Release Notes for the 2016A Manual

Measure Information Forms

Section	Rationale	Description
HBIPS-5	Revisions were made to HBIPS-5 due to the retirement of measures HBIPS-4, HBIPS-6 and HBIPS-7 and the associated data elements. The denominator statement, included populations and excluded populations were revised A new data element Patient Status at Discharge was created, since Patient Referral to Next Level of Care Provider has been retired.	**Change** the denominator statement to: Psychiatric inpatient discharges **Add** under denominator included populations: Patients with ICD-10-CM Principal or Other Diagnosis Codes for Mental Disorders as defined in Appendix A, Table 10.01 discharged on two or more routinely scheduled antipsychotic medications (refer to Appendix C, Table 10.0- Antipsychotic Medications). **Remove** under denominator excluded populations: • Patient's residence is not in the USA, and they are returning to another country after discharge **Remove** under denominator data elements: *Patient Referral to Next Level of Care Provider* **Add** under denominator data elements: *Patient Status at Discharge* **Algorithm changes Remove** Patient Referral to Next Level of Care Provider **Add** with new data element: Patient Status at Discharge **Change** Denominator Statement to: Psychiatric inpatient discharges
PC-01	Clinical trial was removed, since this is a rare occurrence and in order to align with the eCQM version of the measure.	**Remove** under denominator excluded populations: Enrolled in clinical trials **Remove** under denominator data elements: Clinical Trial **Algorithm Changes:** **Remove** *Clinical Trial*
PC-02	Clinical trial was removed as a denominator exclusion,	**Remove** under denominator excluded populations: Enrolled in clinical trials

	since this is a rare occurrence. Risk adjustment has been removed due to recent evidence that variation in rates is related primarily to provider practice and not risk factors.	**Remove** under denominator data elements: *Clinical Trial* **Remove** all references to risk adjustment. **Algorithm Changes:** **Remove** *Clinical Trial*
PC-03	Clinical trial was removed as a denominator exclusion, since this is a rare occurrence.	**Remove** under denominator excluded populations: Enrolled in clinical trials **Remove** under denominator data elements: *Clinical Trial* **Algorithm Changes:** **Remove** *Clinical Trial*
PC-04	Clinical Trial was removed as a denominator exclusion, since this is a rare occurrence.	**Remove** under denominator excluded populations: Enrolled in clinical trials **Remove** under denominator data elements: *Clinical Trial* **Algorithm Changes:** **Remove** *Clinical Trial*
PC-05	Clinical trial was removed as a denominator exclusion, since this is a rare occurrence and in order to align with the eCQM version of the measure.	**Remove** under denominator excluded populations: Enrolled in clinical trials **Remove** under denominator data elements: *Clinical Trial* **Algorithm Changes:** **Remove** *Clinical Trial* **Change** Discharge Disposition allowable value to: • If *Discharge Disposition* equals to 4, 5, 6, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing. • If *Discharge Disposition* equals to 1, 2, 3, 7, 8 , continue processing and proceed to *Term Newborn*.

STK-1	Removal of Aspirin(9) and GCS(4) from VTE Prophylaxis. References have been updated to reflect current evidence.	**Algorithm change** **Change** VTE Prophylaxis allowable values to: A, 1, 2, 3, 5, 6, 7 or 8 **Add** to Selected References: Qaseem A., R. Chou, L. L. Humphrey, M. Starkey, P. Shekelle. “Clinical Guidelines Committee of the American College of Physicians. Venous Thromboembolism Prophylaxis In Hospitalized Patients: A Clinical Practice Guideline from the American College of Physicians.” [In eng]. Ann Intern Med 155, no. 9 (Nov 2011): 625-32.
STK-10	References have been updated to reflect current evidence.	Selected References: **Add** Management of Stroke Rehabilitation Working Group. VA/DoD clinical practice guideline for the management of stroke rehabilitation. Washington (DC): Veterans Health Administration, Department of Defense; 2010. **Remove** Affairs, Department of Veterans, and Department of Defense. "Va/Dod Clinical Practice Guideline for the Management of Stroke Rehabilitation in the Primary Care Setting," In, (2003).
STK-2	References have been updated to reflect current evidence.	**Update** Selected References: Kernan, W.N., B. Ovbiagele, H. R. Black, D. M. Bravata, M. I. Chimowitz, M. D. Ezekowitz, M. C. Fang, M. Fisher, K. L. Furie, D. V. Heck, S. C. Johnston, S. E. Kasner, S. J. Kittner, P. H. Mitchell, M. W. Rich, D. Richardson, L. H. Schwamm, J. A. Wilson. “Guidelines for the Prevention of Stroke in Patients with Stroke and Transient Ischemic Attack: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association.” [in eng.] Stroke 45, no. 7 (May 2014): 2160-223 **Deleted** Selected References: Furie, K. L., S. E. Kasner, R. J. Adams, G. W. Albers, R. L. Bush, S. C. Fagan, J. L. Halperin, et al. "Guidelines for the Prevention of Stroke in Patients with Stroke or Transient Ischemic Attack: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association." [In eng]. Stroke 42, no. 1 (Jan 2011): 227-76. Sacco, R. L., R. Adams, G. Albers, M. J. Alberts, O. Benavente, K. Furie, L. B. Goldstein, et al. "Guidelines for Prevention of Stroke in Patients with Ischemic Stroke or Transient Ischemic Attack: A Statement for Healthcare Professionals from the American Heart Association/American Stroke Association Council on Stroke: Co-Sponsored by the Council on Cardiovascular Radiology and Intervention: The American Academy of Neurology Affirms the Value of This Guideline." [In eng]. Stroke 37, no. 2 (Feb 2006): 577-617.
STK-3	References have been updated to reflect current	**Updated** Selected References: Kernan, W.N., B. Ovbiagele, H. R. Black, D. M. Bravata, M. I. Chimowitz, M. D. Ezekowitz, M. C.

	evidence.	Fang, M. Fisher, K. L. Furie, D. V. Heck, S. C. Johnston, S. E. Kasner, S. J. Kittner, P. H. Mitchell, M. W. Rich, D. Richardson, L. H. Schwamm, J. A. Wilson. “Guidelines for the Prevention of Stroke in Patients with Stroke and Transient Ischemic Attack: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association.” [in eng.] Stroke 45, no. 7 (May 2014): 2160-223. **Deleted** Selected References: Furie, K. L., S. E. Kasner, R. J. Adams, G. W. Albers, R. L. Bush, S. C. Fagan, J. L. Halperin, et al. "Guidelines for the Prevention of Stroke in Patients with Stroke or Transient Ischemic Attack: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association." [In eng]. Stroke 42, no. 1 (Jan 2011): 227-76. Sacco, R. L., R. Adams, G. Albers, M. J. Alberts, O. Benavente, K. Furie, L. B. Goldstein, et al. "Guidelines for Prevention of Stroke in Patients with Ischemic Stroke or Transient Ischemic Attack: A Statement for Healthcare Professionals from the American Heart Association/American Stroke Association Council on Stroke: Co-Sponsored by the Council on Cardiovascular Radiology and Intervention: The American Academy of Neurology Affirms the Value of This Guideline." [In eng]. Stroke 37, no. 2 (Feb 2006): 577-617.
STK-4	Prescribing information about the contraindications and warnings for the administration of tPA were revised by the manufacturer in February 2015. The change updates the selected reference for FDA labeling instructions	Selected References. **Change** last bullet to: • U.S. Drug and Food Administration. (2015). “Label-Activase-Food and Drug.”
STK-6	References have been updated to reflect current evidence.	**Update** Selected References: Kernan, W.N., B. Ovbiagele, H. R. Black, D. M. Bravata, M. I. Chimowitz, M. D. Ezekowitz, M. C. Fang, M. Fisher, K. L. Furie, D. V. Heck, S. C. Johnston, S. E. Kasner, S. J. Kittner, P. H. Mitchell, M. W. Rich, D. Richardson, L. H. Schwamm, J. A. Wilson. “Guidelines for the Prevention of Stroke in Patients with Stroke and Transient Ischemic Attack: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association.” [in eng.] Stroke 45, no. 7 (May 2014): 2160-223. **Deleted** Selected References: Furie, K. L., S. E. Kasner, R. J. Adams, G. W. Albers, R. L. Bush, S. C. Fagan, J. L. Halperin, et al. "Guidelines for the Prevention of Stroke in Patients with Stroke or Transient Ischemic Attack:

		A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association." [In eng]. Stroke 42, no. 1 (Jan 2011): 227-76.

Data Elements

Section	Rationale	Description
Admission to NICU	Clarification was added to address admissions for observation.	**Change** the second paragraph under the notes for abstraction to: 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. There is no time limit for admission to observation. **Add** under the notes for abstraction: If your hospital does not have a NICU, you must always select Value "no" regardless of any reason a newborn is admitted to a nursery.
Antithrombotic Therapy Administered by End of Hospital Day 2	These changes provide clarification in response to questions received from abstractors and clinicians.	Notes for Abstraction **Added** fifth bullet: • Lovenox SQ for VTE prophylaxis (i.e. enoxaparin SQ 40 mg once daily; enoxaparin SQ 30 mg Q12 hours) is not sufficient. If no other antithrombotic therapy is administered by the end of hospital day 2, select “No.”
Appropriate Justification for Multiple Antipsychotic Medications	Revisions were made to reflect the retirement of HBIPS-6 and HBIPS-7.	**Remove** the second paragraph under the notes for abstraction: The recommended plan to taper to monotherapy must appear in the continuing care plan transmitted to the next level of care provider. If an addendum about the recommended plan to taper to monotherapy is added to the continuing care plan within the medical record, it must occur within 5 days after discharge or prior to transmission of the continuing care plan. All other justifications may be documented anywhere in the medical record. **Remove** under suggested data sources: Continuing Care Plan
Arrival Date	These changes provide clarification in response to questions received from abstractors and clinicians.	Notes for Abstraction **Add** third sub-bullet to fourth bullet: • ED Triage Date/Time 06-18-20xx 0025. EMS report indicates patient arrived by ambulance on 06-17-20xx 2355. Patient routed directly to CT. The EMS report is disregarded. Enter 06-18-20xx for Arrival Date. **Change** sixth bullet to:

		• The source “Emergency Department record” includes any documentation from the time period that the patient was an ED patient, (e.g., ED face sheet, ED consent/Authorization for treatment forms, ED/Outpatient Registration/sign-in forms, ED vital sign record, ED triage record, ED physician orders, ED ECG reports, ED telemetry/rhythm strips, ED laboratory reports, ED x-ray reports, ED Head CT scan reports).
Arrival Time	These changes provide clarification in response to questions received from abstractors and clinicians.	Notes for Abstraction **Add** third sub-bullet to fifth bullet: • ED Triage Time 1525. EMS report indicates patient was receiving care 1435 through 1455. ED report documents time of Head CT 1505. The EMS report is disregarded. Enter 1505 for Arrival Time. **Change** seventh bullet to: • The source “Emergency Department record” includes any documentation from the time period that the patient was an ED patient, (e.g., ED face sheet, ED consent/Authorization for treatment forms, ED/Outpatient Registration/sign-in forms, ED vital sign record, ED triage record, ED physician orders, ED ECG reports, ED telemetry/rhythm strips, ED laboratory reports, ED x-ray reports, ED Head CT scan reports).
Atrial Fibrillation/Flutter	Exception no longer applies to the data element.	**Remove** EXCEPTION: If there is conflicting documentation of atrial fibrillation or flutter during the hospitalization, the most current cardiologist documentation should be used. If cardiology documentation is unavailable, the most current documentation by other physician/APN/PA should be used.
Clinical Trial	Clinical trial was removed from all of the PC measures, since this is a rare occurrence and in order to align with the eCQM versions of the PC measures. Measures and measure sets are being removed from CMS’ Hospital Inpatient Quality Reporting program and The Joint Commission’s Flexible ORYX® performance reporting requirements	**Remove** all references to PC under collected for, definition, data collection question, allowable values and the notes for abstraction. **Remove** all references to AMI, CAC and SCIP **Add** to Notes for Abstraction: ACHF and ACHFOP: Only capture patients enrolled in clinical trials studying patients with heart failure.

	beginning with 1/1/2016 discharges.	
Date Last Known Well	These changes provide clarification in response to questions received from abstractors and clinicians.	Inclusion Guidelines for Abstraction **Add:** Code Stroke Form • Stroke Activation Form • Stroke Alert Form • Stroke Assessment Form • Stroke Intervention Form • Stroke Rapid Response Form • Thrombolysis Checklist • tPA Eligibility Form Exclusion Guidelines for Abstraction **Change** to: Code Stroke Form • Stroke Education Form • Core Measure Form
ED Patient	To differentiate between ED and STK Measures	**Added** to ED Subheading (Abstraction Guidelines for ED Measures Only)
Education Addresses Activation of Emergency Medical System	These changes provide clarification in response to questions received from abstractors and clinicians.	**Notes for Abstraction** **Change first bullet to:** Educational material must address activation of the emergency medical system (EMS) if signs or symptoms of stroke or transient ischemic attack (TIA) occur. Example: “Call 911 immediately if you experience signs or symptoms of stroke, such as sudden numbness or weakness of an extremity.” Add new second and third bullets: If the medical record does not contain documentation of education regarding stroke and EMS activation, select “No.” Examples: “Stroke binder given to patient’s family.” “Aneurysm education completed.” If documentation reflects educational material regarding EMS activation was given to the

		patient/caregiver, select “Yes”, even if a copy of the material is not present in the medical record. **Remove:** Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs. **Add new sentence in fourth bullet:** This applies to educational materials in the form of discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, DVDs or other patient-oriented materials. Providing a link to electronic materials is not sufficient. **Add new seventh bullet:** If there is documentation that instructions were given or sent to the patient/caregiver after discharge, select “No.” Suggested Data Sources **Add:** Excluded Data Sources: Any documentation dated/timed after discharge, except discharge summary. Inclusion Guidelines for Abstraction: Warning Signs and Symptoms of Stroke Add new bullet: F.A.S.T. (Face, Arms, Speech, Time)
Education Addresses Follow-up After Discharge	These changes provide clarification in response to questions received from abstractors and clinicians	Notes for Abstraction **Add** new first, second, third, and fourth bullets: • Educational material must address follow-up after discharge. Example: “It is important for you to keep all follow-up appointments with your physician and reschedule appointments that you cannot make as soon as possible.” Educational material which addresses follow-up after discharge for transient ischemic attack (TIA) is acceptable. • If the medical record contains documentation of education that does not include stroke and follow-up after discharge, select “No.” Examples: “Stroke binder given to patient’s family.” “Aneurysm education completed.” • Documentation must reflect that follow-up after discharge will be with a physician/APN/PA in order to select “Yes” for this data element. The date, time, and name of the provider may be mentioned in the written material but all three are not required to select “Yes”. **Add** new sixth bullet:

		• If documentation reflects that educational material regarding follow-up after discharge was given to the patient/caregiver, select “Yes”, even if a copy of the material is not present in the medical record. **Remove:** • Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs. **Add** new sentence in seventh bullet: This applies to educational materials in the form of discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, DVDs or other patient-oriented materials. Providing a link to electronic materials is not sufficient. **Add** new tenth bullet: • If the medical record contains documentation that instructions were given or sent to the patient/caregiver after discharge, select “No.” Suggested Data Sources **Add:** Excluded Data Sources: Any documentation dated/timed after discharge, except discharge summary. Exclusion Guidelines for Abstraction **Add** new bullets: • Follow-up noted only “as directed” or “as instructed” • Follow-up only in the form of a direction to the patient to bring a copy of a form to their next appointment
Education Addresses Medication Prescribed at Discharge	These changes provide clarification in response to questions received from abstractors and clinicians.	Notes for Abstraction **Change** to: Abstraction is a two-step process: 1. Compile a list of all of the medications being prescribed at discharge, based on available medical record documentation. • **ALL** discharge medication documentation in the chart should be reviewed and taken into account by the abstractor. • Discharge medication information included in a discharge summary dated after discharge should be used as long as it was added within 30 days after discharge. • If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use

the dictated date/time over transcribed date/time, file date/time, etc.
Examples:
    - Two discharge summaries, one dictated 5/22 (day of discharge) and one dictated 5/27 - Use the 5/27 discharge summary.
    - Two discharge medication reconciliation forms, one not dated and one dated 4/24 (day of discharge) - Use both.
- If discharge medications are noted using only references such as “continue home meds,” “resume other meds,” or “same medications,” rather than lists of the names of the discharge medications, the abstractor should use all sources to compile a list of medications the patient was on prior to arrival (or in the case of acute care transfers, use the medications the patient was on prior to arrival at the first hospital).
- Discharge medications can be listed in any of the acceptable data sources to be considered a discharge medication. If there is a medication in one source that is not mentioned in other sources, consider it a discharge medication.
  Example:
    - Discharge orders list Lasix but the discharge medication reconciliation form does not mention Lasix. Consider Lasix a discharge medication.
- If there is documentation in the medical record that specifically states a medication was NOT prescribed at discharge, do not consider it a discharge medication.
- If documentation is contradictory (e.g., physician noted “d/c ASA” in the discharge orders, but it is listed in the discharge summary’s discharge medication list), or, after careful examination of circumstances, context, timing, etc., documentation is still unclear, the case should be deemed "unable to determine” (select "No”).
- If there is documentation of a plan to start/restart a medication after discharge or a hold has been placed on a medication for a **defined** timeframe after discharge (e.g., “Start Plavix as outpatient,” “Hold Lasix x 2 days,” “Hold ASA until after endoscopy”), consider this a discharge medication requiring education.
- Disregard a medication documented **only** as a recommended medication for discharge. e.g., “Recommend sending patient home on Vasotec.” Documentation must reflect that the medication was actually prescribed at discharge.
- If a medication name is missing from a discharge medication source, disregard the medication.
- Disregard a discharge medication list labeled as “preliminary” or “interim”.
- As needed (PRN) medications are required on the discharge instructions, with ONE exception: When discharge medications outside of the written discharge instructions are noted using ONLY references such as “continue current medications” or “continue present meds,” rather than lists of the names of the discharge medications, and the abstractor is referencing what medications the patient was taking on the day of discharge (for

comparison against the written discharge instructions, to confirm completeness of that list), medications which are clearly listed as PRN (given on an as needed basis only) do NOT need to be included in the instructions.
- Medications which the patient will not be taking at home (and/or the caregiver will not be giving at home) are NOT required in the medication list included in the written discharge instructions (e.g., monthly B12 injections, dialysis meds, chemotherapy).

2. Check this list of discharge medications against the written discharge instructions given to the patient to ensure that the discharge se instructions addressed at least the names of all of the discharge medications prescribed. If medications are included in the discharge instructions that are not on the a list of discharge medications, or discharge medications are missing from the list in the instructions and it cannot be determined that the list of medications in the instructions is complete, then the case should be deemed “unable to determine” (select “No”).
Example:
Lasix is a medication listed on the discharge instruction sheet but Lasix is not in the discharge summary or documented as a discharge medication elsewhere in the medical record, select “No.”

- **EXCEPTION**: Medications listed on the discharge instructions but not mentioned as discharge medications elsewhere in the medical record are acceptable if the physician/APN/PA has signed or initialed the discharge instructions. Signatures that are dated/ timed after discharge are not acceptable.
  Example:
  - Discharge instruction sheet lists Plavix and aspirin. No other mention of Plavix or aspirin as a discharge medication in the medical record. Discharge instruction sheet is signed by Dr. X – Select “Yes.”
- In making medication name comparisons, consider two medications that are **brand/trade name vs. generic name** in nature or that have the **same generic equivalent** as matches.
  Examples of matches:
  - Coumadin vs. Warfarin
  - ASA vs. EC ASA
  - Plavix vs. Clopidogrel
  - Mevacor vs. Lovastatin
  - Lopressor vs. Metoprolol
  - Metoprolol vs. Metoprolol Succinate
    Example of a mismatch:
  - Lopressor vs. Toprol
- If there is documentation that the patient was discharged on insulin(s) of ANY kind, ANY reference to insulin as a discharge medication in the written discharge instructions can be

considered a match, for the purposes of the Stroke Education measure (STK-8). E.g., D/C summary notes patient discharged on “Humulin Insulin” and “Insulin 70/30” is listed on the discharge instruction sheet – Consider this a match. However, contradictory documentation abstraction guidelines still apply to insulin cases (e.g., D/C summary notes patient discharged on “Novolog 50 unit’s t.i.d.” and “Novolog 50 unit’s t.i.d.” is discontinued on discharge medication reconciliation form – Select “No”).

- Medications must be listed on the discharge instruction by name. Documentation to continue home medications without documentation of home medications listed by name, select “No.”
- Do not give credit in cases where there is a reference to a medication by class only on the written discharge instructions, (e.g., “Continue ACEI Inhibitor”), select “No.”
- Do not give credit in cases where the patient was given written discharge medication instructions **only** in the form of written prescriptions.
- Documentation must clearly convey that the patient/caregiver was given a copy of the discharge instructions to take home which listed all discharge medications prescribed for the patient by name. When the discharge instructions are present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.
- **Use only documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver.
- Written instructions given or sent to the patient/caregiver after discharge, select “No.”
- If the patient refused written discharge instructions/material which addressed discharge medications, select “Yes.”
- If documentation indicates that written instructions/material on discharge medications were not given because the patient is cognitively impaired (e.g., comatose, obtunded, confused, short-term memory loss) and has no caregiver available, select “Yes.”
- The caregiver is defined as the patient’s family or any other person (e.g.,home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.

Suggested Data Sources

Add:

Excluded Data Sources:

Any documentation dated/timed after discharge, except discharge summary.

Exclusion Guidelines for Abstraction

		Change to: • Laxatives • Antacids • Proton pump inhibitors • Vitamins • Minerals (EXCEPT potassium) • Food supplements • Herbs • Medications listed by class only (e.g., “heparinoids”) • Oxygen

Education Addresses Risk Factors for Stroke	These changes provide clarification in response to questions received from abstractors and clinicians.	Notes for Abstraction
		Add sub-bullet under third bullet:
		• **Individual risk factors that are not mentioned in the context of education provided on the risk factors for stroke, do not count** (e.g., discharge instruction to limit alcohol without explicit documentation that excessive alcohol consumption is a risk factor for stroke).
		  ○ If individual risk factors are mentioned in the context of education provided on the risk factors for stroke, then it may be inferred that the education was personalized and patient-specific.
		Add new fourth, fifth, and sixth bullets:
		• Educational material which addresses risk factors for transient ischemic attack (TIA) is acceptable.
		• Documentation of education which does not include stroke and risk factors, select “No.” Examples:
		  ○ “Stroke binder given to patient’s family.”
		  ○ “Aneurysm education completed.”
		• If documentation reflects that educational material regarding risk factors for stroke was given to the patient/caregiver, select “Yes”, even if a copy of the material is not present in the medical record.
		Remove:
		• Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.
		Add new sentence in seventh bullet:
		• This applies to educational materials in the form of discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, DVDs or other patient-oriented materials. Providing a link to electronic materials is not sufficient.

		Add new tenth bullet: • If the medical record contains documentation that instructions were given or sent to the patient/caregiver after discharge, select “No.” Suggested Data Sources **Add:** Excluded Data Sources: Any documentation dated/timed after discharge, except discharge summary.
Education Addresses Warning Signs and Symptoms of Stroke	These changes provide clarification in response to questions received from abstractors and clinicians.	Notes for Abstraction **Change** first bullet to: • Educational material must address what to do if warning signs or symptoms of stroke or transient ischemic attack (TIA) are noted. Example: “Call 911 immediately if you experience signs or symptoms of stroke, such as sudden numbness or weakness of an extremity.” **Add** new second and third bullets: • If the medical record contains documentation of education that does not include stroke and warning signs and symptoms, select “No.” Examples: ○ “Stroke binder given to patient’s family.” ○ “Aneurysm education completed.” • If documentation reflects that educational material regarding warning signs or symptoms of stroke was given to the patient/caregiver, select “Yes”, even if a copy of the material is not present in the medical record. **Remove:** • Acceptable materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs. **Add** new sentence in fourth bullet: • This applies to educational materials in the form of discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, DVDs or other patient-oriented materials. Providing a link to electronic materials is not sufficient. **Add** new seventh bullet: • If the medical record contains documentation that instructions were given or sent to the patient/caregiver after discharge, select “No.” Suggested Data Sources **Add:**

		Excluded Data Sources: Any documentation dated/timed after discharge, except discharge summary. Inclusion Guidelines for Abstraction: Warning Signs and Symptoms of Stroke **Add new bullet:** • F.A.S.T. (Face, Arms, Speech, Time)
Elective Carotid Intervention	These changes provide clarification in response to questions received from abstractors and clinicians.	Notes for Abstraction **Change** to: • When documentation clearly indicates that the carotid intervention is elective (e.g., admitting orders to obtain informed consent for a carotid procedure; pre-operative testing completed prior to admission; surgical orders for carotid endarterectomy dated prior to arrival; physician office visit documentation prior to arrival stating, “CEA with Dr. X planned in the near future”), select “Yes.” • Patients who are sent to the hospital by their physician and admitted for performance of a carotid intervention, select “Yes.” • Patients admitted to the hospital for purposes of performance of a carotid intervention and the intervention cancelled/postponed during the hospital stay, select “Yes.” • Patients who request admission to the hospital for performance of a carotid intervention, select “Yes.” • Patients transferred to the hospital for purposes of surgical evaluation for performance of a carotid intervention, select “Yes.” • When the patient is directly admitted to the hospital post-procedure following an elective carotid intervention performed as an outpatient, select “Yes.” Example: Patient scheduled for elective carotid endarterectomy right side on 05/17/20xx at 08:30. Patient checks into outpatient surgery at 06:13 and proceeds to the O.R., then to PACU. Patient status is changed to inpatient at 11:35 on 05/17/20xx. Patient discharged home on 05/18/20xx. **EXCEPTION:** Patients with documentation of an elective carotid intervention performed and discharged from the outpatient setting prior to hospital admission for stroke. Example: Pt. scheduled for outpatient placement of an elective right carotid stent on 05/17/20xx. Patient discharged home on 05/17/20xx following the procedure. Patient arrives in the ED two days later with complaints of syncope and left-sided numbness, and is admitted to the hospital on 05/19/20xx. • Patients who are symptomatic and come to the ED for treatment of stroke signs and symptoms and then admitted to the hospital are not considered elective admissions, even

		if a carotid intervention was performed after admission, select “No.” • When documentation of the procedure is not linked with “elective,” select “No.”
Exclusive Breast Milk Feeding	Clarification was added to help identify actual feedings the newborn received in order to determine exclusive breast milk feeding.	**Add** under the notes for abstraction: If the newborn received IV fluids this is the same as a medication and not a feeding. Actual feedings must be abstracted from the only acceptable data sources regardless of any documentation about feeding plans and changes to feeding plans which mention inclusion of formula. **Add** under suggested data sources: • Diet flow sheets **Change** under suggested data sources to: ONLY ACCEPTABLE SOURCES: • Diet flow sheets • Feeding flow sheets • Intake and output sheets
Initial Patient Population Size Medicare Only	Adding STK to the TJC manual.	**Add** STK to examples and content when needed.
Initial Patient Population Size Non-Medicare Only	Adding STK to the TJC manual.	**Add** STK to examples and content when needed.
IV OR IA Thrombolytic (t-PA) Therapy Administered at This Hospital or Within 24 Hours Prior to Arrival	These changes provide clarification in response to questions received from abstractors and clinicians.	Notes for Abstraction **Add** second and third bullets: • If there is documentation that the patient received IV or IA thrombolytic (t-PA) therapy and mechanical thrombectomy at this hospital or within 24 hours prior to arrival, select “Yes.” • If there is documentation that the patient received mechanical thrombectomy only with no IV or IA thrombolytic (t-PA) given, select “No.”

Labor	Clarification was added for acceptable documentation for labor.	**Change** the second and third paragraphs under the notes for abstraction to:
		• Documentation of labor by the clinician should be abstracted at face value, e.g., admit for management of labor, orders for labor, etc. There is no requirement for acceptable descriptors to be present in order to answer "yes" to labor.
		• 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 **Add** under suggested data sources: • Labor flow sheet • Physician orders **Change** under the guidelines for abstraction inclusion to: The following are acceptable descriptors for labor: • Active • Early • Latent • Spontaneous **Change** under the guideline for abstraction exclusion to: The following is not an acceptable descriptor for labor: • Prodromal
Last Known Well	These changes provide clarification in response to questions received from abstractors and clinicians.	Notes for Abstraction **Change** to: • Select “Yes” if BOTH a date and time *Last Known Well* are documented. • Select “No” if there is ANY physician/APN/PA documentation that *Last Known Well* is “UNKNOWN.” Documentation must explicitly state that the *Last Known Well* is unknown/uncertain/unclear. Documentation that time of symptom onset is unknown/uncertain/unclear is also acceptable when *Time Last Known Well* is not documented. If *Last Known Well* is not explicitly documented as unknown, **do not make inferences** (e.g. do not assume that patient woke with stroke so *Last Known Well* unknown unless explicitly documented). ○ If one physician documents a *Time Last Known Well* and another documents time of symptom onset unknown, select “Yes.” ○ If physician documents a *Time Last Known Well* and nurse/EMS documents Last Known Well unknown, select “Yes.” ○ If one physician documents *Last Known Well* unknown and another documents a *Time Last Known Well*, select “No.” **EXCEPTION:** ○ If the physician documents *Last Known Well* as unknown and the same physician crosses out unknown or mentions in a later note that *Last Known Well* is now known with a time documented, select “Yes.” • If the *Time Last Known Well* is clearly greater than 2 hours prior to hospital arrival AND **no**

		time is documented, select “No.” Example: “Patient OK last night.” Select “No” because no other documentation of a specific time/time range/time reference was present in the medical record and the time is required for the *Time Last Known Well*. • If the only *Time Last Known Well* is documented as a time immediately before hospital arrival without a specific time range in minutes, e.g., “symptoms started just prior to ED arrival,” select “Yes.” • If there is no documentation that *Last Known Well* or stroke signs/symptoms occurred prior to hospital arrival but there is documentation that *Last Known Well* first occurred after *Arrival Time* (e.g., in-house stroke), select “No.” Exclusion Guidelines for Abstraction **Change** to: Delay in stroke diagnosis
Measure Set	STK is added to TJC manual.	Added STK to the list of measure sets in TJC manual Updated valid values for Measure set element for the Population and Sampling file
Number of Antipsychotic Medications Prescribed at Discharge	The data source was removed, since it is no longer used for the HBIPS measures.	**Remove** under suggested data sources: • Continuing care plan
Number of Previous Live Births	Clarification was added for using parity from the EHR and use of GTPAL.	**Change** the first paragraph under the notes for abstraction to: Parity may be used for the number of previous deliveries resulting in a live birth if zero is documented. For any number greater than zero, parity may ONLY be used provided there is additional documentation indicating the same number of live births experienced prior to this hospitalization. If the number for parity documented in the EHR is "one" and includes the delivery for the current hospitalization, abstract zero for previous live births. **Add** under the notes for abstraction: GTPAL documentation alone does not indicate previous live births. Previous live births may be abstracted from an acceptable data source by adding the number of all previous Term plus Preterm deliveries minus the Stillbirths and the current delivery. If the number of previous live births entered by the clinician in the first document listed 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.

Patient Status at Discharge	This data element was added due to the retirement of HBIPS-4, HBIPS-6 and HBIPS-7 and the removal of the data element *Patient Referral to Next Level of Care Provider* in order to exclude patients who were discharged from the psychiatric care setting under certain conditions.	**Add** new data element *Patient Status at Discharge*.
Reason for Extending the Initiation of IV Thrombolytic	These changes provide clarification in response to questions received from abstractors and clinicians.	Notes for Abstraction **Add** the examples under fourth bullet: • **If "other" reasons are not mentioned in the context of IV thrombolytics, do not make inferences** (e.g., do not assume that IV thrombolytic was initiated in 3 to 4.5 hours because patient consent could not be obtained from family in 3 hours unless explicitly documented). Examples: ○ Documentation to initiate IV thrombolytic for worsening symptoms following documentation to not give tPA because symptoms resolved after hospital arrival, select "Yes." ○ NIHSS score of 1 on arrival. IV thrombolytic ordered 4 hours after hospital arrival, select "No." Exclusion Guidelines for Abstraction **Change** to: • Delay in hospital arrival greater than 2 hours • Delay in stroke diagnosis • Hold IV thrombolytic without a documented reason • No IV access
Reason for No VTE Prophylaxis – Hospital Admission	These changes provide clarification in response to questions received from abstractors and clinicians.	**Updated** flow of bullets in notes for abstraction. **Removed** All VTE and STK subheadings Association of Low Risk Association of Surgery End Date

		Suggested Data Sources • Circulator notes • Operative notes • Preoperative nursing notes **Add** a sub-bullet to 9th bullet • "No VTE Prophylaxis", "No VTE Prophylaxis needed" [no reason given].
Reason for Not Administering Antithrombotic Therapy by End of Hospital Day 2	These changes provide clarification in response to questions received from abstractors and clinicians.	Definition **Change** to: Reason for not administering antithrombotic therapy by end of hospital day 2. • Other reasons documented by physician/APN/PA or pharmacist. Notes for Abstraction **Change** second sub-bullet in fourth bullet to: • ○ Physician/APN/PA or pharmacist documentation of a hold on an antithrombotic medication or discontinuation of an antithrombotic medication that occurs the day of or day after hospital arrival constitutes a “clearly implied” reason for not administering antithrombotic therapy by end of hospital day 2. A hold/discontinuation of all P.O. medications counts if an antithrombotic was on order at the time of the notation. **Add** new fifth bullet: • NPO is NOT a reason for not administering antithrombotic therapy without explicit documentation that no antithrombotic medication should be given. Another route of administration can be used. Inclusion Guidelines for Abstraction **Change** to: • None • Refer to Appendix C, Table 8.2 for a comprehensive list of Antithrombotic Medications. Exclusion Guidelines for Abstraction **Add:** • Antithrombotic medication allergy described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table
Reason for Not Initiating IV Thrombolytic	These changes provide clarification in response to questions received from abstractors and clinicians.	Definition **Add** new fourth bullet: • Documentation by a physician/APN/PA that the patient has “no neurological deficit” or “normal neurological exam” in the emergency department

		Notes for Abstraction **Add** new 4th sub-bullet, under third bullet: • ○ Documentation by a physician/APN/PA that the patient has “no neurological deficit” or “normal neuro exam” in the emergency department **Add** under fourth bullet the Unacceptable examples: • **If “other” reasons are not mentioned in the context of IV thrombolytics, do not make inferences** (e.g., do not assume that IV thrombolytic was not initiated because of a bleeding disorder unless explicitly stated in the documentation). **Acceptable examples** (select “Yes”): ○ “Frail 95 year old – will not give thrombolytics due to age” ○ “Patient with Stage IV cancer – No t-PA” ○ “Increased risk of bleeding – hold t-PA for further evaluation” **Unacceptable examples** (select “No”): ○ “Symptoms resolving” ○ “No gait deficit” ○ “Metastatic brain tumor” **Remove** sixth bullet: • Documentation by a physician/APN/PA that the patient has no neurological deficits, e.g., “normal neuro exam,” “neurological exam has returned to baseline” at the time of presentation to the emergency department, is acceptable as an “other” reason if it is documented on the day of or day after hospital arrival. Exclusion Guidelines for Abstraction **Add** new first bullet: • Delay in hospital arrival greater than 2 hours
Reason for Not Prescribing **Antithrombotic** Therapy at Discharge	These changes provide clarification in response to questions received from abstractors and clinicians.	Definition **Remove:** • Hemorrhagic stroke Notes for Abstraction **Change** first bullet to: • Reasons for not prescribing antithrombotic therapy at hospital discharge must be documented by a physician/APN/PA or pharmacist with one exception: Patient/family refusal of any form of antithrombotic therapy (e.g., “ASA refused,” “Patient refusing antithrombotic therapy”) may be documented by a nurse. Inclusion Guidelines for Abstraction

		Change to: None Refer to Appendix C, Table 8.2 for a comprehensive list of Antithrombotic Medications. Exclusion Guidelines for Abstraction **Change** to: Antithrombotic medication allergy described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table.
Reason for Not Prescribing **Anticoagulation** Therapy at Discharge	These changes provide clarification in response to questions received from abstractors and clinicians.	Definition **Remove:** • Hemorrhagic stroke Notes for Abstraction **Change** first bullet to: • Reasons for not prescribing anticoagulation therapy at hospital discharge must be documented by a physician/APN/PA or pharmacist with one exception: Patient/family refusal of any form of anticoagulation therapy (e.g. “Coumadin refused,” “Patient refusing anticoagulation therapy”) may be documented by a nurse. Inclusion Guidelines for Abstraction **Change** to: None Refer to Appendix C, Table 8.3 for a comprehensive list of Anticoagulant Medications. Exclusion Guidelines for Abstraction **Change** to: Anticoagulant medication allergy described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table.
Reason for Not Prescribing Statin Medication at Discharge	These changes provide clarification in response to questions received from abstractors and clinicians.	Notes for Abstraction **Change** third bullet to: • Documentation of a LDL-c less than 70 mg/dL anytime during the hospital stay is an acceptable stand-alone reason for not prescribing statin medication at discharge – Linkage with statin is not needed. If more than one LDL value is documented, the highest value must be less than 70 mg/dL. Direct or calculated fasting or non-fasting values are both acceptable. LDL values obtained within 30 days prior to hospital arrival are acceptable to select “Yes.”

		Add new fifth bullet: • Reasons for not administering statin therapy must be documented by a physician/APN/PA or pharmacist with one exception: Patient/family refusal of any form of statin therapy (e.g., “Lipitor refused,” “Patient refusing statin therapy”) may be documented by a nurse. Inclusion Guidelines for Abstraction **Change** to: None Refer to Appendix C, Table 8.1 for a comprehensive list of Statin Medications.
Reason for Oral Factor Xa Inhibitor	This change is to accept pharmacist documentation for the reason for Oral Factor Xa Inhibitor.	Suggested Data Collection Question **Add:** or pharmacist Allowable Values **Add:** or pharmacist Notes for Abstraction **Change** first bullet to: The only acceptable reasons are identified in the list of inclusions. No other reasons will be accepted Suggested Data Sources **Change** "PA" to "PA or PHARMACIST" Inclusion Guidelines for Abstraction **Remove** the following bullets: • ICD-10-CM Principal/Other Diagnosis Code of 427.31 or 427.32 • ICD-10-PCS Other Procedure Codes of 81.51, 81.52, 81.53, 81.54 or 81.55 **Change** order to alphabetical order
Sample Size Medicare Only	Adding STK to the TJC manual.	**Add** STK to examples or content when needed.
Sample Size Non-Medicare Only	Adding STK to the TJC manual.	**Add** STK to examples or content when needed.
Sampling Frequency	Adding STK to the TJC manual.	**Add** STK to examples and content when needed.

Term Newborn	Additional clarification was added to determine if the newborn was term.	**Change** the first paragraph under to notes for abstraction to: Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks. Estimated gestational age (EGA) may be used to determine gestational age, including a range of numbers that are 37 weeks or greater, e.g., 37-38 weeks gestation. **Add** under the notes for abstraction: In cases when there is conflicting documentation, e.g., both term and a gestational age of 36 weeks are documented, the gestational age takes precedence.
Time Last Known Well	These changes provide clarification in response to questions received from abstractors and clinicians.	Notes for Abstraction **Add** new first bullet: • The Time Last Known Well must be a time prior to the patient's Arrival Time. Do not use times after hospital arrival for Time Last Known Well. **Change** in third & fourth bullets: time last known well **To** Time Last Known Well **Change** fifth bullet to: • If the *Time Last Known Well* is documented as one **specific time** and entered as *Time Last Known Well* on a "Code Stroke" form or stroke-specific electronic template, enter that time as the *Time Last Known Well*. Documentation of *Time Last Known Well* on a stroke-specific form or template should be selected regardless of other times last known well documented elsewhere in the medical record. **EXCEPTIONS:** ○ ANY physician/APN/PA documentation that *Last Known Well* /onset of signs/symptoms is unknown/uncertain/unclear takes precedence over specific time on "Code Stroke" form. ○ Crossing out of a specific time on a Code Stroke Form and a specific time documented on the same or different Code Stroke Form, use the specific time that is not crossed out. ○ A specific time on a Code Stroke Form and another time reference documented, e.g. <8 hours, on the same or different Code Stroke Forms, use the specific time. ○ Multiple specific times on the same or different Code Stroke Forms, use abstraction guidelines for multiple Times Last Known Well. ○ Unable to determine if a form is a Code Stroke Form, continue to review the medical

		record for *Time Last Known Well* documentation in other sources. **Add** new sixth, seventh, & eighth bullets: • A Code Stroke Form is used by the stroke team or ED staff to document the acute stroke process. • See the inclusion list for acceptable terms used for a Code Stroke Form. The list is not all-inclusive. • Time Last Known Well on a Code Stroke Form may be documented by a nurse. **Add** new tenth bullet: • If the time is noted to be “less than” a period of time prior to ED arrival, assume the maximum range. Example: *Time Last Known Well* less than one hour ago. Subtract one hour from the time of arrival to compute time last known well. Inclusion Guidelines for Abstraction **Add:** Code Stroke Form • Stroke Activation Form • Stroke Alert Form • Stroke Assessment Form • Stroke Intervention Form • Stroke Rapid Response Form • Thrombolysis Checklist • tPA Eligibility Form Exclusion Guidelines for Abstraction **Change** to: Code Stroke Form • Stroke Education Form • Core Measure Form
VTE Prophylaxis Date	Removal of references to GCS	Notes for Abstraction: **Update** first bullet GCS to IPC in **Remove** Suggested Data Sources • Circulator notes • Operative notes

		• Preoperative nursing notes
VTE Prophylaxis	Removal of allowable values '4' and '9' and STK and VTE headings due to retirement of VTE	Format **Change** Occurs to: 1-7 Allowable Values **Remove:** 4 GCS and 9 Aspirin Notes for Abstraction **Change** to: • No value should be selected more than once. If a Value of "A" is selected, no other selection should be recorded. Example: Lovenox is ordered and substituted with dalteparin. Only abstract Value "2" once, as both are LMWH. • Application of mechanical prophylaxis may be documented by any personnel. Example: Nursing assistant documentation of IPC application during the allowable timeframe is acceptable. • Selection of Allowable Values 1-8 includes any prophylaxis that was administered in the allowable time frame. Example: If a patient was admitted on 12/8/20xx and had IPCs applied at 13:00 on 12/09/20xx and LMWH was administered at 22:00 on 12/8/20xx, select Values “2” and “3.” • Only select prophylaxis if there is documentation that it was administered. Documentation in the physician progress notes under assessment/Plan: “DVT prophylaxis – IPC” is not enough to select Value “3.” • If one pharmacological medication is ordered and another medication is substituted (such as per pharmacy formulary substitution or protocol), abstract the medication administered. Note: No copy of the formulary or protocol is required in the medical record. Example: Lovenox is ordered, but not received and is substituted with fondaparinux sodium, which is received by the patient. Abstract fondaparinux sodium as Value “5” for VTE Prophylaxis and abstract the date it was administered for VTE Prophylaxis Date. • Abstract ALL VTE prophylaxis(s) that was administered on the day of or the day after hospital admission. If no VTE prophylaxis was administered during this timeframe, select “A.” • VTE Prophylaxis administered in the ED or Observation prior to the hospital admission order is not sufficient. **Remove** Association of Surgery End Date Suggested Data Sources

		• Circulator notes • Operative notes • Preoperative nursing notes

Supplemental Materials

Section	Rationale	Description
Appendix A - ICD-10 Code Tables	Addition of ACHF and ACHFOP measure sets to TJC Manual. Addition of STK measure set to TJC Manual. ICD-10-CM diagnosis codes were removed from Table 11.10.1 and Table 11.10.2, since these codes are not specifically used to include or exclude cases from PC-04.	**Add** Tables 2.1 and 2.2 **Add** Tables 8.1, 8.2 and 8.3 **Remove** the following ICD-10-CM diagnosis code from Table 11.10.1: R7881 **Remove** the following ICD-10-CM diagnosis codes from Table 11.10.2: R571 and R578 **Add** Table 8.1: Ischemic Stroke I6349 Cerebral infarction due to embolism of other cerebral artery Table 8.3: Carotid Intervention Procedures 021W09D Bypass Thoracic Aorta to Carotid with Autologous Venous Tissue, Open Approach 021W0AD Bypass Thoracic Aorta to Carotid with Autologous Arterial Tissue, Open Approach 021W0JD Bypass Thoracic Aorta to Carotid with Synthetic Substitute, Open Approach 021W0KD Bypass Thoracic Aorta to Carotid with Nonautologous Tissue Substitute, Open Approach 021W0ZD Bypass Thoracic Aorta to Carotid, Open Approach 021W49D Bypass Thoracic Aorta to Carotid with Autologous Venous Tissue, Percutaneous Endoscopic Approach 021W4AD Bypass Thoracic Aorta to Carotid with Autologous Arterial Tissue, Percutaneous Endoscopic Approach 021W4JD Bypass Thoracic Aorta to Carotid with Synthetic Substitute, Percutaneous Endoscopic Approach 021W4KD Bypass Thoracic Aorta to Carotid with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach

		021W4ZD Bypass Thoracic Aorta to Carotid, Percutaneous Endoscopic Approach
Appendix C - Medication Tables	Stroke (STK) measure set is added to the TJC Manual. Table 10.0 was updated to include new antipsychotic medications.	**Add** Table 8.1, 8.2 and 8.3 to the Appendix. **Add** the following medications to Table 10.0: Rexulti (Brexpiprazole) Vraylar (Cariprazine) Aristada (Aripiprazole Lauroxil)
Appendix D - Glossary of Terms	Measures and measure sets are being removed from CMS' Hospital Inpatient Quality Reporting program and The Joint Commission's Flexible ORYX® performance reporting requirements beginning with 1/1/2016 discharges.	**Remove** the following glossary terms in their entirety: **acute myocardial infarction (AMI)** **angioplasty** **antithrombotic therapy** **atrial fibrillation** **atrial flutter** **cardiac module** **controllers** **corticosteroids** **depilatories** **fibrinolytic therapy** **infection module** **intermittent pneumatic compression device** **module** **non-core measure** **oral antibiotics** **pneumonia (PN)** **relievers** **reperfusion** **stent** **surgical care improvement project (SCIP)** **surgical infection prevention (SIP)** **systemic corticosteroids** **thrombolytic therapy**
Appendix G - Resources	Added updated resource information.	**Add** **CMS Abstraction & Reporting Tool (CART)** For technical assistance with CART, please contact the Applications/LocalApps.QualityNet help desk at qnetsupport@hcqis.org, or call 1-866-288-8912.

		CMS Hospital Inpatient Quality Reporting Program For information on measures that are required for CMS Hospital IQR Program and/or used for Public Reporting on Hospital Compare, refer to the Measure Comparison Document at https://www.qualitynet.org/. Please go to the Applications/LocalApps.QualityNet web site and select “Measure Comparison” under “Hospital Inpatient Quality Reporting Program” located under Hospitals-Inpatient; or refer to the Final IPPS Rule at http://www.cms.gov/AcuteInpatientPPS/. For information on voluntary electronic submission of the Hospital IQR Program specified measures requirements and technical specifications, resources are available at https://www.qualitynet.org/. From the Applications/LocalApps.QualityNet web site select “Electronically Specified Clinical Quality Measures (eCQMs) Reporting” located under Hospitals-Inpatient. If you have questions regarding the EHR Incentive Program measures collected for the Hospital IQR Program, please refer to the CMS website, https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html or the Applications/LocalApps.QualityNet helpdesk. **National Uniform Billing Committee (NUBC)** For further information regarding the UB-04 and NUBC related data elements, please refer to the NUBC manual, “Official UB-04 Data Specifications Manual© Copyright American Hospital Association” or website at http://www.nubc.org/index.html.
Appendix H - Miscellaneous Tables	Adding STK to the TJC manual.	**Add** tables 2.1 and 2.7
Introduction to the Data Dictionary	Updates made to remove duplicative text and correct typographical errors.	**Remove** duplicative text and correct typographical errors.
Introduction to the Manual	Updates made to describe the addition of certification measure sets to the manual.	**Add** Certification Process The Joint Commission uses two methodologies for performance measurement for disease-specific care programs. Each certified program collects either standardized or nonstandardized measures, as directed by The Joint Commission. During the certification review the program will demonstrate that it has established a data history that supports quality improvement. Selected standardized measure sets have been incorporated in this specification manual to centralize the measures used for Joint Commission programs into one manual. For more information on the certification process refer to The Joint Commission website and the specific certification program of interest.

Sampling	SCIP, AMI, and CAC measure sets, and HBIPS-4, HBIPS-6 and HBIPS-7 measures are retired. STK measure set is moved to TJC manual.	Remove all references to SCIP, AMI, and CAC measure sets, and HBIPS-4, HBIPS-6 and HBIPS-7 measures. Include STK in the examples in the content as one of the measure sets presented in the manual
Table of Contents	The addition of certification measure sets.	**Change** the Measure Information Forms section into two sections: National Quality Measure Sets and Certification Measure Sets.
Transmission of Data	STK has been added to TJC manual. HBIPS measures 4, 6 and 7 have been retired and new HBIPS element has been added and few HBIPS elements are retired.	**Change** TJC_Allowable_Measure_Sets_Combinations.xlsx document has been updated to include STK to the combination and removing all retired sets 23b_Hospital_ICD_Population__XML_File_Layout.xls has been update to add STK to Stratified sets with the stratum values 23a_Hospital_Clinical_Data_XML_File_Layout.xls has been update with following changes: • STK and its elements have been added. • HBIPS-4, 6 and 7 have been retired throughout the document • Patient Status at Discharge element added to HBIPS-5 • 5 HBIPS elements have been retired: ○ Continuing Care Plan-Discharge Medications ○ Continuing Care Plan-Next Level of Care ○ Continuing Care Plan-Principal Discharge Diagnosis ○ Continuing Care Plan-Reason for Hospitalization ○ Patient Referral to Next Level of Care Provider
Using the The Joint Commission's National Measure Specifications Manual	Updates made to remain consistent with the CMS and Joint Commission aligned *Specifications Manual for National Hospital Inpatient Quality Measures* and to describe the addition of certification measure sets to the manual.	**Add** Measures listed in this manual are Chart-Abstracted Measures. Chart abstraction is the review of medical record documentation from the current episode of care for the purposes of data collection and submission. In addition, some of the measures in this manual have been retooled as eMeasures and are eligible for voluntary electronic submission for ORYX performance measure reporting requirements or the Hospital Inpatient Quality Reporting (IQR) program). For information about the requirements and technical specifications of the Quality Reporting Document Architecture (QRDA) specifications and data submission, see the resources located on QualityNet, [Hospitals-Inpatient], Electronically Specified Clinical Quality Measures (eCQM) Reporting. The Joint Commission ORYX performance measure reporting requirements are available on the

		Joint Commission website under the Measurement tab and on Performance Measurement System Extranet track site (PET) under Manuals and Guides, eCQM Documentation. Selected standardized measure sets used in the Joint Commission Certification programs have been incorporated in this specification manual. This is being done to centralize the measures used for Joint Commission programs into one manual. Note: the Stroke (STK) measures data for certification can be submitted through an ORYX vendor, however the Advanced Certification Heart Failure (ACHF) measures data cannot be submitted through an ORYX vendor and may only be submitted through the Certification Measure Information Process (CMIP).

General Release Notes

Rationale	Description
HBIPS-4, HBIPS-6 and HBIPS-7 have been permanently retired along with the associated data elements in order to align with the Inpatient Psychiatric Facilities Quality Reporting Program reporting requirements for 2016.	**Remove:** all references in their entirety throughout the specifications manual for the following: • Measure: HBIPS-4 • Measure: HBIPS-6 • Measure: HBIPS-7 • Data element: Continuing Care Plan-Discharge Medications • Data element: Continuing Care Plan-Next Level of Care • Data element: Continuing Care Plan-Principal Discharge Diagnosis • Data element: Continuing Care Plan-Reason for Hospitalization • Data element: Patient Referral to Next Level of Care Provider
Adding certification measure sets of Stroke (STK), Advanced Certification Heart Failure (ACHF) and Advanced Certification Heart Failure Outpatient (ACHFOP) to the TJC Manual.	**Add** all MIFs and Data Elements associated with Stroke (STK). **Add** all MIFs and Data Elements associated with Advanced Certification Heart Failure (ACHF) **Add** all MIFs and Data Elements associated with Advanced Certification Heart Failure Outpatient (ACHFOP).
The name of the manual changed from "Specifications Manual for Joint Commission National Quality Core Measures" to "Specifications Manual for Joint Commission National Quality Measures."	**Remove** the word "core" and "non-core" from all locations in the manual.