD, the case will proceed to a Measure Category Assignment of B. • If *Gestational Age* >= 24 and < 34, continue processing and proceed to Antenatal Steroid Therapy Initiated.
PC-05	To clarify intent of measure which is to evaluate only newborns exclusively fed breast milk during the entire hospitalization based on the mother's initial feeding plan.	**Change** PC-05a measure name to: Exclusive Breast Milk Feeding Considering Mother's Initial Feeding Plan **Change** PC-05a description to: • PC-05 Exclusive breast milk feeding during the newborn's entire hospitalization • PC-05a Exclusive breast milk feeding during the newborn's entire hospitalization considering mother's initial feeding plan The measure is reported as an overall rate which includes all newborns that were exclusively fed breast milk during the entire hospitalization, and a second rate, a subset of the first, which includes only those newborns that were exclusively fed breast milk during the entire hospitalization excluding those whose mothers initial feeding plans were not to exclusively breast feed. **Change** PC-05a denominator statement to: • PC-05a Single term newborns discharged alive from the hospital excluding those whose mothers initial feeding plans were not to exclusively feed breast milk **Algorithm Changes**:

		Change PC-05a measure name and denominator statement to: PC-05a Exclusive breast milk feeding during the newborns entire hospitalization considering mothers initial feeding plan Denominator Single term newborns discharged alive from the hospital excluding those whose mothers initial feeding plans were not to exclusively feed breast milk
PN	Measure added to manual.	All updated.
PN-3a	Measure added to manual.	All updated.
PN-6	The Pneumonia (PN) measure set has measures specified in both the aligned Specifications Manual for National Hospital Inpatient Quality Measures and the Specifications Manual for Joint Commission National Quality Core Measures. The Measure Information Form shell has been added to provide the link to the aligned Specifications Manual for National Hospital Inpatient Quality Measures.	Added the Measure Information Form shell.

Data Elements

Section	Rationale	Description
ACEI Prescribed at Discharge	Data Elements added to manual.	All updated.
Admission Date	Alignment with CMS aligned manual.	**Change** the last bullet under **ONLY ALLOWABLE SOURCES** under suggested data sources to: • UB-04 **Change** the bullet under excluded data sources under suggested data sources to: • UB-04, "From" and "Through" dates **Change** Collected For - from Measure Specific to General Data Element
Admission to NICU	To clarify which cases are included or excluded based on the definition of the NICU only.	**Change** the definition to: Documentation that the newborn was admitted to the Neonatal Intensive Care Unit (NICU) at this hospital any time during the hospitalization. **Change** the suggested data collection to: Was the newborn admitted to the NICU at this hospital at any time during the hospitalization? **Change** the allowable values to: Y (Yes) There is documentation that the newborn was admitted to the NICU at this hospital at any time during the hospitalization. N (No) There is no documentation that the newborn was admitted to the NICU at this hospital at any time during the hospitalization or unable to determine from medical record documentation. **Change** the notes for abstraction to: A NICU is defined as a hospital unit providing critical care services which is organized with personnel and equipment to provide continuous life support and comprehensive care for extremely high-risk newborn infants and those with complex and critical illness (source: American Academy of Pediatrics). Names of NICUs may vary from hospital to

		hospital. Level designations and capabilities also vary from region to region and cannot be used alone to determine if the nursery is a NICU. If the newborn is admitted to the NICU for observation or transitional care, select allowable value no. Transitional care is defined as a stay of 4 hours or less in the NICU. If an order to admit to the NICU is not found in the medical record, there must be supporting documentation present in the medical record indicating that the newborn received critical care services in the NICU in order to answer yes. Examples of supporting documentation include, but are not limited to the NICU admission assessment and NICU flow sheet.
Antenatal Steroid Therapy Initiated	Appendix B was changed to Appendix C for medication tables to align with NHQM.	**Change** the inclusion under guidelines for abstraction to: Refer to Appendix C, Table 11.0 Antenatal Steroid Medications
ARB Prescribed at Discharge	Data Element added to manual.	All updated.
Arrival Date	Data Element added to the manual.	All updated.
Arrival Time	Data Element added to the manual.	All updated.
Aspirin Prescribed at Discharge	Data Element added to manual.	All updated.
Birth Weight	To clarify additional data sources and priority for determining birth weight.	**Change** the last bullet under the notes for abstraction to: • It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the suggested data sources listed below. **Add** two bullets under the notes for abstraction: • For newborns received into the hospital as a transfer, the admission birth weight

		may be used if the original birth weight is not available. • If the birth weight is recorded in pounds and ounces and also in grams, abstract the value for grams.
Birthdate	Alignment with CMS aligned manual.	**Change** the last suggested data source to: • UB-04
Blood Culture Collected	Data Element added to manual.	All updated.
Bloodstream Infection Present on Admission	To clarify that receiving antibiotics is considered treatment and the documentation requirements for describing a bloodstream infection upon admission.	**Change** the definition to: Documentation in the medical record within the first 48 hours after admission that the patient had a bloodstream infection present on admission. This includes patients with positive blood cultures or negative or inconclusive blood cultures when the patient is suspected of having a bloodstream infection or septicemia and is being treated for the condition. A blood culture can be defined as a culture of microorganisms from specimens of blood to determine the presence and nature of bacteremia. **Change** the notes for abstraction to: The admission assessment and the NICU admission assessment or NICU notes should be reviewed first for documentation of a suspected or confirmed bloodstream infection present on admission or within the first 48 hours after admission. Documentation of the suspected bloodstream infection being present on admission should be taken at face value regardless of the blood culture results. Routine work up for sepsis for high risk newborns admitted to the NICU should not be considered a suspected bloodstream infection in the absence of positive blood culture results. There must be documentation from the clinician specifically stating that the newborn appeared septic or was showing signs and symptoms of sepsis in order to answer yes. Signs and symptoms of sepsis include but are not limited to: body temperature changes, respiratory difficulty, diarrhea, hypoglycemia, reduced movements, reduced sucking, seizures, bradycardia, swollen/distended abdomen, vomiting and/or jaundice. The results of the initial blood cultures drawn within the first 48 hours of admission which are reported after the first 48 hours may be used to determine if the bloodstream

		infection was present on admission. Birth is considered the same as admission for patients who were born in the reporting hospital. If the present on admission (POA) indicator is present with the diagnosis code for septicemia or bacteremia, answer yes to bloodstream infection present on admission. **Change** the third bullet under the inclusions for the guidelines for abstraction to: • Inconclusive blood culture under treatment **Add** under the exclusions for the guidelines for abstraction: • Rule out sepsis • R/O sepsis • Work up for sepsis • Negative blood culture under treatment • Evaluation for sepsis
Chest X-Ray	Data Element added to manual.	All updated.
Clinical Trial	Alignment with CMS aligned manual.	**Change** Collected For - from General Data Element to Measure Specific **Change** Notes for Abstraction to include measure sets aligned with NHQM. **Change** Notes for Abstraction PC section to: **PC**: Only capture patients enrolled in clinical trials studying pregnant patients or newborns. For Perinatal Care measures **ONLY**, it is appropriate for the ORYX® Vendor to default the data element to "No" unless a diagnosis code for clinical trial is present. If a code is present, or the organization knows via some other electronic method that the patient is participating in a clinical trial, default the data element to "Yes". Hospital abstractors may change defaulted value of "No" based on hospital participation in clinical trial.
Comfort Measures Only	Data Element added to manual.	All updated.
Continuing Care Plan-Discharge	To clarify how to abstract conflicting	**Remove** from the allowable values: PROGRAMMER NOTE:

Medications	documentation. The programmer note has been moved to the xml layout.	In order to identify the specific continuing care plan components that are missing, the internal variables (discharge counter and missing flag) must be stored so calculations of rates for each discharge component can be performed. **Add** to the notes for abstraction: If more than one list of medications is included in the continuing care plan documents and the lists do not match, you should select allowable value "3" which would capture unable to determine. As there is a conflict between two separate documents, a receiving practitioner would not be able to determine the accurate medication regimen.
Continuing Care Plan-Next Level of Care	DSM-5 no longer refers to AXIS. The programmer note has been moved to the xml layout.	**Remove** from the allowable values: PROGRAMMER NOTE: In order to identify the specific continuing care plan components that are missing, the internal variables (discharge counter and missing flag) must be stored so calculations of rates for each discharge component can be performed. **Change** the second bullet under inclusions for the guidelines for abstraction to: • Medical follow-up
Continuing Care Plan-Principal Discharge Diagnosis	The programmer note has been moved to the xml layout.	**Remove** from the allowable values: PROGRAMMER NOTE: In order to identify the specific continuing care plan components that are missing, the internal variables (discharge counter and missing flag) must be stored so calculations of rates for each discharge component can be performed.
Continuing Care Plan-Reason for Hospitalization	The programmer note has been moved to the xml layout.	**Remove** from the allowable values: PROGRAMMER NOTE: In order to identify the specific continuing care plan components that are missing, the internal variables (discharge counter and missing flag) must be stored so calculations of rates for each discharge component can be performed.
Discharge Date	Alignment with CMS aligned manual.	**Change** the last bullet under suggested data sources to: • UB-04
Discharge Disposition	To align with NHQM.	**Change under the first bullet under Notes for Abstraction:** Example:

		Documentation in the Discharge Planning notes on 04-01-20xx state that the patient will be discharged back home. On 04-06-20xx the physician orders and nursing discharge notes on the day of discharge reflect that the patient was being transferred to skilled care. The documentation from 04-06-20xx would be used to select value “5” (Other Health Care Facility).
Event Date	To clarify the missing data policy.	**Add** under the notes for abstraction: When an event (*Event Type*) begins and ends on different dates this is considered 2 separate events; therefore, both dates must be documented in order to determine the total amount of time associated with each *Event Date*. If one of the event dates is missing, the event will be rejected. • Example: The patient is placed in physical restraints on 6-1-20xx at 23:45. The physical restraints are discontinued at 00:30 on 6-2-20xx. The first event must have documentation of a start date of 6-1-20xx and a start time of 23:45. The first event ends at 23:59. The second event automatically begins at 24:00, so there must be documentation of the end date of 6-2-20xx along with the end time of 00:30.
Exclusive Breast Milk Feeding	To provide additional clarification about exclusive breast milk feeding.	**Add** under the notes for abstraction: If the newborn received drops of water or formula dribbled onto the mothers breast to stimulate latching and not an actual feeding, select yes.
Gestational Age	To provide guidance on conflicting data and additional data sources. Patients with no prenatal care are now excluded from the maternal measures.	**Change** the third paragraph under the notes for abstraction to: If the patient has not received prenatal care, select allowable value UTD. **Change** the sixth paragraph under the notes for abstraction to: 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 or two different numbers are listed in the first document and the correct number can be supported with documentation in the other acceptable data sources in the medical record, the correct number may be entered. **Change** the last paragraph under the notes for abstraction to: It is acceptable to use data derived from vital records reports received from state or

		local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed below.
ICD-9-CM Other Diagnosis Codes	To align with changes in the NHQM.	**Change** the description to: The other or secondary ICD-9-CM codes associated with the diagnosis for this hospitalization. **Change** the Allowable Values to: Any valid diagnosis code as per the CMS ICD-9-CM master code table (ICD-9-CM Full and Abbreviated Code Tables):: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html **Change** the last bullet under suggested data sources to: • UB-04
ICD-9-CM Other Procedure Codes	To align with changes in the NHQM.	**Change** the definition to: The other or secondary ICD-9-CM codes identifying all significant procedures other than the principal procedure. **Note:** If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, *ICD-9-CM Other Procedure Date* exists, etc.) will apply. **Change** the allowable values to: Any valid procedure code as per the CMS ICD-9-CM master code table (ICD-9-CM Long and Abbreviated Titles): http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html. **Change** the third bullet under suggested data sources to: • UB-04
ICD-9-CM Other Procedure Dates	To align with changes in the NHQM.	**Change** the last Allowable Value to: UTD = Unable to Determine **Change** Notes for Abstraction to: • If the procedure date for the associated procedure is unable to be determined

		from medical record documentation, select “UTD.” • The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care [after *Discharge Date*]) **and** no other documentation is found that provides this information, the abstractor should select “UTD.” Examples: ○ Documentation indicates the *ICD-9-CM Other Procedure Dates* was 02- **42** -20xx. No other documentation in the medical record provides a valid date. Since the *ICD-9-CM Other Procedure Dates* is outside of the range listed in the Allowable Values for “Day,” it is not a valid date and the abstractor should select “UTD.” ○ Patient expires on 02-12-20xx and documentation indicates the *ICD-9-CM Other Procedure Dates* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *ICD-9-CM Other Procedure Dates* is after the *Discharge Date* (death), it is outside of the parameters of care and the abstractor should select “UTD.” **Note:** Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for *ICD-9-CM Other Procedure Dates* allows the case to be accepted into the warehouse. **Change** the last bullet under suggested data sources to: • UB-04
ICD-9-CM Principal Diagnosis Code	To align with the changes in the NHQM.	**Change** the definition to: The ICD-9-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization. **Change** the allowable values to: Any valid diagnosis code as per the CMS ICD-9-CM master code table (ICD-9-CM Full and Abbreviated Code Tables): http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html. **Change** the notes for abstraction to:

		None **Change** the third bullet under suggested data sources to; • UB-04 **Change** the inclusion guidelines for abstraction to: None **Change** the exclusion guidelines for abstraction to: None
ICD-9-CM Principal Procedure Code	To align with the changes in the NHQM.	**Change** the definition to: The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication. **Note:** If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, *ICD-9-CM Principal Procedure Date* exists, etc.) will apply. **Change** the allowable values to: Any valid ICD-9-CM procedure code as per the CMS ICD-9-CM-PCS master code table (ICD-9-CM Long and Abbreviated Titles: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html. **Change** the notes for abstraction to; None **Change** the third bullet under the suggested data sources to: • UB-04
ICD-9-CM Principal Procedure Date	To align with changes in the NHQM.	**Change** the last Allowable Value to: UTD = Unable to Determine **Change** Notes for Abstraction to: • If the principal procedure date is unable to be determined from medical record documentation, select “UTD.” • The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid date/format or is outside of the parameters of care [after *Discharge Date*]) **and** no other

		documentation is found that provides this information, the abstractor should select “UTD.” Examples: ○ Documentation indicates the *ICD-9-CM Principal Procedure Date* was 02-**42** -20xx. No other documentation in the medical record provides a valid date. Since the *ICD-9-CM Principal Procedure Date* is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select “UTD.” ○ Patient expires on 02-12-20xx and documentation indicates the *ICD-9-CM Principal Procedure Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *ICD-9-CM Principal Procedure Date* is after the *Discharge Date* (death), it is outside of the parameter of care and the abstractor should select “UTD.” **Note:** Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for *ICD-9-CM Principal Procedure Date* allows the case to be accepted into the warehouse. **Change** the last bullet under suggested data sources to: • UB-04
ICU Admission or Transfer	Data Element added to manual.	All updated.
Initial Blood Culture Collection Date	Data Element added to manual.	All updated.
Initial Blood Culture Collection Time	Data Element added to manual.	All updated.
Labor	To clarify documentation requirements for labor.	**Change** the last paragraph under the notes for abstraction to: • Documentation of labor by the clinician should be abstracted at face value. There is no requirement for acceptable descriptors to be present in order to answer "yes" to labor. • Documentation of regular contractions or cervical change without mention of labor

		cannot be used to answer "yes" to labor.
LDL-c Less Than 100 mg/dL	Data Element added to manual.	All updated.
LVSD	Data Element added to manual.	All updated.
Measure Category Assignment	Changes are being made to provide clarification regarding measures for which better quality is associated with a lower score or numerator. Additional clarification is being provided regarding how the records are included in the measure numerator and/or denominator for aggregate data for such inverse measures. To align with NHQM and the addition of AMI, HF and PN measures.	**Add** under Notes: *Measure Category Assignment* must be transmitted to The Joint Commission but cannot be transmitted to CMS. Files transmitted to the QIO Clinical Warehouse that contain *Measure Category Assignment* will be rejected. **Add** under allowable value D: **Note:** For measures for which better quality is associated with a lower score or numerator, i.e.,HBIPS-4,PC-01, PC-02, PC-04, a Measure Category Assignment of D means that the appropriate care was provided and the intent of the measure was met. For aggregate data, the EOC record will be included in the measure denominator only. **Add** under allowable value E: **Note:** For measures for which better quality is associated with a lower score or numerator, i.e., HBIPS-4, PC-01, PC-02, PC-04, a Measure Category Assignment of E means that the appropriate care was not provided and the intent of the measure was not met. For aggregate data, the EOC record will be included in both the measure numerator and denominator.
Measurement Value	Data Element added to manual.	All updated.
Number of Antipsychotic Medications Prescribed at Discharge	Appendix B was changed to Appendix C for medication tables to align with NHQM. To clarify that all routinely scheduled antipsychotic medications should be	**Change** the first paragraph under the notes for abstraction to: An antipsychotic medication is defined as any of a group of drugs, such as the phenothiazines, butyrophenones or serotonin-dopamine antagonists, which are used to treat psychosis. An antipsychotic medication is also called neuroleptic (refer to Appendix C, Table 10.0- Antipsychotic Medications). All antipsychotic medications should be counted regardless of the indication for use or the reason documented for prescribing the antipsychotic medication.

	counted regardless of the indication for use or reason for prescribing.	**Change** the last paragraph under to notes for abstraction to: Only use Antipsychotic NOS in the following situation: • For new antipsychotics that are not yet listed in Table 10.0 in Appendix C. **Add** to the notes for abstraction: It is acceptable to use data derived from pharmacy reports or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the suggested data sources listed below. **Change** inclusion under guidelines for abstraction to: • Refer to Appendix C, Table 10.0- Antipsychotic Medications **Change** the last bullet for exclusion under guidelines for abstraction to: • Short-acting intramuscular antipsychotic medications (refer to Appendix C, Table 10.1- Short-Acting Intramuscular Antipsychotic Medications)
Parity	To provide guidance on conflicting data and additional data sources.	**Change** the second paragraph under the notes for abstraction to: If parity entered by the clinician in the first document listed above is obviously incorrect (in error) but it is a valid number or two different numbers are listed in the first document 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 last paragraph under the notes for abstraction to: It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed below. **Add** under the notes for abstraction: If the number for parity documented in the EHR includes the delivery for the current hospitalization, parity should be answered as one number less than the number documented. If primagravida is documented select zero for parity.

		Add to inclusions under the guidelines for abstraction: • Para
Patient Referral to Next Level of Care Provider	To clarify the different choices for allowable values 2 and 3. To provide additional guidance on appropriate next level of care providers.	**Change** allowable value 2 to: 2 The medical record contains documentation of one of the following: • the patient or guardian refused the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting • the patient or guardian refused to authorize release of information • the patient was readmitted to the same facility within 5 days after discharge **Change** allowable value 3 to: 3 The medical record contains documentation of one of the following: • the patient eloped and was discharged • the patient failed to return from leave and was discharged • the patient has not yet been discharged from the hospital • 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*. • the patient's residence is not in the USA, and they are returning to another country after discharge **Add** under the notes for abstraction: A referral to attend support groups, i.e., Alcoholics Anonymous (AA), Narcotics Anonymous (NA), etc. after discharge is not a referral to a next level of care provider. A referral to support groups is a next level of care recommendation.
Payment Source	To align with the changes in the NHQM.	**Change** the last bullet under suggested data sources to: • UB-04
Pneumonia Diagnosis: ED/Direct Admit	Data Element added to manual.	All updated.
Prior Uterine Surgery	To include an additional prior uterine surgery which necessitates an	**Add** under inclusions for the guidelines for abstraction: History of a cornual ectopic pregnancy

	elective delivery.	
Reason for No ACEI and No ARB at Discharge	Data Element added to manual.	All updated.
Reason for No Aspirin at Discharge	Data Element added to manual.	All updated.
Reason for Not Exclusively Feeding Breast Milk	To provide greater clarity of the intent of this data element.	This data element has been extensively revised and should be reviewed in it's entirety for the updates.
Reason for Not Initiating Antenatal Steroid Therapy	To clarify a time frame for an imminent delivery and documentation examples of an implied reason for not initiating antenatal steroids.	**Change** under the notes for abstraction to: When determining whether there is a reason documented by a physician/APN/PA or CNM for not initiating antenatal steroid therapy, reasons must be explicitly documented (e.g., "patient had an adverse reaction to the medication in the past - unable to initiate antenatal steroid therapy") or clearly implied (i.e., there is documentation of an imminent delivery which occurs within 2 hours after admission to the hospital, there is documentation the fetus has anomalies which are not compatible with life, there is documentation that the patient has chorioamnionitis).
Reason for Not Prescribing Statin Medication at Discharge	Data Element added to manual.	All updated.
Sex	To align with NHQM and the addition of AMI, HF and PN measures.	**Change** Suggested Data Collection Question to: What was the patient’s sex on arrival? **Change** the last bullet under suggested data sources to: • UB-04
Statin Medication Prescribed at Discharge	Data Element added to manual.	All updated.
Substance Use	To clarify the documentation requirements for	**Add** the following bullets under the notes for abstraction: • The intent of this data element is to screen the patient for substance use within the 12 months prior to admission. Documentation of substance use must at a

	performing the screening history.	minimum state over the past 12 months. Documentation of a past history of substance use should differentiate the use being either within the past 12 months or prior to the 12 month time frame. • Documentation of "no history" cannot be used, unless it is associated with a time frame. For example: ○ “No history of substance use within the past 12 months.” Or ○ "History of substance use 2 years ago." **Delete** the last bullet under the notes for abstraction: • Documentation of a past history of substance use must at a minimum state over the past 12 months or over a longer period of time, i.e., life time history. Documentation of "no history" cannot be used, unless the minimum time frame of 12 months or a longer is specified.
Transfer From Another Hospital or ASC	Data Element added to manual.	All updated.
Violence Risk to Others	To clarify the documentation requirements for performing the screening history.	**Add** the following bullets under the notes for abstraction: • The intent of this data element is to screen the patient for being a violence risk to others within the 6 months prior to admission. Documentation of violence risk must at a minimum state over the past 6 months. Documentation of a past history of violence risk should differentiate the risk being either within the past 6 months or prior to the 6 month time frame. • Documentation of "no history" cannot be used, unless it is associated with a time frame. For example: ○ “No history of violence risk to others within the past 6 months.” Or ○ “History of violence risk to others over a year ago.” **Delete** the last bullet under the notes for abstraction: • Documentation of a past history of violence risk to others must at a minimum state over the past 6 months or over a longer period of time, i.e., life time history. Documentation of "no history" cannot be used, unless the minimum time frame of 6 months or a longer is specified.

Violence Risk to Self	To clarify the documentation requirements for performing the screening history.	**Add** the following bullets under the notes for abstraction: • The intent of this data element is to screen the patient for being a violence risk to self within the 6 months prior to admission. Documentation of violence risk must at a minimum state over the past 6 months. Documentation of a past history of violence risk should differentiate the risk being either within the past 6 months or prior to the 6 month time frame. • Documentation of "no history" cannot be used, unless it is associated with a time frame. For example: ○ “No history of violence risk to self within the past 6 months.” Or ○ “History of violence risk to self over a year ago.” **Delete** the last bullet under the notes for abstraction: • Documentation of a past history of violence risk to self must at a minimum state over the past 6 months or over a longer period of time, i.e., life time history. Documentation of "no history" cannot be used, unless the minimum time frame of 6 months or a longer is specified.

Supplemental Materials

Section	Rationale	Description
Appendix A - ICD-9-CM Code Tables	Table 11.09 was re-named to better reflect the intent of the table. Tables added to the manual based on the addition of measures.	**Change** the name of Table 11.09 to: Multiple Gestations and Other Presentations **Add** Tables: 1.1, 2.1, 2.2, 3.1, 3.2, 3.3, 3.4
Appendix C - Medication Tables	To match the CMS aligned manual naming convention. Tables added to the manual based on the	Is now Appendix C. Was Appendix B before. **Add** Tables: 1.1, 1.2, 1.7, 8.1

	addition of measures.	
Appendix D - Glossary of Terms	To match the CMS aligned manual terms and naming convention.	**Change** lettering from Appendix C to Appendix D. **Remove** the following terms: **contraindication** A factor or condition that may render the administration of a drug or agent or the performance of a procedure or other practice inadvisable, improper, and/or undesirable. **measurement system** See *performance measurement system*. **protected (personal) health information (PHI)** A subset of health information, including demographics, that identifies the individual or for which there is a reasonable basis to believe that it can be used to identify the individual. **Change** the following terms to: **Acute Myocardial Infarction (AMI)** Death of heart muscle resulting from insufficient blood supply to the heart. For purposes of this measure set, acute myocardial infarction is identified by the ICD-9-CM codes in Appendix A, Table 1.1. **Episode of Care (EOC)** An Episode of Care (EOC) is defined as the health care services given during a certain period of time, usually during a hospital stay (e.g., from the day of arrival or admission to the day of discharge). **General Data Elements** Data elements that must be collected by hospitals for each patient record. These data are patient demographic data, hospital identifiers, and patient identifiers. **Hospital Inpatient Quality Reporting Program** The Hospital Inpatient Quality Reporting Program initiative is intended to empower consumers with quality of care information to make more informed decisions about their health care, while encouraging hospitals and clinicians to improve the quality of inpatient care provided to all patients. The hospital quality of care information gathered through the Hospital Inpatient Quality Reporting Program initiative is available to consumers on the Hospital Compare website. **National Hospital Inpatient Quality Measure** A standardized performance measure that meets the Centers for Medicare & Medicaid Services and Joint Commission evaluation criteria, has precisely defined specifications, can be uniformly embedded in extant systems, has standardized data collection protocols to permit uniform

		implementation by health care organizations and permit comparisons of health care organization performance over time through the establishment of a national comparative data base. **National Hospital Inpatient Quality Measure Set** A unique grouping of performance measures carefully selected to provide, when viewed together, a robust picture of the care provided in a given area (e.g., cardiovascular care). **parity** The number of live deliveries the patient experienced prior to current hospitalization. **Sampling Method** Describes the process used to select a sample. Sampling approaches for national hospital inpatient quality measures are simple random sampling and systematic sampling. Refer to the “Sampling Approaches” discussion in the Population and Sampling Specifications section for further information. **stratified measure** A performance measure that is classified into a number of strata to assist in analysis and interpretation. The overall or un-stratified measure evaluates all of the strata together. The stratified measure or each stratum consists of a subset of the overall measure. For example, surgical patients who received a prophylactic antibiotic within one hour prior to surgical incision is reported as all surgical patients with the appropriate *ICD-9-CM Principal Procedure Code*, who received the prophylactic antibiotic within one hour prior to surgical incision; however, the stratified measure(s) for SCIP-Inf-1 is reported by the specific ICD-9-CM Principal Procedure, such as CABG (SCIP-Inf-1b) or Other Cardiac Surgery (SCIP-Inf-1c). **Surgical Care Improvement Project (SCIP)** The Surgical Care Improvement Project (SCIP) is a national quality partnership of organizations focused on improving surgical care by significantly reducing surgical complications through performance measurement. Utilizing ten process measures in three separate modules (infection, cardiac, and VTE), the goal is to reduce the incidence of surgical complications nationally **Add** the following terms: **augmentation of clozapine** The addition of a second antipsychotic medication for patients receiving clozapine. **chemotherapy** For purposes of the PN and IMM measure sets, chemotherapy is defined as antineoplastic agents used to treat cancer. Types include targeted agents,

		alkylating agents, antimetabolites, plant alkaloids and terpenoids, topoisomerase inhibitors, antitumor antibiotics, monoclonal antibodies, and biologics and related agents. Hormonal therapies are not included. **emergency department (ED)** A portion of the hospital where emergency diagnosis and treatment of illness or injury is provided. **emergency medical system (EMS)** Network of services coordinated to provide aid and medical assistance from primary response to definitive care, involving personnel trained in the rescue, stabilization, transportation, and advanced treatment of traumatic or medical emergencies. **immunization (IMM)** The process by which a person becomes protected against a disease through vaccination or inoculation. For the purposes of this measure set, the population is defined as hospitalized inpatients screened for pneumococcal and seasonal influenza immunization status. **monotherapy** The use of a single antipsychotic medication. **substance use (SUB)** For the purposes of the Substance Use measure set (SUB) substance use includes unhealthy alcohol use and drug abuse or dependence including opioids, sedative/hypnotics, cocaine, cannabis, amphetamines, and hallucinogens. **tobacco use (TOB)** For the purposes of the Tobacco Treatment measure set (TOB), tobacco use includes cigarettes, pipes, cigars and smokeless tobacco products. **Add** the following Selected References: Disease-Specific Care Certification Manual, 2nd Edition. Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL. 2005. Mosby's Dictionary of Medicine, Nursing & Health Professions, 7th Edition. Mosby Elsevier, St. Louis, MO. 2006. *2008 Comprehensive Accreditation Manual for Hospitals*; The Joint Commission, Oakbrook Terrace, Illinois, 2007. Taber's Cyclopedic Medical Dictionary. F.A. Davis Company, Philadelphia, PA. 1997.
Appendix E - Overview of Measure Information	To match the CMS aligned manual naming	Is now Appendix E. Was Appendix D before.

Form and Flowchart Formats	convention.	
Appendix G - Resources	To match the CMS aligned manual naming convention.	Is now Appendix G. Was Appendix F before.
Appendix H - Miscellaneous Tables	To match the CMS aligned manual naming convention.	Is now Appendix H. Was Appendix E before. Removal of Table 2.7 - it is now linked in Transmission documentation.
Appendix P - preview section of ICD-10 Crosswalks of code tables	Yearly maintenance of crosswalk tables.	Table 11.13.1, Table 11.16.1 and Table 11.17 were removed due to the lack of specific weight codes. Table 11.01.1 will replace Table 11.01, Table 11.02, Table 11.03 and Table 11.04 in order to identify patients delivering during the hospitalization. Table 11.09 was renamed to "Multiple Gestations and Other Presentations".
Appendix P - preview section of ICD-10 Code Tables	Yearly maintenance of code tables.	Table 11.13.1, Table 11.16.1 and Table 11.17 were removed due to the lack of specific weight codes. Table 11.01.1 will replace Table 11.01, Table 11.02, Table 11.03 and Table 11.04 in order to identify patients delivering during the hospitalization. Table 11.09 was renamed to "Multiple Gestations and Other Presentations".
Introduction to the Data Dictionary	To clarify the use of prenatal forms for EHR abstraction.	**Change** under General Abstraction Guidelines to: The intent of abstraction is to use only documentation that was part of the medical record during the hospitalization (is present upon discharge) and that is present at the time of abstraction. There are instances where an addendum or late entry is added after discharge. This late entry or addendum can be used, for abstraction purposes, as long as it has been added within 30 days of discharge, [Refer to the Medicare Conditions of Participation for Medical Records, 42CFR482.24(c)(2)(viii)], unless otherwise specified in the data element. Documents containing amendments, corrections, or delayed entries must employ the following widely accepted record keeping principles (CMS Medicare Program Integrity Manual Chapter 3, Section 3.3.2.4):

		• Clearly and permanently identify any amendments, corrections or addenda; • Clearly indicate the date and author of any amendments, corrections, or addenda; and • Clearly identify all original content. Prenatal forms which are available during the hospitalization and become a permanent part of the patients medical record (electronic health record/EHR or paper)for the current hospitalization may be used for abstraction. It is not the intent to have documentation added at the time of abstraction to ensure the passing of a measure.
Missing and Invalid Data	Clarification of Missing and Invalid Data.	**Change** Missing and Invalid Episode of Care (EOC) and Event Data first bullet to: • The majority of general data elements that are missing data cause the EOC and event records to be rejected. These data elements for *Discharge measure* include but not limited to *Admission Date*, *Birthdate*, *Discharge Date*, and *ICD-9-CM Principal Diagnosis Codes*. For *Event measures* such general data elements include but not limited to *event-type*, *event-date*, *Admission Date*, and *Birthdate*. Refer to the Introduction to the Data Dictionary in this manual for the complete list of general data elements. ◦ Not all patients have an ICD-9-CM Other Diagnosis Code or an ICD-9-CM Principal and Other Procedure Codes. Records will be accepted with missing data for this data element.
Table of Contents	Addition of measures released from the CMS aligned manual. Appendixes renamed and reordered to align with CMS aligned manual.	Addition of AMI, HF and PN measure sets. Renamed and reordered the Appendixes.
Transmission of Data	Alignment with CMS aligned manual.	**Changed** Document format changed to resemble the Aligned Manual Transmission document. Clinical XML Layout document updated to match the Data Dictionary changes, and the time period as updated. Allowable Measure Set Combination table 2.7 in Appendix H (misc Appendix) is moved into transmission document as an excel attachment.

Using the The Joint Commission's National Measure Specifications Manual	Alignment with CMS aligned manual.	**Changed** Appendix letters to match CMS naming convention. **Add** this sentence before Section 1: This manual contains references to CMS and QIO programs that, while not applicable to the Joint Commission, have been retained to remain consistent with the CMS and Joint Commission aligned *Specifications Manual for National Hospital Inpatient Quality Measures*.