

Release Notes for the 2018A Manual

Measure Information Forms

Section	Rationale	Description
<p>ACHFOP - Initial patient population</p>	<p>A new ID number was assigned for Appendix A, ACHFOP E/M Codes for Outpatient Encounters. This is because Table 1.0 will become E/M codes for Emergency Department Encounters to be consistent with the current HOP manual.</p> <p>Algorithm also updated to create consistency with manual format.</p>	<p>Change branch to the right of diamond labelled E/M Code from: Not on OP Table 1.0 (Appendix A) To Not on Table 2.0</p> <p>Change branch going down from diamond labelled E/M Code from: On OP Table 1.0 (OP Appendix A) To On Table 2.0</p> <p>Change branch to the right of diamond labelled ICD-10-CM Principal Diagnosis Code from: Not on Table 2.1 (Appendix A) To Not on Table 2.1</p> <p>Change branch going down from diamond labelled ICD-10-CM Principal Diagnosis Code from: On Table 2.1 (Appendix A) To On Table 2.1</p> <p>Change branch to the right of diamond labelled ICD-10-PCS Principal or Other Procedure Codes from: At least one On Table 2.2 (Appendix A) To At least one On Table 2.2</p> <p>Change branch going down from diamond labelled ICD-10-PCS Principal or Other Procedure Codes from: All Missing or None on Table 2.2 (Appendix A) To All Missing or None on Table 2.2</p>
<p>ACHFOP-01</p>	<p>A new ID number was assigned for Appendix A, ACHFOP E/M Codes for Outpatient Encounters. This is because Table 1.0 will become E/M codes for Emergency Department</p>	<p>Denominator Included Populations Change first bullet From E/M Code for hospital outpatient encounter as defined in OP Appendix A, OP Table 1.0 To E/M Code for hospital outpatient encounter as defined in Appendix A, Table 2.0</p>

	Encounters to be consistent with the current HOP manual.	
ACHFOP-02	A new ID number was assigned for Appendix A, ACHFOP E/M Codes for Outpatient Encounters. This is because Table 1.0 will become E/M codes for Emergency Department Encounters to be consistent with the current HOP manual.	Denominator Included Populations Change first bullet from: E/M Code for hospital outpatient encounter as defined in OP Appendix A, OP Table 1.0 To E/M Code for hospital outpatient encounter as defined in Appendix A, Table 2.0
ACHFOP-03	A new ID number was assigned for Appendix A, ACHFOP E/M Codes for Outpatient Encounters. This is because Table 1.0 will become E/M codes for Emergency Department Encounters to be consistent with the current HOP manual.	Denominator Included Populations Change first bullet from: E/M Code for hospital outpatient encounter as defined in OP Appendix A, OP Table 1.0 To E/M Code for hospital outpatient encounter as defined in Appendix A, Table 2.0
ACHFOP-04	A new ID number was assigned for Appendix A, ACHFOP E/M Codes for Outpatient Encounters. This is because Table 1.0 will become E/M codes for Emergency Department Encounters to be consistent with the current HOP manual.	Denominator Included Populations Change first bullet from: E/M Code for hospital outpatient encounter as defined in OP Appendix A, OP Table 1.0 To E/M Code for hospital outpatient encounter as defined in Appendix A, Table 2.0
ACHFOP-05	A new ID number was assigned for Appendix A, ACHFOP E/M Codes for Outpatient Encounters. This	Denominator Included Populations Change first bullet from: E/M Code for hospital outpatient encounter as defined in OP Appendix A, OP Table 1.0 To E/M Code for hospital outpatient encounter as defined in Appendix A, Table 2.0

	is because Table 1.0 will become E/M codes for Emergency Department Encounters to be consistent with the current HOP manual.	
ACHFOP-06	A new ID number was assigned for Appendix A, ACHFOP E/M Codes for Outpatient Encounters. This is because Table 1.0 will become E/M codes for Emergency Department Encounters to be consistent with the current HOP manual.	Denominator Included Populations Change first bullet from: E/M Code for hospital outpatient encounter as defined in OP Appendix A, OP Table 1.0 To E/M Code for hospital outpatient encounter as defined in Appendix A, Table 2.0
ACHFOP-07	A new ID number was assigned for Appendix A, ACHFOP E/M Codes for Outpatient Encounters. This is because Table 1.0 will become E/M codes for Emergency Department Encounters to be consistent with the current HOP manual.	Denominator Included Populations Change first bullet from: E/M Code for hospital outpatient encounter as defined in OP Appendix A, OP Table 1.0 To E/M Code for hospital outpatient encounter as defined in Appendix A, Table 2.0
CSTK-03	The Hunt and Hess Scale is used to assess stroke severity only for those patients with subarachnoid hemorrhage due to a ruptured cerebral aneurysm.	Denominator Excluded Populations: Add Patients who have an <i>ICD-10-CM Principal Diagnosis Code</i> in Appendix A, Table 8.2a assigned at discharge and documentation of non-aneurysmal SAH or SAH related to head trauma any time during the hospital stay Denominator Data Elements: Add Non-aneurysmal Algorithm Change: Add "Non-aneurysmal" between "ICD-10-CM Principal Diagnosis Code" and "Initial Hunt and Hess Scale Performed". If "Non-aneurysmal" is "Y", it goes to "B". If "Non-aneurysmal" is "N", it flow down to "Initial Hunt and Hess Scale Performed".

CSTK-05	To provide information related to applying the risk models.	<p>Risk Adjustment Notes: Add This section has been moved to the ORYX Risk Adjustment Guide. This guide is available to the public on the Joint Commission's website and, in addition, it is available to performance measurement systems via the Joint Commission's extranet site for measurement systems (PET).</p>
CSTK-08	Align CSTK-08 with CSTK-11 and CSTK-12. To provide information related to applying the risk models.	<p>Denominator Included Populations: Add Patients with documented Failed Attempt at Thrombectomy (ICD-10-PCS Principal or Other Procedure Codes as defined in Appendix A, Table 8.1c for ICD-10 codes)</p> <p>Denominator Data Elements: Add Failed Attempt at Thrombectomy</p> <p>Algorithm Change:</p> <p>Add "Failed Attempt at Thrombectomy" between "Elective Carotid Intervention" and "ICD-10-PCS Principal or Other Procedure Codes". If "Failed Attempt at Thrombectomy" is missing, the case will go to "X". If "Failed Attempt at Thrombectomy" is "Y", the case will go to "D". If "Failed Attempt at Thrombectomy" is "N", the case will go to follow down to "ICD-10-PCS Principal or Other Procedure Codes".</p> <p>Risk Adjustment Notes: Add This section has been moved to the ORYX Risk Adjustment Guide. This guide is available to the public on the Joint Commission's website and, in addition, it is available to performance measurement systems via the Joint Commission's extranet site for measurement systems (PET).</p>
CSTK-10	Adjust the measure flow logic to avoid false inclusion of ischemic stroke patients who do not undergo a reperfusion procedure and are discharged to hospice or expire during the hospital stay. To provide information related to applying the risk models.	<p>Algorithm: Move "Discharge Disposition" data element down after "ICD-10-PCS Principal or Other Procedure Codes" and above "Modified Rankin Score(mRS)Date". If "Discharge Disposition" is missing then go to "X", if "Discharge Disposition" is 2,3,6 then go to "D", if "Discharge Disposition" is 1,4,5,7,8 then flow down to "Modified Rankin Score(mRS)Date".</p> <p>Risk Adjustment Notes: Add This section has been moved to the ORYX Risk Adjustment Guide. This guide is available to the public on the Joint Commission's website and, in addition, it is available to performance measurement systems via the Joint Commission's extranet site for measurement systems (PET).</p>
PC	There is a typo in the PC	Change text 'Diagnosis' to 'Procedure'.

	population element list for PC-Mother measures.	Change 'ICD-10-CM' to 'ICD-10-PCS'.
PC-04	Correction made to Denominator Data Elements.	Change From ICD-10-PCS Other Procedure Dates To ICD-10-PCS Other Procedure Codes

Data Elements

Section	Rationale	Description
Antenatal Steroids Initiated	Notes for abstraction have been updated to clarify abstraction of antenatal steroid initiation.	<p>Change From If there is documentation that antenatal steroids were initiated prior to current hospitalization in another setting of care, i.e., doctor's office, clinic, birthing center, hospital before delivery, select allowable value "yes".</p> <p>If antenatal steroids were initiated in the hospital, the name of the medication must be documented in the medical record in order to select allowable value "yes".</p> <p>To: If there is documentation that antenatal steroids were initiated prior to current hospitalization (e.g., doctor's office, clinic, birthing center, prior hospitalization before delivery), select allowable value "yes".</p> <p>If antenatal steroids were initiated during this hospital episode, the name of the medication and dose must be documented in the medical record in order to select allowable value "yes".</p>
Discharge Disposition	Align Notes for Abstraction with CMS/TJC specifications manual, Version 5.2a.	<p>Notes for Abstraction</p> <p>Add new seventh and eighth bullets:</p> <ul style="list-style-type: none"> • If the medical record states the patient is being discharged to assisted living care or an assisted living facility (ALF) and the documentation also includes nursing home, intermediate care or skilled nursing facility, select Value "1" ("Home"). • If the medical record states the patient is being discharged to nursing home, intermediate care or skilled nursing facility without mention of assisted living care or assisted living facility (ALF), select Value "5" ("Other Health Care Facility").
Discharge Time	To align with the data element definition detailed in	<p>Change Definition</p> <p>From Time of documentation of discharge.</p>

	<p>the Hospital Outpatient manual.</p>	<p>To The time the patient was discharged from acute care, left against medical advice (AMA), or expired during the hospital stay.</p> <p>Notes for Abstraction Add new first bullet:</p> <ul style="list-style-type: none"> • Abstract the earliest documented time of the following: <ul style="list-style-type: none"> ○ Discharge from acute inpatient care ○ Left against medical advice (AMA) ○ Expired <p>Change second bullet From If the time the patient expired is unable to be determined from medical record documentation, enter “UTD.”</p> <p>To If the time the patient was discharged from acute inpatient care, left AMA, or expired is unable to be determined from medical record documentation, enter “UTD.”</p> <p>Change sixth bullet From If the patient was transferred out to another facility or discharged to home, use the time the patient actually left, not the time the order was written.</p> <p>To If the patient was discharged from acute inpatient care, left AMA, transferred out to another facility, or discharged to home, use the time the patient actually left, not the time the order was written.</p> <p>Change seventh bullet From If there are multiple times documented when the patient was discharged, use the earliest time.</p> <p>To If there are multiple times documented when the patient was discharged from acute inpatient care or left AMA, use the earliest time.</p>
E/M Code	<p>A new ID number was assigned for Appendix A, ACHFOP E/M Codes for Outpatient Encounters. This is because Table 1.0 will become E/M codes for Emergency Department Encounters to be consistent</p>	<p>Allowable Values Change Select the E/M code from Appendix A, Table 1.0.</p> <p>To</p> <ul style="list-style-type: none"> • For ASR-OP measures, select the E/M code from Appendix A, Table 1.0. • For ACHFOP measures, select the E/M code from Appendix A, Table 2.0. <p>Inclusion Guidelines for Abstraction Change Refer to Appendix A, Table 1.0, E/M Codes for Emergency Department Encounters</p>

	with the current HOP manual.	<p>To</p> <ul style="list-style-type: none"> • For ASR-OP measures, refer to Appendix A, Table 1.0, E/M Codes for Emergency Department Encounters • For ACHFOP measures, refer to Appendix A, Table 2.0, E/M Codes for Hospital Outpatient Encounters
Education Addresses Activation of Emergency Medical System	To provide clarification for abstractors.	<p>Excluded Data Sources</p> <p>Add Core measure forms.</p>
Education Addresses Follow-up After Discharge	To provide clarification for abstractors.	<p>Excluded Data Sources</p> <p>Add Core measure forms</p>
Education Addresses Medication Prescribed at Discharge	To provide clarification for abstractors.	<p>Notes for Abstraction</p> <p>Change seventh bullet under number 2</p> <p>From 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.</p> <p>To 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. An electronic staff signature documenting in the medical record that the after visit summary (AVS) was printed for the patient/caregiver to take home is acceptable.</p> <p>Excluded Data Sources</p> <p>Add Core measure forms</p>
Education Addresses Risk Factors for Stroke	To provide clarification for abstractors:	<p>Excluded Data Sources</p> <p>Add Core measure forms</p>
Education Addresses Warning Signs and Symptoms of Stroke	To provide clarification for abstractors.	<p>Excluded Data Sources</p> <p>Add Core measure forms</p>

Failed Attempt at Thrombectomy	Align CSTK-08 data elements with CSTK-11 and CSTK-12.	Collected For: Add Failed Attempt at Thrombectomy
Gestational Age	Notes for abstraction and Suggested Data Sources have been updated and reordered to clarify, reduce burden of abstraction and align with the eQIM measure specifications.	<p>Notes have been re-ordered and updated as follows:</p> <p>Change From</p> <p>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.</p> <p>The delivery or operating room record should be reviewed first for gestational age. If gestational age is not recorded in the delivery or operating room record, then continue to review the data sources in the following order: history and physical, prenatal forms, clinician admission progress note and discharge summary until a positive finding for gestational age is found. In cases where there is conflicting data, the gestational age found in the first document according to the order listed above should be used.</p> <p>The phrase "estimated gestational age" is an acceptable descriptor for gestational age.</p> <p>If the patient has not received prenatal care and no gestational age was documented, select allowable value UTD.</p> <p>When the admission date is different from the delivery date, use documentation of the gestational age completed closest to the delivery date.</p> <p>Gestational age should be documented by the clinician as a numeric value between 1-50. Gestational age (written with both weeks and days, eg. 39 weeks and 0 days) is calculated using the best obstetrical Estimated Due Date (EDD) based on the following formula: Gestational Age = (280 - (EDD - Reference Date)) / 7 (source: American College of Obstetricians and Gynecologists reVITALize Initiative).</p> <p>The clinician, not the abstractor, should perform the calculation to determine gestational age.</p> <p>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.</p>

Documentation in the acceptable data sources may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN).

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.

The EHR takes precedence over a hand written entry if different gestational ages are documented in equivalent data sources, e.g., delivery record and delivery summary.

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.

Gestational age should be documented by the clinician as a numeric value between 1-50. Gestational age (written with both weeks and days, eg. 39 weeks and 0 days) is calculated using the best obstetrical Estimated Due Date (EDD) based on the following formula:

Gestational Age = (280 - (EDD - Reference Date)) / 7 (source: American College of Obstetricians and Gynecologists reVITALize Initiative).

The clinician, not the abstractor, should perform the calculation to determine gestational age.

The delivery or operating room record should be reviewed first for gestational age; documentation of a valid number should be abstracted.

If the gestational age in the delivery or operating room record is missing, obviously incorrect (in error, e.g. 3.6), or there is conflicting data, then continue to review the following data sources, starting with the document completed closest to the delivery until a positive finding for gestational age is found:

- History and physical
- Clinician admission progress note
- Prenatal forms
- Discharge summary

Gestational age documented closest to the time of delivery (not including the newborn exam) should be abstracted.

The phrase "estimated gestational age" is an acceptable descriptor for gestational age.

If no gestational age was documented (e.g. the patient has not received prenatal care), select allowable value UTD.

Documentation in the acceptable data sources may be written by the following clinicians:

- Physician
- Certified nurse midwife (CNM)
- Advanced practice nurse/physician assistant (APN/PA)
- Registered nurse (RN)

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.

The EHR takes precedence over a hand written entry if different gestational ages are documented in equivalent data sources, e.g., delivery record and delivery summary.

Change Suggested Data Sources:

From

ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE:

- Delivery or Operating room record, note or summary
- History and physical
- Prenatal forms
- Admission clinician progress notes
- Discharge summary

To

ONLY ACCEPTABLE SOURCES:

- Delivery or Operating room record, note or summary
- History and physical
- Admission clinician progress notes
- Prenatal forms
- Discharge summary

Minutes of Physical Restraint	Updates were made to the Guidelines for Abstraction of the data element Minutes of Physical Restraint to provide clarification for abstraction.	<p>Guidelines for Abstraction Table, column Inclusion Change 5th bullet under Examples of physical restraint To Mittens to prevent intentional self-harm</p> <p>Guidelines for Abstraction Table, column Exclusion Change the 2nd bullet To Methods that involve the physical holding of a patient to conduct routine physical examinations, tests or medication administration</p> <p>Guidelines for Abstraction Table, column Exclusion Change the 6th bullet To Restraint uses that are forensic or correctional restrictions applied and used by designated hospital security personnel to transport the patient to court off the locked unit</p>
Modified Rankin Score (mRS) Date	Provide clarification for the abstractor.	<p>Notes for Abstraction Add new eighth bullet:</p> <ul style="list-style-type: none"> If the Modified Rankin Score was not performed, OR unable to determine (UTD) from the medical record documentation (allowable value '8'), then use the discharge date for the <i>Modified Rankin Score Date</i>.
Non-aneurysmal	The Hunt and Hess Scale is used to assess stroke severity only for those patients with subarachnoid hemorrhage due to a ruptured cerebral aneurysm.	Add new data element "Non-aneurysmal" to the denominator list
Post-Treatment Thrombolysis in Cerebral Infarction (TICI) Reperfusion Grade	Provide clarification for the abstractor.	<p>Notes for Abstraction Change first bullet From</p> <ul style="list-style-type: none"> The TICI grade may be documented by the physician/APN/PA, or a nurse (RN),circulating nurse, operating room technician designated to scribe during the procedure. <p>To</p> <ul style="list-style-type: none"> The TICI grade may be documented by the physician/APN/PA, or a nurse (RN),circulating nurse, operating room technician, radiology technician or other individual designated to scribe during the procedure. <p>Add new third bullet:</p>

		<ul style="list-style-type: none"> When multiple TICIs are documented for the primary vessel occlusion, select the highest grade documented.
Post-Treatment Thrombolysis in Cerebral Infarction (TICI) Reperfusion Grade Time	Provide clarification for the abstractor.	<p>Inclusion Guidelines for Abstraction</p> <p>Add</p> <ul style="list-style-type: none"> Reperfusion time Stroke reperfusion time
Prior Uterine Surgery	Added notes in order to clarify abstraction of prior uterine surgeries.	<p>Add In order to select “yes”, the current episode of care must contain documentation of one of the included surgeries below. An inverted T or J incision would be acceptable only if there is also documentation that the incision extended into the upper uterine segment.</p>
Reason for No VTE Prophylaxis – Hospital Admission	To provide clarification for abstractors.	<p>Notes for Abstraction</p> <p>Add EXCEPTION to sixth bullet:</p> <p>EXCEPTION:</p> <ul style="list-style-type: none"> Documentation within the timeframe specified that the patient is a bilateral lower extremity amputee is an acceptable reason for no mechanical prophylaxis. <p>Exclusion Guidelines for Abstraction</p> <p>Add</p> <ul style="list-style-type: none"> Unchecked checkbox next to a reason (e.g., blank checkbox on a form or electronic template next to “cogulopathy” or “bilateral amputee”). Checked checkbox next to “other reason” with a blank space for the specific reason.
Reason for Not Administering a Procoagulant Reversal Agent	To provide clarification for abstractors.	<p>Notes for Abstraction</p> <p>Add new second sub-bullet under the second bullet:</p> <ul style="list-style-type: none"> Physician/APN/PA or pharmacist documentation of a hold on a procoagulant reversal agent or discontinuation of a procoagulant reversal agent constitutes a “clearly implied” reason for not administering the procoagulant reversal agent.
Reason for Not Administering Antithrombotic Therapy by End of Hospital Day 2	Provide clarification for abstractors.	<p>Notes for Abstraction</p> <p>Add new fifth bullet:</p> <p>For patients with an order for ANY antithrombotic that was NOT administered without a documented reason or administered after day 2, select “No.” Example: Patient has documentation of an order for aspirin on day 2. No documentation that aspirin was administered by end of day 2. No documentation of a hold or discontinuation of the aspirin order or other documented reason, select “No.”</p>

Supplemental Materials

Section	Rationale	Description
<p>Appendix A - ICD-10 Code Tables</p>	<p>Table 11.07: The code 098.72 was inadvertently not included in the previous manual and has been added back to the table.</p> <p>The measure set Acute Stroke Ready Outpatient (ASR-OP) is being added to this manual. Table 1.0 will become E/M Codes for Emergency Department Encounters to be consistent with the code tables in the current HOP manual.</p> <p>Advanced Certification Heart Failure Outpatient (ACHFOP): The Table 1.0 from v2017B for ACHFOP Outpatient (E/M codes) has been renamed to Table 2.0 because the E/M Codes for Emergency Department Encounters applicable to the ASR-OP measures will become Table 1.0.</p> <p>Advanced Certification Heart Failure Outpatient (ACHFOP): The code descriptions, for the new Table 2.0, are being changed to the shortened version in</p>	<p>Table 11.07 Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation</p> <p>Add 098.72 Human immunodeficiency virus disease complicating childbirth</p> <p>Add Table 1.0: ASR-OP E/M Codes for Emergency Department Encounters</p> <p>Change From Table 1.0: Outpatient (E/M codes)</p> <p>To Table 2.0: ACHFOP E/M Codes for Hospital Outpatient Encounters</p>

	order to be consistent with the format of the E/M Codes for Emergency Department Encounters descriptions.	
Appendix H - Miscellaneous Tables	To align Table 2.1 with the Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.4.	<p>Table 2.1 VTE Prophylaxis Inclusion Table</p> <p>Add Oral Factor Xa Inhibitor:</p> <p>Betrixaban⁴</p> <p>BEVYXXA⁴</p> <p>Add footnote:</p> <p>4 The U.S. Food and Drug Administration (FDA) has approved betrixaban (BEVYXXA) for the prophylaxis of venous thromboembolism (VTE) in adult patients hospitalized for an acute medical illness who are at risk for thromboembolic complications due to moderate or severe restricted mobility and other risk factors for VTE.</p>
Introduction to the Manual	Remove reference to a program that is inactive.	<p>Delete:</p> <p>Top Performers</p> <p>In 2012, The Joint Commission introduced the <i>Top Performers on Key Quality Measures™</i> program. This initiative recognizes accredited hospitals that attain excellence on accountability measure performance.</p>
Missing and Invalid Data	General update due to addition of outpatient ASR-OP measure set to the TJC manual.	<p>Add text 'Outpatient Encounter Date and E/M code for outpatient measures sets' under section 'Data Collection and the Unable to be Determined (UTD) Allowable Value'.</p> <p>Add below elements under section – 'Missing and Invalid Episode of Care (EOC) and Event Data' Outpatient Encounter Date, E/M Code, ICD-10-CM Principal Diagnosis Codes, Birthdate and Arrival Time for outpatient measures sets</p> <p>Add Added a new sub-section for Population and Sampling.</p>
Sampling	ASR measure set is added to TJC manual and updates to CSTK measures set.	Add ASR and CSTK measures to example.
Transmission Data	Updated with CSTK	Add CSTK measures to example.

Processing Flow: Clinical	measures set.	
Transmission of Data	<p>ASR measure set is added to the TJC manual and updates to CSTK measures set.</p> <p>For clinical XML layout file- To align with data dictionary changes.</p> <p>For Allowable Measure Set Combination file Rational: Added ASR</p>	<p>Add ASR and CSTK measures to example.</p> <p>File name- "23a_Hospital_Clinical_Data_XML_File_Layout"</p> <p>Add new data element 'Non-aneurysmal' for CSTK-03</p> <p>Add 'Failed Attempt at Thrombectomy' element to CSTK-08.</p> <p>Add references of ASR-IP-1, ASR-IP-2, ASR-IP-3, ASR-OP-1, ASR-OP-2 in Applicable Measure(s) column.</p> <p>Add Under Elements tab, 'encounter-date' and 'arrival-time' elements reference to "ASR-OP-1", "ASR-OP-2".</p> <p>File name- "TJC_Allowable_Measure_Sets_Combinations"</p> <p>Add allowable ASR measure set combination with other measures.</p>

General Release Notes

Rationale	Description
Acute Stroke Ready Inpatient (ASR-IP) is being added to this manual	Acute Stroke Ready Inpatient (ASR-IP), MIFs (1-3) and associated data elements are being added to the manual.
Acute Stroke Ready Outpatient (ASR-OP) is being added to this manual	Acute Stroke Ready Outpatient (ASR-OP), MIFs (1-2) and associated data elements are being added to the manual.
Palliative Care (PAL) is being added to this manual	Palliative Care (PAL), MIFs (1-5) and associated data elements are being added to the manual.